NATIONAL RURAL HEALTH ALLIANCE INC.

Rural Issues Paper on Medicare Locals

Establishing and funding Medicare Locals to serve the people who live in rural and remote communities

In the context of health reform in Australia, Medicare Locals are described as the keys to regional integration and better coordination of local health services. A network of Medicare Locals is being established as the platform for primary care reforms in the health sector, building on the groundwork of the network of Divisions of General Practice, to "become much broader and much deeper – involving a wider range of health professionals and identifying community issues and working to fill gaps in care or service".

The establishment of Medicare Locals is planned to take place rapidly and, if undertaken in the right way, can deliver substantial benefits to rural and remote communities. However, major reorganisations of health systems can impose costs on those systems and can risk damaging the morale of the clinicians and managers involved, which has the potential to undermine existing levels of patient care. For these reasons, there must be clarity of purpose and the benefits of reform need to be both significant and certain.

The overarching purpose of the reforms to primary care outlined in the National Health and Hospital Network is to ensure that the nation's health resources are more appropriately directed to keeping Australians healthy and out of hospital where possible. The reforms aim to encourage models of care that allow providers the opportunity to organise and coordinate care around the needs of the patient. (This would be in contrast to the uncoordinated and poorly integrated episodic care that arises when health care delivery is dictated by funding models and not patients' health care needs.)

For health reform to deliver these significant benefits with certainty in rural and remote areas, the changes implemented need to be owned and thus strongly supported by interested parties (patients and clinicians) at local community levels, fit for local purpose, and rolled out in a logical sequence.

Purpose and functions of Medicare Locals becomes clearer

The purpose of the Medicare Locals is becoming clearer and includes identifying local needs and addressing gaps in services, coordinating and integrating services, bringing health professionals together to work in teams and, over time, bringing more focus onto prevention and early intervention.

The Minister has described how Medicare Locals will build on the strengths of the Divisions network, retaining and expanding activities in areas such as:

- providing support to health care providers – GPs, nurses, allied health professionals, dentists, paramedics, optometrists etc - to provide more integrated care while maintaining the role of general practice;
- improving access to services for patients, especially where after hours care is concerned;
- encouraging integration across primary care, with Local Hospital Networks and with the aged care sector;
- identifying and targeting service gaps and the people most in need, such as gaps in primary mental health care and psychological services;
- delivering local health promotion and preventive health programs, informed by Healthy Community reports which will measure community health and wellbeing;
- facilitating allied health care and other support for people with chronic conditions;
- promoting better safety and quality of services;
- working closely with other Government services and with education and training providers to support the education of primary care professionals; and
- providing a platform for further reforms, including:
    - coordinating after hours primary care services;
    - better integrated primary mental health care in the future; and
    - the adoption of the key infrastructure for e-health.

The most important relationships for Medicare Locals outside their own area - particularly those in rural and remote areas - will be with health services located in the regional centre and the capital city that people in the area see and use as their normal source of tertiary care.

Medicare Locals that serve rural and remote communities

The Minister has advised that the Government's "preferred boundaries" for Medicare Locals and Local Hospital Networks will be announced soon and settled by the end of this year, taking into account feedback to the AGPN report, data analysis on populations and patient flows and the likely shape of other health planning regions.

In rural and remote areas, Medicare Locals must be small enough in area for meaningful relationships to be maintained among individual clinicians, and between them and local hospitals, other service providers and community leaders. They should be based on existing communities of interest – which are defined in part by the current flows of people to the services they access.

Although there is always some tension between the search for economies of size or scale, and the search for the degree of 'localisation' required for effectiveness, the Alliance believes that populations as small as 50,000 are sufficient for the effective undertaking of the tasks envisaged for these new primary care organisations. These tasks include assessing local health needs, putting in place plans to meet those needs, and supporting the programs and personnel once they are in place.

Medicare Locals will not work well in rural and remote areas if they span huge geographic distances or difficult terrain, or if they ignore natural communities of interest - such as is apparently proposed in NT, Tasmania and South Australia. In areas of this size there are not the professional contacts nor the sense of local ownership and control needed to make the new entities work.

Improved structures for local health services will also require contiguous States to agree to have Medicare Locals cross their boundaries. This is absolutely essential.

The integration of health care services that is needed to guarantee continuity of care for patients should start with high level co operation and collaboration. In some more sparsely populated areas, where it is the same clinicians who staff primary, acute and aged care facilities, this will mean the Medicare Local and the Local Hospital Network being merged or operating at a local level as a single entity. Only this will result in the sort of integration necessary to support the interdependence of primary, aged and hospital care that already exists in more remote areas.

Even where they are not merged, Local Hospital Networks and Medicare Locals will have to work together to overcome the artificial demarcations between acute and primary care, and to guard against the perverse incentive for hospitals that are funded on an activity basis to seek more activities through greater numbers of admissions.

The Commonwealth, led by Minister Roxon, has a vital role to play in working with the States and Territories to ensure these outcomes.

Transitional arrangements that preserve rural and remote primary care services
Flexible funding for action on health priorities needs to be commensurate with capacity in the initial phase as Divisions of General Practice morph into broader primary health care agencies.

Rural and remote communities will have particular needs as Medicare Locals start to identify and address service gaps across the range of primary care services in order to support the establishment of a trusted culture of multidisciplinary service managed by the local community. The Government will need to support the new organisations with sufficient resources to employ the epidemiologists, population health experts and service planners needed to develop their business plans and monitor their implementation and evaluation. Medicare Locals serving rural and remote communities may need particular consideration to guard against increasing rural and remote inequities in health care, as the staff to take up the new roles, or the health professionals needed to deliver more integrated health care, may be less available due to existing health workforce shortages.

During this transition, to build a culture of success, the new Medicare Locals should have the capacity to select the key issue(s) for the first focus of their work, whether it be diabetes, more integrated primary mental health care, adoption of key infrastructure for e-health or the coordination of after-hours services. The Medicare Locals will then be able to provide support to the many smaller groups of local health professionals, community leaders and service providers whose passion, flair and understanding of local culture will develop mechanisms to translate plans into implementation.

Rather than imposing new bureaucratic hierarchies by selecting ‘winners’ and ‘losers’ from the current Divisions Network for development into Medicare Locals, the strengths and experience within existing Divisions must be sustained. The possibility for networks of existing divisions to evolve and share expertise, to form coherent and complementary Medicare Local networks, must be promoted.

Governments must work closely, collaboratively and cooperatively with the Aboriginal Community Controlled Health Services (ACCHS) sector on all facets of the establishment, governance and responsibilities of Medicare Locals and the Local Hospital Networks. The new organisations on the ground will have key roles in supporting activity on many fronts to close the gap between Indigenous and non-Indigenous life expectancy, wellbeing and education. Given the level of health need of Aboriginal and Torres Strait Islander people and the fundamental importance placed on community control by many of these people, the establishment of MLs must

be pursued in ways that build capacity in the ACCHS sector. Direct ACCHS engagement with Commonwealth, State and Territory Governments and their joint commitment to the Closing the Gap agreement will also need to be strengthened.

If the Commonwealth leads strongly and the States provide enabling support to the Medicare Locals, including from their cohorts of experienced health service planners and managers, the current round of health reform into which so many people have invested so much energy, will spread out to inspire the hearts and minds of more and more local people and result in improved health services and outcomes.

Resourcing Medicare Locals to build up services in under-served rural and remote areas
The inequities in health access faced by people in rural and remote areas are one of the top priorities to be targeted by the reform process.

As the functions of individual Medicare Locals become clear it will become more apparent what level of resourcing will be required for them to meet their responsibilities. In addition to the means of meeting their particular areas of focus, MLs in rural areas will need sufficient resources to take account of the serious deficiencies in health workforce, Medicare funding, public transport and health infrastructure. These basic and ubiquitous deficiencies will need to be addressed to deliver local, more integrated health care in rural and remote areas. The health workforce challenges in rural and remote areas include both recruitment and retention.

One of the key strengths of health services in rural and remote areas is the living examples they provide of good multidisciplinary care:

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

However, local multidisciplinary health care teams require local players - gaps in local health workforce have to be overcome, as do the additional challenges for ongoing training and support. Integration and better coordination of health services can only occur where health services exist locally or can be complemented by innovative service models such as outreach or telemedicine. And health care has to be affordable and within reach for the patients – including allowance for travel costs and time away from home and work.

Resourcing for upgrading or building infrastructure to meet the challenges of delivering health services in rural and remote communities will also be a consideration for Medicare Locals and Local Hospital Networks. While some communities retain their small rural hospitals and can provide necessary accommodation for visiting health professionals (eg for consulting rooms or overnight stays), some will require upgrades and other under-served rural areas will not have such facilities any more.

Communications infrastructure, and training and support for its uptake, will be a critical part of the role of Medicare Locals serving communities outside major cities and will need to be a part of resourcing arrangements.

NRHA
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