4

Best Practice, Multidisciplinary Teams and Education

Introduction

4.1 Throughout the course of the inquiry the requirement for unified best practice programs and models for chronic disease prevention and management was the strongest theme presented to the Committee. The system of health care in Australia is world-class, but there is always room for improvement and the foundations of care for chronic disease patients is one such element of the system that is experiencing change and could improve to ensure the sustainability of care.

4.2 As discussed in earlier chapters, the sometimes disconnected nature of primary and secondary health care in Australia challenges the ability of the system to deliver consistent care between acute and ongoing treatment episodes for chronic disease.

4.3 Equally there is inconsistent application across the board of prevention programs that educate current or potential chronic disease patients on the best ways to manage or prevent their disease or diseases.

4.4 This chapter presents a summary of the best practice models identified as part of the inquiry and discusses whether the idea of standardised care is appropriate and how the information technology and communication systems need to develop to support any robust developments in care.

Best Practice in Prevention – National and International

4.5 The prevention of chronic disease is not an outcome that can be easily quantified. Many chronic diseases can manifest based on infection, genetic

factors or through trauma, however many of the biggest chronic diseases in Australia have contributory factors that are related primarily to lifestyle, as discussed in Chapters 2 and 3.

4.6 The impact of these lifestyle factors on both the person's wellbeing and the impost they place on the health system can be ameliorated or removed completely, as in the example of a patient with type 2 diabetes, by modifications in behaviour, including diet, exercise, smoking and controlling obesity.[1]

4.7 The ability to effectively prevent these lifestyle factors from causing or further contributing to chronic disease relies on education, intervention and willingness for the patient to modify lifestyle elements that are deleterious to their health.

4.8 Many programs that aid patients in these modifications of lifestyle or awareness of early signs of disease are either already present in Australia or can be highlighted in the international context.

4.9 Preventive health is a key factor in managing the burden of chronic disease. The Public Health Association of Australia identifies the World Health Organization's (WHO) definition of preventive health:

> The WHO describes preventive health as: approaches and activities aimed at reducing the likelihood that a disease or disorder will affect an individual, interrupting or slowing the progress of the disorder or reducing disability. Primary prevention reduces the likelihood of the development of a disease or disorder.[2]

4.10 Funding for preventive health programs is relatively low in Australia, when compared to other OECD countries. The Heart Foundation identified this funding gap:

> In 2011-12, just 1.7% of total government health expenditure went to public health activities, including prevention, protection and promotion. This was well behind New Zealand (7%), Canada (6.5%) and Slovakia (5%).[3]

4.11 While funding may be low comparatively, the requirement for a longer-term time investment in preventive health strategies is a more important goal. Professor Vickery of the University of Western Australia commented:

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1 Diabetes Australia, *Submission 102*, pp 2-3.

2 Public Health Association of Australia, *Submission 111*, p. 5.

3 Heart Foundation, *Submission 131*, p. 12.

> The 40-year program is a preventative program, like the antismoking program: people should exercise more, eat less and not take drugs. They are the three messages that we want to get out. Those messages need to be good public policy—much as we introduce smoking—hiking taxes on low-quality foods and high-energy foods—reducing the access.[4]

4.12 This time investment is a lengthy policy commitment required to reduce the effect of chronic disease, but many programs have had marked effects on chronic disease factors in Australia.

National Prevention and Screening Programs

Tobacco control

4.13 Australia has had one of the most successful tobacco control and smoking reduction strategies in the world. As outlined by the Australian Health Promotion Association (AHPA):

> Australia is a world leader in reducing smoking rates because of the comprehensive, multi-strategy approach implemented in recent years to preventing the uptake of smoking and assisting people to quit. This includes policy and legislative reforms including pricing, supply, smoke free regulations, sponsorship etc.; concerted and continuous social marketing; support services to assist people to quit; upskilling health providers on the importance of the issue and how to assist people to quit and many other strategies.[5]

4.14 The Prevention 1st campaign outlined more critical success factors:

> Starting from as early as 1971 to now, tobacco control has incorporated a suite of strategies such as sustained public education, graphic warning labels and plain packaging laws. In that time there has been an associated decrease in smoking, from 35 per cent of adults in 1980 to 20 per cent in 2010, and male deaths from lung cancer and obstructive lung disease have dropped from peak 1970s and 1980s levels.[6]

4.15 The impact that tobacco tax and policies affecting smoker behaviour could influence policy in other lifestyle areas, as supported by the AHPA:

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4 Professor Alistair Vickery, University of Western Australia, *Official Committee Hansard*, Perth, 11 March 2016, p. 21.

5 Australian Health Promotion Association, *Submission 49*, p. 3.

6 Foundation for Alcohol Research and Education and Public Health Association of Australia, *Submission 114*, p. 9.

> It would be the same if we were to think about obesity; at the national level, we would be in favour of more policies such as the soft drink tax. I think that the severity of obesity is such that we need to learn from tobacco and start to implement some of these things.[7]

4.16 The effects of plain-packaging and taxation have been marked on tobacco consumption within Australia, but as outlined earlier, the time investment has been lengthy, with over 40 years of concerted education and policy control only now having an effect on smoking population totals. However, more could be done, with 13.3 per cent of Australians over the age of 18 reported as being daily smokers in 2013.[8]

Alcohol Consumption Management

4.17 Programs for the management of alcohol consumption in Australia are not as advanced as for tobacco consumption. The taxing of alcohol and national advertising campaigns have had some impact, but more could be done on a national level.[9]

4.18 The entrenched societal aspects of alcohol consumption in Australia make it difficult to counter risky drinking behaviour in Australia, with the regular advertising of alcohol still permitted and sports sponsorship still prevalent.[10]

4.19 Alcohol consumption in Australia is often highlighted in light of risky drinking behaviours, with the Victorian Health Promotion Foundation outlining:

> In 2010, 20 per cent of Australians aged 14 or over had consumed alcohol at a level that put them at risk of alcohol-related disease or injury over their lifetime. Nearly 40 per cent drank at levels that put them at risk of alcohol-related injury from a single drinking occasion over the past 12 months.[11]

4.20 The federal Department of Health outlined the risky alcohol consumption policy work underway and the role that primary care providers can play:

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7 Ms Michelle Herriot, Vice-President, Australian Health Promotion Association, *Proof Committee Hansard*, Adelaide, 4 March 2016, p. 27.

8 Department of Health, 'Tobacco key facts and figures', <http://www.health.gov.au/internet/main/publishing.nsf/content/tobacco-kff>, viewed 18 April 2016.

9 Foundation for Alcohol Research and Education and Public Health Association of Australia, *Submission 114*, pp 13-14.

10 Foundation for Alcohol Research and Education and Public Health Association of Australia, *Submission 114*, p. 15.

11 Victorian Health Promotion Foundation, *Submission 117*, p. 2.

> With alcohol, there is ongoing work around labelling and also information campaigns and the guidelines on alcohol consumption. So there are a number of measures. Of course, we work closely with the NGOs that are very active in this space and also with our states and territories.
>
> There is absolutely no doubt that prevention is the first point of attention in this space, and also recognising, as is evident in the terms of reference for your inquiry, that primary care plays a great role in this. GPs and other primary care practitioners are the first point of contact for Australians in their healthcare system, and they are a great source of authoritative and respected information for consumers about measures that can be taken in the prevention space.[12]

Exercise and Healthy Lifestyle Promotion

4.21 Generalised wellness and healthy lifestyle promotion is one key area to managing the impact of lifestyle-related risk factors.

4.22 As mentioned in Chapter 2, the LiveLighter program is an example of a national awareness campaign, aimed at promoting better lifestyle, diet and exercise choices. The AHPA identified:

> LiveLighter is an initiative developed by the Heart Foundation (WA Division) in partnership with Cancer Council WA. NHF and CCWA were contracted in 2011 by the Department of Health WA to conduct a new public health education program in WA to encourage people to eat well, be physically active and maintain a healthy weight. The LiveLighter campaign aims to encourage healthier changes in behaviour through targeted mass media, effective stakeholder relations, sponsorship and branding opportunities, and planned advocacy. The campaign is currently in the third year of implementation.[13]

4.23 At a state level, programs such as Healthy Together Victoria promote similar healthy lifestyle benefits. The Victorian Council of Social Service outlined the program and its implementation:

> Healthy Together Victoria is a comprehensive preventive health initiative, funded through the National Partnership Agreement on Preventative Health, and designed to improve people's health and wellbeing. Under the initiative a number of "healthy together

12 Dr Lisa Studdert, First Assistant Secretary, Population, Health and Sport Division, Department of Health, *Official Committee Hansard*, Canberra, 21 August 2015, p. 3.

13 Australian Health Promotion Association, *Submission 49*, p. 3.

> communities" have been established across Victoria, including in Wyndham, west of Melbourne.
>
> Only five per cent of adults living in Wyndham eat enough vegetables and about 53 per cent are overweight or obese. 25 per cent of women in Wyndham smoke, well above the national average. In the two-and-a-half years that Healthy Together Wyndham has operated, the program has reached about 54,500 residents. Two-thirds of Wyndham schools, kindergartens and childcare centres are involved in the program, along with 39 businesses.[14]

4.24 Healthy lifestyle programs are not only the responsibility of government; many private health insurers are offering programs to their members to enable them to take better control of their health and limit or at least understand the contribution of lifestyle factors on health.

4.25 Medibank Private[15], HCF[16], Bupa[17], and HBF[18] all outlined either healthy lifestyle promotion programs for their members, or associated programs for their members with chronic disease that emphasises the benefits of healthy lifestyle factors on overall health and the impacts of their particular disease or diseases.

4.26 As outlined in Chapter 3, the role of private health insurers in relation to chronic disease management has potential to expand, but the initial foundation for their involvement in chronic disease prevention is already being undertaken.

4.27 Given the increasing number of Australians that are privately insured, the access to tailored lifestyle and health programs aiding in chronic disease prevention would appear to be an expanding role that could be explored.

4.28 Indeed, the collaboration between Medibank Private, Victoria Department of Health, HBF and the WA Department of Health in the CarePoint trials is evidence that partnerships and collaborations in this space already exist and are achieving results.[19]

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14 Victorian Council of Social Service, *Submission 120*, p. 11.

15 Medibank Private, *Submission 43*, pp 9-10.

16 HCF, *Submission 122*, pp 7-13.

17 Bupa, *Submission 144*, pp [18-22].

18 Mr Robert Bransby, Managing Director, HBF Health Ltd, *Official Committee Hansard*, Perth, 11 March 2016, pp 9-12.

19 Medibank Private, *Submission 43*, p. 10.

Mental Health Awareness and Promotion

4.29 Mental health promotion and support programs are an essential part of preventing the worsening of chronic mental health conditions or lessening the impact of comorbid mental health conditions.

4.30 Beyondblue outlined the importance of mental health promotion, prevention and management programs in helping battle the increasing incidence of mental health issues in Australia:

> Online programs can also be used to facilitate better self-management, and improve physical and mental health outcomes for people with chronic disease. An example of an effective online self-management program is the 'Stepping Up' program …This six to eight week online program is for people with arthritis, back pain or other musculoskeletal conditions. It supports people to deal with some of the physical and emotional challenges of living with a musculoskeletal condition, such as stress, pain, fatigue, depression, low mood, anxiety, worry, sleep problems and making lifestyle changes. The program has been demonstrated to achieve significant reductions in distress, with participants reporting a 17 per cent improvement in their mental health assessment after completing the program. Initiatives such as Stepping Up have the potential to be expanded to other health conditions, and be integrated as a core component of chronic disease management practices within primary care.[20]

4.31 The increased incidence of mental health conditions in Aboriginal and Torres Strait Islander populations[21] and lesbian, gay, bisexual, transsexual and intersex people[22] increases the need for diversified promotion and prevention strategies.

4.32 Coordinated funding and control of mental health programs is an important factor to ensuring success and consistency in delivery, especially in relation to Aboriginal mental health programs.[23]

4.33 Increased awareness of the impacts of mental health conditions and their potential to lead to risky lifestyle behaviours is essential, as beyondblue outlined:

> We also can see that some mental health conditions may be potentially contributing to some of the risk behaviours that we know lead to physical ill health. So the recent child and adolescent

20 Beyondblue, *Submission 37*, p. 6.

21 Royal Australian and New Zealand College of Psychiatrists, *Submission 31*, p. 3.

22 Victorian Council of Social Service, *Submission 120*, p. 22.

23 AMSANT, *Submission 153, Attachment A*, p. 18.

> mental health survey showed that amongst the teenagers that were self-diagnosed or diagnosed with depression they had substantially higher rates of smoking, misuse of alcohol or risky use of alcohol, misuse of cannabis and high levels of obesity. So mental health can drive some of the risk conditions and may drive some of the risk factors that lead to physical health problems down the track.[24]

International Prevention and Screening Programs

4.34 The small number of examples of chronic disease prevention programs with international success identified to the Committee were mainly due to their influence on the establishment or improvement of Australian programs or their potential to be informative models for similar programs within Australia.

4.35 The Obesity Prevention and Lifestyle (OPAL) program identified in Chapter 2 was successfully modelled on a French program called Epode. Epode International Network now provides support to any international organisation or community based program that models their obesity prevention program on the Epode methodology, aimed at reducing childhood and overall obesity in communities.[25]

4.36 Collaborative screening programs, such as the Scottish Diabetic Retinopathy Screening Collaborative, provide concerted awareness and screening programs to identify and counter early signs of chronic disease, such as diabetes-related blindness.[26] Collaborative efforts such as these, where representatives from all National Health Service Boards in Scotland to coordinate screening efforts, could help inform the coordination of similar programs across Primary Health Networks in Australia.

4.37 The WHO identifies a number of international programs in its 2014 report *Global Status Report on Noncommunicable Diseases*:

- Mongolia – Due to a nationwide harmful consumption of alcohol, the Mongolian government set up a network of 80 governmental and non-governmental organisations to increase public awareness, formulate policies and establish a legal environment to reduce the consequences of alcohol use and strengthen implementation of stricter legal

24 Dr Stephen Carbone, Policy Research and Evaluation Leader, beyondblue, *Official Committee Hansard*, Melbourne, 1 October 2015, p. 14.

25 Epode International Network, 'Epode International Network', <http://epode-international-network.com/about/context/2014/09/15/epode-international-network>, viewed 29 March 2016.

26 NHS Scotland, 'Welcome to the Scottish DRS Collaborative', <http://www.ndrs-wp.scot.nhs.uk/>, viewed 29 March 2016.

requirements on such elements as alcohol advertising bans and licensed vendor requirements;[27]

- Tonga - Recognising the seriousness of women's sedentary behaviour, the Tongan ministry of health and Ministry of Internal Affairs, with the support of the Australian Sports Outreach Program, joined with the Tonga Netball Association in a campaign commenced in 2011 that brought together a broad range of technical skills and networks to deliver a highly targeted intervention. The campaign, branded Kau Mai Tonga: Netipol (Come on Tonga, let's play netball!), was launched in June 2012 and has delivered physical activity outcomes to more than 20 netball clubs;[28] and
- Pacific Islands and Kiribati - As a means of reducing the availability of products that are high in salt and fat, the Ministry of Health and Medical Services has decided to include maximum levels of sodium and fat in selected processed food items in the draft Food Regulations and Standards. The maximum levels of salt and fat are derived from the "Salt targets in Pacific Foods" that were agreed and mandated by the meeting of Pacific Ministers of Health in 2013 and supported by the WHO, to help address the Non-Communicable Disease crisis in the Pacific. The draft Food Regulations and Standards also include restrictions on marketing of food and non-alcoholic beverages to children, as well as restrictions on the promotion of breast-milk substitutes and baby-feeding accessories.[29]

4.38 Programs such as those outlined above outline the varied ways that international jurisdictions address lifestyle and dietary factors in chronic disease prevention. Considering the catalysts for such programs can help inform the Australian response to promoting and preventing the increase of chronic disease and their associated lifestyle factors within the community.

The 5As – Framework for Chronic Disease Prevention

4.39 As a general guide for policy and program development within chronic disease prevention systems, the 5As is a framework presented for

27 World Health Organization, *2014 Global Status Report on Noncommunicable Diseases*, 2014, p. 29, <http://apps.who.int/iris/bitstream/10665/148114/1/9789241564854_eng.pdf?ua=1 >, viewed 29 March 2016.

28 World Health Organization, *2014 Global Status Report on Noncommunicable Diseases*, 2014, p. 40, <http://apps.who.int/iris/bitstream/10665/148114/1/9789241564854_eng.pdf?ua=1 >, viewed 29 March 2016.

29 World Health Organization, *2014 Global Status Report on Noncommunicable Diseases*, 2014, p. 47, <http://apps.who.int/iris/bitstream/10665/148114/1/9789241564854_eng.pdf?ua=1 >, viewed 29 March 2016.

organising screening and interventions across modifiable lifestyle risk factors.[30]

4.40 The Royal Australian College of General Practitioners (RACGP), in its *Guideline for preventive activities in general practice: 8th edition* outlines the 5As as '…an internationally accepted framework for organising the assessment and management of all the behavioural risk factors in primary healthcare'.[31]

4.41 More specifically, the 5As entail:

- Ask – a systematic approach to all patients regarding their smoking, nutrition, alcohol or physical activity, which may occur opportunistically as they present for other conditions and/or by recall for health checks;
- Assess – assess readiness to change, and dependence (for smoking and alcohol);
- Advise – provide brief, non-judgemental advice with patient education materials and work with the patient to set agreed goals;
- Assist – provide motivational interviewing; refer to telephone support services, group lifestyle programs or individual providers (e.g. dietitian or exercise physiologist); and consider pharmacotherapy; and
- Arrange – regular follow-up visits to monitor maintenance and prevent relapse.[32]

4.42 This framework can be applied to both the prevention and management of chronic disease, as well as informing research into the effectiveness of such interventions.[33]

4.43 The RACGP has modified the 5As framework to create their own smoking, nutrition, alcohol, physical activity (SNAP) guide. The application of the framework is presented as below.

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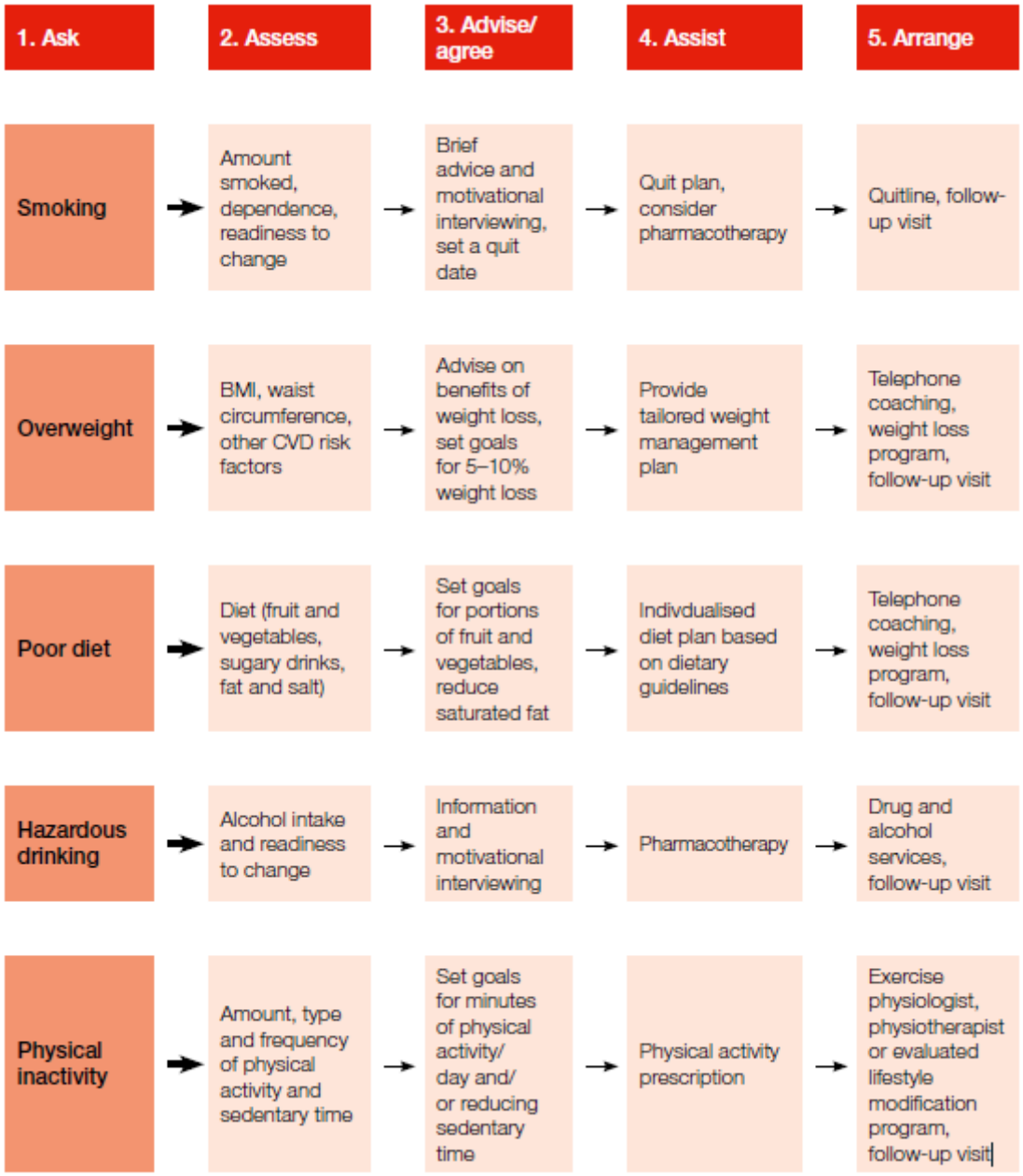
30 PC4, COSA and Cancer Council Australia, *Submission 63*, p. 7.

31 Royal Australian College of General Practitioners, *Guideline for preventive activities in general practice: 8th edition*, 2012, p. 40, <http://www.racgp.org.au/download/Documents/Guidelines/Redbook8/redbook8.pdf>, viewed 29 March 2016.

32 Royal Australian College of General Practitioners, *Guideline for preventive activities in general practice: 8th edition*, 2012, p. 40, <http://www.racgp.org.au/download/Documents/Guidelines/Redbook8/redbook8.pdf>, viewed 29 March 2016.

33 Centre for Primary Health Care and Equity, University of New South Wales, *Submission 6*, p. 1.

Figure 4.1 RACGP use of the 5As for the SNAP guide



Source Royal Australian College of General Practitioners, Smoking, nutrition, alcohol, physical activity (SNAP): A population health guide to behavioural risk factors in general practice, 2nd edn. Melbourne: The Royal Australian College of General Practitioners 2015, p. 7.

4.44 The 'Ask' categories outlined above align with the key lifestyle factors identified in Chapter 2 and earlier in this chapter as being the key factors contributing to the incidence or worsening of chronic disease within Australia. Accordingly, it is pertinent to consider these factors, and the 5As framework, as a guidance tool for prevention policy and programs.

Integrated Health Checks

4.45 As an expression of the preventative and management aspects of models such as the 5As above, the concept of an integrated health check is a key element to achieving the detection and treatment protocols required for chronic disease best practice.

4.46 The National Stroke Foundation advocates for an integrated health check, as developed by the National Vascular Disease Prevention Alliance (NVDPA):

> …to promote the early detection and management of those at high risk of developing chronic kidney disease, type 2 diabetes, heart disease or stroke. An integrated health check, includes the following:
>
> - Establishment of kidney function
> - Establishment of diabetes status including use of the AUSDRISK tool and blood tests to determine risk of developing type 2 diabetes or having undiagnosed existing diabetes.
> - Calculation of an absolute cardiovascular risk score for cardiovascular disease
> - Timely referral to diabetes prevention programs (high risk) or coordinated care service (existing diabetes)
> - Timely referral to cardiovascular disease prevention programs.[34]

4.47 Diabetes Australia also supports the development of the NVDPA's health check approach.[35]

4.48 Health checks do currently exist under the Medicare Benefits Schedule (MBS) for a number of categories:

> There are four time-based MBS health assessment items: **701 (brief), 703 (standard), 705 (long)** and **707 (prolonged)**. The following categories of health assessments may be undertaken by a medical practitioner (other than a specialist or consultant physician) under these items:
>
> - a health assessment for people aged 45-49 years who are at risk of developing chronic disease
> - a type 2 diabetes risk evaluation for people aged 40-49 years with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool
> - a health assessment for people aged 75 years and older
> - a comprehensive medical assessment for permanent residents of residential aged care facilities

34 National Stroke Foundation, *Submission 113*, p. 4.

35 Diabetes Australia, *Submission 102*, pp 3-4.

- a health assessment for people with an intellectual disability
- a health assessment for refugees and other humanitarian entrants[36]

4.49 The first three categories listed above are especially relevant to the population affected by or at risk of chronic disease, however their use is still relatively low in the general population.[37]

4.50 The current stratification of health assessments based on age was questioned by Dr Tracy Brown, who as a geriatrician, questioned whether the trigger point of age 45 and at risk of chronic disease was early enough:

> Then we are going to look at other pivotal points; you can use decades if you want to; I would even like to see it every five years. Let us make it at 25, 30, 35, 40, 45 and 50, and it needs to be a half-hour visit.[38]

4.51 There is also a specific Aboriginal and Torres Strait Islander health assessment (MBS item 715), which is used extensively by health providers such as South Coast Medical Service Aboriginal Corporation:

> For clients with chronic disease in our section we have GP services, so they do health checks, GP management plans, team care arrangements, referrals and ongoing monitoring.[39]

4.52 One issue of concern also raised by the South Coast Medical Service Aboriginal Corporation was the confirmation of a person's Aboriginal heritage when accessing the MBS item 715 health checks:

> One of my concerns overall, I suppose, with regard to chronic disease is that in the health check assessments there is no verification of Aboriginality. We have had, in our clinic, a number of people going down to the chemist writing 'CTG', and they are not Aboriginal people. It is a real concern that we have and it is something that I think really needs to be addressed. Our organisation has—I am looking at Jo's registered clients here—7,115 clients. However, when I last counted Aboriginal people,

36 Department of Health, 'MBS Health Assessments Items 701, 703, 705, 707 and 715', <http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare_mbsitem_general_factsheet>, viewed 4 April 2016.

37 Dr Erin Lalor, Chief Executive Officer, National Stroke Foundation, *Official Committee Hansard*, Sydney, 23 October 2015, p. 9.

38 Dr Tracy Brown, *Proof Committee Hansard*, Newcastle, 31 March 2016, p. 30.

39 Ms Josephine Naughton, Senior Manager, Primary Health Care, South Coast Medical Service Aboriginal Corporation, *Official Committee Hansard*, Bomaderry, 12 February 2016, p. 12.

> there were some 5,700 Aboriginal people, and that was a couple of years back. The ABS statistics say there were 4,316 in 2011.[40]

4.53 This issue was also raised in Tumbi Umbi by Ms Sue Maher, who stated:

> I have a practice manager at Morisset. She got a phone call the other day and the lady said to her, 'What proof does a person have to show to be put on the Aboriginal register to get free scripts,' and Sharon said, 'Well, no, there's no proof. They're encouraged to self-identify, and we're not actually allowed to ask for proof. They don't have to sign.' There are supposed to be three identifying markers for Aboriginal people, which is that they are of Aboriginal descent, that they self-identify and that they are recognised in their community. They are the three identifiers for an Aboriginal person. In general practice we cannot do any of that; they just self-identify. If you were going for a loan or going for Centrelink, you would have to fill those criteria and you would have to sign a stat dec [statutory declaration]. This lady said to our practice manager, 'Well, I just want to report a fraud.' It was a relative of hers who was showing off and bragging about how she has got free scripts because she just went in and told the doctor she was Aboriginal, and she said, 'And I can tell you she's not. So what are you going to do about it.'
>
> That money should really be spent on the Aboriginal people, not on other people, and it is getting out. We have got quite clever people in our area that know how to rort the system—and try to rort the system. My suggestion for it would be that most people that are of Aboriginal or Torres Strait Islander descent would be registered with Centrelink for the healthcare card that they get to take to the chemist and show the chemist to get their scripts, so why can't there be a card which the person has to go and sign a stat dec for at Centrelink or at the Aboriginal clinics? [...] What if they went there and they had to actually sign a stat dec before an elder or they had to do it through Centrelink and then they got a card that they show at the chemist every time they go, instead of just having this ticked on their file that they are registered for the gaps program and they go and get free scripts? To me, it is an area where it has just opened up, and it will get worse.[41]

4.54 Dr Wolf du Plessis added:

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40 Mr Craig Ardler, Chief Executive Officer, South Coast Medical Service Aboriginal Corporation, *Official Committee Hansard*, Bomaderry, 12 February 2016, p. 11.

41 Ms Sue Maher, private capacity, *Official Committee Hansard*, Tumbi Umbi, 19 February 2016, pp 10-11.

> It is not only about the scripts. They have got access to more allied health services and so forth. So, literally, people are abusing it who we believe are not entitled to it. The only thing they have to do is sit in front of you and say, 'I'm Aboriginal.' There is no means test for that. There are no questions asked further.[42]

4.55 The importance of health checks is high, especially when attempting to capture the early stages of chronic disease, or the lifestyle risk factors that contribute to disease, so the robust access and control of these assessments is important to future management of chronic disease growth.

Best Practice in Treatment – Practical and Theoretical

4.56 Chronic disease management and treatment is a role undertaken within the primary care setting for the majority of patients. Episodes of acute care will often occur within the hospital system, but for most patients the foundation of their care and the best benefit to be gained in their disease management is through the primary care system.

4.57 The inquiry's first term of reference seeks best practice examples in chronic disease management and there have been three main themes of best practice emerge:

- Self-management of chronic disease;
- The Wagner Chronic Care Model; and
- The Patient-Centred Medical Home.

Self-Management of Chronic Disease

4.58 Underpinning many of the best practice models and theories for chronic disease care and management is the active participation of the patient in their ongoing wellness.

4.59 Patient-centred outcomes require the patient themselves to have the knowledge and support to manage their condition, as outlined by the Australian Diabetes Educators Association:

> It has now been well recognised that medical intervention alone is insufficient to improve diabetes outcomes. There is an increasing focus on patient-centred outcomes. The critical role of empowering the person with diabetes in their own self-management to improve quality of life, the factors that influence their capacity to self-manage, and the need for self-management support and education provided by a range of health care providers, are widely

42 Dr Wolf du Plessis, private capacity, *Official Committee Hansard*, Tumbi Umbi, 19 February 2016, p. 11.

> acknowledged. Self-management education and support are key strategies identified in both the *National Chronic Disease Strategy* and the *National Service Improvement Framework for Diabetes*.[43]

4.60 More explicitly, the Western Australian Department of Health defines self-management and self-management support:

> Self-management is a shared responsibility between the individual and service provider.
>
> Self-management is defined in the National Chronic Disease Strategy as "the active participation by people in their own health care". Self-management involves consumers adopting attitudes and learning skills that facilitate a partnership with carers, general practitioners, and health professionals in treating monitoring and managing their condition.
>
> Self-management support describes the techniques and strategies that health providers, carers, organisations and systems do to assist those living with chronic conditions to practice self-management. Also known as 'collaborative care strategies', these techniques are based on self-management principles.[44]

4.61 These principles of self-management and self-care must underpin the successful planning and ongoing provision of health care to patients. The tie-in with chronic disease prevention, and how that has evolved with trends in patient-centred care, was raised by the Australian Primary Health Care Research Institute:

> We have gone from a situation a few decades ago where patient education, because that is what it was called then, was something you did on the side of medical care. What we now know is that self-management, supporting self-management and a number of related concepts such as health literacy, empowerment and patient partnerships are central to good care. That does mean that we are not all the same. We do not have all the same needs in terms of support for self-care, so some tailoring is required.[45]

4.62 The Flinders Program of Chronic Condition Management and Self-Management Support (Flinders Program), created by the Human Behaviour and Health Research Unit at Flinders University has been successfully used to demonstrate the impact of self-management support

43 Australian Diabetes Educators Association, *Submission 109*, p. 2.

44 Department of Health, Western Australia, *WA Chronic Conditions Self-Management Strategic Framework*, Perth: Health Networks Branch, 2011, p. 3.

45 Associate Professor Terence Findlay, Head of Programs, Australian Primary Health Care Research Institute, Australian National University, *Official Committee Hansard*, Canberra, 21 August 2015, p. 49.

in chronic disease management, through both the Coordinated Veterans' Care Program (CVC) and the Flinders Closing the Gap Program.[46]

4.63 The flexibility of the Flinders Program was highlighted by the Dietitians Association of Australia:

> The program has been applied in Australia, New Zealand, USA, Canada, Hong Kong, Scotland and Sweden and to population groups such as Aboriginal and Torres Strait Islanders, children, mental health, disability and rural and remote.[47]

4.64 Another example of a self-management program is the Living Well with Persistent Pain Program operated in South Australia.[48]

Case Study – Flinders Program in New Zealand

As a result of surveys and studies in New Zealand in the mid-2000s, identifying the increasing incidence of complex chronic disease in the New Zealand population, a trial introduction of the Flinders Program to train health care providers to enable self-management of chronic disease by patients was commenced.

Trial Goals

The program was implemented in primary health care settings including general practice, community Hauora services and independent nursing practice by a Primary Health Organisation, with one goal being to achieve critical mass by having a certified Flinders Program practitioner in every area or practice capable of supporting patients in self-managing their chronic disease. A team of 10 registered nurses were trained in November 2010 as accredited trainers and this group ran workshops to train providers during 2011.

The majority of those trained were registered nurses including clinical nurse specialists, nurse practitioners, district nurses and practice nurses. However, other health providers, such as those in aged care, prison services, teams providing support needs assessment, community pharmacists, general practitioners, physiotherapists and dietitians also received training.

Outcomes

From February to December 2011, 150 health care providers were trained in the program across thirty practices and the District Health Board in the Hawkes Bay

46 Flinders Human Behaviour and Health Research Unit, *Submission 4*, p. 1.

47 Dietitians Association of Australia, *Submission 148*, p. 18.

48 Adelaide Primary Health Network, *Submission 119*, p. 46.

region, with the majority having at least one certified provider and some practices having all nurses trained in the program.

These providers then helped coach relevant patients in the self-management principles of the program, to help them achieve better outcomes for their chronic condition.

As a result of the trial, the Flinders Program has been widely implemented across District Health Boards in New Zealand, with over 500 practitioners having been trained since 2005.[49]

Coordinated Veterans' Care Program

4.65 The Australian Medical Association recognises the CVC Program as being one of the most innovative coordinated self-management programs in Australia:

> It is a pro-active approach to care that targets support to those veterans with chronic and complex conditions that put them at risk of unplanned hospitalisation. CVC supports improved quality of life for eligible veterans and, in the long term, has the potential to reduce hospitals costs by focusing on improving their care in the community.[50]

4.66 The CVC Program actively involves the patient as part of the coordination of their care:

> The CVC Program aims to improve the health of participants by:
> - providing ongoing planned and coordinated care from a GP and a nurse
> - educating and empowering participants to self-manage their conditions
> - encouraging the most socially isolated to participate in community activities.[51]

4.67 While the key deliverable from a program like the CVC is better health outcomes for the patient, the equally as important outcome is that the veteran is 'more educated and empowered to self-manage their conditions'.[52]

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49 New Zealand Ministry of Health, 'Effective behaviour change in long-term conditions: Case Study 5', <http://www.health.govt.nz/publication/effective-behaviour-change-long-term-conditions>, viewed 12 April 2016.

50 Australian Medical Association, *Submission 107*, p. 7.

51 Flinders Human Behaviour and Health Research Unit, *Submission 4*, p. 3.

52 Department of Veterans' Affairs, 'CVC Guide for General Practice', <http://www.dva.gov.au/about-dva/publications/health-publications/provider-publications/guide-general-practice>, viewed 4 April 2016.

4.68 Key to the success of building capability in the patient to self-manage their conditions is training and educating the care-givers and clinicians in the best ways to support their self-management. This is achieved through the use of accredited learning modules and resources for the care team.[53]

4.69 An especially important component of the CVC program is in trying to engage patients in community activities, as the effect of chronic disease can often lead to patients feeling cut off from the community and suffering 'social isolation, mental health issues, family breakdowns and poor health literacy'.[54]

Flinders Closing the Gap Program

4.70 The Flinders Closing the Gap Program was also developed by the Human Behaviour and Health Research Unit at Flinders University and has:

> …provided training and implementation support to primary health care services providing care to Indigenous populations across Australia in the national initiative known as the Flinders Closing the Gap Program (FCTGP). Its focus has been on training health practitioners and health workers in self-management support.
>
> This training program has aimed to improve the self-management capabilities of Aboriginal and Torres Strait Islander people with chronic diseases and conditions across Australia so that they, together with their health workers and health practitioners, could improve their health outcomes and ultimately close the gap in life expectancy between Aboriginal and Torres Strait Islander people and the general Australian population.[55]

4.71 The work undertaken and results achieved from the program have resulted in '…genuine change in the way clients think about their health as well as the way practitioners work with their clients to achieve better health outcomes'.[56]

Living Well with Persistent Pain Program

4.72 The Adelaide Primary Health Network outlined a successful self-management program run in the norther region of Adelaide – the Living Well with Persistent Pain (LWwPP) Program.

4.73 The program has self-management support at its core:

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53 Flinders Human Behaviour and Health Research Unit, *Submission 4*, p. 3.

54 Australian Association of Social Workers, *Submission 46*, p. 3.

55 Flinders Human Behaviour and Health Research Unit, *Submission 4*, p. 3.

56 Flinders Human Behaviour and Health Research Unit, *Submission 4*, p. 4.

> Combining a group program and individual pain service assessments, this evidence-based program supports individuals to better understand their pain condition, equips them with the necessary tools to improve their quality of life and thereby minimises the burden of pain on them, their families and the wider community…
>
> It provides a holistic self-management course, case coordination and extended allied health services. A GP with a particular interest in managing persistent pain is available to access. A care coordinator undertakes an initial assessment and supports the patient and GP through the process of both group sessions and one-on-one allied health services…
>
> Self-management support is at the heart of the LWwPP program. Both the group education sessions and the individual care plan are centred on the concept that the patient is best placed to determine their own management pathway. The individual assessment is structured in a way that assists the patient to identify their own life-experienced based goals. This is in comparison to indication-focused goals decided on and led by health providers.[57]

4.74 The example of the LWwPP Program shows that self-management is an integral part to achieving better outcomes in chronic disease management, where the patient is involved in their care and support, rather than being at arm's length to the process. Being involved in their own care and management enables a patient to avoid being isolated by their condition, ultimately withdrawing from appropriate care practices or from the people that can support them the most in the community.

Wagner Chronic Care Model

4.75 One of the most resounding and recurring examples of best practice in chronic disease management and care highlighted throughout the inquiry was the Wagner Chronic Care Model, identified by many as the ideal model for creating high quality coordinated care, or as being the basis for existing care models, either in Australia or internationally.[58]

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57 Adelaide Primary Health Network, *Submission 119*, p. 46.

58 Dr Jodi Graham, *Submission 1*, p. 7; Flinders Human Behaviour and Health Research Unit, *Submission 4*, p. 3; Centre for Primary Health Care and Equity, UNSW, *Submission 6*, p. 1; Metro North Hospital and Health Service, *Submission 9*, p. [2]; Graduate School of Medicine, University of Wollongong, *Submission 16*, p. [1]; Lymphoedema Action Alliance, *Submission 33*, p. 26; Victorian Primary Care Partnerships, *Submission 36 – Attachment 1*, p. 16; beyondblue, *Submission 37*, p. 5; Medibank Private, *Submission 43*, p. 4; Australian Association of Social Workers, *Submission 46*, p. 4; The Peninsula Model, *Submission 64*, pp 2-3; Carrington Health, *Submission 72*, p. [1]; Australian College of Rural and Remote Medicine, *Submission 76*, pp 4-5;

4.76 Developed at the MacColl Center for Health Care Innovation in the mid-1990s, and further refined into the 21st century, the Wagner Chronic Care Model (named for one of the original researchers – Dr Edward Wagner) is a widely recognised best practice system for coordinating care. The Centre for Primary Health Care and Equity described the foundations of the model:

> …identifies system supports required for effective patient centred care of patients with chronic conditions - self management support, delivery system redesign for team care, decision support, information systems and electronic health records, health care organisation (including non-fee for service funding and incentives) and community resources (including engagement of non-government and religious organisations.[59]

4.77 The World Health Organization has endorsed the Chronic Care Model in its report *Innovative care for chronic conditions: building blocks for action: global report* as the preferred model and framework for building innovation in coordinated chronic disease care models in chronic disease health care systems.[60]

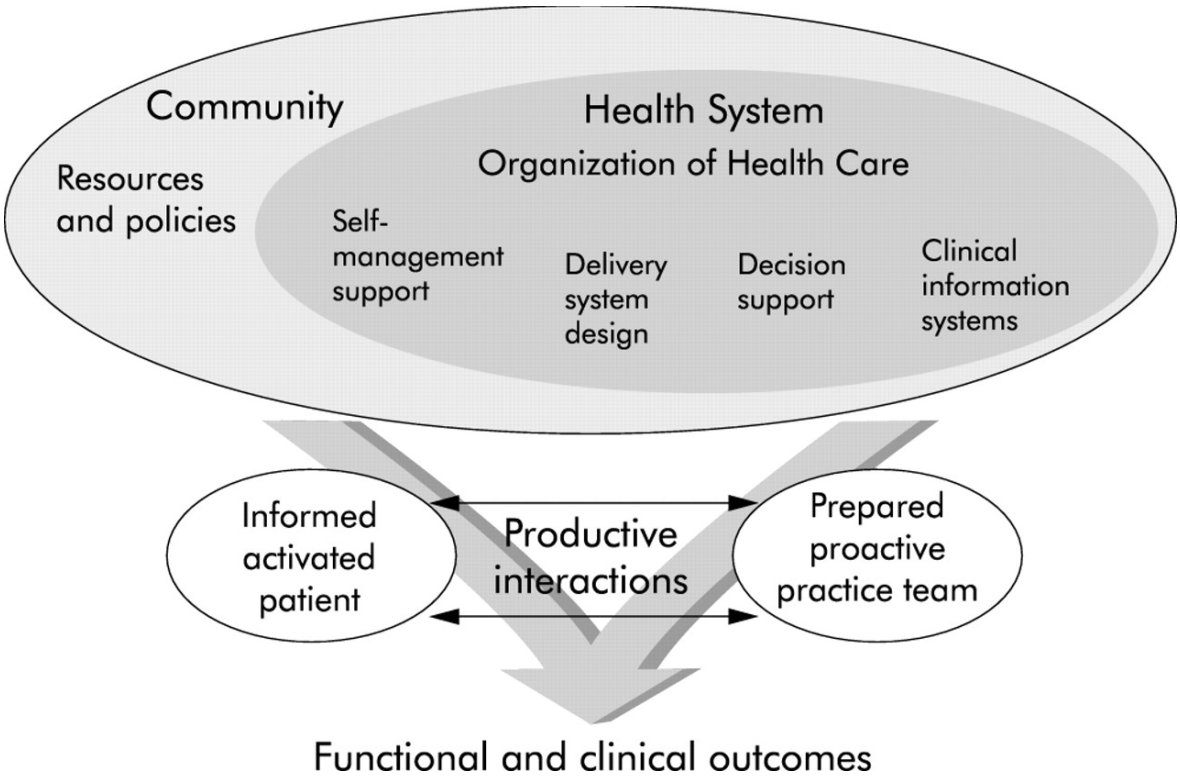
4.78 The theoretical basis for application of this model is visualised below.

Dr Chris Bollen, *Submission 87*, p. 5; cohealth, *Submission 88*, p. 11; Sydney Nursing School, University of Sydney, *Submission 91*, pp 2-3; Dr Paul Burgess, *Submission 92*, p. 5; ACN, CATSINaM, APNA, MCaFHNA & ACMHN, *Submission 106*, p. 46; Australian Medical Association, *Submission 107*, p. 6; Private Healthcare Australia, *Submission 108*, p. [2], Adelaide Primary Health Network, *Submission 119*, p. 11; Australian Psychological Society, *Submission 130*, pp 8-9; Northern Territory Department of Health, *Submission 133*, p. 4; Royal Australian College of General Practitioners, *Submission 135*, p. 4; Health Issues Centre, *Submission 139*, p. 4; Dietitians Association of Australia, *Submission 148*, pp 16-17; Mostyn Street Clinic, *Submission 163*, pp 3-4; WA Primary Health Alliance, *Submission 180*, p. 10; Grattan Institute, *Submission 188 – Attachment 1*, p. 18.

59 Centre for Primary Health Care and Equity, UNSW, *Submission 6*, p. 1.

60 World Health Organization, *Innovative care for chronic conditions: building blocks for action: global report*, 2002, pp 41-65.

Figure 4.2 Wagner Chronic Care Model



Source *National Public Health Service for Wales, 'Chronic Disease Management Models', December 2005, p. 36.*

4.79 The theoretical basis of the Wagner model has practical examples within Australia where programs have been developed to apply the principles of the model to health care planning and/or delivery:

- Peninsula Model - The Peninsula Model is a Primary Health Planning Framework developed through a partnership of agencies with a role in primary health care planning at a catchment-wide level in the Frankston and Mornington Peninsula local government areas in Victoria;[61]
- Hospital Admission Risks Program (HARP) – A Victorian program with a focus on care coordination, self-management support, and specialist care. It aims to reduce avoidable hospital presentations and admissions by targeting those who are current or are at risk of becoming, frequent hospital service users;[62]
- Improving the Diabetes Journey Project – an agreed model for identifying gaps in services to patients with type 2 diabetes in the Eastern Metropolitan Region (EMR) of Victoria. By using elements of the Wagner model to realign service delivery based on a more informed

61 The Peninsula Model, *Submission 64*, pp 2-3.

62 CAN, CATSINaM, APNA, MCaFHNA & ACMHN, *Submission 106*, p. 46.

understanding of the types of education programs that would best suit communities across the EMR;[63] and

- Medibank Private – an example of a private health insurer, recognising and adapting the Wagner model to better inform their member program design through recognising 'positive outcomes for people with long-term health conditions are achievable when they and their families, community partners and health professionals are informed, motivated and working together'.[64]

Case Study – England's House of Care Model

Due to a recognition of the need to reform medical treatment models for chronic diseases (known as long term conditions in the UK), the National Health Service (NHS) in England has introduced a model of care, informed by the Chronic Care Model, known as the House of Care.

The NHS identifies the increasing chronic disease problem in England:

> The 15 million people in England with long term conditions have the greatest healthcare needs of the population (50% of all GP appointments and 70% of all bed days) and their treatment and care absorbs 70% of acute and primary care budgets in England.[65]

As a result of this increasing burden and the identification of the need for patient-centred care, the House of Care Model was developed with the following four key elements:

- *Commissioning* – which is not simply procurement but a system improvement process, the outcomes of each cycle informing the next one.
- *Engaged, informed individuals and carers* – enabling individuals to self-manage and know how to access the services they need when and where they need them.
- *Organisational and clinical processes* – structured around the needs of patients and carers using the best evidence available, co-designed with

63 Victorian Primary Care Partnerships, *Submission 36 – Attachment 5*.

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

65 National Health Service England, 'House of Care Model - Background', <https://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/house-of-care/house-care-mod/>, viewed 12 April 2016.

service users where possible.

- *Health and care professionals working in partnership* – listening, supporting, and collaborating for continuity of care.[66]

By engaging patients and their carers and health care providers in care planning, health literacy and service provision, the House of Care employs a number of the principles of the Chronic Care model, to create the framework envisaged below.

Source *National Health Service England, 'Enhancing the quality of life for people living with long term conditions – The House of Care', <https://www.england.nhs.uk/house-of-care/>*

Whilst mainly a conceptual care framework, the House of Care model enables NHS providers to plan the care required by long term condition patients, by involving the patient's family, carers and numerous providers in their care planning and provisioning, to ensure the best coordinated care outcomes. This model shares a number of similarities to the 'Health Care Homes' reforms announced recently in Australia, with similar coordinated care goals and patient-centred outcomes at the heart of delivery targets.

4.80 The concept of the Chronic Care Model informs other models of coordinated care, such as the patient-centred medical home (PCMH) as discussed below. It also helps inform the 'Healthier Medicare' chronic disease reforms announced by the Australian Government on 31 March

66 National Health Service England, 'House of Care Model - Background', <https://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/house-of-care/house-care-mod/>, viewed 12 April 2016.

2016, which focuses on providing better coordinated care to chronic disease patients, utilising elements of the PCMH.

Patient-Centred Medical Home

4.81 The PCMH is the manifestation of the service delivery coordination and organisation from care models, such as the Wagner Chronic Care Model. The PCMH as a mechanism for delivering the coordinated care for chronic disease patients was the prime example raised with the Committee.[67]

4.82 The PCMH is a coordinated care delivery system developed in the United States since its inception in the early 21st century that has grown to be adapted by many countries and health care systems.[68]

4.83 This model has five key attributes that align with coordinated care, normally led by the patient's general practitioner or primary care provider:

- Comprehensive care that meets the majority of a patient's needs.
- Patient-centred care that prioritises the development of relationships between patients and providers.
- Coordinated care where care is planned and coordinated across healthcare settings to maximise positive outcomes.
- Accessible care, available to patients easily, when it is needed and in responsive settings.

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67 Dr Jodi Graham, *Submission 1*, p. 7; Centre for Primary Health Care and Equity, UNSW, *Submission 6*, p. 4; Pharmaceutical Society of Australia, *Submission 32*, pp 3-4; WentWest Limited, *Submission* 53, p. [2]; Orimary Health Care Ltd, *Submission 71*, pp 2-3; Australian College of Rural and Remote Medicine, *Submission 76*, p.15; cohealth, *Submission 88*, p. 12; Dr Paul Burgess, *Submission 92*, p. 10; Country SA Primary Health Network, *Submission 94*, p. [2]; Painaustralia, *Submission 96*, p.10; Western Health, *Submission 100*, p. 13; ACN, CATSINaM, APNA, MCaFHNA & ACMHN, *Submission 106*, pp 49-50; Australian Medical Association, *Submission 107*, p. 13; Adelaide Primary Health Network, *Submission 119*, pp 37-38; South Eastern Melbourne PHN, *Submission 123*, p. 4; Australian Primary Health Care Research Institute, *Submission 124*, p. 24; Royal Australian College of General Practitioners, *Submission 135*, pp 3-4; Bupa, *Submission 144*, p. 16; NSW Health, *Submission 152*, p. 18; Aboriginal Medical Services Alliance Northern Territory, *Submission 153*, p. 4; Sydney North PNH, *Submission 155*, p. 2; Dr Rosemary Panelli, *Submission 161*, p. 2; Mostyn Street Clinic, *Submission 163*, p. [1]; Department of Health and Human Services Victoria, *Submission 173*, p. 6; WA Primary Health Alliance, *Submission 180*, pp 2-3; Brisbane North PHN, *Submission 182*, p. [3]; Australian General Practice Network and Australian Association of General Practitioners, *Submission 184*, p. 7; Grattan Institute, *Submission 188 – Attachment 1*, p. 18; Professor Timothy Usherwood, Member, Kidney Check Australia Taskforce, Kidney Health Australia, *Official Committee Hansard*, Melbourne, 1 October 2015, p. 8.

68 Improving Chronic Illness Care, 'Patient Centred Medical Home', <http://www.improvingchroniccare.org/index.php?p=Patient-Centered_Medical_Home&s=224>, viewed 6 April 2016.

- Safe and quality care, where practitioners and practice systems aim for continuous quality improvement.[69]

4.84 These principles have guided the development of the 'Health Care Home' presented in the Primary Health Care Advisory Group's (PHCAG) report *Better Outcomes for People with Chronic and Complex Health Conditions: December 2015,*[70] which has been adopted in the Australian Government's 31 March 2016 announcement of the 'Healthier Medicare' chronic disease reforms.

4.85 The Health Care Home will have seven key features (as recommended by the PHCAG):

- **Voluntary patient enrolment** with a practice or health care provider to provide a clinical 'home-base' for the coordination, management and ongoing support of patient care. This includes the development of an individualised care plan for patients tailored to their specific conditions and health care needs.
- **Patients, families and their carers as partners in their care** where patients are motivated to maximise their knowledge, skills and confidence to manage their health, aided by technology and with the support of a health care team.
- **Patients have enhanced access** to care provided by their Health Care Home in-hours, which may include support by telephone, email or videoconferencing, and effective access to after-hours advice or care.
- **Patients nominate a preferred clinician** who is aware of their problems, priorities and wishes, and is responsible for their care coordination.
- **Flexible service delivery and team based care** that supports integrated patient care across the continuum of the health system through shared information and care planning.
- **A commitment to care which is of high quality and is safe**. Care planning and clinical decisions are guided by evidence-based patient health care pathways, appropriate to the patient's needs.
- **Data collection and sharing** by patients and their health care teams to measure patient health outcomes and improve performance.[71]

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69 Royal Australian College of General Practitioners, *Submission 135*, p. 3.

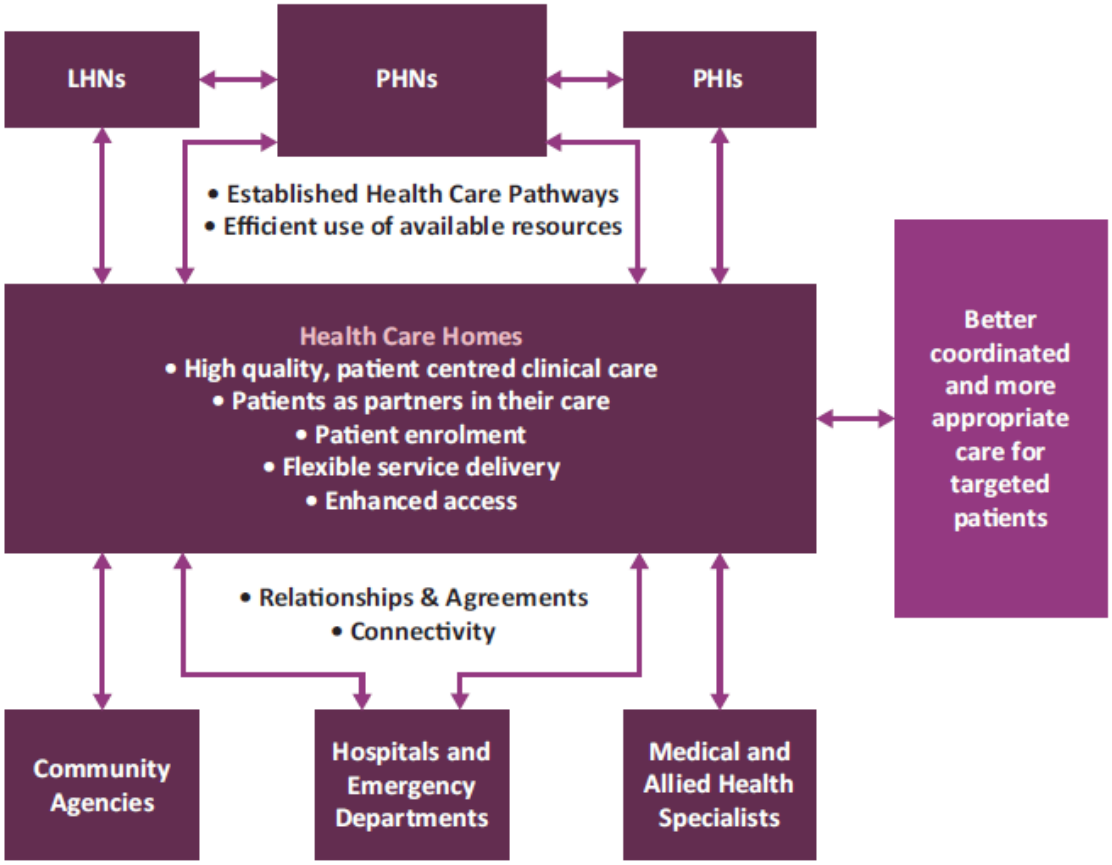
70 Commonwealth of Australia, Department of Health, *Better Outcomes for People with Chronic and Complex Health Conditions: Report of the Primary Health Care Advisory Group*, December 2015, pp 18-21.

71 The Hon. Sussan Ley MP, Minister for Health, Minister for Aged Care, Minister for Sport, 'Health Care Homes to keep chronically-ill out-of-hospital', *Media Release*, 31 March 2016.

4.86 Initial two-year trials will occur in up to 200 medical practices from 1 July 2017, affecting up to 65 000 chronic disease patients across Australia.

4.87 The essential coordination between the patient's 'home' practice, the relevant Primary Health Network, Local Health Network and any relevant Private Health Insurer is depicted in the Health Care Home framework illustrated below.

Figure 4.3 Health Care Home Model



Source *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, p. 19.*

4.88 This adoption of the recommendations of the PHCAG and the concepts of PCMH are a welcome addition to the Australian health care system, as highlighted on the day of the announcement by Mr Brendan Moore from Alzheimer's Australia[72] and Dr Justin Vaughan from NIB health funds.[73]

72 Mr Brendan Moore, General Manager, Policy, Research and Information, Alzheimer's Australia NSW, *Proof Committee Hansard*, Newcastle, 31 March 2016, p. 13.

73 Dr Justin Vaughan, Group Executive, Benefits and Provider Relations, NIB Health Funds, *Proof Committee Hansard*, Newcastle, 31 March 2016, p. 41.

Preventing Multi-morbidity

4.89 The current Medical Benefits Schedule (MBS) claiming restrictions on providing care plans and chronic disease management consultations, as well as standard consultation items, for the same patient on the same day is a concern for managing chronic disease patients, especially in rural or remote settings.[74]

4.90 The presentation of a patient to a general practitioner for a chronic disease management consultation is an important service to that patient, but if the practitioner cannot claim an associated or separate normal consultation item on the same day, then this has restrictions or repercussions, as outlined by Dr Robert Menz from the Royal Australian College of General Practitioners:

> If the patient is not able to get a rebate for a service in addition to the chronic disease management service, then the option is that the doctor either treats the patient for no benefit or charges the patient, who then has to pay it out of their own pocket, or the doctor asks the patient to come back on a different day to provide that service. Most GPs will not do the latter because they have got a sick patient in front of them who needs treatment that day.[75]

4.91 For chronic disease patients trying to manage complications from their disease, that may be affecting their overall health, or that extends into comorbid of multi-morbid conditions, this restriction on claiming multiple MBS items is problematic.

4.92 The challenges of managing multi-morbidity are already high, as outlined by the Australian Healthcare and Hospitals Association:

> Multimorbidity negatively influences a patient's capacity to manage chronic illness in multiple ways: it creates barriers to patients acting on risk factors; it complicated the process of recognising the early symptoms of deterioration of each condition; and it complicates their capacity to manage medication.[76]

4.93 This restriction in the MBS would appear to fall under the purview of the terms of reference for the current Medicare Benefit Schedule Review Taskforce, more specifically:

- Analyse the advice from the Working Groups and, in turn provide advice to the Minister, including advice on the evidence for services,

74 Rural Doctors Association of Australia, *Submission 17*, p. 10.

75 Dr Robert Menz, Corlis Fellow for South Australia, Royal Australian College of General Practitioners, *Proof Committee Hansard*, Adelaide, 4 March 2016, p. 2.

76 Australian Healthcare and Hospitals Association, *Submission 40*, p. 4.

appropriateness, best practice options, levels and frequency of support through Medicare.[77]

4.94 The removal of treatment and management barriers for patients with multi-morbid conditions, or who are at risk of developing multi-morbid conditions, is important to assuring the appropriate allocation and use of primary health care resources. To this end, the Health Care Home trials outlined above should help address some of these hurdles.

4.95 The Australian Healthcare and Hospitals Association points out that the majority of health research into chronic disease is still conducted into 'single index disease states'.[78] However, the increased benefit of disease and treatment data that is predicted to result from the 'Healthier Medicare' reforms will enable more robust datasets and research to occur. The importance of datasets and eHealth records is expanded later in this chapter.

Can Best Practice be 'One Size Fits All'?

4.96 The concept of the medical home and a 'one-stop-shop' for chronic disease management is an attractive and admirable goal and one that was expressed by several health care providers or commissioners.[79]

4.97 However, the concept of having a universal chronic disease management model is challenged by the nature of health care delivery in Australia generally, and even more so by the provision of coordinated chronic disease care for rural, remote and Aboriginal and Torres Strait Islander health services.

Rural, Regional and Remote Services

4.98 'One size will not fit all' is the direct statement of the Rural Doctors Association of Australia.[80] The challenges faced by metropolitan health care providers are very different from those in rural and remote areas, especially related to access to services, retention of workforce and the service requirements of general practitioners.

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77 Department of Health, 'Terms of reference - Medicare Benefits Schedule Review Taskforce', <http://www.health.gov.au/internet/main/publishing.nsf/Content/MBSR-tor>, viewed 6 April 2016.

78 Australian Healthcare and Hospitals Association, *Submission 40*, p. 4.

79 Queensland Government, *Submission 167*, p. 27; cohealth, *Submission 88*, p. 20; NSW Health, *Submission 152*, p. 7;

80 Rural Doctors Association of Australia, *Submission 17*, p. 7.

4.99 The tyranny of distance and the sparse population and separation of many rural Australians from health care providers warrants a special consideration of the models of chronic disease care required in these areas.

4.100 While a robust medical home model, where a physical location is identified for the ongoing care provision and coordination of a patient's chronic disease management is suitable in a metropolitan setting, the use of telehealth services is essential to providing adequate services in a rural or remote setting.[81]

4.101 The retention of rural and remote health care workers is also an ongoing issue for chronic disease management. In the twelve months from December 2011 to December 2012, from 1 707 medical practitioners operating across regional and remote areas in Queensland, 615 separations/departures were recorded.[82] This 36 per cent turnaround in staff is indicative of the challenges faced in retaining a stable and cohesive workforce.

4.102 Additionally, the requirements for a rural GP to maintain qualifications in specialisations such as obstetrics, anaesthetics and surgery can place strain on an already stretched workforce.[83]

4.103 The Australian Government has done extensive work in the rural health care workforce retention space, with the Rural Health Workforce Strategy, and more specifically the introduction of a modified General Practice Rural Incentives Programme from 1 July 2015, where incentive payments are better targeted to GPs who provide continued service in appropriately categorised rural and remote practices.[84]

Aboriginal and Torres Strait Islander Health Services

4.104 As discussed in earlier chapters, the burden of chronic disease in Australia is greater on Aboriginal and Torres Strait Islander (ATSI) peoples. Accordingly, the requirement for catered and appropriate chronic disease care services and models is essential.

4.105 The current blended payment and service models provided by Aboriginal Community Controlled Health Services (ACCHSs) or Aboriginal Medical Services are helping to address the Closing the Gap targets for ATSI people, but the continued high proportion of chronic disease impacts

81 Australian College of Rural and Remote Medicine, *Submission 76*, pp 3-4.

82 Royal Flying Doctor Service, *Submission 20 – Attachment 1*, p. 28.

83 Dr Rodney Pearce, Chairman, Australian General Practice Network Ltd, *Proof Committee Hansard*, Adelaide, 4 March 2016, p. 9.

84 Rural and Regional Health Australia, 'Rural Health Workforce Strategy Incentives', <http://www.ruralhealthaustralia.gov.au/internet/rha/publishing.nsf/Content/changestoGPRIPfactsheet>, viewed 7 April 2016.

warrants a focus on chronic disease prevention and management of risk factors, such as that being coordinated by the National Aboriginal Community Controlled Health Organisation.[85]

4.106 The blended funding of Aboriginal health provision can be seen in The Glen, an Indigenous organisation which treats drug and alcohol addicted patients, both Indigenous and non-Indigenous. The Glen's CEO Mr Joe Coyte stated that there is 'quite a complicated mixture of funding', including funding from the Department of Health, Prime Minister and Cabinet (PM&C), NSW health funding and Indigenous-specific NSW health funding.[86] South Coast Medical Service Aboriginal Corporation also stated that they receive PM&C funding for their 'safety and wellbeing component'.[87]

4.107 The Department of Health funding to help meet Closing the Gap targets is provided through the Indigenous Australians' Health Programme, which commenced in 2014.[88]

4.108 The requirement to work with ATSI communities and people in strengthening both general primary health care principles suitable to ATSI chronic disease pressures, as well as strengthening and supporting the current ACCHSs, is crucial to ensuring that the cultural and medical needs of these communities is met in a sustainable way.

4.109 The ATSI focus of the 'Healthier Medicare' chronic disease reforms will potentially help the closing of the gap in mortality and burden of chronic disease in ATSI populations, but the results of the Health Care Home trials will require specific ATSI data analysis to ensure that the reforms are culturally sustainable and provision of the model can be continued through the existing strong community health care mechanisms.

4.110 As outlined by the Improvement Foundation, currently the Australian Primary Care Collaboratives (APCC) program only captures half of the relevant Closing the Gap health outcome data, as only ACCHs are required to provide ATSI specific data for analysis.[89] If an ATSI patient

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85 NACCHO, 'The state of Aboriginal health', <http://www.naccho.org.au/aboriginal-health/aboriginal-health-state/>, viewed 7 April 2016.

86 Mr Joe Coyte, Chief Executive Officer, The Glen, *Official Committee Hansard*, Tumbi Umbi, 19 February 2016, p. 4.

87 Mr Craig Ardler, Chief Executive Officer, South Coast Medical Service Aboriginal Corporation, *Official Committee Hansard*, Bomaderry, 12 February 2016, p. 11.

88 Department of Health, 'Indigenous Australians' Health Programme', <https://www.health.gov.au/internet/main/publishing.nsf/Content/indigenous-programme-lp>, viewed 28 April 2016.

89 Dr Dale Ford, Principal Clinical Adviser, Improvement Foundation, *Proof Committee Hansard*, Adelaide, 4 March 2016, p. 24.

visits a community GP, then that treatment data does not flow into relevant datasets for Closing the Gap purposes.

Telehealth and eHealth Support

4.111 The importance of telehealth and eHealth initiatives, especially to rural, remote and low-mobility chronic disease patients, is a focus for many health care providers and commissioners.

4.112 Programs such as the Royal Flying Doctor Service's 'Medical Chests' program allow patients to access the services they would not normally be able to access easily. The Medical Chests program allows for pharmaceutical dispensing for inflammation, wound care or antibiotics via caches of supplies and specialised telehealth consultations to aid in dispensing these pharmaceuticals in specific circumstances.[90]

4.113 Innovative programs and services using telehealth and eHealth support, such as linking in multidisciplinary teams to rural cancer centres[91] is essential to coordinating the chronic disease management of affected rural and remote populations.

4.114 Simplified video or telephone consultations for disease management, such as 'home monitoring, coaching, video consultation appointments and home medication management'[92] is a key benefit that can be realised in the delivery of health care via eHealth initiatives.

4.115 eHealth support in the form of websites that allow for the convenient delivery of relevant information or secure messaging between providers of relevant records or patient information are essential to diversified health care delivery.[93]

4.116 eHealth records, such as the expanding 'My Health Record' initiative are also an important component of diversified and supported health care management.

Case Study – Diabetes Telehealth

The Royal Flying Doctor Service's Victorian Section has run it Diabetes Telehealth Service since 2013, allowing comprehensive diabetes telehealth consultations to be conducted in rural Victoria.[94]

The Service is based in Mildura where there is no resident diabetes specialist. Hosted by Monash School of Rural Health in Mildura, local diabetes patients are connected with endocrinologists from Baker IDI Heart and Diabetes Institute in

90 Royal Flying Doctor Service, *Submission 20 – Attachment 1*, pp 26-27.

91 NSW Health, *Submission 152*, p. 21.

92 Australian Pain Management Association, *Submission 52*. p. 11.

93 ACN, CATSINaM, APNA, MCaFHNA & ACMHN, *Submission 106*, p. 30.

94 National Rural Health Alliance, *Submission 67*, p. [15].

Melbourne. Additionally, consultations can be conducted at a number of locations across rural Victoria, hosted by local health services.[95]

Source *Royal Flying Doctor Service, Diabetes Telehealth website gallery, https://flyingdoctortelehealth.org.au/gallery#!RFDS_Telehealth_1*

Currently the partnered services are:

- Mildura Base Hospital
- Mallee District Aboriginal Services
- Sunraysia Community Health Services
- Robinvale District Health Services
- Dareton Primary Health Service
- Balranald Primary Health Service
- Northern District Community Health Service
- West Wimmera Health Service
- Robinvale District Medical Practice
- Murray Primary Health Network

The telehealth service allows support not only for patients, but also GPs and diabetes educators.The service is 100 per cent bulk billed and can allow for timely access to specialists via videoconference.

95 Royal Flying Doctor Service Victorian Section, 'Diabetes Telehealth: About the Service', <https://flyingdoctortelehealth.org.au/index.php/about-diabetes-telehealth/about-the-service>, viewed 7 April 2016.

Data Registries and eHealth Records

4.117 Regardless of the expansion of the services and coordination of chronic disease care, without the appropriate data, records and patient information, both for care and evaluation and research needs, the fragmentation of chronic disease management in Australia will continue.

eHealth Records

4.118 While primary health care, especially general practice, is a technologically advanced sector of society, the same cannot be said for allied health providers, specialists and surgeons. In 2012 only approximately 37 per cent of specialists and 22 per cent of surgeons relied on computerised patient records.[96]

4.119 Similarly, even though general practice do generally use electronic patient records, there are still multiple proprietary systems used and on the market. It is for this reason that the Australian Government and state and territory governments established the National Electronic Health Transition Authority (NeHTA) in 2005 to help promote eHealth initiatives and create standards for the health care sector to adopt.[97]

4.120 These standards and their application to patient records aid in the connectivity required for multidisciplinary and coordinated care.[98] The Health Network Northern Territory highlighted the importance of eHealth in a diverse community:

> Given the large geographical size of the Northern Territory, increased access to eHealth technology will greatly improve the prevention and management of chronic disease. The use of eHealth has been demonstrated internationally to decrease the administration burden of health care service delivery, improve the quality of care, increase efficiencies and encourage patient self-management. Best practice includes an electronic patient record, electronic prescribing and medication administration, telehealth services and secure message services for health professionals.[99]

4.121 The establishment of the Personally Controlled Electronic Health Record (PCEHR) in July 2012, now the My Health Record, has enabled a universal platform for the storage and management of health information about patients in Australia and placed the control of that information with the

96 Cancer Australia, *Submission 65*, p. 5.

97 NEHTA, 'About NEHTA', <http://www.nehta.gov.au/about-nehta>, viewed 7 April 2016.

98 Victorian Primary Care Partnerships, *Submission 36*, p. 16.

99 Health Network Northern Territory, *Submission 27*, p. [2].

patient themselves. The review of the PCEHR released in May 2014 establishes a firm foundation for the My Health Record to become the central repository of patient information[100], for both general health and chronic disease management.

4.122 NeHTA will transition into the Australian Digital Health Agency as of 1 July 2016, continuing its work in the electronic health standards space, as well as taking responsibility for the continued management of the My Health Record.

4.123 Access to the My Health Record is currently limited to the patient and any 'nominated healthcare provider' that is granted access by the patient's consent; however access to the health information stored within can be accessed by certain parties in the case of an emergency.[101]

4.124 The patient data stored within the My Health Record, as well as in the wider electronic patient and other health record systems across Australia, can form the datasets and data registries that many identify as being crucial to coordinated chronic disease care, as well as evidence-based research and policy development.

Datasets and Registries

4.125 The creation of a unified national health dataset, by combining the information from federal government data (Medicare, Pharmaceutical Benefits Scheme (PBS) and aged care) along with private and public hospital data, is an ideal outcome that could help drive health outcomes and reform.[102]

4.126 However, the reality of multiple sources, formats, quality and access to the health care data existing in Australia's systems places barriers on accessing a centrally consistent dataset or data registry for use in chronic disease prevention or management.

4.127 Currently there are multiple datasets of patient information within the health care sector, as well as potentially replicated data held by private health insurers related to their members. The potential to access that de-identified or secure member data, to supplement any consolidated government patient data, is a compelling reason to investigate sharing and

100 Department of Health, 'My Health Record', <http://health.gov.au/internet/main/publishing.nsf/Content/ehealth-record>, viewed 7 April 2016.

101 Department of Health, 'My Health Record – Managing access, privacy and security', <https://myhealthrecord.gov.au/internet/mhr/publishing.nsf/Content/privacy?OpenDocument&cat=Emergency%20Access>, viewed 7 April 2016.

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

consolidating data related to chronic disease and wider health status and outcomes.

4.128 The ability to plan adequate care and analyse treatment outcomes is placed at risk by these multiple sources, as expressed by the Australian Health Services Alliance:

> Consolidating diverse data sets into a single, longitudinal consumer journey record will yield insights into health trends and effectiveness of interventions undertaken. This cannot be gleaned from siloed data in multiple, separate systems.[103]

4.129 The Australian Healthcare and Hospitals Association calls for Medicare Benefits Schedule (MBS) data to be made available to states and PHNs to allow for proper analysis of chronic disease impacts and multi-morbidities, as well as advocating for the increased promotion and utilisation of a complete My Health Record. [104]

4.130 Likewise, the Victorian Healthcare Association identifies the equally as important requirement to have state hospital and treatment data available 'to facilitate benchmarking, performance evaluation and population health planning. An efficient and effective health system requires continuous quality improvement, and data to inform such processes'.[105]

4.131 More realistically, the Australian Institute of Health and Welfare calls for the linking of Australian Government held data within the MBS, PBS and Repatriation Pharmaceutical Benefits Scheme (RPBS):

> …linkage of MBS, PBS, RPBS and other important data sources such as hospital data, within existing strict privacy regimes, would rapidly enhance the nation's capacity to better understand the patterns of service use and health outcomes experienced by those hospitalised for chronic disease.[106]

4.132 The quality improvements expected of PHNs and to arise from the 'Healthier Medicare' reforms must be data-driven.[107] This data can help create 'Patient health care pathways', as identified by the Primary Health Care Advisory Group, clinical support tools to assist care planning and delivery, based on local patient and service data.[108]

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103 Australian Health Services Alliance, *Submission 26*, p. 1.

104 Australian Healthcare and Hospitals Association, *Submission 40*, pp 9-10.

105 Victorian Healthcare Association, *Submission 78*, p. 8.

106 Australian Institute of Health and Welfare, *Submission 127*, p. 5.

107 Dr Paul Burgess, *Submission 92*, p. 7.

108 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, p. 28.

4.133 These pathways are an embodiment of the practical application of datasets and data registries enabling better coordination and improvement in health care for chronic disease. One such example is the Canterbury Experience in New Zealand.

The Canterbury Experience

4.134 The Canterbury Experience is an online tool for health care providers where centralised data regarding patients in the Canterbury District Health Board can be accessed by practitioners, such as referrals, diagnostic information and treatment options within the district, based on data from the area.[109]

4.135 Complementing this in an online tool called 'HealthInfo', that allows patients to access similar consumer-targeted information to allow for their self-management of their conditions and to complement the health pathways recognised by the District Health Board.[110]

4.136 The framework created for the Canterbury Experience was adopted by a number of Medicare Locals and is now being used by multiple PHNs across Australia to help establish similar practice and consumer information portals and datasets.[111]

Australian Primary Care Collaboratives

4.137 Domestically, the APCC (delivered by the Improvement Foundation and funded until recently by the Department of Health) creates a similar health pathways framework and dataset for the Australian health care system.

4.138 Performance and improvement tools for general practice, based on practice data is the key to the APCC's goals, as expressed by the Improvement Foundation:

> …our experience has been that people, by and large, think they are doing a good job, because they are working hard and they are concentrating on the relationship with the individual. But unless they have the data that shows where they fit against their peers, against benchmarks and, more importantly, against what the evidence says you should do, nothing happens.[112]

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109 Canterbury District Health Board, 'HealthPathways', <http://www.cdhb.health.nz/Hospitals-Services/Health-Professionals/Pages/Health-Pathways.aspx>, viewed 12 April 2016.

110 Canterbury District Health Board, 'HealthInfo', <http://www.healthinfo.org.nz/>, viewed 12 April 2016.

111 Grattan Institute, *Submission 188 - Attachment 1*, p. 27.

112 Dr Dale Ford, Principal Clinical Adviser, Improvement Foundation, *Proof Committee Hansard*, Adelaide, 4 March 2016, p. 19.

4.139 The data collected from practice systems can then be used to train practitioners on better ways to manage their patients:

> The model supports general practices to improve clinical outcomes, help maintain good health for those with chronic and complex conditions, and improve access to Australian general practice by promoting a culture of quality improvement in primary health care.[113]

4.140 The key role that data plays in building an improvement framework such as the APCC, is an example of how intelligent use of data can drive better outcomes for patients, as well as create snapshots of data from individual practice level, up to national dataset levels.

Healthier Medicare Reforms

4.141 As part of the 31 March 2016 announcement of the chronic disease focus of 'Healthier Medicare' reforms, the role of the My Health Record is to be prioritised in coordinating care for patients, as well as providing de-identified data to help establish a 'quality improvement framework and the foundation of a National Minimum Data Set'.[114]

4.142 The details of this dataset are still to be determined, but any move to integrate coordinated data, with the help of the PHNs, can help to support the role of quality data in chronic disease management into the future.

Privacy Concerns

4.143 Underlying the use of patient data, either in eHealth records or in general datasets and data registries, is the key consideration that overarching the data integrity of any such information is that privacy requirements in Australia may potentially threaten any expansion of use of such data.

4.144 Queensland PHNs commented:

> One real problem we have at the moment is the privacy commissioner, who has identified that, fundamentally, every general practice is in breach of the privacy rules and could be subjected to massive fines if they used the My Health Record.[115]

4.145 When asked to comment on whether they had any concerns around privacy breaches regarding the use of the My Health Record, the Royal Australian College of General Practitioners commented:

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113 Country South Australia PNH, *Submission 94*, p. 1.

114 The Hon. Sussan Ley MP, Minister for Health, Minister for Aged Care, Minister for Sport, '*My Health Record* & Improved Health Data to better coordinate care', *Media Release*, 31 March 2016.

115 Dr Richard Kidd, Clinical Lead, Brisbane North Primary Health Network, *Official Committee Hansard*, Brisbane, 18 February 2016, pp 8-9.

> The legislation that provides for the national eHealth record system (My Health Record) establishes a privacy regime that generally operates concurrently with Commonwealth, state and territory privacy laws. However, the My Health Record legislation and regulations do place significant new responsibilities and risks on general practices participating in My Health Record. For example, a privacy breach can result in significant fines or criminal penalties. In addition to these obstacles, clinical and functionality issues need to be resolved before My Health Record will become an embedded component of the healthcare landscape and a useful tool for GPs.[116]

4.146 Generally, the sharing of patient information, including under the My Health Record system, is based on obtaining patient consent to share relevant information.[117] To this end, the Office of the Australian Information Commissioner provides guidance on how an individual can best manage and safeguard their own My Health Record.[118]

4.147 Extending beyond eHealth records, the aggregation of health data for epidemiological and disease trend bases can be achieved with de-identified patient data, so any privacy concerns related to use of that information should be negated.

Concluding Comment

4.148 During the course of the inquiry, the Committee was overwhelmed with the enthusiasm and passion that many clinicians, researchers, patients and providers showed for improving the systems of chronic disease prevention and management in Australia.

4.149 The myriad examples of best practice models and programs for educating and involving patients in their own care and wellness, as well as coordinating and participating in the management of their conditions, was a clear indication of the desire to create better systems for chronic disease, both internationally and domestically.

4.150 There is also a clear indication that systems developed and implemented to address chronic disease must be based on two clear principles – they must be evidence-based and evaluated, and they must be flexible enough

116 Royal Australian College of General Practitioners, *Submission 135.1*, p. [3].

117 Victorian Primary Care Partnerships, *Submission 36*, p. 17.

118 Office of the Australian Information Commissioner, 'My Health Records', <https://www.oaic.gov.au/individuals/faqs-for-individuals/health/my-health-records>, viewed 12 April 2016.

to apply to the wide range of cultures, populations and service circumstances that the Australian community presents.

Chronic Disease Prevention

4.151 The importance of education and awareness in the general population of the lifestyle/risk factors that can contribute to a lot of chronic diseases is evident.

4.152 Federal, state and territory governments, peak bodies, private health insurers and interested health care providers currently do a great deal of work in promoting healthy lifestyles or advocating reductions in consumption of tobacco and alcohol. The impacts of tobacco reform in Australia in past decades have been especially relevant to the discussion on how to create chronic disease prevention strategies.

4.153 Additionally, the role of health checks and assessments are crucial to potentially identifying early chronic disease or risk factors that may contribute to the onset of conditions in the future.

4.154 The argument for an integrated health assessment check for cardiovascular, kidney disease risk and diabetes to be added to the current MBS is a valid one.

4.155 The issue of people accessing MBS item 715 health checks through self-identification, when they may not be of Aboriginal or Torres Strait Islander descent was raised a number of times during the inquiry. The Committee believes there is an opportunity for a review of the self-identification process for accessing health checks and the like.

Best Practice in Chronic Disease Management

4.156 The 'Healthier Medicare' chronic disease reforms announced on 31 March 2016 embody many of the principles of best practice coordinated care that the Committee has been presented with and considered through the course of this inquiry.

4.157 The Australian Government is to be commended on the announcement of the Health Care Home trials, as well as the continued work in the Medicare Benefits Schedule Review, Medicare Compliance Review and Primary Health Care Advisory Group.

4.158 The Committee welcomes the intent behind the targeting of these trials to chronic disease patients, as well as the commitment to prioritise Indigenous and rural and remote communities in the trials and wider reforms in train.

4.159 The Committee believes these trials are an embodiment of the best practice models considered in the inquiry and support their prioritisation, evaluation and expansion into the future.

4.160 The Committee also believes that the current restrictions on clinicians not being able to claim a rebate for a chronic disease management consultation, as well as a general consultation rebate, for the same patient on the same day should be reviewed.

Data and Chronic Disease

4.161 The importance of patient records and associated data related to chronic disease cannot be understated. The continuity and quality of care that stems from consistent patient records, discharge summaries and test results is far superior to that managed by isolated and sometimes indecipherable paper files.

4.162 The expansion and promotion of the My Health Record is a welcome step to creating a centre of patient information for coordinated chronic disease care, however, the utilisation of the record by patients and providers must occur for the data to be meaningful for research, analysis and policy development.

4.163 Privacy concerns appear to be in the forefront of development of the expansion of eHealth tools and records, so as long as the promotion of patient control of their data and the requisite consent is acquired, then the privacy of such information (including de-identified) data should be assured.

4.164 The Committee does feel that the existing health datasets within federal and state government control should be reviewed in regard to analysis and potential combination for the purposes of the National Minimum Data Set or associated data registries.

4.165 The AIHW's suggestion for linking of MBS, PBS and RPBS data, with any applicable hospital data appears to have merit and the Committee supports the analysis of any such work.

Recommendations

Recommendation 6

4.166 **The Committee recommends that the Australian Government examine the inclusion of an integrated health assessment check for cardiovascular, kidney disease risk and diabetes as per that developed by the National**

Vascular Disease Prevention Alliance, where a patient does not already qualify for an existing assessment and the treating practitioner suspects they are at risk of these chronic diseases.

Recommendation 7

4.167 **The Committee recommends a review of the self-identification process for accessing health checks and the like.**

Recommendation 8

4.168 **The Committee recommends that the development and implementation of the Health Care Home trials, as part of Healthier Medicare, be prioritised and continue to be developed in consultation with relevant expert panels; and**

That the outcomes of the trials be evaluated as they occur to inform further coordinated care developments for chronic disease patients and the wider Australian community.

Recommendation 9

4.169 **The Committee recommends that the Australian Government examine reforms to the Medicare Benefit Schedule to allow for a practitioner to claim a rebate for a chronic disease management consultation and a general consultation benefit, for the same person on the same day.**

Recommendation 10

4.170 **The Committee recommends that the Australian Government examine the feasibility of linking relevant Medicare Benefits Schedule, Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data, with applicable hospital patient data, to create a unified patient dataset, or to consider this link when developing the National Minimum Data Set for Healthier Medicare purposes.**