The Royal Australasian
College of Physicians

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Discussion Paper

Response to the Commonwealth Government's Medicare Locals Proposals

17 December 2010

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Definitions

Physician
Physicians and paediatricians are specialists in internal medicine who have completed advanced training after their initial medical training is completed in a general internal medicine or ' a specialty' and diagnose and manage complex medical conditions in adults, children, adolescents and young people.

Paediatrician
Specialist in internal medicine focusing on the diagnosis and management of children, adolescents and young people.

Acute Care
Is the treatment of a patient for a relatively short period of time in which a patient is treated for a severe episode of illness. Acute care incorporates a broad spectrum of health care, including hospital and primary health care, as well as emergency medical services.

Ambulatory Care
Ambulatory care includes community based care including diagnosis, investigation, management and treatment and rehabilitation that is provided in the community care settings.

Primary Health Care
Primary health care refers to initial or ongoing care in the community. It includes general practice, medical specialist services, allied health services and other community based health services.

Sub-acute Care
Sub-acute care includes continuing medical care in the non- acute setting and includes rehabilitation, palliative care, mental health and geriatric services, in both hospitals and the community.

Community Care
Community care can share a number of characteristics of primary care and primary health care services, as well as provide more specialized community based health services for defined target groups, for example post acute care, aged care, mental health, drug and alcohol, sexual assault.

Hospital and non-hospital Care
Hospital care is when a person has medical care in a hospital, while non hospital care is all health care not requiring an overnight stay, including primary care and community care.

Co-morbidity
A co-morbidity is a disease or condition that coexists with a primary disease but adds to the complexity of patient care.

Chronic illness
Chronic illness is of long duration and involves ongoing health care requirements.

Outpatient Care
Outpatient care is any health care service provided to a patient who is not admitted to a facility. Outpatient care may be provided in a doctor's office, clinic, the patient's home or hospital outpatient department.

Medicare Locals

Purpose

The Royal Australasian College of Physicians (RACP) is committed to the development of a more sustainable and efficient health care system into the 21st Century that can manage the increasing demands of complex and chronic illness, including preventative health and self-management, to deliver better health outcomes and improved quality of life for all Australians.

Australia's health system faces long-term challenges from population ageing, a growing burden of chronic and complex disease, pressure on access to services, Indigenous health gaps and inadequate, historical payment arrangements that are inefficient and unresponsive to changing health care needs. The RACP values the achievement of health equality for all - equal health care for equal need - to ensure we achieve the best outcomes from health care services.

Delivering on this ambition however should first recognise that there is a frustrating focus on hospital related health care across Australia, relative to other OECD countries. Concentration of health care investment in hospital services can drive high health care costs and may restrict provision of ambulatory and community health services that are locally accessible, responsive to chronic and complex care needs and essential to health improvement and illness prevention.

To complement hospital service delivery and care in Australia and reduce unnecessary demand on those services, community-based care could be strengthened and provided with appropriate infrastructure and necessary resources. Strategic planning to work towards health care service models based on a continuum of care will improve the coordination of care and management of chronic illnesses; increase health promotion and health awareness; and reduce stress on acute hospital services.

The purpose of this paper is to promote discussion within the fellowship on the development and implementation of the Commonwealth Government's National Health and Hospitals reform and the role of Australia's physicians & paediatricians in national health reform.

Whilst recognizing the variety of different health care settings in which specialists including physicians and paediatricians are engaged, the focus of the discussion paper is on the impact of health reform on ambulatory and primary care in particular the new Local Hospital Networks and Medicare Locals, as well as enhancing ambulatory care in primary health care settings nationally . However, many of the issues raised in this paper could apply to all physicians and paediatricians in all medical settings.

This paper has been developed on the fundamental proposition that primary health care does not only relate to general practitioners (GPs) but more widely to other health care professionals including physicians and paediatricians who play a crucial role in ambulatory care in primary health care settings and whose roles include promoting and maintaining health and preventing illness, as well as the diagnosing/treating and management of illness.

In developing this paper the RACP has made a number of assumptions based on the available materials. Firstly, the RACP has engaged in the health reform process in the belief that all parties have a genuine commitment to the success of the process and that we are seeking to bring together the various and often fractured elements of Australia's overall health care system to improve health outcomes. Secondly, the RACP has also assumed that the reform process will attempt to integrate the various elements of the ongoing reform process, including activity based funding, state and commonwealth arrangements, the Intergenerational Report, the National Health and Hospitals Reform Commission, Health Workforce Australia, and other previous health reform activities.

For the specific purpose of this paper the RACP has sought to focus on the role of specialists in the care settings currently under debate, namely the non-acute settings with a focus on ambulatory, and primary, sub-acute care and aged-care and mental health. The RACP suggests that the current health reform process affords a unique opportunity to explore ways to develop a more coordinated and multidisciplinary approach for the entire health care system especially to better connect ambulatory and primary care with the other care settings.

Executive Summary

Australia's physicians and paediatricians can play a critical role in the improvement of quality and safety of health care, in the overall patient care experience and in the management of resources and complexity for the coordination of treatment.

The focus of this paper is on how the Royal Australasian College of Physicians ("RACP") ("College") can facilitate the continued improvement of Australia's health care system and in particular the development and implementation of national health reforms.

COAG has recognized that our hospitals are currently treating an increasing number of patients, including those who could be satisfactorily treated within ambulatory care in primary health care settings.

The College is committed to working with government on how to ensure improved health outcomes through the ambulatory and primary health care settings and in particular how physicians and paediatricians can support these reforms.

Health outcomes are significantly improved when the primary and ambulatory health care system is effective. (1)

Increasingly in ambulatory and primary health care settings, medical practitioners will be faced with an ever increasing span of control in the management and treatment of complex and chronic conditions. However with fragmentation of health care across multiple settings there can be an increasing inefficiency and confusion for clinicians, patients and their families.

> ***"Australia's primary health care system is a complex mix of Commonwealth, state and territory, and privately funded and delivered services. While it performs reasonably well for many, for the growing number of people with chronic disease, and especially those with multiple and complex conditions, this is not the case.[21] These people generally have multiple complex health care needs, often provided in different settings and by different health professionals and are often at risk of experiencing an acute event. For these patients, the need to navigate their own way through the system and between multiple services and health care providers can be a daunting experience, with poor coordination leading to worsening outcomes, preventable acute events and emergency department and hospital admissions. With an ageing population, and a growing prevalence and burden of chronic disease, these issues will only become more acute."***
>
> Towards a National Primary Health Care Strategy;
> Department of Health and Ageing 2009

To achieve more measurable positive health outcomes can we link ambulatory and primary health care and support with medical specialists, including physicians and paediatricians, within acute and sub-acute care and also improve services to residential aged care, mental health and other community health care settings. This would require significant coordination between the new Commonwealth Local Hospital Networks, and the Medicare Locals, as well as other health providers in the jurisdictions and private health sector.

It could be assumed that the Medicare Locals when acting as purchaser/providers will distinguish responsibility for demand (purchasing) from that of supply (provision). It is also assumed that Medicare Locals will partner with other entities, including but not limited to Local Hospital Networks and Lead Clinician Groups.

However in the development of those arrangements, the Medicare Locals may need to have access to medical practitioners, and in particular medical specialists such as physicians and paediatricians, through well designed funding and strategic purchasing models.

This will no doubt require a 'diverse toolbox of funding models'(2) including Medicare Benefits Schedule ("MBS") items as well as a possible Visiting Medical Officers ("VMO") style fee-for-service arrangement, through which the Medicare Local can identify necessary medical services and utilise the most appropriate funding arrangement to meet the health care needs of the patient. The latter could be structured around either the number of hours the physician spent in the primary or ambulatory care setting, such as a skin cancer clinic, based on the VMO fee-for-service independent contractor market rates.

The contracting of medical specialists such as physicians and paediatricians will still therefore need to be on a fee-for-service basis that will require an alignment with the MBS including appropriate item numbers for both the new arrangements and new services for specialists in the primary and ambulatory setting.

Under any new arrangements through the Medicare Locals or other health reforms, there must be a 'no-disadvantage' test applied, in either the contractual or financial arrangements, to ensure the continuing high standards of care in our health care system.

Working together, the Medicare Local and Local Hospital Network would need to coordinate the local health requirements, especially for chronic and complex illness, and then make the necessary arrangements for any required specialist services outside of the hospital, taking into account the cost benefit to the hospital of any expected reduction in the number of avoidable admissions.

The arrangements for contracting specialist services must 'offer' to physicians and paediatricians the incentive to provide that identified service based on a market rate that takes into account any costs associated with the provision of those services in the ambulatory and primary setting including direct costs such as travel as well as opportunity costs associated with clinical time outside of the hospital and acute setting.

Any additional budget outlays would be expected to be offset against reduced admissions in the more costly hospital setting, more costly acute treatments that could have been avoided and additional costs impacts such as ongoing rehabilitation and social security payments such as the disability support pension. For example if better managed cared in the ambulatory setting for a diabetes patient avoided an amputation then the benefits to the patient and the positive saving to the health system and the community are enormous.

This is further supported by the recently released annual report from the NSW Bureau of Health Information, stating that the major weaknesses in Australia's health system were its treatment of patients with chronic conditions such as lung disease and diabetes, the rates of avoidable hospitalizations and in ensuring that services remain affordable. Rates of lower limb amputations in NSW were 17.7 per 100,000 people, this was only less then the US which had 35.7 per 100,000 people. Other countries such as Canada, Norway and Britain all had less amputations per 100,000 than Australia.

To deliver coordinated multidisciplinary care the Medicare Locals will need to have access to the appropriate MBS items, including tele-health item numbers or fee-for-service services in the primary and ambulatory settings, as well as other out-of-hospital and non-acute settings for physician and paediatrician consultation fees as well as specified items for treatment within coordinated care.

Working with the Medicare Locals and other health bodies, Australia's physicians therefore can play a key role in the brokering of an efficient model of care.

As purchasers or commissioners of services, Medicare Locals can thereby help to improve coordination, identify service delivery gaps and reshape under-performing elements within the continuum of care (such as management of chronic disease) and to address identified service delivery gaps by appropriately directing funding through open and transparent governance to new or existing providers.

The Government could adopt health policies that reduce Australia's reliance on acute care services by:

- Interaction between Local Hospital Networks and Medicare Locals to coordinate care;
- Increasing the availability of sub-acute health services for older people, people with complex and chronic conditions or injury and disability, and those with severe and persistent mental illness;
- Increasing the availability of, and access to, post-acute and ambulatory health services providing community based care;
- Amending 'episode of care' payments;
- Promoting coordination and integration of care between health professionals and across all health settings; and
- Over time investing a higher percentage of the health budget in the prevention of ill health and the promotion of good health at community and population levels with the aim of medium to long term sustainability. (3)

This care must be well coordinated if people with complex needs are to receive care that is comprehensive and continuous, and if they are to take an active role in their own care and their future health needs. It is proposed that we could improve coordination of care and support within and between ambulatory and primary health care settings and other health-related services through the following strategies (3):

- Improving communication between service providers
- Develop and implement new systems to support the coordination of care
- Coordinating clinical diagnosis, management, treatment and care
- Support and advise other service providers on optimum care arrangements
- Support for patients, partners/spouses, families and carers
- Improving relationships between service providers
- Joint planning, funding and/or management
- Coordination of agreements between organizations
- The organisation and operations of the health care system

Better coordinating of care includes recognising Australia's changing demographics, such as population ageing and the increasing prevalence of chronic disease (and in particular multiple morbidities), the ever increasing requirements for more people to receive complex and overlapping care (from a variety of health care providers in the continuum of care such as general practitioners and medical specialists), and linking through ambulatory care, hospital settings, sub-acute care and often additional community support for patients in their own homes. This care must be well coordinated if people with complex needs are to receive care that is comprehensive and continuous, and if they are to take an active role in their own care and their future health needs.

These strategies could allow the health system to develop the necessary systems and processes, such as care plans, for use by a range of providers across both national and state funded services to integrate the care provided by different services. The strategies might also facilitate the development and uptake of improved systems for communicating or sharing information between ambulatory and primary health care, such as e-health, telehealth and the National Broadband Network.

Background

The rate of chronic disease (and in particular co-morbidities) increases with an ageing population. More people are receiving complex care from a variety of health care providers often with combined hospital or specialist care in addition to ongoing care in the community. Chronic illnesses contribute 60% of the global burden of disease, which by the year 2020 will increase to 80%, (4) and the increase in life expectancy and record declining death rates contribute to the ageing of Australia's population.

With our ageing population Australia must plan for the projected increase in costs of chronic illness, and aim for cost effective care with containment of costs.

It is suggested that shifting the focus of health care and support from acute intervention to proactive management of chronic conditions and preventive interventions and health promotion will be needed to improve quality of life and contain rising health care costs.

This will require new processes for the delivery of health care and the coordination of management and support.

As a result of our current federated structure we have a number of financial and clinical impediments to the management of care and support for people with chronic conditions.

General practice is funded on a fee for service basis and acute care is episodic. These arrangements are demarcated and reactive (4).

Moving forward, the national health reforms will need to focus on bridging these gaps, while still maintaining the direct accountability of the medical practitioner to the patient, facilitating the provision of care and encouraging quality of care. In the ambulatory and primary care setting, any funding arrangements should reflect the level of effort, resources, skill and training of the practitioner and physicians should be able to set appropriate fees to ensure the appropriate quality and standards and access to health care.

"Under the MBS, remuneration generally focuses on the activity involved in individual episodes of treatment. Health professionals are not supported to provide care that takes a whole-of population focus, and do not always have the capacity and tools (eg. clinical decision support systems) to deliver evidence-based and best practice care."

Towards a National Primary Health Care Strategy;
Department of Health and Ageing 2009

This paper proposed that Australia must move from a reactive health system to a proactive one, from one focused on hospital based acute care to one more focused on non-acute care, including enhanced programs of preventative care involving comprehensive community based care

The National Health and Hospitals Network for Australia's Future provides an unprecedented opportunity to develop a national approach to coordination and continuity of care and support for people with multiple service needs, where care is accessed from combined funding through the appropriate funding model from existing commonwealth and state programs through the Local Hospital Networks and the Medicare Locals.

Fragmentation of Care

The Commonwealth Government's Medicare Locals discussion paper on governance and functions states that;

"The Australian health care system care is currently fragmented, both within the primary health care sector and across hospitals, aged care and specialist care. This fragmentation, and the current uncoordinated

proliferation of primary health care services (across program types, sectors, providers and funders) has often led to the most vulnerable patients and clinical populations missing out on the services they require, or receiving treatment in inappropriate settings."(5)

The following scenario was published in the MJA in 2005;

> A, a 70-year-old Maltese migrant with limited English, has diabetes and vascular compromise of his right foot. He also has a standing but stable mental illness, managed by his Maltese-speaking psychiatrist, Dr B, and his general practitioner, Dr C. Mr. A nds the combined diabetic, surgical and foot clinic at the nearest teaching hospital**.** The clinic sends its reports about Mr. A to Dr C, scans them into her paperless patient record, but she has no direct access to the results of Doppler imaging or pathology tests. Dr C tinues standard diabetes monitoring between Mr. A's clinic attendances, sending results to the clinic.
>
> various consultants at the hospital clinic decide that Mr. A needs to have a below-knee amputation. Although Mr. A tells Dr C of the ned surgery, the relevant letter does not arrive until three weeks after the operation. Only then does Dr C learn that Mr. A was rred to a rehabilitation hospital.
>
> does not get a discharge summary from the rehabilitation hospital, as it goes to the referring surgical registrar from the vascular n at the hospital.
>
> A spends 6 weeks in the rehabilitation hospital. The patient's family asks Dr C to intervene because Mr. A is becoming depressed. Dr C tacts the rehabilitation registrar, who tells her about an impending psychiatric referral with an interpreter. The registrar is surprised to n of the existing arrangements for Mr. A's psychiatric care, as the referral from the hospital made no mention of this.
>
> Mr. A is still in the rehabilitation hospital, the decision to continue with the new, separate stream of psychiatric care stands.
>
> *g-term effect of fragmented health care delivery*
> *use of increasing allied health costs and lengths of stay when health care delivery for individual patients is fragmented, the wait for pital beds for patients with vascular conditions doubles, within the space of a year, from 3 weeks to 6 weeks.*

The Role of Physicians and paediatricians

The Definition of 'Physician'

The RACP represents over 13,500 physicians and paediatricians, covering the fields of internal medicine, paediatrics, public health medicine, rehabilitation medicine, occupational and environmental medicine, child health, sexual health medicine, addiction medicine and palliative medicine and representing physicians in over 20 specialty areas.

Physicians and paediatricians are specialists who have completed advanced training after their initial medical training is completed in a particular area or 'specialty' and diagnose and manage complex medical conditions in adults, children and young people.

Physicians and paediatricians provide care and support for complex medical conditions and continue to see the patient until these problems have resolved or stabilised. They have expertise in the diagnosis and treatment of conditions affecting different systems in the body and can therefore treat multiple illnesses in a patient, especially the difficulties faced by clinicians when confronted by the co-morbidities of complex and chronic diseases which are often undifferentiated.

Physicians and paediatricians have skills in managing undifferentiated problems and conditions across specialty areas and have an awareness of the psychosocial and the biological aspects of illness, they offer "whole person" patient care and support and can act as advocates for their patient. A broad understanding of the principles of general internal medicine can help ensure that fragmented care across different systems and medical practitioners in a multitude of settings does not result in significant co-morbidities and patient concerns unrelated to the admission being overlooked, misdiagnosed or inappropriately managed.

The focus of this submission is on the role of physicians and paediatricians in the variety of non-acute settings, including ambulatory, sub-acute, community and primary and ambulatory care as they relate specifically to the COAG reforms and the wider health reform agenda.

In discussing the role of physicians and paediatricians in non-acute care and outside of the specialist hospital setting this submission refers to general physicians as general internal medicine specialists specializing in the broad discipline of internal medicine, or a 'Dual trained Physician' who is a general specialist with another specialty interest and a 'Specialist' who has a capacity for internal medicine within a primary specialty.

For all physicians the clinical reality is that patients and their health providers often manage more than one condition. Most acute hospital admissions present with complex multisystem problems.

"Not only in general practice, but in other primary health care services, the scope and extent of preventive activity is restricted. Research also suggests low rates of detection for many significant conditions with, for example, evidence that 50% of people with diabetes and 75% of people with Chronic Obstructive Pulmonary Disease (COPD) were not aware that they had the condition."

Towards a National Primary Health Care Strategy;
Department of Health and Ageing 2009

Advances in medicine have increased the complexities in health care and have also increased the complexity of treatment regimens which can increasingly require specialist advice, support and coordination.

All physicians, and paediatricians, can play an important coordinating role for patients with multiple problems who are exposed to the effects of polypharmacy and can advise of the appropriate use of invasive interventions as health practitioners grapple with the complexities of their patients' conditions requiring co-ordination and management in the ambulatory care setting (6)

Physicians and paediatricians also play a vital role in preoperative assessment and perioperative management.

It is important to note that in the current heath reform debate that many physicians and paediatricians maintain procedural skills (e.g. echocardiography and endoscopy) and provide valuable investigational procedures, particularly in areas outside major metropolitan hospitals (6)

For our paediatricians it is important to note that the health profile of children and young people has become much more complex over the past few decades requiring very different sets of responses from the health sector. Greater survival through adolescence of children with previously fatal conditions (e.g. congenital heart disease), is compounded by a higher incidence of other chronic conditions (e.g. Type 1 and Type 2 diabetes), and of previously uncommon conditions such as obesity, depression and anxiety, eating disorders, sexually transmitted infections and substance abuse.

Paediatricians can therefore play a crucial role in the development of a set of headline indicators for young people, with a commensurate youth health strategy to identify how to populate such indicators is required. Knowing that much chronic disease in adults has its origins in childhood and adolescence (eg smoking, obesity) it is critical to ensure that a focus on non-communicable diseases and chronic disease prevention includes prevention efforts that focus on children and adolescents. Leaving such interventions until targeted approaches are required in older adults is far less cost effective than population based prevention efforts for adolescents.

All physicians but especially adult and paediatric general medicine specialists have the breadth and the capacity to embrace these new challenges. Generalists can continue to learn from experienced specialists and can acquire both the knowledge and procedural skills that might be necessary in a particular city or rural hospital or community settings(6). They can also provide leadership in public health, clinical epidemiology, ethics and decision making, clinical infomatics, health technology assessment, clinical audit, and health service research.

"Often, and especially for patients with multiple, ongoing and complex conditions, poor communication and information transfer means that the range of health professionals involved are not well informed of all aspects of care the patient may be receiving, and are therefore constrained in supporting the patient's overall care. Navigating a complex system on behalf of a patient can be a significant and time consuming activity for health professionals."
Towards a National Primary Health Care Strategy;
Department of Health and Ageing 2009

For the purposes of this paper it should be noted that general physicians co-operate with other colleagues (e.g. in general practice, adolescent medicine, emergency medicine, intensive care, coronary care, surgery psychiatry, and geriatric medicine) to help integrate medical care and support and provide an overview of medical management . This holistic approach provides them and all physicians with the capacity to positively influence models of care and to ensure they are patient centered and reflect the social determinants of health.

The role of physicians and other specialists in the hospital and acute care setting could also benefit from greater coordination and involvement in the planning of care through the Local Hospitals Networks.

The ambulatory and primary care setting would benefit greatly from the broader perspective of physicians as well as the potential for greater involvement of specialists outside of the hospital and acute setting for the prevention and treatment of chronic and complex conditions. Rural areas would also benefit greatly through the availability and access to more physicians and at a minimum more general specialists.

In summary at present there are concerns about a significant gap in the continuum of care as the role of physicians and other specialists have not traditionally been as well covered in primary and ambulatory care settings and the decline in general specialists needs to be addressed.

Multidisciplinary & Coordinated Care
Coordinating service provision can be particularly difficult across system boundaries: between general practice and hospitals or community health, and between generalist and specialist services. (3)

There are considerable difficulties working across different funding sources, and inter-professional and industrial relations systems. Our current system is also largely systematic and financially based on discrete episodes of care involving single diagnoses of individual patients by an assigned medical practitioner . In looking at major health reform new funding models need to be developed which encompass patient centered care across multiple sites of care and aiming to promote independence and support in communities.

"While the importance of multidisciplinary teams in providing primary health care services is increasingly recognised, team-based models

of care can be restricted by current program and funding arrangements."
Towards a National Primary Health Care Strategy;
Department of Health and Ageing 2009

To begin with, the Local Hospital Networks and the Medicare Locals may have the potential to support effective chronic care management programs through population based planning strategies to deliver and support care to defined patient populations to ensure that effective interventions reach all patients who need them.

Coordinated care and support with a patient centred approach can ensure that the required interventions are specified and delegated to members of a highly effective multidisciplinary team. Treatment plans for each patient could assist in the effectiveness of chronic illness programs, and more formal, written plans may not only help to organise the work of teams but help patients to navigate the complexities of multidisciplinary care and support. At a minimum physicians and paediatricians are in a strong position to facilitate improved patient centred care and support models through their ability to not only deliver care but to coordinate a patient's health care journey.

The current Medicare arrangements for Treatment & Management Plans require careful alignment with the potential benefits of the new Medicare Locals, including greater alignment with the Local Hospital Networks and an increased focus on specialist care in primary and ambulatory care settings .

Strategies for coordinating care and support fall into two main groups. The first relates to processes used by clinicians or program staff to coordinate care and support. These processes include communication between service providers, support for service providers and support for patients. They may vary in formality from a communication relating to regular and formal case conferences, to an expectation that members of a multidisciplinary team keep the physicians and paediatricians informed of patient progress and changes in care. A better ehealth system would greatly assist these strategies. (3)

The second group of strategies relate to structural arrangements put in place to support these coordinating activities. These include the use of systems to support coordination (for example shared records, pro-formas for communication or consistent decision support), structuring the relationship between service providers and/or the roles and responsibilities they have in providing care and support (co-location, case management, multidisciplinary teams or assigning a patient to a specific primary and ambulatory health care service provider) and the coordination of clinical activities to promote continuity of care and support, including shared assessments, joint or coordinated consultations and arrangements for patients to have accelerated access to services. (3)

The UNSW research Centre for Primary Health Care and Equity (CPHCE) in their paper *"Coordination of Care within Primary Health Care and With Other Sectors: A Systemic Review"* published the following table in 2006; (3)

Table 18: Strategies that provide structure to support coordination

Strategy	Specific activities
Coordination of clinical activities	PHC consultations coordinated with those from other providers in/outside PHC, including joint consultations Shared assessment involving PHC clinician Arrangements for accelerated access to a PHC service/for PHC patient to non-PHC service
Relationships between service providers	Co-location between PHC and other service providers Case management Multi disciplinary team (MDT) involving PHC Assigning a patient to a particular PHC

	provider
Systems to support the coordination of care	□ Shared care plan used by PHC clinicians □ Decision support shared by PHC clinicians and other clinicians □ Pro formas used by PHC clinicians □ Patient held record used for PHC care □ Information or communication systems used by PHC clinicians □ Shared records used by PHC clinicians □ Register of patients used to support PHC

Within these strategies there are obvious limitations of the traditional consultation with a patient with multiple chronic conditions who have complex care needs. Primary and ambulatory health care could incorporate the ongoing specialist medical care and could keep all health practitioners informed of developments and changes in health status and health care needs provided by other services (3).

Increased care through multidisciplinary teams could become a feature of Australian primary and ambulatory health care. Compared to the UK, Australia has small general practice teams, providing less opportunity for multidisciplinary care within the practice and less capacity for developing teams with health workers outside the practice. (3)

An alternative might be to develop more clinics and support services for patients with chronic and complex conditions and similar needs—e.g. asthma or diabetic clinics for "group consultations, education and support services" (consultations with several patients during a program session) or for older patients to assist patients in their preventive care and self-management. These broader consultations may provide a particularly efficient vehicle for the complementary functions of team care and support, especially in the delivery of health maintenance and health prevention programs.(7)

There is potential for the new GP super clinics to become chronic and complex illness centers especially for already identified and active practices in areas such as diabetes and cancer treatments.

Sustained follow-up especially for at high risk and disadvantaged groups requires coordinated care and support. There are obvious benefits for the effectiveness and efficiency of the health system in reducing hospital re-admissions and in positive outcomes of care.

"Poor linkages between general practice and state and territory funded services, including hospitals, community health and other community based services, can adversely impact on patient care, for example, through inadequate planning and coordination on discharge from hospital."

Towards a National Primary Health Care Strategy;
Department of Health and Ageing 2009

Significant improvement in outcomes can be achieved with these strategies that support coordination and development programs, particularly co-located multidisciplinary teams that include physicians and paediatricians to promote coordinated primary and ambulatory health care consultation, team care and case management.

This may, however, require re-looking at the way care and support is organised and extending beyond clinician support activities, communication between providers, and the establishment of Local Hospital Networks and Medicare Locals.

It is already we understood that management and care and support plans are intended to set out a course of action for the treatment and/or management of a patient's presenting condition/s. The current course of action, where a patient is referred by a GP to a physician or paediatrician, for assessment and diagnosis of the condition/s or for confirmation of a diagnosis, is that the physician or paediatrician recommends a course of action after which the patient returns to the GP for development of a comprehensive management plan and to oversee the ongoing management, except in those cases where management by the physician for a longer period is indicated.

It might be better if the arrangements were that the GP prepares a management plan, and then forwards the management plan for "sign off" be adjusted so that: where a care plan is prepared by a GP in the absence of a referral to a physician or paediatrician, that care plan should be linked to a team care arrangement and a case conference arranged which is attended by a physician and/or a paediatrician and that there be an appropriate patient Medicare Benefit Schedule benefit associated with the medical specialist consultation process.

The new arrangements would be such that:

1. A patient should be eligible when there has been a consultation with a physician or paediatrician, and then the management plan prepared by the GP should reflect the medical specialist advice.

2. Patients should be eligible for a management plan when they have been previously assessed by a physician or paediatrician (under item 132 or 133), and the plan should then be based on the plan provided by the physician or paediatrician. The appropriate Medicare item for the general practitioner consultation prior to referral should be a normal consultation based on duration.

3. If a general practitioner prepares a management plan for a patient who has not been referred to a physician, the plan should be linked to both a Team Care Arrangement and a Case Conference. The case conference should be attended, usually by telephone, by a physician or paediatrician. At this conference the physician will concur with the plan, suggest an alternative course of action, or determine that referral for an initial consultation is required (8)

There exists significant opportunity through the Commonwealth Government's GP SuperClinics to establish primary and ambulatory care clinics involving physicians and other specialists that would align with the roles and responsibilities of the Medicare Locals and Local Hospital Networks.

As the Minister for Health, the Hon Nicola Roxon has stated;

> "These clinics will bring together general practitioners, practice nurses, visiting medical specialists, allied health professionals and other health care providers to deliver integrated multidisciplinary, primary health care services aimed at addressing the needs and priorities of local communities. Importantly, clinics can play a role in training the next generation of health professionals" (5)

Within a potential 'hub and spoke' model the GP Super Clinics could provide allied health services, preventive and/or specialist clinics on an outreach basis. Alternatively, a virtual service delivery model can be used where individuals and/or individual practices operate in a network to provide specific services and/or functions from separate sites within a community but communicate and work collaboratively with each other through common integrated information technology and information management systems. These arrangements could be supported by the telehealth capabilities of the new broadband infrastructure and MBS item numbers.

Under either approach, the role of physicians and paediatricians will be crucial to the development of arrangements that focus on the needs of the patient and how their care is managed through the various settings of the health care system.

Medicare Locals & Local Hospital Networks

The RACP welcomes the Medicare Locals objective to facilitate improved access to services for patients and encourage greater integration between the primary, ambulatory, hospital and aged care sectors.

To begin with there should be effective and efficient coordination between Medicare Locals, Local Hospital Networks, aged care One Stop Shops, GP Super Clinics and Lead Clinician Groups.

It is assumed that the Medicare Locals when acting as purchaser/providers will distinguish responsibility for demand (purchasing) from that of supply (provision).

Priority setting is an inherent feature of the needs assessment and resource allocation process and all health practitioners must have a role through the Medicare Locals in deciding which particular services to buy, how many services are required and which providers to purchase them from.

Both National and Local Lead Clinician Groups have the potential to link Medicare Locals to Local Hospital Networks through their key responsibilities to "assist with service planning and efficient allocation of clinical services" and develop local solutions to local issues. At a local level, physicians and paediatricians are well-placed to advise on the operational and systemic linkages between MLs and LHNs because of their presence in all parts of the health care supply chain.

In this process physicians and paediatricians, especially public health physicians, can play a critical role in the population based resourcing and priority setting, as well as the evaluation and monitoring of the performance of Medicare Locals in meeting local health care needs, including preventive health. All physicians and paediatricians play a role in the efficient and effective allocation of resources with local community health care needs.

Medicare Locals can play a crucial role in population health, with a focus on health promotion and health protection and a particular emphasis on reducing socio-economic differentials in health. Ensuring that a primary health care approach to population health is based on sound public health principles, including evidence-based practice, needs-based planning and monitoring of health outcomes. There are a multitude of physicians and specialist services that need to be better coordinated and managed. The recommendations of the NHHRC and the National Preventative Taskforce should be implemented and in particular, the involvement of an agency to guide national strategic direction in public health.

We also need to ensure that we address the issue of equity of access and to ensure that the purchaser / provider arrangements do not restrict access through unresponsive and inflexible billing arrangements resulting from prescriptive contractual arrangements that limit available services.

As purchasers or commissioners of services Medicare Locals can help to improve coordination, reshape certain aspects such as chronic disease care and to address identified service delivery gaps by appropriately directing funding through open and transparent governance to new or existing providers. At the same time, the connection to other sectors of the health care system, including Local Hospital Networks, needs to be explicitly retained.

The College is very encouraged by the aim of the Commonwealth through the Medicare Locals *"to encourage a model of care that allows providers the opportunity to organise and coordinate care around the needs of the patient."* (5)

Medicare Locals could:

1. Refer to population health planning for priorities and allocations.

2. Support preventative health measures.
3. Manage and support chronic and complex illness.
4. Coordinate multidisciplinary care in all health care settings.
5. Support self-management and patient centred care.
6. Provide integration across the continuum of care.
7. Overcome jurisdictional issues and other systemic restrictions.
8. Coordinate with Local Hospital Networks.
9. Integrate with other service providers such as GP SuperClinics, aged care One Stop Shops
10. Complement existing activities such as the new national diabetes program.

Overall the Medical Locals could be looking to provide services to patients who could be better cared for in non-acute settings and to reduce patient visits to hospital Emergency Departments for conditions that could be treated in the primary and ambulatory setting.

Under any new arrangements for out-of-hospital care medical specialists will still need to be on a fee-for-service basis through a 'diverse toolbox of funding models'.

This could include the development of appropriate item numbers through the Medicare Benefits Schedule ("MBS") and/or a possible Visiting Medical Officers ("VMO") style fee-for-service arrangement for consultation fees for specialists including physicians and paediatricians as well as specified items for treatment in coordinated care.

At present the involvement of physicians in primary and ambulatory care for coordinated care is limited to the currently available item numbers for either one or two consultations per patient per year. For the effective and efficient management of care for patients with chronic and complex illness the MBS will need to recognise the specific requirements of coordinated multidisciplinary care plans across the different setting and in particular for the potential involvement of medical specialists such as physicians and paediatricians in the primary and ambulatory setting (9).

Currently, patients with at least two morbidities, including complex congenital, behavioral or developmental conditions, are eligible for treatment under Item 132 (initial patient assessment) and Item 133 (patient review). However, if under the new arrangements physicians and paediatricians could be offering additional services in the primary and ambulatory setting that were not previously possible, then Medicare Item Numbers could be a funding mechanism that could be aligned with any change in practice arising from the national health reforms (9).

In addition to the use by the Medicare Locals of appropriate Medicare items a possible Visiting Medical Officers ("VMO") style fee-for-service arrangement could be incorporated management of care for patients with chronic and complex illness. This could be structured around either the number of hours the physician spent in the primary or ambulatory care setting, such as a skin cancer clinic, based on the VMO fee-for-service independent contractor market rates.

As discussed earlier this could begin with the GP Super Clinics that would extend into practices that offered clinics for chronic and complex illness or even other specialist centres.

With more flexible options for more tailored care the Medicare Local can then identify necessary medical services and utilise the most appropriate funding arrangement in agreement with the health care professionals to meet the health care needs of the patient.

These new arrangements and capabilities not only present a number of opportunities for the involvement of physicians and paediatricians in the Medicare Local program but more importantly they actively require their participation in the activities of the Medicare Locals and the coordination of health care in our communities.

In rural and remote areas, Medicare Locals must promote strong and effective working relationships among individual clinicians across the primary, acute and sub-acute care settings.

Medicare Locals in rural and remote communities will need to provide effective and efficient coordination of primary and ambulatory care, including specialists, with aged and community care, local acute, rehabilitation and palliative care services through the local hospital or Multi-Purpose Services to ensure that services are provided as close to home as possible and continuity of care for patients who need to travel for more specialised treatment within the region or to specialised services in urban centres.

Medicare Locals have the potential through more coordinated care to provide seamless care for patients in their rural and remote communities. The patient must feel confident and know where and how their care will be provided within the region, as well as the regional entity making sure that all types of care required are catered for.

Rural people with complex care requirements have particular needs for extended coordination and case management. Medicare Locals could coordinate tertiary referral strategies to address the time consuming and logistically difficult task of coordinating several appointments within one trip to the city or regional centre for a hospital visit. This would result in savings on time, trips and costs to both the patient and the health system.

It is critical that safety requirements for primary care in rural and remote communities take full account of the potential safety risks for patients, not only of the primary care that is available to them close to home, but also the risks of not having such care close to home. These include the risks associated with travelling large distances over poor roads or in difficult conditions to receive care; travelling when injured or in ill health; receiving care a long way home without the support of family and friends; or not travelling and therefore not receiving care because it is not affordable or too far from family responsibilities.

Greater coordination through multidisciplinary teams facilitated by the Medicare Locals working with the Local Hospital Networks will improve the clinical handover standard.

By working together Medicare Locals and Local Hospital Networks can contribute valuable evidence on potentially preventable hospitalisations, which currently increase by remoteness for a range of chronic, acute and vaccine-preventable conditions.

Conclusion *(Specialists are leaders in Ambulatory and Primary Care)*
As medical specialists, physicians and paediatricians already play a major role in the provision of health care in the primary and ambulatory setting despite the difficulties faced through the current health care arrangements in Australia, as well as the acute, sub-acute, outpatient, aged and community care settings.

There are a great many benefits to potentially be gained through the greater involvement of physicians and paediatricians in primary and ambulatory care, especially for chronic and complex illnesses.

In the primary and ambulatory setting physicians and paediatricians can provide health assessments, counseling and management to reduce and prevent lifestyle illness and improve the coordination of care and

management of chronic illness to reduce the cost and impact of these conditions on individuals, acute hospital services and the economy.

The Medicare Locals and Local Hospital Networks have an opportunity to plan and resource to reduce avoidable admissions, including escalations in the severity of procedures that could have been avoided through more coordinated and patient centred care. For example, a diabetes clinic, involving all relevant health clinicians could reduce the likelihood of an amputation through an effective care plan that promoted patient compliance with their treatment program through both the multidisciplinary support and provision of the care in a single community based location.

However, more work is required, including economic modeling, to examine the outcome of coordinated care outside the hospital, such as in the primary and ambulatory setting, on hospital utilisation rates, admissions to emergency departments or rates of surgical interventions to determine the health care costs that could be avoided.

Reductions in the number of avoidable admissions is a benefit to the entire community, as patients avoid more serious procedures or outcomes that could be avoided, which reduces pressures on our hospitals which in turn reduces the financial impact on the hospital and the taxpayer. This will improve the quality of life for large numbers of people and promotes a healthier community.

To achieve this, physicians and paediatricians can play a crucial role in the planning and resourcing of health care, particularly through Medicare Locals in the primary and ambulatory care settings.

In addition, general physicians can play an important role in the coordination of care and management of multidisciplinary teams, especially in rural areas.

Further modeling is also required to investigate the cost effectiveness of group consults, where a team of health workers such as a GP, allied health worker, nurse and specialist, could coordinate their time in a clinic or another setting such as an aged care facility.

In the non-acute setting physicians include:

- paediatricians and community and child health specialists;
- physicians who have a significant role in non-hospital care;
- physicians who work in chronic disease management and participate in team management and case conferences;
- physicians and paediatricians whose practice in rural and regional areas encompasses a wide range of services that complement and support primary and ambulatory health care
- public health physicians working in health promotion, disease prevention, epidemiology, health planning and management;
- occupational and environmental health physicians;
- rehabilitation physicians and
- physicians in palliative care, sexual health and addiction medicine who provide vital roles in community health care.

There are already a number of examples, where physicians and paediatricians provide vital care outside of the hospital and the acute care setting.

In the case of endocrinologists and diabetes management, especially around improvements in Indigenous health outcomes, shared care models between GPs and endocrinologists should be explored (as occurs with antenatal shared care) to improve communication and coordination of care for people with diabetes.

With the prevalence of end-stage renal failure in Aboriginal communities rising and with a marked excess of presumed or proven diabetic nephropathy the experienced specialists who visit rural and remote Aboriginal or Torres Strait Islander communities strive to use hospitalization only as needed and encourage community-based care.

The number of skin cancer clinics functioning within Australia's primary care environment is increasing rapidly and specialist dermatologists have a crucial role to play in helping manage the more complex cases.

There are gastroenterology services provided in clinics for public and private inpatient and outpatient services such as endoscopies.

Clinical Immunologists/allergists work in a range of settings, including hospitals, private practice, diagnostic immunology laboratories, research centers and universities.

For hypertension, physicians from the Society of Obstetric Medicine of Australia and New Zealand (formerly the Australasian Society for the Study of Hypertension in Pregnancy) treat and manage hypertensive diseases and medical disorders in pregnancy.

Treatment of cancer and care for people with cancer is most effective when there is involvement from a variety of medical and allied health care professionals in a multidisciplinary team setting, including but not limited to: Surgeons, Medical Oncologists, Radiation Oncologists, Cancer Care Nurses, Psycho-oncologists, Haematologists and General Practitioners. A multidisciplinary primary and ambulatory care team can collaborate to tailor an individual treatment plan for each patient and work in conjunction to allow patients to remain at home for treatment or receive treatment as a day stay case with community support.

While neurologists commonly treat strokes in the hospital or acute care setting, other illnesses such as headaches/migraines, nerve and muscle diseases, seizures/epilepsy, memory problems, multiple sclerosis Parkinson's disease and movement disorders can be treated and/or managed in the primary and ambulatory setting.

Rheumatologists predominantly treat patients in primary care and in specialists' rooms and out-patient clinics manage diseases associated with inflammation or pain in muscles, joints, or fibrous tissue; includes treatment of arthritis, rheumatism, and related diseases, including gout.

With an ageing population, the Bone and Mineral Society physicians of the RACP clearly have a major role in the management of patients in the field of metabolic bone disease and mineral metabolism, especially osteoporosis and multi-skeletal disease. Medicare Locals are well placed to better coordinate the major benefits of enhanced preventative health in primary and ambulatory settings and the difficulties of patient management.

Physicians managing and treating respiratory health care face increasing challenges in managing the challenges of increasing complex and chronic illness as well the challenges of an aging and obese population.

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