THE GEORGE INSTITUTE
for Global Health

Submission to the Standing Committee on Health: Inquiry into Chronic Disease Prevention and Management in Primary Healthcare

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Summary

While Australia's health system is among the world best in the world, health spending per person is predicted to double by 2055. The prevalence and cost of chronic disease makes a substantial contribution to this statistic. The question we need answer is not whether *we need reform* the current prevention and treatment of chronic diseases in primary care, but *how* we do we do this effectively and efficiently.

The George Institute for Global Health is a leading, not-for-profit medical research institute which works to identify effective, affordable and sustainable solutions to gaps in chronic disease prevention and management.

This report outlines four main areas for reform and makes the following recommendations:

Recommendation 1	Capitalise on e-health and mhealth innovations such as shared electronic records, electronic decision support systems, telemedicine and home monitoring.
Recommendation 2	Implement an expanded range of care delivery models that utilise a broader healthcare workforce, including consumers
Recommendation 3	Implement population-level interventions directed at diet and physical activity.
Recommendation 4	Investment in nationally coordinated programmes that target the biggest causes of death and disability from chronic disease

Background

Chronic diseases affect more than 1 in every two Australians. These conditions are complex, lifelong and often require care by multiple providers across the healthcare sector. Nearly half of avoidable hospitalisations are attributable to chronic disease. The economic and social burden of chronic disease is set to increase in line with Australia's ageing population and high rates of obesity and inactivity.

The George Institute commends the Government's commitment to explore key areas for healthcare reform, as evidenced by the *Inquiry into Chronic Disease Prevention and Management in Primary Care*, the *Medicare Reform* and *Reform of the Federation* and we welcome the opportunity to contribute to this process.

Our submission reflects our unique experience in a broad range of chronic diseases including cardiovascular, renal, respiratory, musculoskeletal disease and diabetes and their associated risk factors. It also reflects our strong interest in developing and evaluating innovative strategies to support doctors and other providers in delivering high quality care and to help consumers access care and adhere to recommended treatments.

We understand that innovations in health care delivery, if they are to be sustainable, need to consider wider system factors such as funding models, the health workforce and information technology. Accordingly, our submission is informed by research across a number of different

domains relevant to chronic disease including clinical, economic, social and behavioural, analytical and technological.

Our recommendations are also informed by the experience of our clinician researchers and our network of clinical collaborators working at the coalface of healthcare, including general practitioners, specialists, pharmacists, allied health professionals and others.

We believe our recommendations will help grow a state-of-the art, equitable healthcare system capable of responding to the current and future demands imposed by chronic disease.

Recommendations

RECOMMENDATION ONE: A connected and integrated health system is critical to achieving effective, equitable and streamlined care for patients with chronic disease. The system needs to capitalise on state-of-the-art technologies and e-health initiatives such as shared electronic records, electronic decision support systems, telemedicine and home monitoring.

An easy to navigate health system and having access to the right treatment at the right time are integral components of an optimal health system able to effectively respond to the complex, ongoing care needs of patients with chronic disease. Such a system requires Commonwealth, States and Territories, the private sector, pharmacies, allied health professionals and consumers to work together to facilitates this. The system also needs to capitalise on state-of-the-art technologies and e-health initiatives.

The George Institute supports a shared electronic health record centred on consumer needs. A shared record can facilitate communication between the consumer and the many providers they are likely to receive services from as well as prevent unnecessary and expensive duplication of investigations and medication errors. A consumer-centred record helps the patient understand their condition, adhere to preventive treatment and avoid costly hospitalisation.

Many gaps exist between best evidence and practice and providers need better support to guide appropriate and safe investigation and treatment of patients. The George Institute has developed electronic decision support tools for providers in partnership with GPs, allied health professionals, specialists, and community service providers. Our electronic decision support tool - ‘HealthTracker’ – has been rigorously evaluated in mainstream general practices and in Aboriginal Controlled Community Health Services and has been shown to improve cardiovascular disease risk measurement and treatment. HealthTracker can be easily modified for use in patients with other complex and chronic conditions and the tool has been designed to operate within existing GP electronic record systems to facilitate uptake. Used in ‘real time’ and utilising cloud-based systems, these tools can help GPs access the recommended guidelines for assessing, treating and monitoring patients at risk of chronic disease and address gaps in health among all Australians, including Aboriginal and Torres Strait Islander people.

Similarly, patients need support to understand their disease, track and manage their risk in conjunction with their GP and help them move between different levels of care. The George Institute has developed ‘Connect’ to help keep the patient at the centre of care. We have also designed and evaluated semi-personalised, text-messaging systems to help patients at high risk of cardiovascular disease adhere to medication and to healthy behaviours (‘TextMe’). Such affordable innovations have been shown to significantly reduce risk factor levels,

including blood pressure, among those at high risk of events and have potential to dramatically reduce hospitalisation costs.

Telemedicine and home monitoring are ways to potentially improve consumer reach and efficiency by avoiding the need for face-to-face interaction. Use of these technologies may be able to address gaps in access for those living in rural and remote areas and other groups where significant transport, cost and other barriers exist. The George Institute is partnering with the telecommunications industry and providers to evaluate whether the use of GP telephone consultations can more effectively triage patients, guide self-management where appropriate and avoid presentation to hospital emergency departments. We are also assessing whether the use of video consultations with specialists in mental and allied health can improve access to quality healthcare, are acceptable to patients and translate to improved patient outcomes. These technology-driven initiatives have been used with success in other developed countries. If proven effective and safe in the Australian context, they have enormous potential to transform healthcare.

RECOMMENDATION TWO: An optimal health system demands an expanded range of care delivery models that are both innovative and evidence- based. Capitalising on the broader healthcare workforce is critical.

Engaging a broader workforce to manage chronic disease has the potential to improve care with evidence showing that sharing tasks from doctors to non-physicians is successful in treating chronic diseases like heart disease, diabetes and depression in other country settings. This is highly relevant in Australia; previous reports have suggested that even if the current medical workforce were to triple in size, it would be insufficient to address the future burden of chronic disease in this country and in some rural and remote regions, there is especially poor access to GPs and specialists.

Expanding the healthcare role and skills of non-physicians like pharmacists, community workers and nurses to allow them to prescribe some medications and provide basic health checks could improve accessibility to much needed treatment in some of Australian's most disadvantaged areas. The George Institute has successfully shown that with minimal additional training and with the support of simple electronic screening and treatment algorithms, non-physician healthcare workers can deliver safe and effective care. Providing community nurses with access to shared electronic medical records and identifying a specialised workforce (with training and accreditation processes) to support patients to independently manage their heart disease, are other examples where engaging a broader workforce could be useful. Currently the George is undertaking a large study to assess the effectiveness of a model of care for chronic disease that has community pharmacists playing a significant role.

Allied health professionals, such as physiotherapists, psychologists, and diabetes educators, make up a significant component of the health workforce, delivering over 200 million services annually across metropolitan, regional and remote Australia. They play a central role in the prevention and treatment of chronic diseases including osteoarthritis and back pain, respiratory disease, stroke and falls prevention. Increasing Medicare funding for these interventions is required to support these health professionals. Evidence shows these treatments are effective when they can influence behavioural change, with at least 10-15 sessions. Currently eligible patients can only claim a maximum of five allied health services sessions per year (MBS items 10950-10970).

An expanded chronic disease management program for allied health would include:

- An increase in funded allied health services from 5 to 10 per calendar year if the patient is receiving services from one allied health profession, and up to 15 if receiving services from more than one
- Provision of allied health group services for *all* eligible patients with a chronic disease not only those with diabetes
- Expansion of the list of group service providers to include physiotherapists

RECOMMENDATION THREE: Effective prevention and treatment of chronic disease requires the 'upstream' factors of chronic disease to be addressed through population-level interventions directed at diet and physical activity.

Developing and implementing community-based interventions is key to controlling the upstream risks that put people in hospital and drive health care utilisation. This ranges from planning urban developments that encourage physical activity and creating healthier workplaces, to introducing legislation and taxation in health.

Poor diet, and in particular excessive consumption of salt, sugar, harmful fats and calories, is now the leading upstream cause of ill health in Australia. It is a major contributor to heart attack, stroke, high blood pressure, kidney disease and diabetes. Enforced standards restricting advertising of junk food to children, taxation of sugar sweetened beverages and requiring display of the Health Star Rating food labelling on all food products (including fresh foods, fast foods and school canteen foods) are practical strategies that have the potential to prevent childhood obesity and deliver immediate large health benefits in Australia at very low cost. Furthermore, programs to address the limited supply and relatively high cost of fresh healthy food choices in Aboriginal and Torres Strait Islander communities, where poor diet is also the main driver of the chronic disease epidemic, also need to be supported.

Australia has committed to the World Health Organization '25 by 25' goal of reducing avoidable chronic disease deaths by 25% by 2025. A core component of this commitment is a 30% cut in salt levels equating to a 3g/day reduction from the current 9g/day average, in Australia. A national strategy of this type is projected to be one of the most cost-effective possible ways of addressing the burden of chronic disease. Investing $20m per annum to implement such a program would save over $200m in health costs and about 3400 lives each year. As a designated World Health Organization Collaborating Centre in salt reduction, The George Institute is uniquely well placed to support such action.

The program would be multi-faceted and national in scope with strong government leadership and close collaboration with the food industry to reduce salt in fast food meals and processed foods. The work could be integrated with the Health Star Rating labelling scheme and serve as a model for broader food supply improvements addressing sugars, harmful fats and calories. Community education campaigns, schools programs and workplace interventions accompanied by a robust monitoring program would form the core of the initiative.

RECOMMENDATION FOUR: Nationally coordinated programmes that target the biggest causes of death and disability from chronic disease such as cardiovascular disease and chronic lung disease.

A National Cardiac Care Scheme

Heart disease is Australia's biggest killer with heart attack survivors accounting for about half of all heart disease admissions and costing Australia $8.4 billion annually. Patients need

continued monitoring and appropriate ongoing management and support, including monitoring of risk factors, lifestyle modification and evidence-based medical treatments. Despite this, 1 in 3 patients a year after a heart attack are not taking medications, and even fewer have achieved targets such as blood pressure control, smoking cessation and adequate physical activity.

A national system that can effectively support heart attack patients after they leave hospital and maintain appropriate care is urgently needed. This requires strengthening primary care management by better integrating primary, acute and specialist care, and providing heart attack survivors with the support to better manage their conditions. Such a program could prevent up to one-quarter of all second heart attacks annually in Australia.

A secondary prevention quality improvement program, comparable to the successful National Integrated Diabetes Program, could comprise the following:

- Incentives for primary care to facilitate more regular and ongoing secondary prevention care for Australians living with heart disease as currently exist for diabetes, asthma, and cervical screening. The scheme would include practice and service incentive payment models and require the introduction of a dedicated secondary prevention of heart disease MBS item.
- Electronic quality improvement systems to facilitate patient recall, enable the recording and management of risk factors, and provide a mechanism for regular reporting on key progress indicators of heart attack survivors.
- A standardised secondary prevention resource for patients before they are discharged from hospital to help them navigate different care options, including cardiac rehabilitation, once back in the community. Ideally, the resource would also have the capacity to save and update essential personal health data, link to key websites and information about managing heart disease and potentially the patients' providers, including their GP.

A National Pulmonary Rehabilitation Program

Chronic Obstructive Pulmonary Disease (COPD) affects an increasing proportion of the Australian population and is the third leading contributor to disability-affected life-years from chronic disease. However, currently there are numerous barriers to effective pulmonary rehabilitation including limited access in regional and remote communities.

Evidence shows that pulmonary rehabilitation can be effectively delivered in a community setting and has proven health benefits in COPD, including reducing hospitalisations and symptoms and consequently healthcare costs associated with these. Effective rehabilitation can reduce the risk of hospitalisation by 78% and is highly cost effective, with the average cost of hospitalisation for COPD being between $4500 and $7800.

Investing in a national pulmonary rehabilitation program to increase access and facilitate service delivery, in particular across regional and remote communities, is needed to reduce the escalating burden of chronic obstructive pulmonary disease. Such a program would include:

- Support to well-developed accredited programs
- Community and GP education campaigns
- Training for community and hospital physiotherapists in pulmonary rehabilitation.

Conclusion

A health system that can that deliver the best care to all Australians needs to be based on careful consideration of what we know works and what doesn't, and be equipped to effectively and efficiently prevent and treat chronic disease on a national and significantly impactful scale. Such a system requires an integrated approach to preventing and treating chronic conditions, including community-based prevention interventions, primary and acute care, and the allied health profession, and to promote the long term financial sustainability of the Australian health system. It also requires forward thinking, an innovative approach and working in partnership across health sector to develop patient-focus health care solutions. By making the necessary shifts to current health care practices to adequately respond to the complex and ongoing needs of patients with chronic disease, we can help Australians, today and in the future, live healthier lives. The George Institute welcomes the opportunity to make this submission and the urgent reforms needed to build a sustainable 21st century health system.

About The George Institute for Global Health

The George Institute conducts targeted, innovative health research aimed at reducing the burden of leading causes of death and disability in Australia and around the world and to ensure all Australians have access to safe, effective treatments. For the past 16 years our research has influenced medical guidelines and changed ways of thinking about some of the most common medical treatments around the world. Since its establishment, The George Institute grown globally with offices in China, India and the United Kingdom, as well as retaining its presence in Australia, and has over 500 staff and 50 ongoing research projects. It has raised over $500 million for global health research, and is affiliated with the University of Sydney, Peking University Health Science Centre, and the University of Oxford. For the fourth year running The George Institute was listed in the SCImago Institutions Rankings as one of the world's top 10 research organisations for impact. In addition, the National Health and Medical Research Council's (NHMRC) 'Measuring Up Australia 2013' report ranked the George Institute first among Australian research organisations.

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