Australian Health Care Reform Alliance

SUBMISSION TO THE AUSTRALIAN GOVERNMENT REVIEW OF MEDICARE LOCALS, DECEMBER 2013

AUSTRALIAN HEALTH CARE REFORM ALLIANCE

The Australian Health Care Reform Alliance (AHCRA) is a coalition of about 30 peak health groups (professional, consumer and service) working towards a better health system for Australia's future. We believe all Australians are entitled to high quality and accessible health care, regardless of income, location or linguistic and cultural background. (See Appendix 1 for AHCRA membership.)

KEY RESPONSES

1. **Centrality of primary health care**. It is well-known that Australia is heading for an unaffordable and unsustainable health system within 20 years and current rates of health inflation and expenditure. The most effective ways of addressing this are through better prevention, early intervention and management of chronic diseases in the community. The primary health care (PHC) system is central to all of this.

2. **Medicare Locals are the only bodies working for change systematically**. The Australian PHC system has a high number of providers, most very small in size, and is therefore highly fragmented causing significant access and navigation problems for consumers and carers, and poorer performance in relation to early intervention, chronic disease management and prevention, i.e. a lack of planning and market failure in the domains where the community requires strong performance. This ultimately impacts on the population's status and increases pressure on hospital emergency departments. Medicare Locals (MLs) are the only bodies established and funded around Australia with the mandate to improve these factors. They are therefore very important elements of the evolving primary health care system and have significant potential to improve the system and its equity and sustainability and to build its capacity.

3. **First ever local comprehensive PHC planning**. Medicare Locals' population health planning provides the first such planning which encompasses all of the primary health care system. This provides much better quality data for planning than has ever been available before.

4. **MLs working to more effective system**. MLs are involving GPs, allied health practitioners and community health services among others in their collaborative planning and implementation work. These are stepping stones towards gradually creating a more integrated system, multidisciplinary system, the commonly accepted gold standard for primary health care. Research indicates that such systems optimize the skills of (and taxpayers' investment in) health practitioners and improve the patient journey and ultimately their population's health status. Any move to refocus the organisations to just the role of GPs would be a backward step with cost-implications for the health budget over time.

5. **Early days**. The performance of Medicare Locals has to be considered in relation to their maturity. Most of the Tranche 1 MLs commenced less than 2.5 years ago, and the Tranche 3 MLs less than 18 months ago. Further whilst the organisations are sensibly built on some of the foundations of the previous GP Divisions, most had to merge and create new partnerships and relationships. It is a truism to state that such development takes time and assessment of performance needs to take this into account. Despite this, AHCRA considers that many MLs have made a valuable start and started to chalk up real achievements.

6. **Improvements**. There are some improvements that could be made to how MLs function, in particular to measuring their performance against indicators that reflect how the community wants it PHC system to preform, e.g. indicators of equity of consumer access and outcomes. Additionally MLs should limit their service provision role to that of temporary or last resort provider. However State and Federal Governments should be encouraged to channel future health fuding increasingly through MLs which can coordinate the service arrangements that best meet local needs and the local context.

RESPONSES TO REVIEW CRITERIA

Role of Medicare Locals and their performance against stated objectives

AHCRA considers that the primary health care system is the core of a future sustainable health system in Australia. The current primary emphasis of all governments on acute care (rather than prevention and early intervention) is ultimately both unaffordable and commits Australians to a less than optimal health status. Yet primary health care is provided in a highly fragmented manner with high rates of consumer dissatisfaction about access and navigation of the system, despite the high quality professionals working within it. There are multiple funding sources, a high percentage (well over 50%) of medical and allied health practitioners working as sole practitioners or in very small separate practices, and quite different 'systems' in each state. Previously there was no one entity with responsibility for steering the ship, ensuring that passengers got what they needed and wanted or that this was done efficiently. This was not a good deal for either consumers nor governments and taxpayers. Medicare Locals (MLs) crucially offer the first opportunity to provide this steering, to take responsibility for the stewardship of the primary health care to ensure it is structured to provide the care where and how it is needed, and in the most effective/efficient way.

Performance of Medicare Locals in administering existing programs, e.g. after hours

Three obvious examples of initial successes for MLs are around population health planning, after-hours medical care, and the improvement of local service delivery systems.

The Population Health Needs Assessments undertaken by all MLs provide the whole of the primary health care sector *for the first time* a good quality picture of the actual needs and health status of the entire catchment. This forms a good basis for regional planning of services and subsequent collaborative action with local services and organisations to plug gaps and improve the consumer journey. The current maldistribution of services within catchments and across Australia illustrates clearly that the previous approach failed to provide a fair and efficient system in many ways. The current distribution of services has been created mainly by multiple separate decisions by individual practitioners or organisations making business (not health-based) choices about the location of services. This predominantly market-based arrangement has left many consumers with inadequate access to services, especially in rural and low-income areas, and over-concentration of practitioners in better-off suburbs.

Although AHCRA does not have data about ML performance, members do report that there has been a more systematic approach to the provision of after hours service, previously highly ad hoc and fragmented. Similarly AHCRA Is aware of the increasing take up of the Pathways approach to developing care-specific pathways for best quality care of a wide range of conditions to guide GPs in their difficult, currently information-varied referral role.

Recognising general practice as the cornerstone of primary care in the functions and governance structures of Medicare Locals

AHCRA recognises the crucial and difficult role that general practitioners (GPs) play in our system. Australia has many fine such GPs. It would appear that Medicare Locals have deliberately made a strong effort to ensure that GPs are structurally central to the new entities (e.g. with constitutions that require a certain number of GP Board members for example) and GP involvement in committees, projects and programs. It is also clear that practice support to GPs continues in a very substantial way (some MLs claim they provide more than the previous Divisions did) and that MLs have and are engaging GPs in arrange of ways, and are working to do this more systematically.

However AHCRA does believe that the future primary health care system should be based on the significant evidence that a multi-disciplinary integrated approach to health care is both more effective in meeting consumers' health needs (e.g. multidisciplinary care for people with diabetes and coordinated care for people with mental health conditions are obvious examples) and more satisfactory for consumers and their carers. Thus AHCRA hopes that Medicare Locals will work alongside general practices (the majority of which are still 1-2 GP practices) to gradually evolve the sector into a network of multidisciplinary services, where consumers can receive the right care at the right time from the right practitioner in a team-based manner.

Ensuring Commonwealth funding supports clinical services, rather than administration

AHCRA considers this a difficult criterion to interpret, given that Medicare Locals were not primarily established to provide clinical services. However if this implies working to improve clinical services available to the community, then AHCRA sees the great majority of work of MLs aimed at improving clinical services. However it also perceives an unusually high level of accountability being required of MLs by the Department of Health. This has undoubtedly meant that MLs have felt obliged to create accountability and documentation positions simply to meet these demands. AHCRA suggests that loosening the requirements would both enable MLs to be more innovative and member-focussed and perhaps enable some savings to be made. Reducing ML funding without reducing bureaucratic red tape would be highly unreasonable.

Assessing processes for determining market failure and service intervention, so existing services and are not disrupted or discouraged

AHCRA sees MLS playing constructive roles in fostering collaboration among diverse services in the sector in a range of ways. The provision of more equitable and effective after hours services around Australia, the development of e-referral services between GPs and allied health (Eg in Barwon) are examples of this.

However some MLs level of service provision does concern AHCRA. It considers that MLs' roles are to identify where there are no appropriate services for consumers (or market failure in the terms of this criteria) and to work collaboratively with local service providers and other organisations to fill gaps in a consumer-centred effective and efficient way. AHCRA does not believe MLs should see themselves as the providers of such services, except in a few limited circumstances. Becoming a provider, or competitor, undercuts MLs' ability to facilitate collaboration, its primary task.

Australian Health Care Reform Alliance, c/o NRHA PO Box 280, Deakin West, ACT 2600 or chair@healthreform.org.au

Appendix 1: Current members of AHCRA

- Allied Health Professions Australia
- Audiology Australia
- Australian College of Nurse Practitioners
- Australian Council of Social Service
- Australian Federation of AIDS Organisations
- Australian Healthcare and Hospitals Association
- Australian Nursing Federation
- Australian Rural Health Education Network
- Australian Women's Health Network
- Australian Wound Management Association
- Catholic Health Australia
- Chiropractors' Association of Australia
- Chronic Illness Alliance
- Continence Foundation of Australia
- Country Women's Association
- CRANAplus
- Doctors Reform Society
- Family Planning Victoria
- Health Care Consumers' Association (ACT)
- Health Consumers Action Group WA
- Health Consumers Network
- Health Consumers of Rural and Remote Australia
- Health Issues Centre
- National Council on Intellectual Disability
- National Rural Health Alliance
- Paramedics Australasia
- Public Health Association of Australia
- Public Hospitals, Health and Medicare Alliance, Queensland
- Royal College of Nursing Australia
- Services for Australian Rural and Remote Allied Health
- Tasmanian Medicare Action Group