Feedback on potential boundaries for Medicare Locals and Local Hospital Networks

Introduction

Women's Health West (WHW) is the regional women's health service for the western metropolitan region of Melbourne in Victoria. Our services include research, health promotion, community development, training and advocacy around women's health, safety and wellbeing. Since 1994, WHW has also hosted the region's largest family violence crisis support and prevention program. These two main arms of the service place WHW in a unique position to incorporate women's experiences directly into our research, health promotion and project work, ensuing that we clarify the connections between structural oppression and individual experience.

As a feminist organisation we focus on redressing the gender and structural inequalities that limit the lives of women. WHW's work is underpinned by a social model of health and, as such, we recognise the important influence of, and aim to improve, the social, economic and political factors that determine the health, safety and wellbeing of women and their children in the western region. By incorporating a gendered approach to health promotion work that focuses on women, interventions to reduce inequality and improve health outcomes will be more effective and equitable.

Informed by our vision of equity and justice for women in the west, WHW's work is guided by the following five strategic goals:

- Delivering and advocating for accessible and culturally appropriate services and resources for women across the region
- Improving conditions in which women live, work and play in the western region of Melbourne
- Putting women's health, safety and welling on the political agenda to improve the status of women
- Recognising that good health, safety and wellbeing begins in our workplace

- Working with others to achieve our goals.

WHW sits on the Board of the HealthWest Partnership and the Interim Governance Group of the Inner North West Primary Care Partnership. We are also a member of the Women's Health Association of Victoria and the Australian Women's Health Network. As one of the twelve women's health services across Victoria, WHW is well positioned to provide expertise and advice on the intersection between women's social experience and their health and wellbeing. Our submission endorses and, in part, draws on the submission by Women's Health Victoria.

Question 1: Principles for determining boundaries or catchment areas for Medicare Locals, including potential differences between metropolitan, rural and remote areas (e.g. size of catchment populations, natural catchment areas)

Recommendation: Health equity should be included as a principle for developing Medicare Local boundaries. Medicare Locals should incorporate similar roles regardless of the size or density of the region's population.

While *A National Health and Hospitals Network for Australia's Future* (2010) promises to improve responsiveness of the system to local needs and enhance the quality of health services, the focus on hospitals and general practitioners risks the ambitious health equity framework required to underpin changes to our health system. A greater focus on prevention, population health and health promotion are integral to the vision of a healthy and fair Australia. DoHA's report into *Primary Health Care Reform in Australia* (2009), for instance, outlined multi-government agreement that Australia's health system should be shaped around the health needs of individuals, their families and communities, with a focus on prevention of disease and the maintenance of health, not simply the treatment of illness. Support for an integrated approach to the promotion of health is required to achieve this, with hospitals, primary and community care agencies working together. Not all Australians receive equitable levels of primary health care services as a result of their geographical location, financial ability or the condition of their health, as outlined in the report. On the other hand, 'research shows that those systems with strong primary health care are more efficient, have lower rates of hospitalisation, fewer health inequalities and better health outcomes' (p. 8).

Ensuring strong primary health care services in tandem with a health equity approach are key to development of Medicare Local boundaries. Catchment areas must facilitate equitable distribution of health services to their target populations. This means ensuring that Medicare Locals are resourced to take on the same role regardless of population size or region

density. Small rural communities should benefit from the same standard of planning, population health activity and service delivery as those in cities.

Recommendation: Provider numbers for General Practitioners should be allocated to geographical areas to ensure equitable access to services in low socioeconomic, rural and remote areas.

WHW support Women's Health Victoria's point that the principle of health equity is undermined by the allocation of provider numbers to individual general practitioners who are able 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.

Question 2: Suggestions about the optimum number of Medicare Locals in a particular state, territory or region, including potential boundaries in each area

Recommendation: That Primary Care Partnerships are used as the foundation for Medicare Local boundaries.

Recommendation: That specific expertise in health promotion, population health and women's health are included at the local level and upstream at the population level.

In Victoria we have well-established Primary Care Partnerships (PCPs) that have built the capacity for collaborative relationships leading to a range of actions in the areas of acute care, service coordination and integrated health promotion. Women's Health West participates in PCPs at the governance and health promotion levels, and has found the legitimacy given to collaborative work, along with the development of frameworks for a continuum of actions from primary prevention to tertiary intervention, has resulted in region-wide buy-in and has added enormous value to all of our work. WHW works across seven local government areas comprising two PCPs. Our experience suggests that rather than there existing an optimum number of Medicare Locals, the best outcomes will be achieved by building on the strength of existing networks, common priorities and collaborative responses to demonstrated need. In the western metropolitan region the PCPs are active and innovative, with region-wide collaboration led by different agencies with particular expertise. For instance Women's Health West has led catchment-wide initiatives in the areas of prevention of violence against women, and sexual and reproductive health.

The report by Carla Cranny and Associates (2010) acknowledges the strength of PCP catchments as the basic building blocks for primary health care organisations (PHCOs), stating that these provide the population focus required by PHCOs to undertake their role. Women's Health West suggest that it is not simply the catchment area that should be the

building blocks for Medicare Locals, but the relationships that have developed over the last decade of PCP funding. *Going Forward* (2002) outlined the PCP strategy developed by the Victorian Department of Human Services, which was founded on the social model of health, and aimed to improve the health and wellbeing of the population – and reduce the preventable use of hospital, medical and residential services – by strengthening relationships between and within the primary care and acute sectors and through improved service coordination, planning and health promotion programs. As Barry Hahn (2002) pointed out:

> While all governments recognise that part of the answer to cost containment in the health sector lies in health promotion and a stronger primary care sector, political realities make shifting the balance to increase funding to the primary care sector a daunting task.

Women's Health West encourages the more ambitious health care reforms originally flagged, with less emphasis on divisions of general practice becoming the building blocks for Medicare Locals, and more on the vision of the PCP strategy, reflected in DoHA's earlier reports. We recommend that specific expertise in health promotion, population health and women's health are included at the local level and upstream at the population level to complement the clinical skills of Divisions of General Practice and ensure that health services are responsive to the social determinants of health.

Question 3: How boundaries might be defined in cross border areas

Recommendation: Provide assurances to state-based and regional organisations regarding their ongoing roles and funding.

There are a range of health programs in each state and territory that do not exist in other jurisdictions. The Victorian Women's and Community Health program is a clear example of agencies providing responsive solutions to local and specialised needs. The women's health program includes state wide and regional services. It is not clear how these unique services will be integrated into the matrix of Medicare Locals and Local Hospital Networks, particularly in the absence of a national women's health policy available to provide a concrete framework. Arrangements should be defined as soon as possible to provide assurance to organisations in the relevant fields regarding their ongoing roles and funding.

Recommendation: Before finalising Medicare Local boundaries, the Department of Health and Ageing should consider how health promotion will be achieved at local, regional and state wide levels.

Women's Health West have concerns about how regional – or state wide – health promotion or service delivery organisations might fare with funding delivered directly from the Commonwealth to Medicare Locals. These local structures do not take account of organisations and services that deliver on a regional or a state-wide basis, crossing multiple Medicare Local boundaries. The benefits of region-wide or state-wide health promotion services cannot be stressed strongly enough. WHW has led and participated in a number of collaborative initiatives in the western metropolitan region that have resulted in innovative strategies for planning, delivering and evaluating services from primary prevention to tertiary intervention. The ability to work across boundaries is key to regional and state wide services.

Question 4: Potential barriers or difficulties that will need to be addressed in establishing new boundaries and catchment areas for Medicare Locals

Recommendation: Consider the social determinants of health through health promotion activity at the population level.

One of the most important and complex roles of our health care sector is to ensure health equity by focusing on the social determinants of health – such as gender, culture and socio-economic advantage – and the impact this has on individual and population health. The complexity and understanding of health promotion initiatives in Victoria has strengthened considerably over the previous decade, with activities implemented locally, regionally and at a state-wide level. If health promotion initiatives were to be confined to the local service delivery environment under Medicare Locals, they risk losing broader scope and application. Disconnecting local initiatives from broader population-based initiatives fails to acknowledge the importance of strategic upstream action required to tackle the social determinants of health.

Question 5: Specific comments on the Carla Canny & Associates report (where relevant)

Recommendation: Medicare Locals should incorporate governance structures that promote the diversity of interests in primary care and avoid medical dominance.

Women's Health West was surprised by the unprecedented move by the Department of Health and Ageing in implicitly endorsing the Cranny report by making it available for comment. This move reinforces an assumed leadership role for Divisions of General Practice (DGP) in facilitating Medicare Locals. It also ignores the level of collaboration required across the health sector among a range of health professionals, including allied health, health promotion and population health, which is well outside the expertise or scope

of DGP's current role. The interests of general practitioners represent only a segment of the health professionals that will be working together under Medicare Locals.

The Cranny report (2010: 19-20) acknowledges that 'PHCOs represent a new entity in the Australian health system landscape with a wider range of functions than current GP Divisions or other primary care or community health services'. They will work closely with DGPs, but require broader governance that represents all of the interests and expertise in the primary care sector, rather than favouring the interests of one group over another.

The Victorian Department of Health (2010) has set strict governance protocols for Primary Care Partnerships that facilitate inclusion of relevant communities of interest. These include:

At least one representative from each of the following core service providers:

- Aged Care Assessment Service
- Community Health
- Hospital or Health Service
- Division of General Practice
- Local Government and
- District Nursing Service or its equivalent in rural or regional Victoria

At least two representatives from the following specialist service providers:

- Mental Health Service
- Drug Treatment Service
- Ethno-specific Service
- Women's Health Service and
- Sexual Assault Service

This governance structure avoids the medical dominance that would occur if hospitals or GP divisions were to hold responsibility for governance, and ensures the range of actions required to improve population health – primary care, health promotion, service coordination, etc – can occur. It also ensures that all of the organisations and networks that have responsibility for health care are collaborating. Women's Health West recommend that similar governance structures are adopted for Medicare Locals, drawing together existing skills and experience.

Recommendation: The Department of Health and Ageing should undertake independent analysis and mapping of the health system that takes account of all existing health services, including health promotion activities.

Similarly, the Cranny report maps DGP services available, but does not consider the link between these and existing health promotion and population health initiatives – despite the fact that these are outlined as key elements of Medicare Locals. This narrow definition of health services, and consultation with only one element of the health system, is not just a limitation of the report, it is a serious concern. Independent analysis and mapping of the health system is required as a key element in the process of informing boundary development and composition of Medicare Locals.

Question 6: Comments on Local Hospital Networks

Recommendation: Incorporate a governance requirement for formal linkages between Local Hospital Networks and Medicare Locals.

Local Hospital Networks must have strong links with Medicare Locals to facilitate effective transitions from acute care to primary and community care services. A requirement to collaborate must be incorporated into governance requirements for Local Hospital Networks and Medicare Locals.

Question 7: Other issues

Recommendation: Clearly define key terms such as 'health promotion' using the Declaration of Alma-Ata, Ottawa Charter for Health Promotion and Victorian Department of Human Services (now Department of Health) Integrated Health Promotion Resource Kit.

The varying use of undefined language adds to uncertainty. Terms such as 'health promotion', 'primary health care' and 'primary and secondary prevention' mean different things to different parts of the health sector. This ambiguity in meaning must be resolved.

Given its key role in transitioning to a more equitable health system, WHW recommends using the World Health Organisation's Declaration of Alma-Ata (1978) and the Ottawa Charter for Health Promotion (1986) as the foundation for this work. The Ottawa Charter defines health promotion as:

> ...the process of enabling people to increase control over, and to improve, their health. To each a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing.

The Victorian Department of Human Services (now Department of Health) Integrated Health Promotion Resource Kit (2003) is also useful in detailing health promotion practice in Victoria, where the term refers to agencies in a catchment working collaboratively on priority health topics, using a mix of health promotion actions and capacity building strategies to bring about health and wellbeing outcomes. The key points are collaborative partnerships; a balance of individual and population-wide health promotion interventions supported by capacity building strategies; and clear identification of the key partners across a broad range of sectors essential to tackling the determinants of health. This includes parties outside the traditional primary health care sector, who are equally drivers of health reform.

Recommendation: Ensure that Medicare Locals respond to the social determinants of health.

Recommendation: Define how health promotion and women's health organisations will be affected by the current national health reforms.

In December 2010 COAG will meet to consider questions that could impact on the funding of Victorian health services. As the document *Delivering the Reforms* (2010: 26) states, potential changes to funding arrangements arising out of the COAG agreement include either transfer to the Commonwealth or 'strong national reform efforts' for programs including community health promotion and population health programs, including preventive health.

This includes the majority of Victorian health promotion and women's health organisations, yet it is not clear how health promotion organisations and the way they function will be affected. WHW is concerned that the social model of health that is currently supported by PCPs will be replaced by a model of medical dominance under Medicare Locals, losing the very positive collaboration and program development that has focused on strategies to tackle the social determinants of health in Victoria.

Regardless of which body might fund women's services, there are key principles that are required for positive health outcomes. Women's health services must retain their independent governance structure. They must be able to participate in a range of actions with a range of organisations, not constrained by one employer.

Recommendation: Health reforms incorporate the full spectrum of health promotion activity from the local to the population level.

Recommendation: The skills and knowledge of health promotion practitioners are acknowledged and used effectively in developing the reforms.

Recommendation: A social model of health is a central feature of the health reforms.

There are two other reports that complement the current reforms – the National Primary Health Care Strategy (NPHCS) and the report of the National Preventative Health Taskforce. In each of these reports the priority for improving health care in Australia is prevention. Both the NHHRC and the Taskforce (2010: 26-7) recommended that a national health promotion and prevention agency be established to facilitate this work, given the critical gap in national infrastructure. Medicare Locals are also seen to have a facilitating role, connecting national and local resources and infrastructure. The National Primary Health Care Strategy (2010: 34) outlines the role for Medicare Locals in prevention and health promotion as follows:

> It is envisaged that Medicare Locals will play a key role in delivering health promotion and preventive health programs targeted at risk factors in communities. They will be supported in this role by the National Preventive Health Agency, once established, which will develop and disseminate national guidelines and standards.

This recognises that, as the front line of Australia's health system, general practice and other primary health care settings are the key environments for delivering primary and secondary prevention measures. This includes transferring funding and policy responsibility to the Commonwealth, bringing 'state funded community health services and Australian Government funded services together in the one setting for integrated primary health care' (DoHa 2010: 22).

However, a centralised funding model limits the ability of women's health and other health promotion agencies to deliver a range of interventions from individual to population-wide actions, as well as engagement in rigorous advocacy. The question of how population health initiatives will link with local initiatives to reach effective and complementary goals must be clarified before finalising Medicare Local boundaries.

Similarly, devolving responsibility for health promotion to Medicare locals de-professionalises health promotion practice, particularly where the focus of health promotion is on addressing risk factors to the detriment of the social determinants of health. This de-professionalising would be compounded by the NPHCS suggestion to expand the role of practice nurses to encompass health promotion requirements of Medicare Locals.

Each of the Commonwealth Government documents released to date have focused on health promotion and prevention as methods to deal with chronic diseases and conditions, particularly those linked to poor lifestyles, such as cardiovascular disease, diabetes and cancers associated with tobacco use. This focus on changing individual behaviour associates health promotion with individualised care to respond to chronic disease. It does not challenge the social determinants of health. Yet it is these factors that must be tackled

through health promotion and population health initiatives if we are to realise the ambitious vision of health equity for Australians.

The principles of health promotion, prevention and the social model of health are key to the development of an efficient health care system with lower rates of hospitalisation, fewer health inequalities and better health outcomes. These principles risk being lost in the health reforms, which give primacy to general practitioners and clinical skills as the mainstays of primary health care.

In Victoria the women's and health promotion sectors are well established as leaders and innovators, with numerous examples of primary prevention and population health initiatives that embed the social model of health across our catchments. The key to this work is having lead agencies, such as Women's Health West, responsible for driving reforms through collaborative practice. If health promotion becomes the responsibility of bodies such as the National Preventative Health Agency or Medicare Locals, without lead organisations with responsibility for the scope of health promotion and population health practice between these levels, progress is at risk. The chronic disease and behavioural change focus of the National Preventative Health Agency – and Medicare Locals it seems – with its initial focus on smoking, binge drinking and obesity, mean that a range of important health promotion activities will fall outside their sphere of activity. This leaves initiatives like advocacy, developing healthy public policy, redressing the broader social determinants of health, and acting to reduce inequities and injustices in the community, at risk of being lost. As the World Health Organisation (2005) point out, 'progress towards a healthier world requires strong political action, broad participation and sustained advocacy. Health promotion has an established repertoire of proven effective strategies which need to be fully utilized'.

We recommend that the commonwealth recognise and support the expertise of health promotion and population health organisations, including women's health services, to undertake these functions.

A population health approach to service planning should have two key goals in mind; to maintain and improve the health status of the entire population and to reduce inequities in health status between population groups. This is also the goal of the health care reforms. Any consideration of health care reforms, including boundaries for Medicare Locals, must begin by ensuring that all of the elements required to enact these goals are front and centre.

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24 September 2010

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