Submission to the

House of Representatives Standing Committee on Health Inquiry into Chronic Disease Prevention and Management in Primary Care

30 July 2015

Contact:

Alison Verhoeven
Chief Executive
Australian Healthcare & Hospitals Association

Post: PO Box 78, Deakin West, ACT 2600

W: www.ahha.asn.au

Executive Summary

National programs and initiatives have provided some national direction for improving prevention and care for a number of chronic diseases.. However, with the increased prevalence of chronic health conditions and the associated demand for care being key drivers in the growth of health spending in Australia, a national plan for chronic disease management is urgently required.

Significant structural issues in the current system exist and prevent an integrated approach to managing chronic disease. Engagement and coordination between primary care, hospitals and specialised community-based services (including allied health services) need examination, as do the impact of funding models and the delivery of services occurring through different levels of government. Together these create a 'complex web' that gives rise to shifting responsibilities and uncoordinated care.

A more integrated approach to managing chronic diseases is needed, one that:

- Is centred around patients, rather than diseases, to deliver care tailored to those with multimorbidity;
- Supports regional-specific approaches that are more coordinated and easier for patients to navigate;
- Addresses the structural issues around funding models and the delivery of services between different levels of government, implementing funding arrangements that are patient-centred and support the right care in the most appropriate environment; and
- Facilitates the sharing and use of data with open and transparent evaluation, with reports from Government-funded projects and research released in a timely manner.

Introduction

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to provide a submission to the House of Representatives Standing Committee on Health inquiry into chronic disease prevention and management in primary health care.

The AHHA is Australia's national peak body for public hospitals and health care providers. Our membership includes state health departments, Local Hospital Networks and public hospitals, community health services, Primary Health Networks and primary healthcare providers, universities, and individual health professionals and academics. We are uniquely placed to be an independent, national voice for universal high quality healthcare to benefit the whole community.

The AHHA submission has been prepared within the context of a broad and comprehensive view of the *scope* of primary health care; the current *structure* of, and relationships within, the primary health care system in Australia; and the *patients* with chronic disease.

The *scope* of primary health care

The World Health Organization (WHO) Alma-Ata declaration of 1978 defined primary health care (PHC) as:

> *Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.*[1]

In Australia, a broad and comprehensive view of primary health care is taken. It recognises that primary health care is wide and extends beyond the traditional 'general practice' focus to include community-based primary health care, that responds to the needs of local communities by focusing on the integration with specialist care and other health sectors, including acute care, aged care and Indigenous health services.[2]

The *structure* of primary health care within the health system

One of the major barriers to effective and coordinated service provision for chronic health conditions, for both consumers and clinicians, is the paucity of direct engagement and coordination

[1] World Health Organization. (1978). Declaration of Alma Ata, International conference on PHC, Alma-Ata, USSR, 6-12 September.
[2] National Primary Health Care Strategic Framework. Commonwealth of Australia; 2013. At www.health.gov.au/internet/main/publishing.nsf/Content/nphc-strategic-framework

between hospitals and community-based primary health care, and between the independent providers of primary health care.[3]

The primary health care system in Australia is structured largely around episodic care. In providing this care, there is a paucity of direct engagement between primary care services, particularly GP services, and specialist consultant care, pharmacies, allied health providers and acute care services. Communication is often limited to prescriptions and referrals.

Coordination between hospitals and community-based primary health care is needed.[4] Hospitals have expanded their operations from a focus on inpatient care with some associated outpatient services, teaching and research, to offer a broader range of services, including non-inpatient referral-based specialist services in medicine and allied health, satellite clinics and community outreach services. Teaching has expanded to include consumer education (in-house and online).[5] While this expanded 'footprint' gives hospitals great scope to support primary health care, it also increases the complexity of engagement and coordination between providers.

Our federated health arrangements – in policy, funding and service delivery – add to the complexity.[6]

The *patients* with chronic disease in primary health care

Chronic disease is defined as illness that is prolonged duration, does not resolve spontaneously, and is rarely cured completely. Examples include cardiovascular conditions, cancers, many mental disorders, diabetes, many respiratory diseases, musculoskeletal diseases, chronic kidney diseases and oral diseases.

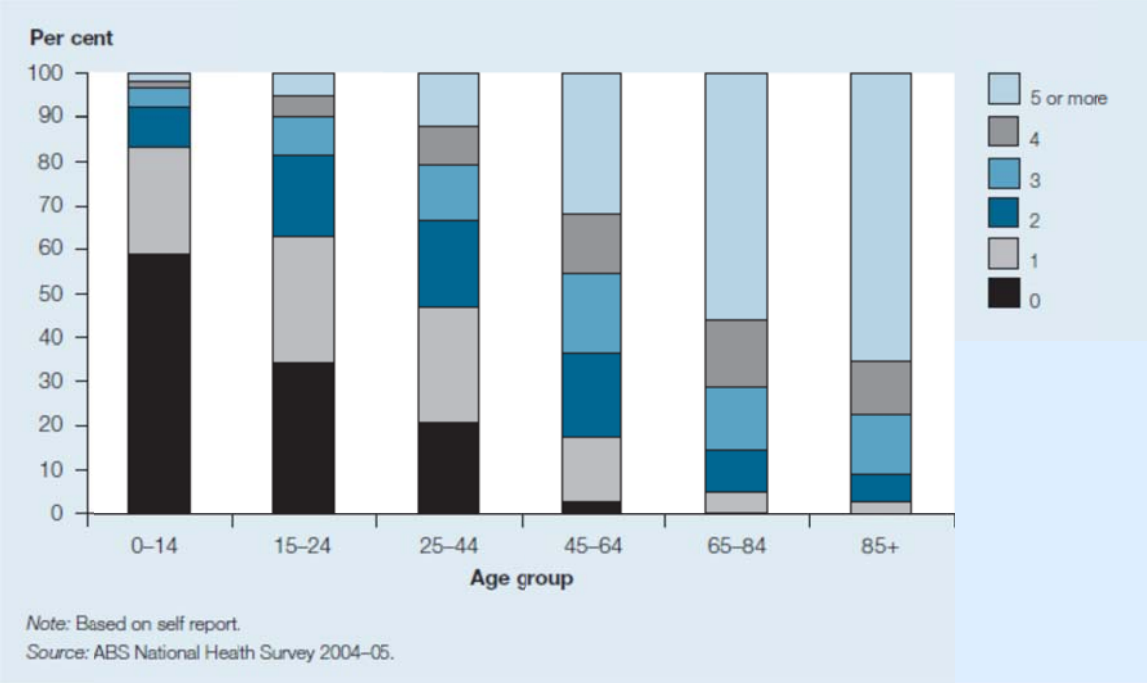
One-third of the population (or 7 million people) reported having at least one of the following conditions: asthma, type 2 diabetes, coronary heart disease, cerebrovascular disease (largely stroke), arthritis, osteoporosis, COPD, depression or high blood pressure. However, they affect some population groups more than others; for example, the proportion affected increases with age, socioeconomic disadvantage, and among Indigenous people.[7]

The co-existence of multiple chronic diseases is common, especially in the older population. Figure 1 reflects the extent of multimorbidity in the Australian population. These estimates include long term conditions that are not often included in the definition of chronic disease (e.g. sensory impairments such as vision problems and deafness), but which are still relevant when considering a person's capacity to manage their health .Of those Australians aged 65 years and older, 80% are reported to have three or more chronic conditions.[8] Rates of multimorbidity are also increasing across the

[3] Calder R. Health policies, funding and Federalism. The Health Advocate 2015; 30:16-17.
[4] Dugdale P. Improving the response of hospitals to patients with multi-morbid chronic conditions. In: Hospitals and multi-morbid chronic conditions. International Hospital Federation; 2013.
[5] ibid
[6] Calder R. Health policies, funding and Federalism. The Health Advocate 2015; 30:16-17.
[7] Australian Institute of Health and Welfare. Australia's Health 2014. Canberra: Australian Government; 2014.
[8] Australian Bureau of Statistics. National Health Survey: Summary of Results 2004-2005. Canberra: Commonwealth of Australia; 2006.

lifespan, with recent estimates suggesting 10% of young people (from infancy to young adulthood) have two or more chronic diseases.[9]

Figure 1. Number of long-term conditions by age group. 2004-2005[10]



Multimorbidity negatively influences a patient's capacity to manage chronic illness in multiple ways: it creates barriers to patients acting on risk factors; it complicates the process of recognising the early symptoms of deterioration of each condition; and it complicates their capacity to manage medication.[11] Multimorbidity brings increasing numbers of concurrent medications, and an increased risk of adverse drug events. Almost 88% of those aged 65 years and older are using at least one prescription medicine, with reports of 43-55% taking four or more medications regularly.[12]

In the majority of deaths in Australia, more than one disease is indicated as causing or significantly contributing to the death.[13] As patterns of cause of death are usually compiled using only one of the conditions reported on the death certificate – the 'underlying cause' – the contribution of multimorbidity to mortality may be underestimated.

There is a need for a greater awareness from both clinicians and patients of the importance of managing a patient's health status within the context of multiple disease states. Unfortunately, the majority of research on chronic disease is based on single index disease states. The study of

[9] Ryan R, Hill S. Improving the experiences and health of people with multimorbidity: exploratory research with policymakers and information providers on comorbid arthritis. Australian Journal of Primary Health 2014;20:188-196.
[10] Australian Institute of Health and Welfare. Indicators for chronic diseases and their determinants, 2008. Cat no. PHE 75. Canberra: AIHW; 2008.
[11] Jowsey T, et al. Challenges for co-morbid chronic illness care an policy in Australia: a qualitative study. Australian and New Zealand Health Policy 2009;6(22).
[12] Caughey G, et al. Prevalence of comorbidity of chronic diseases in Australia. BMC Public Health 2008;8:221.
[13] Australian Institute of Health and Welfare. Bulletin 105 Multiple causes of death. Canberra: Australian Government; 2012. At http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737422598

multimorbidity is still relatively new, and there are comparatively few Australian studies that focus on comorbidity associated with chronic disease. This can limit the ability to translate research findings into clinical practice for this population.[14]

Despite the limited research, the high reported prevalence of patients with multiple morbidities highlights the need for integration and coordination of continuing care.[15] Future policy initiatives need to move away from single illness orientation toward strategies that meet the needs of people with comorbid conditions and strengthen their capacity to self-manage.[16]

[14] Caughey G, et al. Prevalence of comorbidity of chronic diseases in Australia. BMC Public Health 2008;8:221.
[15] ibid
[16] Jowsey T, et al. Challenges for co-morbid chronic illness care and policy in Australia: a qualitative study. Australian and New Zealand Health Policy 2009;6(22).

Submission against the terms of reference

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

A focus on multimorbidity

National programs and initiatives have provided some national direction for improving prevention and care for a number of chronic diseases. However, this disease-specific focus does not actively recognise the needs of people with multimorbidity. Research into care models to respond to these needs is relatively new, and there are comparatively few Australian studies that focus on comorbidity associated with chronic disease. This can limit the ability to translate research findings into clinical practice for this population.[17]

To enable both the delivery of individualised care tailored to those with multimorbidity; as well as overcome problems created by fragmented care organised around diseases (rather than patients), recent research suggests first addressing communication challenges to move towards patient-centred models of care.[18] This requires:

- Making explicit the problems of multimorbidity. At an individual level, this includes understanding and addressing the ways in which doctors' treatment priorities differ from those of their patients, and how the differing priorities of multiple specialists or treatment providers are negotiated and coordinated. At a policy level, more inter-agency dialogue is required to highlight research and research-policy gaps (e.g. between National Health and Medical Research Council and the Australian Commission on Safety and Quality in Health Care).
- Recognition that both multimorbidity and communication issues are compounding factors. Patients are often unsure of coordination or communication between services or professionals, or who is to assume responsibility for their follow up and care. They may be left to coordinate their own care and treatment when there is poor overlap of professional disciplines/specialities and a lack of collaboration for multiple diseases. Informed decision-making is difficult as options are unclear to patients, and the balance of benefits and harms may be uncertain in the presence of multiple diseases.
- Taking action at a policy level, service delivery level and at an individual level. Health professionals need to be supported by consistent and cohesive information about managing patients with multimorbidity. Health services need to adopt a broader perspective on managing health, not just focusing on one dominant condition. Individuals require information and communication to be tailored to address additive problems, and encompass actions to promote more personalised or individualised approaches.[19]

[17] Caughey G, et al. Prevalence of comorbidity of chronic diseases in Australia. BMC Public Health 2008;8:221.
[18] As cited in: Ryan R, Hill S. Improving the experiences and health of people with multimorbidity: exploratory research with policymakers and information providers on comorbid arthritis. Australian Journal of Primary Health 2014;20:188-196.
[19] Ryan R, Hill S. Improving the experiences and health of people with multimorbidity: exploratory research with policymakers and information providers on comorbid arthritis. Australian Journal of Primary Health 2014;20:188-196.

Best practice in care coordination

Care coordination has been defined as:

> *the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.*[20]

While care coordination can represent a wide range of approaches at the service delivery and systems level, a literature review indicates their effectiveness is most likely dependent upon appropriate matching between intervention and care coordination problems.[21]

In Australia, care coordination has been an area of particular focus in recent times. The Department of Veterans' Affairs (DVA) Coordinated Veterans' Care (CVC) program commenced on 1 May 2011, and is a team-based program designed to increase support for veterans with one or more targeted chronic conditions or complex needs, and those who are at risk of unplanned hospitalisation. The learnings from this program would be invaluable. However, while the program is monitored and independent evaluations of its effectiveness have been completed, the evaluation reports have not been made publicly available.

Since their establishment over 2011 to 2012, Medicare Locals worked to shift the balance in health care away from acute interventions toward prevention, early intervention and chronic disease management. Regional-specific approaches to address the management of chronic and complex conditions through care coordination have been implemented, and it is expected that these might continue under the newly-established Primary Health Networks. While improvements in population health outcomes are difficult to evaluate at this early stage given the long-term nature of such interventions, early evaluations are positive.

One successful example is the Tasmania Medicare Local's Tasmanian Care Coordination Program, a non-clinical model that was developed to draw on and enhance the capacity and scope of organisations already operating in the care coordination/case management space within local communities. It built on a model that had been used as a basis for the Closing the Gap Care Coordination, Veterans' Care Coordination and the Metro Brisbane North Medicare Local Team Care Coordination programs. An overview is described in Box 1.

[20] Care Coordination, Quality Improvement: Structured Abstract. October 2014. Agency for Healthcare Research and Quality, Rockville, MD. www.ahrq.gov/research/findings/evidence-based-reports/caregaptp.html
[21] ibid

Box 1. Tasmanian Medicare Local statewide Care Coordination Program[22]

The model

- A non-clinical model was developed to draw on and enhance the capacity and scope of organisations already operating in the care coordination/case management space within local communities (General Practice, aged care providers, community nursing providers, etc)
- In its most simplified form, the Program involves:
    - Multidisciplinary and multi-sectorial referral pathways into the Care Coordination Service.
    - A Care Coordinator working with patients, undertaking a comprehensive assessment and enrolment process that includes patient-centred planning and the development of a patient owned care plan and goal setting.
    - The Care Coordinator making contact with the patient's GP, where another referral source has been involved, and involving the GP in care planning including decision making with regard to services the patients may require.
    - The Care Coordinator continuing to work with the patient rolling back involvement until the patient no longer needs intensive support and has gained maximum benefit from the program.
- The Program has access to a carefully managed flexible fund pool to ensure patients can access required health services that are not available by other means and/or when all other avenues have been exhausted.

Achievements

- The Program is accessible and easily implemented. Within 18 months, the Program is established in 27 of Tasmania's 29 Local Government Areas, with work continuing to expand across the full population. There is consistent growth in patient numbers across all regions.
- The Program improves integration of primary health care. There has also been successful engagement with the acute sector, allowing identification of high and frequent users of medical and health services and their referral into care coordination services.
- The Program has demonstrated strong evidence of successful patient health outcomes, as well as positive consumer feedback in relation to the value and outcomes of the Program.
- The Program demonstrates early trends that indicate cost-efficiency, effectiveness and value for money. If the Program reduces hospital use by a single attendance per annum, the benefit is a saving in the healthcare cost of that individual by over $4,300. A 'data linkage' evaluation project is currently underway to assess the impact of the Program on hospital attendance and length of stay; results should be available late August.

[22] Submission to the Australian Government House of Representatives Standing Committee on Health – Inquiry into Chronic Disease Prevention and Management in Primary Health Care. Care Coordination for people with chronic disease and aged care clients. Tasmania Medicare Local; June 2015.

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

Funding sensitive to local needs

It has been noted previously that MBS activity-based funding is insensitive to local primary health demands and that there is a need for financing models that allow for local flexibility to meet a specific community's requirements and the need for inter-sectoral collaboration.[23]

An example of a solution to this constraint of the MBS was the use of outcome-based funding (using both facilitation and reward payments) in the National Partnership Agreement on Preventive Health (NPAPH). While this was terminated in the 2014-2015 Commonwealth budget, the principles underpinning this funding strategy remain salient: (1) a focus on outcomes and (2) allow those most proximal to the delivery of services to be financed in a manner that assists in the effective delivery of services. As such, it would be appropriate to centre primary health care finance policy options around Primary Health Networks; as a new middle-level governance structure for primary health care and with a new performance indicator framework matched to this governance mechanism.[24]

Effectively incorporating allied health services

Since 2004, the Medicare Chronic Disease Management program has offered Australian patients with chronic or complex disease access to 13 allied health professions via private clinics on referral from the GP, with costs subsidised by Medicare. Examination of the utilisation of these services indicates that:

- There were no nationally consistent service levels found for an allied health provider profession.
- On referral from GPs, podiatry, physiotherapy and dietetics provided most services (82%) in 2008-09.
- Professions had unique patterns of referral instanced by age range and gender of clientele.
- Wide variation was apparent in per capita utilisation of allied health services by State or Territory; some with far less than average national use and others with high use.
- Annual number of GP Management Plans or Team Care Arrangements was low, indicating low use of care planning.[25]

This suggests allied health services are not yet being effectively incorporated into effective team care that involves shared care and decision making in the prevention and management of chronic diseases, despite evidence that it can enhance the capacity of the primary care sector to provide continuity of care with multidisciplinary input. As such, more needs to be known about the dynamics that affect referral, the local accessibility of allied health providers, communication mechanisms between allied health and general practitioners, and issues that affect uptake by patients. Medicare

[23] National Health and Hospitals Reform Commission. A healthier future for all Australians. Commonwealth of Australia; 2009. In: Fitzgerald, J. Options for finance in primary care in Australia. Deeble Institute Issues Brief. Canberra: Australian Healthcare and Hospitals Association; 2015.
[24] Fitzgerald, J. Options for finance in primary care in Australia. Deeble Institute Issues Brief. Canberra: Australian Healthcare and Hospitals Association; 2015.
[25] Cant R, Foster M. Investing in big ideas: utilisation and cost of Medicare Allied Health services in Australia under the Chronic Disease Management initiative in primary care. Australian Health Review 2011;35:468-74.

Benefits Schedule (MBS) data need to be made available to states and PHNs; evaluation of this data, particularly in relation to multimorbidity, would be greatly enhanced by the availability of patient-based data rather than service or episode level data.

Further, evidence-based efficiency and quality improvement initiatives need to be built into the Medicare Chronic Disease Management program. Much like the *Choosing Wisely* campaign currently being rolled out, GPs need to be supported and encouraged to refer to and collaborate with allied health providers where high value care has been demonstrated, and minimise referrals where there is no or low value.

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

Care coordination can represent a wide range of approaches at the service delivery and systems level. However, a literature review indicates their effectiveness is most likely dependent upon appropriate matching between intervention and care coordination problems.[26] As such, Primary Health Networks (PHNs) are well placed to progress such activity at a local level.

However, the care of patients with chronic conditions must be a joint effort by all healthcare providers in a community, including hospital-based services (public and private), primary care health practitioners, home care teams and hospices. To work efficiently, health systems need to develop all these components to a harmonious level of function.[27]

There are important gains to be had through improving linkages between hospital and referral-based care, and primary and community based care. This will require a shift on both sides from episodic care toward coordinated, tracked or managed care.[28] The drive toward patient-centred care must be supported at all governance levels, and be recognised in the accountability framework.[29]

The evidence suggests the following specific governance elements are important to achieving integrated care that spans the primary-secondary continuum. There are many opportunities for Primary Health Networks (PHNs) to coordinate and support chronic disease prevention and management; however their success will also be dependent on external influences on these governance elements:[30]

- **Joint planning**: PHNs will 'undertake regional needs assessments and conduct service planning for their regions, in collaboration with Local Hospital Networks and State and Territory Governments. With support from Clinical Councils and Community Advisory Committees, PHNs will seek to develop local strategies to improve the operation of the health care system for patients and facilitate effective primary health care provision, to reduce avoidable hospital presentations and admissions within the PHN catchment area.' [31]
- **Integrated information communication technologies**: The lack of a fully functioning electronic health record (EHR) system in Australia, where clinicians and patients can readily access, record, store and review individual clinical information, contributes to increased risks, costs and inefficiencies in supporting chronic disease prevention and management in primary health care.[32] PHNs will need to continue to support the uptake and meaningful use of the myHealth Record (by medical practitioners and allied health professionals), and the Government will need to work with PHNs through the implementation process.

[26] Care Coordination. Closing the Quality Gap: A critical analysis of quality improvement strategies. Agency for Healthcare Research and Quality; 2007. At www.ahrq.gov/research/findings/evidence-based-reports/caregap.pdf
[27] Dugdale P. Improving the response of hospitals to patients with multi-morbid chronic conditions. In: Hospitals and multi=morbid chronic conditions. International Hospital Federation; 2013.
[28] ibid
[29] ibid
[30] Nicholson C, Jackson C, Marley J. Best-practice integrated health care governance – applying evidence to Australia's health reform agenda. MJA 2014;201(3)S64-66.
[31] 2014/15 Department of Health Portfolio Budget Statement - Outcome Five Primary Health Care
[32] eHealth: AHHA Primary Health Network Discussion paper 6. Canberra: Australian Healthcare and Hospitals Association; 2015.

- **Change management**: A shared vision, leadership, time and committed resources are necessary for successful implementation. Bipartisan strategic frameworks must be developed and implemented to ensure long-term planning and support for primary health care.[33]
- **Shared clinical priorities**: Partnerships between professionals with shared priorities, across sectors and including consumers, strengthen the capacity of organisations to improve both individual and population health and reduce health risks.[34] PHNs hold great potential to integrate both health and social care for their communities. However, they will need to ensure that all partners share a common purpose and commitment to the partnership and its goals throughout the time required to achieve these outcomes. This means that the partnership needs to carefully orchestrate a collaborative culture and purposefully facilitate collaborative action to achieve collaborative advantage.[35] The *Peninsula Model for Primary Health Planning* is an example of a model with effective partnerships, collaborative advantage and accelerated primary care reform in chronic disease management. It is described in Box 2.
- **Aligning incentives**: Chronic disease prevention and management in primary healthcare will require pooling multiple funding streams and creating equitable incentive structures; there will need to be mechanisms for PHNs to work closely with the acute sector and their primary health care partners to influence these for their regions.
- **Data as a measurement tool**: Challenges with regard to sourcing accurate, timely, useful and verifiable population health data which can be linked across datasets are well recognised. PHNs will need to have access to, and be able to link, a wide range of population health data to inform planning, decision-making and commissioning of services, if they are to effect change in chronic disease management.
- **Consumer/patient engagement:** The formation of effective community advisory groups will be critical to the success of PHNs in influencing better health outcomes at regional level.
- **Resources to support innovation:** It must be acknowledged that adequate resources are needed to support innovation to allow translation of research evidence into care delivery.

[33] Position statement: Primary health care coordination. Canberra: Australian Healthcare and Hospitals Association; 2015.
[34] Keleher H. Partnerships and collaborative advantage in primary health care reform. Deeble Institute evidence brief. Canberra: Australian Healthcare and Hospitals Association; 2015.
[35] ibid

Box 2. The Peninsula Model for Primary Health Planning[36]

The model

- This is a catchment-based partnership between a range of health and community service organisations, key stakeholders, consumers, carers and communities.
- Working collaboratively, the partnership identifies the health needs of Frankston and Mornington Peninsula communities and develops effective service responses to meet those needs. Chronic disease was one of the priorities determined by population health data and through a comprehensive engagement process.
- Based on a population health approach, the model wraps the collective effort of providers around agreed health priorities to address service gaps for the catchment. This collective effort maximises impact and makes efficient use of resources through integrated planning, reduced duplication of effort, and shared ownership of processes and outcomes.
- The Model has multiple tiers of collaboration, meaningfully engaging all stakeholders at all levels:
    - A governance layer, in which existing organisations have mandated responsibilities for local area health planning
    - A strategy layer representing a broad range of local organisations, providing a vehicle for engagement of stakeholders across the catchment and oversight of coordination of strategy and collaboration
    - A coordination layer for implementation, the 'power house' level of the model
    - A delivery layer, incorporating the range of participating health and social service organisations in the catchment.
    - A resource layer, controlled by the delivery layer ad comprising people, sites, financial resources, information systems, policy, models of care and bases of evidence.
- A *Chronic Disease Management Alliance* was established in 2013, comprising health and community service managers, private practitioners and consumers in the region, with the agreed priorities in 2014 of diabetes, chronic heart failure and chronic pain.

Examples of achievements

- 9 care pathways in development, including for paediatric asthma, chronic back pain and depression in adults.
- Quality improvement program for diabetes screening in general practice.
- Capacity building through provider forums and training, including oral health, dual diagnosis and collective impact.

Critical success factors

An evaluation conducted in late 2014 of the Peninsula Model showed that critical success factors included: [37]

- Robust core structures, processes and common agenda
- Backbone resourcing particularly for the necessary breadth and depth of engagement
- Commitment from partnerships despite impact of external reforms
- Continuous communication of the vision and 'wins' more broadly
- Investment in resources and skills (direct and in-kind).

[36] The Peninsula Model for Primary Health Planning. At www.peninsulamodel.org.au
[37] Keleher H. Partnerships and collaborative advantage in primary health care reform. Deeble Institute evidence brief. Canberra: Australian Healthcare and Hospitals Association; 2015.

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

In 2007, legislative reforms were introduced that allowed private health insurers to broaden the products they offer to include programs that help patients with a chronic disease better manage and reduce the effects of that disease. A range of benefits was expected to flow from the reform: patients would stay healthier longer and have their conditions better managed; insurers would face fewer, less expensive claims over time; health insurance premiums would be less likely to rise with fewer expensive claims reducing the cost pressures; and pressure on the health system, including public hospitals, would also be reduced.

Early signs have indicated these programs offered by private health insurers are being increasingly utilised, and that these programs can help improve health outcomes for some members (at least in the short term). However, published evaluations of these programs are scarce, and more detailed data and analysis is required, with effectiveness and outcomes compared to similar publicly funded programs.[38]

While innovation in the delivery of primary health care services for chronic disease prevention and management is welcomed:

- The Government must clearly define its expectations of the role of private health insurers in primary care
- Open and transparent evaluation of private health insurer initiatives is essential and must be publicly released to inform debate
- Any increased role for private health insurers must neither reduce access nor increase costs for non-insured consumers. [39]

[38] Chronic disease management: the role of private health insurance. Research paper, 2013-14. Canberra: Department of Parliamentary Services, Parliament of Australia; 2013.
[39] Position statement: Private health insurers and primary care. Canberra: Australian Healthcare and Hospitals Association; 2015.

5. The role of State and Territory Governments in chronic disease prevention and management

The role of State and Territory Governments in chronic disease prevention and management can only be meaningfully discussed in the context of the full health care system: the Commonwealth Government; State and Territory Governments; and primary health insurers. None of them act alone, be that in the delivery of the funds or in the services that are funded.

A system needs to be designed with coherent roles, accountabilities and principles:

- A strategic vision of the Australian health system backed up with policy must be articulated. Reform in primary healthcare, public hospitals and the health system more broadly must be done in genuine partnership with all levels of government, health service providers, health researchers, consumers and the broader health community. The key focus must be on maintaining and improving the health status of all Australians.[40]
- Subsidiarity can be improved. Primary care lends itself to local input and regional level governance; population healthcare catchments can be built around the new PHNs.[41]
- Coherence, consistency and cooperation are important to implementation. This requires clarity in roles, responsibilities and accountabilities to remove duplication, overlap and inefficiency between different levels of government. Such clarification should be linked with evaluation criteria that focus on quality and outcomes; data strategies must be developed as an important first step to ensure any change can be measured and assessed to improve future implementation.[42]
- Fair and sustainable funding arrangements must be put in place. Funding arrangements must be patient-centred, supporting the right care in the most appropriate environment. Bundled payments options for patients with chronic or complex conditions hold potential. However, they require strong investment in ensuring ongoing integration of care, not just service delivery. Underlying policy settings must be robust, with sufficient evidence, data and funding to support the diversity of needs.[43]

Primary care is currently largely the responsibility of the Commonwealth. For Commonwealth, State and Territory budgets and health services to begin to meet Australia's health challenges, policy and funding needs, and particularly those that arise from the incidence and impact of preventable chronic diseases, the evidence of what works must be heeded:

- A networked system of healthcare delivery is most effective when coordinated locally by primary care providers – both general practitioners and other health professionals. As such, Australia's health policy and funding needs to be reoriented to a network of health care services located across Australia.

[40] Media Release: Strategic vision and genuine consultation essential to improving the health and wellbeing of Australians. Australian Healthcare and Hospitals Association; 25 June 2015.
[41] Address by Dr Rosemary Calder AM, Mitchell Institute for Health and Education Policy. AHHA: Think Tank on reform of the Federation and Health. March 2015.
[42] Integrated healthcare: policy pathways and pitfalls. Canberra: Australian Healthcare and Hospitals Association;2014.
[43] ibid

- Care of chronic and complex conditions, whether lifestyle or age-related, is most effective when provided through a range of health services at the primary and community care level.[44]

The work on federation should be the platform that provides Australian government and state and territory governments with the opportunity to work together to begin the construction of a *national health system* – one that could focus funding on prevention and early intervention services to reduce the risk of avoidable diseases, with equal emphasis on the optimal coordination of primary, community and acute care services for people with chronic diseases who require long-term and complex management, and for those needing high cost healthcare.

[44] Address by Dr Rosemary Calder AM, Mitchell Institute for Health and Education Policy. AHHA: Think Tank on reform of the Federation and Health. March 2015.

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

In October 2014, more than 80 health leaders participated in an Integrated Care Simulation hosted by the AHHA, working on a number of health policy initiatives to understand their likely impact on health services and system integration. These policy initiatives included the introduction of bundled care packages for chronic diseases; Private Health Insurers financing primary care services; and the transition from Medicare Locals to Primary Health Networks (PHNs).[45] The objective was to provide a realistic but stage-managed environment for participants from the public, private and not-for-profit sectors to gain insight into how these current policy considerations might play out across the health sector. The discussion and recommendations are particularly relevant when looking at models in chronic disease prevention and management

Discussion across all Scenarios highlighted how disconnected the various parts of the health system are, with recognition that:

- Health policy needs to have clear goals, be evidence-based and well-thought through, taking account of all potential consequences, and be specific on details for all elements of the system, including providers and patients.
- People working within the health sector need to engage regularly with policy makers at all levels in government to highlight any perverse or unintended consequences of policies, as well as to offer alternative solutions.
- Healthcare cannot operate in isolation from social supports and care, and policy and planning should be undertaken together where possible.
- The Australian healthcare system needs a greater focus on inter-professional leadership, requiring all areas of the health sector to actively collaborate and engage.[46]

Discussion centred on equity, choice and respect for the individual, with recognition that, while financial sustainability of the health system is critical, policy makers must not lose sight of consumer interests – these must be central to health policy. Evaluation criteria for health policies and programs should focus on quality and outcomes.[47]

It was acknowledged that integrated care strategies and models could work well for people with high health care needs, however more research is required to better support health promotion and illness prevention strategies, including for generally well people. Australia should invest in the foundations of health system integration enablers, including funding, data collection and sharing, coordination capability in primary care, shared systems such as electronic records, and addressing parts of the health system not funded by Medicare. When developing policies, data strategies must be developed as an important first step to ensure any change can be measured and assessed to improve future implementation. Consideration must be given to data availability and consistency as well as data linkage and sharing. In particular, improved access to, and use of, granular MBS and PBS data must be supported by Government, in order to ensure a robust evidence base for health policy development.

[45] Integrated healthcare: policy pathways and pitfalls. Canberra: Australian Healthcare and Hospitals Association;2014.
[46] ibid
[47] ibid

As one of the most frequently accessed primary health care services, community pharmacy may also play an important role in improving coordination of care for consumers. The burden of chronic disease, and the role of community pharmacy in assisting people to better manage their condition(s), has been researched through funding under the 5th Community Pharmacy Agreement. The project was completed in December 2014, but the outcomes for this project are noted as still being considered by the Minister for Health prior to being published.[48]

[48] Chronic illness project. At: http://5cpa.com.au/programs/research-and-development/current-projects/chronic-illness-project/

7. Best practice of multidisciplinary teams chronic disease management in primary health care and hospitals

Multiple factors are required for successful team-based models of primary care, including:

- **Interprofessional education and learning (IPEL).** IPEL is recognised internationally as helping primary care professionals work more effectively in team-based care.[49] In June 2015, the forum '*Collaborating for Patient Care – Interprofessional learning for interprofessional practice*' brought together representatives of the regulated health professions' national boards, accreditation authorities, self-regulating health professions, education providers, government health departments and health service providers, seeking to confirm respective roles in delivery, standards setting and regulation of responsive, flexible and innovative interprofessional education. This built on the research published by Prof Maree O'Keefe on collaborating across boundaries[50] and the development of competencies for interprofessional practice. The report from this forum is expected to be released in July 2015.
- **Organisational and management policies and systems.** Evidence from the UK, NZ and Canada strongly suggests that regional-level primary care organisational structures, policies and systems can enable and support team-based models of primary care through financial, governance and institutional support mechanisms. However, success is also dependent on funding, organisational and regulatory arrangements aligning.[51]
- **Practice support systems.** Performance management and payment systems have the potential to both enable and discourage team-based care within primary health care. Capitation payment has the potential to enable teamwork; however there has been little evaluation of the contextual and mitigating factors influencing teamwork outcomes. Fee-for service payment systems have been shown to be a barrier to teamwork within primary care, as they reinforce professional autonomy and independence. They have been shown to be particularly inappropriate for patients with chronic and complex conditions, who often require continuous care by multiple professionals working together. Blended payment systems are being used to reward teamwork, although their effect on teamwork and outcomes is unclear.[52]

[49] Naccarello L. A framework to support team-based models of primary care within the Australian health care system. MJA 2012;1 Suppl 3:22-25.
[50] O'Keefe M. Collaborating across boundaries: a framework for integrated interprofessional curriculum. Final report; May 2015.
[51] Naccarello L. A framework to support team-based models of primary care within the Australian health care system. MJA 2012;1 Suppl 3:22-25.
[52] ibid

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

There are two outstanding international reference models for the care of people with chronic conditions: the Wagner Chronic Care Model and Kaiser Permanente's Pyramid model.[53]

The Wagner model provides a framework that can help facilitate health system transition towards a chronic care oriented model,[54] where integration of care is an important feature and interventions at the primary care level are structured and simultaneous.[55] The model identifies the following essential elements of efficient health service delivery for people with chronic illness:

- Patient-centredness
- Effectiveness
- Efficiency
- Equity
- Timeliness.

Patient-centredness in healthcare has been shown to increase patient engagement, satisfaction and compliance; improve quality of life and reported patient outcomes; and reduce patient anxiety. However if patient-centredness is to have meaning within policies for the care of people with chronic illnesses, it must be clearly defined. This must be sufficient to enable necessary and relevant actions to be defined, and then those actions to be examined in the context of institutional and community based clinical practice, accountability, financing and management.[56]

Patient-centredness is of particular importance in the management of people with multiple morbidities, as co-morbidities may:

- Create barriers to acting on risk factors, e.g. clinical depression may reduce motivation to follow a healthy diet or exercise, arthritis may impact on ability to complete exercise or rehabilitation programs
- Hinder recognition of the early symptoms of deterioration of other condition, e.g. shortness of breath being related to asthma or heart failure, tiredness/cognition being related to dementia or hypoglycaemia
- Reduce capacity to manage the number of medications being prescribed.[57]

[53] Paolucci F, McRae I. A greater Australia: population, policies and governance. Melbourne: Committee for Economic Development of Australia; 2012.
[54] Mirzaei M, et al. A patient-centred approach to health service delivery: improving health outcomes for patients with chronic illness. BMC Health Services Research 2013: 13(251). At www.biomedcentral.com/content/pdf/1472-6963-13-251.pdf
[55] Paolucci F, McRae I. A greater Australia: population, policies and governance. Melbourne: Committee for Economic Development of Australia; 2012.
[56] Mirzaei M, et al. A patient-centred approach to health service delivery: improving health outcomes for patients with chronic illness. BMC Health Services Research 2013: 13(251). At www.biomedcentral.com/content/pdf/1472-6963-13-251.pdf
[57] Jowsey T, et al. Challenges for co-morbid chronic illness care and policy in Australia: a qualitative study. Australia and New Zealand Health Policy 2009;6(22). At www.anzhealthpolicy.com/content/pdf/1743-8462-6-22.pdf

A patient-centred (rather than disease-specific) approach will better address these additional challenges faced by patients with multiple chronic conditions in relation to preventive care and self-management.

There have been subsequent extensions and adaptations of the Wagner model, including the WHO's Innovative Care for Chronic Conditions (ICCC) framework and the Expanded Chronic Care Model, with some evidence of improved efficiency and quality of care for these models.[58]

The second model is Kaiser Permanente's Pyramid, which takes a population health management approach. With this approach, the needs of different strata of a population are understood, with targeted interventions (from health promotion to end-of-life care) across a spectrum of interventions. In this model, the main goal is identifying people with different types and levels of risk, classifying them into categories according to their level of complexity.[59]

In the UK, five years of health care reform addressing chronic care were examined and it was concluded that '*it is the cumulative effect of different interventions that is likely to have the greatest impact*'. The analysis identified the 10 characteristics of high-performing chronic care systems, summarised as:

- Having universal coverage;
- The care being free at the point of use;
- Focused on the prevention of illnesses;
- Reinforcing the tole of patients with chronic conditions to self-manage their conditions;
- Giving priority to primary healthcare;
- Emphasising population management;
- Integrating healthcare provision;
- Having improved information technoloty for chronic care;
- Being effectively coordinated; and
- Having all of the above nine characteristics linked to form a coherent whole.[60]

With any model of care, a long-term approach in chronic disease prevention and management is needed in Australia that follows this multi-faceted structure, with bipartisan support and agreement between the Commonwealth and state and territories.

[58] Paolucci F, McRae I. A greater Australia: population, policies and governance. Melbourne: Committee for Economic Development of Australia; 2012. At www.ceda.com.au/research-and-policy/policy-priorities/health/past-work/2012/03/healthcare-delivery
[59] ibid
[60] Ham C. The ten characteristics of the high-performing chronic care system. Health Econ Policy Law 2010;5(Pt 1):71-90. In: Paolucci F, McRae I. A greater Australia: population, policies and governance. Melbourne: Committee for Economic Development of Australia; 2012.

Conclusion

To improve the prevention and management of chronic disease, a national plan is urgently required. It must be developed in genuine partnership with all levels of government, health service providers, health researchers, consumers and the broader health community. Bipartisan support and agreement between the Commonwealth and state and territories is essential. Patient equity, system efficiency and quality of patient care must be prioritised. The plan must:

- Be centred around patients, rather than diseases, to deliver care tailored to those with multimorbidity;
- Support regional-specific approaches that are more coordinated and easier for patients to navigate;
- Address the structural issues around funding models and the delivery of services between different levels of government, facilitating funding arrangements that are patient-centred and support the right care in the most appropriate environment; and
- Facilitate the sharing and use of data with open and transparent evaluation.