Wiser Healthcare response to the Consultation Draft from the Primary Health Reform Steering Group

8th November 2021

Wiser Healthcare welcomes the opportunity to provide our views on the 10-year plan for Primary Health Care with the aim of strengthening the primary health care system to deliver the best health outcomes for Australians.

Who we are

Wiser Healthcare is a group of collaborating researchers with the aim of conducting research that reduces the unintended consequences of overtesting, overdiagnosis, and overtreatment. We are a multidisciplinary and innovative research team from Bond University, Monash University, The University of Sydney, and the University of Wollongong. We are uniquely positioned to provide evidence-based recommendations to drive improvements in the delivery of appropriate health care, reduce the harms associated with inappropriate care, and improve the efficiency and sustainability of health care systems.

Response to consultation draft recommendations

The plan misses a significant opportunity to address the overtesting, overdiagnosis, and the overuse of low-value care in the primary health care setting. Not only does low-value care mean that appropriate care is not provided, but it is care that has little or no benefit to the patient, may cause harm, or yields marginal benefits at a disproportionately high cost. Achieving the Plan's overarching aims of improving people's experience of care, the health of populations, and the cost-efficiency of the system will be threatened due to inaction in addressing the overuse of care that is ineffective, harmful, or cost-ineffective.

As presented, the plan provides recommendations to improve access to appropriate care for disadvantaged populations (e.g., rural and remote populations, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse populations, and people with disability); a goal that we agree should be supported. However, the lens from which these recommendations are made is that access to health care services alone is the issue, rather than the appropriateness of care that is ultimately delivered. Delivery of inappropriate care risks serious patient harm to individuals and represents a waste of finite resources.

Overall, the absence of an explicit strategy to improve the appropriateness of health care delivery, by addressing the unintended consequences of low-value health care, will undermine the ability of the Plan to achieve its aims and objectives.

We have provided specific recommendations to several action areas outlined in the plan, as well as areas that are absent. We would be very happy to follow-up this submission with further evidence or participation in on-going consultation.

Stream 1, Action Area B

Recommendation 1: Improve the availability and quality of data on the extent of low-value care use to drive improvements in the delivery of appropriate care

An absence of data on the appropriateness of care provided in the primary health care setting has limited any meaningful quality improvement intervention. Measuring the extent that high- and low-value care is utilised is a prerequisite for developing and monitoring policies that will reform primary health care towards high-value care.

Data on the appropriateness of care delivery in the primary health care setting is restricted to service use data, limiting any ability for data-driven improvements in appropriate health care delivery. X-ray and CT requests for low back pain in primary care is a widely recognised example of low-value care.[1] However, these services may be appropriate where there are clinical indicators of serious pathology/diseases. Ensuring that a primary health care dataset contains minimum data to directly measure individuals who have undergone low-value care is critical to identifying and addressing overdiagnosis and overtreatment.

In Australian hospitals, the development of direct measures of low-value care has enabled the extent of the problem to be established, with trends over time and regional variation assessed.[2] These measures utilise data that is routinely collected by hospitals. The development of quality improvement indicators of appropriate primary health care needs to ensure that it does not disrupt clinician workflow, as this is a critical barrier to implementation.

We fully support the Plan's proposed action to improve the quality and value of primary health care through data-driven insights and digital integration. Action in measuring the underuse of high-value care and overuse of low-value care will ultimately improve individuals experience of health care, the health of the population, and the cost-efficiency of the system.

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[1] Choosing Wisely. Recommendations for back pain.

[2] Badgery-Parker et al. Low-value care in Australian public hospitals: prevalence and trends over time. *BMJ Quality & Safety* 2019;28:205.

Stream 1, Action Area B

Recommendation 2: The development of eReferral needs to be a priority to facilitate the implementation of clinical decision support tools to aid appropriate referral for imaging and pathological testing

The large number of diagnostic tests available to primary care clinicians in Australia has created a complex diagnostic process, where clinicians lack of knowledge contributes to inappropriate or unnecessary testing.[3] Reducing unnecessary testing will not only reduce waste of health care resources but will also reduce the unintended consequences of increased secondary health care utilisation and unnecessary hospitalisation. For example, unnecessary MRI for knee and hip osteoarthritis has been shown to drive high arthroscopy rates for older individuals; a costly surgical procedure that has no effectiveness and risks patient harm.[4]

Clinical decision support tools are one mechanism available to aid appropriate referral for diagnostic testing. The final report from the Medicare Benefits Schedule Review Taskforce recommended the expanded use of these tools in primary care.[5] Clinical decision support tools have already been developed for the Australian context, such as the Western Australian Government's Diagnostic Imaging Pathways and RANZCR's Imaging Clinical Decision Rules. While not a clinical decision support tool, the Royal Australian College of General Practitioners' Guidelines for preventive activities in general practice (Red Book) is also available to support evidence-based preventive activities in primary care and improve the appropriateness of care.

We support the recommendation in the Primary Health Care Plan to introduce clinical decision support tools for diagnostic imaging requests, pathology, and quality prescribing. However, this Action Area appears to lack recognition on how these tools can best be utilised in primary care or how this recommendation can leverage off ongoing reform within the Australian health system.

Legislative reforms in the United States have mandated the use of clinical decision support tools for clinical areas where inappropriate imaging referral is an issue. However, this funding arrangement has been delayed due to concerns of disrupted workflow and increased administrative burden on primary care professionals; concerns that have also been raised in the Australian context. The Steering Committee, in consultation with the Australian Digital Health Agency, should consider prioritising the implementation of clinical decision support tools within eReferral as part of the Primary Health Care data asset.[6] This would aid workflow

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[3] Lam et al. Why clinicians overtest: development of a thematic framework. *BMC Health Services Research* 2020;20:1011.

[4] Deveza et al. Is the use of knee magnetic resonance imaging one of the drivers of persistently high arthroscopy rates in older adults? – An analysis of national data in Australia. *Osteoarthritis and Cartilage* 2018;26;S249.

[5] Medicare Benefits Schedule Review Taskforce. An MBS for the 21st Century. Recommendations, Learning and Ideas for the Future. Final Report to the Minister for Health. 2020

[6] Docking et al. Reducing diagnostic errors related to medical imaging. *Deeble Issues Brief No. 44* 2021

and enable the assessment of patient outcomes and secondary health care utilisation for imaging referrals that are adherent to appropriate use criteria compared to non-adherent referrals, This will ultimately drive safety and quality improvements in primary health care.

Stream 1 Action Area C

Recommendation 3: In the absence of robust evidence that precision medicine results in an improvement of population health, precision medicine should not be an objective of the primary health care plan

The goal of precision medicine outlined in the primary health care plan is poorly defined and risks furthering overdiagnosis and overtreatment. We assume that the goal of using genomics and precision medicine in primary health care is to improve the health of populations. How this will be achieved is unclear in the plan and action in this appears to be an aspirational goal, rather than one that is supported by current evidence.

There have certainly been advances in the use of genomics to direct treatments in certain cancers. These examples appear to be outside the arena of primary health care.

Another frequently described goal of precision medicine is the prediction of diseases that could be avoided, or where health consequences can be ameliorated by early intervention. There is a significant risk that such a goal will harm healthy individuals and lead to overdiagnosis and overtreatment. Genetic associations observed for certain diseases ultimately have a small effect on disease development, as many diseases develop due to a complex interplay between our genetics, the environment, and sociological factors. As a result, the predictive power of genetic testing is limited. This risks test results being misinterpreted or disclosure of a predisposition for a condition that will never manifest clinically.[7] This may create psychological distress for individuals where predisposition for conditions with no effective treatment are disclosed (e.g., Alzheimer's) or unnecessary treatment may be sought. Any gains in population health through precision medicine may be outweighed by the unintended consequences of overdiagnosis and overtreatment.

The Plan points to an auspicious survey where 75% of Australian's state that they would be willing to use genetic testing to identify the most effective drug to treat their disease. This desire is based on the promise of precision medicine rather than a reflection of the current evidence.

Genetic testing and precision medicine should not be an action area in the primary health care plan due to an absence of robust evidence that it results in an improvement in population health and the risk that it will increase health care use due to overdiagnosis. Should the committee continue to recommend investment in this area, it is critical that the goal of precision medicine within primary health care is outlined so that this recommendation can be assessed against current evidence.

[7] Scott et al. Promises and perils of using genetic tests to predict risk of disease. *BMJ* 2020;368:m14.

Stream 2, Action Area F

Recommendation 4: Engagement with government entities, such as NPS Medicine Wise and Choosing Wisely, is critical to empower people and communities to navigate the health care system and reduce low-value care

In reforming primary health care from an illness system to a wellbeing system, it is critical that the Plan addresses information asymmetry and empower people and communities to manage their own health. Individuals with greater capacity to manage their own health have fewer contacts and less wasteful usage of the health care services.[8]

Engaging and empowering individuals within the clinician-patient interaction has been shown to be an effective strategy in reducing low-value care.[9] There are several Government initiatives already in place, such as NPS's Choosing Wisely and NPSMedicineWise, that are ideally placed to enable individuals to ask questions on what options they have and the potential harms that are associated with certain health care options.

It is recommended that the Primary Health Care plan references/leverages off the successes of these Government programs to encourage individuals and communities to be enablers of high-value care and reduce overtesting and overdiagnosis, which will ultimately improve their experience of care, health outcomes, and the cost-efficiency of the system.

Recommendation 5: The Plan needs to provide leadership in addressing primary health care's carbon emissions, particularly through the overconsumption of inappropriate or unnecessary health care

The Primary Health Care Plan misses an opportunity to address health care's contribution to climate change. The climate crisis is of particular concern to the health sector as it negatively impacts the health of Australian's and will drive more people to seek health care. The health care system contributes to ~7% of Australia's total carbon emissions.[10] It is vitally important that a document such as this, which outlines a vision for primary health care for the next 10-years, considers how primary health care can reduce its contribution to climate change.

The National Health Service in the United Kingdom is a leading example where carbon emissions have decreased 26% over a 19-year period.[11] Most of this achievement has come from the decarbonisation of the energy system. Yet, addressing the overconsumption of low-

[8] Barker et al. Self-management capability in patients with long-term conditions is associated with reduced healthcare utilisation across a whole health economy: cross-sectional analysis of electronic health records. *BMJ* 2018;27:989.

[9] Sypes et al. Engaging patients in de-implementation interventions to reduce low-value clinical care: a systematic review and meta-analysis. *BMC Medicine* 2020;18:116.

[10] Malik et al. The carbon footprint of Australian health care. *Lancet Planet Health* 2018;2:e27.

[11] Tennison et al. Health care's response to climate change: a carbon footprint assessment of the NHS in England. *Lancet Planet Health* 2021;5:e84.

value health care is an untapped opportunity to reduce the environmental impact of the health care system.

For example, the carbon footprint of pathology testing was quantified from two Melbourne hospitals.[12] While the carbon footprint of individual tests is relatively small (ranging from the equivalent of driving a car for 3 to 770 metres), the large volume of haematology and biochemistry tests performed in Australia each year (~74 million in 2018-19) means that it has an appreciable contribution. Opportunities to reduce the carbon footprint of an individual test are limited as the majority of emissions are related to blood sample collection. Reducing pathology testing that is not clinically indicated[13] will not only reduce the unintended consequences of overtesting and overdiagnosis, but will also reduce health care's carbon emissions.

It is recommended that the Plan includes an objective to transform primary health care to a sustainable, emissions-reducing system. This objective is in line with the plans aims to improve the health of populations.

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We thank you again for the opportunity to contribute and are happy to follow-up if needed.

Yours Sincerely,

The NHMRC funded Wiser Healthcare research collaboration executive: Professor Kirsten McCaffery, University of Sydney; Professor Alex Barratt, University of Sydney; Professor Chris Maher, University of Sydney; Professor Stacy Carter, University of Wollongong; Professor Paul Glasziou, Bond University; Associate Professor Rae Thomas, Bond University; Assistant Professor Ray Moynihan, Bond University; Professor Rachelle Buchbinder, Monash University; Associate Professor Denise O'Connor, Monash University; Leah Hardiman, representative, Health Consumers Queensland; Dr Steph Mathieson, University of Sydney; Tom Dakin, Wiser Coordinator, University of Sydney; Dr Sean Docking, Monash University.

[12] McAlister et al. The carbon footprint of pathology testing. *Medical Journal of Australia* 2020;212(2):377.

[13] Zhi et al. The landscape of inappropriate testing: a 15-year meta-analysis. *PLoS One* 2013;8:e78962.