

## **AUSTRALIAN CHRONIC DISEASE PREVENTION ALLIANCE**



strokefoundation

### **Submission on the Australian Government Discussion Paper: Towards a National Primary Health Care Strategy**

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*The Australian Chronic Disease Prevention Alliance (ACDPA) is an alliance of five non-government health organisations who are working together in the primary prevention of chronic disease, with particular emphasis on the shared risk factors of poor nutrition, physical inactivity and overweight and obesity.*

*The members of the ACDPA are:*

- *Cancer Council Australia*
  - *Diabetes Australia*
  - *Kidney Health Australia*
  - *National Heart Foundation of Australia*
  - *The National Stroke Foundation*
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**27 February 2007**

## **1. Introduction**

The Australian Chronic Disease Prevention Alliance (ACDPA) is an alliance of five non-government health organisations who are working together in the primary prevention of chronic disease, with particular emphasis on the shared risk factors of poor nutrition, physical inactivity and overweight and obesity.

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ACDPA welcomes this opportunity to provide input to the development of a primary health care strategy for Australia which provides opportunities to improve health outcomes by enhancing the role of primary health care providers in the prevention and management of chronic disease.

The focus of this submission is on issues relating to enhancing preventative care and support of healthy lifestyles through the primary health care sector. This submission complements and supports submissions to the Taskforce from the individual member organisations of the ACDPA which also address other issues in more detail.

Nonetheless, ACDPA would like to highlight that nationally agreed approaches to improving health service provision for chronic disease already exist in the form of the National Service Improvement Frameworks (NSIF) developed under the National Chronic Disease Strategy. Frameworks currently exist for cancer,<sup>1</sup> heart, stroke and vascular disease,<sup>2</sup> and diabetes,<sup>3</sup> as well as for other chronic diseases. These frameworks are designed to encourage the delivery of more person-centred, equitable, timely, effective, affordable and cohesive health care and identify a number of opportunities where Australia might most usefully invest to reduce the impact of these chronic diseases, a number of which relate to the provision of primary health care. ACDPA is pleased that the principles and elements identified in the primary care strategy discussion paper largely reflect the principles embodied in these Frameworks and recommends that the Frameworks be used to guide the further development of the primary care strategy,

## **2. The importance of prevention**

ACDPA is strongly supportive of the current impetus to bring a greater focus on prevention to the health system. Cancer, cardiovascular disease, diabetes and renal failure together account for nearly 45% of the total burden of disease and injury in Australia.<sup>4</sup> This burden is expected to grow significantly in line with the aging of the population and increasing prevalence of shared chronic disease risk factors such as overweight and obesity, poor nutrition and physical inactivity. Health care expenditure for cancer, cardiovascular disease and diabetes is projected to nearly triple from \$14.4 billion in 2002/03 to \$41.3 billion in 2032/33.<sup>5</sup>

This burden is however largely preventable with nearly two thirds of the disease burden for cardiovascular disease and for diabetes and one third of the disease burden for cancer attributable to modifiable risk factors,<sup>4</sup> a number of which are common to all these diseases, as well as to chronic kidney disease. The most significant common risk factors for these diseases include overweight and obesity, physical inactivity, poor nutrition and tobacco smoking.

In order to address the increasing but largely preventable burden of chronic disease a reorientation of the health system and other systems towards health, illness prevention and health promotion must occur and must become embedded in our concept of “health care”.

Consequently ACDPA strongly commends the increased focus on prevention embodied in the National Health Reform Agenda and in the reform strategies being recommended by the National Health and Hospitals Reform Commission (NHHRC) and the National Preventative Health Taskforce (NPHTF). We believe it is essential for the primary care strategy to complement and support the reform strategies outlined by these bodies and we are pleased to see many of the principles underpinning these strategies, such as an increased focus on prevention and healthy lifestyle support, reflected in the primary health care strategy discussion paper

### **3. Greater focus on prevention, including support of healthy lifestyles**

Primary health care is a key component of a comprehensive chronic disease prevention strategy because it is the frontline of the health care system and the gateway to other health care services. Eighty-six percent of the Australian population visits a general practitioner (GP) each year, providing many opportunities for GPs to identify individuals at high risk of chronic disease and undertake opportunistic prevention interventions during consultations.<sup>6</sup>

While many GPs do provide preventative health care there is much scope for improvement. In 2005-06, GP interventions comprising counseling for nutrition, weight and exercise occurred at a rate of less than 5 per 100 encounters,<sup>7</sup> despite the fact that more than half the adult Australian population is overweight or obese.<sup>8</sup> Counseling relating to smoking and alcohol consumption was also low at 0.6 and 0.3 per 100 encounters<sup>7</sup> although nearly one in four adults smokes and 13% of adults consume alcohol at levels risky to their health.<sup>8</sup>

There are a number of factors that limit general practice capacity to establish and maintain effective preventative care services, including lack of time, competing priorities, workforce shortages, lack of support systems and remuneration issues.<sup>9</sup> These factors need to be adequately addressed if primary health care is to be reoriented to encourage and support the delivery of quality prevention and health promotion services.

In addition, the primary health care sector will play a significant part in the rollout of broader national prevention initiatives aimed at curbing rising obesity levels and reducing the prevalence of smoking and excessive alcohol consumption under the national preventative health strategy recommended by the NPHTF. It will be essential for systems to be in place to appropriately support and resource primary care practitioners to provide services that are integrated with national programs and initiatives and that are aligned with the messages of major social marketing campaigns.

### ***Enhancing primary health care to better support prevention activities***

Primary care could be enhanced to better support prevention activities by the adoption of a more systematic and proactive approach to implementing prevention interventions. This approach needs to be adopted both at a practice level and through the establishment of appropriate regional organizations such as the Divisions of Primary Care recommended by the NHHRC, to support primary health care practitioners in the delivery of prevention services. In particular primary health care practitioners will require systematic support to help them implement the primary care component of national prevention strategies and to align their activities to support social marketing campaign messages.

Key strategies include:

- Design and implementation of model best practice preventative care plans around known risk factors for chronic disease which primary health care practitioners could use to guide provision of preventative health services within their own practice.  
  
These plans would include elements such as a chronic disease health checks and risk assessment tools, guidelines for evidence-based interventions; development of a management plan; pathways for referrals for lifestyle and dietary advice, smoking cessation, exercise and weight management programs; needs of disadvantaged groups; patient registers and recall systems for patient follow up; and tracking of outcomes. These model plans would build on existing resources such as the SNAP (Smoking, Nutrition, Alcohol and Physical Activity) Framework, the Lifescripts program and the Royal Australian College of General Practitioner's Red and Green books, which provide guidelines for implementing preventative care in general practice.
- Provision of regional support for primary health care through 'Divisions of Primary Care', to assist in planning and co-ordination of regional primary care services in accordance with local needs, supporting local practitioners in implementing chronic disease prevention and management programs tailored to the needs of their practice population, and providing resources and training.
- Expansion of programs to support quality improvement at the practice level such as the Australian Primary Care Collaboratives (APCC) program. The APCC program is designed to assist GPs and primary health care providers work together to improve patient clinical outcomes, reduce lifestyle risk factors, help maintain good health for those with chronic and complex conditions and promote a culture of quality improvement.
- Remuneration arrangements that encourage the provision of preventative health interventions and encourage long term management of risk factors and chronic conditions and which include components linked to patient outcomes. Remuneration should include both fee- for-service and practice level elements

Fee-for- service elements could include a Medicare preventative care item covering either individual consultations, along the lines of the Healthy Kids Check or the Type 2 Diabetes Risk Evaluation Item, or a program of care. This should be available both for general

practitioners and for appropriately trained and qualified staff such as practice nurses, either directly or on a “for and on behalf of” basis.

In addition, practice level remuneration along the lines of the Practice Incentive Payments could be provided to support the implementation of systems to underpin the provision of more proactive preventative health care such as patient registers and recall arrangements and the supportive staff and infrastructure required to implement them. Reporting and accountability arrangements would need to be put in place, with a portion of the payment based on performance and outcomes.

- Better management of health information through the implementation of a national eHealth strategy including electronic patient health records to facilitate sharing of information across sectors and health professions which would assist in reducing fragmentation and duplication of services and assist in monitoring and reporting outcomes.
- Provision of adequate education and training for primary care practitioners in various aspects of preventative health care including provision of nutritional advice, behaviour modification counseling etc.

### **Enrolment of patients**

Voluntary enrolment of patients with specific chronic disease prevention and management needs in a single practice offers the potential to encourage a more proactive and coordinated approach to patient management by reducing fragmentation and duplication of service provision and by identifying target groups for appropriate interventions and linking them to particular health care providers for the course of an intervention strategy or treatment plan.

Patient enrolment would also allow effective monitoring and evaluation of preventative health initiatives for national reporting. Registers of patients within a practice with particular risk factors or chronic conditions which are the target of population-based preventative health programs would identify the target groups for implementation of appropriate interventions. Additional data covering patient health and demographic status, intervention strategies implemented and patient outcomes, would need to be collected for these groups of patients to meet national reporting requirements for the programs, supported by appropriate electronic health information management and data collection systems. This would be particularly important for interventions aimed at reducing obesity, where there is a need to build the evidence base on effective intervention strategies.

### ***Determining preventative care priorities***

Priority setting needs to take into account several factors including:

- a need to focus on conditions and risk factors that account for the greatest preventable burdens of chronic disease
- the availability of evidence-based and cost-effective prevention strategies to reduce the burden of chronic disease although recognizing that particularly in the area of obesity, there is a need to build the evidence base for what works.

- equity for high-risk and socially disadvantaged groups including Aboriginal and Torres Strait Islander people and those living in rural and remote areas.

#### **4. *Accessibility and disadvantaged groups***

Social gradients are evident for many of the major chronic diseases and their risk factors with Australians with low socio-economic status more likely to have shorter lives, higher levels of disease risk factors and increased disease incidence and prevalence than those with more social and economic advantages. There is also evidence that uptake of preventative care (screening, early detection and intervention for risk factors) is lower amongst disadvantaged groups in the community.<sup>10</sup> Disadvantaged groups are also more likely to be overweight or obese, exercise less, eat less fruit and smoke than those of higher socio-economic status.<sup>11</sup>

Aboriginal and Torres Strait Islander people in particular typically experience significantly more ill health and disease risk factor prevalence than other Australians. People living in rural and remote areas also tend to have shorter lives and higher levels of illness and disease risk factors than those in major cities. Although migrant populations have relatively good health,<sup>11</sup> cultural and linguistic barriers can reduce their access to preventative health services.

In order to address the inequalities of health and access experienced by these groups, the development of tailored programs will be required which are culturally sensitive and which address the prevalent risk factor profiles, health requirements and access issues of each group. Arrangements for monitoring and evaluation of these programs need to be an integral and ‘a priori’ component of these programs.

Organisations providing regional support for primary health care, such as Divisions of General Practice, have a role in defining the population profile of their region to identify disadvantaged groups, planning appropriate preventative health care services and working with local primary health care professionals to support the delivery of programs, including practitioner education and training, to meet local preventative health care needs. Organisations and health professionals in disadvantaged areas will need to have adequate funding, for example through grant funding and practice incentive payments, to support programs designed to address the more concentrated prevention and health care needs of their local population.

More specifically, to support the needs of Aboriginal and Torres Strait Islander peoples, wider uptake of the existing Medicare item for health checks for indigenous people should be promoted. Uptake has been limited for the existing items for delivery of adult checks for indigenous people aged 15-54 years as well as the annual health check for those aged 55 years.

The use of special PBS arrangements (SPBSA) for the supply of PBS medicines to remote Aboriginal and Torres Strait Islander Health services, should also be extended to urban areas. These arrangements were successful in improving access to medicines for indigenous people with PBS expenditure on indigenous people increasing by \$36.5 million between 2000–01 and 2002–03.

In regional and remote areas where health care services are scarce telemedicine has the potential to provide a mechanism for the delivery of some preventative health care services or

for the provision of peer support and advice for isolated practitioners. There is also scope for workforce flexibility to address service provision in areas where doctors are unavailable. Services in these areas could be provided, with adequate training, by practice nurses or other health professionals. These measures would need to be supported by access to Medicare benefits for allied health professionals providing services under these circumstances, as well as for consultations conducted by telemedicine.

Issues of accessibility and equity for patients living in rural and remote regions are compounded when patients are required to travel to receive appropriate care. Current patient transport assistance schemes are generally inadequate and vary considerably across the country.

## **5. Patient-centred care**

Patient enrolment in a single practice offers the potential to improve patient-centred care by encouraging a more proactive, co-ordinated and integrated approach to patient management. This measure has the potential to reduce fragmentation and duplication of services, facilitate continuity of care and encourage the proactive implementation of chronic disease prevention and care management plans tailored to individual patient needs.

Target groups that might benefit from enrolment for preventative health interventions, active clinical care and service co-ordination include

- indigenous people living in urban as well as rural and remote areas
- populations with low socio-economic status, CALD, and people living in rural and remote areas
- people at high risk of developing chronic disease, those with existing disease and those with co-morbidities and complex care needs

Electronic patient health records, with access provided by patient consent, would also be a valuable aid in enhancing patient-centred and coordinated health care by allowing the sharing of information across different service providers and sectors to support patient management, again reducing fragmentation and duplication of services and reducing the potential for adverse events.

These measures would need to be underpinned at a national level by development of compatible data collection and management systems and within practices by sufficient capacity in information technology systems and staff resources (including appropriately trained nurses) to provide implementation support for preventative care programs and care co-ordination.

## **6. Quality of care and quality improvement programs**

### **Quality improvement**

Programs to support quality improvement and change management at the practice level such as the Australian Primary Care Collaboratives (APCC) program should be expanded to both extend practice coverage and include a greater focus on management of chronic disease risk factors. The APCC program is designed to assist GPs and primary health care providers work together to improve patient clinical outcomes, reduce lifestyle risk factors, help maintain good health for

those with chronic and complex conditions and promote a culture of quality improvement. Support services are provided through the Divisions of General Practice. Promising results have been achieved in the management of patients with diabetes and coronary heart disease.<sup>12</sup> A key aspect of the program has been the establishment of performance indicators in these areas for monitoring progress and reporting and the provision of training

The establishment of performance indicators that can be applied at the practice level, underpinned by incentive arrangements, is critical to driving improvements in chronic disease prevention and management. A cohesive set of performance indicators relating to chronic disease risk factor reduction, as well as chronic disease care, needs to be developed and implemented for all general practices in Australia.

Performance indicators could include

- Proportion of general practices using register / recall systems for people at high risk of developing chronic disease
- Proportion of people aged 45-74 who have had a chronic disease risk assessment within the past five years
- Percentage of adult patients with smoking status, alcohol intake, physical activity, weight, height and waist circumference (SNAP risk factors) recorded in their medical records
- Percentage of patients at risk (identified from SNAP risk factors) offered education or referral and the proportion of those that take it up
- Percentage of patients with identified risk factors that have shown a reduction in their level of risk, such as smoking cessation, weight loss, improved nutrition and increased physical activity
- Percentage of adult patients who have been tested/screened for specific disease indicators eg blood pressure checks, blood sugar tests, pap smears

Implementation of quality improvement programs needs to be rolled out systematically across primary care, underpinned by advice, support and assistance provided through regional primary care support organisations or program support field officers.

Incentive payments should be available for program implementation, quality of care provided and patient outcomes in accordance with agreed goals and targets.

### **Enhancing the research culture in primary care**

To improve the current research culture in primary care there is a need to better support health professionals to participate in innovation that is accessible to them. Action based research and linking of health professionals to experienced researchers who can mentor and assist clinicians to undertake research should be considered as avenues to encourage research within general practice. Partnership models should be developed between academic researchers and health professionals to have an impact on primary health care.

Enhanced research at the primary care level is particularly important in the area of obesity control where there is a need to build the evidence base on effective interventions through a “learning by doing” approach.



## **7. Better health information management**

The use of shared electronic patient health records and data linkage is needed to reduce duplication and improve coordination of care for patients across multiple providers. The development of universal data sets is critical in allowing information to be shared effectively.

The existing work of National eHealth Transition Authority (NEHTA) needs to be supported and informed by actual practice needs, involving clinicians in this work to make sure it is relevant and delivers what is useful to assist in coordinated care.

Progress in implementing a national eHealth strategy needs to be accelerated, to avoid increasing numbers of primary health care professionals investing in their own stand-alone or locally networked eHealth systems, decreasing their preparedness to sign on to a new, national system.

eHealth capabilities would also support improved data collection and reporting providing a mechanism for linking service outcomes and delivery for the purposes of program evaluation and allocation of incentive and outcomes based remuneration.

## **8. Responding to community needs**

Provision of regional support mechanisms for primary health care services would provide an important mechanism for responding to the chronic disease prevention and health care needs of local communities. This support could be provided as recommended by the NHHRC through regional Divisions of Primary Care.

The role of these regional support organizations would include:

- To assist in planning and co-ordination of regional primary care services in accordance with local needs to provide integrated service delivery
- To identify and develop programs to address the chronic disease prevention and health care needs of the particular population groups within the local community and provide implementation advice and support to primary health care providers for their implementation. This may entail adapting national programs to local resources and requirements
- To provide or arrange education and training to address gaps in skills shortages amongst local primary health care providers.
- To provide advice and support to assist local primary health care practitioners with infrastructure improvements that may be required to implement programs such as electronic patient health records or telemedicine approaches.

Regional support organisations would need to have adequate representation and consultation arrangements in place to ensure the alignment of their activities with local needs and views.

Responsiveness to community needs can also be encouraged at the practice level, based on profiling of the local practice population and the implementation of appropriate proactive chronic disease prevention and management initiatives eg targeting Aboriginal and Torres Strait Islander people, people who are disadvantaged socially or economically or particular CALD populations. Practice incentive payments or grants linked to the patient profile of the practice and outcomes could be provided. Payments at a practice rather than individual practitioner level would allow practices to invest in the resources they need most to address the disease prevention needs of the patient population, whether that be staff, information technology or other infrastructure

## **9. Workforce**

The increased emphasis on prevention activities relating to obesity under the National Preventative Health Strategy is likely to require capacity development for particular sectors of the primary health care workforce and other sectors to provide services in areas such as dietary and lifestyle advice, behavior modification counseling and weight management, exercise and smoking cessation programs.

The roles of practice nurses and other allied health professionals could be expanded to provide patient support in these areas, where proven to be effective, such as for lifestyle advice or secondary prevention for people with chronic disease. Remuneration for such services by practice nurses could be provided through the general practitioner on a “for and on behalf of basis”.

Increasing participation by primary care practitioners in multidisciplinary teams with specialists will also add to the workload of primary care practitioners and it will be important to ensure arrangements are in place to facilitate their participation.

Increased emphasis on prevention in primary care will also require preventative health care competencies to be embedded into education and training programs for primary health care practitioners.

## **10. Fiscal sustainability**

With expected increases in the cost of chronic disease to the health system as a result of the increasing prevalence of risk factors such as obesity, poor nutrition and physical inactivity, investment in prevention and early detection of chronic disease is a critical priority because of its potential to deliver long-term economic gains and reduce strain on the health system.

Outcomes based funding arrangements should also be adopted wherever possible as they are likely to improve health outcomes and be highly cost-effective.

Implementation of an eHealth strategy should also be a key priority. In addition to providing benefits for patients through improved care co-ordination and information sharing across multiple service providers, implementation of an eHealth strategy offers the potential to curb health care costs by reducing duplication of services and providing data to support outcomes based evaluations of services.

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