



Public Health Association
AUSTRALIA

**Submission from the Public Health Association of Australia on
governance and functions of Medicare Locals**

The Public Health Association of Australia (PHAA) believes that a far greater effort is needed in the governance and function arrangements of Medicare Locals to address concerns:

- *Information to date has NOT indicated an appropriate emphasis on ensuring Medicare Locals comprehensively encompass primary health care.*
- *The Aboriginal Medical Services (AMSs) that have been highly successful in providing high level, holistic care for Aboriginal and Torres Strait Islander peoples will be undermined by the transition to Medicare Locals as currently proposed.*

Therefore, the PHAA calls on the government to ensure:

- Medicare Locals are comprehensive enough in both their functions and governance to provide an appropriate emphasis across the full spectrum of primary health care from promoting healthy communities and populations through to medical treatment, and to provide such service an equitable way.
- AMSs will not be disadvantaged regarding their funding, functions and work because of the transition to Medicare Locals.

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Background

The Public Health Association of Australia Incorporated (PHAA) is recognised as the principal non-government organisation for public health in Australia and works to promote the health and well-being of all Australians. The Association seeks better population health outcomes based on prevention, the social determinants of health and equity principles.

The PHAA is a national organisation comprising around 1600 individual members and representing over 40 professional groups concerned with the promotion of health at a population level. This includes, but goes beyond the treatment of individuals to encompass health promotion, prevention of disease and disability, recovery and rehabilitation, and disability support. This framework, together with attention to the social, economic and environmental determinants of health, provides particular relevance to, and expertly informs, the Association's role.

Key roles of the organisation include capacity building, advocacy and the development of policy. Core to our work is an evidence base drawn from a wide range of members working in public health practice, research, administration and related fields who volunteer their time to inform policy, support advocacy and assist in capacity building within the sector. The PHAA has been a key proponent of a preventive approach for better population health outcomes championing such policies and providing strong support for the government and for the Preventative Health Taskforce and NHMRC in their efforts to develop and strengthen research and actions in this area across Australia.

The PHAA has Branches in every State and Territory and a wide range of Special Interest Groups. The Branches work with the National Office in providing policy advice, in organising seminars and in mentoring public health professionals. This work is based on the agreed policies of the PHAA. Our Special Interest Groups provide specific expertise, peer review and professionalism in assisting the National Organisation to respond to issues and challenges as well as a close involvement in the development of policies. In addition to these groups the Australian New Zealand Journal of Public Health draws on individuals from within the PHAA who provide editorial advice, review and who edit the Journal.

In recent years the PHAA has further developed its role in advocacy to achieve the best possible health outcomes for the community, both through working with all aspects of government and promoting key policies and advocacy goals through the media and other means.

The PHAA is grateful for the opportunity to comment on the issues and express our real concerns around the development of the Medicare Locals which we hope to see as genuine Primary Health Care Organisations (PHCOs) rather than continuing the role that the Divisions of General Practice have played in the past as primarily Primary Medical Care Organisations (PMCOs).

Introduction

One of the key elements in health reform was ending the blame game and with it the impact of the “silo” effect on the way the health care system was running.

The PHAA has observed the focus that governments have put on the hospital system as the first tranche of the health reforms. The report of the Australian Health and Hospitals Commission, however, did emphasise the importance of the relationship between prevention, early intervention and the delivery of medical services from primary medical care through to highly sophisticated care in tertiary teaching hospitals. Similarly, the reports of the External Reference Group for the Primary Health Care Strategy and the Preventative Health Taskforce also addressed the importance of coordinated approaches to care across the spectrum from prevention through to tertiary care.

Transition from Divisions of General Practice

The nature of the Divisions of General Practice, that were set up to support GPs and improve their medical practice, means that their model of health care delivery has been primary care which is largely based on a medical model that focuses on the individual. By definition they have therefore been organisations involved in Primary Medical Care. The PHAA recognises that some of the outstanding Divisions of General Practice did much more than this. However, the model of care has been driven by fee-for-service medicine.

Medicare Locals provide an opportunity to build capacity to also address issues on a population basis. We believe that with the right governance structures and the appropriate functions Medicare Locals must be given the mandate to address all the issues that will build healthier communities which are strong and resilient, and therefore empowered to work on prevention and health promotion.

Although the PHAA recognises that some lip service has been paid to prevention and addressing primary health care as more than what is delivered by GPs, it has been a matter of frustration that the dialogue around primary health care is most often drawn back to a medical model and how these issues can be managed by GPs in association with (more recently) allied health professionals.

The focus has largely been on medical care to address sickness while prevention is often in relation to chronic conditions and how ‘prevention’ techniques and interventions can be used to manage the condition so that it does not get worse. We note that the term ‘preventative health’ is a misnomer and advise that the terms ‘disease prevention’ and ‘health promotion’ are clearer in their intent.

There has been precious little suggestion that the Medicare Locals will play a role in ensuring people stay as healthy as possible which should be the starting point for the way Medicare Locals build their strategic planning. Indeed, this is the point of the proposal for Medicare Locals to prepare Health Community Plans.

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The achievement of building healthy communities requires a guarantee of the capacity within Medicare Locals to address the determinants of health as well as communicable diseases and sickness from the population level through to the individual level. Such an approach means ensuring appropriately skilled public health professionals are part of either the Medicare Local Board or on the key stakeholder/advisory mechanism. Additionally, key senior staff of the Medicare Locals must include individuals who hold professional qualifications at least equivalent to a Master's Degree in Public Health and preferably with a sound understanding of how to develop population health plans to meet the mandate for Medicare Locals to develop Healthy Communities Plans that will provide the template for the Health Communities Reports as outlined in the discussion paper. The Victorian Healthcare Association has developed considerable resources on population health planning that will be informative for Medicare Locals¹.

The Healthy Communities Reports requirement and the Plans that overlay them will go some way to meeting this criterion. However, it is important that while such reports collect data on incidence and prevalence of disease and the delivery of medical and prevention services, they must also report on the determinants of health consistent with reports being developed elsewhere², to ensure healthy communities in a manner consistent with guidelines from DoHA³ and recommendations of the World Health Organization (WHO). This means that the data in reports must be interrogated to draw out the inequities in any given community or catchment as well as identifying the modifiable determinants of health and disease which the Plans should address as priorities.

Recommendation 1 – Healthy Communities Reports and Planning

Healthy Communities Reports cover the broad spectrum of primary health care from maintaining and encouraging healthy communities to reporting on incidence and prevalence of disease and draw on the principles and practice of comprehensive population health planning.

Australian Preventive Health Agency

There have been a number of references to the work of prevention being the role of the (pending) Australian Preventive Health Agency. The PHAA believes that this is a very narrow view of how population health services are achieved. The Agency does have a key role in a national approach to better health by focussing on the issues that are responsible for the greatest burden of preventable disease – tobacco, alcohol and obesity.

However, the work of the Agency will not be successful without support and parallel work at the local level. It will be the role of Medicare Locals, if they are given the appropriate functions, to run

¹ Victorian Healthcare Association. 2010. Population Health Planning. Available: <http://www.vha.org.au/positionstatements2010.html>

² Marmot M. 2010. *Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010*. Available <http://www.ucl.ac.uk/gheg/marmotreview>

³ Department of Health and Ageing, Building Healthy Communities - A Guide for Community Projects. Available: <http://www.health.gov.au/internet/main/publishing.nsf/Content/ruralhealth-pubs-BHC.htm>

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programs that integrate with the social marketing, regulatory and other prevention methods either recommended or initiated and run by the Agency. It is important that planning for prevention and delivery includes appropriate understanding of the parallel roles and integrated approaches that are a normal part of the work of public health and health promotion professionals. They will be in a position to deliver at the local level while the Agency takes the national perspective and coordinates the most effective methods of dealing with these issues.

The functions, staffing and governance of Medicare Locals will play a major part in determining whether outcomes of the Preventive Health Agency are likely to be successful in achieving a reduction in smoking, in inappropriate use of alcohol and in achieving an improvement in healthy weight across the community.

Recommendation 2 – Relationship with Preventive Health Agency

The Medicare Locals, with appropriate staffing, should be in an appropriate position to tackle these issues taking into account the social determinants of health including:

- Appropriate action within the context of the specific socio-economic variations within the area for which they have responsibility
- Recognising specific needs of people from varying cultural backgrounds
- Specifically addressing the needs of Aboriginal and Torres Strait Islander peoples, primarily through the Aboriginal Medical Services in the area but also through ensuring culturally appropriate service delivery in mainstream agencies.

Medicare Local Functions

1. What will Medicare Locals do?

In addressing the issue of what Medicare Locals will do, the PHAA considers that we still have limited information about the details of the government's intention. We make the assumption that they are intended to deliver functions that have been the responsibility of the Divisions of General Practice as well as playing an additional role of ensuring that primary health care services that have been delivered in the past by other organisations will also come under the umbrella of the Medicare Locals to ensure that the community experiences integrated services and improved client journeys when using the system.

The issue of governance will be addressed later. However, as some Divisions were previously delivering services themselves as well as providing education through programs in areas such as chronic disease, mental health, immunisation and Indigenous health, the PHAA assumes that Medicare Locals will remain responsible for delivery of such programs. This raises the issue as to what extent the Medicare Locals will be a *provider* or a *conduit for service delivery* and the ramifications that this carries for other services such as the Aboriginal Medical Services (AMSs). There would be a conflict of interest if Medicare Locals were in a position to deliver services to Aboriginal peoples and were also the conduit for purchasing services from an AMS.

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The concern for the PHAA is that under such circumstances the work of the AMS may well be compromised at a time when it is critical to support all services that contribute to improving Aboriginal and Torres Strait Islander health. The PHAA recognises that there are outstanding examples of AMS services that provide high quality primary health care on an holistic model to Aboriginal and Torres Strait Islander people and that there are variations in the calibre of the AMSs. Therefore, health reform needs to recognise best practice, provide support, evaluate and encourage all services to meet the highest standards.

Similarly, the National Aboriginal Community Controlled Health Organisation (NACCHO) needs to be supported to provide networking, coordination, capacity building and support for AMSs across the country.

Health equity should be used as a principle for developing Medicare Local boundaries. It is important that Medicare Local catchment areas facilitate equitable distribution of health services to their target populations, and that health equity is considered when resourcing Medicare Locals.

The PHAA also supports Medicare Locals supporting a wide range of models of healthcare delivery including those now well established in Community and Women's Health Services which address both social equity and the determinants of health. They do this through low or no-cost allied health services as well as the delivery of a range of community-based programs to address chronic conditions and health improvement as well as community development. The spectrum of services they provide are much more than 'reaching the underserved' in Primary Medicare Care. Community and Women's Health sectors deliver a wide range of services on local, regional and state-wide bases funded by the States and Territories with programs in chronic disease, mental health, Indigenous health, women's health and community engagement especially for hard-to-reach communities and individuals, drawing on a broader primary health platform than PMC. The fee-for-service- model of Primary Medical Care is often a cause of poor access to health services by people without the finances to pay out-of-pocket costs, so the provision of programs and primary care by Aboriginal Medical Services, Community Health Services and Women's Health Services should not be undermined by Medicare Locals. Indeed, these established systems, built on decades of experience with minority groups with complex and chronic conditions, will need to be supported and expanded if they are to reach the growing pool of people living on low incomes. These are equity principles which are essential to the fabric of Medicare Locals. As local structures, funding for Medicare Locals will be delivered directly from the Commonwealth. The PHAA is concerned that Medicare Locals, constructed on Divisions of General Practice, will not sufficiently support these services to ensure that they continue to provide essential services that are complementary to Primary Medical Programs.

The role of Medicare Locals should not differ according to the size or population density of the region in which they are based. Small rural communities should benefit from the same standard of planning, population health activity and service delivery as people in larger cities. This principle of health equity is undermined by the allocation of provider numbers to individual General Practitioners, who are then free to practice where they choose rather than where there is greatest need. Equitable access to services in low socioeconomic, rural and remote areas is more assured through provider numbers being allocated to geographical areas.

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Recommendation 3 – Health Equity

Health equity should be included as a principle for developing Medicare Local boundaries and the range of services for which Medicare Locals will be responsible. Medicare Locals should incorporate similar roles regardless of the size or density or characteristics of the region's population.

Community Health Services, Women's Health Services and Aboriginal Medical Services also deliver vital health promotion services at a population level, which should become an important component of Medicare Locals. Health promotion at population levels spans from the provision of health education and information through to behaviour and lifestyle change programs, to community action and organisational change through to policy and regulation. Divisions of General Practice are not experienced across this range of health promotion actions which are supported by the WHO Ottawa Charter for Health Promotion and subsequent conference declarations, most recently that from Nairobi (2009).

Recommendation 4 – Population Level Health Promotion

Quality integrated health promotion practice and delivery should focus on implementing an appropriate mix of health promotion interventions (that encompass a balance of both individual and population-wide health promotion interventions).

This type of work is not within the remit of Medicare Locals at this stage. It is vital that the need for upstream health promotion is not lost within these reforms. Such interventions will only be effective if they are built on analysis of the social determinants of health. Divisions of General Practice do not have the necessary experience and expertise to develop such broad-based work so additional and appropriate expertise will need to be brought into Medicare Locals to ensure the efficacy of Healthy Communities Plans.

Recommendation 5 - Service delivery or purchasing services?

The PHAA recommends clarification of the role and responsibilities in the context of Medicare Locals with regard to the extent to which Medicare Locals will purchase services compared to the extent to which they will be involved in service delivery.

Recommendation 6 - Aboriginal Medical Services

The PHAA recommends clarification of roles and responsibilities in the context of Medicare Locals with regard to:

- Aboriginal Medical Services throughout Australia
- NACCHO in the context of the Medicare Locals

The PHAA understands that there is much more expected of the Medicare Locals in delivery of primary medical care and health care broadly. Without in any way diminishing the importance of

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these responsibilities and functions, it is appropriate for our organisation to emphasise the key messages around prevention, social equity and building healthy individuals through healthy communities.

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

On initial reading of this section of the discussion paper it appears that the issues of public health are addressed. Not so. The Health Community Reports, for example, are narrowed to providing information that will “give consumers and providers access to greater levels of information *regarding health services and performance*”. Clearly the thinking behind such statements is that planning at the beginning of the health care spectrum (from population health and health promotion strategies to self-care) is not intended to be part of the reporting of the Healthy Communities Report. While the table on page 6 of the discussion paper does mention “increasing the focus on prevention” in a couple of places, the PHAA notes the notion that reports and prevention activities are almost always seen in the context of “more appropriate service utilisation, improved patient access and greater clinical and administrative efficiency”. While these are laudable goals, the thinking is clearly from a medical model. The information should also be used, for example, to assess the levels of alcohol use, overweight and smoking in order to tackle community issues around prevention. Furthermore, it must be used in the context of socio-economic mapping so that it becomes clear where equity demands the greatest effort to keep people out of primary medical services.

Recommendation 7 – Primary Health Care and ‘Primary Medical Care’

- More effort be made to ensure that thinking behind the Medicare Locals is based on Primary Health Care rather than ‘Primary Medical Care’
- The Healthy Community Reports be reframed to include socio-economic mapping and ensure focus on specific populations to ensure the greatest efforts at keeping people healthy and minimising the need for primary medical services as well as addressing health equity.

The PHAA recognises the full spectrum of services required across the health care system and supports the efforts to improve functions of primary medical services in the context of the primary health system as well as strong coordinating links into the Local Hospital Networks.

Medicare Local Governance – to support the full spectrum of functions

2. What will Medicare Locals look like?

Purchaser, provider: or both?

It is not clear to the PHAA, from information circulated to date whether the Medicare Locals will be funded as a conduit to purchase services locally or whether they will also be able to deliver services.

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The PHAA does not submit on the most effective legal framework in which Medicare Locals will operate as others have far greater knowledge and understanding in this area. However, whatever the model that is established, it will need to ensure the clear delineation of roles.

Conflict of interest

Our major concern is the risk of conflict of interest in as far as it has the potential to undermine the most effective delivery of the full spectrum of health care. The dangers to the effective delivery of primary health care services are most obvious with regard to the relationship between the AMSs and Medicare Locals. However, the same principles apply across the spectrum.

Recommendation 8 – Conflict of Interest

Conflict of interest should be considered a key principle in the establishment of Medicare Locals.

3. How will Medicare Locals interact with patients and providers?

This is the Problem – a ‘Primary Medical Care’ Model

This question demonstrates the very issue the PHAA is concerned about. The clear focus is the provision of medical care. Providers have a very important role in dealing with patients in the context of a Primary *Medical* Care Model. However, a Primary *Health* Care Model deals with both patients and people.

Discussion of the role of the National Performance Authority does not include performance in terms of population outcomes but rather implies that the majority of the reporting will be ‘outputs’. The reason for reform in the health system is really based on improving health outcomes. What we need to measure in each of the Medicare Locals (as well as the outputs) are the improvements that are being achieved in mortality and morbidity, primarily measured on life expectancy and on Disability Adjusted Life Years (DALYs).

Recommendation 9 – Measuring OUTCOMES as a priority over OUTPUTS

The National Performance Priority adopts a framework in which outcomes are the key measurement and the outputs are identified as a subset of those outcome measurements.

For a realistic primary health service that supports the government’s intentions to improve health across the community it is important that the big picture is not lost. Outcomes rely on a range of factors that are totally beyond the control of GPs and Allied Health Professionals and relate to such matters as socio-economic status, housing, education and other socially determined factors. It is only when these are measured and considered at the local level that there is real hope of a considerable improvement of health across the community. The alternative, that has been the main focus, so far, of the discussion on the Medicare Locals has been a focus on individuals and the work needed to take care of their health needs on personal prevention matters, on early intervention and

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on appropriate management of chronic conditions. It simply is not enough if the driving force behind the Minister's goals is to be recognised and responded to appropriately.

Conclusion

This submission has outlined the rationale for 9 key recommendations in relation to the issues raised in the Discussion Paper. The PHAA is hopeful that the recommendations included in this paper will inform the government's health reform agenda and will provide assistance in taking steps to improve the health outcomes of the community. The PHAA would like to thank the government for the opportunity to make this submission and would be pleased to provide additional information to further assist the Committee should it be appropriate.



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