



Submission to the

**Primary health care advisory group:
Better outcomes for people with chronic and complex health
conditions through primary care**

3 September 2015

Contact:

Alison Verhoeven
Chief Executive
Australian Healthcare & Hospitals Association
T: 02 6162 0780 | F: 02 6162 0779 | M: 0403 282 501
Post: PO Box 78, Deakin West, ACT 2600
Location: Unit 8, 2 Phipps Close, Deakin, ACT
E: averhoeven@ahha.com.au
W: www.ahha.asn.au

Executive Summary

The primary health care system works well for people with chronic and complex health conditions when regional-specific approaches are supported that are more coordinated and easier for patients to navigate.

To achieve this:

- The primary health care system must be centred around patients, rather than diseases or providers, in order to provide better integrated care and support better health outcomes for those with chronic disease and multimorbidity.
- Funding needs to promote affordable, accessible, person-centred care; care models that involve enrolment should not constrain patient choice.
- The interoperability of health care information software is necessary to optimise health outcomes.
- The measurement and reporting of outcomes and costs are essential, and interoperability and data sharing are fundamental to this.
- Health outcomes need to be prioritised, recognising the complementary roles of individual and collective responsibility.
- Funding needs to promote person-centred care, be sensitive to local needs and effectively incorporate allied health services.
- Australia's health workforce must be enabled to work to the full extent of their scope of practice.
- Innovation in the delivery and funding of primary health care is welcomed. However, any increased role for private health insurers must neither reduce access nor increase costs for non-insured consumers.

Introduction

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to provide a submission to the Primary Health Care Advisory Group consultation into the reform of primary health care to support patients with complex and chronic illness.

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.

This submission responds to the questions posed against the four themes identified in the Primary Health Care Advisory Group discussion paper: *Better outcomes for people with chronic and complex health conditions through primary healthcare*:

- Theme 1: Effective and appropriate patient care
- Theme 2: Increased use of technology
- Theme 3: How do we know we are achieving outcomes?
- Theme 4: How do we establish suitable payment mechanisms to support a better Primary Health Care System?

Theme 1: Effective and appropriate primary care

1. What aspects of the primary health system work well for people with chronic and complex health conditions? What are the key aspects of effective coordinated patient care?

The primary health care system works well for people with chronic and complex health conditions when regional-specific approaches are supported that are more coordinated and easier for patients to navigate.

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.¹

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. However, while the program is monitored and independent evaluations of its effectiveness have been completed, the evaluation reports have not been made publicly available.

The former 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 (e.g., via clinical pathway programs), and it is expected that these might continue under the Primary Health Networks. While improvements in population health outcomes are difficult to evaluate given the long-term nature of such interventions, early evaluations are positive.

One example is the Tasmania Primary Health Network'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.

¹ Care Coordination, Quality Improvement: Structured Abstract. October 2014. Agency for Healthcare Research and Quality, Rockville, MD. At: www.ahrq.gov/research/findings/evidence-based-reports/caregapt.html

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

The primary health care system must be centred around patients, rather than diseases or providers, in order to provide better integrated care and support better health outcomes for those with chronic disease and multimorbidity.

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 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.²

Despite the limited research, the high reported prevalence of patients with multiple morbidities highlights the need for integration and coordination of continuing care.³ 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.⁴

The co-existence of multiple chronic diseases is common, especially in the older population. Of those Australians aged 65 years and older, 80% are reported to have three or more chronic conditions.⁵ Rates of multimorbidity are also increasing across the lifespan, with recent estimates suggesting 10% of young people (from infancy to young adulthood) have two or more chronic diseases.⁶

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.⁷ 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.⁸

In the majority of deaths in Australia, more than one disease is indicated as causing or significantly contributing to the death.⁹ 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.

² Caughey G, et al. Prevalence of comorbidity of chronic diseases in Australia. BMC Public Health 2008;8:221.

³ ibid

⁴ 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).

⁵ Australian Bureau of Statistics. National Health Survey: Summary of Results 2004-2005. Canberra: Commonwealth of Australia; 2006.

⁶ 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.

⁷ 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).

⁸ Caughey G, et al. Prevalence of comorbidity of chronic diseases in Australia. BMC Public Health 2008;8:221.

⁹ Australian Institute of Health and Welfare. Bulletin 105 Multiple causes of death. Canberra: Australian Government; 2012. At: www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737422598

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

Funding needs to promote affordable, accessible person-centred care, and care models that involve enrolment should not constrain patient choice.

Care models that involve the enrolment of people with chronic diseases are worth exploring. There are already high levels of affiliation by people across Australia with an individual GP or general practice (89% fully or partially affiliated).¹⁰ Pilot projects should be utilised to explore implementation of more formal care and funding models that involve enrolment, with robust evaluation and due consideration of the perverse incentives and unintended consequences of formal enrolment.

Any enrolment model should not constrain patient choice, i.e. people should be free to choose their preferred general practitioner. Individuals should be free to change their preference, and funds and records should move freely and easily with them (not be the 'property' of the GP).

Consideration could be given to Primary Health Networks acting as fund holders rather than general practices, noting that Primary Health Networks have a formal role in reducing preventable hospitalisations and ensuring better health outcomes for their communities. This would limit the opportunity for conflict of interest in general practice business models that might take commercial decisions to build market share via enrolment programs at the expense of a focus on health outcomes.

Consideration should also be given to funding models where individuals are fund-holders rather than providers, as has been implemented in recent disability and aged care reforms.

4. How can patient pathways be used to improve patient outcomes?

Patient pathways must be regional-specific and developed collaboratively to lead to improved patient outcomes.

An example is that developed by Capital Health Network (CHN) and COORDINARE (South Eastern NSW PHN), in collaboration with ACT Health and Southern NSW Local Health District. Local clinician engagement (GPs, specialists, allied health providers) is identified as a critical process in development. For more information, see www.actml.com.au/programs/healthpathways

¹⁰ Oliver-Baxter J. PHCRIS Research Roundup: Patient enrolment in Australian primary health care. June 2014. At: www.phcris.org.au/phplib/filedownload.php?file=/elib/lib/downloaded_files/publications/pdfs/phcris_pub_8429.pdf

Theme 2: Increased use of technology

5. How might the technology improve the way patients engage in and manage their own health care? What enablers are needed to support an increased use of the technology to improve team based care for people with chronic and complex health conditions? How could technology better support connections between primary and hospital care? How could technology be used to improve patient outcomes?

The interoperability of health care information software is necessary to optimise health outcomes.

Achieving effective person-centred care requires a person's information to follow them across care settings. Patient transitions between primary and hospital care (including admissions, readmissions, discharge and transfer) would be better supported with technology that provides shared electronic health records and communication of discharge/transfer plans.

Technology can also be leveraged to improve communication between people and health care professionals, reducing hospitalisation and readmission rates. At an individual level, this may be achieved through patients having access to information about care provision and follow-up, different health care providers having access to information across the continuum of care, remote monitoring, and more. At the collective level, data can be captured and linked across the health care delivery system, enabling continuous quality improvement in the effectiveness of different models of care.

Interoperable practices, technologies and policies, like in banking and telephone industries, are essential. The use of proprietary architectures cannot be supported.

The potential of electronic health records must be realised - issues that should be explored include:

- Role for government as steward of an e-health system, rather than as architect and manager, with more emphasis on individual ownership of records on commercial platforms
- Privacy and security – the opt-out policy will assist in increasing uptake
- E-health being developed in silos, without regard to integration (e.g. GP vs hospital vs aged care software, state vs federal initiatives)
- Time to implementation being too long to provide any value (e.g. technology changing faster; commercial products, mobile apps being developed)
- Medico-legal accountability uncertainties, including information integrity and currency
- Greater broadband speed to facilitate use
- The need for IT conversant users (e.g. a significant % of older users not online)
- The value of summary records (vs fully distributed and shareable clinical records)
- Public vs private involvement (e.g. a shared ledger system such as the one that underpins cyber-currencies would mean unnecessary for government to be involved as no centralised infrastructure would be needed)
- How unstructured data should be managed.

Primary Health Networks (PHNs) are well placed to:

- Better understand the needs of local populations in supporting increased use
- Consider initiatives that apply different technologies in providing health services, and the evidence for their use
- Build in evaluations of their impact
- Make interoperability a prerequisite of new applications, reducing inefficiencies of isolated systems
- Facilitate and support use.

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

6. Reflecting on Theme 3, is it important to measure and report patient health outcomes?

The measurement and reporting of outcomes and costs are essential, and interoperability and data sharing are fundamental to this.

As identified recently in relation to hospital care, too many people get a treatment they should not get, even when the evidence is clear that it is unnecessary or does not work.¹¹ The same is true in primary care.¹²

Reasons why practitioners sometimes choose inappropriate treatment include evidence about treatments being difficult to access, evaluate and use. However there is little systematic monitoring of where 'do not do' treatments happen.¹³

*'To improve value, the measurement of both outcomes and costs is essential. Without these data, clinicians lack the information needed to validate choices, guide improvement, learn from others and motivate collaboration and change. Value measurement is also needed to demonstrate the impact of innovations and justify additional investments.'*¹⁴

Evidence-based efficiency and quality improvement initiatives need to be built into the Medicare Chronic Disease Management program. The *Choosing Wisely* initiative has potential to encourage a much needed 'fundamental shift of medical practice to maximising high-value care'.¹⁵ The Department of Health has identified *Choosing Wisely* as an approach to minimising no-and low-value interventions,¹⁶ and the Productivity Commission has also favourably cited this approach to improving productivity within the health sector.¹⁷

Interoperability of software is required to capture and link data across the health care delivery system, to enable continuous quality improvement in the effectiveness and efficiency of different models of care. While individual privacy and confidentiality must be protected, a transparent and collaborative culture for the timely sharing of outcome and cost data is critical. Information 'hoarding' and delays in timely information exchange must be prevented. This will allow data integration, sharing and analytics to be leveraged to create a much more value conscious, and more effective, healthcare system.

¹¹ Duckett S, et al. Questionable care: avoiding ineffective treatment. Grattan Institute; 2015.

¹² Unnecessary tests and procedures in the health care system. The ABIM Foundation; 2014. At: www.choosingwisely.org/wp-content/uploads/2015/04/Final-Choosing-Wisely-Survey-Report.pdf

¹³ Duckett S, et al. Questionable care: avoiding ineffective treatment. Grattan Institute; 2015.

¹⁴ Porter M, et al. Redesigning primary care: a strategic vision to improve value by organizing around patients' needs. *Health Affairs* 2013;32(3):516-25.

¹⁵ Scott I. Ten clinician-driven strategies for maximising value of Australian health care. *Australian Health Review* 2014;38.

¹⁶ Department of Health FOI Request 100-1415, Document 8 (accessed 5 February 2015)

¹⁷ Productivity Commission. *An ageing Australia: Preparing for the future*. Canberra: Australian Government; 2013.

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

Granular, patient level, health outcome and care data need to be measured to:

- be relevant in serving clinical, not just administrative, purposes;
- support use in quality improvement processes at the organisational/regional level.

Limitations must be recognised though, e.g. outcome measures often only being proxy indicators, outcome data not necessarily reflecting the 'quality' of service delivery (due to external influencing factors), the risk that unmeasured work will be sacrificed for measured work.

Reporting of such data should generally be done in a non-punitive context, focusing more on processes used by providers/organisations/regions to analyse and respond to variations in data.

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

Health care providers could be commissioned for outcomes, with payment measures designed around quality frameworks rather than episodes of care. This may involve 'rewards', e.g. for compliance with evidence-based guidelines/standards or better patient outcomes, or 'penalties', e.g. for poorer outcomes or adverse events.

Where funding is linked to service quality, anticipation of (and mitigation for) unintended adverse consequences is important to ensure the payment mechanism has its intended effect.

[As advised to Dr Hambleton, the PHCAG Chair, a detailed paper on bundled care will be provided separately to the Committee by 21 September.]

9. To what extent should patients be responsible for their own health outcomes? How could patient responsibility for their own health outcomes be achieved?

Health outcomes need to be prioritised, recognising the complementary roles of individual and collective responsibility.

As stated in the recent Mitchell Institution discussion paper: *'The 'it's all down to personal responsibility' mantra assumes well-functioning markets: that everyone has perfect information about the risks and benefits of particular behaviours; that they all act in rational self-interest; and that individual decisions are not influenced by external factors, including societal pressures and environmental conditions.'*¹⁸

The Government has a role as the steward of the health system, but more than this, it has a responsibility to shape a healthy society. There are many examples where governments have responded to evidence of public harm, exercising leadership and authority, and taking action to keep people safe. These include such things as regulating seat belts and speed limits to reduce traffic-related injuries; regulating the sale of alcohol and tobacco products; and regulating workplace health and safety.

¹⁸ Willcox S. Chronic diseases in Australia: Blueprint for preventive action. Mitchell Institute; 2015.

Government action also includes supporting individuals to make informed choices, free from the 'domination' of industry advertising and other strategies. Government leadership and investment is required, in particular, to promote health literacy and to drive behavioural change in relation to risk factors and determinants.

The complementary roles of individual and collective responsibility must be recognised and reconciled when considering the extent to which patients should be responsible for their own health outcomes.

Theme 4: Payment models

10. How should primary health care payment models support a connected care system?

Funding needs to promote patient-centred care, be sensitive to local needs and effectively incorporate allied health services.

Funding sensitive to local needs: It has been noted previously that MBS activity-based funding is insensitive to local primary health demands. There is a need for financing models that allow for local flexibility to meet a specific community's requirements, as well as a need for inter-sectoral collaboration.¹⁹

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.²⁰

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.²¹

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. More needs to be known about the dynamics that affect referral, accessibility of allied health providers, communication mechanisms between allied health and general practitioners, and patient uptake. MBS data should be made available to states and PHNs; evaluation of data, particularly in relation to multimorbidity, would be greatly enhanced by the availability of patient-based data rather than service or episode level data.

¹⁹ 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.

²⁰ Fitzgerald, J. Options for finance in primary care in Australia. Deeble Institute Issues Brief. Canberra: Australian Healthcare and Hospitals Association; 2015.

²¹ 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.

Funding models: Funding models should focus on fiscal responsibility, benefit to patients in terms of affordability, accessibility, quality and efficacy; and sustainable provision of services and conduct of business by private health providers in a contestable environment. *‘Moving from a funding approach that encourages volume, to one that incorporates drivers that recognise and prioritise high-quality care provided in the most efficient manner possible, is clearly essential.’²²*

Many of the key objectives of payment systems and financial incentive programs, such as lowering costs, improving quality and driving appropriate change, are achievable only in concert with other policy initiatives. Concepts such as risk, outcomes, performance and responsibility must also be addressed.²³

Fee for service remuneration continues to work in many circumstances, e.g. acute episodic care, infrequent users of the health system, specialist procedures. However, for people with chronic and complex diseases and for disadvantaged groups, alternative payment mechanisms need to be considered, e.g. risk-stratified and capitation-based funding, as well as performance-based models.²⁴

A blended payment system that adds a broader range of capitation-based payments promoting patient-centred care to current models is supported.²⁵ Primary Health Networks could adopt practices such as a shared services finance model to better support primary health providers. There should be a focus on reducing financial risk, relieving duplication and centralising core services and operating liabilities.²⁶

[As advised to Dr Hambleton, the PHCAG Chair, a detailed paper on bundled care will be provided separately to the Committee by 21 September.]

Australia’s health workforce must be enabled to work to the full extent of their scope of practice

Health professionals working to the full extent of their scope of practice has been recognised as having the potential to meet some of the growing demand for healthcare across the nation.

However, ‘many of the difficulties in adapting the workforce are created by existing legislation and regulation, the funding models for health professional services, and entrenched professional cultures.’²⁷ Recent examples include the regional variations allowing for pharmacist administration of vaccines and prescribing rights for non-medical healthcare professionals.

Funding models also need consideration. The European Observatory on Health Systems and Policies Series suggested, *‘In general, a system that rewards professionals for undertaking procedures frequently obstructs less powerful professions (generally those other than medicine) from taking*

²² Investing in healthier lives: pathways to healthcare financing reform in Australia. Sydney: The George Institute for Global Health; 2015.

²³ Fitzgerald J. Deeble Institute Issues Brief. Options for finance in primary care in Australia. Canberra: Australian Healthcare and Hospitals Association; 2015.

²⁴ Investing in healthier lives: pathways to healthcare financing reform in Australia. Sydney: The George Institute for Global Health; 2015.

²⁵ ibid

²⁶ Fitzgerald J. Deeble Institute Issues Brief. Options for finance in primary care in Australia. Canberra: Australian Healthcare and Hospitals Association; 2015.

²⁷ Leggat S. Deeble Institute Issues Brief. Changing health professionals’ scope of practice: how do we continue to make progress? Canberra: Australian Healthcare and Hospitals Associate; 2014.

them on'. If one health profession is compensated for a particular procedure, there is little incentive to facilitate transfer of this procedure to another health profession. The MBS should focus on services by other health professionals, not just GPs, and without the need for a GP referral when the condition can be 'self-identified'. Cost efficiencies could be achieved through bulk billing of such services, e.g. consumers with obesity receiving nutritional advice from dieticians.

Without urgent attention, individual health services and health systems will be unable to implement changes to their health professional and practitioner workforce that enable them to meet the access, quality and financial targets necessary for sustainable operation of the health system.

11. What role could Private Health Insurance have in managing people with chronic and complex health conditions in primary health care?

Innovation in the delivery and funding of primary health care is welcomed. However, any increased role for private health insurers must neither reduce access nor increase costs for non-insured consumers.

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 are being increasingly utilised, and can help improve health outcomes for some members (at least in the short term). However, published evaluations of these programs are scarce. More detailed data and analysis is required, with effectiveness and outcomes compared to similar publicly funded programs.²⁸

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.²⁹

²⁸ Chronic disease management: the role of private health insurance. Research paper, 2013-14. Canberra: Department of Parliamentary Services, Parliament of Australia; 2013.

²⁹ Position statement: Private health insurers and primary care. Canberra: Australian Healthcare and Hospitals Association; 2015.

Conclusion

The Government has a responsibility to exercise leadership to create a primary health care system that works well for people with chronic and complex health conditions. Regional-specific approaches to people-centred care must be supported – the system should be more coordinated and easier for patients to navigate. Funding needs to promote person-centred, affordable care; be flexible and sensitive to local needs; and effectively incorporate allied health services. Challenges related to use of health data must be addressed urgently, and the health workforce should be enabled to work to the full extent of their scope of practice.