AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | info@ama.com.au
W | www.ama.com.au
42 Macquarie St Barton ACT 2600
PO Box 6090 Kingston ACT 2604

7 August 2015

Mr Shane Armstrong
Inquiry Secretary, Standing Committee on Health
Department of the House of Representatives
PARLIAMENT HOUSE
CANBERRA ACT 2600
health.reps@aph.gov.au

Dear Mr Armstrong,

Re: Submission to the House of Representatives Standing Committee on Health Inquiry into Chronic Disease Prevention and Management in Primary Care

The AMA welcomes the House of Representatives Standing Committee on Health Inquiry into Chronic Disease Prevention and Management in Primary Health Care.

The AMA recognises that care for people with chronic disease is a major challenge confronting the Australian health system. The increasing incidence of chronic diseases such as diabetes, cardiovascular disease, and respiratory disorders mean more people in Australia are living with debilitating illness, unable to work or participate in their communities, and facing poor mental health, disability and premature death. Addressing and managing the health needs and escalating costs associated with the growing incidence of chronic diseases requires further policy emphasis on supporting the role of primary health care, particularly general practice.

The AMA notes that this Inquiry aims to investigate and report on best practice in chronic disease prevention and management in primary health care. In this regard, this Submission is directed at the following aspects of the Terms of Reference (TOR), to identify:

1. Examples of best practice in chronic disease prevention and management, both in Australia and internationally;
2. Opportunities for the Medicare payment system to reward and encourage best practice and quality improvement in chronic disease prevention and management;
3. Opportunities for the Primary Health Networks to coordinate and support chronic disease prevention and management in primary health care;
4. The role of private health insurers in chronic disease prevention and management;
5. The role of State and Territory Governments in chronic disease prevention and management;
6. Innovative models which incentivise access, quality and efficiency in chronic disease prevention and management;
7. Best practice of Multidisciplinary teams chronic disease management in primary health care and hospitals; and

8. Models of chronic disease prevention and management in primary health care which improve outcomes for high end frequent users of medical and health services.

In considering this issue it is also important to note that GPs work hard to provide quality affordable patient care. However, the inadequate indexation of Medicare patient rebates over many years, now coupled with a Budget imposed indexation freeze is making it harder to maintain the viability of practices so that patients can access the range and quality of services they have come to expect from general practice.

Medicare rebates for GP services were last indexed on 1 July 2014 and the Government plans to keep these rebates frozen until mid-2018. However, practice costs including wages for practice staff, rent, electricity, computers, continuing professional development, practice accreditation and professional insurance – are constantly rising. In responding to ongoing funding constraints, general practice has undergone enormous change in a drive for greater efficiency including through the adoption of team based care, technology and a move towards larger practices. With these gains largely having been exhausted, general practices cannot continue to absorb the ever-increasing costs of running a small business and remain viable.

The perverse effect of the rebate freeze will be to impact disproportionately on the vulnerable in the community. The current practice of bulk billing concession card holders and children will decrease due to the imperative to maintain practice viability and provision of services. Concession card holders will be charged a gap that will be in excess of the bulk billing incentive simply to maintain the same quality care they enjoy now.

Therefore the Medicare rebate freeze must be lifted as soon as possible.

In addition, the administrative arrangements for Medicare paying patient rebates should be simplified so that where patients are charged a fee over and above the Medicare Scheduled fee by a practice, they should only be required to collect the gap from the patient as opposed to the full up-front fee. This would cut red tape, reduce up-front costs for some patients and support GPs in having more discretion in charging modest out of pocket costs for those patients who can afford to contribute towards the cost of their care. With strong safety nets in place for patients, this would help strike a better balance that would support the ongoing sustainability of general practice, give greater recognition to the value of the services that GPs provide and help to engage patients more in their care.

Chronic disease in Australia - overview

Defining chronic disease

Many illnesses and health conditions that are long lasting, not able to be resolved quickly and are rarely cured completely are referred to as chronic disease.[1] Chronic diseases are complex and vary in terms of their nature, how they are caused and the extent of their impact on the community. Features common to most chronic diseases include:[2]

- Complex causality, with multiple factors leading to their onset;

[1] NMTAN (2015) Scoping paper: Changing clinical work with projected changing burden of chronic disease.
[2] NMTAN Ibid.

- A long development period, for which there may be no symptoms;
- A prolonged course of illness, perhaps leading to other health complications; and
- Associated functional impairment or disability.

Chronic diseases require ongoing management, yet most are preventable for many people through healthy lifestyle choices. While they are more common in older people, chronic diseases are becoming increasingly common in children and younger people.

Diseases that fall under the broad heading of chronic disease include: cardiovascular conditions (such as coronary heart disease and stroke), endocrine disorders (most commonly diabetes), some respiratory diseases (commonly asthma and COPD), kidney disease, musculoskeletal diseases (such as osteoarthritis and rheumatoid arthritis), mental and nervous system disorders, and cancers. [3]

Burden associated with chronic disease

Chronic conditions are responsible for about 85% of the total burden of disease in Australia.[4] Conditions such as heart disease, diabetes and mental illness are among the top 10 causes of premature death. People with chronic conditions account for a large share of the 635,000 potentially avoidable hospitalisations in 2011–12.[5]

The Bettering the Evaluation and Care of Health (BEACH) Report, *General Practice Activity Australia in 2010-2011*, confirms that GPs are increasingly treating older patients with more complex care needs and the chronic problems most often treated by GPs are hypertension, diabetes, depressive disorder, cholesterol-related disorders, chronic arthritis, oesophageal disease, and asthma. Many older patients suffer from two or more chronic conditions, complicating diagnosis and management.

The Australian Institute of Health and Welfare (AIHW) reported that in 2007-08 there were 33.6 potentially preventable admissions per 1,000 people and that more than half of those were due to chronic conditions, costing over $1.3 billion a year.

Primary health care and tackling chronic disease

Primary health care has been demonstrated as the most effective way to deliver health services and Australia must continue to embrace and strengthen this model. International studies show that the strength of a country's primary health care system is associated with improved population health outcomes for all-cause mortality, all-cause premature mortality, and cause-specific premature mortality from major respiratory and cardiovascular disease. Furthermore, increased availability of primary health care is associated with higher patient satisfaction and reduced aggregate health care spending. [6]

[3] AIHW (2010) Premature mortality from chronic disease. Bulletin 84, 2010.
[4] Plant et al (2015) Coordinated care versus standard care in hospital admissions of people with chronic illness: a randomised controlled trial. Med. J. Aust. 2015: 203(1):33-38
[5] NHPA (2015) Healthy Communities: GP care for patients with chronic conditions in 2009-2013 http://www.myhealthycommunities.gov.au/Content/publications/downloads/NHPA_HC_Report_GP_Care_Report_December_2014.pdf
[6] AMA (2010) Primary Health Care 2010 position statement. https://ama.com.au/position-statement/primary-health-care-2010

Increasingly, people with chronic disease are being treated by primary care teams. This team based approach allows patients access to a broad range of professional expertise and has helped improve access to care for patients as well as the quality of care that they receive. However, it is important to recognise that for this approach to be both clinically and cost effective, patients require a medical diagnosis and for their care to be properly coordinated. In this regard, general practitioners are the highest trained general health care professional. They bring experience and training in whole-patient, multi system continuous care, and have been traditionally recognised as the most appropriate primary care professional to manage a patient's care. It is important that this fundamental role is preserved, otherwise Australia risks creating a more fragmented health system that will deliver poorer outcomes for patients and cost the community more.

In this context, the AMA supports a primary health care system that:

- Recognises the fundamental and pivotal role of general practice in primary health care;
- Encourages and supports multidisciplinary care with access to a broad range of allied health services and other support services;
- Supports preventative medicine and proactive care;
- Ensures non-medical health professionals operate within their scopes of practice and work in an interdependent, co-operative relationship with medical practitioners;
- Funds services on the basis of need without compromising the doctor/patient relationship;
- Supports the use of effective e-health and telecommunications technology to ensure access to, continuity and coordination of care; and
- Seeks to enhance existing and proven funding models with supplementary funding mechanisms where necessary.

Importantly, primary health care is critical to providing quality, effective and empowering care for people with chronic disease. With more than half of all potentially preventable hospital admissions due to chronic conditions, costing more than $1.3 billion a year, there are significant benefits in ensuring access to timely, clinically necessary and well-coordinated health care.

The Coordinated Care Trials in Queensland in 2008 for example, demonstrated that GP led care reduced hospital admissions by up to 25%, reduced inpatient costs by 26%, reduced patients' rate of depression and improved their quality of life.[7] The trial demonstrated that when all costs are included (MBS, PBS, hospital etc.), service provision costs can be reduced by 8%. In addition, the trial found that when patients were connected to community models rather than acute models of care that they were more active in their own health maintenance.

Furthermore, strengthening and integrating the role of primary health care providers is a common thread in recommendations from the Garling Report (2008),[8] the National Health

[7] GP Partners, Coordinated Care (2008) Team Care Health II Perspectives, http://www.gppartners.com.au/content/Document/report_teamcare.pdf.

[8] Garling P. (2008) Final report of the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals. Sydney: NSW Government, 2008.

and Hospital Commission Report (2009),[9] and the National Primary Health Care Strategy (2010).[10]

AMA specific comment relating to the TOR

Examples of best practice in chronic disease prevention and management, in Australia and internationally

Prevention

Globally, for lifestyle related health problems, the main risk factors are alcohol and tobacco use, overweight and obesity, sedentary lifestyle, high fat and calorie intake with low fruit and vegetable intake, hypertension, hypercholesterolemia, and driving and working under the influence of drugs.[11] These risk factors are highly prevalent among older adults.[12] Although some approaches are recognised as effective, intervention implementation requires consideration of specific issues for different target populations and settings; that is, additional planning to ensure maximum reach, participation and adherence to maximise outcomes may be required.[13]

For example, older adults are not a homogeneous population, and within the age range of 55-74 years, people are experiencing different life stages and circumstances that need to be taken into consideration when planning and implementing a portfolio of programs.[14] Additionally, programs should be specifically tailored and implemented to reach older people in rural and remote areas, socioeconomically disadvantaged people, older Indigenous Australians, older people from culturally and linguistically diverse backgrounds, and people ageing with a longstanding disability, all of whom experience additional social and economic barriers.

Furthermore, chronic disease prevention approaches vary according to the health system and the dominant political opinions involved. Different countries may place different emphasis on the responsibility of the community and the individual, depending on cultural views regarding the role of state and individual autonomy. Scandinavian policies, for example, attach considerable importance to environmental factors and social conditions. Other countries, such as France, Germany and the United States focus more on the individual's attitude to risk factors such as tobacco, alcohol and nutrition. United Kingdom, Canada and New Zealand, on the other hand, emphasize integrated approaches, with clinical care systems as part of a broader approach that involves public health and health promotion efforts linked to disease management and support for self-care.[15]

Prevention initiatives target people with high risk factors for developing a chronic disease, focussing on the social determinants of health and the underlying factors that make population groups at greater risk of ill health. The aim is to improve the health and well-

[9] National Health and Hospitals Reform Commission (2009) A healthier future for all Australians: final report June 2009. (http://www.health.gov.au/internet/nhhrc/publishing.nsf/content/nhhrc-report
[10] Department of Health and Ageing. Building a 21st Century Primary Health Care System – Australia's First National Primary Health Care Strategy. Canberra: DOHA, 2010
[11] Busse et al. (2010) Tackling chronic disease in Europe. Observatory Studies Series No 20.
[12] Hector et al. (2012) Reducing the risk of chronic disease in older adults. PANORG, 2012.
[13] Hector et al (2012) Ibid.
[14] Hector et al (2012) Ibid.
[15] Busse et al. (2010) Ibid.

being of people prior to the onset of a chronic disease, and this may include primary prevention, integrated health promotion, risk reduction and whole of population approaches.

In this context, in Australia, over the past few years, the Commonwealth and State/Territory governments have implemented a range of programs which aim to improve the health of Australians, with varying degrees of success. These include strengthened tobacco legislation, a Chronic Disease Strategy, Eat Well Be Active programs to reduce weight and obesity through physical activity and healthy eating, The Life program to identify people with pre-diabetes and to provide intervention to support lifestyle changes, Smart Moves and Smart Choices physical activity and health food supply policies in state schools, and the Indigenous Chronic Disease Package, to name a few.[16,17] Although undoubtedly worthwhile in their own right, there appears to be a lack of coordination of programs and linkages across governments/communities.

In this regard, the AMA is of the view that healthy behaviour change comes from complex, long-term and multi-layered processes that enable people to take control of the decisions that influence their health. The actions needed to combat preventable chronic disease will require long-term commitment and investment, must be better led and coordinated, and should be delivered as a partnership between the Government and the community.

Management of chronic disease

With regard to management of chronic disease, the AMA acknowledges the Wagner Model for Improving Chronic Care (The Chronic Care Model - CCM)[18], endorsed by the WHO, as the basis/model to inform and guide the service system redesign required to support people with chronic disease. The model proposes that managing chronic disease requires nothing less than a transformation of health care, from a system that is essentially reactive – responding mainly when a person is sick – to one that is proactive and focused on keeping a person as healthy as possible. The CCM is a well-established framework for chronic disease management and practice improvement. There is considerable evidence showing that this model leads to more effective care and improved patient outcomes for people with chronic disease.[19,20] Key elements of the model include better integrated and coordinated care, collaboration across a multidisciplinary team of care providers, planned care with regular follow-up and review, and support for patient self-management.

Digital technologies can assist chronic disease management by decreasing the administrative burden of care delivery, improving quality of care, increasing practice efficiencies and better supporting patient self-management. For example, shared electronic health records could improve sharing of information across the care team, e-Referral

[16] Queensland Government (2008) Queenslanders tackling chronic disease: becoming Australia's healthiest state.
[17] DHS Primary Health Branch (2008) Revised Chronic Disease Management Program Guidelines for Primary Care Partnerships and Primary Health Care Services.
[18] Wagner et al (2001) Improving chronic illness care: translating evidence into action. Health Aff (Millwood), 20:64-78, 2001.
[19] Coleman et al (2009) Evidence on the chronic care model in the new millennium. Health Aff. (Millwood) 2009, 28:75-85.
[20] Dennis et al (2008) Chronic disease management in primary care: from evidence to policy. Med. J. Aust. 2008, 188 (Suppl.):S53-58.

systems can streamline conventional 'point-to-point' referrals, care plan templates provided in most GP clinical systems can be used to generate text-based care plans, and digital systems can track appointments and progress, automate time-consuming collaborative processes, automate administrative tasks thus reducing red tape and could support patient self-management.[21]

Opportunities for the Medicare payment system to reward and encourage best practice and quality improvement in chronic disease prevention and management

In considering this issue, it is important to recognise that Australia already has a high quality primary health care system that performs better than those of most OECD countries. Although it is underfunded, the Medicare Benefits Schedule (MBS) supports patients with access to GP services, choice of provider, and access to many specialist and diagnostic services.

Specific chronic disease management (CDM) items have been included in Medicare, which are intended for use by a patient's usual GP and provide a structured approach to care. They also support patients with chronic and complex disease to access some Medicare funded allied health services on referral from their usual GP in defined clinical circumstances.

However, existing chronic disease management arrangements are too limited, difficult for patients to access, do not reflect established referral practices and are hindered by red tape and bureaucracy. In this context, the AMA has previously proposed, while maintaining overall funding levels, that the current CDM items should be restructured to:

- Strengthen the role and definition of a patient's usual GP;
- Tackle the complex requirements specified in the items so that they reflect modern clinical practice and involve less red tape;
- Streamline requirements for referral to allied health services; and
- Ensure that the structure of MBS items encourage longitudinal high quality and appropriate care.

However, we also know that existing CDM items do not differentiate for those patients with higher care needs. The Department of Veterans' Affairs (DVA) has moved to innovate in this area through the introduction of the Coordinated Veterans' Care (CVC) program. DVA already provides veterans with GP referred access to a broad range of funded allied health services and the CVC builds on this by funding enhanced care coordination for eligible patients through their general practice.

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. The introduction of a properly funded CVC style model more broadly, combined with reform of existing CDM items would represent a significant step forward in funding arrangements to support the effective management of chronic disease.

[21] Georgeff, M. (2014) Digital technologies and chronic disease management. Aust. Fam. Physician, Vol. 23, No 12.

The above represents incremental reform to current funding arrangements. It is achievable and builds on existing frameworks that are now well accepted by the medical profession and patients. That said, there is the potential to consider bolder reform that would involve root and branch reform of CDM items and opening up of GP referred access to additional allied health services and other important supports for patients such as aids and appliances.

The AMA put forward a proposal AMA Chronic Disease Plan (**Attachment 1**) in 2010 that outlined what a new model might look like and a copy of this is attached. It has not been costed and early discussions with the Department of Health indicated that it cut across areas of funding responsibility and could lead to a 'blow out' in allied health costs. Nonetheless, the principles on which it is based are sound and it could be further refined if there was a genuine appetite to consider such an all-encompassing approach to the management of patients with chronic and complex disease.

Opportunities for the Primary Health Networks (PHNs) to coordinate and support chronic disease prevention and management in primary health care

The AMA has always acknowledged the importance of a network of primary health organisations to facilitate improved patient access to primary care services. The PHNs, which commenced operation on 1 July 2015, provide an opportunity for a fresh start to support consistent high-quality primary care services across the country. To this end, the AMA believes that PHNs should focus on the following areas:

- *Population Health*

  Identifying community health needs and gaps in service delivery; identifying at-risk groups; supporting existing services to address preventive health needs; and coordinating end of life care.

- *Building General Practice Capacity*

  Supporting general practice infrastructure to deliver quality primary care through IT support; education and training of practices and staff; supporting quality prescribing; training and supporting the use of e-Health technology and systems; and facilitating the provision of evidence-based multidisciplinary team care.

- *Engaging with Local Hospital Networks (LHNs)/Districts*

  Identifying high risk groups and developing appropriate models of care to address their specific health issues (e.g. those at high risk of readmissions, including noninsulin-dependent diabetes mellitus, congestive cardiac failure, chronic obstructive pulmonary disease, and other chronic diseases); and improving system integration in conjunction with local health networks.

The establishment of the PHNs also provides an environment to support good transfer of care arrangements in the health system to ensure continuity of care. Continuity is a key tenet of quality care. Continuity of care is associated with improved preventative and chronic care, greater patient and clinician experience, and lower costs.[22]

[22] Bodenheimer et al (2014) The 10 Building Blocks of High-Performing Primary Care. Annals of Fam. Med., Vol. 12, No. 2.

PHNs and LHNs should have formal engagement protocols and some common membership in governance structures, and work together where possible in areas such as assisting with patients' transitions out of hospital and, where relevant, into aged care. In this regard, PHNs and LHNs could fund appropriately skilled GPs and hospital specialists to devise collaborative pathways for transfer of care ensuring that best practices are implemented.[23] While the AMA acknowledges that the previous Medicare Locals/LHNs have commenced work on improving care pathways across various part of the health system in their areas, this is not happening consistently across Australia and there is scope for this to be applied across the country.

The role of private health insurers (PHIs) in chronic disease prevention and management

The AMA supports a limited role for PHIs in general practice/primary care. In 2014, the AMA released its position statement Private Health Insurance and Primary Care Services 2014 (**Attachment 2**) that recognises the potential for targeted reforms to improve patient care and save the health system money.

GPs provide holistic and well-coordinated care for patients, including preventative health, yet this largely goes unrecognised in current private health insurance arrangements. PHIs have introduced a number of programs that provide their members with access to services such as telephone coaching, exercise physiologists, dieticians, and physiotherapists to better manage their chronic conditions. While these programs can potentially benefit patients, they generally work in isolation to the usual GP who understands their patients care needs. This is a significant problem and fragments patient care.

In this context, there is certainly scope for PHIs to explore the potential for greater engagement with general practice to improve the coordination of patient care, ensure care is provided in the most appropriate clinical settings, and avoid unnecessary hospital admissions.

The attached position statement outlines the areas that the AMA believes could be explored including wellness programs, maintenance of shared electronic records, hospital in the home, palliative care, minor procedures, and GP directed hospital avoidance programs.

However, it is important to stress that patient choice and clinical autonomy are among the great strengths of our health system and we do not want to proceed down the managed care route adopted in countries such as the United States. Some PHIs seem to be taking a more interventionist approach to the funding of the provision of care for their members and, to this extent, any model implemented would need to satisfy a number of criteria including:

- Recognition and support for the usual GP as the central coordinator of patient care;
- A collaborative approach to care, with the usual GP retaining overall responsibility for the care of the patient;
- Appropriate access to care based on a patient's clinical needs;
- Preservation of patient choice; and
- Protection of clinical autonomy.

[23] AMA (2013) General practice/hospitals transfer of care arrangements 2013 https://ama.com.au/position-statement/general-practicehospitals-transfer-care-arrangements-2013

The role of State and Territory Governments in chronic disease prevention and management

Prevention

State and Territory Governments play a substantial role in preventive health initiatives, both directly, and indirectly. An obvious role for State Governments is the direct delivery of health promotion activities and services, as well as with the delivery of preventive health education in schools and other community settings via classes on gardening and cooking, physical activity, resilience building and mental health promotion, safe sex education etc.

Community health programs also provide an avenue for health prevention and surveillance activities. These programs may be universally available or more targeted to specific sections of the population, with a good example being maternal and child health clinics where many Australian infants are measured and weighed, new parents are provided with advice and support, and typically some basic health and development screening is undertaken. These community health programs also provide linkages to other health professionals (including GPs) and services. Such services are also a valuable source of data for research and analysis, which in turn informs future activities.

State Governments are also responsible for the regulations around access, availability and promotion of certain products that can negatively impact on health, including alcohol, tobacco and junk food. Licensing regulations limit location and opening hours of retail outlets and the placement of any associated advertising signage. Similar regulations exist around participation in certain activities, including combat sports and gambling.

State Governments need to adopt effective labelling of alcohol and foods as advocated in recent years by the AMA and many other health and community organisations. We need to prevent Foetal Alcohol Spectrum Disorder (FASD). FASD is the most common preventable cause of birth defects in Australia, and has profound lifelong consequences, impacting not only individuals but also on families, the health care system, the social service system, the criminal justice system, and the education and employment systems. The United States has mandated against drinking alcohol during pregnancy with Surgeon General warning labels on alcohol beverages since 1988. France and many other countries have effective labelling of alcohol warning that there is no known safe level of alcohol consumption in pregnancy.

An increasingly recognised area in which State Government decision making has an impact on preventive health is in the legislation and regulation associated with development and community infrastructure. Utilised in the right way, decisions relating to development and community infrastructure can facilitate and enhance participation in healthy behaviours and activities, and decrease less healthy or risk taking behaviours. This include avenues such as setting suitable speed limits, providing opportunities for active transport such as dedicated walking and cycle paths, street lighting and providing access to local parks and recreation facilities such as swimming pools. It may also extend to planning decisions related to public transport that promote reasonable access to supermarkets, local swimming pools and health care facilities.

Another example of the role of State Governments in decision making that impacts on health is regulations and incentives around industry and land use or management. Such

decisions are likely to be largely driven by the economic and social consequences for local populations, but they may also have significant impacts on health. The approval of mining sites, chemical processing facilities and even the location of new roads, is likely to impact air quality, which in turn can have impacts on health directly and indirectly. This highlights the importance of such decisions being informed by thorough health impact assessments, which identify and quantify health risks.

While not extensive, these examples highlight the integral role that State and Territory Governments have on the prevention of chronic disease, both directly and indirectly.

Management of chronic diseases

Greater integration of community care with acute care providers is essential to streamline the patient journey, to ensure health care is not fragmented, to minimise wastage and duplication within the health system, and to prevent disease exacerbation and thus demand for more specialised (including hospital) services. State and Territory Governments can facilitate greater integration by streamlining access from one sector to another, by developing partnerships between government and non-government organisations that facilitate a team approach to health care and service delivery.

State and Territory governments have a role to play in supporting and trialling innovative models of care to better support patients with chronic and complex illnesses, and in sharing the outcomes to inform the development of programs that are better targeted and designed to deliver the best outcomes for participants and the health system overall. The NSW Chronic Disease Management Program and its Evaluation, for example, provided useful insights for State and Territory Governments when looking at how to better integrate health care services. The outcomes of this program highlighted the need to:

- manage chronic disease proactively and longitudinally;
- respond to latent risk, rather than realised risk (i.e., the need to identify those at risk of unplanned hospitalisations, rather than those who have already had many);
- engage with primary care, in particular general practice, for better patient risk stratification and for patient centred chronic disease management; and
- invest in infrastructure, training and re-orienting of the existing health care system with a greater focus on the chronic rather than the acute.

In addition, recent research on Care Navigation[24] - a framework for nurse-led hospital-based coordinated care, concluded that hospital based care coordination did not improve quality of life or reduce unplanned hospital presentations despite an increase in utilisation of community health services. It recommended exploring potential benefits of linking navigated intra-hospital care to ongoing, proactive care planning and delivery in the community. State and Territory governments therefore have a role to play in providing intra hospital care and community services but also in working in an integrated and collaborative fashion with the key providers of chronic disease management, i.e. general practice.

[24] Plant et al (2015) Coordinated care versus standard care in hospital admissions of people with chronic illness: a randomised controlled trial. Med. J. Aust. 2015, 203(1):33-38.

Poor oral health has been linked to cardiovascular disease, diabetes, respiratory illnesses, stroke, and dementia[25]. Improving patient access to public dental health services should be a priority for State and Territory governments in chronic disease management. Increasing access to public dental health services could have a significant and positive effect on chronic disease prevalence and exacerbation within a state or territory's population.

State and Territory Governments should focus on how they can strengthen their response to inequity in access to health care services, particularly for areas or groups that are experiencing social or economic disadvantage. These vulnerable groups are more likely to have poorer health outcomes and are at greater risk of chronic disease.

In addition, State and Territory Governments should focus on ensuring the medical and allied health workforce is sufficient to meet community needs. State Governments should work closely with Primary Health Networks to identify where there are gaps in GP and allied health services and develop sustainable solutions for addressing those gaps.

With the ageing population and the increasing incidence of chronic disease and multiple co-morbidities complicating care needs, people increasingly are accessing a range of services from different health care sectors. State and Territory Governments have a role to play in ensuring that the transitions from one sector to another are facilitated with appropriate transfer of care or shared care arrangements, where relevant information is communicated expeditiously so that care is streamlined and not fragmented.

Importantly, accurate and timely hospital transfer of care summaries are integral to ensure optimal ongoing care of patients. State and Territory governments should do all they can to ensure that all public hospitals have appropriate protocols in place for accurate and timely transfer of care arrangements and that these are strictly followed.

<u>Innovative models which incentivise access, quality and efficiency in chronic disease prevention and management</u>

The AMA believes the following models incentivise access, quality and efficiency in chronic disease prevention and management:

AMA Chronic Disease Plan

Please refer to earlier comments and see attachment.

DVA Coordinated Veterans' Care (CVC) Program

Please refer to earlier comments on the CVC program.

Western Sydney Integrated Care Pilot

Western Sydney Integrated Care Pilot is currently being trialled in Western Sydney as part of the NSW Integrated Care Project. This model is GP-led and targets patients with either diabetes, chronic heart failure, ischaemic heart disease and chronic obstructive pulmonary disease, or any combination thereof, and involves:

- GP development of a shared care plan for each patient, using a linked electronic health record, known as Linked EHR;

[25] Dental Health Services Victoria, 2011. *Links between oral health and general health - the case for action*

- GP focus on maintaining and regularly reviewing the shared care plan – which includes specialist's updates to their own action plans following each consultation;
- Appointment of a care facilitator assigned to a number of practices, to assist GPs monitor each patient's plan and ensure the items on the care plan are being delivered – the care facilitator will work across the primary, community and hospital services to ensure required care is provided, and where possible streamlined; and
- Establishment of rapid access and stabilisation clinics, staffed by specialists, senior registrars, nurses and appropriate allied health clinicians who will be quickly available for integrated patients and to GPs – these will enhance patient care before being transferred back to their GP and will provide a support line for GPs to assist them in managing the patient.

Indigenous Chronic Disease Package

The Indigenous Chronic Disease Package is part of the COAG National Partnership Agreement on Closing the Gap: Tackling Indigenous Chronic Disease. It has three main elements:

- tackling chronic disease risk factors;
- improving chronic disease management and follow-up care; and
- expanding and supporting the primary care workforce.

In tackling chronic disease risk factors two national networks have been set up. One, of regional tobacco coordinators and action workers who through community based programs are helping Indigenous communities to reduce their levels of smoking; and the other, of healthy lifestyle workers to help reduce the lifestyle factors that contribute to chronic disease.

In improving chronic disease management and follow-up care, the Practice Incentives Program (PIP) Indigenous Health Incentive encourages greater uptake of health assessments and the provision of follow-up care in a coordinated, accessible and systematic manner. The incentive recognises the central role of the GP and general practice or Indigenous health service in healthcare with sign-up, registration, and outcomes payments. These payments support practices to undertake cultural awareness training and have in place systems that record registered patients and assist with patient recalls and reminders; to register patients; and to provide targeted services and ongoing care. In addition, the program in effect is encouraging Indigenous peoples to have a medical home.

<u>Best practice of Multidisciplinary teams chronic disease management in primary health care and hospitals</u>

The AMA recognises the potential for the medical home model of primary care to deliver improved outcomes for patients, especially through well-coordinated multidisciplinary care for patients with chronic and complex disease. Adoption of the model overseas has resulted in improved quality measures, performance and service use, with a highly significant reduction in avoidable hospital admissions, emergency department use and overall care costs.[26]

[26] Jackson, C. L. (2012) Australian general practice: primed for the "patient-centred medical home"? Med. J. Aust. 2012, 197(7): 365-366

In translating overseas models to the Australia, it is important that regard is had to the Australian context. Many Australians already have a medical home with the majority of the population having a usual GP or usual general practice. The AMA is currently looking at how the medical home model might operate in the Australian context, bearing in mind its impact on patient choice, whether it will be able to deliver benefits to the same extent as has been achieved overseas and how it might be structured and funded.

Models of chronic disease prevention and management in primary health care which improve outcomes for high end frequent users of medical and health services

For many individuals, the primary health care services they access and the quality of care that results, has depended on where they live, their specific condition, and the service providers involved, as much as their clinical needs and circumstances. Many patients, particularly those with complex needs, have either been left to navigate a complex system on their own or, even when supported by their GP, have been affected by gaps in information flows, and a limited ability to influence care decisions in other services.[27] In this context, the AMA believes prevention and management of people with chronic and complex diseases would be best addressed via the medical home that strengthens the role of general practitioners in the health system and delivers better outcomes for patients by encouraging longitudinal care.

In discussing this issue, it is also important to recognise that the goal of achieving integration of patient care remains somewhat elusive in what is a fragmented and complex health care system in Australia, and that no single 'best practice' model of integrated care exists.[28] However, the AMA believes that the funding reforms discussed previously could improve outcomes for high end frequent users of medical and health services.

Importantly, achieving the triple aim of health reform – better health, improved patient experience, and more affordable costs – is dependent on a foundation of high-performing primary care. In this regard Bodenheimer et al (2014)[29] identified 10 building blocks that can help practices in the journey toward becoming high-performing medial homes that included:

1. Engaged leadership, creating a practice-wide vision with concrete goals and objectives;
2. Data driven improvement using computer-based technology;
3. Empanelment, linking patient to a care team and a primary care clinician;
4. Team-based care;
5. The patient-team partnership that recognises the expertise that patients bring to the medical encounter, as well as the evidence base and medical judgement of the clinician and team;
6. Population management - practices that stratify the needs of their patients and design team roles to match those needs;
7. Continuity of care which links each patient to a clinician and team;

[27] Dept. of Health and Ageing (2010) National Primary Health Care Strategy: Building a 21st century primary health care system

[28] The KingsFund (2012) Integrated care for patients and populations: Improving outcomes by working together. A report to the Department of Health and the NHS Future Forum.

[29] Bodenheimer et al (2014) The 10 Building blocks of high-performing primary care. Annals Fam. Med. Vol. 12, No 2.

8. Prompt access to care and allowing patients to decide which takes priority;
9. Comprehensiveness and care coordination – the capacity of a practice to provide most of what patients need and to arrange for services that primary care is unable to provide; and
10. Template for the future – a daily schedule that does not rely on the 15-minute in-person clinician visit but offers patients a variety of e-visit, telephone encounters, group appointments, and visits with other team members.

The Minister for Health has commissioned a review of primary health care that, among other things, will investigate options to provide better care for people with complex and chronic illness. The initial findings from the review are expected in late 2015. It is important that this Inquiry is conscious of this review and allows for it to be examined and considered as part of your work, which potentially would require a further round of submissions later this year or early next year.

Yours sincerely

Professor Brian Owler
President

Improving care for patients with chronic and complex care needs

Revised 2012

1. Introduction

The AMA recognises the need for more efficient arrangements to support the provision of well-coordinated multidisciplinary care to patients with chronic and complex disease. If access to coordinated multidisciplinary care is improved then patients will benefit, the number of avoidable hospital admissions can be reduced, and long-term savings to the health system will be generated.

The AMA supports a comprehensive approach to the management of chronic and complex disease based on arrangements that:

- Provide GP-coordinated access for patients to services based on clinical need;
- Provide a patient's usual GP with the support they need to improve the care they can provide/organise for patients with chronic and complex disease;
- Support GPs to facilitate access for their patients to other members of a multi-disciplinary primary care team;
- Continue to ensure that funding follows the patient;
- Lead to better collaboration with existing service providers; and
- Simplify and enhance the existing MBS chronic disease arrangements.

The AMA believes that significant gains can be made in improving care for patients with chronic and complex care needs by improving existing systems and processes so that they provide GPs and their patients with the support they need.

In considering this issue, it is important to recognise that current MBS arrangements are meeting the needs of most patients. The Government's own draft Primary Care Strategy said in this regard that *supported by the Medicare Benefits Schedule (MBS), most Australians have good access to affordable services provided through general practice, have a choice of provider, and have been supported in their access to many specialist and diagnostic services*.

2. Background

2.1 Care for patients with chronic and complex needs

The care needs of Australians are becoming more complex with the ageing population and increasing incidence of chronic disease. Increasingly patients are suffering from multiple chronic conditions, which complicate their care needs. These patients need the services of a range of medical and allied health services in managing their conditions. Care in this environment can easily become fragmented unless that care is coordinated and appropriate referral and reporting mechanisms are in place to monitor the patient's progress in line with their treatment and management plan.

The increasing burden of chronic disease has a significant cost impact on Australia's health system. Fifty percent of GP consultations involve patients with a chronic disease, such as heart disease, cancer or diabetes[1]. This cost of chronic disease is further added to with at least 10% of hospitals stays for patients with chronic conditions potentially preventable had timely and adequate non-hospital health care been provided[2]. The Australian Institute of Health and Welfare reported that in 2007-08 there were 33.6 potentially preventable admissions per 1,000 people and that more than half of those were due to chronic conditions[3]. With preventable admissions costing over $1.3 billion a year[4] there is an incentive for Government to support more coordinated care in order to keep people out of hospital by better caring for them in the community.

Coordinated care ensures the patient receives the care and services they need to better manage their health in a community setting and prevents avoidable hospital admissions.

2.2 Evidence from the research

The benefits of coordinated care are recognised around the world. In 2011 the World Medical Association issued a statement on the Global Burden of Chronic Disease[5]. In this statement the WMA advocates for the promotion of prevention health strategies, team based chronic disease management, and continuity of care for patients with chronic disease and this was backed by findings from a number of studies.

The Coordinated Care Trials in Queensland in 2008 for example, demonstrated that coordinated care reduced hospital admissions by up to 25%, reduced inpatient costs by 26%, reduced patients rate of depression and improved their quality of life[6]. The trial demonstrated that when all costs are included (MBS, PBS, hospital etc), service provision costs can be reduced by 8%. In addition, the trial found that when patients were connected to community models rather than acute models of care that they were more active in their own health maintenance.

In 2005 SA HealthPlus successfully implemented a generic model of coordinated care with improved health and wellbeing outcomes[7]. Evidence gathered suggested that the key components of the model were the programs and goal approach, the care plan, and service coordinators working with general practitioners and patients. It was determined that costs savings in the short

---

[1] Australian Institute of Health and Welfare (2006), Chronic diseases and associated risk factors in Australia 2006, (Australian Institute of Health and Welfare: Canberra)

[2] National Health and Hospital Reform Commission, A Healthier Future for all Australians Final Report June 2009, p56

[3] Australian Institute of Health and Welfare (2010), Australia's Health 2010, p486 (Australian Institute of Health and Welfare: Canberra).

[4] Estimated from data presented by Wilcox S, Making Prevention the Priority, 10th Annual Health Congress 2008, Health Policy Solutions.

[5] World Medical Association (2011) Global Burden of Chronic Disease, the 62nd WMA General Assembly, Montevideo, Oct 2011.

[6] GP Partners, Coordinated Care (2008) Team Care Health II Perspectives, http://www.gppartners.com.au/content/Document/report_teamcare.pdf.

[7] Battersby, Malcom W and the SA HealthPlus Team, Health reform through coordinated care: SA Health Plus. BMJ, Vol 330, 19 March 2005.

term were best achieved by better targeting those patients who would benefit the most from coordinated care. Those patients most likely to benefit are those who:

- are not already linked with services,
- lack knowledge of their condition,
- are depressed,
- lack motivation to change behaviour,
- have lifestyle risk factors, and
- conditions are poorly controlled.

Further, the study concluded that better targeting of coordination activities should be based on patients who have had a prior admission to hospital and a potential to improve self-management.

A systematic review[8] of various care coordination strategies has found that in more than 50% of studies all were associated with improved health and/or patient satisfaction. The strategies identified for the review were classified into two groups: i) communication and support for providers and patients, and (ii) structural arrangements to support coordination. Those interventions that used multiple strategies were found to be more successful than those using single strategies.

Another study, an analysis of community care models in North Carolina, USA, has demonstrated that the potential health system cost savings models of comprehensive and proactive primary care should generate are between 7% to 15%[9]. The study concluded that cost savings were associated with reduced costs for emergency room visits, inpatient hospital admissions, and other services as patients receive improved access to primary care, prescription drugs, and other appropriate treatments for chronic conditions. These were the expected cost savings from future medical services that would have but were avoided by earlier intervention.

Overall the evidence suggests that coordinated care is: beneficial for patients; improving their health and wellbeing; and is beneficial to the health system (because it reduces the costs that would eventuate through poorer health outcomes and avoidable hospital admissions).

2.3 Effective care coordination

The AMA believes effective care coordination involves:

- Care that is led by the patient's usual GP and based on clinical need.
- Actively involving the patient in goal setting and decision-making.
- Enabling patients to better understand and manage their condition.
- Funding that follows the patient, i.e. through the existing Medicare Benefits System (MBS), and supports the provision by GPs of initial and ongoing care.
- Funding that supports the coordination and transition of patient care between health care providers and across health care and community sectors.

[8] Powell Davies, Gwaine, et. al. (2008) Coordinating primary health care: an analysis of the outcomes of a systematic review. MJA 2008; 188 (8 Suppl): S65-S68.

[9] Cosway, Robert et al. (2011) Analysis of Community Care of North Carolina Cost Savings, Millman Report for the North Carolina Division of Medical Assistance, 15 December 2011.

2.4 Current MBS arrangements for funding chronic and complex care needs

Current Medicare arrangements provide support to patients so that they can see a GP when they need to. MBS funding follows the patient and the rebate is directly linked to the provision of a service by a GP. Patients with chronic and complex disease can also access some allied health on referral from a GP in defined clinical circumstances. The Government only pays for the services that are delivered.

Where patients face significant out-of-pocket costs for out-of-hospital services, the Medicare Safety Net will pick up 80% of these costs once certain thresholds are reached.

In addition, patients with total net (out of pocket) medical expenses of over $1,500 in certain categories (including Medicare payable items) can claim through the income tax system a 20% rebate on those expenses.

3. GP-coordinated care for patients with chronic and complex diseases

GPs are highly trained professionals who are accountable to their patients and work within established codes of professional conduct. GPs are the highest trained general health professional assessing and managing patient care according to their individual overall health needs. The AMA considers GPs are the best placed health professional to lead coordinated care for patients with chronic and complex disease.

GPs are the most visited health professional, with about 85% of the population seeing a GP at least once a year[10]. The National Health and Hospital Reform Commission (NHHRC) recognised this (GPs being the most visited health professional), proposing to build on it by improving access to a more comprehensive and multidisciplinary range of primary health care and specialist services in the community. The NHHRC also recognised the value that a 'medical home' provided to patients in ensuring coordinated care[11]. AMA research shows that 88% of people have a usual family doctor[12] and therefore a 'medical home'. Having a trusted family doctor is good for your health, with research showing that people who have an ongoing relationship with a family doctor have better health outcomes and lower death rates.

GPs manage a vast array of conditions with over one-third of the problems they manage chronic in nature. The chronic problems most often managed by GPs being hypertension, depressive disorder, diabetes, lipid (cholesterol-related) disorders, chronic arthritis, oesophageal disease and asthma[13]. Since 1998-99 there has been statistically significant increases in the management rate of each of these conditions, except asthma, which has been declining.

---

[10] Australian Institute of Health and Welfare (2008), Australia's Health 2008, (Australian Institute of Health and Welfare: Canberra).

[11] National Health and Hospital Reform Commission, A Healthier Future for all Australians Final Report June 2009 Chapter 4, 4.2.1 Primary health care as the cornerstone of our future health system

[12] Essential Research. National Patient Poll, Commissioned by AMA, 2010.

[13] Australian Institute of Health and Welfare (2010), Australia's health 2010, (Australian Institute of Health and Welfare: Canberra).

The Government has acknowledged the value in GP-coordinated care for patients with chronic and complex diseases by funding the Department of Veterans' Affairs (DVAs) Coordinated Veterans Care (CVC) program. The AMA was involved throughout the program's design and as such it upholds and supports the GPs role in providing clinical leadership and oversight to the coordination of patient care. Building on existing funding mechanisms, the program sets a benchmark for the management of chronic and complex diseases. With a few changes to expand current funding arrangements this benchmark could be extended throughout the rest of the community in order to proactively manage and care for patients, preventing avoidable hospital admissions and saving scarce health resources in the process.

4. AMA model for improving care of patients with complex and chronic disease

Australia's high-quality primary health care system is built on the solid foundation of the role of the GP. GPs could do more to provide access to multidisciplinary care and support services for patients with chronic and complex disease. However, existing chronic disease management arrangements are too limited, cumbersome, difficult for patients to access, unreflective of established referral practices and are wrapped up in red tape and bureaucracy.

To deliver real benefits for patients and maximise the impact of available funding, new arrangements need to be put in place that better support GPs to provide patients with chronic and complex disease with access to multidisciplinary care and essential support services.

The NHHRC suggested "An enhanced Medicare in the future"[14] that:

- Supplements medical services with a broad package of health services (allied health, nursing and other health professionals) to support complex and continuing care;
- In addition to personal individual consultations, encourages and supports team-based and multidisciplinary care;
- Adds to current benefits as it pays for a mix of private and publicly delivered services (expanded to cover state-funded primary health care services, public hospital outpatient specialist services and selected allied health and other health professional services);
- Adds greater scope to support stronger focus on prevention, health promotion, early intervention and wellbeing, including supporting people in self-management;
- Supports a broader range of specified services by health professionals providing care within their defined scope of practice (and provided it is safe and cost-effective) and for innovative, collaborative care models within services;
- Supports the development of more integrated safety net arrangements that protect people from unaffordable costs; and
- Also pays for different types of services – email, telephone, telehealth (e.g. video conferencing) – that do not involve the physical presence of the patient. Payment for these services may be part of episodic payment or grant payments.

[14] Excerpts from National Health and Hospital Reform Commission Final Report June 2009 Table 4.1 An evolving Medicare.

The AMA plan provides a comprehensive and coordinated care for patients with complex and chronic disease, which satisfies the intentions of the NHHRC goals as detailed above.

4.1 Level 1 - GP Management Plans

GP Management Plan (GPMP) arrangements in the MBS provide a structured approach to caring for patients with chronic and complex disease, although presently they do not provide patients with access to allied health and other support services. To provide access to allied health services GPs must also prepare a team care arrangement, which involves additional red tape.

We know that early intervention helps to improve health outcomes and in this regard initial access to a limited number of multidisciplinary and other support services through GPMPs could yield significant benefits for patients. The GPMP pathway could also provide access to medically appropriate preventive health services for individuals at high risk, e.g. developmental delay in children.

The AMA believes that GPMP arrangements should be simplified and reformed so that they provide "automatic" access to a predetermined number of GP referred services. On referral from a patient's usual GP, GPMP arrangements should provide patients with access to:

- Five funded visits to allied health services per annum[15];
- Parenting programs for children at risk; and
- Selected home aids including home safety, mobility aids, vital call, diabetes equipment, continence aids and therapeutic appliances.

This arrangement is similar to that in place with the Department of Veterans' Affairs (DVA), which enables access to allied health providers upon referral from a medical practitioner, typically the patient's usual GP.

Unlike the existing Team Care Arrangement (TCA) item that provides patient access to allied health services, the requirement for the GP to consult with other care providers prior to referral would be removed under this revised arrangement for the GPMP. Prior consultation with allied providers is burdensome and does not accord with accepted medical practice. When patients are referred by GPs for services from other health care providers, such as other specialists, they are not subject to the same level of prescription and red tape that the current TCAs impose.

In relation to home aids, we believe that it would be possible for Medicare Australia to contract with relevant suppliers for the provision of these services, much like the DVA does for veterans needing extra support to continue living at home.

4.2 GP Management Plan Review

The existing GP Management Plan Review item in the MBS should be retained in order to check patients progress against the plan and to make amendments to the plan if clinically required. If in the GPs opinion, extra clinically relevant allied health services are required, the review item should enable access to additional referred services.

[15] Noting that private providers, community health centres or public hospitals could provide these services

Where the GP determines upon subsequent review that a patient's likely health outcomes are not improving, there is a significant risk of hospitalisation or rehospitalisation due to their condition/s, and that they would benefit from a more coordinated approach to their care, the GP may consider the patient eligible for access to a coordinated care program.

4.3 Level 2 - Coordinated Care for patients that need more support

The Coordinated Care program, administered through Medicare Australia, would provide those patients with chronic and complex disease that need greater support than can be provided through a GPMP, particularly those at risk of a preventable hospital admission, with streamlined and coordinated access to a range of services relevant to their clinical needs.

Similar to the DVA's Coordinated Veterans' Care (CVC) program, access to the program would be determined by the GP upon the completion of an eligibility assessment. If the patient is assessed as eligible and is willing to participate in the program the GP (with the assistance of a Practice Nurse or Aboriginal Health Worker) will conduct a needs assessment and develop a Comprehensive Plan for Coordinated Care, which is shared with the patient. The needs assessment and resulting Comprehensive Plan for Coordinated Care will essentially be a revised and simplified version of the current TCA item.

The AMA accepts that strict eligibility guidelines would need to be developed to govern access to the program, including the requirement for the patient to already have a current GPMP in place. Patients would only be eligible to access the program where they were assessed by their usual GP as requiring and likely to benefit from additional support beyond that which is available through a GPMP.

Under a Comprehensive Care Plan for Coordinated Care, the GP funded access should be available to the following:

- GP-referred allied health and nursing services;
- A broader range of home aids, ramps for disability, home safety, mobility aids, wheel chairs and vital call;
- Transport services to assist with access to medical or allied health care;
- An enhanced safety net for medications;
- Dressings; and
- Education programs.

The program would retain a review mechanism similar to existing MBS review items in order to assess a patient's progress and ongoing eligibility for this extra support.

GPs may enlist the assistance of a Practice Nurse or Aboriginal Health Worker to act as a Care Coordinator for the patient. The Care Coordinator:

- coordinates patient access to referred services, liaising where required with providers to identify available services, facilitating access (applications etc) and arranging appointments and transport if required;

- monitors patient health and wellbeing, and progress against the plan – via phone, home visit or videoconference – providing regular feedback to the GP;
- provides patient advice and education, where appropriate, on better managing their health and well being;
- liaises with the patient's carer as to patient's progress against the plan or of any changes to the plan;
- liaises with emergency and/or hospital discharge departments; and
- maintains patient records as to monitored action and coordination activities.

Under the program, GPs in addition to the relevant MBS items, would be supported with funding to prepare their practices for coordinated care with an additional payment per patient with a Comprehensive Care Plan for Coordinated Care and ongoing quarterly payments to support the additional services (e.g. monitoring, liaising, educating, coordinating etc.) provided on behalf of the patient.

This Care Coordination Model is line with the DVA's CVC program to which the AMA was a key contributor.

5. How does the AMA plan addresses the needs of patients with chronic and complex disease?

The AMA proposal is a comprehensive plan to address the needs of patients with chronic and complex disease. The AMA's proposal:

- Ensures that patients do not lose their entitlement to a Medicare rebate;
- Ensures services are funded on an as needs basis and under arrangements that do not compromise the doctor/patient relationship;
- Means patients would have more choice and greater control over decisions about their health care;
- Provides patients with multiple chronic conditions and related complex care needs with improved access to GP coordinated care services ensuring continuity of care;
- Seeks to enhance proven existing arrangements so that they work better for patients;
- Provides access to a broad range of allied health and other support services;
- Supports proactive care and preventive medicine;
- Respects the professionalism of GPs and the comprehensive care that they provide to patients;
- Reduces the red tape burden on GPs; and
- Is both clinically and cost effective.

6. The role of Primary Health Care Organisations in Coordinated Care

The AMA acknowledges the potential reach of Primary Health Care Organisation (PHCOs), also known as Medicare Locals, in supporting and in coordinating services for people with chronic and complex disease. However, Medicare Locals need to be introduced in a way that is respectful of the existing role of GPs and other community based Specialists and in a fashion that seeks to maximise positive relationships and partnerships at all levels.

The AMA believes that the activities of Medicare Locals, should be to support and complement general practice. In this context, Medicare Locals will be of assistance to general practice by:

- improving population health planning at the local level so as to help reduce the risk factors that lead to the development of chronic conditions; and
- organising allied health services in areas of unmet need so that GPs can provide patients with access to such services.

Prepared by the Australian Medical Association
April 2010 - Revised February 2012

AMA

AMA POSITION STATEMENT

Private Health Insurance and Primary Care Services - 2014

March 2014

The AMA believes that any move to expand the role of private health insurers (PHIs) should be carefully planned and negotiated with the profession to ensure that the outcome is in the best interest of patients and does not compromise the clinical independence of the profession or interfere with the doctor/patient relationship.

The AMA would not support any move to completely deregulate the funding of GP services by PHIs, or any changes that would undermine the principle of universal access to health care.

Areas that could be explored include wellness programs, maintenance of electronic health care records, hospital in the home, palliative care, minor procedures, and GP directed hospital avoidance programs.

Any model implemented would need to:

- recognise and support the usual GP as the central coordinator of patient care;
- adopt a collaborative approach to care, with the usual GP retaining overall responsibility for the care of the patient;
- provide patients with appropriate access to care based on their clinical needs;
- preserve patient choice;
- protect clinical autonomy; and
- recognise the rights of medical practitioners to set their own fees.

Background

Under the *Private Health Insurance Act 2007*, PHIs are prevented from providing a benefit for out of hospital services where there is a Medicare benefit payable, unless the Private Health Insurance (Health Insurance Business) Rules provide otherwise. This limits the extent to which PHIs can fund GP services for their members.

In 2007 the Government made limited legislative reforms to private health insurance arrangements that introduced the concept of Broader Health Cover (BHC), which enabled health insurers to offer benefits to members for programs that either prevent or substitute for hospitalisation, or that help patients with a chronic disease better manage and reduce the effect of the disease.[1]

Key concerns

Key concerns about any expanded role for PHIs in primary care include equity of access, the maintenance of the relationship with the usual doctor, the independence of the doctor/patient

[1] Biggs, A. (2013) Chronic disease management: the role of PHI, Dept of Parliamentary Services Research Paper, 2013-14

relationship, the potential rationing of care and the risk that PHIs might focus on cost reduction as opposed to the quality and continuity of care.

Existing programs

As a result of the 2007 BHC reforms, PHIs have introduced a number of programs that provide their members with access to services such as exercise physiologists, dieticians, and physiotherapists to better manage their chronic conditions. While these programs can potentially be of benefit to patients, they generally work in isolation of the usual GP who is best placed to understand the patient's care needs. Rather than work in parallel or in competition with the usual GP these programs should only be offered with the full knowledge and support of the usual GP.

AMA Recommendation

GPs provide holistic and well-coordinated care for patients, including preventive health. By supporting a greater role for GPs in PHI arrangements, the coordination of patient care could be improved, care could be provided in the most appropriate clinical settings, and unnecessary hospital admissions can be avoided.

The AMA is supportive of targeted reforms that would better support GPs to effectively utilise PHI funded wellness/support programs in caring for patients and also allow PHIs to fund a broader range of GP services for privately insured patients.