Submission to the "Inquiry into Chronic Disease Prevention and Management in Primary Health Care"

Author Dr Vicki McCartney
General Practitioner

Background: I am a GP in a rural area of high chronic disease & need.

Issues affecting best care for people at risk or having chronic diseases:

- ***"Fee for service model" is not fit for purpose when dealing with the longitudinal nature of chronic disease management.***
  - The complex chronic disease group of patients have frequent needs, which require a multidisciplinary team but may not always require face-to-face care. There is an often-unnecessary consultation due to the "Fee for service model".
  - There is no recognition or payment for members of the multidisciplinary team whom often need to spend considerable time & resources to **coordinate** the patients care.
- ***Medicare item descriptors tend to reduce innovative approaches to care.***
  - Preventive health care – to identify, early, at risk groups such as indigenous, pacific islanders & patient with chronic mental health problems. Some of this work could occur in a group or be led by another member of the team to free up the GP's time.
  - Ongoing Chronic disease management where, at present, the emphasis is on the initial chronic disease management plan & not on the effective review & the relationship building between the patient & the health team.
- ***GP / Chronic Disease Management Plans (GPMP) – require a lot of time & paperwork. The item numbers do not discriminate the level of need for individual patients.***
  - Working in a rural area, there are good relationships with many allied health practitioners who contribute to the GPMP. It is inefficient & unnecessary to speak to the team member about every patients needs. For example: low risk diabetics who may need an annual foot check. The GPs time would be much better spent discussing a patient at high risk of major foot complications.
  - There is a range of needs: from a GPMP with some simple patient led goals to GPMP with multidisciplinary team & coordination. The GP is best placed to identify these individual needs, achieve agreement with the patient & lead the planning for each individual plan. These individual needs should not be dictated by complex & unhelpful Medicare item descriptors.

Changes that, from my experience, would improve the management of patients with Chronic & complex care needs:

- ***Patient voluntary registration.***
  - The GP should inform the patient of this option & lead the discussion about the changes this would bring to their care.
  - All members of the general practice should respect the patients' rights to decide what is best for them. The patient should be seen as the centre of the care team in partnership with the GP.
  - The care should be "Patient focused" which means the GP & patient recognise the benefit of having a long-term partnership. In this way, all matters for that individual, which have an impact on their health can be taken into account by the team eg: They are a carer for a relative, live with a partner who has a dependency or are unemployed.
  - The patient benefits from a patient centred approach to their care & can be supported to develop a more active role in their own health through improved health literacy & education.
- ***Funding to facilitate effective care coordination from within the general practice.***
  - If patient registration proceeds then the need for a chronic disease coordinator for a practice in a part-time or full-time capacity could be established. Practices within a region could share the services of a coordinator.
- ***Infrastructure planning to improve the accommodation of multidisciplinary teams within general practice.***
  - The registration of patients would provide more certainty about the team a general practice required to support the management of the group of patients with complex chronic disease.
  - In a rural town, it may not always be practical to co-locate all services. However, for some more specialised practitioners who may move between regions, it might allow planning and the ability to attract their services.
- ***Broadening criteria for consultations that can occur by "Telehealth" & be covered under Medicare to include some specialised allied health practitioners. This would help provide more specialised allied health services to rural & remote areas.***

IN CONCLUSION:

- ***Improve funding to General practice in a way that rewards quality not quantity & values holistic & patient focused care.***
- ***Recognises the cost effectiveness of general practice when compared to hospital based care.***
- ***Lift many of the constraints that have evolved in the MBS which is now out of date & lacks relevance to a population that is***
  - ***Aging***
  - ***Living longer with complex & chronic disease***

- ***Prefers to have their care close to home***
- ***Does not want to rely on hospital care***
- ***Values a "whole of person approach"***
- ***Who will support value for money health care.***

I believe the Australian community is aware of the escalating costs of health care & hence the time is right to start this conversation with them as consumers. As an engaged GP, I am ready to participate in this process & I am confident that many GPs would agree that we are in a good position to start this process of change & education for our communities.

VMcC
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