RACGP

RACGP submission to the Primary Health Care Advisory Group – September 2015

Overall

What aspects of the current primary health care system work well for people with chronic or complex health conditions?

Timely and supported access to general practitioners (GPs) and their teams are key advantages of the current primary healthcare system.

GPs provide a comprehensive range of preventive serivces, acute care, and chronic disease management. GPs have training and expertise in longitudinal care at every stage of a patient's life. They are experts in appropriate investigation and diagnosis of undifferentiated symptoms, and are often the primary case manager, synthesising complex information from multiple sources to support their patients.

Patient-centred care provided by GPs is fundamental to enable patients to improve their understanding and management of illness and disease. This is a particularly important function for optimising health outcomes and reducing healthcare costs.

One of the key roles of a GP is to be the 'filterer' of care to other primary and secondary health services – ensuring these services are provided when needed and that scarce healthcare resources are used efficiently. Due to their breadth of knowledge and training, GPs can expertly recognise and facilitate the appropriate engagement of other providers in primary and secondary healthcare.

These roles work to optimise population health and minimise demand for more expensive hospital-based care.

This is particularly the case in rural and remote areas, where GPs often develop a range of advanced skills to meet the needs of their community in the absence of specialist services.

What is the most serious gap in the primary health care system currently provided to people with chronic or complex health conditions?

b) Nationally?

Our current model of healthcare primarily promotes the provision of care for single diseases and 'partialist' (highly specialised) practice. Multimorbidity, where an individual has multiple chronic conditions, is common and increasingly the norm in general practice patients. The prevalence of multimorbidity increases with age, and as Australia's population ages, the proportion of the population with multimorbidity will also increase. Multimorbidity is associated with reduced quality of life, polypharmacy issues and increased risk of hospitalisation.

As generalists, GPs are best suited to tackle multimorbidity and the rising disease burden, particularly among disadvantaged populations, and rural and remote communities. Evidence demonstrates that these patient groups will need generalists, not multiple specialists. Consultations will need to deal with more complex problems, last longer and rely on a strong multidisciplinary referral network.

Guidelines and guideline-derived targets are generated from research without appropriate consideration of multimorbidity. Disease management targets are therefore not appropriate for many patients. Similarly, specialist referral pathways and hospital outpatient departments are aimed at single diseases, leading to fragmented and duplicated care of the patient. Medicare chronic disease management item numbers are a one-size-fits-all model. The additional needs of complex patients with advanced disease or multiple diseases are not acknowledged.

Related to this issue is the need for better support for the coordination and integration of services within the health system, both public and private, and in all areas – from urban to rural and remote practices.

In spite of the best efforts of primary health clinicians and the systems they work in, urban–rural disparities in health status, life expectancy and prevalence of disease are widely documented. For rural and remote communities, the prevalence and burden of chronic disease are compounded by the availability of, and access to, health services. Access to primary healthcare clinicians remains a key barrier to achieving equitable health outcomes for those living in rural and remote areas.

What can be done to improve the primary health care system for people with chronic or complex health conditions:

b) Nationally?

The RACGP's *Vision for general practice and a sustainable healthcare system* (the Vision) proposes a re-orientation of funding in order to enable GPs and general practices to provide care in a more flexible way, supporting the delivery of patient-centred care. Each patient having one general practice as their medical home will improve access to, and continuity of care.

While there are a number of misconceptions regarding the medical home, including capitated funding arrangements and reduced patient choice, if it is designed and implemented appropriately for the Australian context, the medical home will support efficient use of scarce healthcare resources without reducing patient choice.

A key part of the Vision is to better target chronic disease management in order to support patients with the highest needs. Better coordinated and tailored support will ensure efficient allocation of resources to assist patients who are most at risk of hospitalisation.

Chronic disease management for patients with complex health conditions is improved through service integration, enabling movement between various care settings in order to facilitate optimal clinical care, and providing more cost effective and integrated models-of-care. In particular, improvements should be made to enable capacity building and resourcing in rural and remote communities, based on the needs of the locations, include a broad range of approaches and be flexible enough to encourage local innovation.

Another element of the Vision seeks to support general practices that provide a comprehensive range of services to their community. This element will support general practice teams to reduce the number of patients seeking care from hospitals. The RACGP will release the final version of the Vision, which includes input from more than 1000 GPs and healthcare stakeholders, in the coming weeks.

The primary healthcare system could be improved for Aboriginal and Torres Strait Islander peoples with chronic and complex conditions. This can be done through investments to ensure they can access clinically and culturally appropriate healthcare wherever they present, in addition to ongoing support for Aboriginal Community Controlled Health Organisations (ACCHOs).

What are the barriers that may be preventing primary health care clinicians from working at the top of their scope of practice?

The RACGP supports health professionals operating at their full scope of practice, rather than 'at the top of their scope of practice'. Focusing on the 'top of their scope of practice' will erode broad ranging skills and reduce generalism within health professions. Increased partialism/specialisation increases healthcare costs and fragments care, with no evidence of improved health outcomes.

It is also important that 'support to operate within full scope of practice' is not confused with task substitution. The RACGP is concerned that patient safety will be compromised if task substitution is used to address workforce shortages. The RACGP supports the delivery of care by suitably trained and qualified health professionals. Role and task substitution to less trained or skilled health professionals is not a solution to workforce shortages.

For GPs, the Medicare Benefits Schedule (MBS) is a major barrier to operating at their full scope of practice. As it is currently structured, it discourages GPs from spending the time required with patients who have chronic and complex health issues. Patients with complex problems often cannot access the care they need, which requires most or all of their problems to be considered and care carefully coordinated within the 10–15 minutes the GP can afford to spend with them.

GPs also face:

- difficulty accessing colleagues and other specialists for support

- poor infrastructure support
- a scarcity of training opportunities
- barriers put in place by other specialists, preventing GPs from operating at their full scope to meet patient needs.

Due to the workforce issues in rural and remote areas, diverse and complex rural and remote communities need well-trained GPs who can work across a broad scope. To support this, increased recognition (right to practice and credentialing) in rural and remote areas is important. Standardisation and agreement on credentialing arrangements for small rural hospitals needs to be secured.

Increasing access to quality primary care in rural and remote communities is predominantly achieved by skill-specific solutions addressing service gaps, through increasing rural and remote GPs' skills, nurses and other health professionals within their scope of practice.

Theme 1: Effective and appropriate patient care

As described in Theme 1 of the Discussion Paper, a 'healthcare home' is where patients enrol with a general practice, which becomes the patient's first point-of-care and coordinator of other services.

Do you support patient enrolment with a health care home for people with chronic or complex health conditions?

Patient enrolment involves the patient agreeing to see on an ongoing basis the health provider/s of their choice.

✓ **Yes** ☐ No ☐ Prefer not to answer

Why do you say that?

The RACGP supports the establishment of voluntary patient enrolment (VPE) for all patients, not solely for those with chronic and complex health conditions. VPE creates and maintains a formal link between a patient, their preferred GP and the general practice. This makes VPE a key enabler of health service coordination and continuity of care, particularly for preventive activities and chronic disease management.

VPE will support general practices to establish a better and clearer understanding of their practice population, enabling general practices to tailor services to the needs of their community. The process of enrolment, and the obligations and responsibilities it places on the practice, will lead to the establishment of stable and enduing relationships between GPs and patients. Enduring GP–patient relationships have been found to have positive impacts on patient health outcomes. For these reasons, the RACGP holds that VPE within a general practice would be beneficial for all Australian patients, not solely for those with chronic and complex health conditions. The 'well patient' also benefits from a suit of preventive health activities that are best coordinated through a single general practice.

The RACGP supports voluntary enrolment for the patient and their GP. In this model, patients can choose whether they wish to register with a preferred GP and practice. Similarly, GPs and practices should be able to choose to participate in an enrolment system. It is important to note that under VPE, patients would be able to move between practices as needed. Additionally, although patients are encouraged to seek care from their medical home, they will still be able to access standard consultations through any general practice. This differs from chronic disease management, integration of care and preventive health, which will be limited to their medical home.

However, VPE must not be confused with capitation. Patient enrolment does and should not preclude patients from accessing fee-for-service patient rebates.

Do you support team-based care for people with chronic or complex health conditions?

✓ **Yes** ☐ No ☐ Prefer not to answer

Why do you say that?

The RACGP considers that GP-led multidisciplinary teams are well placed to provide holistic, comprehensive, coordinated and continuing primary healthcare to patients with chronic or complex health conditions.

In addition to the care they receive from their GP, patients with chronic and complex health conditions need to access a range of specialist and allied health services to assist them to manage their health issues. GP-led, team-based care reduces fragmentation and improves continuity for patients. Patients benefit from coordinated and integrated care that is planned with their GP, and targeted at addressing their needs.

General practice teams are diverse and vary significantly in size, composition, structure and operation. Team members may be collocated or spread across a number of sites. The key to the effectiveness of GP-led teams is the establishment of clearly defined roles. Aligned with licensing requirements, competency, education and training of the individual, this can maximise their contribution to the team.

An important factor in providing team-based care is the effective coordination of care. General practice nurses are often key members in the GP-led team, coordinating care and integrating systems to support patients to access care from multiple team members.

Another key to effective coordination of care is appropriate and timely communication between healthcare providers. While the myHealth Record has some role in supporting information sharing by the healthcare team, it is not a communication tool or the 'answer' to fragmentation of care. Rather, direct communication between providers facilitates team-based care and reduces fragmentation.

What are the key aspects of effective coordinated patient care?

Please number in order of importance.

1. **Care coordinators**

   A care coordinator refers to a role or a specific person responsible for organising patient care activities and sharing information among participants concerned with a patient's care to achieve safer and more effective care.

2. **Patient participation**

   Patient participation refers to shared processes in which both the patient and health professionals contribute to medical decision-making and care planning. It requires health literacy, self-management, self-awareness, collaboration and empowerment of patients in decisions regarding their health.

3. **Patient pathways**

   Patient pathways are nationally or regionally standardised, evidence-based multidisciplinary management plans which identify an appropriate sequence of clinical interventions, timeframes, milestones and expected outcomes for a patient group.

4. **Other**

   GPs' delegation of care coordination responsibilities within their team is a good model for ensuring patient care is coordinated while being overseen by a GP.

   However, there is currently minimal support for GPs and their teams to undertake coordination work on behalf of their patients. Much of this work is not remunerated despite the considerable amount of time GPs and their teams devote to coordinating care with other providers.

How can patient pathways be used to improve patient outcomes?

Patient pathways are nationally or regionally standardised, evidence-based multidisciplinary management plans which identify an appropriate sequence of clinical interventions, timeframes, milestones and expected outcomes for a patient group.

Patient pathways have the potential to develop local solutions to local issues that prevent access to appropriate care and good health outcomes.

However, the RACGP notes that for a patient pathway to be successful and accepted:

- GPs need to be integral in its design and implementation
- it should not add to the administrative burdens that general practices already face
- it should be designed to improve patient outcomes rather than ration access to services
- it should capitalise on GPs' skillset to initiate investigations prior to referring patients to specialists and assume responsibility for follow-up monitoring, while acknowledging the need for GPs to access timely specialist advice to support this (via means other than referral for advice)
- it should be dynamic and support access according to needs rather than addressing patient needs on a 'first-come, first-served' basis
- it is not an alternative to 'patient-focused' decision making by highly skilled health practitioners
- it could result in more expensive care through increased referrals and testing.

Additionally, patient pathways that block access to services will not help GPs to support their patients to access the care they need or improve health outcomes. Patients with complex conditions and issues may not be well served by rigid pathways that only assist them to address their problems in isolation rather than holistically.

Are there other evidence-based approaches that could be used to improve the outcomes and care experiences of people with chronic or complex health conditions?

There is a range of evidence-based approaches that could be used to improve the outcomes and care experiences of people with chronic or complex health conditions.

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

The Trial found improvements in care, with reduced growth in inpatient costs and increased utilisation of the MBS and Pharmaceutical Benefits Scheme (PBS) for the Trial's intervention group.

Other examples of evidence-based approaches improving outcomes are the New South Wales-based care coordination programs based on the model used in the Trial, and after-hours phone support services for residential aged care facilities to prevent unnecessary attendances at emergency departments. The RACGP can provide the Primary Health Care Advisory Group (PHCAG) with more information on these and other programs if needed.

Theme 2: Increased use of technology

How might the technology described in Theme 2 of the Discussion Paper improve the way patients engage in and manage their own health care?

Home-based self-testing and the use of in-home monitoring devices may have a number of benefits, and includes improved engagement and self-management. However, patients may be reluctant to use the types of technology described in the Discussion Paper as they may feel more at ease seeing their healthcare professional face-to-face. There may be some anxiety regarding administering their own medications and treatments. The high cost of investing in these devices can also be prohibitive for healthcare providers and patients.

Health professionals are not currently supported to monitor and assess data transmitted from a patient's home. Medicare patient rebates are only available for in-clinic monitoring of patients with chronic or complex disease. Supporting patients to manage and interpret the output from these technologies requires mechanisms to support GPs and other health providers.

What enablers are needed to support an increased use of the technology described in Theme 2 of the Discussion Paper to improve team-based care for people with chronic or complex health conditions?

The RACGP has been a strong advocate for a national shared electronic health record system. It welcomes the commitment made by the Federal Government in its 2015–16 budget to strengthen the national eHealth system and supports the continued development of the myHealth Record.

However, there are significant problems with the current model that require meaningful engagement between the Federal Government and general practice to address these problems effectively, and for the myHealth Record to be a success. It is the RACGP's view that the myHealth Record program needs to focus on the continuity of care clinical documents (*Shared health summary* and *Event summary*) and interoperable point-to-point communication (secure message delivery). These are the core functions of clinical value for GPs and other clinicians, providing the platform for engaging with the clinical community in the myHealth Record.

While technology is becoming more prevalent across the healthcare sector, there is still a lack of trust around technology and scepticism of its benefits. There is concern that technology interferes in the traditional GP–patient relationship.

Education must focus on the positive effects of the myHealth Record. The benefits of interaction with other healthcare providers must be highlighted as a way to support the delivery of better patient care, more efficient practice, and patient management and data collection, which support the provision of safe and high-quality care.

How could technology better support connections between primary and hospital care?

Interoperable point-to-point communication (secure message delivery) between health professionals, including those in primary healthcare sector and hospitals, is an important enabler of efficient, safer and higher quality care that is currently under-utilised and under-supported.

How could technology be used to improve patient outcomes?

Shared electronic clinical records have many aspects that will contribute to better patient health outcomes. This can be done through supporting better management and sharing of health records between clinicians working in a team, either within the same organisation or across health sectors. These include:

- allowing easier access to electronic records than paper records, by multiple clinicians simultaneously, who may be physically within the practice and/or somewhere away from the practice (eg a residential aged care facility or the patient's home)
- improving capacity to send the information legibly and cheaply to other health professionals and organisations who need it
- providing the option of automated manipulation and summarisation of the record
- automating reminders to patients and GPs, assisting GPs to do their job more efficiently.

However, it is important to recognise that clean, accurate and reliable data are essential components of a shared health record. Without these fundamentals in place, the use of shared health records is limited or compromised.

Theme 3: How do we know we are achieving outcomes?

Reflecting on Theme 3 of the Discussion Paper, is it important to measure and report patient health outcomes?

✓ **Yes** ☐ No ☐ Prefer not to answer

Why do you say that?

Measuring and reporting patient health outcomes on an aggregate level, as currently undertaken by a range of statutory authorities and government departments, is a valuable exercise. Understanding where outcomes are sub-optimal supports reorientation of services and systems to better address patient needs.

At the general practice level, the RACGP supports a practice culture that seeks to continuously improve though the use of patient and practice data. The RACGP's *Standards for general practices*, 4th edition, (the Standards) requires practices to use relevant patient data to engage in quality improvement activities in order to improve the quality of care for patients.

The RACGP warns that publicly measuring and reporting patient health outcomes at an individual level will create disincentives for GPs to provide care to disadvantaged patients who may have poor health outcomes, despite the practitioner and practice's efforts. It is well documented that socioeconomic status is a significant factor in health outcomes for patient populations. Efforts to implement health outcomes reporting is likely to have the opposite of the intended effect, creating more red-tape, reducing clinician–patient time and increasing issues relating to maldistribution of the workforce.

There is no evidence to suggest that reporting health outcomes improves the quality or safety of care, and there are no successful overseas models that can be adopted. Any system that reports on patient health outcomes must ensure that it is not used as a mechanism to reward or penalise individual GPs or general practices.

How could measurement and reporting of patient health outcomes be achieved?

The RACGP does not support the reporting of individual patient's health outcomes, except if it is necessary for internal quality improvement purposes.

However, the RACGP does acknowledge the reporting of de-identified, aggregate patient data for the purposes of informing health system planning.

To what extent should health care providers be accountable for their patients' health outcomes?

Making healthcare providers accountable for their patients' health outcomes is problematic at best. Health providers cannot be held accountable due to a number of factors, also known as the social determinants of health. These are out of their control, and affect and influence patients' health outcomes (ie housing, education, socioeconomic status, rurality). Penalising healthcare providers for poor health outcomes related to issues that are entirely out of their control or scope of practice would not build trust or good will, and will result in disadvantaged patients potentially being denied access to care.

Accountability for patients' health outcomes is more logically the domain of the Federal Government and state and territory governments who design and fund the operation of the various levels of the health system.

How could health care provider accountability for their patients' health outcomes be achieved?

The RACGP contends that the value or worth of making healthcare providers accountable for their patients' health outcomes has not been established. Determining how health provider accountability for patient health outcomes would be achieved could only follow if there is agreement that there is value in the approach. Measurement and reporting of health outcomes across the system will divert time and financial resources without evidence of health improvement.

To what extent should patients be responsible for their own health outcomes?

Patient-centred healthcare systems, like the one the RACGP recommends in its *Vision for general practice and a sustainable health system*, seek to empower and improve patient participation in the planning and delivery of care by making them partners with their healthcare providers.

The RACGP supports moves to encourage and assist patients to self-manage, and assume responsibility for the management of their chronic and complex health issues, in collaboration with their usual GP. However, the RACGP does not support proposals to increase patients' access to over-the-counter medications for self-care without adequate support and guidance from GPs.

How could patient responsibility for their own health outcomes be achieved?

Improving health literacy, patient involvement in care planning and delivery, and encouraging VPE are all strategies for enabling and empowering patients to take responsibility for their own health outcomes. Similarly, improving patient understanding of the GPs' and other primary healthcare providers' role would support them to seek access from the most appropriate healthcare providers.

The Standards include a range of indicators that support patients proactively engaging in and managing their care. The Standards emphasise the importance of providing patients with sufficient information regarding the purpose, importance, benefits, risks and possible costs associated with proposed investigations, referrals or treatments to enable patients to make informed decisions about their health.

Reinforcing the rights and responsibilities of patients through patient charters and support for consumer health organisations are other ways to engage patients in their care and to assist them to assume responsibility for their own health outcomes.

Theme 4: How do we establish suitable payment mechanisms to support a better primary health care system?

Theme 4 of the Discussion Paper discusses different payment mechanisms. How should primary health care payment models support a connected care system?

If you prefer a blended model, as described in Theme 4, select all the components that should apply.

☐ **Pay for performance**

Pay for performance is a way of funding health services. Providers receive payment for delivering certain types of care or achieving specific outcomes for their consumers, typically related to quality of care, access to care, patient-satisfaction measures and service provider productivity.

☐ **Capitated payments**

Capitated payments or 'capitation' is a way of funding health services. Providers are paid a set amount per enrolled client or resident of an area, per time period – often monthly, quarterly or annually.

☐ **Salaried professionals**

Salaried professionals are employed and paid independently of their productivity or their patient's outcomes. This way of funding health services is often combined with expected standards of performance for health professionals and also incentives such as 'pay for performance'.

✓ **Fee for service**

Fee for service is a way of funding health services, similar to other types of retail transaction. Providers are paid a fee based on the services they provide to consumers, usually based on the time taken to deliver the service, effort or cost.

✓ **Other (specify)**

In addition to the fee-for-service model, the RACGP is advocating for the provision of supplementary funding to support a range of patient services not currently or appropriately recognised in the health system. This includes coordination, integration and continuity of care, and comprehensiveness of services (support for delivering a defined suite of services with proven community benefit).

Supplementary funding is also needed to support service provision to complex patient groups (ie rural and remote, Aboriginal and Torres Strait Islander peoples, older patients and lower socioeconomic groups), enabling greater patient access to services.

Should primary health care payments be linked to achievement of specific goals associated with the provision of care?

✓ **Yes** ☐ No ☐ Prefer not to answer

Why do you say that?

The RACGP supports, with some alterations that will be outlined in the RACGP's Vision, the Practice Incentives Programme (PIP), elements of which links payment to completion of evidence-based processes of care and use of resources (eg eHealth technology). However, linking practice or practitioner payments to specific goals related to patient health outcomes is not appropriate as there is limited evidence that this improves health outcomes.

Current schemes generally only pay in relation to completion of evidenced-based processes, possibly in acknowledgement of the difficulty of controlling all variables when considering health outcomes. An example of this is that single condition-focused goals would not reflect the complexities of providing care to patients with comorbid or multimorbid conditions.

Therefore, the RACGP does not support the introduction of a pay-for-performance system, like the UK's Quality and Outcomes Framework, in Australia.

More broadly, there is a lack of evidence identifying other, more successful approaches for paying for primary healthcare services. Fee-for-service funding, with supplementary funding (significantly more than the current Service Incentive Program [SIP] and PIP payments) to recognise those activities not currently supported, is the best model for funding primary healthcare in Australia.

What role could Private Health Insurance have in managing or assisting in managing people with chronic or complex health conditions in primary health care?

While the RACGP has its 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 chronic disease management.

One of the RACGP's main concerns regarding the involvement of private health insurers is the likelihood of them 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.

Our principles for the involvement of private health insurers in general practice are that:

- duplication and fragmentation of care should be prevented
- there should be no impact on a GP's clinical judgement
- access to services is arranged according to need and not health insurance status
- people without private health insurance are provided with access to services of equal quality and within the same timeframes.

Noting the concerns and principles, under strictly agreed conditions, there are opportunities for private health insurers to support the delivery of general practice care. Possible mechanisms may include:

- preventive healthcare, including information, advice and health assessments
- evidence-based chronic health prevention program with risk minimisation to support private health insurers who have a larger number of members who require support
- targeted chronic disease management 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 chronic disease management via general practice rather than 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.

Do you have anything you would like to add on any of the themes raised in the Discussion Paper?

The guiding principles set out in the Discussion Paper are missing the key underpinning principle of a primary healthcare system for patients: equitable access to affordable primary healthcare for all patients.

Access to well supported primary care is the most effective way of improving the quality of care and health outcomes for patients with chronic and complex health conditions. Therefore, it is imperative that Medicare patient rebates keep pace with increasing general practice costs, ensuring patient access.

The indexation freeze will mean that the real value of patient rebates fall.

The ongoing indexation freeze 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 in the value of their rebate over time, paying even higher out-of-pocket costs to access healthcare.

Increased out-of-pocket costs for patients can be a deterrence to accessing healthcare and threatens the implementation of best practice care for patients with chronic and complex health issues. Regular and timely review of care plans and monitoring is not feasible if a patient cannot afford to attend the practice. Attending a general practice for any but the most acute reasons will limit the potential for practices to provide care to patients with chronic and complex health issues.