RACGP

RACGP's submission to the Standing Committee on Health

Inquiry into chronic disease prevention and management in primary health care

August 2015

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Executive summary

This submission presents The Royal Australian College of General Practitioners' (RACGP's) response to the Standing Committee on Health's 'Inquiry into chronic disease prevention and management in primary health care'.

General practitioners (GPs) are at the forefront of the primary healthcare sector's efforts to support patients to prevent and manage chronic disease. There is a range of international models that may support the efforts of GPs and other primary healthcare providers to enhance their services. However, their success in Australia requires nuanced adaptation and informed implementation to match local needs and settings.

General practice sustainability and patient access to care is being threatened by the freeze on patient rebates. While there are many areas to better target the Medicare Benefits Schedule (MBS) to support GPs and their teams, the rebate freeze will be a large barrier to the prevention and management of chronic disease.

Primary Health Networks (PHNs), private health insurers, and state and territory governments have various interests in ensuring effective prevention and management of chronic diseases. The key to their involvement is collaboration with general practices to improve outcomes for patients, reduce duplication of services to ensure continuity of care.

Primary healthcare is provided by multidisciplinary teams, where different team members contribute to care, as part of a GP-led team. This model is the most appropriate for allocating scarce health resources and best managing patient care. The RACGP does not support the establishment of alternative avenues to access primary healthcare through health professionals who operate independently to general practices and who do not have appropriate skills and training comparable to that of GPs.

The RACGP is finalising its *Vision for general practice and a sustainable healthcare system*. This framework is underpinned by the patient-centred medical home model and supported by a clear evidence base, resulting in improved patient outcomes and a reduction in demand for hospital services. Our model seeks to reorient health funding toward primary care, and to better support general practices to assist patients to prevent and manage chronic disease. We have no doubt that support for the quality general practice of the future, encompassing the medical home, is required and paramount to maintaining good health outcomes for all Australians.

Summary of recommendations

The RACGP has made a number of recommendations throughout this submission:

Recommendation 1: The National Health and Medical Research Council (NHMRC) and the Australian Commission on Safety and Quality in Health Care (ACSQHC) should prioritise multimorbidity when considering the development of new evidence-based guidelines.

Recommendation 2: Reverse the indexation freeze on Medicare patient rebates as a matter of priority.

Recommendation 3: Explore options to reform chronic disease management (CDM) items to better resource and target services toward those most in need, and to focus on review and follow-up.

Recommendation 4: Reverse the restriction on same-day billing of CDM and general consultation items to prevent fragmentation of care for patients with chronic disease.

Recommendation 5: Appropriate funding is required to support general practice nurses and credentialed mental health nurses to engage in chronic disease prevention and management that is appropriate to their skill set.

Recommendation 6: Consider effective methods for allowing private health insurers to work with general practices (within clearly defined parameters) without limiting patient access or clinical independence.

Recommendation 7: Funding for primary healthcare research on chronic disease prevention and management should be prioritised.

Contents

Introduction

The Royal Australian College of General Practitioners (RACGP) thanks the Standing Committee on Health (the Standing Committee) for the opportunity to contribute to discussions regarding chronic disease prevention and management in primary healthcare.

The RACGP believes this inquiry is timely and will help to facilitate important discussions between governments, health professions and patients regarding much needed improvements to the prevention and management of chronic disease in primary healthcare.

We note that this inquiry is taking place in tandem to the work of the Primary Health Care Advisory Group (PHCAG), covering similar topics. It would be useful to have a better understanding of how the Standing Committee and PHCAG will collaborate and share information.

About the RACGP

The RACGP is Australia's largest professional general practice organisation representing more than 30,000 members working in or towards a career in general practice. The RACGP sets and maintains the standards for quality clinical practice, education and training in Australian general practice, and supports general practitioners (GPs) in their pursuit of excellence in patient care and community service.

RACGP's submission to the Standing Committee on Health

The RACGP notes that the Standing Committee has been tasked with inquiring into and reporting on best practice in chronic disease prevention and management in primary healthcare, 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 healthcare
- 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 healthcare and hospitals
- models of chronic disease prevention and management in primary healthcare which improve outcomes for high-end frequent users of medical and health services.

The RACGP's submission responds to these terms of reference, focusing on chronic disease prevention and management in general practice. Our submission provides an overview of key issues, and where appropriate, highlights recommendations for the Standing Committee's consideration.

Members of the RACGP's National Standing Committees for Quality Care, General Practice Advocacy and Support, Research, Standards and eHealth; the National Faculty of Special Interests; the National Rural Faculty; and the National Faculty for Aboriginal and Torres Strait Islander Health provided significant input into this submission.

Gaps in the terms of reference

The RACGP believes that there are a number of gaps in the terms of reference that need careful consideration when exploring best practice in chronic disease prevention and management in primary healthcare. The identified gaps are detailed below.

Multimorbidity

The terms of reference do not recognise the complexities in managing patients with multimorbidity in the primary healthcare setting. Multimorbidity, the presence of multiple chronic conditions in a single individual, is common and increasingly the norm in general practice patients. The prevalence of multimorbidity increases with age, and as Australia's population ages, we expect this figure to grow.[1,2] Multimorbidity is associated with reduced quality of life, polypharmacy issues and increased risk of hospitalisation.[3,4]

One of the main issues with supporting patients with multimorbidity is the lack of resources available to assist GPs. Single disease-specific guidelines for chronic diseases do not adequately address the assessment and management of patients with multimorbidity. Multimorbidity requires GPs and their teams to undertake greater care planning and service coordination due to the complexity of the patient's health conditions. Patient-centred approaches are vitally important to improve health outcomes for this patient group.

Recommendation 1: The National Health and Medical Research Council (NHMRC) and the Australian Commission on Safety and Quality in Health Care (ACSQHC) should prioritise multimorbidity when considering the development of new evidence-based guidelines.

Aboriginal and Torres Strait Islander health

The Standing Committee's terms of reference has not identified chronic disease prevention and management for Aboriginal and Torres Strait Islander peoples as a priority. The needs and priorities of Aboriginal and Torres Strait Islander peoples often differ from the needs of non-Indigenous Australians. Given the increased complexity and poorer health outcomes experienced by Aboriginal and Torres Strait Islander peoples, the Standing Committee should prioritise consideration of this population group's needs.

Broad understanding of chronic disease

Lastly, the RACGP suggests the Standing Committee consider a broader concept of chronic disease, encompassing a range of physical and mental health issues, including addiction and chronic non-cancer pain. While this broadens the scope of recommendations and best practice models for the Standing Committee's consideration, it would recognise the broad range of chronic issues currently managed by GPs and their practice teams. It would also recognise the need to better integrate physical and mental health in the management of chronic disease.

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

The RACGP plays a key role in disseminating best practice information to GPs through the ongoing development of evidence-based clinical guidelines. Among these and key to the Standing Committee's inquiry, are the RACGP's:

- *Guidelines for preventive activities in general practice, 8th edition (*the Red book*)*
- *General practice management of type 2 diabetes – 2014–15*
- *Smoking, nutrition, alcohol, physical activity (SNAP): A population health guide to behavioural risk factors in general practice*

The RACGP reviews these resources regularly, providing GPs and their practice teams with access to up to-date and clinically relevant information on best practice in chronic disease prevention and management.

1.1 Models and trials for consideration

There are a range of models currently used to support chronic disease prevention and management across Australia and internationally. The RACGP highlights that all successful models need adaptation to suit local contexts. The extent and quality of the model's implementation can limit or promote its success.

The patient centred medical home

The patient-centred medical home (PCMH) model underpins the RACGP's *Vision for general practice and a sustainable healthcare system*, described in more detail in Chapter 6.

The PCMH has five attributes that closely align with the role of general practice in the Australian health system:

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

PCMH models have been associated with:

- increased access to appropriate care for the health issue[5]
- decreased use of inappropriate services (particularly emergency department use)[6,7]
- increased provision of preventive services (eg cancer screening)[8]
- improved care experiences for patients and staff[6,9]
- cost savings.[10]

Characteristic of PCMH is continuity of care. Continuity of care (specifically seeing the same practitioner/GP consistently), has been shown to reduce emergency department use and preventable hospital admissions.[11–14] Research also found that continuity of care, contributes to an overall lowering of healthcare costs, increased patient satisfaction and greater efficiencies in the wider health system.

The Kaiser Permanente Pyramid

The Kaiser Permanente Pyramid (the Kaiser pyramid) segments populations into groups to which interventions can be targeted. The smallest group is generally the group with the highest needs and at the highest risk of hospitalisation, to whom the most intensive interventions should be targeted.[15,16] Supported by modelling, the Kaiser pyramid presents an approach to targeting scarce health resources toward those most in need.

Wagner's Chronic Care Model

Wagner's Chronic Care Model presents a structure for organisation and practice change to improve patient outcomes. Part of its aim is to increase the involvement of patients in their own care, as this can yield positive outcomes across a range of health indicators.[17–19]

In this model, team care, led by a care-manager such as a GP or a general practice nurse, is provided in a way that is proactive, planned and aimed at preventing harm. Practices change systems of care from traditional episodic care, where patients present with acute symptoms, to one of planned appointments with protocol driven monitoring and management tasks. To achieve systemic change, general practices need support and guidance on how to provide new models of care, which can often require reorganisation of health delivery systems.

One example of use of the Wagner's Chronic Care Model in Australian general practice is the TrueBlue project. This project sought to improve outcomes for comorbid patients diagnosed with depression and type 2 diabetes, and patients with depression and coronary heart disease. Patients improved significantly following treatment intensification. These improvements were sustained over 12 months of intervention, which resulted in reduced 10-year cardiovascular disease risk.[20,21]

Department of Veterans' Affairs Coordinated Veterans' Care program

RACGP members often cite the Department of Veterans' Affairs Coordinated Veterans' Care (DVA CVC) program as an example of how care for patients with chronic and complex conditions could be organised more effectively. Key to this program is support for care coordination and regular review of management plans.

Further evaluation of the program's benefits and its costs effectiveness when applied to larger groups would be useful at this stage.

Prevention and management of diabetes

Some of the best practice in chronic disease prevention and management has been characterised by coalescence of a strong consumer advocacy or advocacy organisation along with consumer engagement in self management. Combined with clear, evidence-based medical research and pragmatic implementation guidelines, this approach represents a template or model for improving prevention and management of diabetes. For example, the National Vascular Disease Prevention Alliance (NVDPA) – an alliance of the Stroke Foundation, Kidney Health Australia, the Heart Foundation and Diabetes Australia – has developed guidelines for cardiovascular risk management and absolute cardiovascular disease risk assessment tools. Additionally, the RACGP's *General practice management of type 2 diabetes – 2014–15* is the result of ongoing collaboration between Diabetes Australia and the RACGP.

The Team Healthcare Trial

The Team Healthcare Trial (the Trial) was conducted between 2003–05 in Brisbane general practices as part of the Department of Health and Ageing funded Coordinated Care Trials. The Trial focused on improving coordination of primary care, and coordination of care between primary, hospital and residential aged care services.

The Trial found the cost of care for the intervention group was trending downwards by the end of the trial when compared to the control group as a result of slower growth in inpatient costs.

Service use substitution occurred, whereby inpatient services were substituted for Medical Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) services at a lower cost, indicating improvements in care.[22]

1.2 Reconsidering terminology and best practice for diabetes care

The RACGP has serious concerns with the use of the term 'pre-diabetes'. The term is contributing to a widening definition of diabetes, capturing people with impaired fasting glucose (IFG) and impaired glucose tolerance (IGT). Though acknowledging the risk of progression to type 2 diabetes is higher within this cohort, care needs to be exercised as it has the potential to lead to over diagnosis, resulting in unnecessary and expensive interventions, tests and treatments.

Similarly, the recent lowering of diagnostic thresholds for gestational diabetes will result in a large increase in the number of women classified with gestational diabetes mellitus. The benefits of this have not been proven. This is likely to lead to women being unnecessarily screened for type 2 diabetes after pregnancy. The RACGP does not support these lower diagnostic thresholds and its position on this is articulated in the RACGP's *General practice management of type 2 diabetes – 2014–15*.

1.3 Considering the use of technology to support best practice

Information systems that analyse patient health status, and present targeted education and information to a patient and to a patient's usual GP or general practice nurse, offer great potential to increasing chronic disease prevention, detection and management. These technologies can ensure chronic disease prevention, detection and management is reliable, thorough and consistent, supporting GPs and their teams to provide appropriate preventive care, while also addressing health issues and needs. There are applications that can provide very sophisticated information and reminders to clinical staff but also to patients.

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

2.1 Indexation of patient rebates would be more valuable than rewards

Well-supported primary care is the most effective way of improving the quality of care and health outcomes for patients with chronic disease.[23,24] Therefore, it is imperative that Medicare patient rebates keep pace with the increasing general practice costs, while ensuring patient access. Appropriately indexing patient rebates should be prioritised before the implementation of any amendments to the Medicare system.

The current indexation freeze will mean that the real value of patient rebates will fall by approximately 6%.[25] The ongoing freeze on indexation of patient rebates threatens the sustainability of practices that opt to bulk bill their patients. The indexation freeze will force these practices to pass on costs to their patients as gap fees. Patients who already pay gap fees will experience a reduction over time in the value of their rebate and/or paying higher out-of-pocket costs to access healthcare.

Increased out-of-pocket costs for patients can be a deterrent to access healthcare, and threatens the implementation of best practice in chronic disease prevention and management. Regular and timely review of care plans and monitoring is not feasible if a patient cannot afford to attend the practice.

The cumulative effect of the indexation freeze is that even children and concession cardholders will inevitably face an increase in out-of-pocket costs when practices are forced to increase fees to cover the cost of delivering care.

Attending a general practice for any but the most acute reasons will limit the potential for practices to undertake crucial chronic disease prevention and management activities.

Recommendation 2: Reverse the indexation freeze on Medicare patient rebates as a matter of priority.

2.2 Opportunities to reform the MBS Chronic Disease Management items

Currently, the MBS includes a range of items collectively known as Chronic Disease Management (CDM) items, including General Practice Management Plans (GPMPs) and Team Care Arrangements (TCAs). CDM items enable GPs to plan and coordinate services for patients with chronic or terminal health conditions. Patients with a TCA are eligible to receive Medicare rebates for allied health services when referred by their GP.

CDM items support general practices to introduce structured chronic disease care programs that allow GPs to establish cycles of care. They also support a multidisciplinary team approach to CDM. One of the main benefits of the CDM items are that general practice nurses can spend time with patients to assist GPs in assessment and management. This can often result in the identification of issues that require further input, investigation and management by the GP.

However, our members have identified a number of limitations regarding the CDM items as they currently operate:

- The items do not allow for differentiation between patients' needs. Patients with relatively simple chronic disease with little or no impact on their life are entitled to the same package of CDM services as a patient who has a complex condition that significantly incapacitates them. Risk assessment of patients could support GPs to determine appropriate levels of service that is based on clear risk assessment tools. Allowing a tailored approach to providing services would be more efficient at meeting individual patient needs.
- There is a significant amount of red tape associated with the use of CDM items. The *Health Insurance (General Medical Services Table) Regulations 2010* outlines requirements for these items and specifies requirements for CDM items to an unnecessary level of detail. GPs understand that they need to obtain consent, take sufficient notes, and discuss treatment options and plans, just as with any other consultation. Recrafting the requirements and descriptors to reduce the prescriptiveness and increase flexibility will assist GPs to better use the items to plan and coordinate care.
- Similarly, referrals to allied health professionals are complicated (by the requirement to prepare a TCA). This process could be streamlined by adopting the same process used for specialist referrals. This involves a GP writing a referral letter to a specialist, rather than developing a plan separate to a GPMP at the time of referral to coordinate care.
- Current CDM patient rebates are heavily weighted to generating GPMP documents. Real benefits for patients come from reviewing plans at the planned follow-up appointments.[26] At these review appointments, the patient's progress measurements and blood test results are reviewed and gaps in care are identified. Goals are re-negotiated, service requirements are reviewed and patient self-management actions are assessed. Patient rebates should be more evenly weighted to these review appointments to encourage regular and proactive review and follow up over an extended period.

The RACGP has developed a draft model to better support CDM and integration of care as part of its *Vision for general practice and a sustainable healthcare system*, which is scheduled for release in late 2015. The model provides support for coordination and care provision, with the greatest resources directed at those patients most in need. Key to this is increasing the support available to patients to address and manage their health issues. We would welcome the opportunity to discuss its proposed remodelling of GPMPs and TCAs in further detail.

Recommendation 3: Explore options to reform CDM items to better resource and target services toward those most in need, and to focus on review and follow-up.

2.3 CDM items and same day billing with general consultation items

Restrictions on claiming CDM and general consultation items when the service is provided by the same GP on the same day poses a number of issues for delivering best practice care for patients with chronic diseases. Imposed in the 2013–14 Federal Budget, this is a very unpopular restriction. The RACGP has received a significant number of member complaints on this issue.

The RACGP maintains that it can often be appropriate and clinically relevant to provide services that would attract CDM and general consultation patient rebates on the same day. The restriction impedes a GP's ability to provide comprehensive quality care in a timely and efficient manner. It threatens GP's capacity to document a care plan and effectively manage the chronic disease, as acute conditions often take priority during consultations.

It is often convenient for patients to be able to address CDM issues at the same time as addressing other concerns. This provides scope for GPs to opportunistically add value to consultations with patients. Asking patients to return on a subsequent occasion to address issues that their GP should be able address during the current consultation risks losing the patient to follow-up.

The restrictions also encourage fragmentation of care, where multiple care providers are involved and care is neither integrated nor coordinated. Patients can claim rebates for a CDM item and a general consultation item on the same day as long as two different GPs provided the services. Preventing these claims restricts patients' access to their preferred GP, hampering continuity of care.

The RACGP has consistently called on the government to remove the restrictions on same day billing and instead adopt compliance measures that prevent inappropriate claiming of these items.

Recommendation 4: Reverse the restriction on same-day billing of CDM and general consultation items to prevent fragmentation of care for patients with chronic disease.

2.4 Chronic disease prevention

There are various health assessment items provided by the MBS (ie 45–49 health assessment, 75+ health assessment), which support GPs to undertake assessment and detect risk factors for chronic disease or chronic health issues. Considering their application and expansion should form part of the approach to improving chronic disease prevention. However, our members have expressed concerns regarding the capacity of the MBS to support preventive activities. For example, patients who are obese are not eligible to access services available to patients with chronic diseases such as diabetes or coronary heart disease, including care from allied health professionals, to prevent development of additional health issues.

2.5 Specialists and ongoing care for CDM

The RACGP has concerns regarding an increasing trend where medical specialists assume care for patients with chronic disease for whom GPs could manage in the general practice setting, while also attending to all their health needs, at a fraction of the cost. This often involves specialists conducting periodic checks that GPs can safely perform in general practice. Examples include periodic review by psychiatrists of patients with uncomplicated depression or gynaecologists performing Pap tests.

Similarly, referral between specialists to address emerging patient issues can often lead to unforeseen quality and safety issues. While useful for addressing serious patient concerns, without coordination with the patient's primary GP, services may be duplicated and safety issues may arise when information held by the GP is not factored into the specialist assessment. Systems for supporting better coordination between specialist and GPs would reduce or prevent quality and safety issues occurring.

2.6 General practice nurses' role in prevention and management

General practice nurses are valuable members of the general practice team. General practice-based guidelines that support general practice nurses in providing prevention and management activities would further assist them to work alongside GPs and extend the capacity of general practice to meet the needs of their communities.

Incentivising practices to employ general practice nurses to provide care within the scope of such evidenced-based guidelines presents an opportunity to expand access to primary healthcare services, ensure high-quality care and strengthen the general practice team.[20,27]

Additionally, supporting access to credentialed mental health nurses in general practice, who work in close collaboration with GPs and other specialists, enhances the ability of general practices to prevent and manage chronic mental health issues.

Recommendation 5: Appropriate funding is required to support general practice nurses and credentialed mental health nurses to engage in chronic disease prevention and management that is appropriate to their skill set.

3. Opportunities for the Primary Health Networks to coordinate and support chronic disease prevention and management in primary healthcare

To support chronic disease prevention and management in primary healthcare, Primary Health Networks (PHNs) should recognise the central role that GPs and their teams have in patient care. GPs provide efficient care resulting in good patient outcomes and satisfaction. General practices can deliver high-quality preventive care, health promotion and chronic disease management to local communities in response to the community's needs.[23,28]

The RACGP's *Position statement – Primary Health Networks* provides further details regarding their role and operation, and is available at www.racgp.org.au/download/Documents/Policies/Health%20systems/RACGP-Position-statement-Primary-Health-Networks.pdf

The following points (3.1–3.5) provide a description of the ways that PHNs can support chronic disease prevention and management in primary healthcare.

3.1 Value the GP–patient relationship

PHNs' support for the GP–patient relationship is vital. The relationship is key to ensuring access to high quality, safe healthcare through helping patients navigate through complex health and social care systems. General practices are a patient's medical home and GPs are usually the coordinators of their care.

3.2 Foster integration between sectors and develop improved systems of care and care pathways

PHNs can improve the patients' journey and outcomes through coordination and integration of care, and reducing service duplication. Their main role must be to foster integration between primary healthcare providers and other health service providers (eg state/territory primary healthcare, hospitals, aged care, mental health care and palliative care services). Increasing meaningful communication between these groups will improve collaborative care and patient pathways, leading to better health outcomes and less waste.

Facilitating reciprocal, secure electronic communication between general practice and the other parts of the health system would be a practical approach for PHNs to improve integration of care for people with chronic disease. While many general practices already use secure electronic systems to communicate with other health professionals and organisations, public hospitals and other Federal and state/territory funded services do not have this capacity.

3.3 Ensure patient access to services

A key priority for PHNs should be improvements in patients' access to primary healthcare, particularly for disadvantaged groups within their catchment. Increased access to services should result in improved health outcomes on a regional basis, requiring robust data collection systems to demonstrate improvements. Identifying local gaps in chronic disease service provision and strategically addressing the issues at a local level is crucial to ensuring patient access to appropriate services.

Another aspect of this could involve undertaking health promotion activities in partnership with service providers in order to improve health literacy and to encourage access to services.

3.4 Champion service quality and safety

PHNs should also support improvements in quality and safety within the primary healthcare services in their catchment. This could involve assisting primary healthcare providers to attain and maintain accreditation, adopt best practice, and supporting improved reporting and data analysis on outcomes and safety. Other practical steps include providing education and training, or facilitating and supporting research and innovation.

PHNs should support practices in their efforts to understand the impact of their services and identify areas for improvements.

3.5 Adopt robust clinical change management strategies

PHNs need to develop strong clinical change management strategies and capabilities to support change and improvements within their catchments.

4. The role of private health insurers in chronic disease prevention and management

The RACGP advocates for health reforms that will support quality general practice and result in improved health outcomes for Australians. While the RACGP has reservations, it is open to exploring the possible roles for private health insurers in chronic disease prevention and management. Within defined parameters, private health insurers could play a role in supporting or delivering preventive activities and CDM.

The RACGP's *Position statement – Private health insurance in general practice* is available at www.racgp.org.au/download/Documents/Policies/Health%20systems/racgp-position-statement-private-health-insurance-in-general-practice.pdf

4.1 Potential problems with the involvement of private health insurers in general practice

GPs have significant reservations regarding the role private health insurers could play in the primary healthcare sector.

The RACGP's main concern is the likelihood of private health insurers prioritising profit and cost savings over continuity of care delivered by highly-trained, autonomous general practice teams who have ongoing relationships with their patients. Additionally, the spectre of managed care models, where private health insurers may ration care to reduce costs, concern GPs who adopt a holistic, patient-centred approach.

4.2 Principles for the involvement of private health insurers in general practice

The RACGP does not support amendment to the *Private Health Insurance Act 2007* to allow private health insurers to fund services currently funded by Medicare.

Prevent duplication and fragmentation of care

A number of programs offered by private health insurers are of benefit to their customers. However, these programs often take place in isolation from the patient's usual GP, who is best placed to understand patients' needs and make treatment recommendations. Of further concern, private health insurers can often duplicate services available from the patient's general practice.

Private health insurers must not encourage or require patients to see 'preferred GP providers' on the basis of the GP or general practice's participation in a private health insurance pilot project or program.

When choosing a GP or general practice, patients should be free to choose based on quality of care, access, convenience, relationships and other preferences. However, the RACGP acknowledges that patients may choose to attend a GP based on their participation in a private health insurance pilot project or program.

Limit impact on clinical judgement

Private health insurers must not require or encourage GPs to refer patients to certain providers of care based on their participation in a private health insurance pilot project or program. Similarly, private health insurers should not require GPs to adhere to treatment rules, regulations or protocols unless it is in the patient's best clinical interest to do so. GPs must be able to refer to other providers and provide treatment as clinically appropriate, based on the GP's professional judgement and patient's need.

Ensure access based on need, not on patient private health insurance status

The RACGP considers targeted support and care coordination programs to be more effective approaches to improving patient health, when compared to prioritised access. The RACGP supports equity of access to general practice services for all people, regardless of income or private health insurance status.

Private health insurers must not create a system where patients with insurance are given priority or preferential access to GPs over patients who do not have insurance and are potentially in greater need. Without appropriate safeguards, there is a risk that involving private health insurers in primary healthcare will reduce access to care for uninsured people, particularly if private health insurers arrange preferential treatment for their patients. Access to preventive and primary healthcare should be universal, and not restricted by a patient's capacity to pay.

For patients who can least afford healthcare, the government must provide services equivalent to those offered by private health insurers to prevent inequalities in access to and quality of care.

4.3 Potential areas for involvement of private health insurers

Noting the concerns and principles, under strictly agreed conditions, there are opportunities for private health insurers to support general practice to prevent and manage chronic disease. Possible mechanisms may include:

- preventive healthcare, including information, advice and health assessments
- evidence-based chronic health prevention programs with risk minimisation to support private health insurers who have a larger number of members who require support
- targeted CDM and hospital avoidance programs (eg hospital in the home and integration of care)
- other supports for GPs and general practices to flexibly meet the needs of their patients, supporting local solutions to local challenges.

Key to this is that private health insurers should consider facilitating evidence-based enhanced CDM via general practice rather than in parallel to it. For example, funding a patient to attend a falls and balance program or an extended cardiac rehabilitation program via a GP referral could help reduce hospital admissions and reduce duplication or fragmentation of care.

Private health insurers have essentially 'enrolled' patient populations with a useful subset of information on their customer's use of health services. There are opportunities for private health insurers to use this information to support general practices to target care toward patients most in need of services.

Recommendation 6: Consider effective methods for allowing private health insurers to work with general practices (within clearly defined parameters) without limiting patient access or clinical independence.

4.4 Private health insurers and evidence-based services

The RACGP recently adopted the position that private health insurers should not supply rebates for or otherwise support services or products that do not have an evidence base. Specifically, this is due to concern that health insurance premiums continue to rise as funds disburse significant sums for the use of homeopathy and other alternative therapies lacking rigorous evidentiary support.

Offering subsidies for the use of homeopathy sends a confusing message to consumers. Listing homeopathic treatments alongside evidence-based modalities in a list of member benefits lends legitimacy to a practice that is not supported by scientific data.

The acceptability of expanding private health insurer involvement in chronic disease prevention and management should be considered in light of continued support for alternative therapies that lack an evidence base.

5. The role of state and territory governments in chronic disease prevention and management

States and territories have a major role in population chronic disease prevention by influencing the social determinants of health (eg food supply and marketing, urban design, public transport, community safety, education). States and territories are motivated to reduce potentially preventable hospital admissions and offer services with the same aim as CDM in general practice – keeping people well and out of hospital.

State and territory primary healthcare services provide a safety net for patients who cannot afford to access private allied health or nursing services, or when the patient requires more support from allied health professionals and have exhausted their allowed Medicare rebates.

5.1 Reducing duplication of service provision

There is, unfortunately, a large amount of duplication of services across general practice, and state and territory primary healthcare services. Duplication and poor integration unnecessarily complicates and confuses the patients' journey.

One option for better managing demand and reducing duplication of care is for referral pathways to state and territory services to operate through general practice, similar to TCA referrals.

The RACGP proposes that the government commits and appropriately funds general practices to operate as PCMHs.

This model is characterised by coordinated and comprehensive care and would position general practices to coordinate patient care across settings, including access to state- and territory-funded services. The move toward these models will result in the efficient use of limited health services.

Another related issue is the lack of coordination of regulations across different jurisdictions. National standardisation of regulations, particularly in the area of drugs of dependence, would support better and consistent practices across the country.

5.2 State and territory collaboration with PHNs

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

With utilisation of local knowledge and support networks and directories, states and territories should be encouraged to create opportunities and maintain availability, and attract specialised allied health and medical services into regional and rural areas, in collaboration with PHNs. There should be national support for innovative care models such as telemedicine, point-of-care testing and cross-cultural and refugee health initiatives.

Community outreach specialist services that provide care in existing primary care locations would improve access to these services in regional and remote areas. Similarly, states and territories could support the provision of telehealth services in rural and regional areas, including Aboriginal and Torres Strait Islander communities. Queensland provides a good example of a state enhancing access to services through support for telehealth services.[29]

5.3 Ensuring access to evidence based therapies

States and territories have an important role to play in ensuring access to evidence-based therapies and management through the public hospital systems. A key example of this is access to bariatric surgery for patients who are obese. There is a strong evidence base for anti-obesity surgery in those with a body mass index (BMI) of more than 35 with comorbidities or a BMI of more than 40 with no comorbidities. Our members have expressed concerns that private health insurers are decreasing support for this surgery, making access to this evidence-based management strategy difficult.

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

6.1 The RACGP's *Vision for general practice and a sustainable healthcare system*

The RACGP has a vision for general practice and a sustainable healthcare system. Our draft consultation paper proposes a re-orientation of incentive funding toward better rewarding patient-centred care, ultimately reducing the need for expensive hospital care. Key to this is the formal adoption of the patient-centred medical home.

One part of this vision is the proposal to better target CDM support toward patients with the highest needs. Better coordinated and more tailored responses to patients' needs will ensure the allocation of the scarce resources available to general practice teams to assist patients most at risk of hospitalisation.

Another element of the vision seeks to reward GPs who provide a comprehensive range of services to their community. This measure will support general practice teams to provide a broad range of services and prevent patients seeking care from hospitals. One further element of the model seeks to improve support for quality and safety within general practices partially through incentivising GPs' participation in primary healthcare research.

We will release our vision shortly, having just completed two rounds of consultation with stakeholders.

6.2 Supporting primary healthcare research to develop innovative models

Primary healthcare research is an important driver for the development of innovative models that respond to the local context and health needs. More support is needed for primary healthcare research, particularly innovative and effective models for chronic disease prevention and management, and the implementation of new technologies to support CDM. It is imperative that chronic disease prevention and management research is undertaken in primary care where the majority of prevention and management takes place.

Primary healthcare research is also needed to continually enhance and strengthen the evidence base for the care GPs and their teams provide. As patient needs change, gaps in the evidence base emerge. For example, there is a lack of clinical evidence on preventing and managing multimorbidity. This hinders the development of appropriate clinical guidelines and resources to support GPs.

Recommendation 7: Funding for primary healthcare research on chronic disease prevention and management should be prioritised.

7. Best practice in multidisciplinary teams chronic disease management in primary healthcare and hospitals

Effective leadership is central to the performance of multidisciplinary teams. The RACGP strongly supports the role of GPs as leaders of multidisciplinary general practice teams that provide coordinated and comprehensive primary healthcare.

GPs undergo extensive training in assessment and diagnosis and operate in open access environments where a broad range of undifferentiated health problems are managed. As team leaders, GPs must ensure each team member has a clearly defined role to support this work, aligned with licensing requirements, competency, education, and the individual's training and scope of practice.

Therefore, the RACGP would not support proposals to expanding chronic disease prevention and management services in primary care when these are not under the auspice of the GP-led team. Expansion of services in this manner, such as the establishment of independent nurse-led or pharmacy-based clinics, increases the number of health services providing entry into the health system. This may lead to poorer health outcomes and increased costs. It also has the potential to fragment care, leading to little or no continuity of care for the patient and duplication of effort.

The key to effective operation of multidisciplinary teams is consistent and clear communication between team members. It is important for GPs to understand the services available in their community, and to understand the appropriate referral processes, recognising that the multidisciplinary primary healthcare team is often located in multiple different locations and services.

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

There are a number of enablers for improving outcomes for all patients, but especially frequent health service users, including:

- ensuring continuity of care between general practice, other primary healthcare providers, specialists and hospitals
- improving GP–patient continuity of care
- monitoring outcomes and coordinating care plan reviews
- shared clinical records or, at a minimum, support for secure electronic transfer of health information as data and not as images (ie scanned documents)
- effective recall and reminder systems
- data integration to identify high frequency users
- integrated service pathways that assist patients and their GPs to navigate the range of services high needs patients require.

The RACGP supports voluntary patient enrolment as an approach to formalising relationships between GPs and patients. It forms a foundational element of the RACGP's *Vision for general practice and a sustainable healthcare system*. Enrolment has the potential to improve outcomes for high-end frequent users of health and medical services supporting continuity of care. Evidence have found a good GP–patient relationship can prevent hospital admissions for primary care sensitive conditions.[11–14]

RACGP's members identified a range of models that assist them to address the needs of patients with more complex health conditions that result in frequent health service use.

The identified models are detailed below.

8.1 Diabetes care

- The RACGP resource *General Practice management of type 2 diabetes – 2014–15* supports GPs and their teams to provide high-quality management by providing up-to-date, evidence-based information tailored for general practice.
- High risk foot guidelines, which helps GPs to stratify diabetes-care management for high risk patients.
- The telehealth endocrinology services provided by Queensland Health, as part of its larger telehealth service program, which provides an accessible service and allows the primary Healthcare team to be present during patient consultations with endocrinology specialists.
- The Inala Chronic Disease Management Service demonstrates that opportunities exist for diabetes care to be devolved from hospitals when care is provided by multidisciplinary, community-based, integrated primary-secondary diabetes services. These trials have reduced hospitalisations with no change in quality or outcomes of care.[30]

8.2 Depression and chronic disease

- Comorbid depression is present in about 30% of patients with a chronic disease. It is likely that many frequent and high-end users of health services have comorbid anxiety or depression, and it is associated with poor outcomes including increased morbidity and mortality. Depression symptoms may be masked by physical illness, making it harder to detect.
- Some national guidelines now include recommendations to screen for depression and anxiety in patients with diabetes and heart disease. While there is some debate on whether routine screening is best practice, GPs and general practice nurses are well placed to be alert for comorbid depression. Training, GPMP templates, data collection and feedback could all encourage a case finding approach for comorbid depression

8.3 Prescribing drugs of dependence

- A national real-time, online prescription monitoring program (as currently operating in Tasmania) would better support GPs to make informed treatment decisions for all patients, particularly frequent health-service users.

8.4 Non-drug interventions

- The RACGP has committed to promoting effective non-drug treatments for range of health issues to provide GPs with a greater range of choices when considering prevention and treatment of chronic disease through the development of the Handbook of Non-Drug Interventions (HANDI). For example, non-drug interventions for addressing mental health issues will contribute to reducing Australia's high rate of prescribing to address these issues.

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