RACGP submission

Refresh of the National Strategic Framework for Chronic Conditions

May 2024

RACGP

RACGP submission - Refresh of the National Strategic Framework for Chronic Conditions

Introduction

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to provide a submission to the Department of Health and Aged Care (the Department) on the refresh of the National Strategic Framework for Chronic Conditions (Framework).

The RACGP is Australia's largest professional general practice organisation, representing over 40,000 members working in or toward a specialty career in general practice, including four out of five rural doctors. The RACGP sets and maintains the standards for high-quality general practice care in Australia and advocates on behalf of the general practice discipline and our patients. As a national peak body, our core commitment is to support general practitioners (GPs) and their broader healthcare teams to address the primary healthcare needs of the Australian population.

The GP role

Australia's population is ageing and complex, and chronic conditions, such as diabetes and mental health conditions, are becoming more prevalent, [1] with half of all Australians (50%) having at least one chronic condition, and approximately 22% experiencing multimorbidity. [2] As the prevalence of chronic conditions increases, it is expected that multimorbidity will also become more common. [3]

Australians visit their GP more than any other health professional. In 2020-21, GPs and their teams provided over 171 million services, with almost nine in ten people consulting a GP.[3] 80% of Australians have a usual GP and 90% have a usual general practice.[4] This provides opportunities for general practice to provide comprehensive and coordinated preventive care, which will keep patients out of hospitals and relieve pressure on other parts of the health system, while helping them stay active in the community and economy.[5]

As highly trained specialist generalists, GPs play a fundamental role in the prevention, diagnosis, and management of chronic conditions and multimorbidity, reducing the impact of these conditions.[6] The holistic, patient-centred, and relationship-based approach of general practice ensures the effective delivery of care and treatment. However, our current health system focuses on acute treatments and costly hospital care, rather than on chronic disease. [1]

The RACGP appreciates the Australian Government's recognition of the key role of primary care in the prevention and management of chronic conditions. We provide responses to key consultation questions taken from the online survey for the Department's consideration.

RACGP response to the online survey questions

Part 1: Overview of the Framework

2. Have you engaged with and used the Framework, and if so, how?

The RACGP provided feedback on the second draft of the Framework in 2016. The current framework focuses on the underlying principles for the prevention and management of chronic conditions which has relevance to general practice, as treating people with chronic conditions makes up a significant proportion of the work carried out in general practice.

3. The Vision of the Framework (Vision) is: "All Australians live healthier lives through effective prevention and management of chronic conditions."

To what extent do you agree the Vision is still relevant?

(Optional): Please provide further comments about your response, including any suggested amendments to the Vision.

RACGP response:

The RACGP agrees the vision of the framework is still relevant to general practice and primary healthcare.

It is in line with the RACGP's Vision for general practice and sustainable healthcare systems which outlines a model of care that aims to address many of Australia's longstanding healthcare challenges. The RACGP Vision calls for reforms which include support for building multidisciplinary teams within general practice, to ensure continuity of high-quality care for all patients. This evidence-based approach is particularly important for the growing number of people with chronic and complex conditions.

There are 7 enablers to achieving the Vision included in the Framework. Each of these enablers are shown below.

1. *Governance and leadership — supports evidence-based shared decision-making and encourages collaboration to enhance health system performance.*
2. *Health workforce — a suitably trained, resourced and distributed workforce is supported to work to its full scope of practice and is responsive to change.*
3. *Health literacy — people are supported to understand information about health and health care and appropriate health care settings, to apply that information to their lives and to use it to make decisions and take actions relating to their health.*
4. *Research — quality health research accompanied by the translation of research into practice and knowledge exchange strengthens the evidence base and improves health outcomes.*
5. *Data and information — the use of consistent, quality data and real-time data sharing enables monitoring and quality improvement to achieve better health outcomes.*
6. *Technology — supports more effective and accessible prevention and management strategies and offers avenues for new and improved technologically driven initiatives.*
7. *Resources — adequate allocation, appropriate distribution and efficient use of resources, including funding, to address identified health needs over the long-term.*

4. (Optional): Are there any other enablers you think should be included in the Framework

RACGP response:

The RACGP agrees with the inclusion of these enablers and provides the following feedback for consideration.

- Effective **governance and leadership** require collaboration across different government jurisdictions, including federal, state, territory, and local levels including local communities, with shared responsibilities and funding arrangements.
- As indicated in our previous submission, it is important to incorporate **effective change management.** Translating research into practice takes time and has several fundamental steps that need to be effectively managed at all levels.
- The central role of general practice in supporting patients with preventive healthcare and management of chronic conditions needs to be specifically identified in the composition of the **Health Workforce**.
- Inclusion of 'culturally safe' within point 2 as follows: **Health workforce**: a suitably trained, culturally safe, resourced and distributed workforce.
- The lack of interoperability across the healthcare system poses a significant barrier to **data and information** sharing and **technological advancement**. This needs to be addressed to enable the vision to be achieved. Our response to question 7 includes comments on sharing of information and data among health professionals.
- The RACGP recommends adding an overarching principle to align with the commitments in Closing the Gap. This is applicable across all the enablers to ensure Aboriginal and Torres Strait people have a genuine say in design and delivery of policies, programs and services that affect them.

Part 2: Objectives of the Framework

Objective 1: Focus on prevention for a healthier Australia

The Framework identifies determinants of health that influence the prevention, treatment and management of chronic conditions. Several are listed below. These are commonly referred to as the social, cultural, environmental and economic or commercial determinants of health.

- *Employment*
- *Income level*
- *Living in a rural/regional/remote location*
- *Education*
- *Language and writing skills*
- *Refugee or migration status*
- *Housing*
- *Living with a disability*
- *Promotion of unhealthy products*
- *Social connection*
- *Racism and discrimination*
- *Air and water quality*
- *Climate change*
- *Opportunities to take part in physical activity*
- *Weight related stigma*
- *Access to safe, nutritious and culturally appropriate food*

5. Please discuss which, if any, of the above determinants of health have most significantly impacted you or the work of your organisation. Additionally, are there any other determinants of health that you think the Framework should focus on? If yes, please note them. (Optional):

RACGP response:

GPs and their practice teams provide care through all stages of life and consider patients within their social, cultural and environmental contexts, which includes all the identified determinants.

Objective 2: Provide efficient, effective and appropriate care to support people with chronic conditions to optimise quality of life

One of the aspirational outcomes of Objective 2 is that people with chronic conditions have equitable access to quality health care. Pages 35-36 of the Framework discuss this in further detail.

6. To what extent do you agree with the following statements?

- *Australians with chronic conditions can easily access primary care services, including regular care with a GP and/or allied health providers.*
- *Australians with chronic conditions can easily access specialty healthcare services when* required.

(Optional): Please provide further comments about any of your responses to the previous statements.

The RACGP does not fully agree with the statements. Our comments are as below.

Access to services

Primary care services - GPs specialise in managing multimorbidity across the full patient spectrum, from paediatrics to aged care. People with multimorbidity need to access health services more often and this care needs

to be well coordinated across the system. However, the ability of GPs and their practice teams to deliver this care effectively is challenged by the limitations of funding models, inadequate guidelines and fragmented healthcare systems built around single-disease states. Australians are currently experiencing several barriers to accessing services in their communities, including in general practice, where bulk billing rates have declined because of chronic underinvestment.

Specialist services - Australians with chronic conditions struggle to access specialised (both medical and non-medical non-GP specialists healthcare services due to issues such as out-of-pocket expenses, long waiting lists and uneven distribution of specialist services. Additionally, GPs face challenges in seeking advice from non-GP specialists who do not routinely engage in shared care with GPs despite the clear benefits of doing so.

Affordability

Studies demonstrate that chronic diseases are occurring at younger ages among the most economically disadvantaged, including Aboriginal and Torres Strait Islander peoples.[3, 8-10] This suggests those in greatest need of early and consistent chronic care are often the least likely to afford it.

Medicare systematically defunds care where it is most needed. Longer consultations are needed for handling the most complex cases[11] yet longer consultations are poorly funded and short consultations incentivised.

Chronic Disease Management Plans facilitate access to allied health clinicians, such as podiatrists, diabetes educators and dietitians. However, there are cost barriers to people, especially from lower socioeconomic backgrounds as the MBS rebate does not cover the full cost of care for these services which can be expensive. The current MBS rebate system follows a one-size-fits all model, allowing for five visits per calendar year via time-consuming team care arrangements. Shifting to a referral process like that used for medical non-GP specialists, using informative letters, could be considered as it would streamline access to allied health services. To increase access, rebates for allied health appointments should be based on an individual's needs, rather than being limited to five visits for individuals with a chronic disease/s.

Out-of-pocket costs often deter people who really need healthcare from seeking the appropriate care. This lack of affordable access is worsened by the shortage of allied health services and non-GP specialists in areas of high need. Funding and workforce resources need to be directed to where they are needed most, including Aboriginal and Torres Strait Islander communities, rural and remote areas, and low socioeconomic areas.

Our response to question 10 includes additional comments on equitable access to quality health care.

Objective 2: Provide efficient, effective and appropriate care to support people with chronic conditions to optimise quality of life

Another of the aspirational outcomes of Objective 2 of the Framework is effective sharing of information and data. Pages 37-38 of the Framework discuss this in further detail.

7. To what extent do you agree with the following statement?

I have access to health information and data, and use this to help make decisions regarding the prevention, diagnosis, treatment and management of chronic conditions.

(Optional): Please provide further comments about your response, and if appropriate, provide examples of ways you have or have not used information and data.

RACGP response:

The Australian healthcare system is highly decentralised, with information captured by many government and non-government healthcare provider organisations. When a healthcare provider sees an individual, the provider should ideally have a full view of clinically relevant information that is easy to access to deliver efficient and effective care.[12]

Current healthcare IT systems use different coding and terminology across fragmented systems making it difficult to transfer, compare and analyse data, a key barrier to effective data exchange and interoperability.

Timely collation and analysis of real-time data, along with electronic clinical decision support, is needed to optimise safety and effectiveness of care. These systems are currently emerging (e.g. the Primary Sense data extraction and clinical support tool and other similar tools) and need to be supported to reach their full potential.

Many secondary/tertiary health services and government agencies do not use IT systems compatible with those used in primary care. Even systems designed for use within general practice are often unable to link together to exchange or share data. As a result, general practice staff are required to manually transfer information both to and from clinical and administrative systems, by scanning and uploading letters, reports and requests; faxing and posting information to others; and entering details into online forms. These processes pose a number of problems and demonstrate the need for a national enterprise-wide platform that supports interoperability of hardware, software, data and services.

For further information, refer to the RACGP's Interoperability and useability requirements for general practice CISs and Electronic clinical decision support in general practice position statements.

Unique challenges around digital health may be faced in rural and remote areas, where there may be limited access to infrastructure (i.e. a stable internet connection) and greater need for digital communication to support continuous care (e.g. due to long distances to health services). Addressing these challenges may require broader initiatives to enhance infrastructure and targeted support for general practices offering services in these regions.

Australian governments, as part of their commitments to Closing the Gap, have committed to share access to data and information at a regional level. This is important to support Aboriginal Community Controlled Health Organisations (ACCHOs) to access data to inform decisions related to supporting Aboriginal and Torress Strait Islander patients with prevention, diagnosis and management of chronic conditions. In this case, the effective sharing of data needs to be information by Indigenous data sovereignty principles.

Our response to question 10 includes additional comments on lack of access to research and data.

Objective 3: Target priority populations

The Framework aims to act as a broad overarching guidance document that is inclusive of the full spectrum of chronic conditions.

8. To what extent do you agree with the following statements?

1. *Australians living with chronic conditions, including myself, friends/family, patients, or members of the organisation I represent if applicable, are recognised in the Framework.*
2. *The Framework is representative of the diversity of population groups in Australia.*
3. *The Framework recognises the individual needs of the many different groups in Australia.*
4. *The Framework provides guidance about how the prevention and management of chronic conditions can be tailored to the needs of different population groups.*

(Optional): Please provide further comments

RACGP response:

Overall, the RACGP agrees the framework encompasses the spectrum of chronic conditions. As highly trained specialist generalists, GPs play a fundamental role in the prevention, diagnosis, and management of chronic conditions, working with patients at every stage of their healthcare. The holistic, patient-centred, and relationship-based approach of general practice ensures the effective delivery of care and treatment.

The RACGP Guidelines for preventive activities in general practice (Red Book) is widely accepted and should be used as guidance on evidence-based preventive activities for the general population.

The NACCHO-RACGP *National guide to preventive healthcare for Aboriginal and Torres Strait Islander people* is the key guideline to support effective, culturally safe preventive healthcare for Aboriginal and Torres Strait Islander people.

Objective 3: Target priority populations

The Framework includes the following list of priority populations, but notes this list is not exhaustive.

- *Aboriginal and Torres Strait Islander people*
- *People from culturally and linguistically diverse backgrounds*
- *Older Australians*
- *Carers of people with chronic conditions*
- *People experiencing socio-economic disadvantage*
- *People living in remote, or rural and regional locations*
- *People with disability*
- *People with mental illness*
- *People who are, or have been incarcerated*

9. Please provide information known to you on the experiences of people with chronic conditions in the above, or additional, priority population groups including any challenges and barriers in accessing prevention and/or treatment services that you think may be of relevance to the refresh of the Framework. (Optional):

RACGP response:

The list of priority populations should include lesbian, gay, bisexual, transgender, intersex, queer, asexual (LGBTIQA+) people. Mental health and general physical health are poorer for LGBTIQA+ adults compared with non- LGBTIQA+ adults, and a higher proportion have two or more chronic illnesses.[13] This gap is associated with marginalisation, social rejection, and other forms of discrimination.

The greatest burden of chronic illness is experienced by socioeconomically disadvantaged groups. Government policies and decisions should recognise and address the inequalities faced by these groups.

Preventive care and long-term management of chronic disease is particularly important for rural and remote communities. The rate of potentially preventable hospitalisations and potentially avoidable deaths increase with remoteness.[14] Having adequate access to coordinated care that includes screening, early disease management, and supportive care interventions through primary and community care are imperative to closing gaps in health equity for rural and remote patients and reduces the need to travel for hospitals and acute care services.

People living in disadvantage should have access to appropriate health services to reduce risk of poorer outcomes. GPs are often the first, and sometimes only, contact within the health system and must be supported to spend sufficient time with their patients to address preventive, complex care issues.

The RACGP has been advocating for voluntary patient enrolment since 2015 as a means of enhancing continuity of care and as an enabler to practice based population health. In principle, the RACGP supports MyMedicare for voluntary patient enrolment where fee-for service remains central so patients with chronic conditions can establish a relationship with a general practice to receive comprehensive, multidisciplinary care.

Part 3: Focus on the Future

10. Potential barriers for people with chronic conditions are shown below. Which of these barriers do you believe significantly impact Australians living with chronic conditions (including yourself if applicable)?

- ☐ *Difficulty in finding an appropriate healthcare provider or facility*

- ☐ *Long wait lists*
- ☐ *Lack of coordinated care and communication between health professionals*
- ☐ *Lack of information sharing and exchange between healthcare providers*
- ☐ *Financial cost of healthcare*
- ☐ *Limited awareness and understanding of chronic conditions and/or prevention by patients and/or carers*
- ☐ *Limited understanding of the healthcare system by patients and/or carers*
- ☐ *Limited knowledge of some chronic conditions by healthcare professionals*
- ☐ *Stigma associated with chronic conditions and risk factors*
- ☐ *Stigma of accessing healthcare*
- ☐ *Not being able to attend appointments due to geographical location/transport*
- ☐ *Difficulty using technology to receive or navigate healthcare services*
- ☐ *Lack of health promotion education and prevention activities*
- ☐ *Low English proficiency and other language challenges*
- ☐ *Limited availability of publicly funded health programs*
- ☐ *Lack of access to research and data*
- ☐ *Lack of culturally safe healthcare*

(Optional): Are there any other barriers that you would like to draw attention to?

RACGP response:

All the barriers listed will impact people living with chronic conditions. The RACGP focusses our discussion on the selected barriers below.

Refer to our response to questions 6 and 7, which include comments on the challenges surrounding inadequate coordination and communication among health professionals, as well as the lack of information sharing and exchange among health professionals.

Multidisciplinary care teams

Australia's health system is fragmented, with patient care becoming more complex as the population ages and the prevalence of chronic disease increases.[3] Implementing best practice multidisciplinary care teams (MDCTs), which enables coordinated, continuous whole of person care, is essential to meeting these challenges. Different types of health professionals work in the primary care setting, all attending to the needs of their patients.

MDCTs should include a GP working collaboratively with other health professionals such as nurses, nurse practitioners, pharmacists, Aboriginal and Torres Strait Islander Health Practitioners and other allied health practitioners to improve patient outcomes.

Benefits of shared multidisciplinary care include improved quality and continuity between services, reductions in hospital admissions, cost savings to the health system, improved patient health outcomes, higher levels of follow-up care and patient adherence to treatment.[15] Investment in shared care models enable GPs and other health professionals in the team to work collaboratively and effectively at the top of their existing scopes of practice.

The RACGP 2024-25 pre-Budget submission includes recommendations to support MDCTs.

Care coordination

Patients with complex health needs and/or chronic disease can face a significant burden when managing their care and interactions across various health and social services. General practice can be a central point of coordination for patients with complex needs who are accessing care from multiple sources, reducing duplication across the health system and associated inefficiencies.[1] Prioritising coordinated care ensures valuable health resources are targeted to patients who would benefit most from services, such as patients with chronic conditions.[1] It also enables information sharing across providers, which ultimately improves communication and clinical decision making.[1]

The RACGP 2024-25 pre-Budget submission outlines the need for greater funding to support GPs to coordinate the care of their patients. Innovative funding paid directly to assist GPs to coordinate the care of their patients, particularly those with complex needs, reduces fragmentation and duplication.

Importance of shared care

GPs, as expert generalists in the health system, provide holistic management and play a vital role in care coordination. When patients are referred for specialist care there can sometimes be a disconnect with the GP. The Shared Care Model aims to ensure that the management of co-morbidities and preventive activities remain prioritised.[16] It also allows patients to benefit from interim review scheduled between specialist visits. Shared care already happens in some settings, and for some conditions, but is not yet normalised in the management of serious or complex conditions. The model aligns with the RACGP Vision.

Financial cost of healthcare

Australians are experiencing a cost of living crisis. More and more people are struggling to afford essentials such as food, utilities, housing and healthcare. Across Australia, over three million people are living below the poverty line.[17] According to the most recent Australian Bureau of Statistics (ABS) data released in November 2023, the proportion of patients who delayed or avoided a GP consultation has doubled. The latest ABS figures indicate 7% of people viewed out-of-pocket costs as a barrier to care.[18] The most affected cohorts were younger people and those living in areas of greater socioeconomic disadvantage.

Although short general practice consultations support straightforward issues, longer consultations are needed for chronic illnesses and complex health concerns.[19, 20] Longer consultations with a GP provide an opportunity to address major risk factors by allowing more time for preventive care and early intervention for chronic conditions.[17] They also support GPs to spend time coordinating care across team members, disciplines and interfacing with hospitals. Increasing funding for standard general practice consultations longer than 20 minutes is a simple and effective way to build additional support for people with complex health needs.

A well-resourced general practice sector is essential to addressing the existing and future cost of living challenges facing patients, funders and providers. Key solutions aimed at reducing out-of-pocket medical costs for patients are outlined in the RACGP 2024-25 pre-Budget submission, which in turn address cost-of-living pressures.

Lack of access to research and data

Funding, infrastructure and capacity for research has been progressively moved away from general practice and primary care. The bulk of currently conducted research is irrelevant to primary care. While general practice sees over 90% of the Australian population each year, only 18% of the activity is underpinned by research carried out in general practice.[21] It is important to note evidence derived in other specialty areas often does not translate into the unique general practice context.

Limited access to local community health and hospital data (e.g. antibiotic resistance and infectious disease data) and other disease information and evidence, hinders GPs and their teams in tailoring care to their communities.

Guidelines are critical pieces of health infrastructure needed to support the delivery of evidence-based care. GPs and their teams use our guidelines to provide effective and low-cost preventive and chronic disease health care, and deliver sustainable, equitable, high-value healthcare, benefiting patients, providers, and funders. The RACGP has traditionally produced a range of preventative health and chronic disease management guidelines and should be funded to develop and maintain these guidelines, as outlined in the RACGP 2024-25 pre-Budget submission.

Lack of culturally safe healthcare

Experiences of racism are common among Aboriginal people in healthcare settings[22, 23] and the link between racism and health is well established. [22-25] Episodes of racism create major barriers to healthcare access and can lead to a compromised quality of medical care. [26]

NACCHO and the RACGP are developing a chapter on interventions to prevent the health impacts of racism in the fourth edition of the *National guide to preventive healthcare for Aboriginal and Torres Strait Islander people* which will be published in the second half of 2024.

As part of the refresh of the Framework, condition-specific Action Plans and Strategies will be reviewed to ensure that the documents are complementary to, and build on, the Framework.

11. Do you support this description of the inter-relationship between the Framework and condition specific Action Plans and Strategies? *(Required)*

☑ *Yes*

☐ *No*

☐ *Not applicable*

(Optional): Please elaborate on your response.

RACGP response:

Comments have been included in our response to question 13.

The condition-specific Action Plans and Strategies include a number of commonalities in priorities and actions.

It is proposed to embed these common priorities and actions in the refreshed Framework. Therefore, any condition-specific guidance would be focussed on tailored actions for that condition, where the need exists.

12. Do you support this approach? *(Required)*

☑ *Yes*

☐ *No*

☐ *Not applicable*

(Optional): Please elaborate on your response.

RACGP response:

Comments have been included in our response to question 13.

Many common issues and challenges can be found in the prevention, treatment and management of different chronic conditions. Several of these issues are listed below.

- *Multi-disciplinary care*
- *Managing multimorbidity*
- *Continuity of care across life stages*
- *Transitions of care as a patient moves across and through the health system*
- *Enhanced and targeted support for priority populations*
- *Health promotion and education*
- *Self-management*
- *Life stage transitions*
- *Embedding prevention in the continuum of care*

13. Do you believe a focus on these common issues is relevant, accurate and appropriate for Australians living with a chronic condition?

☑ *Yes*

☐ *No*

☐ *Not applicable*

(Optional): Please elaborate on your response and/or include any other common issues across chronic conditions that you would like to note.

RACGP response:

Patient centred, not disease focused care gets the best outcomes. Patients often present with multiple, not single conditions. Single disease-specific guidelines/plans 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.

Many chronic conditions share common risk factors that are largely preventable or treatable, for example: tobacco, insufficient physical inactivity, poor diet, overweight and obesity and other biomedical risk factors such as high blood pressure. Preventing or modifying these risk factors can reduce the risk of developing a chronic condition and result in large population and individual health gains by reducing illness and rates of death.

Currently, there is a missed opportunity to engage patients in local affordable group activities, this is the purpose of social prescribing. The challenge lies in the availability of community asset lists and trained link workers able to tailor recommendations to individual needs and facilitate attendance. Social prescribing can provide a valuable addition to the existing range of healthcare options in Australia and should be nationally supported and integrated with general practice. This is a patient centred approach to care that can address key risk factors for poor health, including social isolation, loneliness, unstable housing, multi-morbidity, and mental health problems. [7] The joint RACGP and Consumer Health Forum Social prescribing report outlines how social prescribing can be incorporated into the Australian healthcare system.

A social prescribing system which includes a link worker role will support general practice to connect people to communities, and provide opportunities to reduce loneliness, increase physical activity, learn skills, add purpose to life through volunteering and build community resilience.

Our response to question 10 includes comments on some of the listed common issues and challenges including multidisciplinary care teams and care coordination.

A large number of resources, training modules, tools and guidelines have been developed to support the prevention, treatment and management of chronic conditions. There is an opportunity for digitisation to reduce duplication, improve effectiveness of support and enhance impact. Use of emerging digital technologies provide opportunities for enhanced chronic conditions management into the future.

This will be a key consideration for the refresh of the Framework.

14. Please provide information on any opportunities for digitisation to enhance the prevention, treatment and management of chronic conditions. *(Optional):*

RACGP response:

Our response to question 7 includes additional comments regarding access to health information and data.

The RACGP has produced the Minimum requirements for general practice clinical information systems to improve usability report. The report identifies and details several key clinical information systems (CIS) functions and roles and provides recommendations focused on improving usability in the collection, management, use and sharing of information.

Emerging consumer digital tools show some promise. Tools that track and monitor targets or prompt behavioural changes are likely to play an increasing role in healthcare. The RACGP Healthy Habits initiative is an example of an innovative digital tool working to connect patients with GPs and their teams. The program aims to support GPs and their practice teams to encourage patients to achieve healthier lifestyles, through increased physical activity and improved nutrition. The Healthy Habits app makes it easy to set simple, personalised goals to move more or eat better, and share and celebrate progress with the GP and Primary Care Nurse.

Artificial intelligence (AI) has great potential in advancing healthcare management and support, but as these technologies evolve, the risks that may arise must be carefully considered and appropriately mitigated. This is articulated in the RACGP's Artificial intelligence in primary care position statement.

COVID-19 has had significant impacts on the Australian healthcare system, including the prevention, treatment and management of chronic conditions.

15. Please describe any impacts (positive or negative) of COVID-19 that you would like to highlight. *(Optional):*

RACGP Response:

The COVID-19 pandemic had a severe impact on various aspects of everyday life, including health care. The pandemic demonstrated how a health crisis can drastically influence the delivery of primary care services within the community, as seen by changes in consultation styles with patients and the uptake of digital health advancements.[15]

The introduction of Medicare rebates for telehealth consultations throughout the pandemic have been critical to improving access primary healthcare. RACGP members have consistently raised concerns about how the removal of rebates for longer phone consultations has the potential to worsen health gaps for specific groups, including Aboriginal and Torres Strait Islander people and people living in rural and remote areas.

The role of GPs as frontline health providers must be formally recognised in pandemic preparation, response and recovery. GPs have continuous relationships with their communities before and during health emergencies and should be firmly embedded in national and state/territory planning.

For more information, refer to RACGP response to the Australian Government's COVID-19 Response Inquiry Panel.

16. Which of the following statements are most important to you in terms of how the Australian Government enhances and uses the Framework in the future? Please select up to 5 options. *(Required)*

☐ Greater promotion of the Framework to peak bodies to increase awareness

☑ Greater promotion of the Framework to health professionals and researchers to increase awareness

☐ Greater promotion of the Framework to consumers and the general public to increase awareness

☑ Increased focus on how organisations can work together to improve the management of chronic conditions

☑ Improve the collaboration between state and territory governments and the federal government

☑ Refresh the content of the Framework to be better aligned with other state and territory, national and international policies, strategies and plans

☐ Refresh the content of the Framework to focus on emerging risks and issues (e.g. the use of e-cigarettes)

☐ Refresh the content of the Framework so it reflects the post COVID-19 health landscape

☑ Increased focus on the importance of lived experience in the Framework

☐ Greater emphasis on the needs of priority populations

Conclusion

Thank you again for the opportunity to provide feedback on the refresh of the National Strategic Framework for Chronic Conditions (Framework). For any enquiries regarding this response, please contact Stephan Groombridge, National Manager, Practice management, Standards and Quality Care on (03) 8699 0544 or stephan.groombridge@racgp.org.au.

References

1. The Royal Australian College of General Practitioners. Vision for general practice and a sustainable healthcare system. East Melbourne: RACGP; 2019. Available at https://www.racgp.org.au/advocacy/advocacy-resources/the-vision-for-general-practice/the-vision.
2. Australian Bureau of Statistics. Patient Experiences [Internet]. Canberra: ABS2022.
3. Australian Institute of Health and Welfare. Chronic conditions and multimorbidity. Australian Government; [updated 14 Dec 2023; accessed 2024 12 April 2024]. Available at https://www.aihw.gov.au/reports/australias-health/chronic-conditions-and-multimorbidity.
4. Australian Department of Health. Annual Medicare Statistics – Financial Year 1984-85 to 2019-20. Canberra: Department of Health; 2020.
5. Wright M, Hall J, van Gool K, Haas M. How common is multiple general practice attendance in Australia? Aust J Gen Pract 2018 May;47(5):289-96.
6. Australian Government. National Preventive Health Strategy 2021–2030. 2021. Available at https://www.health.gov.au/resources/publications/national-preventive-health-strategy-2021-2030?language=en.
7. The Royal Australian College of General Practitioners. Social Prescribing Roundtable November 2019 Report. East Melbourne: RACGP; 2019. Available at https://www.racgp.org.au/advocacy/advocacy-resources/social-prescribing-report-and-recommendations.
8. Barnett KM, S; et al. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. The Lancet 2012;380(9836):37-43.
9. Carman W IM, Trounson JS, et al. Epidemiology of physical–mental multimorbidity and its impact among Aboriginal and Torres Strait Islander in Australia: a cross-sectional analysis of a nationally representative sample. BMJ Open 2022;12.
10. Randall DL, S; Havard, A; Eades, S; Jorm, L. Multimorbidity among Aboriginal people in New South Wales contributes significantly to their higher mortality. Med J Aust 2018;209(1):19-23.
11. The Royal Australian College of General Practitioners. Medicare structure worsens healthcare in deprived areas: RACGP. 2023. Available at https://www1.racgp.org.au/newsgp/professional/medicare-structure-worsens-healthcare-in-deprived.
12. Australian Digital Health Agency. Connecting Australian Healthcare – National Healthcare Interoperability Plan 2023-2028. Australian Government; 2023. Available at https://www.digitalhealth.gov.au/about-us/strategies-and-plans/national-healthcare-interoperability-plan.
13. Victorian agency for Health Information. The health and wellbeing of the lesbian, gay, bisexual, transgender, intersex and queer population in Victoria: Findings from the Victorian Population Health Survey 2017. State of Victoria, Melbourne: VAHI; 2020 [accessed 2024 12 April]. Available at https://vahi.vic.gov.au/reports/population-health/health-and-wellbeing-lgbtiq-population-victoria.
14. Australian Institute of Health and Welfare. Rural and remote health. Australian Government; [updated 11 September 2023; accessed 2024 12 April 2024]. Available at https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health.
15. Australian Institute of Health and Welfare. General practice, allied health and other primary care services. Australian Government; [updated 07 March 2024; accessed 2024 12 April 2024]. Available at https://www.aihw.gov.au/reports/primary-health-care/general-practice-allied-health-primary-care.
16. The Royal Australian College of General Practitioners. Shared Care Model between GP and non-GP specialists for complex chronic conditions position statement. East Melbourne: RACGP; 2023. Available at https://www.racgp.org.au/advocacy/position-statements/view-all-position-statements/clinical-and-practice-management/shared-care-model-between-gp-and-non-gp-specialist
17. Davidson PB, B; and Wong, M. Poverty in Australia 2022: A snapshot Australian Council of Social Service Strawberry Hills, NSW: Australian Council of Social Service (ACOSS) and UNSW Sydney2022.
18. Australian Bureau of Statistics. Media release: More people putting off seeing health professionals due to cost. 2023 [accessed 2024 1 March 2024]. Available at https://www.abs.gov.au/media-centre/media-releases/more-people-putting-seeing-health-professionals-due-cost

19. Dugdale DC, Epstein R, Pantilat SZ. Time and the patient-physician relationship. J Gen Intern Med 1999 Jan;14 Suppl 1(Suppl 1):S34-40.
20. Wilson A, Childs S. The relationship between consultation length, process and outcomes in general practice: a systematic review. Br J Gen Pract 2002 Dec;52(485):1012-20.
21. The Royal Australian College of General Practitioners. RACGP Pre-Budget submission 2024-25. East Melbourne: RACGP; 2024. Available at https://www.racgp.org.au/advocacy/reports-and-submissions/view-all-reports-and-submissions/2024-reports-and-submissions/racgp-pre-budget-submission-2024-25
22. Thurber KA, Colonna E, Jones R, et al. Prevalence of Everyday Discrimination and Relation with Wellbeing among Aboriginal and Torres Strait Islander Adults in Australia. Int J Environ Res Public Health 2021 Jun 18;18(12).
23. Department of Health and Human Services. Racism in Victoria and what it means for the health of Victorians. Melbourne: State Government of Victoria; 2017. Available at https://www.health.vic.gov.au/population-health-systems/racism-in-victoria-and-what-it-means-for-the-health-of-victorians.
24. Priest NC PY, Gunthorpe W, et al. Racism as a determinant of social and emotional wellbeing for Aboriginal Australian youth. Med J Aust 2011;194(10):546-50.
25. Marmot M, Friel S, Bell R, Houweling TA, Taylor S. Closing the gap in a generation: health equity through action on the social determinants of health. Lancet 2008 Nov 8;372(9650):1661-9.
26. Coory MD, Walsh WF. Rates of percutaneous coronary interventions and bypass surgery after acute myocardial infarction in Indigenous patients. Med J Aust 2005 May 16;182(10):507-12.