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Provision of Primary Health Care for Chronic Disease

Introduction

3.1 Health care for chronic disease in Australia would ideally be a cohesive and coordinated care cycle; however it is often a result of competing priorities or interactions between the patient, their primary care provider (GP or specialist), allied health providers and hospital or emergency care.

3.2 The disconnected nature of many care pathways for chronic disease sufferers is often the result of poor planning, education and awareness, lack of coordination between acute and primary care, or due to the complications that arise from having comorbid or multi-morbid conditions. For example, an elderly patient with diabetes may often have over 100 encounters with the health care system per year, seeing anywhere up to eight or nine different providers.[1]

3.3 The requirement for a patient-centred holistic care model has been a central message received by the Committee during the conduct of this Inquiry, with best practice models, programs and coordinated care frameworks provided as the solution to improving chronic disease management and prevention in Australia. These suggested models and reforms are discussed in more detail in Chapter 4.

3.4 Currently in Australia the overarching system of health care is moving towards an adaptive model of health care and an understanding of that current system is crucial to understanding the elements that can improve.

3.5 The 31 March 2016 announcement of the 'Healthier Medicare' chronic disease management reforms, to introduce trials of Health Care Homes, is a step in the right direction to providing coordinated, multidisciplinary

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1 Professor Libby Roughead, *Submission 41*, p. 2.

care for chronic disease sufferers. However, trials are not scheduled to start until July 2017, so analysing the current primary health care system is relevant to chronic disease prevention and management in the shorter term.

3.6 This Chapter will outline how the current system caters for chronic disease management and will identify some of the pilot programs, reviews and changes that are currently occurring in primary health care.

Responsibilities – Role of Commonwealth and States

3.7 The dichotomy of health care in Australia is related to the Commonwealth's responsibility for primary health care and the state and territory responsibility for acute hospital care. Policy responsibilities for the two are separated, though the funding mechanisms are not as clearly separated.

3.8 According to the Australian Institute of Health and Welfare (AIHW), in 2011-12:

> The second largest component of health spending was for primary health care services ($50.6 billion, or 36.1% of total health expenditure). Primary health care includes a range of front-line health services delivered in the community, such as GP services, dental services, other health practitioner services (for example, physiotherapists, optometrists), and all community and public health initiatives. It also includes the cost of medications not provided through hospital funding.[2]

3.9 Hospital services are the largest component of health care, totalling $53.5 billion, with $42 billion of that expenditure through public hospitals.[3]

3.10 These large components of the health care system, and their associated expenditures, reflect the essential components of the health care system that interact with patients suffering from chronic disease, however the separation of responsibilities between the Commonwealth and state and territory governments for these components of health care is complex.

3.11 Additionally, state and territory governments have some responsibility over the social determinants of health, as outlined by the Royal Australian College of General Practitioners (RACGP):

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2 Australian Institute of Health and Welfare, *Australia's Health 2014*, 2014, Chapter 4.2: 'Chronic disease – Australia's biggest health challenge', p. 49.

3 Australian Institute of Health and Welfare, *Australia's Health 2014*, 2014, Chapter 4.2: 'Chronic disease – Australia's biggest health challenge', p. 48.

> States and territories have a major role in population chronic disease prevention by influencing the social determinants of health (eg food supply and marketing, urban design, public transport, community safety, education). States and territories are motivated to reduce potentially preventable hospital admissions and offer services with the same aim as CDM in general practice – keeping people well and out of hospital.
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> State and territory primary healthcare services provide a safety net for patients who cannot afford to access private allied health or nursing services, or when the patient requires more support from allied health professionals and have exhausted their allowed Medicare rebates.[4]

3.12 These social determinants can impact on a person's overall wellbeing and the policy directions set for primary health care can affect their overall influence on a patient as well.

3.13 The complexities of the interactions patients face was outlined in the Reform of the Federation White Paper *Issues paper 3: Roles and Responsibilities in Health:*

> …there is currently no single overarching 'health system' in Australia. Rather, health care is a complex web of services, providers and structures. All levels of government—the Commonwealth, the States and Territories, and local government—share responsibility for health. They have different roles (funders, policy developers, regulators and service deliverers) and in many cases those roles are shared.
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> The Commonwealth is predominantly responsible for primary care, which includes general practitioners and some medical specialists. Since the successful referendum on social services in 1946, the Commonwealth has become increasingly involved in almost all aspects of health care. The States and Territories are predominantly responsible for public hospitals, ambulances, community and mental health services, and health infrastructure. Both levels of government have a role in community health, mental health, public health programmes, and the health workforce. The not-for-profit and private sectors have significant roles in health care, particularly in service delivery…[5]

3.14 The evolution of Commonwealth involvement in primary health care has been a constant process since after World War I. Prior to that and at the point of Federation, health care was considered to be a local issue and was the responsibility of state governments.

3.15 The landmark introduction of the Pharmaceutical Benefits Scheme (PBS) in 1944 and the successful referendum of 1946 established the social

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4 RACGP, *Submission 135*, p. 13.

5 Commonwealth of Australia, *Reform of the Federation White Paper: Roles and Responsibilities in Health: Issues Paper 3*, December 2014, pp 1-2.

security foundation for Commonwealth provision of primary health care. The creation of Medibank in 1975 and Medicare in 1984 have guided the policy and primary health care system development into the general practitioner-led system that Australia has today.[6] More detail on Medicare and the Medicare Benefits Schedule (MBS) are outlined in Chapter 5.

3.16 This constitutional separation of health care responsibility has led to robust developments in primary health care nationwide, with associated state and territory driven hospital and tertiary care services. However, the coordination required for the multidisciplinary care of chronic disease patients is often complicated or threatened by transition between the two systems.

3.17 While the coordination of care in transition is a challenge to chronic disease care, the cooperation between the sectors is increasing, as commented on by the Centre for Research Excellence:

> I think the discussion around the new approach to federalism and looking at much better cooperation between the state and the Commonwealth has—just over the last six months—really lifted that out of contention. Now we are seeing many hospitals looking at these very complex patients who are not well-served by the episodic visit, and thinking, 'How can we keep these people healthy in the community?' and being true consultants to a chronic disease process, which… lasts for years. The hospital is just a snapshot.[7]

3.18 Additionally, the intent of the Health Care Home reform trials announced to commence in 2017 will presumably allow for closer coordination between state hospitals and multidisciplinary care teams in primary care, to allow for better discharge care coordination.

3.19 Also, the Council of Australian Governments (COAG) Health Council communique of 8 April 2016 reflects a common agreement that the challenges of coordinating care for chronic disease patients can only be addressed across systems and 'that major pressures on the health system can only be fully addressed if governments act collaboratively'.[8]

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6 More detailed information on the history of this development can be found in Chapter 2 of *Reform of the Federation White Paper: Roles and Responsibilities in Health: Issues Paper 3*, December 2014.

7 Professor Claire Jackson, Director, Centre of Research Excellence in Quality and Safety in Integrated Primary-Secondary Care, University of Queensland, *Official Committee Hansard*, Brisbane, 18 February 2016, p. 25.

8 Council of Australian Governments Health Council, 'Communique', 8 April 2016, <http://www.coaghealthcouncil.gov.au/Publications/Communiques/ArtMID/522/ArticleID/92/CHC-Communique-8-April-2016>, viewed 12 April 2016.

Patient Transition – Tertiary to Primary Care

3.20 The nature of the impact of many chronic diseases results in patients receiving acute care in the hospital system, either for their chronic condition directly, or complications related to comorbid or concurrent conditions. After this care is complete, the patient will transition back into the primary care system to allow for their ongoing usual care to proceed.

3.21 The importance of a clear and concise discharge and care plan between a patient's tertiary acute care and their ongoing primary care is paramount, as outlined by Dr Jodi Graham:

> I think it is all about communication, however you communicate with the GPs. At the moment in my hospital in WA we do not have electronic health records. If we had an electronic health record that you could share with the GPs it would be a very easy way to put the discharge summary out there so that they could see it immediately. It is really the immediacy of getting the information to the GPs so that they can take over management… It is a matter of improving that communication and of the hospitals making sure that they actually get good information available to the GPs immediately so that there is no gap for the patients.[9]

3.22 Additionally, Dr Graham highlighted the variable timeliness and quality of discharge summaries and that progressing to a system of timely treatment information is essential:

> It varies between two hours and four weeks, and the quality is highly variable. It depends on who does the discharge summary. In hospitals we have a lot of junior doctors. If the junior doctor does the discharge summary and they do not know what the specialist was thinking, you get a different answer coming out of them. So sometimes I see people walking out with a discharge summary, and I would look at it and go, 'Wow, that looks nothing like what I thought the patient actually had—nothing like it'.
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> …
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> Real-time information is the key to treating people. It really is.[10]

3.23 This requirement for patient treatment information and coordination is especially relevant given the identification of instances where patients were not able to be treated in hospitals or primary care due to privacy concerns around identifying the patient or their care history.

3.24 Dr Peter Dobson identified the issue of privacy restrictions hampering the timely and appropriate care of a patient:

> I can sit in my office with a lady who has had a CT of her brain—she might have had a stroke; she might not have—and I am not

9 Dr Jodi Graham, *Official Committee Hansard*, Perth, 11 March 2016, p. 7.

10 Dr Jodi Graham, *Official Committee Hansard*, Perth, 11 March 2016, p. 7.

> able to get the result out of the local hospital. Of course, the receptionist says, 'No. You have to get a signed declaration from the lady, and send it in to our medical records. We'll have a look at it and we'll send you the result.' This lady is dribbling in the chair next to me. I need the result now. It is ridiculous.[11]

3.25 This aspect of care coordination, provision of care information, or the provision of channels to provide it, and the direct management of a patient's care into a multidisciplinary care setting is one that the Primary Health Networks (PHNs) are ideally established to manage.

3.26 The RACGP stated:

> States and territories need to have the will and ability to work with PHNs to create an integrated system. It is in the interest of all parties to facilitate patient transition from hospitals to primary care when the patient has a long-term condition, but does not require specialist care.[12]

3.27 Lung Foundation Australia also commented on PHN coordination with peak bodies:

> The new Primary Health Networks, as commissioning bodies, should look to engage these peak bodies as partners to deliver evidence-based and nationally consistent training and to provide direct support to patients as they transition from hospital to the community. Ideally, this should be done in partnership with the hospital networks.[13]

3.28 Partnering with hospitals, either by the PHNs or directly by other primary care providers (general practices or community health providers) is essential to managing a patient's ongoing care needs and coordination. The enhanced role of electronic patient records is also a contributing factor to this coordination required.

3.29 The evolving role of the PHNs is discussed below and the models and electronic records that can be used to inform better practice for managing transition and care are discussed in Chapter 4.

Role of Primary Health Networks

3.30 In May 2014, the then Health Minister, the Hon. Peter Dutton MP, announced the establishment of Primary Health Networks (PHNs), centred around general practice, and aligned to state and territory health

11 Dr Peter Dobson, Chair, Central Queensland, Wide Bay, Sunshine Coast Primary Health Network, *Official Committee Hansard*, Brisbane, 18 February 2016, p. 9.

12 RACGP, *Submission 135*, p. 13.

13 Mrs Heather Allan, Chief Executive Officer, Lung Foundation Australia, *Official Committee Hansard*, Brisbane, 18 February 2016, p. 11.

network arrangements to ensure efficiency and effective working relationships.[14]

3.31 The then Health Minister acknowledged primary health care as the sector best positioned to manage chronic disease, and committed PHNs to working with both public and private providers to develop innovative health solutions.[15] PHNs started operating from 1 July 2015, and replaced existing Medicare Locals.

3.32 To date, 31 PHNs have been established and interact with general practitioners via GP-led Clinical Councils in each PHN. Allied health professionals are also be represented in Clinical Councils. Further, Community Advisory Committees will be established to allow members of the community to interact with PHNs.[16]

3.33 As commissioners of health care services (from 1 July 2016), the PHNs are limited in delivering services; however, they can do so if required:

> Where the PHN needs assessments identify that there is a lack of, or inequitable access to medical and healthcare services, PHNs must exhaust all possibilities for local service provision by an external provider prior to seeking the department's approval to directly provide services either as an interim or longer term arrangement. In these instances, the PHN must demonstrate to the department that the region is lacking appropriate services and the PHN has investigated alternative avenues for service delivery.[17]

3.34 Against this background, there was much evidence presented during the inquiry addressing the role of PHNs in chronic disease management and prevention. A number of common themes arose, including the role of each PHN as a commissioner of services, as coordinator of partnerships within their regions, and the various programs developed and piloted by PHNs, often in conjunction with state and territory governments.

3.35 The Brisbane South Primary Health Network commented on the central role of coordination and integration that PHNs are aiming for:

> With the commissioning process there is the opportunity for primary health networks to provide a better coordinating and integrating role and I suppose, through a contract with the service provider, provide more detail about what sorts of services are

14 The Hon. Peter Dutton MP, Minister for Health, Minister for Sport, 'Rebuilding Primary Care', *Media Release*, 13 May 2014.

15 The Hon. Peter Dutton MP, Minister for Health, Minister for Sport, 'Rebuilding Primary Care', *Media Release*, 13 May 2014.

16 Department of Health, *Frequently Asked Questions on the Establishment of Primary Health Networks*, pp. 4- 5, <http://www.wapha.org.au/wp-content/uploads/2016/01/Primary-Health-Networks-FAQ.pdf>, viewed 19 April 2016.

17 Department of Health, *Frequently Asked Questions on the Establishment of Primary Health Networks*, p. 5.

> offered and what level of integration there is with other care providers. So I suppose that commission does provide some opportunities there.[18]

3.36 Similar comments were made by the Murray PHN:

> I think a big change will be the introduction of the commissioning role that Primary Health Networks will play from 1 July 2016, based upon identification of needs and then commissioning health services to specifically ensure that services are available and, in addition, ensure greater coordination and engagement of those services that are available for those specific health needs.[19]

3.37 Primary Health Tasmania reaffirmed this approach,[20] adding that it has an established reputation demonstrated through its role as facilitator which:

> …has been evidenced in work with the mental health services sector in preparation for Partners in Recovery funding and with the health and aged care sector in preparation for Better Access to Palliative Care (THAP) funding. In both instances the PHN role was valued as a neutral leader who, in not competing for funding, could assist the sector to most appropriately plan for and develop collaborative approaches to applications.[21]

3.38 On the commissioning role, Adelaide PHN stated:

> As a commission agency, the Adelaide PHN will ensure existing and new services meet criteria around best practice in chronic disease prevention and management. The assessment processes will look at the services from a number of viewpoints – ensuring they meet population health outcomes, evidence-based indicator guidelines, best practice chronic care, and value for money.[22]

3.39 Adelaide PHN also provides GP support through a variety of methods, and encourages local primary healthcare research in collaboration with research organisations and universities.[23] The Adelaide PHN also aims to foster community engagement and clinical input into governance of the PHN, developing the connections between health providers and the community across the region.[24]

3.40 South Eastern Melbourne PHN (SEMPHN) stated that PHNs are:

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18 Dr Peter Adkins, Brisbane South Primary Health Network, *Official Committee Hansard*, Brisbane, 18 February 2016, p. 5.

19 Mr Matthew Jones, Murray Primary Health Network, *Official Committee Hansard*, Melbourne, 1 October 2015, p. 56.

20 Primary Health Tasmania, *Submission 142*, pp 13-14.

21 Primary Health Tasmania, *Submission 142*, p. 13.

22 Adelaide Primary Health Network, *Submission 119*, p. 32.

23 Adelaide Primary Health Network, *Submission 119*, p. 32.

24 Adelaide Primary Health Network, *Submission 119*, p. 34.

> …ideally placed to bring health leaders together to encourage the partnerships needed for fully integrated out-of-hospital care.[25]

3.41 Ways in which PHNs can fulfil the role of bringing together various service providers were enumerated in SEMPHN's submission.[26]

3.42 This theme was repeated throughout the various submissions received from PHNs.[27] As Murrumbidgee PHN outlined, PHNs:

> …have the ability to be the 'glue' between providers and services to effectively improve coordination of care for the benefit of the consumer, without the goal of organisational commercial gain.[28]

3.43 Country South Australia PHN stated:

> The ideal sought by our Primary Health Network is to create real, local networks of the patient-centred care model with the patient at the centre of care, supported by local general practice with wraparound of wider allied health and other services.[29]

3.44 Health Network Northern Territory (HNNT) highlighted the potential for PHNs to provide health literacy support:

> Primary Health Networks are well positioned to provide coordinated health literacy support and resources for health professionals, clinic managers and reception staff. To ensure sustainability, allocation of funding for culturally appropriate resource development and updating is recommended.[30]

3.45 This view was shared by SEMPHN.[31]

3.46 The HNNT also stated that chronic disease prevention and management networks and forums could 'link academic, research, policy and practice professionals', enabling a coordinated approach.[32]

3.47 Initially, to help inform government on performance and data relevant to PHN areas, the PHNs are required to report on four national performance headline indicators:

- Potentially preventable hospitalisations;
- Childhood immunisation rates;
- Cancer screening rates; and
- Mental health treatment rates.[33]

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25 South Eastern Melbourne PHN, *Submission 123*, p. 6.

26 South Eastern Melbourne PHN, *Submission 123*, p. 7.

27 See e.g. WA Primary Health Alliance, *Submission 180*, pp 6-7; Brisbane North PHN, *Submission 182*, p. 2;

28 Murrumbidgee Primary Health Network, *Submission 168*, p. 1.

29 Mr Kim Hosking, *Proof Committee Hansard*, Adelaide, 4 March 2016, p. 13.

30 Health Network Northern Territory, *Submission 27*, p. 2.

31 South Eastern Melbourne PHN, *Submission 123*, p. 3.

32 Health Network Northern Territory, *Submission 27*, p. 2.

3.48 These indicators and the relevant data that is collected will allow for the initial stage collection of consistent data for these critical chronic disease indicators and their relevant datasets. The role of datasets is discussed in Chapter 4.

Primary Health Network Programs

3.49 The PHNs gave evidence of a number of programs they are involved in supporting or coordinating. Some examples of these are listed below.

3.50 The Western Victoria PHN cited several activities it has been undertaking in the chronic disease area: the Rural Allied Health Project, a pilot model which includes a diabetes education telehealth service, and multidisciplinary face-to-face services; HealthPathways, an online central source of information for GPs and healthcare providers; and encouraging Nurse Led Best Practice, Prevention and Support in Chronic Disease Management.[34]

3.51 WentWest, the PHN covering Western Sydney, has been a project partner in the Western Sydney Integrated Care Demonstrator Project, funded by the NSW Government. WentWest's role has been 'to expand the impact of Patient Centred Medical Home principles'.[35]

3.52 The HNNT identified an opportunity for PHNs to coordinate and support child health, development and well-being programs, 'supporting the prevention of chronic disease from an early age in high risk and disadvantaged populations'.[36]

3.53 The role that PHNs have in the current primary health care system is still evolving, especially in the chronic disease space, however as identified above, many PHNs are already experimenting with alternative models of care for chronic disease patients. The 'Healthier Medicare' reform trials from July 2017 will also potentially expand their coordination and measurement roles into the future.

Role of Other Health Care Providers

Allied Health

3.54 Allied health is an umbrella term generally encompassing all primary health providers excluding doctors and nurses. In general terms, allied

33 Mr Richard Nankervis, Chief Executive Officer, Hunter New England and Central Coast Primary Health Network, *Official Committee Hansard*, Tumbi Umbi, 19 February 2016, p. 17.

34 Western Victoria PHN, *Submission 54*, pp 3-8.

35 WentWest, *Submission 53*, p. 2.

36 Health Network Northern Territory, *Submission 27*, p. 2.

health providers can include, but are not limited to, providers such as: osteopathy, optometry, physiotherapy, pharmacy, podiatry, and occupational therapists. The term can apply in a wider sense to practitioners such as: counsellors, speech therapists, social workers and nutritionists.[37] The Department of Health explains:

> In very broad terms, allied health professionals provide services to enhance and maintain function of their patients (clients) within a range of settings including hospitals, private practice, community health and in-home care.[38]

3.55 Allied health providers play an essential role in chronic disease health care provision. Services for Australian Rural & Remote Allied Health (SARRAH) states that allied health services are 'basic and fundamental to Australians' health care and wellbeing'.[39] Allied Health Professions Australia (AHP Australia) called the role of allied health in prevention, management, and treatment of chronic disease 'essential', adding:

> Best practice guidelines for the management of chronic conditions encompass access to a range of services across the health and social services spectrum. As many allied health disciplines span this continuum, allied health professionals are able to provide seamless care for those needing a range of services.[40]

3.56 According to AHP Australia, there are an estimated 120 000 allied health practitioners in Australia.[41]

3.57 One of the main issues for allied health providers and consumers identified throughout the inquiry is the lack of access to these services. There were two main reasons for this raised in evidence: the challenges of adequate resourcing in remote areas, and the limited cover of Medicare for allied services.

3.58 Regarding the challenge of the allied health workforce in rural areas, SARRAH identified three areas which require action:

> Comprehensive data on the allied health workforce that can be used to map supply and demand for allied health services…
>
> Support and incentives for AHPs to relocate or remain in rural and remote settings…

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37 Department of Health, 'Allied Health Workforce', <http://www.health.gov.au/internet/publications/publishing.nsf/Content/work-review-australian-government-health-workforce-programs-toc~chapter-8-developing-dental-allied-health-workforce~chapter-8-allied-health-workforce>, viewed 28 April 2016.

38 Department of Health, 'Allied Health Workforce', <http://www.health.gov.au/internet/publications/publishing.nsf/Content/work-review-australian-government-health-workforce-programs-toc~chapter-8-developing-dental-allied-health-workforce~chapter-8-allied-health-workforce>, viewed 28 April 2016.

39 Services for Australian Rural & Remote Allied Health, *Submission 115*, p. 2.

40 Allied Health Professions Australia, *Submission 77*, p. 2.

41 Allied Health Professions Australia, *Submission 77*, p. 1.

> Funding models for health services that enable AHPs to establish financially viable practices…[42]

3.59 This issue was raised by Primary Health Networks as well. For example, Western Victoria PHN said that:

> Workforce issues and the greater need for health services have meant that the current allied health service delivery models in rural communities have become difficult to maintain and therefore further investigation into alternative ways in which health services can be delivered in rural areas is required.[43]

3.60 Allied health provision in rural areas is a challenge to providing multidisciplinary care, however the challenge of maintaining an adequate GP workforce, as well as allied health professionals to support the population is an issue that is addressed further in Chapter 4.

3.61 A number of submissions contended that, as it currently stands, the allied health MBS item numbers provide up to five treatment sessions for allied professions, and that this may not be sufficient for people with ongoing chronic conditions.[44]

3.62 The current restriction of session numbers may not adequately allow for the treatment of the person's condition adequately, while also restricting a lot of treatments from certain allied health providers (such as social workers or genetic counsellors), as well as excluding care providers such as nurse practitioners.[45]

3.63 It was contended by a number of witnesses and submissions that the current funding model does not allow for efficient coordination of health services, and results in 'professional silos'.[46] AHP Australia stated:

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42 Services for Australian Rural & Remote Allied Health, *Submission 115*, p. 3.

43 Western Victoria PHN, *Submission 54*, p. 3.

44 Australian Pain Society, *Submission 35*, pp 6-7; Victorian Healthcare Association, *Submission 78*, p. 6; cohealth, *Submission 88*, pp 25-27; Emma Bird, *Submission 103*, p. 2; Australian Diabetes Educators Association, *Submission 109*, p. 8; Services for Australian Rural & Remote Allied Health, *Submission 115*, pp 7-9; Speech Pathology Australia, *Submission 118*, p. 2; Occupational Therapy Australia, *Submission 137*, pp 5-6; Australian Physiotherapy Association, *Submission 145*, p. 2; the George Institute for Global Health, *Submission 169*, pp 4-5.

45 Victorian Healthcare Association, *Submission 78*, p. 6.

46 Australian Association of Social Workers, *Submission 46*, p. 2; Allied Health Professions Australia, *Submission 77*, p. 3; Diabetes Australia, *Submission 102*, pp 6-7; Australian Podiatry Council, *Submission 125*, p. 1; Dr Thomas Wenkart, *Submission 146*, pp 1-2; Mr Jason Trethowan, Chief Executive Officer, Western Victoria Primary Health Network, *Official Committee Hansard*, Melbourne, 1 October 2015, p. 57; Professor Sophie Zoungas, President Elect, Australian Diabetes Society, *Official Committee Hansard*, Sydney, 23 October 2015, p. 19; Mr David Quilty, Executive Director, Pharmacy Guild of Australia, *Official Committee Hansard*, Canberra, 23 February 2016, p. 2; Associate Professor Alistair Vickery, Associate Professor, Primary Health Care, School of Primary Aboriginal and Rural Health, University of Western Australia, *Official Committee Hansard*, Perth, 11 March 2016, p. 22;

> The current model of funding, rather than promoting service integration and supporting team-based care, has created "professional silos", which results in medical and allied health professionals working independently of each other, leading to poor overall services and outcomes.[47]

3.64 One other problem identified is the 'circular referral process'. In order to access the MBS rebate, a patient has to consult a GP for a referral to an allied health provider. In addition, a patient must consult the GP again for a referral to a specialist, as a referral from the allied health provider does not attract a rebate.[48] Allowing access to MBS rebates for direct referrals from allied health professionals to specialists was raised as an important way to increase efficiency and remove a significant financial and time burden from the patient.[49]

Nursing

3.65 A number of organisations and individuals submitted that nurses have an integral role in primary health care. Their broad skills can transcend disciplines and cover a wide range of conditions, and they are well placed to coordinate multidisciplinary care.

3.66 For example, Sydney Nursing School highlighted the role of community health nurses (CHNs), their advanced skills and extended scope of practice, and their capacity to work 'across disciplinary boundaries in consultation with other health professionals'.[50]

3.67 Sydney Nursing School also stated the role of practice nurses:

> Nurses working in general practice are now recognised as integral members of the PHC [primary healthcare] multidisciplinary team. This is associated with increasing evidence about the effectiveness of their involvement in chronic illness prevention and management of population groups with high behavioural health risk. Also related to the increasing importance of practice nurses is the role they continue to play in maintaining the capacity of PHC services, both in metropolitan and in rural areas.[51]

3.68 The Australian Nursing and Midwifery Federation (ANMF) added that general practice nurses work in collaboration with GPs and provide a

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47 Allied Health Professions Australia, *Submission 77*, p. 3.

48 Queensland Government, *Submission 167*, pp 9-10.

49 Exercise and Sports Science Australia, *Submission 24*, p. 2; Australian Dental Association, *Submission 55*, p. 5; Allied Health Professions Australia, *Submission 77*, p. 4; Australian Medical Association, *Submission 107*, p. 7; Australian Diabetes Educators Association, *Submission 109*, p. 11; Services for Australian Rural & Remote Allied Health, *Submission 115*, p. 8; Australian Physiotherapy Association, *Submission 145*, p. 10; Queensland Government, *Submission 167*, p. 10.

50 Sydney Nursing School, *Submission 91*, p. 4.

51 Sydney Nursing School, *Submission 91*, p. 5.

range of services including chronic disease management.[52] The ANMF highlighted several other areas in which nurses have a leading role, with occupational health nurses, school nurses, maternal and child health nurses, rural nurses, remote area nurses, and mental health nurses all playing a crucial part of primary health care in those areas.[53]

3.69 The joint submission by ACN, CATSINaM, APNA, MCaFHNA, and ACMHN commented on some of the other roles nurses can fulfil:

> Other significant roles involve nurses working in the aged care, cancer, mental health, and Aboriginal and Torres Strait health areas where chronic disease rates are highest, or in maternal, child and family health nursing where the opportunity for primary prevention is greatest. Moreover, nurses in general practice and other primary health care settings work across the full spectrum of chronic disease areas playing pivotal roles in the creation of a 'no wrong door' system that works to treat people efficiently and seamlessly.[54]

Role of Private Health Insurers

3.70 Private health insurers (PHIs) have an essential role in Australia's health system. While Australia has a strong public health care system, about half of all Australians are insured with a private insurer.[55] Hirmaa, a peak body representing 19 community-based not-for-profit private health insurers,[56] states that private health insurers have a commercial relationship with over 55 per cent of the population.[57]

3.71 Defining factors in the role that PHIs have in chronic disease management in Australia are the impact of community rating and risk equalisation:

- Community rating – PHIs are not permitted to exclude anyone from joining or alter the price of cover based on pre-existing conditions, health status or risk factors such as age, gender or race; and
- Risk equalisation – introduced in 1976, risk equalisation allows PHIs to share the risk of higher cost members in the premiums of younger and

52 Australian Nursing and Midwifery Federation, *Submission 110*, pp 28-29.

53 Australian Nursing and Midwifery Federation, *Submission 110*, pp 23-33.

54 ACN, CATSINaM, APNA, MCaFHNA, and ACMHN, *Submission 106*, pp 13-14.

55 Mr Robert Bransby, *Official Committee Hansard*, Perth, 11 March 2016, p. 13.

56 Hirmaa, 'What is hirmaa?', <http://www.hirmaa.com.au/what-we-are/>, viewed 22 March 2016.

57 Hirmaa, *Submission 25*, p. 3.

healthier members. This risk pool of premiums is then shared across members, even between different PHIs.[58]

3.72 These factors help support the universal health care system within Australia and equitable access to health insurance, but the risk equalisation burden would appear to be potentially untenable into the future, as the proportion of older or complex chronic disease patients increases. NIB highlighted that currently at the age of 55, 20 per cent of hospital claims enter the risk equalisation pool, with approximately 80 per cent at the age of 85.[59]

3.73 PHIs also have an important role in chronic disease prevention and management. As well as paying billions of dollars in healthcare costs for members with chronic conditions, PHIs are also heavily invested in developing programs for management and prevention of chronic disease, often in partnership with state governments.

3.74 There are strong financial incentives for PHIs to invest in these programs. According to Private Healthcare Australia (PHA), PHIs paid a total of $7.4 billion during 2013-14 for hospital services treating patients with at least one chronic disease.[60] The Australian Health Service Alliance (AHSA), which represents 23 'small to medium-sized' PHIs,[61] states that its member funds estimate that 'outlays almost doubled for chronic disease related claims' over the last decade.[62]

3.75 Medibank Private stated in its submission that, as a funder of 'predominantly hospital based care' it is 'exposed to the cost of hospital admissions resulting from chronic disease', and thus motivated to invest in effective clinical care.[63]

3.76 As two examples of high cost ongoing chronic conditions, Medibank Private stated that congestive heart failure and chronic obstructive pulmonary disease cost over $8 000 per year per patient on average, and type II diabetes and coronary artery disease average over $4 000 per year per patient. Given these high costs, the affordability of private health insurance depends largely on improving prevention and management of

58 Commonwealth of Australia, Department of Health, *Better Outcomes for People with Chronic and Complex Health Conditions: Report of the Primary Health Care Advisory Group*, December 2015, pp 30-31.

59 Dr Justin Vaughan, Group Executive, Benefits and Provider Relations, NIB Health Funds, *Proof Committee Hansard*, Newcastle, 31 March 2016, p. 40.

60 Private Healthcare Australia, *Submission 108*, p. 2.

61 Australian Health Service Alliance, *Submission 26*, p. 1.

62 Australian Health Service Alliance, *Submission 26*, p. 5.

63 Medibank Private, *Submission 43*, p. 4.

chronic disease. [64] This principle was reinforced by Geelong-based PHI GMHBA.[65]

3.77 Australian Unity, a 'national healthcare, financial services and retirement living organisation',[66] stated that 'effective chronic disease prevention and management is a critical component [of] a PHI provider's business model'.

3.78 Bupa also advocated for a core role for PHIs in the chronic disease healthcare space:

> The ability of health insurers to be more than just passive players will be essential to foster innovation and quality improvements in the chronic disease prevention and management space… As such, no matter what form the next iteration of Australia's chronic disease prevention and management approach takes, health insurers must be included and their expertise leveraged.[67]

3.79 The contribution of PHIs to chronic disease prevention and management is generally acknowledged through the sector, including by government departments. In most states, PHIs have an important role and often partner with state governments.

3.80 For example, the Commonwealth Department of Health identified the role Chronic Disease Management Plans (CDMPs) have in increasing allocative efficiency, stating:

> Private health insurance helps with the cost of a range of non-Medicare funded services, such as dentistry, allied health and private hospital treatment and assists patients in avoiding long waiting lists in the public system.[68]

3.81 The Department of Health and Human Services in Victoria (DHHS) commented that the limits applied to reimbursements for primary health services mean that PHI models 'may not adequately cover the cost of care', resulting in extra costs for patients or the decision to access publically funded care.[69] The DHHS stated:

> Governance of a larger role for private insurers could be supported by strengthening the performance monitoring role of the Primary Health Networks, across all service providers in the primary care sector (including private insurers).[70]

3.82 The DHHS highlighted the CarePoint integrated care trial, a joint initiative between the Department and Medibank Private.[71] NSW Health also

64 Medibank Private, *Submission 43*, pp 8-9.

65 GMHBA, *Submission 157*, p. 6.

66 Australian Unity, *Submission 75*, p. 2.

67 Bupa, *Submission 144*, p. 7.

68 Department of Health, *Submission 143*, p. 11.

69 Department of Health and Human Services Victoria, *Submission 173*, p. 13.

70 Department of Health and Human Services Victoria, *Submission 173*, p. 13.

71 Department of Health and Human Services Victoria, *Submission 173*, p. 13.

identified the innovative role in chronic disease prevention and management PHIs have and their partnerships with government, such as through the CarePoint trial program.[72]

3.83 The CarePoint program is discussed further below.

3.84 NSW Health identified the 'major role' PHIs have in the health system, commenting:

> By collaborating with the public sector on service integration, chronic disease prevention and management programs, and sharing information to avoid service duplication (e.g. test results), the private sector can play a significant role in helping to improve efficiencies and health outcomes.[73]

3.85 Many of the Primary Health Networks also commented on the role of PHIs. For instance, South Eastern Melbourne PHN stated that PHIs 'shared the same sustainability concerns as the public sector', highlighting the 'disproportionately high cost of long hospital stays'.[74] Brisbane North PHN similarly identified the 'alignment between the motives of private health insurers and PHNs when it comes to chronic disease management and prevention'.[75] The Brisbane South and Darling Downs and West Moreton PHNs also highlighted the current collaboration and the potential for more collaboration with PHIs.[76]

3.86 Several PHNs also discussed the joint collaborations between governments and private insurers, discussed above.[77]

3.87 Several other organisations commented on the role of private health insurers in chronic disease prevention and management. For example, the joint submission from the nursing organisations ACMHN, MCaFHNA, APNA, CATSINaM, and ACN made note of PHI activity in prevention and health promotion, and suggested that PHIs should be encouraged to ensure smooth transitions from hospital to community settings and to ensure appropriate follow-up care.[78]

3.88 The submission added that PHIs should be obligated to coordinate with other sections of the health system. This could be done by providing 'de-identified population health data from their members for input into PHN comprehensive needs assessments', providing evaluation results from

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72 NSW Health, *Submission 152*, p. 15.

73 NSW Health, *Submission 152*, p. 14.

74 South Eastern Melbourne PHN, *Submission 123*, p. 8.

75 Brisbane North PHN, *Submission 182*, p. 2.

76 Dr Peter Adkins, Senior Clinical Adviser, Brisbane South Primary Health Network, *Official Committee Hansard*, Brisbane, 18 February 2016, p. 7; Dr Roland Owen, Director, Darling Downs and West Moreton Primary Health Network, *Official Committee Hansard*, Brisbane, 18 February 2016, p. 7.

77 See e.g. South Eastern Melbourne PHN, *Submission 123*, p. 8; WAPHA, *Submission 180*, p. 3.

78 ACN, CATSINaM, APNA, MCaFHNA, and ACMHN, *Submission 106*, p. 34.

their interventions, and communicating generally with other elements of the system such as general practices to avoid duplication, inefficiency, and waste.[79]

3.89 The potential role of PHI data is discussed further in Chapter 4.

3.90 Some organisations were wary of PHI involvement. While most government departments viewed the role of PHIs positively, the Northern Territory Department of Health stated that there is 'limited role for private providers in chronic disease prevention and management' due to the greater burden of chronic disease in remote areas with low PHI coverage.[80]

3.91 While also noting the 'very strong' role PHIs have in 'working with the rest of the system in a coordinated way', WestWent Limited, the Western Sydney PHN, was concerned that chronic disease management be well coordinated and not 'siloed', commenting:

> It is a very important part of that analysis to make sure that integrated care is integrated care for everybody, not just for people with private health insurance. I think we are very conscious of that in Western Sydney.[81]

3.92 The Australian Medical Association (AMA) identified the range of programs PHIs have introduced but commented that PHIs 'generally work in isolation to the usual GP who understands their patient's care needs', calling this a 'significant problem [that] fragments patient care'.[82] The AMA was also wary of the PHIs' 'more interventionist approach' to funding.[83]

3.93 Similarly, the Royal Australian College of General Practitioners (RACGP) was concerned with PHI involvement in general practice, stating as their main concern the 'likelihood of private health insurers prioritising profit and cost savings over continuity of care'.[84]

3.94 The RACGP offered three principles for PHI involvement in general practice: preventing the duplication and fragmentation of care; limiting the impact on clinical judgement; and ensuring access based on need rather than on insurance status.[85]

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79 ACN, CATSINaM, APNA, MCaFHNA, and ACMHN, *Submission 106*, p. 34.

80 Northern Territory Department of Health, *Submission 133*, p. 1.

81 Adjunt Associate Professor Walter Kmet, Chief Executive Officer, WentWest Limited (Western Sydney Primary Health Network), *Official Committee Hansard*, Sydney, 23 October 2015, pp 52-53.

82 Australian Medical Association, *Submission 107*, p. 9.

83 Australian Medical Association, *Submission 107*, p. 9.

84 Royal Australian College of General Practitioners, *Submission 135*, p. 11.

85 Royal Australian College of General Practitioners, *Submission 135*, pp 11-12.

3.95 However, Mr Rob Bransby, Managing Director of HBF, highlighted that often due to the disconnect between PHIs and GPs, services may often be duplicated, when PHIs provide chronic disease plans:

> So there is a very high likelihood that we are providing a chronic disease management service to our membership at our cost, and it is very likely that they are on a GP's own program, which is just a massive piece of duplication. The very fact that we do not talk to each other and integrate it is a massive concern. All that is doing is putting a greater impost back onto the community, in terms of health premiums, and/or on the health system in general.[86]

3.96 The Australian Health Promotion Association (AHPA) acknowledged the role PHIs have in supporting their members but was wary of 'the risk of developing a two-tiered health system'.[87] Such concerns were shared by the Public Health Association of Australia[88] and the Aboriginal Medical Services Alliance NT (AMSANT). AMSANT said PHI involvement in primary health care would be 'inflationary' and 'produce a two tier PHC system'. The AMSANT also questioned whether PHIs improve outcomes in primary health care.[89]

3.97 The WA Primary Health Alliance, while also noting the CarePoint trial, cautioned that any increased role for PHIs must not result in 'barriers to access', increased costs for non-insured consumers, or a 'negative impact on clinical independence or a shift towards managed care models'.[90] Managed care models are where clinicians 'ration care to reduce costs' rather than adopting 'a holistic, patient-centred approach'.[91]

3.98 Similar comments were made by the Health Care Consumers' Association of the ACT[92] and by Vision 2020 Australia, who said those with private health insurance benefit from a 'two-tier health system' and enjoy 'privileged and disproportionate access' to tailored disease management and prevention programs.[93]

3.99 Other submissions similarly stated the importance of maintaining a strong universal health care system, and that private health insurance should not threaten this principle.[94]

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86 Mr Rob Bransby, Managing Director, HBF Health Ltd, *Official Committee Hansard*, Perth, 11 March 2016, p. 10.

87 Australian Health Promotion Association, *Submission 49*, p. 7.

88 Public Health Association of Australia, *Submission 111*, p. 7.

89 Aboriginal Medical Services Alliance NT, *Submission 153*, p. 5.

90 WA Primary Health Alliance, *Submission 180*, p. 7.

91 Royal Australian College of General Practitioners, *Submission 135*, p. 11.

92 Health Care Consumers' Association of the ACT Inc, *Submission 116*, p. 7.

93 Vision 2020 Australia, *Submission 89*, p. 13.

94 Rural Doctors Association of Australia, *Submission 17*, p. 9; Primary Care Collaborative Cancer Clinical Trials Group, Clinical Oncology Society of Australia, and Cancer Council Australia,

3.100 Some submissions and witnesses raised international examples of the integrated roles PHIs can have in a country's health system. One such example is the hybrid model introduced in the Netherlands.

Case Study – Private Health Insurance in the Netherlands

In the Netherlands, the health care system is provided in partnership with private health insurers (PHIs).

Since 2006, under the Dutch Health Insurance Act, all residents of the Netherlands have been required to purchase basic statutory health insurance, via their employer, at a contribution rate of 7.75 per cent of up to €50 853 of annual taxable income (as at 2013).[95]

There are four types of statutory insurance:

- *Zorgverzekeringswet* (Zvw), often called 'basic insurance', covers common medical care.
- *Wet langdurige zorg* (Wlz) covers long-term nursing and care.
- *Wet maatschappelijke ondersteuning* (Wmo) covers every day support services provided by the municipality.
- *Jeugdwet* covers short and long-term medical care for youth.

The basic insurance is what is mentioned above, whereas the Dutch government automatically cover residents for long-term nursing care.[96]

The basic insurance generally covers:

- GP consultations;
- Treatments from specialists and hospital care;
- Certain mental health care;
- Medication;
- Dental care up to 18 years;
- Care from certain therapists, such as speech therapists;
- Dieticians; and
- Maternity care.[97]

Submission 63, p. 9; Aboriginal Medical Services Alliance NT, *Submission 153*, Attachment A, p. 13; Consumers Health Forum of Australia, *Submission 159*, p. 9.

95 Bonney A, Iverson D and Dijkmans-Hadley B, *A Review of models for financing primary care systems in the Netherlands, Ontario-Canada, United Kingdom and USA: A report for Peoplecare*, University of Wollongong, 2015, p. 9.

96 Expatica, 'Healthcare in the Netherlands', <http://www.expatica.com/nl/healthcare/Healthcare-in-the-Netherlands_100057.html>, viewed 14 April 2016.

97 Expatica, 'Healthcare in the Netherlands', <http://www.expatica.com/nl/healthcare/Healthcare-in-the-Netherlands_100057.html>, viewed 14 April 2016.

The services covered above are more expansive than that provided under the Medicare system in Australia, however the percentage of income contribution is a lot higher than the current 2 per cent Medicare levy. Low-income earners in the Netherlands still need to purchase insurance, however they can apply for a 'care allowance, to help with the cost of premiums if they earn under a certain amount.[98]
Much like Australia, the premiums are community-rated, so each member with each insurer pays the same premium regardless of age, gender, nationality and health status.[99]

3.101 The TROG cited the Dutch care model of hospitals funded by insurers rather than the government, calling it a 'public-private partnership by definition'. Hospitals are funded 'on the basis of delivering the best quality care', as well as for research and innovation.[100]

3.102 The Graduate School of Medicine, University of Wollongong (UoW) also cited the Dutch 'bundled payment scheme', with PHIs involved in primary care funding. At the public hearing in Bomaderry, Professor Bonney described the Netherlands' system of universal health care via private health insurers.[101] The UoW stated that 'exploration of private insurer involvement in a similar capacity is warranted'.[102]

3.103 The role of alternate funding schemes and relevant international examples are covered in Chapter 5.

Regulation of Private Health Insurers in Chronic Disease Management

3.104 The role of PHIs in chronic disease prevention and management was expanded in 2007 with the Broader Health Cover (BHC) initiative. The initiative was designed to encourage insurers to cover 'clinically appropriate alternatives to hospital treatment',[103] and include Chronic Disease Management Programs (CDMPs) employing dieticians,

98 Expatica, 'Healthcare in the Netherlands', <http://www.expatica.com/nl/healthcare/Healthcare-in-the-Netherlands_100057.html>, viewed 14 April 2016.

99 Bonney A, Iverson D and Dijkmans-Hadley B, *A Review of models for financing primary care systems in the Netherlands, Ontario-Canada, United Kingdom and USA: A report for Peoplecare*, University of Wollongong, 2015, p. 9.

100 Dr Fiona Hegi-Johnson, Member, Trans Tasman Radiation Oncology Group Cancer Research, *Proof Committee Hansard*, Newcastle, 31 March 2016, pp 34-35. See also TROG Cancer Research, *Submission 190*, p. 10.

101 Professor Andrew Bonney, Roberta Williams Chair of General Practice, Graduate School of Medicine, University of Wollongong, *Official Committee Hansard*, Bomaderry, p. 6.

102 Graduate School of Medicine, University of Wollongong, *Submission 16*, p. 3.

103 Medibank Private, *Submission 43*, p. 6.

physiotherapists, exercise physiologists and other practitioners.[104] According to hirmaa, there has been significant growth in BHC services in that time, with 10 000 services and about $2 million in benefits paid in 2007 rising to more than 450 000 services and $47 million in benefits paid across the PHI sector in 2014.[105]

3.105 Medibank Private submits that the vision of this BHC initiative has been 'stymied' in subsequent years, in particular by Rule 12 of the *Private Health Insurance (Health Insurance Business) Rules 2015*.[106] Despite the policy goal underpinning the rule being 'sound', Medibank Private states that it is 'one of the reasons the vision [of the BHC] has never been fully realised.[107] Many of the PHIs shared similar concerns about this Rule.

3.106 Among other things, Rule 12, which is titled 'Chronic disease management programs', requires management programs to involve one of a list of 14 allied health service modalities.[108] Private Healthcare Australia calls this list 'too restrictive', stating:

> The rule states that the treatment must involve one of a list of provider modalities all within the allied health practitioner field. This list is too restrictive and should be removed to allow health funds to pay for the most appropriate care for any given chronic disease or illness. These may or may not involve allied health professionals, medical doctors etc. Positioning health insurers to access funding of primary health care is critical to the management of chronic diseases.[109]

3.107 Medibank Private similarly calls the rule 'unnecessarily restrictive', commenting that the rule prevents insurers from doing all they can to address chronic disease.[110]

3.108 Medibank Private contends that the rule contains three 'key impediments': one, that the program must involve an allied health service; two, that the allied health practitioner must be eligible to claim a Medicare rebate for the service provided; and three, that although insurers can provide programs which are not compliant with Rule 12 to members, they are not subject to risk equalisation processes, meaning that insurers are less willing to invest in such programs.[111]

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104 Hirmaa, *Submission 25*, p. 2.

105 Hirmaa, *Submission 25*, p. 2.

106 Medibank Private, *Submission 43*, pp 5-6.

107 Medibank Private, *Submission 43*, pp 5-6.

108 Rule 12, *Private Health Insurance (Health Insurance Business) Rules 2015* (Cth),

109 Private Healthcare Australia, *Submission 108*, p. 3.

110 Medibank Private, *Submission 43*, p. 6.

111 Medibank Private, *Submission 43*, p. 6.

3.109 Medibank Private adds that relaxing Rule 12 would 'enable further innovation in chronic disease management program delivery',[112] adding that doing so would not result in additional costs for the Commonwealth but would benefit all health system funders, including the Commonwealth.[113]

3.110 Similar comments were made by Bupa,[114] Hirmaa,[115] and Australian Unity.[116]

3.111 Bupa agreed that Rule 12 should be relaxed. In its submission, Bupa stated that the rule is:

> …drafted in a manner which unfortunately prevents health insurers from doing all they can to assist their members in preventing and managing chronic conditions. It is also our experience that Rule 12 does not promote best practice evidence, which supports a wider variety of providers in the provision of chronic condition prevention and management than mandated by Rule 12.[117]

3.112 Bupa supported a review of the regulations, specifically the removal of the requirement of an allied health service from a prescriptive list be included on a chronic disease management program.

3.113 Some comments on the regulations came from allied health and other peak bodies. The Australian Orthotic Prosthetic Association commented on the restrictive effects of 'red tape',[118] stating:

> The exclusion of orthotics and prosthetics as a listed health service in the *Health Insurance Regulations 1975* determination restricts access to orthotists under Medicare and clinical rebates for orthotist services within the private health insurance system.[119]

3.114 While PHIs broadly agreed that the regulations were too restrictive, other submitters warned against relaxing the regulations too quickly. For example, the Queensland Government stated that tight regulations were due to Australia's commitment to universal health care and stated that 'consideration of any changes would need to be carefully explored to avoid unintended consequences'.[120]

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112 Medibank Private, *Submission 43*, p. 7.

113 Medibank Private, *Submission 43*, p. 7.

114 Dr Robert Grenfell, Bupa, *Official Committee Hansard*, Melbourne, 1 October 2015, p. 62. See also Bupa, *Submission 144*, p. 8.

115 Hirmaa, *Submission 25*, p. 3.

116 Australian Unity, *Submission 75*, p. 7.

117 Bupa, *Submission 144*, p. 8.

118 Australian Orthotic and Prosthetic Association, *Submission 140*, p. 5.

119 Australian Orthotic and Prosthetic Association, *Submission 140*, p. 1.

120 Queensland Government, *Submission 167*, p. 16.

3.115 The RACGP said in its submission it does not support amending the *Private Health Insurance Act 2007* to allow PHIs to fund services currently funded by Medicare.[121]

Pilot Programs

3.116 Partly as a response to the rising costs of chronic disease, PHIs are heavily invested in developing chronic disease management programs (CDMPs). Insurers have developed a number of these programs, and are frequently involved in piloting programs in conjunction with state and territory Governments.

3.117 After launching a number of 'small scale pilot projects' in 2005 in conjunction with suppliers of CDMPs, HCF began to implement larger initiatives in 2007.[122] My Health Guardian was launched in 2009 as 'a long-term strategy to improve the health and well-being of members with chronic health conditions'.[123] The program is delivered by registered nurses, promoting healthy behaviours and adherence with medications and GP action plans, and encouraging active engagement by members in their own health.[124]

3.118 Managing Director of HCF, Dr Shaun Larkin, stated that My Health Guardian is a $100 million investment and has provided phone-based support to about 40 000 members suffering from chronic conditions. Dr Larkin added that the program has been effective:

> Peer reviewed studies of My Health Guardian published in 2013 in *Population Health Management* and earlier this year in *Health Services Research* found that the program significantly reduced the rate of hospital admissions for participants with cardiovascular disease and diabetes, which together, as the committee would know, make up the bulk of chronic illness in Australia today.[125]

3.119 In its submission, Bupa outlines several CDMPs it has developed.[126] These include the COACH Program for members who have experienced cardiac or stroke-related illness; Genesis Heart Care; the Integrated Osteoarthritis Management Program; Young At Heart; GP Clinic; and Bupa Model of Care, which aims to provide an improved level of care and access to services with a multidisciplinary and person-centred approach.[127] Considered to be 'front and centre' of these programs is the Bupa Medical

121 Royal Australian College of General Practitioners, *Submission 135*, p. 11.

122 HCF, *Submission 122*, p. 5.

123 HCF, *Submission 122*, p. 7.

124 HCF, *Submission 122*, p. 7.

125 Dr Shaun Larkin, *Official Committee Hansard*, Sydney, 23 October 2015, p. 22.

126 Bupa, *Submission 144*, Appendix C.

127 Bupa, *Submission 144*, Appendix C.

TeleHealth business, a telephonic coaching program provided to Bupa members identified through its hospital claims database.[128]

3.120 At the time of its submission, Geelong-based insurer GMHBA was conducting a Health and Wellbeing Pilot involving ten GP practices in the region. Members of GMHBA with chronic disease are identified who have a GP management plan and require more than five subsidised allied health visits. According to GMHBA, the Pilot program has been successful and has begun to foster 'some sound relationships with health providers that traditionally would not have a relationship purely due to funding arrangements'.[129]

3.121 In Western Australia, HBF acquired a chain of pharmacies to provide services in an 'out of hospital' setting:

> Things we provide are flu vaccinations—which are incredibly important for the elderly—health checks; healthy weight programs; hearing checks; and diabetes programs, funded by the fund.[130]

3.122 Medibank Private runs a suite of programs called the 'Care Suite',[131] which includes CareFirst, CarePoint, and CareTransition. CareFirst is a 16-week program with a specifically designed care plan for members. CarePoint is 'an integrated care model which focusses on intensive support and behavioural improvement'. CareTransition focusses on members with complex needs, such as older members with comorbidities. This suite of programs is being funded in partnership with the two state Health Departments (Victoria and Western Australia) and Perth-based private insurer HBF.[132]

3.123 The CarePoint trial was discussed in some detail at the public hearing in Melbourne by representatives of the Victorian DHHS.[133] The trial program is designed 'to keep people out of hospital'. People involved in the trail have had 'multiple admissions to hospital – a total of four in the previous two years – with a significant chronic illness'. The role of GPs in the program was emphasised. The patients are identified through general

128 Ms Natalie Dubrowin, Bupa, *Official Committee Hansard*, Melbourne, 1 October 2015, p. 63.

129 GMHBA, *Submission 157*, pp 7-8.

130 Mr Robert Bransby, Managing Director, HBF Health Ltd, *Official Committee Hansard*, Perth, 11 March 2016, p. 9.

131 Mr James Connors, Medibank Private, *Official Committee Hansard*, Melbourne, 1 October 2015, p. 61.

132 These programs are outlined in Medibank Private, *Submission 43*, pp 8-10.

133 Professor Robert Thomas, Chief Advisor Cancer, Principal Investigation CarePoint, and Ms Josephine Beer, Relationship Manager, CarePoint Trial, Department of Health and Human Services, Victoria, *Official Committee Hansard*, Melbourne, 1 October 2015, pp 1-5.

practice, and a 'program of support' developed for each patient, constructed with the patient's GP.[134]

3.124 Also appearing at the public hearing in Melbourne were representatives of Medibank Private. Mr James Connors identified other Care Suite programs including the GP-led chronic disease management program CareFirst, which encourages 'self-treatment and behaviour modification that is supported by health coaching, health system navigation and online education segments', and the CareTransition program, a collaboration between Medibank Private and hospitals to enhance the discharge process for people with a higher risk of readmission.[135]

3.125 In Western Australia, the CarePoint trial is a collaboration between Medibank Private and the Western Australian Government, with the University of Western Australian to review the trial.[136]

3.126 It was stated at both hearings that there are, as yet, no evaluation reports.[137] The Western Australia Primary Health Alliance identified that the first evaluation report in Western Australia is due in May of 2016.[138]

3.127 Increasingly, PHIs are offering programs promoting healthy lifestyles as a preventative strategy against chronic disease. This will be discussed further in Chapter 4.

Care Coordination

3.128 Bringing together the contributions that all of the above health care providers can bring to a patient's care ideally leads to a coordinated care plan and provision for chronic disease patients.

3.129 The AMA listed five key points for effective care coordination:

- Care that is led by the patient's usual GP and based on clinical need.
- Actively involving the patient in goal setting and decision-making.

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134 Professor Robert Thomas, Chief Advisor Cancer, Principal Investigation CarePoint, Department of Health and Human Services, Victoria, *Official Committee Hansard*, Melbourne, 1 October 2015, p. 1.

135 Mr James Connors, Head of Government and Regulatory Affairs, Medibank Private, *Official Committee Hansard*, Melbourne, 1 October 2015, p. 61.

136 Mr Robert Bransby, Managing Director, HBF Health Ltd, *Official Committee Hansard*, Perth, 11 March 2016, p. 9.

137 Ms Lucinda Bilney, Senior Strategy Manager, Medibank Private, *Official Committee Hansard,* Melbourne, 1 October 2015, p. 63; Professor Learne Durrington, Chief Executive Officer, Western Australia Primary Health Alliance, *Official Committee Hansard*, Perth, 11 March 2016, p. 16.

138 Professor Learne Durrington, Chief Executive Officer, Western Australia Primary Health Alliance, *Official Committee Hansard*, Perth, 11 March 2016, p. 16.

- Enabling patients to better understand and manage their condition.
- Funding that follows the patient, i.e. through the existing Medicare Benefits System (MBS), and supports the provision by GPs of initial and ongoing care.
- Funding that supports the coordination and transition of patient care between health care providers and across health care and community sectors.[139]

3.130 Opinion on the GP-led nature of care coordination was divided.

3.131 As discussed above, many organisations and individuals view the role of nurses as central to effective management of chronic conditions, including the potential for nurse-led care coordination for chronic disease management. For example, the joint submission by ACN, CATSINaM, APNA, MCaFHNA, and ACMHN stated:

> …nurses act as care coordinators for people with chronic heart failure, diabetes and chronic obstructive pulmonary disease (COPD), applying prevention and management strategies that work to keep people well and out of hospital.[140]

3.132 This view is shared by the Sydney Nursing School.[141]

3.133 The Adelaide Primary Health Network supported nurse-led care management:

> Studies have shown that nurse-led management of chronic disease has a positive effect on many aspects of the patient journey, including patient satisfaction, hospital admissions and mortality. There is also evidence to suggest that medical practitioners recognise the skills of practice nurses in screening and risk assessment roles and that they support the concept of nurse-led care.[142]

3.134 Another PHN, Western Victoria PHN, emphasised the role nurses have in chronic disease management and prevention:[143]

> The Western Victoria PHN supports practice nurses to promote examples of best practice in chronic disease prevention and management locally through continued professional development activities, nurse leadership forums and health expos. We also support practice nurses to promote best practice models nationally through presentations at conferences.
>
> Western Victoria PHN supports practice nurses to share skills and best practice models in chronic disease management through a

139 Australian Medical Association, *Submission 107*, p. 3.

140 ACN, CATSINaM, APNA, MCaFHNA, and ACMHN, *Submission 106*, p. 13.

141 Sydney Nursing School, *Submission 91*, p. 5.

142 Adelaide Primary Health Network, *Submission 119*, p. 27.

143 Western Victoria PHN, *Submission 54*, pp 6-8.

> Nurse Leadership Peer Network (NLPN) which meets at regular intervals. This provides local practice nurses with opportunities to share innovative ways to tackle chronic disease within the primary care setting.[144]

3.135 The CarePoint model discussed above is an example of a 'system-wide coordinated care approach to high utilisers'. CarePoint focuses on:

> patient engagement, patient experience, patient activation and general practitioner led care, along with close collaboration between providers to enhance patient outcomes and reduce hospital admissions/readmissions.
>
> …
>
> The model integrates and coordinates care across the entire spectrum of health and social services via a unique blend of physical and virtual touch points, underpinned by integrated data and a proactive care integration workflow.[145]

3.136 The Coordinated Veterans' Care (CVC) Program was raised in several submissions as an Australian example of best practice coordinated care. [146] The program was initiated in 2011 by the Department of Veterans' Affairs. More detail on the CVC program is provided in Chapter 4.

3.137 The Patient-Centred Medical Home (PCMH) is an example of a coordinated care model, developed in the United States for ageing populations with chronic conditions.[147] The PCMH was raised repeatedly in submissions and will be discussed further in Chapter 4.

Filling Treatment Gaps

3.138 Effective care coordination as outlined above has been identified as the key to filling treatment gaps experienced by consumers. The South Eastern Melbourne Primary Health Network stated that care coordination is 'one of the big challenges' to filling treatment gaps, and better facilitation of team based approaches is needed.[148]

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144 Western Victoria PHN, *Submission 54*, p. 6.

145 Department of Health and Human Services Victoria, *Submission 173*, p. 9.

146 Flinders University, Human Behaviour & Health Research Unit, *Submission 4*, pp 2-3; Centre for Primary Health Care and Equity, University of NSW, *Submission 6*, p. 2; Australian Healthcare and Hospitals Association, *Submission 40*, p. 7; Pain Australia, *Submission 96*, p. 10; Australian Medical Association, *Submission 107*, pp 7-8; Royal Australian College of General Practitioners, *Submission 135*, p. 4.

147 Cohealth, *Submission 88*, p. 12.

148 Ms Anne Lyon, General Manager and Acting CEO, Primary Health Services, South Eastern Melbourne Primary Health Network, *Official Committee Hansard*, Melbourne, 1 October 2015, p. 55.

3.139 Primary Health Networks were identified in several submissions as having a key role in providing this facilitation and coordination. For example, La Trobe University stated:

> …the Primary Health Networks… must be planners and commissioners of healthcare, and not service providers. In cases where there are service gaps, the PHNs should not duplicate or replicate services that are available in other locations, but must commission and coordinate service providers to fill these gaps.[149]

3.140 The Centre for Primary Health Care and Equity at the University of New South Wales stated that one of the objectives of PHNs as defined in their foundation documents is to understand the health care needs of their communities, and that this should include:

> …identifying those groups who have trouble accessing services, including specialist services, and the social, economic and physical environments that may be contributing to the emergence of chronic disease. They will know what services are available and help to identify and address service gaps where needed, including in rural and remote areas, while getting value for money.[150]

3.141 This crucial aspect to the role of PHNs was supported by a number of submissions, including from PHNs themselves.[151] Adelaide Primary Health Network also identified the role of Clinical Councils within the PHNs, stating:

> Clinical Council members have the appropriate knowledge and specific skill sets to address inter-sectoral care, service gap[s] and integrated care pathways.[152]

3.142 The Rural Doctors Association of Australia highlighted the 'critical' role of PHNs in addressing market failure and filling service gaps in rural areas.[153] This view was supported by Services for Australian Rural & Remote Allied Health (SARRAH).[154]

3.143 The Victorian Council of Social Service (VCSS) highlighted the 'Peninsula Model for Primary Health Planning', based in Frankston and the Mornington Peninsula. The model is based on a population health approach and 'wraps the collective effort of providers around agreed health priorities to address service gaps for the catchment'.[155] The VCSS identified the opportunity provided by the PHNs to continue building upon examples such as the Peninsula Model.

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149 La Trobe University Rural Health School, *Submission 164*, p. 7.

150 Centre for Primary Health Care and Equity, UNSW, *Submission 6*, p. 3.

151 Primary Health Tasmania, *Submission 142*, p. 1; NSW Health, *Submission 152*, p. 14; see also Royal Australian and New Zealand College of Ophthalmologists, *Submission 58*, p. 7.

152 Adelaide Primary Health Network, *Submission 119*, p. 34.

153 Rural Doctors Association of Australia, *Submission 17*, p. 11.

154 Services for Australian Rural & Remote Allied Health, *Submission 115*, pp 9-10.

155 Victorian Council of Social Service, *Submission 120*, p. 16.

3.144 The Dietitians Association of Australia (DAA) commented on the 'long standing' gaps in service delivery in rural and remote areas, and agreed that PHNs have a 'vital role' in filling these service gaps,[156] but added that state and territory governments should take the lead in responding to such gaps and ensuring that 'the spectrum of health care is comprehensive'.[157] As an example of a state government doing this, the Australian Pain Society and Painaustralia identified the Chronic Pain Service Plan being developed by the South Australian Government, modelled on a similar NSW plan and tailored to address 'massive service gaps especially in rural and regional SA'.[158]

3.145 Technology also has an important role in filling treatment gaps. In its submission, GMHBA supported telehealth and video conferencing as a way to address service gaps, noting that allied health providers, nurses, and care coordinators in addition to GPs should have access to MBS item numbers for these consultations.[159] Later on, GMHBA notes that a central data system such as My Health Record requires support by all sectors 'to enable the health care team to create a holistic view of the patient'.[160]

3.146 The complex nature of coordinated care for chronic disease patients, and the requisite identification and filling of treatment gaps, is a challenge for primary and secondary health care providers. However, systems and frameworks exist that would suggest that models can be adapted to ensure the best coordinated care for patients can be achieved. These are discussed in Chapter 4.

Concluding Comment

3.147 The Committee acknowledges the breadth of dedicated and professional health care providers, both in the primary and secondary systems, currently providing world-class care to Australian patients.

3.148 The health care provided to the majority of Australians by their GP is suitable and well-supported by the current Medicare system, as well as by private health insurance for any ancillary or allied health treatment required. However, once the complexities of chronic disease or diseases enter into a patient's treatment framework, the interconnected web of primary health care becomes somewhat tangled.

3.149 The Committee understands that a lot of the concerns outlined in this chapter will be addressed by the introduction of Health Care Homes

156 Dietitians Association of Australia, *Submission 148*, pp 4, 9-10.

157 Dietitians Association of Australia, *Submission 148*, p. 11.

158 Australian Pain Society, *Submission 35*, pp. 9-10; Painaustralia, *Submission 96*, p. 20.

159 GMHBA, *Submission 157*, p. 8.

160 GMHBA, *Submission 157*, p. 8.

under the 'Healthier Medicare' reform trials, however the need for the following issues to be considered by the Australian Government is still valid, given that the reforms are only entering trials as of July 2017.

Primary Health Networks

3.150 The evolution of Medicare Locals into PHNs is still at its early stages, but with the potential impact of Health Care Homes under the 'Healthier Medicare' reforms, the role that PHNs can have in coordinating and commissioning multidisciplinary services for chronic disease patients can only grow.

3.151 The PHNs coordination role is also important for care during transition periods for patients. The situation where a primary care provider cannot identify a condition or treat a patient, due to privacy concerns or restricted access to patient records is a circumstance that requires reform. The PHNs must have a central role in creating channels for this coordination and developing ways to easily access relevant records.

3.152 The data that both PHNs and PHIs collect about their patients, especially chronic disease patients, can be used in furthering the analysis of chronic disease treatment efficacy and coordination efforts. The Committee believes that the data targeted by headline performance indicators should be prioritised for research and analysis and expanded as the PHNs enter into key future phases of their development.

3.153 Additionally, as PHN data increases, this can help feed further information into the burgeoning eHealth space, as discussed in Chapter 4.

Allied Health, Nursing and Other Care Providers

3.154 The Committee also recognises the wider elements of primary health care provision to chronic disease patients, often provided by allied health professionals and other qualified care providers, including nurses. The requirements of care for chronic disease patients are wide and often that care may not fall directly to their GP or key allied health professionals for short periods of time.

3.155 The Committee recognises the important assistive role of nursing care in chronic disease management and treatment. The Committee believes that the role of nurses in relation to chronic disease prevention and management should be considered for possible expansion and better utilisation in this care space.

3.156 The current requirement for a referral from a GP for a restrictive number of allied health treatments may not always be the best mechanism for ongoing care for a chronic disease patient and a change to referral processes and numbers of treatments may be warranted.

Private Health Insurers

3.157 The Committee was grateful to the PHIs that both submitted to the inquiry, as well as appeared before the Committee to provide frank advice about the work that they have been doing in a restrictive environment, to both educate their members on the lifestyle factors that can contribute to their wellness, as well as the potential room for improvement in providing chronic disease management programs (CDMP) to their members with chronic disease.

3.158 The Committee recognised that the regulatory and legislative framework that governs private health insurance in Australia is complex, but believes that there are small areas of improvement that could be made to the *Private Health Insurance (Health Insurance Business) Rules 2015* regarding expanding the providers that can be used in a CDMP.

Recommendations

Recommendation 1

3.159 **The Committee recommends that the Australian Government undertake an independent review of the privacy restrictions governing medical practitioner access to patient records.**

Recommendation 2

3.160 **The Committee recommends that the Highlight Performance Indicators for Primary Health Networks be expanded in future cycles to include the specific data capture of the:**

- **incidence of chronic disease in Primary Health Network catchments and the number of people with comorbid or multi-morbid conditions;**
- **range of services that these people access and how often they utilise different forms of treatment (general practice, allied health, hospital); and**
- **that this data be prioritised for research to inform targeted service provision to chronic disease populations and the expansion of Health Care Home trials and programs.**

Recommendation 3

3.161 **The Committee recommends that the Australian Government investigate expanding the number of allied health treatments that can attract a Medicare Benefits Schedule rebate (MBS items 10950 to 10970) within a year, on the proviso that the patient has the relevant General Practitioner Management Plan and Team Care Arrangements in place.**

Recommendation 4

3.162 **The Committee recommends that the Australian Government examine the process for a chronic disease patient to be referred for initial specialist assessment by a Medicare Benefits Schedule registered allied health professional without the need to get a referral from their general practitioner, only when:**

- **the patient was originally referred to the allied health professional by their general practitioner; and**
- **the original referral indicates that specialist assessment may be warranted if the allied health professional agrees it is warranted.**

Recommendation 5

3.163 **The Committee recommends the Australian Government explore ways to expand and better utilise the role of nurses in the provision and coordination of care for chronic disease management within a general practitioner-led care system.**