National Health and Hospital Networks, COAG and Mental Health Reform

Medicare Locals

Position Paper

Medicare Locals will have strong links to local communities, health professionals and service providers. Your Medicare Local is about providing more services to you and to your community. They will help provide more coordinated care, improve access to services and drive integration between GP and primary care services, hospitals and aged care. Importantly, one of their first tasks will be delivering extra after hour's services.

Minister for Health and Ageing, Nicola Roxon, 1 July 2010

Introduction

The Mental Health Council of Australia (MHCA) is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector, committed to achieving better mental health for all Australians. The membership of the MHCA includes national organisations of mental health service consumers, carers, special needs groups, clinical service providers, community and private mental health service providers, national research institutions and state/territory peak bodies.

In April 2010 at the Council of Australian Governments (COAG) meeting, the Federal Government won the support of all states/territories (with the exception of WA) for the National Health and Hospitals Network (NHHN) Agreement.

This Agreement has three primary objectives:

- Reforming the fundamentals of our health and hospital system, including funding and governance, to provide a sustainable foundation for providing better services now and in the future.
- Changing the way health services are delivered, through better access to high quality integrated care designed around the needs of patients, and a greater focus on prevention, early intervention and the provision of care outside of hospitals.
- Providing better care and better access to services for patients right now, through increased investments to provide better hospitals, better infrastructure, and more doctors and nurses.

COAG agreed that the Commonwealth will have full funding and policy responsibility for general practice and primary health care, as defined in the National Health and Hospitals Network (NHHN) Agreement, including community health centres, primary mental health care, immunisation, and cancer screening programs.

Of the $7.4 billion announced in the COAG Agreement and the 2010 Federal Budget for health reform, only $181.3 million over the four years was specifically directed to mental health. Of this, a mere $115 million was identified by the Government as new funding – the remainder either being redirected or restorative funding. This represented less than 1.6% of all new healthcare funding.

In February 2011, concerns from a number of state governments relating to the proposed Commonwealth take over of funding resulted in a new Agreement between all state and territory governments. Despite this new Agreement, the situation for mental health remains unchanged. Moreover, changes in government at the state and territory level continue to threaten commitments enshrined in these two Agreements and further perpetuates a state of unease and uncertainty within the Australian health and mental health sectors in relation to these reforms.

The aim of this Position Paper is to briefly summarise the commitments made in relation to Medicare Locals as they pertain to the mental health sector, and possible issues arising as a result of these commitments. This Paper also details a series of position statements for MHCA members to consider as part of a sector-wide response in the lead up to the 2011 Federal Budget and the next COAG meetings.

Issues for the Mental Health Sector

Key issues for the Mental Health Sector in relation to the Medicare Local Initiative.

1. At a fundamental level, community-managed mental health care services are grossly inadequate across Australia. They are the missing link in the delivery of modern, recovery-focused mental health services. Furthermore, they are entirely absent from the COAG NHHN Agreement and the announcements of the Federal Government.
2. There is considerable concern about the overtly bio-medical focus of the COAG reform agreement. There is little in the public documents or announcements related to the reform agreement that reflects a focus on recovery or in broader terms, consumer-directed care. Key tenets such as person orientation, person involvement and self-determination while evident in the report on Primary Health Care Reform handed to the Government in 2009[1], are absent from the Discussion Paper and announcements on Medicare Locals.
3. The mechanisms and levers for bringing together critical services to support recovery – including community and peer support, employment, education and training and housing – are absent from the Government's statements. There is an implication that the mere establishment of Medicare Locals will bring about such service integration.
4. Some stakeholders and many community mental health organisations and other service providers are very supportive of increased investment in community based services and would support a Medicare Locals model that encompassed a comprehensive view of primary health care that extended into community based residential care, subject to appropriate governance.
5. Most state/territory health departments would appear to see a continuing direct relationship and 'care pathway' from acute care to community-managed mental health services including supported residential programs. This may make integration with Medicare Locals more difficult and align specialist community-managed mental health services more with hospitals and acute units.
6. In relation to proposed discussions between states/territories and the Commonwealth over arrangements for community mental health and the Commonwealth's stated commitment to take over all primary care, most states/territories have already moved to align and define all community mental health services (state run and community-managed) as part of Area Mental Health Services (AMHS) or future Local Hospital Networks. In states such as Victoria, public mental health services have been managed by public hospitals since mainstreaming was implemented in the mid to late 1990s. Each of the twenty-one AMHS is managed by the local public hospital and the service mix covers both inpatient and community-based services, including primary mental health care teams, who work directly with GPs to support clients with more complex needs.
7. The papers released by the Government make no reference to a split in purchaser-provider roles. Such a requirement is a fundamental to contemporary governance arrangements. Indeed the documents imply that Medicare Locals will undertake both. Furthermore, the papers do not state that Medicare Locals must be not-for-profit but leave open the possibility that they are companies limited by guarantee. Some

[1] Department of Health and Ageing (2009). *Primary Health Care Reform: Report to support Australia's First National Primary Health Care Strategy,* Canberra.

members of Divisions of General Practice, state-based bodies and GPs have expressed a degree of concern relating to this point.

8. There appears to be inherent conflicts of interest in the envisaged roles. This combination of roles – service planning and development, service purchasing and contract management, and service provision – will cause tensions with other service providers.
9. The Department of Health and Ageing and the Federal Minister, and supported by the Australian General Practice Network (AGPN), have made it clear for some time that Medicare Locals will be developed from the existing Divisions infrastructure. Indeed the first round of tenders will only go to Divisions. A number of Divisions are well advanced on joint ventures, partnerships and some have commenced amalgamation, but not all.
10. Most independent assessments conclude that Divisions have had a varied and sometimes limited impact on their overall objective of connecting general practice with the other elements of the Australian health care system for the purpose of better consumer care. The reasons for this are many, however a universal limitation in the Division model is the lack of leverage they have had over any element of the health care system. Even in relation to engaging and reforming general practice the only levers available to Divisions have been rather limited program funds and support through training and development. A fundamental problem has been the lack of any formal authority to drive change in any area of health care. Many of those working in Divisions express a frustration in engaging GPs in training or other initiatives. It is not clear what, if any, changes are proposed by the Government in terms of the authority of Medicare Locals.
11. The Government has stated that Medicare Locals will be "independent legal entities", have "strong clinical governance" and "be accountable to the Australian Government". It is not clear how independent legal entities will have any authority over primary health care or any health care service providers. Nor it is clear how a Medicare Local could have authority in terms of clinical governance and practices by individual providers. These are generally the domain of the professional bodies. Finally, is it not clear how a Medicare Local could implement effective accountability across vast regions and manage data collection from hundreds, sometimes thousands, of providers. Divisions currently have very limited capability and experience in this area. Furthermore, Medicare Locals will be relatively powerless when compared with the statutory authority legislative basis of the Local Hospital Networks.
12. While there are a small number of Divisions of General Practice that have developed appropriate linkages and service systems in the area of mental health, the limitation of the Divisions approach has been an over-emphasis on doctor-centred care and perpetuation of the small-business, fee-for-service clinic model that lacks responsiveness to the needs of people with a mental illness. There has been little systematic support for development of best-practice collaborative care models for consumers with longer-term (chronic), complex, persistent or episodic illnesses. The focus on remuneration for single occasions of service and reluctance to reward enhanced management of episodes of care has only perpetuated inequity and poor access for socio-economically challenged, geographically-isolated and other high risk groups. It is not clear from any of the documents on Medicare Locals how they will facilitate a move to a more balanced collaborative recovery model of care.

13. A concern of many stakeholders is the inherit conflicts of interest in the current governance structures of many Divisions and the lack of clarity on governance for the new Medicare Locals. In order to address the 'doctor bias', it is important that the structure and governance arrangements for the proposed Medicare Locals include consumers, carers, people drawn from the local community, and people who manage community-based services in the region. Without this critical input from the community, Medicare Locals are destined to repeat past failures.
14. Both state and territory governments have agreed that the creation of Medicare Locals will lead to services that are more responsive to the needs of local communities, as a result of local governance arrangements and their proximity to the communities they serve. A number of proposed Medicare Local jurisdictions, however, stretch across vast geographical distances and nearly or fully cover entire state and territory boundaries (i.e. WA, TAS, SA and NT). These Medicare Locals will have the unenviable and near impossible task of determining the local community needs of people living in vastly different regions and circumstances.
15. Whilst the Government has indicated that funding arrangements of Medicare Locals will take into consideration rurality, socio-economic status, health and Aboriginal and Torres Strait Islander status of the community, it is unclear what amount of funds will be provided to Medicare Local staff who need to travel, at significant expense, across vast geographical terrain in order to assess and meet the needs of their diverse constituents. It would be unacceptable for such travel costs to come at the expense of service delivery in these jurisdictions.

A Mental Health Sector-wide Position on Medicare Locals

These issues or principles are proposed to underpin a whole of sector advocacy position in relation to the NHHN Reforms relating to Medicare Locals.

Position: There is a need for clarity in relation to what is covered by 'primary health'

- Primary health care is more than general practice.
- Primary health in the COAG Agreement is focussed on high prevalence disorders; it does not address the higher order more serious physical and medical conditions and the lower prevalence serious mental illnesses. This is problematic and simplistic. People with severe mental illness have multiple physical health needs which, in many cases, can best be addressed through integrated primary care that is effectively supported by specialist mental health services.
- It would be helpful to identify the scale of under-provision of service and funding for moderate and severe mental illness

Position: Services need to be integrated

- Separation of clients by illness is not helpful. Primary care, specialist community care and hospital care need to be seamless for all clients across the lifespan.
- Mental health services, both clinical and non-clinical, must also be integrated with other relevant services such as employment, housing, education, training etc.

Position: Community mental health services must have adequate representation in the governance structures, if they are not fully independent.

- Governance arrangements for the new Medicare Locals are critical. In line with contemporary governance practice, they should be fully independent and professional.
- Governance structures should ensure adequate representation of service providers, consumers, carers and community mental health organisations.

Acknowledgements

This position paper has been prepared by the Mental Health Council of Australia with input from MHCA members and Board members, and in consultation with ConNetica Consulting. The MHCA thanks those members who contributed to the development of the paper.