SUBMISSION TO REVIEW OF MEDICARE LOCALS

Prepared by
COTA Australia National Policy Office

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COTA AUSTRALIA

COTA Australia is the peak national policy body of older Australians. Its members are the eight State and Territory Councils on the Ageing (COTA) in NSW, Queensland, Tasmania, South Australia, Victoria, Western Australia, ACT and the Northern Territory.

COTA Australia has a focus on national policy issues from the perspective of older people as citizens and consumers and seeks to promote, improve and protect the circumstances and wellbeing of all older Australians; promote and protect their interests; and promote effective responses to their needs.

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INTRODUCTION

Australia's population is ageing and this will accelerate as the baby boomers move into older age. In 2011 there were 3 million people over the age of 65, making up around 14 per cent of the population and this figure will rise to over 8 million in 2050 or 25 per cent of the population. This has important implications for health service design and practice and the needs of older people must be explicitly included in any health system redesign.

Older people are more likely to have complex needs, co-morbidities and chronic conditions that need attention. To manage these conditions people need access to good quality primary health care. In the past Australia's primary health care was fragmented, uncoordinated and there were obvious gaps in services. In our recent Election Panel survey of 900 members health care came up as the number one concern for the survey participants and many identified access to good quality primary health as the key to good health.

This submission concentrates on the roles they either do or could play and how to ensure their functions continue. We also believe that more could be done to promote good practice across the network so what is working well can be shared and inform innovation and improvements across primary health care.

ISSUES

The role of MLs and their performance

Medicare Locals, as primary health care organisations, were developed to help coordinate services, undertake much needed local needs based planning and look at ways to fill service gaps. Their structure, membership and governance arrangements are all designed to develop strong partnerships between service providers to ensure a more integrated approach.

We note that the performance of the Medicare Locals has been quite variable. Feedback from COTA members, some of whom are involved with their Medicare Locals on Boards or consultative bodies, suggests that they are all improving and starting to make a difference to the way primary health care services are organised and operate.

State and Territory COTAs have developed good working relationships with a number of Medicare Locals to help deliver programs and messages. To improve the delivery of the Living Longer Living Stronger program of strength training for older people COTA WA has been working closely with metropolitan Medicare locals (North Metro, Central and East Metro, Fremantle, Bentley Armadale and South Coastal). They are looking at improved referrals of patients through Medicare Locals' Primary Health Plans and EPC forms, increasing awareness of the program in medical practice's offices, including implementation of streamlined online referral tools for GPs and establishing additional Tier 1 providers in their Directorates, with the training and accreditation of their exercise physiologists as Living Longer Living Stronger instructors.

In SA COTA is working with Central Adelaide Medicare Local to deliver health promotion messages through COTA's peer education programs, which have a successful history but have recently lost ongoing support from national bodies like NPS and Beyond Blue despite

their formally evaluated demonstrable positive impact. Medicare Locals can see that impact at the coal face.

Most Medicare Locals have only been fully operational for two years and COTA believes that this is insufficient time to make a full appraisal of their performance given the change in attitudes and work practices that they need to lead to bring the various players together into a system. Winding them back or abolishing them is likely to mean most significant gains are lost and the primary health care system could become more fragmented than before - with consumers being the main losers in that situation.

One of the determinants of whether Medicare Locals are performing is how successful they are in engaging with their communities. The ones that are doing this best have Boards that reflect the composition of their communities from a consumer perspective i.e. by age and cultural diversity. They also have engagement strategies that reach out to all groups within the area. COTA believes that one of the guiding principles for Medicare Locals should be that their engagement with consumers reflects the composition of their communities and that they have tried to engage some of the groups that traditionally are difficult to engage with i.e. homeless people.

Recognising the breadth of primary care practice, including but not limited to GPs, in the ML functions and governance structures

We believe that Medicare Locals have a key role in ensuring Australians have access to the full range of primary health care including general practice services. Most older Australians value their relationship with their general practitioner and general practice is an vital and integral part of the health care team.

It is important to remember that many older Australians, particularly those living in rural and remote areas, have limited access to a GP. For example Queensland is a state with a large number of residents who do not have access to a GP within driving distance. Residents in many parts of Queensland receive the vast majority of their primary health care (in fact, their health care in general) from an allied health workforce. Therefore we think it is critical Medicare Locals continue to be supported to ensure that all primary care providers are working to their full scope of practice.

One of the strengths the Medicare Locals have over their predecessor organisations, Divisions of General Practice, is that they do bring the multidisciplinary approach to all aspects of planning, consultation and service delivery - which ensure consumers get the best possible outcomes.

Interaction between MLs and Local Hospital Networks and other health services, including boundaries

One hallmark of Medicare Locals we believe are working well (i.e. delivering innovative and solutions-based projects) is meaningful collaboration with Local Hospital Networks (LHNs) (however named and defined), consumers and across the primary care disciplines. Our observation is that there is considerable variation across the Medicare Locals in this regard.

Some Medicare Locals and LHNs are working very closely doing joint engagement activities with health consumers, carers, organisations and the communities. This maximises effective engagement for all involved, especially for peak statewide consumer organisations that are engaging with a number of LHNs and Medicare Locals.

COTA Queensland has identified the introduction of the position of Queensland Medicare Local State Coordinator and Senior Policy Adviser as a key step towards improving the coordination of engagement, planning and collaboration between the Medicare Locals and stakeholders in that state. This role provides a central contact point for those wishing to engage with all Queensland Medicare Locals and progress cross-Medicare Local collaborations. COTA believes there would be merit in creating similar roles in all States and Territories.

One area where COTA believes Medicare Locals could do better is working with aged support and care services. As older people are staying living in the community longer, with higher levels of need for support, there need to be closer relationships between primary health care providers and aged specific services to ensure people are receiving the best mix of services to meet their changing needs.

Older people can make many transitions between the health and aged care systems e.g, from community to acute and back to community, or community to acute to transition care or rehabilitation and back to community. Medicare Locals can provide a vital link between the services in their communities, acting as an information conduit, education and facilitator of collaborations.

There is an urgent need to link the two planning processes, particularly at the local level. Aged care planning is done at a regional level to feed into the Aged Care Approvals Round for Residential Care and Home Care packages, and for the separate Home and Community Care Services (HACC - to become Home Support Services on 1 July 2015). This planning looks at aged care services that are available in the area but not really taking into account other services such as primary health that are key to people being able to remain living in the community.

Needs based planning would be easier if the boundaries for Medicare Locals, LHNs and Aged Care were to be aligned. However where this is not possible it would be helpful if there was a better understanding of the patient flows across all three sectors and mechanisms for sharing data and collaborative planning processes.

Medicare Locals needs based planning does not automatically include what is happening with ACAR and Home Support planning but it clearly should as it has a significant impact on demand for primary health services . We believe that Medicare Locals should be required to include aged care needs in their planning processes and should link with ACAR processes to do so. As the new Aged Care Gateway (currently called My Aged Care) develops to its full operational capacity over the next couple of years it may well be the an important and appropriate linkage point with Medicare Locals as its data base will be an unprecedented source of information on trends in needs and service preferences, waiting lists, etc.

CONCLUSION

COTA believes that Australia needs a network of primary health organisations to identify needs and develop responses at the local level to ensure we have an integrated primary health care system. These organisations need to be able to be responsive to local communities needs and also to develop partnerships across primary health care providers and with other parts of the health and aged care systems.

Given that they need to be responsive to local community needs and that there is great variability across regions in terms of service provision we do not believe a more prescriptive approach to the structure and function of primary health care organisations would be helpful. We believe there needs to be a stronger set of guiding principles for primary health care organisations that ensure they build the appropriate links with the health and aged care systems and add value for both providers and consumers of services.

Feedback from consumers shows that the name "Medicare Locals" has contributed to poor understanding of the purpose of Medicare Locals in the community. We believe the name should be changed to better reflect the true nature of the organisations.

We would welcome the opportunity to meet with the review team to provide more information.

COTA Australia
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