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## CONFERENCE ABSTRACT

### Physicians call for integrated cross sector complex care in Australia

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**Introduction:** This presentation proposes health reform policy changes (developed with consumer input) to enable an integrated approach for the management of patients with chronic multi-morbidities to address these problems. An innovative feature of this new proposed approach is it better develops and defines the role of consultant physician expertise which has hitherto either been overlooked in previous models of health care integration (e.g. Health Care Homes) or underutilised. Another innovative feature is the call for use of better integrated funding sources.

**Policy context and objective:** The next five-year national health agreement (NHA) asks Commonwealth and state governments to 'integrate systems and services to improve health outcomes for Australians'. The present system, based on the fee for service system (for GPs and other private healthcare practitioners) and activity-based funding of public hospitals, leads to patients with multi-morbidities accessing services from multiple providers in different locations on an episodic basis. Patients may not be referred to the right services, there can be unnecessary and wasteful repetition of services (for example, imaging and pathology); prescribing related issues; and conflicting advice from different providers.

Policy needs to support:

- The more effective provision of substructure for specialists to diagnose, treat, co-manage care for these patients, collaborating with GPs;
- Connecting mechanisms for specialists to work in community-based ambulatory settings.
- The availability of suitable facilities in the community for patients with chronic, complex and multiple healthcare needs.

**Targeted population:** A Model of Chronic Care Management is proposed for patients known to incur high system costs due to cardio-vascular related multi-morbidities.

**Highlights:** The Model provides more opportunities for specialists to collaborate with GPs in an ambulatory care setting, managing such patients and preventing chronic disease exacerbations with other members of a multidisciplinary team which may include specialist nurses and allied health practitioners. This could occur in accessible community settings or through 'virtual' collaborations.

One key change should be strengthening the linkages between Commonwealth-funded Primary Health Networks (PHNs) and State Government local health and hospital networks, to enable jointly planned and localised regional healthcare. Another highlight is that participating clinicians

would be compensated under a non-fee for service basis (specifically through a salary rather than on an episodic fee basis).

**Comments on transferability:** The model can be adapted to address other types of multi-morbidities, such as in geriatric care or CALD groups. The model creates long-term roles for specialist physicians, nurses and allied health practitioners.

**Conclusions:** Models of care should be patient-centred, inclusive of multiple providers and settings, and better support the prevention of exacerbations of chronic disease.

Health policy reform must allow for better configurations of universal care service funding processes for integrated primary care teams, with fewer restrictions on site of service delivery. Integrating consultant physician expertise, trained in complex chronic care would improve the timely access to care for those who would most benefit.