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To the Chair of the Standing Committee on Health,

Re: Inquiry on Chronic Disease Prevention and Management in Primary Health Care

The intent of this letter is to contribute to the Inquiry on Chronic Disease Prevention and Management in Primary Health Care. We support this inquiry, and applaud the Standing Committee on investigating opportunities to improve the way that Australians receive support for managing chronic disease through primary health care services.

This letter advocates for system-wide, effective strategies to support patients to have healthy dietary behaviours. Poor dietary behaviours are a pervasive behavioural risk factor for chronic disease, influencing the aetiology of 7 of the 10 most prevalent chronic diseases in Australia; the top 3 being stroke, ischaemic heart disease and type 2 diabetes (1). Nearly all (93%) Australian adults are at risk of chronic disease due to poor dietary behaviours (1). Throughout this letter, we refer to the term 'nutrition care', which refers to any practice conducted by a health professional to support a patient to improve their dietary behaviours and subsequent biomarkers of chronic disease (2). It is well recognised that several factors within the current model of primary health care, such as time and funding, prevent the inclusion of nutrition care into consultations with patients who have, or are at risk of chronic disease (3). Therefore, we feel that this Inquiry represents considerable opportunity to support the inclusion of nutrition care throughout the continuum of primary health care services.

We have provided responses that are directly relevant to three of the terms of reference for the Inquiry:

1. *Examples of best practice in chronic disease prevention and management, both in Australia and internationally*

Best practice guidelines for supporting patients to have healthy dietary behaviours include regular, ongoing access to health professionals that provide nutrition care (predominantly General Practitioners (GPs), Practice Nurses, and Dietitians) (4-7). The recommended appointment frequency, and consultation lengths are stipulated in the best practice guidelines. For example, the practice guidelines for Dietitians recommends an initial consultation to be >60 minutes, followed by monthly consultations of 30-45mins in order to provide sustained support to improvements in dietary behaviours. However, the current Chronic Disease Management (CDM) program does not facilitate these types of interactions with dietitians, and therefore do not facilitate best practice chronic disease prevention and management for nutrition care. Opportunities for facilitating best practice for nutrition care include:

- Increasing access to dietitians through the CDM program, with unlimited consultations available per year.
- Increasing the support for longer consultations with dietitians (rather than the current 20 minute provision) that align with recommended lengths from best practice guidelines.
- Expanding the eligibility criteria for the CDM program to include overweight/obesity, as well as risk factors for chronic disease, such as poor dietary behaviours.

We would also like to acknowledge that patients generally do not utilise all dietetic consultations available to them through the CDM program, despite more frequent consultations being associated with better outcomes (8). Therefore, strategies that highlight the role and benefit of receiving dietetic care, and utilise support and encouragement from other health professionals are also warranted.

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

The Practice Incentive Program aims to improve patients' health outcomes by encouraging continuing improvements in general practice through financial incentives (9). General practice clinics are able to claim incremental rewards for practices related to diabetes, asthma, cervical screening and Indigenous health (9). Incentives are provided for clinics that utilise particular structures for patient management, as well as for GPs and other primary health professionals that complete particular tasks within a consultation. A systematic literature review on pay-for-performance incentive schemes, such as the Practice Incentive Program, demonstrated that GPs who claimed incentives were more likely to comply with national requirements than GPs who did not claim incentives (10). This infers that the Practice Incentives Program is able to support GPs to adhere to the guidelines for the conditions included in the Program.

Nutrition care is not a practice or service included in the Practice Incentives Program. We believe there is opportunity to encourage best practice nutrition care by aligning the Practice Incentives Program with the SNAP guidelines (Smoking, Nutrition, Alcohol, Physical activity) for primary health professionals (7). These guidelines recommend that GPs and Practice Nurses advocate about the importance of healthy dietary behaviours when in consultations with patients who are at risk of chronic disease (7). Within the guidelines, the '5As' (Ask, Assess, Advise, Assist, Arrange) approach is recommended to be used to provide nutrition care to patients (7). Therefore, the Practice Incentive Program could reward health professionals for each step of the 5As process, thereby rewarding and encouraging best practice nutrition care that is in line with clinical guidelines.

6. *Innovative models which incentivise access, quality and efficiency in chronic disease prevention and management.*

An alternative approach to providing patients with access to regular, ongoing nutrition care has yielded success in the UK. Public Health and NHS commissioners are able to purchase 12-week or 52-week referral packages from a number of commercial weight-loss providers (such as Weight Watchers) at a reduced cost. Through this arrangement, GPs and other health professionals are able to provide patients with vouchers to attend meetings with no out of pocket cost. Although the focus is on prevention and management of overweight and obesity, the weight-loss providers encourage improvements in dietary behaviours that are relevant to all lifestyle-related chronic diseases, including cardiovascular disease and Type 2 Diabetes. In the UK context, commercial weight management programmes are seen as more clinically and cost effective than GP- or dietitian-led interventions, and align better with participants' expectations about receiving appropriate care (11, 12).

Preliminary evaluation shows that the voucher system has positive effects on patients, by framing the experience as medically pertinent with clear health benefits (13). Patients report that this system is successful because they have previously received little to no practical support from primary health professionals, and they interpreted the referral system as a personal invitation from their doctor, which they then accepted. Therefore, we strongly support consideration of utilising a model such as this in Australia.

Overall, we thank you for the opportunity to provide input into the Inquiry on Chronic Disease Prevention and Management in Primary Health Care.

Yours sincerely,

Dr Lauren Ball,

On behalf of the nutrition in primary care researchers at Griffith University:

- Dr Lana Mitchell
- Ms Sarah Jansen

Supporting References

1. Australian Institute of Health and Welfare. Risk Factors Contributing to Chronic Disease. Canberra: Australian Government, 2012.
2. Ball, Hughes R, Leveritt M. Nutrition in General Practice: Role and workforce preparation expectations of medical educators. Australian Journal of Primary Health. 2010;16(4):304-10.
3. Foster M, Cornwell P, Fleming J, Mitchell G, Tweedy S, Hart A, et al. Better than nothing? Restrictions and realities of enhanced primary care for allied health practitioners. Australian Journal of Primary Health. 2009;15(4):326-34.
4. Australian Government Department of Health and Ageing. Clinical Practice Guidelines for the Management of Overweight and Obesity: a Guide for General Practitioners. Canberra: 2014.
5. Dietitians Association of Australia (DAA). Best Practice Guidelines for the Treatment of Overweight & Obesity in Adults. Canberra 2011 Accessed July 2015.
6. Dietitians Association of Australia (DAA). Evidence Based Practice Guidelines for the Nutritional Management of Type 2 Diabetes Mellitus for Adults. Sydney 2011 Accessed July 2015.
7. Royal Australian College of General Practitioners (RACGP). Smoking, Nutrition, Alcohol and Physical Activity (SNAP): A population health guide to behavioural risk factors in general practice. 2nd edition. Melbourne: 2015 Accessed July 2015.
8. Spencer L, O'Shea MC, Ball L, Desbrow B, Leveritt M. Attendance, weight and waist circumference outcomes of patients with type 2 diabetes receiving Medicare-subsidised dietetic services. Aust J Prim Health. 2014; 20(3):291-297
9. Australian Government Department of Human Services. Practice Incentives Program (website) 2015, Accessed July 2015. Available from: http://www.medicareaustralia.gov.au/provider/incentives/pip.
10. de Bruin S, Baan C, Struijs J. Pay-for-performance in disease management: a systematic review of the literature. Health Services Research. 2011;11(1):272.
11. Jebb S, Ahern A, Olson A, Aston L, Holzapfel C, Stoll J, et al. Primary care referral to a commercial provider for weight loss treatment versus standard care: a randomised controlled trial. Lancet 2011;378(9801):1485-92.
12. Fuller NR, Carter H, Schofield D, Hauner H, Jebb SA, Colagiuri S, et al. Cost effectiveness of primary care referral to a commercial provider for weight loss treatment, relative to standard care: a modelled lifetime analysis. International journal of obesity. 2014;38(8):1104-9.
13. Allen JT, Cohn SR, Ahern AL. Experiences of a commercial weight-loss programme after primary care referral: a qualitative study. Br J Gen Pract. 2015;65(633):e248-55.