Submission to the Standing Committee on Health

Inquiry into Chronic Disease Prevention and Management in Primary Health Care

ABOUT US

Arthritis Australia

Arthritis Australia is the peak arthritis consumer organisation in Australia and is supported by affiliate offices in ACT, New South Wales, Northern Territory, Queensland, South Australia, Tasmania and Western Australia.

Arthritis Australia provides support and information to people with arthritis as well as their family and friends. It promotes awareness of the challenges facing people with arthritis across the community, and advocates on behalf of consumers to leaders in business, industry and government.

Australian Rheumatology Association (ARA)

The ARA is an association of rheumatologists in Australia that is a specialty society of the Royal Australasian College of Physicians.

Rheumatologists are specialist physicians with particular expertise in the diagnosis and holistic management of diseases that affect joints, muscles and bones.

They treat all forms of arthritis, autoimmune connective tissue disease, spinal and soft tissue disorders and certain metabolic bone disorders, such as osteoporosis and chronic musculoskeletal pain syndromes.

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Summary of key points

Arthritis is one of the most common, costly and disabling chronic diseases in Australia affecting 3.3 million people[1] and costing the health and welfare systems more than $5.6 billion a year.[1 2] Arthritis and other musculoskeletal conditions are one of nine National Health Priority Areas.

There is considerable scope to improve arthritis prevention and management in primary care, as recommended in the *Time to Move: Arthritis* strategy (See section 2). These recommendations align with strategies for improving prevention and care for other chronic conditions. In the context of this Inquiry, the key approaches of relevance from the Strategy are:

- Support primary health care practitioners to assist people with or at risk of chronic disease to adopt healthy lifestyles
- Support early diagnosis and intervention to slow or prevent chronic disease progression
- Increase support for people to self-manage their condition
- Improve access to multidisciplinary care in line with an individual's clinical needs, including care coordination for more severe and complex cases
- Build workforce capacity to better manage people with chronic conditions
- Support quality improvement in primary care through better data collection and research.

Recommendations

Based on the *Time to Move: Arthritis* recommendations, the primary care based strategies which offer the greatest scope for improving care for people with arthritis are:

- **Improve conservative (non-surgical) management of osteoarthritis in primary care.**

  This could save the health system more than $156 million[17] a year in reduced joint replacements alone, as well as achieving better health, reduced disability and increased workforce retention for people living with the condition.

  A couple of models are currently being trialled/developed to determine the best way to deliver conservative management in primary care (See Section 3.1).

  Priority actions:

  - Provide funding to support the development and testing of models to deliver effective conservative management of osteoarthritis in primary care.

- **Support early diagnosis and urgent referral to specialist care for inflammatory forms of arthritis such as rheumatoid arthritis and juvenile idiopathic arthritis**

  Early diagnosis and treatment of these conditions are critical to prevent or delay joint damage, increase the chance of disease remission and achieve good long-term outcomes.

  Information and educational materials and programs for primary care practitioners and internet tools such as Health Pathways and Map of Medicine can help to improve timely diagnosis and management of these conditions. (See section 3.2.1).

  Priority actions:

  - Primary Health Networks to develop/provide tools for local clinicians to assist them in diagnosis and management of chronic conditions, including appropriate referral pathways

- Provide funding support to NGOs and professional associations to develop and deliver information and education materials to primary health care practitioners to enhance chronic disease management.

- **Improve access to multidisciplinary care for severe and complex forms of arthritis**

  This will require building appropriately skilled multidisciplinary teams in primary care and improving funding of allied health services, including reviewing MBS Chronic Disease Management (CDM) items.

  Nurses in general and specialist practice can support multidisciplinary care by providing patient education and support and care coordination and improving linkages between primary and secondary health care services (see Sections 3.2.2 and 5.3).

  Priority actions:

  - Review MBS CDM items to increase access to allied health services, in line with clinical need
  - Enhance funding for nurses in general practice and extend MBS items to nurses in specialist practice.

- **Provide outreach clinics and telehealth to improve access to specialist services in rural areas and support local primary health care practitioners**

  The Australian Rural Rheumatology Service is a rural outreach and education service which has improved access to specialist care for people with arthritis while building capacity to manage these conditions within local health services (see 3.2.3). An important aspect of the program is its focus on education and capacity building of local health care professionals. The service could be enhanced by including outreach services by specialised allied health practitioners.

  Priority actions:

  - Support increased funding for rural outreach and telehealth services, including by allied health professionals.

- **Improve data collection in primary care to increase efficiency in chronic disease prevention and management**

  Accurate, reliable and timely information is required to assist in improving quality, effectiveness and outcomes for chronic disease management in primary health care.

  Priority actions:

  - Prioritise and incentivise uptake and effective use of electronic health records (the myHealth Record) by and for people with chronic conditions.

1. Introduction

Arthritis Australia and the Australian Rheumatology Association welcome the opportunity to provide a submission to the House of Representatives Standing Committee on Health inquiry into chronic disease prevention and management in primary health care. The comments and examples provided relate primarily to arthritis, but reflect common issues and possible solutions that are relevant across chronic conditions.

There are over 100 different types of arthritis, affecting people of all ages. The most common types are osteoarthritis (OA), rheumatoid arthritis (RA) and, in children, juvenile idiopathic arthritis (JIA). OA is a degenerative joint disease, while RA and JIA are inflammatory, autoimmune forms of arthritis. These three forms of arthritis are the focus of the arthritis and musculoskeletal conditions National Health Priority Area.

Arthritis is one of the most common, disabling and costly chronic diseases in Australia (see figures 1-3), affecting more than 3 million people and costing the health system well over $4.3 billion a year.[1]

Arthritis is also a leading cause of disability and early retirement in Australia. Arthritis costs over $1.3 billion a year in Disability Support Pension payments[2] and over $9.4 billion in lost GDP due to early retirement.[3]

These costs could be substantially reduced by adopting prevention strategies and providing better primary care for people with arthritis.

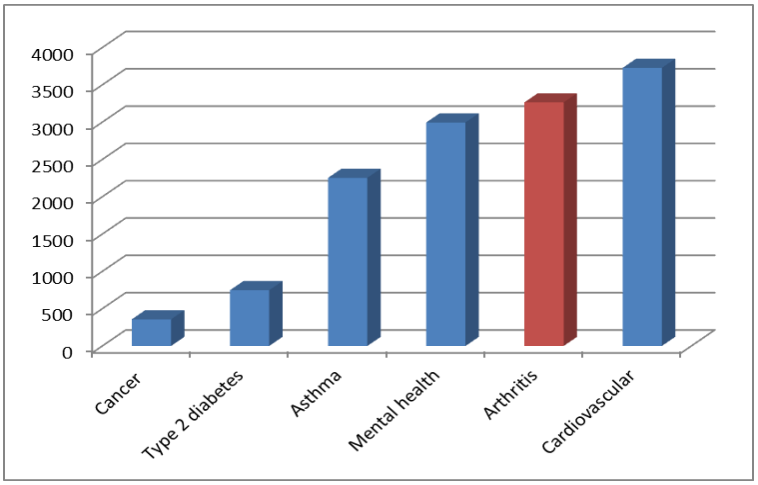
Contrary to popular perception, arthritis is not an inevitable part of ageing that must be endured, and much can be done to prevent and better manage the condition.

Up to 70 per cent of OA is preventable by reducing overweight and obesity[4] and preventing joint injuries,[5] while smoking is a major risk factor for developing RA[6]. Better care meanwhile can slow arthritis progression, reduce disability and help to preserve independence, quality of life and workforce participation. It can also reduce demand for joint replacements, which currently cost the health system over $2 billion a year.[7]

There is substantial scope to improve care for people with arthritis in Australia through improved chronic disease prevention and management strategies. Currently, up to 57% of Australians with OA, the most common form of arthritis, do not receive appropriate care,[8] while GPs report dissatisfaction with the care they are able to provide.[9] Early diagnosis and treatment are critical for RA and JIA, yet significant delays in diagnosis are common.[10]

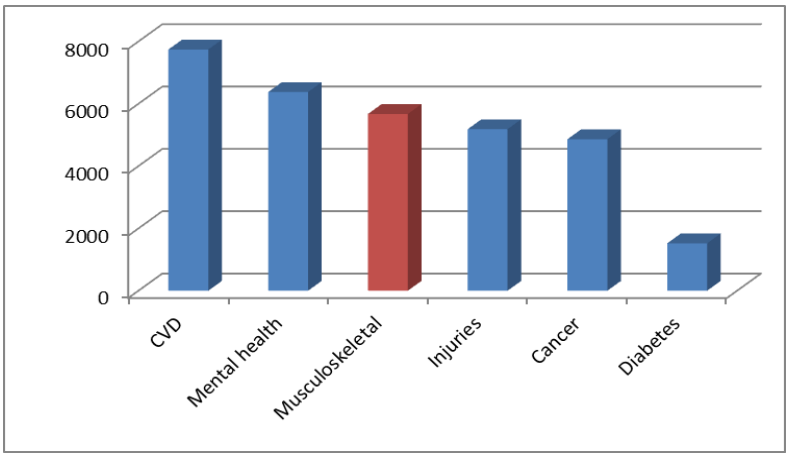
In addition, two in three people with arthritis report they are faring badly with their condition.[11] Limited services, inequity of access, delays in diagnosis and treatment, limited access to multidisciplinary care, fragmented care, inadequate information and support for self-management, lack of psychosocial support and a heavy financial burden are commonly reported problems.

Figure 1: Prevalence of major chronic conditions in Australia 2011/12 (000's people)



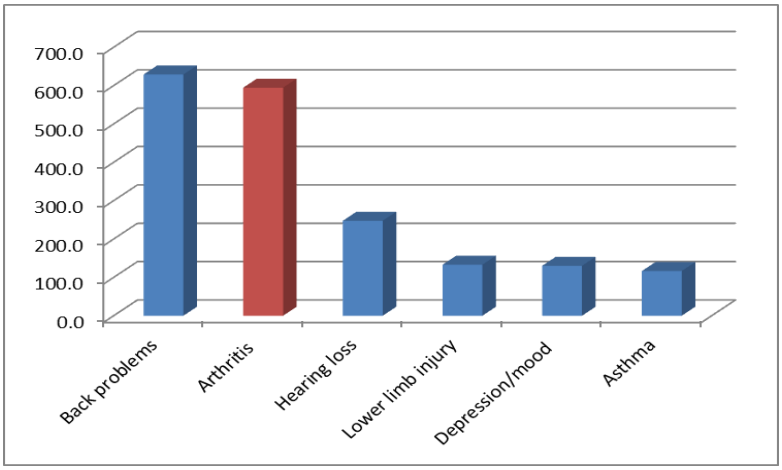
Source: Australian Health Survey 2011/12

Figure 2: Health system expenditure on National Health Priority Areas by disease group, Australia, 2008/09: top five, plus diabetes ($ million)



Source AIHW Health system expenditure on cancer 2008/09

Figure 3: Most common causes of disability, Australia 2009 (000's people)



Source: ABS Survey of disability ageing and carers 2009

2. Time to Move: Arthritis strategy

The *Time to Move: Arthritis* strategy, launched in 2014, provides a range of solutions for delivering better care for people with arthritis across the spectrum of intervention from prevention to advanced disease.[12]

The recommendations of the strategy are highly relevant to primary care and also align with recommendations for improving care for other chronic conditions. The key recommendations are as follows:

- **Increase public, health practitioner and policymaker awareness and understanding of arthritis and opportunities for prevention and improved management.** Few people are aware that up to 70% of osteoarthritis is preventable by reducing overweight and obesity and preventing joint injuries, while smoking is a major risk factor for developing rheumatoid arthritis. Chronic disease prevention strategies that address obesity, physical inactivity, smoking and excessive alcohol consumption are as relevant for arthritis as for other chronic conditions.

- **Support lifestyle modification to prevent arthritis and to help people with arthritis to manage their condition.** In addition to reducing the risk of developing arthritis, adopting a healthy lifestyle, especially weight loss and exercise, is important in managing most forms of arthritis. Primary care has an important role to play in supporting lifestyle modification for people with or at risk of chronic disease.

- **Support early diagnosis and intervention by supporting improved education of primary health care professionals.** This is especially important for inflammatory, autoimmune forms of arthritis, such as RA, where early aggressive treatment can increase the chance of remission and improve long term outcomes. Earlier intervention for people with osteoarthritis is also important to help them better manage symptoms and delay disease progression. Effective early management of arthritis can also reduce the risk, and improve the management of associated comorbidities such as cardiovascular disease and diabetes, because the pain of arthritis can be a major barrier to physical activity. Uncontrolled inflammation itself also increases the risk of cardiovascular disease.

- **Improve information, education and support for people to self-manage their condition**. This recommendation includes increasing the use of nurses (both in general and specialist practice) and/or other allied health professionals to provide patient education, support and, for more complex cases, care coordination. It also includes referral to arthritis state and territory organisations for access to information resources, self-management education and support groups.

- **Provide equitable and timely access to multidisciplinary care for people with severe or inflammatory arthritis.** This includes improving access to appropriately skilled multidisciplinary teams in primary care both in the private and public sector and the development of improved incentives/funding models to support the delivery of multidisciplinary care in the private sector. Funding for allied health visits under existing

MBS Chronic Disease Management items is inadequate for people with severe arthritis who may need to see a range of health professionals to effectively manage their condition, including physiotherapists, occupational therapists, podiatrists, dietitians and psychologists. The recommendation also includes improving access for people in rural and underserviced areas by using outreach clinics, with additional support through telehealth.

- **Support best practice treatment and care for arthritis.** Of particular relevance to primary care, weight loss, muscle strengthening and pain management strategies for people with severe OA have been shown to significantly reduce the disability associated with the condition as well as reducing demand for expensive joint replacements. However, there is very little uptake of these non-surgical management strategies in Australia.
- **Build health workforce capacity to better manage people with arthritis.** This recommendation includes developing information and education materials and tools, eg decision support tools and care pathways such as Health Pathways[1] and Map of Medicine[2] for GPs, specialists, nurses and allied health practitioners.
- **Support quality improvement in arthritis care** through better data collection and increased research funding.

3. Examples of best practice prevention and management

3.1 Improving management of osteoarthritis in primary health care

Optimal management of osteoarthritis at all stages entails a combination of pharmacological and non-pharmacological modalities, usually referred to as conservative management. Non-pharmacological interventions include patient education and self-management, weight loss, exercise and physical therapy.

There is particularly strong evidence for the benefits of exercise and weight loss in osteoarthritis. Weight loss of more than 5% significantly improves the pain and disability of osteoarthritis,[13] with a 9% improvement in symptoms for every 1% of body fat shed.[14] The benefits of exercise are similar to those attained with analgesics and non-steroidal anti-inflammatory medications, but with fewer side effects.[15]

Despite this evidence, management of OA in Australia is largely palliative, with a focus on advanced disease and surgery. Typically, treatment is limited to the use of analgesic and/or anti-inflammatory medications to reduce symptoms until the condition worsens, at which point the patient is referred for a joint replacement.[16]

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[1] Health Pathways provides an online health information portal for primary care clinicians to use at the point of care; it also includes a guide to local resources. http://www.healthpathwayscommunity.org/About.aspx , viewed 14 August 2015

[2] Map of Medicine is a collection of evidence-based, practice-informed care maps that connect knowledge and services around a clinical condition and can be customised to reflect local needs and practices. http://mapofmedicine.com/, viewed 14 August 2015

While joint replacement is a very effective treatment, it is also invasive and expensive for both the health system and the individual, with the cost for a single procedure averaging $25,000. The total cost of knee and hip replacements for OA is currently more than $2 billion annually and this cost is increasing at a rate of more than $80 million a year.[7]

Effective conservative management can delay or avoid the need for joint replacement surgery in some people with osteoarthritis. Evidence from hospital based programs and programs run by private health insurers (see below) shows targeted conservative management programs for people with severe OA can reduce demand for joint replacements by over 10%, with the potential to save the health system well over $100 million dollars annually.

Even greater benefits could be achieved by improving conservative management of people with OA in the primary care sector. The most effective and equitable model for delivery is not yet clear but a couple of models are currently being trialled/developed by the NSW Agency for Clinical Innovation and the PARTNER project (see below).

3.1.1 Osteoarthritis Chronic Care Program (OACCP)

In NSW, the Osteoarthritis Chronic Care Program (OACCP) is offered in some hospitals for people on joint replacement waiting lists. The program offers conservative management interventions, including weight loss and exercise, to help people manage their symptoms while they await surgery. Similar programs are run in some other States.

As part of the OACCP, a musculoskeletal coordinator, in conjunction with a multidisciplinary team, assesses individuals and links them with relevant team members, who then provide care in accordance with the individual's needs.

As a result of the program, 11% of participants awaiting knee replacement and 9% of those awaiting hip replacement have been removed from the waiting list because they no longer require surgery. A similar pilot program in Victoria found 27% of those managed conservatively no longer required surgery.

Additional benefits include reduced surgery waiting times for patients, more appropriate prioritisation of surgery in line with clinical need and reduced bed days for those who do undergo surgery.

If this program was implemented nationally, the reduction in joint replacement costs would range from $156 million in the first year to around $430 million by 2032.[17]

The NSW Agency for Clinical Innovation is currently implementing a Primary Health Initiative based on the OACCP program, and including other musculoskeletal conditions, to test whether a similar program in primary care can achieve comparable results. This initiative is based on providing a local care co-ordinator linked to a primary health network to engage with local health care providers and co-ordinate care for people with severe OA and other musculoskeletal conditions. The program is being trialled in three Medicare Locals (now Primary Health Networks) in NSW.

3.1.2 Osteoarthritis Healthy Weight for Life program – Private Health Insurers

A number of private health insurers are offering the *Osteoarthritis Healthy Weight for Life*[18] program to members identified by their GP as being at high risk of joint replacement surgery within two years, with the aim of reducing demand for joint replacements. They have an incentive to do so because joint replacements are the most expensive line item for most private health insurers in Australia, accounting for around 10% of outlays for hospital services.[19]

This program, delivered through a commercial third party (Prima Health Solutions Pty Ltd) is a structured, remotely delivered 18 week knee and hip arthritis disease management program that integrates weight loss, muscle strengthening and exercise; pain management strategies; and monitoring and engagement strategies to help people manage their OA. The cost of the program is around $750 per participant compared to an average cost of $25,000 for a joint replacement, so avoiding just three joint replacements would cover the costs of the program for 100 members.

Reporting on the outcomes of the program, a Bupa representative advised that it reduced key OA symptoms and limitations in participants by close to 50% of that achieved by joint replacement surgery in patients with similar profiles. He estimated that there was a 20% reduction in joint replacement surgery as a result of the program, providing a return on investment of nearly 4:1. If implemented nationally, this would represent millions of dollars of benefit nationally.[20]

While this approach is yielding substantial benefits for insurers and people with private health insurance, funded participation is not available for people without health insurance.

3.1.3 PARTNER project

The PARTNER project currently underway aims to develop and evaluate the best model to support improved conservative management of OA in primary health care, targeting the general practitioner and patient. For the general practitioner, the model will include education, electronic medical record decision support, and feedback to enhance conservative non-pharmacological management and reduce inappropriate surgical referral. For the patient, it involves self-management support targeting exercise and weight loss, including referral to the *Osteoarthritis Healthy Weight for Life Program* where appropriate. The project will include a randomised controlled trial to assess the benefits of the model.

The PARTNER project is expected to be completed by 2018, subject to funding availability. It will allow the clinical and economic benefits of implementing conservative management of OA in primary care in Australia to be quantified and disseminated to key stakeholders with the longer-term objective of implementing the model of care nationally across primary care settings.

3.1.4 MyJointPain.org.au

MyJointPain.org.au is a world first, evidence based website designed to assist people with osteoarthritis to self-manage their condition. Developed by Arthritis Australia in partnership with Bupa Health Foundation and others, the website provides an excellent example of the potential to use digital tools and resources to support improved care for people with chronic conditions.

MyJointPain.org.au provides users with a screening tool, information about arthritis management and treatments, and a tailored action plan with tracking tools and links to local healthcare providers. Users can print the action plan to take along to their GP and/or other healthcare providers to discuss their management options.

Initially launched in 2013, an evaluation of the website after 12 months found a significant improvement in self-management, weight reduction and physical activity amongst users. The website is currently being enhanced to make it more user-friendly and suitable for use on a range of different devices, in line with evaluation findings and internet usage trends. There is also scope to encourage GPs and other primary health care professionals to use the website to assist in care planning and self-management support for their patients with OA.

3.2 Improving management of inflammatory arthritis

There are an estimated one million Australians with various inflammatory forms of arthritis, such as RA and JIA.

RA is the most common form of inflammatory arthritis. It is a serious, chronic autoimmune condition affecting nearly half a million Australians. It causes pain, fatigue, joint swelling and stiffness. If poorly treated, the condition can be highly disabling because it causes progressive and irreversible joint damage and loss of function.

Although managed primarily by specialists in secondary care, primary health care practitioners play an important role in early detection and diagnosis of RA and other inflammatory forms of arthritis as well as in ongoing monitoring and management of the condition and the patient's overall health.

3.2.1 Support early diagnosis and treatment

Early diagnosis and treatment of RA and JIA (as well as other forms of inflammatory arthritis) are critical to prevent or delay joint damage, increase the chance of disease remission and achieve good long-term outcomes, including the reduction of disability. Yet delays in diagnosing these conditions in Australia are common and timely access to the specialist care required for effective treatment is limited, especially in rural and remote areas.

Evidence indicates that the following interventions in primary care may assist in improving early diagnosis and treatment.

- Educational strategies for primary care practitioners have reported success in terms of improving practitioners' awareness, knowledge and ability to detect inflammatory arthritis, and increasing referrals to rheumatologists. Screening tools such as self-administered patient questionnaires and referral guidelines have also been used to increase timely diagnosis and referral of those suspected of having RA.[21]

- Internet-based programs and tools such as Health Pathways and Map of Medicine, can provide easily accessible information to GPs and allied health practitioners on diagnosing and managing inflammatory conditions such as RA and JIA, including information on

local services and referral pathways. These tools were being implemented by some Medicare Locals prior to the shift to Primary Health Networks.

- 'Early arthritis clinics' – specialist clinics for the early assessment of patients with inflammatory arthritis – have been successful in reducing delays in initiating treatment for RA. These clinics offer a more structured approach to triage, assessment and referral of patients with inflammatory arthritis.[22] [23] Some hospital-based early arthritis clinics operate in Australia, but there is scope for creating clinics at the community level as well. In addition, innovative triage models such as telephone hotlines or online clinics could be used.

- Increased use of specialist rheumatology nurses (or other appropriately trained health practitioners, such as GPs and allied health professionals) to undertake triage for referral to rheumatologists. This may be a particularly useful strategy in rural and remote or other underserviced areas in Australia where appropriately trained nurses could also assist in the delivery of supportive care. In one study, GPs and rheumatology nurses who had been trained in assessing early inflammatory arthritis for referral, achieved accuracy approaching that of a group of experienced rheumatologists.[24] In another UK study, a nurse-led early arthritis clinic reduced the average delay in access to specialised rheumatology care from three months to three weeks.[25]

3.2.2 Improve access to multidisciplinary care

Multidisciplinary team care is a key principle for the management of RA and other inflammatory forms of arthritis as it allows the best possible care to be provided, reducing patients' risk of developing the complications and disability associated with these conditions. However, multidisciplinary team care for inflammatory arthritis is not widely available in Australia, particularly in rural and remote areas and in the private sector, in which the majority of rheumatology practice takes place. Also, specialists cannot develop care plans under MBS Chronic Disease Management items, as these are only available to GPs.

Referral to allied health services at the primary care level is also limited. In 2008–09, GP referrals to allied health were made at a rate of only 2.1 per 100 RA problems managed, while 2007–08 data show that only 8.6 percent of people with RA reported seeking help from an allied health professional in the previous 12 months. The uptake of managed care plans by people with RA is unknown.[26].

In addition to limited referrals, the cost of accessing allied health practitioners in the private sector is a major barrier to the uptake of multidisciplinary care for people with these conditions. Current CDM Medicare items are limited to just five per year. This number is inadequate to meet the range of allied health services that a person with RA is likely to require for optimal care. The current CDM funding arrangements need to be reviewed to allow them to be more effectively support optimal management of these complex and debilitating conditions.

Interventions which are likely to assist with the delivery of multidisciplinary care include:

- Use care coordinators. Locally and internationally, care coordination has demonstrated clinical and economic benefits in a range of musculoskeletal and chronic conditions.[27 28]

- The use of specialist nurses to provide care coordination as well as patient education and other elements of monitoring and care has also been shown to be effective in enhancing continuity of care for people with severe RA.[29] Specialist nurses in rheumatology have been found to improve patient outcomes and reduce costs in both primary and specialist care.[30] Specialist nurses could be employed by a practice or group of practices or linked to a Primary Health Network where appropriate.

- Workforce capacity building to provide improved access to appropriately qualified multidisciplinary teams. This will require educational strategies for allied health practitioners to increase their confidence in managing RA and other inflammatory forms of arthritis. An example is the RAP-eL online educational program which provides physiotherapists with essential disease-specific knowledge and clinical practice strategies to manage people with RA.[31]

- Enhanced funding arrangements for team based care which support access to clinically effective and cost-effective care.

- Arranging 'one-stop' multidisciplinary clinics providing coordinated appointments with different service providers. This model would make it easier to access multidisciplinary care, would facilitate communication across service providers, and is similar to the model recommended in the Service Model for Community Based Musculoskeletal Health released recently in Western Australia.[28] Clinics could be hospital-based or community-based, with the latter facilitated by Primary Health Networks. Telehealth and other outreach options could be used to extend services into rural and remote areas.

3.2.3 Rural services: outreach clinics and telehealth

RA prevalence is twice as high amongst males living in regional and rural areas of Australia than it is in males living in major cities, although rates for females are similar across all regions.[32] Rural patients also tend to present with more severe disease than their city counterparts.[33]

However, access to specialist rheumatology care in rural and regional areas is limited. As a result, people with RA and other inflammatory and severe forms of arthritis living in these areas face the added stress and costs of needing to travel long distances to receive appropriate care. Alternatively they are managed by health practitioners who are not trained to deliver best-practice care for these conditions, risking inadequate or inappropriate treatment and poor outcomes.

Lack of access to rheumatologists is of particular concern because, together with clinical immunologists, they are the only practitioners under the PBS who can prescribe some of the specialised medications used to treat these conditions.

To try to improve access for people in rural Australia, the Australian Rheumatology Association and Arthritis Australia, with support from Janssen Pharmaceuticals, have recently established the

Australian Rural Rheumatology Service. This service provides specialist outreach clinics, together with education for consumers and health professionals in the local community, to help build capacity within local area health services.

An external evaluation of the pilot service found access to specialist care for people with arthritis improved dramatically:

- The proportion of patients needing to travel over 200kms to access specialist care reduced from 50% of patients to only **5.2** while only **3% of patients travelled two or more hours** to the current clinic compared to **42%** previously.
- The proportion of patients **waiting two or more months to their first appointment decreased from 64% to 21%.**

Services are currently available in seven sites in NSW, two in Queensland and one in Victoria but ongoing services and further expansion are limited by rheumatology workforce constraints and lack of ongoing funding. Primary Health Networks (PHNs) in underserviced areas could play an important role in facilitating these clinics to help ensure their ongoing availability, for example by providing rooms and/or administrative support free of charge.

An important aspect of the program is its focus on education and capacity building of local health care professionals. The service could be enhanced by including outreach services by specialised allied health practitioners where required.

Telehealth services are considered viable for rheumatology [34] [35] and offer great potential to facilitate access to rheumatologists and multidisciplinary teams for people in underserviced areas. A mixed model offering both face-to-face and virtual consultations, however, appears to offer the best option.

Dedicated local support and training would be required to maximise the benefits of this model. This support could be provided by GPs or rheumatology nurses, who could provide assistance with medication monitoring, patient education and engagement with local health care providers for people with RA or other inflammatory forms of arthritis. PHNs could foster these services.

4. Opportunities for Primary Health Networks.

PHNs have been established with the key objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time.

PHNs have an important role to play in improving chronic disease prevention and management. Some examples of PHNs/Medicare Locals activities to support improved services in their local areas have been noted above. In summary, their role should include:

- Addressing health needs at the local population level and developing prevention and treatment programs and strategies to address gaps in services and programs.

- Developing and adapting models of care in collaboration with local stakeholders, taking into account local needs, networks and resources, to ensure effective local health service delivery. This would include facilitating outreach and telehealth services in rural and underserviced areas.
- Linking health care and service providers across primary and secondary sectors and hospitals to increase collaboration and information sharing and to develop a more integrated and coordinated approach to addressing local health needs and services.
- Establishing local care pathways and protocols to reduce unwarranted variations in care, eg by implementing programs such as HealthPathways and Map of Medicine.
- Developing local workforce capacity, including facilitating education and training of local health care professionals and fostering services such as care-coordinators and specialist nurses.
- Supporting the transition to new models of care for chronic disease.
- Supporting quality improvement in local services.

5. Medicare Funding

5.1 Review Medicare funding arrangements to support better chronic disease prevention and management

The current predominantly fee for service funding of health care in Australia does not adequately support or reward effective chronic disease prevention and management, either for health care professionals or individuals with chronic disease.

However, there is only limited evidence to support different funding models for chronic disease prevention and care and all have the potential to create perverse incentives. Blended payment systems which incorporate fee-for-service, capitation payments and outcomes based payments, probably offer the best option to support and incentivise chronic disease prevention and management and the current debate in this area is welcome.

5.2 Improve funding for allied health services

Medicare funding does not adequately support multidisciplinary care delivery in the primary health care sector. There is an urgent need to review Medicare's Chronic Disease Management (CDM) funding arrangements to make them more flexible and to ensure they align with clinical need and benefit and are targeted to those most in need.

Currently, CDM funding is limited to just five allied health visits per year, an arbitrary number that does not align with clinical needs and is often inadequate. For example, in knee OA, evidence indicates that exercise programs with more than 12 directly supervised sessions lead to the greatest improvements in pain and physical function.

The situation is exacerbated for people with comorbidities. Forty per cent of those aged 45 years or older have more than one chronic condition, with arthritis being the most frequently occurring comorbid condition.[36] A person with arthritis and one or more other chronic

conditions is likely to require the services of several allied health practitioners – a dietician, a podiatrist, a physiotherapist and a psychologist as well as, say, a diabetes educator – to help manage their various conditions.

This level of need simply cannot be accommodated under the current five visit limit. Coverage under private health insurance is also limited, so out-of-pocket costs to access appropriate levels of multidisciplinary care quickly become prohibitive for consumers.

5.3 Fund nurses to provide patient education and support and care coordination

Nurses in primary and secondary care can play an important role in delivering disease management education, support for self-management and care coordination.

MBS items already provide some funding for nurses in general practice to support chronic disease management, although the uptake for arthritis to date is limited. However, there is no similar funding mechanism to support nurses in specialist practices.

Specialist nurses in rheumatology have been found to improve patient outcomes and reduce costs in both primary and specialist care.[37] They could also support improved care for people in rural and remote areas of Australia where access to specialist care is limited.

However, there are very few rheumatology nurses in Australia. Extending MBS funding to nurses in specialist practice will help to build this workforce to assist in improving care and support for people with chronic conditions that are primarily managed by specialists.

6. Improve data collection in primary care to increase efficiency in chronic disease prevention and management

Accurate, reliable and timely information is required to assist in improving quality, effectiveness and service outcomes in primary health care. However, available data in Australia does not provide a comprehensive picture of activity in this sector. Current data collections relating to general practice are limited[38] and there is very little national information available about the use of allied health and other primary health care services.[39] This is a particular issue for understanding care patterns for people with arthritis, which is mostly managed in primary health.

The long awaited adoption of electronic health records will help to address some of these issues while also allowing clinical flows across all health care sectors to be assessed. This data is essential to improve coordination and integration of health care services for people with chronic conditions, as well as to assess service quality, efficiency and outcomes.

In order to optimise their effectiveness, electronic health records must include comprehensive data across general and specialist practice, allied and community health services, hospitals (public and private), diagnostic imaging and pathology.

We recommend that ongoing development of the myHealth Record should prioritise and incentivise uptake and effective use of the record by and for people with chronic conditions.

There is also scope to improve data collection in other areas to enhance management of chronic conditions. For example, more support for pharmacovigilance data collection and adverse events

monitoring would allow the clinical efficacy and safety of relevant prescribed medicines in the Australian market to be better monitored. This is especially relevant in the context of the introduction of new medications such as biologics and biosimilars in the management of chronic disease, and of the prevalence of multi-morbidity requiring multiple medications, which increases the potential for adverse events.

7. Conclusion

There is substantial scope to improve the prevention and management of arthritis and other chronic conditions in primary care. With the prevalence and severity of these conditions set to increase exponentially in coming decades, it is imperative that a proactive and collaborative approach to improving the management of chronic conditions is adopted if we are to alleviate the personal, social and economic burden of these conditions.

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[1] Arthritis and Osteoporosis Victoria (2013). *A problem worth solving*. Elsternwick: Arthritis and Osteoporosis Victoria.

[2] Estimated from ABS 2009. *Disability, Ageing and Carers, Australia: Summary of Findings, 2009* and Department of Social Services 2013 *Characteristics of Disability Support Pension Recipients* , June 2013 and Australian Government Budget figures. Arthritis is the main disabling condition in one third of people aged 65 years or less disabled by a musculoskeletal condition, and 26.1% of DSP recipients are disabled by a musculoskeletal condition. So arthritis accounts for 8.7% of DSP expenditure, or $1.3 billion in 2013-14

[3] Schofield DJ, Shrestha RN, Percival R, Passey M, Callander E, Kelly S, 2013. The personal and national costs of lost labour force participation due to arthritis: an economic study. *BMC Public Health* 2013; 13:18822

[4] Muthuri SG, Hui M et al., 2011. What if we prevent obesity? risk reduction in knee osteoarthritis estimated through a meta-analysis of observational studies. Arthritis Care & Research; 63(7): 982-990

[5] Hunter DJ, 2011. Lower extremity osteoarthritis management needs a paradigm shift. Br J Sports med 2011; 45:283-288

[6] Bang S et al. Smoking increases rheumatoid arthritis susceptibility in individuals carrying the HLA-DRB1 shared epitope regardless of rheumatoid factor or anti cyclic citrullinated peptide antibody status. Arthritis Rheum 2010, Feb; 62(2): 369-77. doi: 10.1002/art.27272

[7] Australian Orthopaedic Association National Joint Replacement Registry https://aoanjrr.dmac.adelaide.edu.au/procedures-reported viewed 29/1/2015 for joint replacement numbers. Average cost of a joint replacement is $25,000

[8] Runciman WB et al 2012. CareTrack: assessing the appropriateness of health care delivery in Australia. Med J Aust 2012: 197 (2): 100-105.

[9] Arthritis Australia, 2012. Whose Problem is it Anyway? The Voice of GPs on Arthritis 2012

[10] Van Doornum S, et al 2013. Time to institution of disease modifying anti-rheumatic drugs in Australian patients with early RA. American College of Rheumatology Annual Meeting (Poster)

[11] Arthritis Australia 2011. The Ignored Majority: The Voice of Arthritis 2011.

[12] http://www.arthritisaustralia.com.au/index.php/reports/time-to-move-arthritis-reports.html

[13] Christensen R, Bartels EM, Astrup A, et al. Effect of weight reduction in obese patients diagnosed with knee osteoarthritis: A systematic review and meta-analysis. Annals of the Rheumatic Diseases. 2007 Apr; 66(4):433–9103

[14] Christensen R, Astrup A, Bliddal H. Weight loss: the treatment of choice for knee osteoarthritis? A randomised trial. Osteoarthritis Cartilage 2005 Jan; 13(1):20-

[15] Fransen M, McConnell S. Exercise for osteoarthritis of the knee. *Cochrane Database of Systematic Reviews* 2008; Issue 4. Article no CD004376. DOI: 10.1002/14651858. CD004376.pub2

[16] NSW Agency for Clinical Innovation Musculoskeletal Network, 2012. Osteoarthritis Chronic Care Program Model of Care

[17] O'Connell Advisory 2012 Better Arthritis and Osteoporosis Care Initiative Scoping Study

[18] http://oa.hwfl.com.au/static.php?item=overview

[19] Personal advice from Bupa and Medibank

[20] Goldstein S, Bupa Australia. Presentation to OA Summit, Sydney, October 2014

[21] Villeneuve E, Nam JL et al., 2013. A systematic literature review of strategies promoting early referral and reducing delays in the diagnosis and management of inflammatory arthritis. Annals of the Rheumatic Diseases

22 Roberts LJ, Cleland LG, Proudman SM, Thomas R, 2006. Early combination disease modifying antirheumatic drug treatment for rheumatoid arthritis. Med J Aust 2006; 184(3): 122-125

[23] Quinn MA, Emery P. Are early arthritis clinics necessary? Best Pract Res Clin Rheumatol 2005; 19: 1-17

[24] Gormley GJ, Steele WK, Gilliland A, Leggett P, Wright GD, Bell AL, Matthews C, Meenagh G, Wylie E, Mulligan R, Stevenson M, O'Reilly D,Taggart AJ, 2003. Can diagnostic triage by general practitioners or rheumatology nurses improve the positive predictive value of referrals to early arthritis clinics? Rheumatology (Oxford) 2003, Jun; 42(6): 763-8

[25] El Miedany Y, Palmer D, El Gaafary M, 2006. Diagnosis of early arthritis; outcomes of a nurse-led clinic. British Journal of Nursing 2006; (15)7: 394-9

[26] AIHW, 2013. A snapshot of rheumatoid arthritis. AIHW bulletin 116. Cat no AUS 171. Canberra: AIHW

[27] Berry LL, Rock BL, Houskamp BS, Brueggeman J, Tucker L, 2013. Care coordination for patients with complex health profiles in inpatient and outpatient settings. Mayo Clinic Proceedings; 88(2): 184-194

[28] Department of Health, Western Australia, 2013. Service model for community-based musculoskeletal health in Western Australia. Perth: Health Strategy and Networks, Department of Health, Western Australia

[29] Van den Hout WB, Tijhuis JMW, Breedveld FC, Vliet Vlieland TPM, 2003. Cost effectiveness and cost utility analysis of multidisciplinary care in patients with rheumatoid arthritis: a randomised comparison of clinical nurse specialist care, inpatient team care, and day patient team care. Ann Rheum Dis 2003; 62: 308-315

[30] Leary A, Oliver s 2012. Clinical nurse specialists: adding value to care. Royal College of Nursing Rheumatology Nursing Forum, UK.

[31] http://www.rap-el.com.au/

[32] AIHW analysis of ABS 2007-08 National Health Survey CURF

[33] Personal advice from participants in the Australian Rural Rheumatology Service

[34] Roberts LJ, LaMont EG, Lim I, Sabesan S, Barrett C 2012. Telerheumatology: an idea whose time has come. Internal Medicine Journal. Royal Australasian College of Physicians, 2012; 1072-1078

[35] Davis P, 2003. The application of telehealth to rheumatology. Clinical Rheumatology Sep 2003; 22:168-172

[36] http://aihw.gov.au/chronic-diseases/common-comorbidities/ viewed 14 August 2014

[37] Leary A, Oliver s 2012. Clinical nurse specialists: adding value to care. Royal College of Nursing Rheumatology Nursing Forum, UK.

[38] Australian Institute of Health and Welfare 2008. Review and evaluation of Australian information about primary health care: a focus on general practice. Cat. no. HWI 103. Canberra: AIHW.

[39] Australian Institute of Health and Welfare 2014. Health-care expenditure on arthritis and other musculoskeletal conditions 2008–09. Arthritis series no.20. Cat. no.PHE 177. Canberra: AIHW.