

State level roles and functions for Medicare Local support and coordination

This discussion paper identifies some of the roles and functions that may be necessary to effectively support Medicare Locals in Victoria, and provides some examples of the effect these roles might have in a few particular areas.

GPV would welcome divisions' comments on the issues raised here, to take into account as it continues to negotiate with Commonwealth and state Ministers and Departmental staff about plans beyond 2012, after the initial establishment of Medicare Locals.

Summary: building a more integrated system

State level support and coordination for Medicare Locals will enable consistent implementation of policy and practice, across Australia.

The majority of Australia's health services are coordinated from the state level, as are health policies and legislation. To implement Commonwealth designed services and programs without the benefit of adequate assessment and negotiation of how they can best work in unison or parallel with state initiatives significantly risks fragmenting health sectors, duplicating programs, undermining relationships and confusing community members.

State level organisations can help to secure state government investment in MLs, as they have done for divisions. This would provide a better basis for a coordinated health system, rather than treating medical primary care as solely the business of Commonwealth government and hospital, sub-acute and broader primary health care as the concern of state government.

Adapting initiatives to the state context

The Commonwealth programs to be implemented by Medicare Locals will be a combination of existing programs that are currently run through the Divisions Network and new initiatives. All of them aim to improve access for patients, to prevent the development of chronic disease, to provide a better coordinated patient journey through the system, to contribute to quality improvement and to provide the care that is needed in the most appropriate setting. Their successful implementation will require collaboration between Local Hospital Networks, Medicare Locals and a wide range of other service providers and organisations – both public and private.

State level organisations will facilitate relationships and partnership with state-wide services and state funded services. Medicare Locals will have strong relationships at the local level. They will also need relationships with state-level organisations, including:

- state-level health foundations (e.g. Cancer Council, Diabetes Australia, Heart Foundation, Foundation for Survivors of Torture)
- in Victoria, the Primary Care Partnerships
- consumer organisations
- health and primary health care-related state government departments
- specialist tertiary settings
- major service providers like RDNS

- rural workforce agencies
- state branches of national organisations and peak bodies, such as
 - RACGP
 - NACCHO
 - Heart Foundation
 - Australian Psychologists Society
 - Physiotherapists
 - Speech Pathologists
 - Osteopathic Association
 - Aust Association of Social Workers
 - Diabetes Educators
 - Australian Podiatry Association
 - Dieticians Association
 - Aged & Community Care Victoria
 - Palliative Care Victoria

These types of state-level organisations will not find it practicable to liaise with each Medicare Local in order to bring together plans covering the wide range of players that need to be involved. A state-level support and coordination organisation for the Medicare Locals would be a more effective mechanism for transfer of information, and for engaging the range of players who need to be involved if the Commonwealth programs are to work.

Addressing access and equity

State involvement is necessary to address the needs of vulnerable populations. Additionally, there are high-need populations with low-prevalence conditions which are best addressed at a state-wide level, which can link with state-based health organisations, colleges, specialists and hospitals with whom they need to work. There is not a sufficiently large group of medical providers (nor patients) to warrant a Medicare Local addressing the full range of these issues, and the national level is too remote.

Emergency response

Emergency response will remain a state responsibility. The primary health care response to emergencies needs to be organised at a state level not only with state-funded agencies, but with a range of providers. Medicare Locals will be major contributors to local health responses to epidemics and natural disasters and a state-level peak body for Medicare Locals will enable state departments to disseminate information effectively to the multiple MLs that need it and get the provider involvement that they need, when they need it. A state level organisation for Medicare Locals can negotiate appropriate roles with the state government and help implement existing state protocols through Medicare Locals.

Public Health

Likewise public health will remain a state government responsibility. Medicare Locals need to pay attention to the prevention and treatment of infectious disease as well as chronic disease and much of the former is driven by state government public health departments. State Government public health departments need primary care provider involvement in the notification, prevention and treatment of infectious disease but will be unable to achieve this involvement through numerous separate Medicare Locals for whom infectious disease might be a minor issue. A state level organisation would have the capacity to develop protocols that are effective and assist in the identification of programs and providers who could assist in the curtailment of infectious disease

Clinician input to health policy for effective program implementation

There will need to be input on behalf of the primary health care system to state-level initiatives, if they are to be implemented effectively, and enable integration with Commonwealth initiatives, rather than establishing separate processes and strategies. A state level organisation would be able to draw on the experience across a number of Medicare Locals and so contribute to the development of policy and planning, and help to secure successful implementation of strategies.

Capacity building for Medicare Locals

While capacity building for Medicare Locals could be undertaken for generic skills at a national level, there are benefits to conducting training at a state level (including establishing local relationships and networks, and achieving greater 'reach' among the target group, as it is easier and cheaper to attend training delivered at state level than nationally). Additionally, there are benefits to a state level delivery for training and information exchange that focuses on more specific programs. For example, best practice work that is relevant to the state context can be showcased, and the relevant key players can be brought together. For some topics, Medicare Locals in one state have more in common than across Australia as a whole and so the lessons can be more relevant.

Most appropriate setting for care

There will continue to be a trend to shift some areas of patient care from current hospital settings to community settings for a range of reasons including better access for patients as well as cost containment. (Just one example is hepatitis – in Victoria there has been a program to enable more care to be provided through general practice which requires a range of training and other supports. One outcome is that country patients do not need to travel to the city for treatment and are therefore more likely to seek and complete required treatment). These types of initiatives are best organised through a state level organisation. There is not a sufficiently large group of medical providers (nor patients) to warrant a Medicare Local addressing the full range of high-need populations with low prevalence conditions; but the national level is too remote, and not so well able to link with the state-based health organisations, specialists and hospitals with whom they need to work.

Workforce

The states play a key role in undergraduate education and in the provision of specialist training places. A state level organisation could ensure that the state's work in this arena included coordination with Medicare Locals so that primary care settings were included in undergraduate training considerations and that the allocation of specialist training places reflected population health needs as determined by Medicare Locals.

eHealth

To achieve an electronic communication pathway that captures the patient's journey in and out of acute care and through a range of primary care providers there needs to be compatibility and understanding between those developing the state run eHealth systems and those involved in the primary care sectors. A state level organisation could bring together the private and public, local, state, and national players within the state's context to develop common understanding and tools, and work towards the implementation of interoperable systems that ultimately offer patients better care.

Linkage with Local Hospital Networks

It is anticipated that Medicare Locals will link strongly to their Local Hospital Networks. A state level organisation would be well placed to pick up the common structural issues that cannot be solved at the local level and work with the state government on these issues. This might include funding arrangements for specialist clinics, the provision of education to primary care providers

to reduce the hospitalisation of those with ambulatory sensitive conditions, improvements in the transfer of patients from small hospitals to larger hospitals, improvements in the provision of specialist mental health services to rural areas, etc. Likewise a state level organisation would be well placed to work with the state-wide hospitals and services to improve their linkages with primary care providers through Medicare Locals.

State government response

In Victoria, the state government's response to the Commonwealth on Medicare Locals supported the establishment of independent state level organisations. It proposed that their roles be:

- Relationship management and partnership with state-wide services
- Support consistent implementation of policy and practice
- Provide centralised functions to support more efficient use of Medicare Local resources.

GPV supports these roles, but believe more needs to be added, as outlined above.

GPV's consistent message to the Victorian Department of Health has been that in order to achieve better patient care through the Medicare Locals, there are important roles and functions to be fulfilled at all three levels: national, state and local.

Some case studies of what a state level organisation with good relationships with other stakeholders could help to achieve

Example 1

Refugees are predominantly settling in the outer suburbs and regional centres. In one area a specialist clinic notices that a lot of refugees are coming to the clinic at the hospital to get access to long acting Vitamin D. He arranges for GPs in the catchment area to get ethics approval to provide long acting Vitamin D in their practices. This takes the pressure off the hospital clinic and is more accessible for patients. Through the state level organisation working with the Foundation for Survivors of Torture the state government asks how this approach could be scaled up to other geographic areas where there are refugee populations. As the state level organisation in partnership with the Foundation for Survivors of Torture convenes a refugee health primary health network involving a range of primary health providers and the settlement service provider for the state this initiative is discussed at that forum and steps for other Medicare Locals to scale up this approach are outlined. By the end of the year the three main areas where refugees live have GPs accredited as long acting vitamin D providers. As the numbers and issue grows in other areas the state level organisation assists those MLs work out how to get accreditation for their GPs.

Example 2

Medicare Locals subcontract **mental health nurses** to a range of GP and primary health services. An adverse event occurs in one area where a patient seeing a mental health nurse and other state government-funded specialist mental health services commits suicide. However the coroner and the public are reassured because the state level organisation can work with the state government department to ensure communication protocols with primary health services are developed and acted upon by the specialist mental health services. The state level organisation also regularly meets with the mental health program workers in Medicare Locals through network meetings to ensure they have a good grasp of clinical governance as it applies to subcontracted services and that the clinical governance is consistent across the state. This helps mental health nurses know what they can expect whichever Medicare Local employs them and what they need to take care of themselves in terms of supervision, credentialing, record keeping, complaints, home visiting, etc. The local state representative of the Mental Health Nurses Association is very helpful and interested in this work

also, and is included in the educational networking opportunities convened at state level. The state level organisation can work with both the Medicare Locals and the state government so that they both have a good understanding of each other's mental health services and can work towards encouraging safe and complementary service provision.

Example 3

The Commonwealth will continue to fund allied health services to **aged care** facilities. However from 2012 this will be a function of Medicare Locals. As the allied health services to be funded through MLs will be expanding to include community based aged care this could potentially duplicate what is already being delivered through HACC. The state level organisation can facilitate cooperative and consistent approaches across MLs and the Home and Community Care (HACC) Sector by bringing the two sectors together. A state level organisation can also deal with the queries from allied health providers who want to be part of the scheme, and keep the aged care sector informed about how the program is going through the ongoing relationship with Aged & Community Care Victoria.

Example 4

The Commonwealth will fund Medicare Locals to develop **after hours medical services**. This is a complex undertaking. A state level organisation could negotiate on behalf of all the metropolitan Medicare Locals with the existing locum services in the state about their role and capacity. The organisation could also facilitate a dialogue between the state government and Medicare Locals so that the new developments build on and take into account the state-run Nurse-on-Call service, the co-located clinics in hospitals, and the needs of palliative care services and aged care facilities. In the rural areas in particular it will be important that the hospitals and Medicare Locals have cooperative after hours arrangements in place as the workforce is scarce. A state level organisation can facilitate the state's understanding of the needs of Medicare Locals and the value in cooperative arrangements that might entail cooperative funding arrangements. The state level organisation could also work with the Pharmacy Guild to facilitate access to pharmacy supplies in the after-hours period. This is particularly needed in relation to palliative care and aged care.