

Menzies Centre for
**Health
Policy**



**Response to the Australian
Government Department of
Health and Ageing Discussion
Paper
'Medicare Locals: Discussion
Paper on Governance and
Functions'**

November 2010

Menzies Centre for Health Policy

Thank you for the opportunity to comment on the Discussion Paper. The Menzies Centre for Health Policy, a collaborative centre between The Australian National University and The University of Sydney, was established in 2006 through a competitive grant from the Sir Robert Menzies Memorial Foundation. The Menzies Centre for Health Policy aims to provide the Australian people with a better understanding of their health system and what it provides for them. The Menzies Centre encourages informed debate about how Australians can influence health policy to ensure that it is consistent with their values and priorities and is able to deliver safe, high quality health care that is sustainable in the long term.

The Menzies Centre for Health Policy's submission responds to the five key objectives for Medicare Locals that are outlined in the Discussion Paper.

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

The Menzies Centre for Health Policy has considerable experience researching and working with hospitals, community health and general practice in Western Sydney and the Australian Capital Territory, focussing on the identification of need for coordination and integration of care for people suffering from, often multiple, chronic illnesses and on developing policy and system interventions that would improve their outcomes.

Money and support matter for success

The most relevant lessons arising from this experience include that little meaningful, sustained and successful coordination or integration of care occurs without sufficient and ongoing funding and commitment from Commonwealth, State or local agencies. Funding is only effective and sustainable with considerable local control and active involvement of those providing care, allowing variation, responsiveness and flexibility.

No one size fits all

The makeup of primary care and its relationship with Local Hospital/Health Networks (LHNs) in any given location or area, and significant variations in local populations and health needs, means that no standard template will be able to account for specific population characteristics at the local level. Different models should be tried and compared, taking careful note of context. Medicare Locals give a real opportunity for a diversity of responsive and flexible solutions to develop in collaboration or partnership with LHNs, community health, allied health professionals and consumer groups.

Medicare Locals should also be funded to support research that: identifies key issues that relate to their communities, for example socioeconomic issues, indigenous communities, access problems; informs service and quality improvements; and evaluates new models and programs.

Broadening the definition of 'service providers'

The Discussion Paper suggests Non-Government Organisations that provide health and/or community services support to the primary health care sector may also play a role in Medicare Locals. The Menzies Centre for Health Policy supports this approach and advocates, from our experience in talking with patients and evaluating programs of care in western Sydney and the ACT, for involvement to be further broadened to include agencies outside the health sector that provide care, support and community services in a range of different contexts and settings. These include state housing agencies, transport services and, in the case of NSW, the Department of Community Services. This may be critical when planning to address the health and care needs of disadvantaged groups, lower socioeconomic populations or areas with significant communities of Indigenous and/or non-English speaking peoples. Similarly, their role in meeting complex care needs for people with long term conditions is well known to users of services, and their inclusion as part of the Medicare Locals structure is a new and important experiment for integration across agencies at a local level.

Integrating primary care WITHOUT a super clinic

HealthOne Mount Druitt is a NSW Health initiative that is delivered by the Mount Druitt Community Health Service in Western Sydney. It is an example of a local flexible model of care that focuses on coordination and integration by networking GPs, Community Health and local hospitals. Instead of aggregating all the services in one place and expecting people to come to the service, staff actually travel to the patient or the GP: a wise response in Mt Druitt where public transport is poor and many people lack private transport.

Two GP Liaison Nurses act as case managers, one for patients with chronic and complex conditions and the other to address the health needs of children and families. These nurses identify patient needs based on referrals from 'out there' that they receive. They facilitate communication, case conferencing and care coordination between the partners involved in patients' care, including hospital discharge planners, GPs, Community Health, allied health professionals and in some instances agencies outside the health sector.

GP Liaison Nurses assist local GPs, in collaboration with other health professionals in the primary care sector, to develop care plans and make use of Enhanced Primary Care Medicare items to improve the treatment provided to their patients. We have been involved heavily in the evaluation of all aspects of HealthOne and it is a remarkable experiment in decentralised community care. It offers a valuable contrast to the superclinic model, which may be more appropriate in areas where physical collocation of services gives real benefits, such as rural centres. Evaluation of these, and other emergent models will help to create a culture of service improvement and innovation in primary care. **Research and evaluation must be an expected and funded part of Medical Locals.**

Piloting patients with chronic problems through hospital and beyond

Medicare Locals are a perfect opportunity to build stronger connections between acute hospital services and community care to reduce unnecessary hospitalisations and improve the care of the chronically ill. Every State and Territory has experimented with 'frequent flyer' programs to identify patients at risk and improve the hospital end of treatment. Links to care in the community have been a major stumbling block in each of these experiments.

'Care Navigation', an initiative of Sydney West Area Health Service, is attempting to bridge this gap and provides some useful lessons for the design of Medicare Locals. We are involved in the evaluation of this program of care for patients with serious and continuing illnesses through a randomised controlled trial funded through the NHMRC at Nepean Hospital in Penrith. The program seeks to pilot, or 'navigate', patients who come to hospital back into community care so as to maintain them optimally. One marker of success is that further hospital emergency department visits and admissions, if they occur, are timely and appropriate.

The Care Navigation trial is a hospital-initiated system of coordinated care for patients who present to the Emergency Department with a deterioration in their chronic illness. Care Navigation engineers patients' progress through the hospital according to their immediate needs for care and then prior to discharge provides patients, carers and GPs with a personalised care plan for subsequent management. The systems for coordinated care within the hospital are now well organised. The real challenge faced by the program is the haphazard nature of connections between hospital and the primary care services that should provide seamless services for discharged patients. Medicare Locals offer the opportunity to build improved lines of communication between hitherto fragmented services, improving the integration of acute and primary care. These links should be a significant element in the governance arrangements of both LHNs and Medicare Locals. Cross representation should be structured around service improvement, rather than just formal representation on boards.

The value of evaluation

As stated, the Menzies Centre for Health Policy is evaluating both the HealthOne and Care Navigation initiatives. These evaluations will identify critical elements for the implementation of future coordinated care programs. Other current and future research should feed into the development and delivery of Medicare Locals. For example, we are undertaking a national survey of older people with and without chronic illness to establish whether some aspects of coordination of care are more likely to lead to unplanned admissions to hospital, providing further useful evidence for Medicare Local policies about where the 'best bets' are in new care models.

Vive la difference!

If some Medicare Locals build on the examples of HealthOne Mount Druitt and Care Navigation, these local models may look quite different from Medicare Locals built on the Victorian Primary Care Partnerships model. Structural, governance, funding and partnership arrangements of Medicare Locals must be sufficiently flexible to enable development of models that are responsive to local needs.

How will Medicare Locals actually fit with LHNs?

Our research in Western Sydney and ACT has found a major barrier to effective cooperation is the GP perception that problems are being 'dumped' on them by hospitals, often as part of an elaborate cost shifting endeavour. This is a bad omen and leads to disgruntlement. Hospitals likewise grumble that chronically ill patients are dumped in their Emergency Departments and dysfunctionality in the relationships between hospital and community grow worse.

Successful models of integrated care have broken into this cycle by first identifying and solving the problems of GPs, including a greater sensitivity to the pressures faced by their business models. For example, in managing complex chronic cases in HealthOne Mount Druitt the service has reached out to GPs, especially those working alone, offering a helpful service. What works in the community does not necessarily work well in hospital and one challenge for LHN/Medicare Local cooperation will be to avoid solutions developed to solve a problem in one sector being imposed on the other.

Back to assessing need

Medicare locals will require epidemiological expertise in the identification of health needs of local areas and in the planning and provision of primary care services as well as disease monitoring and surveillance. Detailed local population health and service planning functions will also need to be underpinned with the evaluation of health service innovations that ultimately should translate into changes in local epidemiology.

One of the things that GPs with whom we work speak about with feeling is that prevention has been dumped on them, along with chronic care. It is currently unclear from the Discussion Paper who will be responsible for prevention and health promotion activities. It seems reasonable to assume Medicare Locals are the most appropriate organisation to undertake those aspects of prevention that concentrate on individuals (immunisation and mammography and treating CVD risk) but this argument falls apart when community or population-based prevention is considered, including access to recreational facilities, healthy food security and alcohol supply. Are we expecting prevention to work with one arm tied behind its back? If not, how will Medicare Locals relate to broader prevention initiatives? Working closely with other services and government agencies is likely to offer most. Their formal inclusion in governance and funding decision making bodies will be necessary to make it happen.

Improving the patient journey through developing integrated and coordinated services

As the Discussion Paper points out, episodic care is currently under- or uncoordinated and poorly integrated as a result of care and funding models being oriented towards organisational goals and timetables rather than patient's health care needs. This is particularly the case for patients suffering from chronic illnesses where multiple service providers, both within the hospital system and within the primary health care setting, are usually involved.

Our preceding exposition of HealthOne and Care Navigation models show how intensely interested we are in seeing services scheduled and delivered according to the patient's agenda and their needs, rather than those of the administrative and other needs of health organisations providing the care. Meaningful representation of the consumer perspective on LHN and Medicare Local boards is critical to getting this right, as has been demonstrated repeatedly in the many accounts in the literature of successful approaches.

Provide support to clinicians and service providers to improve patient care

NSW already has a body, the Clinical Excellence Commission (CEC), that provides 'a comprehensive quality improvement and patient safety program across NSW'. Other states and territories have similar bodies. The risk is remoteness: an expert group unfolding their wisdom that doesn't work in the trenches.

To avoid this 'Churchill phenomenon' as one practitioner put it (referring to Churchill's hopeless oversight, from a great distance, of the Gallipoli disaster), how will the programs of the Commission be integrated within the NSW LHNs and Medicare Locals? This question remains unanswered in the midst of the organisational churn started by the shake-up leading to the formation of LHNs. What are the National Lead Clinician Groups and the National Performance Authority supposed to do, and how can they remain relevant to local needs being so far away? This is far from clear and indeed worrying.

Appropriate national standards will only work if they are rooted in reality and not in a bureaucratic fantasy of what goes on 'out there'. The mythic nature of 'out there' is inevitably prevalent when policymakers and practitioners operate independent of each other, and indeed independent of any consumer input into what is needed, what would work and what it would cost.

Consideration also needs to be given to appropriate standardised measures nationally and across States. Measures that might suit hospital and Medicare Local administrators may not fit criteria for clinical excellence. Careful thought must be given to measures that align nationally and across States and that achieve stated aims.

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

Experiments by GP Divisions and Networks in areas such as e-Health have widened the acceptance of new technologies and approaches to practice, although their success has been limited by the lack of their operation in a responsive system. They have also been limited by the absence of effective evaluation and systems of diffusion of successful experiments. The development of Medicare Locals gives an unprecedented opportunity to build an organisational culture built on evidence and exchange of knowledge. The staged introduction of Medicare Locals recognises the very uneven organisational capacities of primary care at present, making this process of experimentation, evaluation and dissemination even more essential. Support for systematic evaluations at the Commonwealth, State and local level with an integrated standardised evidence based database of findings would significantly improve the implementation and successful performance of primary health care initiatives and programs.

The role of formal change management seems barely to be appreciated. In Kaiser Permanente in the US, by contrast, change management has been understood as critical to effecting substantial and sustainable innovation. For example, the roll-out of a full functioning IT basis for every single aspect of their integrated service was achieved over ten years at a cost of billions of dollars, almost half of which went into change management! We expect things to happen by magic, like a clip from a Harry Potter movie, by the wave of a bureaucratic wand!

Be efficient and accountable with strong governance and effective management

A central question relating to efficient, accountable, strong governance and effective management is this: who are the budget holders in the new LHN/ Medicare Local system? Are budgets to be held at Commonwealth, State, LHN, or Medicare Local level, or some combination thereof? Until this is made clear, it is very difficult to comment on effective governance and management. However, whatever the fund holding arrangements are, effective and efficient governance and management will be dependent on sufficient funding, appropriate budget items, managers with a clear vision and formal linkages between LHN/Medicare Locals. Without data systems, failure looms.

She'll be right mate - maybe

The Discussion Paper asks the reader to take much on trust, assuming that the mechanisms of funding, provision and accountability across primary care can all be sorted out as we go- a 'she'll be right' approach.

Given the stakes in setting up Medicare Locals, a once in a generation reform, there is great need for ongoing and critical research to provide evidence for good decision making, for the evaluation of structural and funding experiments and for the development of an Australian knowledge base so that future development builds on solid foundations. Divisions of General Practice have achieved much and some have successfully integrated allied health and formed strong community links. These remain a minority, and it will be important to involve a wide array of interests in building Medicare Locals, rather than just creating a bigger and better GP Network by default.

About us

The Menzies Centre for Health Policy is committed to promoting, through research and scholarship, the development of policies and systems for the care of people with chronic illness. We manage several projects that describe current chronic disease management strategies and evaluate new interventions designed to enhance the quality of life of people with these problems. The Menzies Centre for Health Policy welcomes the opportunity to provide further advice on the Department's health reform initiatives.

Talk to us. We are keen conversationalists.

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The Menzies Centre:

- produces and publishes high-quality analyses of current health policy issues;
- delivers public seminars and education programs on a wide variety of health policy topics;
- undertakes comprehensive research projects on health policy issues.

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