VACCHO

Submission to the National Review of Medicare Locals

VACCHO is the peak body for Aboriginal health in Victoria and advocates for the health equality and optimum health of all Aboriginal people in Victoria. VACCHO represents 27 Member Aboriginal Community Controlled Health Organisations (ACCHOs) and is accountable to the Aboriginal community through our Membership. The majority of ACCHOs are multi-functional services with health as a key component of their role, although some solely specialise in health service delivery.

VACCHO endeavours to ensure the sustainability of Aboriginal community controlled health services. Membership capacity is built through strengthening support networks and partnerships, increasing professional development opportunities and developing leadership capability and good governance.

VACCHO endorses the need for a coordinated approach to primary health care across the regions, however there needs to be acknowledgment of the specialist status of ACCHOs in the health care system if the health needs of the Aboriginal population is to be met.

Currently the diverse approaches taken by Victoria's 17 Medicare Locals and the apparent lack of clarity in their objectives and roles in both primary health and population health has actually impeded the planning coordination and delivery in both these areas.

The role of Medicare Locals and their performance against stated objectives

The role of Medicare Locals is unclear. As are their overall programme objectives.

- There is no clear indication whether their principle role is in the allocation of Primary Health funding or the provision of primary health services. There is no explicit guidance to prevent a conflict of interest between these two roles.
- Medicare Locals are mandated to undertake population health planning but they have no capacity to implement the plans they create and to support population health planning.
- Every Medicare Local has to have an Aboriginal and Torres Strait Islander health plan; however there is demonstrable lack of expertise and a low level of partnership with local ACCHOs or the community e.g. there are currently eight Medicare Locals have not had contact or established a relationship (good or bad) with their local ACCHO. Consequently, it is likely that representation of Aboriginal health needs in Medicare Local needs assessment reports vary in accuracy.
- There is overlap of Medicare Local population planning and other statutory health planning processes at local and state government level (i.e. Local Government Area Municipal health and wellbeing plans and Victorian Public Health and Wellbeing Plan)

  The following excerpt was provided by the Gippsland and East Gippsland Aboriginal Co-operative, and exemplifies the lack of clarity in Medicare Locals' roles and objectives in relation to working with Aboriginal organisations:

  > "In the last 12 months GEGAC have had two workers from the Medicare Local visit us in the Elders, HACC and Disability Team. The worker had no clarity on what he was doing. Another worker came week after week and helped in the kitchen for the planned activity group (PAG) lunches and then sat with one Elder at a time yarning however we never saw any outcomes or formalisation of anything during or after the visits….
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  > The second worker attended GEGAC after a reshuffle to the Medicare Local and promised to fund buses for funerals as this was where the Medicare Local worker perceived a gap in funding and what should have been a priority. It was evident that this worker had no clarity on his job role and it was perceived by us that he was making it up as he went along. He has since left and nothing has come of the funds. Recently, GEGAC have had contact with a nurse employed through the Medicare Local, looking at ways of working with the Elders, HACC and Disability Team".

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The performance of Medicare Locals in administering existing programmes

Medicare Locals' administration of existing programmes is extremely variable. Despite examples of exemplary programme management:

- The relationship between Rumbalara and Hume Medicare Local (HML) sees that HML pay to do case coordinating, HML contract Rumbalara to deliver the chronic disease programme and consultation was sought from Rumbalara and the Aboriginal community on HML's Aboriginal health plan. This consisted of Rumbalara bringing in traditional owners group, leading to the development of an Aboriginal mentor programme and Rumbalara delivering cultural training to HML staff four times a year.

Examples of poor programme administration abound including:

- A Care Coordination Supplementary Services (CCSS) worker was employed at Dhauwurd Wurrung Elderly and Community Health Service (DWECH) to "case manage and manage supplementary services" – funding was originally delivered as 0.8FTE and has now been reduced to 0.2FTE. Service delivery has been significantly impacted as a result.
- The lack of relationship between Medicare Locals and the Australian Medicare Local Alliance obstructs the process of administering coordination and support of networks
- Notably there is a low level of coordination of established partnerships with Indigenous Health Project Officer (IHPO), Aboriginal and Torres Strait Islander Outreach Workers (ATSIOW), Care Coordinators located within Medicare Locals, ACCHOs and NACCHO state affiliates.

Recognising general practice as the cornerstone of primary care in the functions and governance structures of Medicare Locals

- As previously mentioned health is a key component of the majority ACCHOs. MBS claims data support the suggestion that most ACCHOs have received minimal practice support for their GPs.

  Medicare Locals have been given significant funding to support the implementation of E-health and Tele-health initiatives. There is minimal evidence to suggest that Medicare Locals have developed effective partnerships support the work of ACCHOs in E-health and Tele-health.

Ensuring Commonwealth funding supports clinical services, rather than administration

The contracting and administrative requirements imposed by Medicare Locals often serve to support administration rather than clinical services. The management of CCSS provides several significant examples of this.

- The needs of ACCHO clients are frequently complex and services spend considerable resources and time "working out what fits their setting". Currently it is the CCSS workers who are burdened with the responsibility of delivering the service delivery model, which is essentially an accounting rather than the clinical role for which they are employed. The huge administrative burden makes it difficult to effectively "case manage" clients.
- Great South Coast Medicare Local in Victoria has imposed reporting requirements that involve double entry of data by clinical CCSS workers.

Assessing processes for determining market failure and service intervention, so existing clinical services are not disrupted or discouraged

There are examples of Medicare Locals:

- **Providing services to the detriment of existing service providers:** Eastern Melbourne Medicare Local (EMML) provides of multiple services that are difficult to access by the clients of Healesville Indigenous Community Services Association (HICSA). EMML service provision discourages other clinicians from providing services closer to Healesville.
- **Failing to mitigate market failure where services have been withdrawn or are non-existent:** When there was a General Practice Division in South West Victoria, General Practice Victoria provided Dietetic services in the South west region. With instigation of the Medicare Local the position converted to a Management role. There is now no dietetic service or dietician position available to ACCHOS in the region
- **Failing to develop or maintain referral paths which could ensure adequate service in thin markets:** Where Medicare Locals that do not have a relationship with their ACCHO, there is little chance of developing an appropriate referral paths for an Aboriginal clients.

Evaluating the practical interaction with Local Hospital Networks and health services, including boundaries

It is evident that a significant number of Victorian ACCHOs do not have successful relationships or partnerships with their local Medicare Locals. However, the relationship between Hume Medicare Local, Mungabareena Aboriginal Corporation (MAC) and Rumbalara Aboriginal Co-operative provide exceptions to this.

- The MAC CEO sits on the Albury Wodonga Aboriginal Health Reference Group (AWAHRG), consisting of Albury Wodonga Health Service, Gateway Health Service, MAC, Albury Wodonga Aboriginal Health Service, and Hume Medicare Local (HML). Therefore there is an excellent relationship with the Hume Medicare Local and MAC and HML CEOs meet regularly.
- The Rumbalara CEO has been on the board HML for 12 months and has recently secured another three year term.

These relationships provide effective resource allocation and practical support for the care of Aboriginal clients. This should be the pattern on which other Medicare Locals base their interactions with their local ACCHOs.

Tendering and contracting arrangements

There are no standardised contracts, reporting requirements or explicit funding guidelines for Medicare Locals to engage with ACCHOs or community health service delivery clinics. Psychiatric Disability Rehabilitation and Support Services (PDRSS), CCSS, tele-health and e-health funding are all administered by Medicare Locals. The lack of clarity frequently sees the shift in funding and contract arrangements with corresponding negative impacts on service delivery. Note the previously cited example of a CCSS worker employed at Dhauwurd Wurrung Elderly and Community Health Services (DWECH) to "case manage and manage supplementary services". The funding was originally delivered as 0.8FTE and has now been reduced to 0.2FTE. Service delivery has been significantly impacted as a result.

Other related matters

- The NACCHO Healthy for Life Report Card evidences the effectiveness of ACCHOs as providers of primary health care to Aboriginal people[1]. Medicare Locals have a role in resourcing ACCHOs as specialist providers of Primary Health Care with a key role in the consultation of their population health plan. VACCHO have encouraged Members to develop positive relationships with their local Medicare Local and actively seek input into the Medicare Local population health analysis comprehensive needs assessment for their region. However, this has been hindered by repeated demands by some Medicare Locals for access to our member's confidential information and free access to Aboriginal communities' intellectual property.
- VACCHO recommends that every Victorian Medicare Local establish a sound relationship and effective partnership with their local ACCHO with continued consultation on programme funding contracts and deliverables, Aboriginal Health Plans and Reconciliation Action Plans and develop sustainable and efficient referral pathways.

VACCHO concludes that there is a degree of willingness from some Medicare Locals to genuinely engage with the Aboriginal Community and that this should inform the basis, at least at an operational level, a clear action plan for closing the health gap. It is possible to achieve excellent outcomes in culturally safe access for Aboriginal people where Medicare Locals in Victoria have collaborated with ACCHOs regarding their coordination and population health roles. However, the current lack of clarity in individual Medicare Locals roles and objectives has resulted in inefficient and ineffective funding allocation for coordination and programme delivery within the primary health care sector.

As noted by Professor Stephen Duckett:

> "Medicare Locals have a weak evidence base for their existence or usefulness, an ambiguous role, weak levers for policy or health sector change or enforcement of policy and have a tendency to emphasize the average outcomes in the health sector and not the true reflection of range of outcomes and activity across Australia"[2]

1. NACCHO Healthy for Life Aboriginal Community Controlled Health Services Report Card, AIHW 2013 Cat. No. IHW 97

2. Professor Stephen Duckett, health economist and advisor to Medicare Locals, speaking at the Population Health Thinktank hosted by Loddon-Mallee-Murray Medicare Local 21-22/11/13