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Introduction

1.1 Chronic diseases are the leading cause of illness, disability, and mortality in Australia, accounting for 90 per cent of all mortalities in 2011.[1] According to the Australian Institute of Health and Welfare, in 2014 seven million people, or 35 per cent of the population, have at least one of nine major chronic conditions: asthma, type 2 diabetes, coronary heart disease, cerebrovascular disease, arthritis, osteoporosis, chronic obstructive pulmonary disease, depression, or high blood pressure.[2]

1.2 This large percentage of the Australian population suffering from chronic disease is indicative of the changing nature of how Australians suffer from disease, and how the current primary health care system in Australia, whilst world class, is predicated on a system of health care that is largely based on a notion of episodic and disjointed care, that is costly and does not cater to the needs of chronic disease patients.

1.3 This cost imposed by chronic disease on Australian society is very large. The direct health care cost of the four most expensive chronic diseases alone – cardiovascular diseases, oral health, mental disorders and musculoskeletal conditions – was estimated at about $27 billion, or 36 per cent of total allocated health expenditure, in 2008-09.[3]

1.4 This does not account for the broader social costs, such as lost productivity and residential care, outside of the health care system. For example, musculoskeletal conditions including osteoarthritis, osteoporosis and back and neck pain are estimated to cost the Australian community

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1 Department of Health, 'Chronic disease', http://www.health.gov.au/internet/main/publishing.nsf/Content/chronic-disease, viewed 14 January 2016.

2 Australian Institute of Health and Welfare, *Australia's Health 2014*, 2014, Chapter 4.2: 'Chronic disease – Australia's biggest health challenge', p. 95.

3 Australian Institute of Health and Welfare, *Australia's Health 2014*, 2014, Chapter 4.2: 'Chronic disease – Australia's biggest health challenge', p. 98.

$55 billion per year;[4] chronic pain is estimated to cost $34 billion per year;[5] and diabetes costs are estimated at about $14.6 billion per year.[6]

1.5 These significant costs indicate the requirement to consider alternative funding models and the potential for a shift in the Medicare system from episodic care support, where a patient's care needs are supported related to each discrete visit to a healthcare provider, to a more holistic care cycle system, where a patient's support is calculated and paid based on wellness and their overall care needs and outcomes, from all appropriate health care providers.

1.6 Often chronic diseases impact on the hospital and emergency health care systems, through the escalation of often preventable complications of chronic disease. These costly episodes could potentially be avoided in some cases by providing appropriate holistic and patient-centred care in the primary health care setting, resulting in a better use of resources and better outcomes for the patients involved.

1.7 Improved health education, promotion and screening have also been shown to significantly impact on the burden of chronic disease, by helping patients, or potential patients, to understand the contributory lifestyle and other factors that often lead to chronic diseases such as diabetes, cardiovascular disease and chronic kidney disease.

1.8 The combination of improved chronic disease education, coordinated care, and revised funding models, as experienced in some international jurisdictions, could ultimately reform chronic disease management in primary health care in Australia.

About the inquiry

Objectives and Scope

1.9 On 26 May 2015, the Minister for Health, the Hon. Sussan Ley MP, referred the Inquiry into Chronic Disease Prevention and Management in Australia (the inquiry) to the House of Representatives Standing Committee on Health (the Committee).

4 Arthritis and Osteoporosis Victoria, *Submission 82*, p. 1.

5 Australian Pain Management Association, *Submission 52*, p. 2.

6 Diabetes NSW, *Submission 60*, p. 1.

1.10 The terms of reference required the Committee to inquire into and report on best practice in chronic disease prevention and management in primary health care, specifically:

- Examples of best practice in chronic disease prevention and management, both in Australia and internationally;
- Opportunities for the Medicare payment system to reward and encourage best practice and quality improvement in chronic disease prevention and management;
- Opportunities for the Primary Health Networks to coordinate and support chronic disease prevention and management in primary health care;
- The role of private health insurers in chronic disease prevention and management;
- The role of state and territory Governments in chronic disease prevention and management;
- Innovative models which incentivise access, quality and efficiency in chronic disease prevention and management;
- Best practice of Multidisciplinary teams chronic disease management in primary health care and Hospitals; and
- Models of chronic disease prevention and management in primary health care which improve outcomes for high end frequent users of medical and health services.

Inquiry Conduct

1.11 The inquiry was announced on 26 May 2015 via media release, with submissions sought by 31 July 2015. In an effort to capture as much evidence as possible for the duration of the inquiry, the Committee accepted submissions after this date.

1.12 In total, the Committee received 210 submissions and 30 exhibits from a wide range of individuals and organisations. Submissions and exhibits received during the inquiry are listed at Appendices A and B respectively.

1.13 The Committee held 13 public hearings as shown below.

Date	Place
18 August 2015	Canberra, ACT
21 August 2015	Canberra, ACT
18 September 2015	Sydney, NSW

1 October 2015	Melbourne, Vic
23 October 2015	Sydney, NSW
18 November 2015	Bendigo, Vic
12 February 2016	Bomaderry, NSW
18 February 2016	Brisbane, Qld
19 February 2016	Tumbi Umbi, NSW
23 February 2016	Canberra, ACT
4 March 2016	Adelaide, SA
11 March 2016	Perth, WA
31 March 2016	Newcastle, NSW

1.14 The witnesses who gave evidence at these hearings are listed at Appendix C. Submissions received and transcripts of public hearings are available on the Committee's webpage at: <www.aph.gov.au/health>.

Senate Inquiry into Tick-Borne Diseases

1.15 On 12 November 2015, the Senate referred the matter of 'The growing evidence of an emerging tick-borne disease that causes a Lyme-like illness for many Australian patients' to the Senate Community Affairs References Committee.[7]

1.16 As part of this Committee's chronic disease inquiry, there were a number of submissions received highlighting concerns about the categorisation, identification and treatment of a Lyme-like tick-borne disease in Australia.[8] As a result, the Committee held a roundtable public hearing in Sydney on 18 November 2015 to hear about the growing evidence and concern about how this illness is managed in Australia.

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7 See the Inquiry homepage at <http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Lyme-like_Illness>

8 Lyme Disease Association of Australia, *Submission 85*; Ms Emily O'Sullivan, *Submission 156*; Karl McManus Foundation, *Submission 158*; Dr Richard Schloeffel, *Submission 162*; Sarcoidosis Lyme Australia, *Submission 166*; Name withheld, *Submission 171*; Ms Sharon King, *Submission 176*; Mrs Joanne O'Donoghue, *Submission 186*.

1.17 However, the relevant condition covered by this hearing is one of only a number of conditions that can be classified as chronic diseases within Australia.

1.18 The Senate Inquiry is welcomed by the Committee, as this important emerging condition can be given special focus by that inquiry, and accordingly the Committee has referred the Senate Committee to the evidence received to date.

1.19 Due to the specific focus of the Senate inquiry, this report focuses on the evidence received regarding tick-borne and Lyme-like illnesses as a case study.[9]

'Healthier Medicare' Chronic Disease Announcement

1.20 On 31 March 2016, the Prime Minister, the Hon. Malcolm Turnbull MP, and the Minister for Health, the Hon. Sussan Ley MP, made a joint announcement introducing a package of reforms as part of 'Healthier Medicare' aimed at modernising and uniting the chronic disease management process in Australia.[10]

1.21 The reforms outlined in this package align substantively with the models and best practice reforms suggested to the Committee during the conduct of this inquiry. The two year trial of Health Care Homes, to be undertaken from 1 July 2017, will introduce many elements of the suggested reforms discussed in this report.

1.22 The Committee welcomes this announcement, and will acknowledge the reforms, as relevant, throughout the evidence and consideration ahead.

Report Structure

1.23 The report is comprised of 5 chapters and outlines the Committee's findings, comments and recommendations in relation to its Inquiry into Chronic Disease Prevention and Management in Primary Health Care in Australia. More specifically:

- Chapter 2 defines what chronic disease means in Australia; the major conditions constituting the burden chronic disease has on Australian

9 Please see Appendix A.

10 The Hon. Malcolm Turnbull MP, Prime Minister and The Hon. Sussan Ley MP, Minister for Health, Minister for Aged Care, Minister for Sport 'A *Healthier Medicare* for chronically-ill patients', *Media Release*, 31 March 2016.

health care; the role of prevention in chronic disease health care and what the role of primary health care is within the current system. This chapter also discusses a number of other conditions that were raised with the Committee during the conduct of the inquiry that may not normally be considered widely in the discussion of chronic disease in Australia.

- Chapter 3 discusses the current provision of chronic disease primary health care in Australia and how state and territory Governments, Primary Health Networks, allied health providers and private health insurers contribute to this system. This chapter also discusses what the identified gaps in current care provision may be and how they can be better catered for. Relevant international examples are also outlined.
- Chapter 4 outlines the extensive evidence that the Committee received on best practice in chronic disease management, multidisciplinary teams and education for both prevention and management of chronic disease. The chapter also discusses whether best practice can, or should, be a 'one size fits all' concept, as well as the benefits and risks of the expansion of electronic health technology and the associated patient and health data.
- Chapter 5 concludes the report by discussing the issue of funding for chronic disease prevention and management, practice incentive payments, how the current model can potentially be informed by recent and current changes in international jurisdictions, as well as the recently announced reform trials in Australia.