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Submission to the Medicare Locals Review

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This Submission is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies.

Overview

The National Rural Health Alliance (NRHA) is the peak non-government organisation for rural and remote health and wellbeing. Information about the membership of the NRHA and its work is available at www.ruralhealth.org.au As a key stakeholder in the health sector, the NRHA is pleased to provide input to the review of Medicare Locals.

The NRHA is a strong supporter of Medicare Locals (by whatever name they are to be known) and believes that the Commonwealth Government should lead the way in investing trust, confidence and resources in them and their future. These investments should be matched by equivalent support – in terms of both attitudes and resources – from State, Territory and local governments; and will be balanced by the acceptance of public accountability on the part of the Medicare Locals themselves.

Greater community involvement in the management of local hospitals has been on the policy agenda for a considerable time and it makes good sense for rural primary care as well to be organised locally rather than centrally. The NRHA believes it is best for local communities and clinicians to have a genuine say in the management of all their health care, so that health services are responsive to local needs.

Important principles for achieving cost-effectiveness in the health system are embedded in Medicare Locals although, given the short period of time for which they have so far been established, they cannot be expected to have delivered on them fully as yet:[1]

- they provide the basis for collaborative and cooperative work across all of those individuals and professions involved in the delivery of primary care in their specific locality;
- they comprise a central point or 'locus of primary care authority' to enable the primary care system to negotiate and manage an efficient and effective relationship with hospitals and other acute care services;
- they offer the prospect of a valuable amount of direct local engagement of health consumers with health services;
- they constitute a new (and useful)[2] level at which analyses of health and health-related services may be tracked; and
- eventually they will be able to engage more fully across the breadth of primary health care activity for the people of their region, through such things as health education, special programs for those who are experiencing long term unemployment or living in unstable or unsuitable housing, and targeted support for at-risk individuals in their homes.

If they are properly supported and resourced, the work of Medicare Locals will ultimately result in a simpler and safer patient journey, a more patient-centred focus for the health services provided, and a closer relationship than currently exists in the sector between health need and health expenditure.

The role of MLs and their performance against stated objectives

The prescribed strategic objectives for Medicare Locals are shown in Attachment 1 and the NRHA acknowledges the very high expectations set for Medicare Locals – and welcomes them.

The more than 6.7 million people of rural and remote Australia have much to gain from improvements in the performance of the health system and the NRHA believes that Medicare Locals can deliver. Locally-focused and responsive services are needed but may well be constrained by workforce shortages. Population health needs are greater outside the major cities. Patient journeys are more

[1] Evidence from one Medicare Local with which the NRHA has a close relationship shows a most impressive performance in relation to providing services for the first time for underserved populations. It also shows other great local work strengthening private practice and bringing acute and primary health care together with a much better 'journey' that is mutually planned.

[2] Part of the usefulness comes from the fact that, broadly speaking, Medicare Locals are based on catchments ie where people go for 'local' services.

complex for rural people, integration and coordination of services is more challenging over large distances, and health professionals are more likely to be working remotely from their multidisciplinary teams.

To enable effective local participation in the governance of Medicare Locals in rural and remote locations there is likely to be the need for further information, capacity building, training and support for communities, health professionals and service providers. The NRHA is aware that a number of Medicare Locals are making good headway in involving rural community representatives, health service providers and researchers in their governance and programs. Clinicians should be trusting and supportive and make the success of their own Medicare Local a self-fulfilling prophesy.

Currently the most important work of the Medicare Locals is the preparation of needs assessments to identify key health priorities and activities for the local community. These priorities are to be addressed by each Medicare Local in its Annual Plan. This process will provide the strategic overview that has been missing from local health service planning and delivery to date.

Independently-derived baseline data of health status and service usage in Medicare Local catchments are starting to become available from the National Health Performance Authority. The figure at Attachment 2 shows that most of the Medicare Locals in the regional and rural peer groups have poorer health status than the national average (16/19 in these peer groups). Only 6 of the 16 have more GP attendances per person than the national average, despite their poorer health status. Nine of the 16 have fewer GP attendances, despite the anticipated higher health needs of their population.[3]

Medicare Locals have an important role in developing and implementing targeted health promotion and illness prevention programs that will work effectively in specific rural and remote areas. People in those areas have higher rates of obesity, smoking and risky alcohol consumption. The rates of potentially preventable hospitalisations for chronic conditions remain high, especially in more remote areas - and not just because of the higher proportion of Aboriginal and Torres Strait Islander people.[4]

Development of a National Rural Health Plan by the Commonwealth could play a significant role in clarifying the responsibilities of various governments, Medicare Locals and Local Health Networks and thus in improving health outcomes.

The performance of MLs in administering existing programs

After-hours medical services have been a mainstay of the work of MLs to date.

There are good models of after-hours care that have worked in rural and remote areas, such as the GP Assist program in Tasmania. It was an integrated nurse triage and GP phone support system, with referral by phone directly to the local GP where needed. With the move to a national nurse triage scheme, GP Assist ceased to exist until the Tasmanian Medicare Local received funding for its GP component.

The challenge for Medicare Locals in a case such as this is the disconnect between the national triage nurse and the local primary care arrangements, which often results in triaging the patient to the nearest emergency department, rather than making use of GP Assist and/or the local GP.

This is a good example of how Medicare Locals with local knowledge and contacts will be able to provide more effective local solutions for rural communities than is possible through national systems alone, and ensure that the best use is made of all health professionals available locally.

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[3] Note that GP attendances are MBS non-referred attendances provided by medical practitioners, excluding services provided by practice nurses and Aboriginal and Torres Strait Islander health practitioners on behalf of medical practitioners.

[4] COAG Reform Council. Healthcare 2011-12: comparing outcomes by remoteness. Supplement to the report to the Council of Australian Governments. 30 April 2013. http://www.coagreformcouncil.gov.au/reports/healthcare/healthcare-2011-12-comparing-performance-across-australia

Another major activity of Medicare Locals in the early days has been the provision or brokering of mental health services. The National Primary Mental Health Care program is funded by the Department of Health and is designed to support the implementation of mental health services and programs in primary care through the 61 Medicare Locals. Such services as these are particularly important in more remote areas because of the shortage or absence there of GPs and other clinicians equipped to work in mental health. The Access to Allied Psychological Services (ATAPS) program is another of those where the work of Medicare Locals can help make up for the maldistribution of GPs.

Another example of where some Medicare Locals are involved proactively in a matter of importance for rural people is the work of the Australian National Preventive Health Agency with MLs to develop programs to reduce smoking rates. This is critical for people in rural and remote areas where national health promotion programs (eg for reducing smoking rates) have been relatively ineffective.

Recognising general practice as the cornerstone of primary care

The NRHA welcomes the role of general practice in the functions and governance structure of Medicare Locals but there is more to primary care than general practice. In any case it must be recognised that there are shortages of GPs in many areas and primary care services may be delivered through remote area nurses, Aboriginal health services, visiting or outreach services, small local hospitals or Multi-Purpose Services. Both collectively and as individuals, GPs hold in their hands much of the 'grace and favour' it will take to have Medicare Locals succeed.

Ensuring funding supports clinical services rather than administration

The role of service coordination, whether carried out by clinicians or their administrative staff, has to be recognised as a critical part of what needs to be done for a safe and effective patient journey in rural and remote Australia. While it is true that taking up clinicians' time with administrative tasks is not a good use of their skills, such things as service planning and development and maintaining protocols for patient handover and referral, and support for the patient in making the necessary arrangements for healthcare at a distance, are parts of good management, not administration.

One of the key strengths of health services in rural and remote areas is their flexibility and the ease with which they can be adapted to a variety of purposes:

- GPs have multiple roles in aged care and in acute care in local hospitals as well as primary care;
- Multi-Purpose Services combine primary, aged and acute care; and
- rural hospitals include elements of community care, aged care, health promotion such as immunisation and diabetes education, primary care and various allied health services.

Local health teams know the services available locally and are well placed to work with patients and the health and other workers in their area. They are also critically aware of the need to coordinate with visiting health practitioners and regional and city health services and clinicians. They have first-hand experience of the challenges and costs for the patient, their families and carers when they need to travel for specialised care.

Local coordination of appointments with fly-in, fly-out services or visiting specialists through Medical Specialist Outreach Assistance Program, as well as follow-up and support for the local health workers on the ground needs to be factored into the front line service requirements of rural and remote communities. It is very useful for upskilling to occur when local practitioners sit in with or assist a visiting specialist, or share teaching lunch with them to discuss challenging cases in an informal setting. The remote area nurse or Aboriginal Health Worker might feel unable to ask for clarification on a telehealth hook up but can discuss things easily face-to-face. Medicare Locals have an important role to play in facilitating such arrangements and ensuring the best use of Commonwealth-funded clinical programs for training, systems and technical support of local health services and workers.

Ensuring that existing clinical services are not disrupted by ML programs

It is critical that Medicare Local programs are developed in consultation with local communities including community members, the health professionals and services available locally – as well as with other services such as aged care. This provides particular challenges for Medicare Locals that cover large areas – and where many of the existing services are quite vulnerable to changing requirements. The system needs to guard against, for example, a specialised centre in a major teaching hospital inserting itself as the provider of specialised services over the heads of local services.

Medicare Locals need sufficient resources to employ or contract the expertise of the epidemiologists, population health experts, business advisers, communicators and service planners needed to develop their business plans, seek funding for and commission services, and monitor their implementation and evaluation. Some Medicare Locals are already finding ways to fill service gaps identified in their consultations with rural and remote communities. Other parts of rural and remote Australia have reported closures or reductions in State-funded primary care services on the basis that Medicare Locals will take them on – but ahead of the establishment of the capacity within the Medicare Locals to do so. This is a serious challenge for Medicare Locals but it speaks not of any deficiency in their work or their principles but of the pressures on cash-strapped State agencies.

Interaction between MLs, Local Hospital Networks and other health services

It is critical that Medicare Locals work effectively with Local Health/Hospital networks to provide seamless patient journeys no matter the funding source. Shared boundaries for MLs and LHNs will assist with rational approaches to needs based planning and service delivery. People in NRHA networks are already reporting that their involvement in Medicare Locals and Local Health/Hospital Networks is helping rural health service providers across primary and acute care to identify shared opportunities or benefits of working together. For people living in rural and remote communities, it is particularly important for the boundaries to align with patient flows for secondary and tertiary health services. The Medicare Locals situated across the Victorian and NSW State borders provide a good example of such a rational approach.

Tendering and contracting

The NRHA is concerned that competitive tendering processes will not be sufficient to achieve needed health programs in rural and remote communities where the market for the services is limited. In these situations it will sometimes be necessary for Medicare Locals to have the flexibility to broker innovative service delivery models or commission selected services. Medicare Locals seeking to fill service gaps in rural and remote areas may also need to provide support and help to build the capacity of potential local service providers, including the capacity for tendering and managing contracts. A sophisticated approach to the commissioning of services is required.

Other matters

Governments must work closely, collaboratively and cooperatively with the Aboriginal Community Controlled Health Services (ACCHS) sector on all facets of the work of MLs and Local Hospital Networks. Medicare Locals must operate in ways that build capacity in the community controlled sector.

The significant populations of Aboriginal and Torres Strait Islander peoples in rural and remote areas need healthcare, including allied health services, that is accessible, affordable, available, appropriate and culturally responsive to the needs of Aboriginal and Torres Strait Islander peoples. Medicare Locals need to be aware of this, provide the appropriate service, lead cultural safety in the workplace, encourage training and development of staff, and include local Aboriginal people in their business either through their Board or some other partnership.

Attachment 1

Medicare Locals' Strategic Objectives[5]

While individual Medicare Locals may use different approaches to meet the needs of their local community, all Medicare Locals are required to meet the following five strategic objectives:

Objective 1: Improving the patient journey through developing integrated and coordinated services

To achieve this objective Medicare Locals are expected to:

- work to make the health system function seamlessly for patients, through links with Local Hospital Networks, so that primary health care is a part of an integrated health system;
- establish processes to engage effectively with patients, clinicians, Local Hospital Networks and the National Lead Clinicians Group, and other stakeholders to identify and remedy service gaps and breakdowns in service integration and coordination;
- work with patients and the local clinical community to develop, monitor and maintain high patient care standards and integrated and coordinated clinical pathways to improve access to services, including after-hours services and telehealth services, provided in the most appropriate setting, and connectedness between services in the local area; and
- improve patient awareness of the availability of services by maintaining and ensuring access to relevant and current service directories.

Objective 2: Provide support to clinicians and service providers to improve patient care

To achieve this objective, Medicare Locals are expected to:

- proactively engage with practitioners across the spectrum of primary health care provision;
- provide practice support to improve the uptake of best practice in primary health care;
- integrate varied provider types and models of care to reflect optimal care coordination; and
- assist primary health care providers to meet safety and quality standards of service delivery, including monitoring and providing feedback to providers on their performance.

Objective 3: Identification of the health needs of local areas and development of locally focused and responsive services

To achieve this objective, Medicare Locals are expected to have the appropriate expertise in data collection and analysis, strategies and referral pathways to:

- maintain a population health database including community health and wellbeing measures, provide input to population health profiles, and undertake population health needs assessment and planning;
- actively participate in the performance and accountability framework of the Government's health reforms;
- undertake detailed analyses of primary health care service gaps and identify evidence-based strategies to improve health outcomes and the quality of service delivery in local area populations, including for disadvantaged or under-serviced population groups;
- conduct joint service planning with Local Hospital Networks and other appropriate organisations; and
- facilitate a reduction in inappropriate or inefficient service utilisation and avoidable hospitalisations.

Objective 4: Facilitation of the implementation and successful performance of primary health care initiatives and programs

To achieve this objective, Medicare Locals are expected to:

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[5] Australian Government Department of Health and Ageing. Medicare Locals Operational Guidelines April 2013. 3. Strategic Objectives. Downloaded 17 December 2013 http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/ml-operational-guidelines-toc~strategic-objectives#

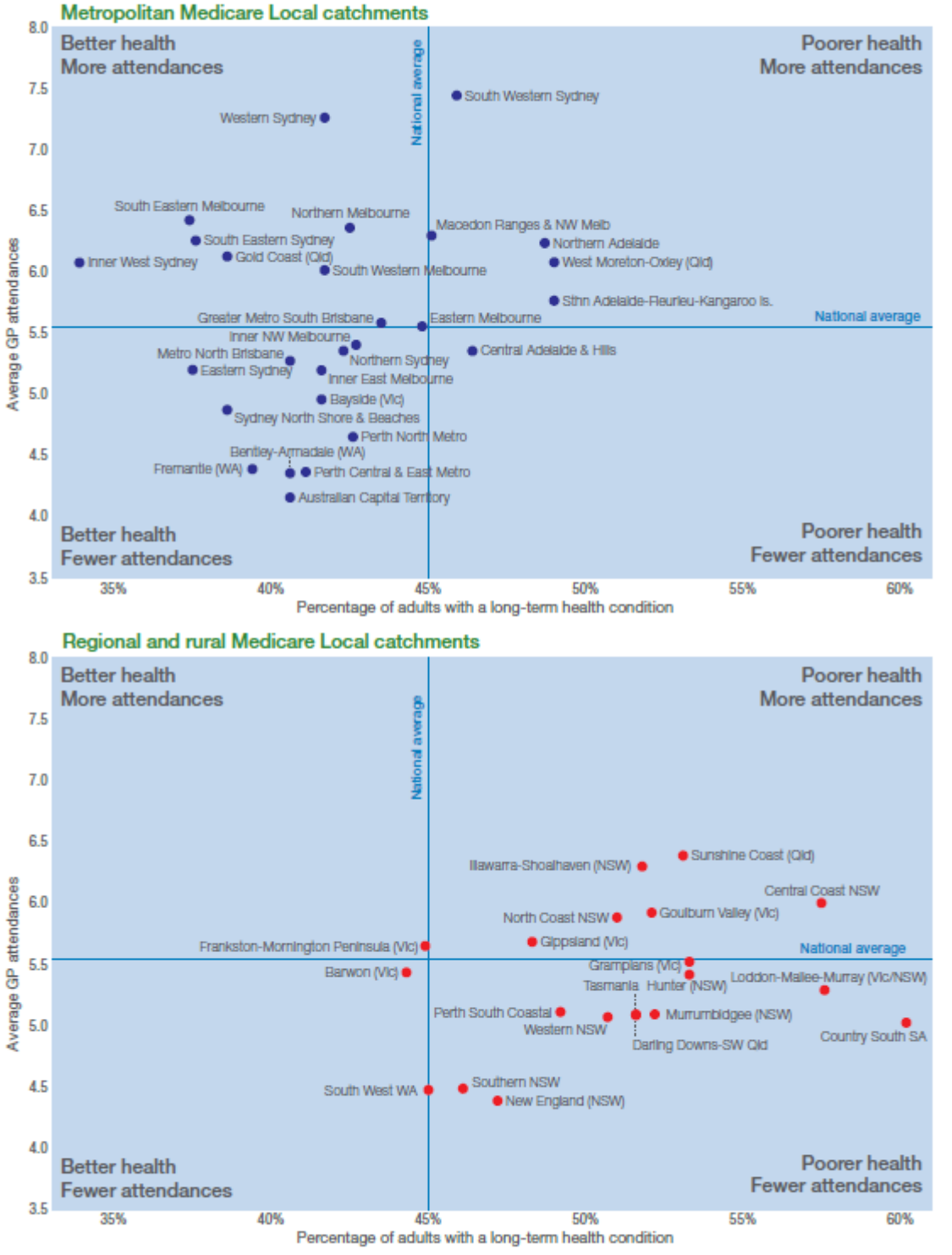
- improve the focus on prevention and early intervention in primary health care;
- improve service delivery, clinical efficiency and efficacy, and drive appropriate service utilisation;
- coordinate the delivery of local area primary health care reform initiatives; and
- ensure the seamless transition of programs and services from existing Divisions of General Practice operating within the local area, including transfer of funding, staffing and corporate knowledge.

Objective 5: Be efficient and accountable with strong governance and effective management
To achieve this objective, Medicare Locals are expected to have:

- appropriate company, board and senior management structures and processes – to manage risk, ensure compliance with all legal and fiduciary responsibilities, ensure financial viability and accountability, and to attract and retain essential skills across the extent of corporate and primary health care expertise;
- capacity to drive more efficient utilisation of health and administrative resources – including through contract management, resource allocation and acquittal, budget management, and contributing to efficiency and equity across health sectors in the local area;
- sufficient capacity and expertise to effectively and efficiently manage flexible funding to target services to their local community's specific needs;
- mechanisms to appropriately integrate information relating to clinical priorities and governance – including links with Local Hospital Networks and the National Lead Clinicians Group;
- appropriate data collection, performance monitoring and reporting processes – including a commitment to participating within a nationally consistent performance framework and monitoring of definitive outcomes related to Medicare Locals' core business requirements;
- decision making processes that are responsive to local health care needs and accountable across the spectrum of the local community and primary health care providers; and
- capacity to remain flexible and responsive to evolving circumstances.

Attachment 2[6]

Figure 3: Average number of GP attendances[1] per person by health status[2] in *metropolitan* and *regional* Medicare Local catchments, 2011–12



1. GP attendances are non-referred Medicare benefits-funded patient/doctor encounters and exclude services provided on the GP's behalf.
2. Health status within Medicare Locals catchments is estimated by the percentage of adults having one or more long-term health conditions.

Sources: Australian Bureau of Statistics, Patient Experience Survey 2011–12, Department of Human Services Medicare Benefits statistics 2011–12 and Australian Bureau of Statistics Estimated Resident Population 30 June 2011.

[6] Figure 3 from National Health Performance Authority. Healthy Communities: *Australians' experiences with access to health care 2011-12*, released 20 June 2013, including associated media information and supplementary data. http://www.nhpa.gov.au/internet/nhpa/publishing.nsf/Content/Healthy-communities