28 January 2016

Committee Secretary
Standing Committee on Health
PO Box 6021
Parliament House
CANBERRA ACT 2600

Dear Committee Secretary

Submission to the inquiry into Chronic Disease Prevention and Management in Primary Care

This submission is based on input from the Queensland PHNs and reflects the overarching principles held by the Queensland PHNs in relation to chronic disease prevention and management in primary care.

Current health service utilisation data indicates that more than 80 per cent of Australians will visit their GP an average of 5.5 times in a year compared to the relatively small number, around 10 per cent, that will attend a secondary or tertiary health facility. Of those that attend a GP practice 56 percent are patients who have at least one chronic disease, indicating that these people rely on their GP to assist in the management of their chronic health conditions.

It is well recognised that treatment of chronic diseases in secondary and tertiary settings is significantly more costly than the prevention and management activities undertaken in primary care. However significantly more funding continues to be directed to funding hospital beds when investment in primary care and management could have a significant impact on reducing the cost of managing chronic disease in Australia.

The impacts of social determinants on a person's wellbeing is another important factor to consider as population health data clearly shows a correlation between lower socio-economic status and the incidence of chronic disease. There are also equity concerns effecting issues such as access to services and the availably of culturally appropriate services for Aboriginal and Torres Strait Islander communities. Together they highlight the need for investment in the improvement of social determinates such as housing, education and nutrition as improvements in these areas have been shown to have a positive impact on the reduction of chronic disease.

Mental health issues also feature highly on the agenda of PHNs when it comes to the prevention and management of chronic disease in primary care. The recent announcement that PHNs will be given responsibility for Primary Mental Health and Alcohol and Drugs service, provides an opportunity to improve governance and person-centre care across the whole sector.

As the Queensland PHNs each undertake a population health needs assessment in their respective regions, the gaps in chronic disease prevention and management will become evident and each PHN will utilise the commissioning process to initially understand the local needs; then determine the existing capacity to service these needs; and work with local communities and service providers to build capacity and capability to address the burden of chronic disease while monitoring and evaluating the effects of these interventions over time.

Response to Terms of Reference

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

While there are a number of examples of effective chronic disease prevention and management models evidenced both in Australia and overseas, the nature of the Australian health system and regional diversity often constrains the comprehensive implementation of these models. However, key principles emerging from these models include a move away from disease specific models to models that focus on whole of patient-centred care. In addition, international health systems are moving towards adopting a risk stratification methodology rather than a disease specific approach when assessing people's need for service intervention.

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

It is becoming evident that the current fee-for-service model in primary care in Australia is not fit for purpose when it comes to chronic disease prevention or management. On the one hand practitioners are incentivised to provide single discipline, episodic, reactive care and treatment for their patients rather than planned multidisciplinary, proactive care. On the other hand providers are limited to a face-to-face mode of consultation which constrains the use of innovative models such as telemedicine which may well be more cost effective and convenient for both the provider and the consumer.

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

PHNs are well placed to play a significant role in understanding their regional health service environment and using the commissioning framework to build capability and capacity in primary care to address the needs of their communities. However, it is recognised that this cannot be achieved in isolation from the rest of the health care system. It is critically important that PHNs form robust partnerships with community health and social service providers as well as local Hospital and Health Services if we are to have an impact on chronic disease management.

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

There is clear alignment between the motives of private health insurers and PHNs when it comes to chronic disease management and prevention and private health insurers should be encouraged to innovate in their approaches to member engagement in preventing chronic disease.

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

State and Territory Government should be encouraged to partner with PHNs to reduce the burden of chronic disease through improvements in integration between primary and secondary care, improved engagement with primary care providers and by sharing data with PHNs to assist in the comprehensive needs assessment process. A long term solution to the rising costs of hospital care would be to transfer funds from tertiary care to invest in primary care and prevention strategies.

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

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The current funding model in primary care is based on outputs rather than outcomes and provides little incentive for innovative practice models. More flexibility in the system would allow for proactive providers to implement models that are better suited to the needs of their clients. One example of an innovative model that is emerging in the literature is the concept of "bundled" annual payments to primary care providers who are then responsible for providing the registered client with access to all their primary care needs to keep them healthy and out of hospital.

7. Best practice of Multidisciplinary teams chronic disease management in primary health care and Hospitals; and

International evidence suggests that a "patient centered medical home" or "health care home" approach to caring for people with chronic and complex health conditions produces better health outcomes. This approach is under investigation in Australia with a number of regions keen to pilot the model that involves close partnership between state funded hospital and health services and primary care organisations and a radical change to the funding model in primary care. This approach would see a move away from fee-for-service for patients registered in the program and the introduction of a "bundled" annual payment to the practice to cover the costs of providing comprehensive team based multidisciplinary primary care and care coordination for the patient. This model would allow a flexible approach to delivering care, including non-face-to-face methods and better use of technology.

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.

A number of international studies have shown the benefit of primary care based care coordination models in the reduction of hospital utilisation and improved health outcomes for people with complex care needs. There are many variations to the delivery of care coordination but the evidence shows that the key elements to a successful model include close collaboration with the patient's GP, care coordinators based in the community (not the hospital) and holistic patient centered approach as opposed to a disease specific model.

Yours sincerely,

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On behalf of the Queensland PHNs