

Medicare Locals – The benefits
AMA National Conference 28 May, 2011
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Good morning and thank you for inviting AGPN to speak at this important *Political Hot Topics Session* at AMA's National Conference.

The case for Medicare Locals is quite clear: reforming Australia's primary health care system to the Medicare Local model of care is fundamental to managing an over-burdened system that is too reliant upon the hospital sector.

The **overarching function** of Medicare Locals is to ensure services are better targeted to address local community health needs by:

- undertaking population health and service planning;
- identifying and tackling health inequalities and ensuring access to primary health care services to meet community need;
- coordinating care across health care providers by promoting cooperation and collaboration; and
- driving continuous improvement in the quality of services and programs, particularly by effective use of good data

Key areas of initial focus will be: teams working for:

- chronic disease management and prevention
- after hours care facilitation
- mental health
- aged care
- eHealth.

The **Benefits of Medicare Locals** include:

- Better planning so that there will be more equitable access to services for Medicare Locals' regional populations.
- An increased focus on primary health care – we know that Australia has for too long focused on the acute care setting and this needs rebalancing

- Accountability and an increased focus on Continuous Quality Improvement. Medicare Locals will be required to provide Healthy Community Reports to the National Health Performance Authority – with reports made public. Moreover, Medicare Locals, over time will be the single point of accountability for primary care outcomes and performance in their regions. The blame game will be on its way out and there will be a focus on quality.
- There will be a greater focus on primary (as well as secondary) prevention and the opportunity to provide more truly comprehensive primary care. Over time, Medicare Locals will link with other agencies and service providers both within and outside of the current health system so that regionally we can start to address the social determinants of health
- There will be better integrated and coordinated care across the primary care sector. There will also be greater connectivity with the secondary/acute sector through linkage with Local Hospital Networks resulting in more integrated care between the primary and secondary care sectors.
- For GPs, there will be access to a much greater range of resources and support so that we are no longer working in isolation but are supported to provide care for our patients through multi professional teams, through service coordination and through access for our patients to services that impact on their health but that currently as GPs we can do little about - like housing, welfare etc.
- Regional service planning and the development of new models of care will help address workforce issues and will potentially provide more choice for GPs (eg After Hours, Aged Care) - important given our ageing workforce and that many younger generation doctors choose not to work the long hours we all have.
- Through ML linkage with academia, there will be more opportunity for grass roots input into research as well as potentially greater dissemination of learning and innovation
- The major benefit of Medicare Locals is that they will help reorient the system towards Primary health care.
- And the reality is we need a focus on **Primary Care now more than ever**. Medicare Locals provide that system.

Fundamentally it comes down to this:

- Do we accept a definition of health that goes beyond just the treatment of disease but that also addresses the social determinants of health?

- Do we support a system of health care that is universally accessible to individuals and families in the community through their full participation, that includes a multi-sectoral as well as multidisciplinary approach to health and is at a cost that the community and the country can afford to maintain?
- Do we support health as a human right?

I know AGPN supports this view and I believe the AMA does too – the AMA’s statement of values includes:

- Promoting and advancing the public health
- And advancing, not just the professional interests of doctors but also the health of the community.
- The AMA code of ethics also underlines the importance of a number of these views of health.

Where we differ is in how we see these goals realised. AGPN’s view is that achieving these goals requires a PHCO system in Australia.

It is because of support for this view from various agencies - from evidence about the role of PHCOs in rebalancing the health system as well as support from our current government - that we have reached this point – the point where we are about to establish Medicare Local PHCOs.

PHCOs – or Medicare Locals - are here by design not by accident.

They are here because without such bodies as Primary health Care Organisations it is going to be difficult to get the traction required in the PHC sector and we will continue to be an acute sector dominated health system. A system we cannot afford and that does not produce the results we want for our patients.

We know – and international evidence overwhelmingly demonstrates - that health systems oriented towards primary health care produce better outcomes, at lower costs, more equity and with higher user satisfaction¹.

¹ [Keynote address of Dr. Margaret Chan at the International Seminar on Primary Health Care in Rural China in November 2007](#)

Critics of medical professionals often say that doctors aren't good at changing their behaviour. I would argue with that. In fact, when shown the data about our performance we usually learn quickly and change our behaviour correspondingly.

But we're not good, as a profession, at listening. (Some studies suggest we interrupt our patients within 18 – 23 seconds of them starting a conversation – even though they do not need much more than a minute to tell their story).

I'm asking you to listen and really see the data in front of us.

Access to health care in this country is not equitable:

- Indigenous peoples and those living in rural/remote areas have higher rates of illness and live shorter lives.
- Remote areas have half the supply of medical practitioners & dentists than major cities (FTE per 100,000 pop)

Health care is costly and rising:

- Health spend per person in Australia has increased 45% over the last decade
- In all OECD spending on healthcare is rising faster than economic growth and it is predicted that the cost of health care could reach 20% of GDP by 2020²

A reasonable proportion of illness could be prevented:

- 9% hospital admissions are considered potentially preventable yet only 2% of health spend on prevention /health promotion.

Primary care doctor supply is 9% lower than eight years ago

We see some of this as GPs in our practices – but we really don't see it all. As a profession we are taught to deal with the patient in front of us. We may do the best possible job with that patient – but that still doesn't help other patients – not necessarily ours – who are not getting the care they need. And the answer is not just more doctors. Good primary care needs a team of skilled professionals and it also needs linkage with other parts of the system.

² HWA draft strategic framework

So as a start, one way in which we need to change is that we have to take a more helicopter view - a more population view. As a system, for purposes of equity, we need to have a way of looking at whole communities. Medicare Locals are that vehicle. And it is one of their major benefits.

This is actually good news for GPs.

In the new world of PHC, the core role of GPs will in fact be emphasised even further – **general practice IS the hub of primary health care**. As United General Practice Australia (UGPA) we all contested the role of Nurse Practitioners and ensured it remained collaborative and integrated with a patient's usual GP.

But being central does not mean being isolated in our practice.

In the newly focussed world of PHC, we will be bolstered in our role at the centre of primary health care whilst also being supported through Medicare Local activities to marshal around us the other services- health and non-health - that our patients need.

More than that – other people, patients that may not be ours who may have been lacking care, will also have their needs better catered for through regional health service planning.

This is a different view of the world – it's a view where we are part of a whole system - a system who's goal is to ensure equitable access for all. GPs will still be central to that system – but the system – Medicare Locals - will be taking a population view.

They will be assessing population needs and they will be focusing on service gaps.

This is NOT socialist medicine. It is the fundamental tenet of comprehensive primary health care and of the view of health as a human right – a view that we as a country have signed up to.

I think we all want the best outcomes for primary health care. But it means change. And that is where our points of difference are – in how we get there.

AGPN considers the role of PHCOs to be critical to reform and a key mechanism in reorienting the system towards PHC to achieve the well established benefits that brings for our patients, for us and for the system as whole.

Thank you.