



Municipal Association of Victoria

Health Reform

Response to Commonwealth Consultation

November 2009



HEALTH REFORM

Introduction

The Municipal Association of Victoria (MAV) is the legislated peak body representing the 79 Victorian councils. Following consultation with councils, the MAV is responding to the recent reports on Australian health reform regarding the recommendations of most relevance to local government in Victoria. In particular, a number of proposals impact on current local government planning, funding and service provision roles including the proposed reforms to primary care and prevention (including Home and Community Care, Maternal and Child Health and Immunisation programs) , as well as councils' Municipal Health Plans. The National Health and Hospitals Reform Commission (NHHRC) Report also suggests changes to governance and financing structures, and the MAV will examine how these may impact on local area representation in decisions about the health system.

There is a strong history in Victoria of the State working in partnership with local government to develop health and community services, with a significant focus on services for older people and family and children's services. Councils wish to maintain a co-operative approach to planning, service development and quality improvement, rather than the centralized planning and purchasing approach currently used in, for example, the Commonwealth aged care program.

In response to previous COAG proposals for a vertically integrated national aged care program, in which HACC for older people becomes part of a national aged care program, the MAV has questioned how such a structure could manage national objectives and outcome consistency without losing local knowledge and innovation. Victorian local government delivers a large number of home care services, and the MAV also raised concerns about how the Commonwealth Government could manage the large HACC programs in each state, especially in terms of the numbers of providers and relationships, if the Commonwealth were to take over responsibility for service delivery. Local HACC services are currently coordinated horizontally with the local and regional network of primary care and preventive services, which results in older Victorians having access to a wide range of high quality services.

In the broad area of promotion of community health and wellbeing, Victorian councils also have a legislated requirement to prepare Municipal Public Health Plans, which could be capitalized on as part of the increased focus by the Commonwealth on health prevention.

MAV Key Response Positions

- The MAV supports the intent of the reform goals to achieve greater access and equity and longer term sustainability in a health system which is responsive to community needs.
- The MAV acknowledges the need for the Commonwealth to review intergovernmental responsibilities for planning, funding and achieving equitable outcomes nationally, however the ongoing role of State and local government in Victoria is not identified in the reform proposals.

- The MAV recognises the position expressed by State Health Minister Daniel Andrews (as reported in The Age 23 October) that Canberra is ‘too remote’ to run state health and therefore opposing the NHHRC proposals for a federal takeover of funding for hospitals and primary health care. He preferred a ‘dialogue and partnership’ that would improve existing services, rather than a return to a ‘command and control’ model. Better aged care funding was also a vital part of any reform package, and access to Medicare could be broadened to include more state-funded health workers.
- The MAV strongly supports the continued role of the State in the management and implementation of health reform in Victoria. Given the well developed policy and service delivery capacity at both State and local levels, citizen representation and local area knowledge and considerations, the MAV is not confident that Commonwealth level operation and implementation could adequately replace what we have now.
- The MAV strongly recommends that the Commonwealth negotiate service delivery systems with flexibility to retain and build on the strengths of all jurisdictions and does not take a national “one size fits all” approach.
- The MAV seeks to be involved in dialogue with the Commonwealth and State around models and funding for Victoria, given the history of local government service provision and investment in health and community services.
- In Victoria, the model should be developed through the involvement of the major stakeholders working together with local, State and Commonwealth Governments.

Strengths of the Victorian System

The strengths in the Victorian service system need to be specifically maintained and built upon, not lost, as part of the reform process. Strengths include:

- History and enduring pattern of core public sector and NGO service providers in primary care and community care across Victoria: in metropolitan areas – local councils, community health centres, Royal District Nursing Service (RDNS) and in rural areas – local councils, community health centres, hospitals and bush nursing services
- Role and capability of State government in primary health policy and administration, and promotion of local and regional service development and service co-ordination - building links between promotion, prevention, acute and primary care.
- Role of local government across Victoria in local population planning, service provision and funding and contribution to co-ordination of efforts, plus the local community expectation of local involvement.
- History of effective State/local government partnership in ensuring service equity and adequacy across the state – in many communities, hospitals and councils have been the only organisations with the administrative infrastructure and scale to be the service providers.
- Trust and relationships between core providers, peak representative bodies and State government - through partnerships and working together on issues over time.

Program Areas

1. Commonwealth responsibility for all primary health care policy and funding

Maternal and Child Health Services

- Victoria has one of the most effective engagement systems with young families through the legislative requirement of local government to follow-up all birth notifications.
- The Maternal and Child Health Service (MCHS) is a locally based universal primary care program providing services for families with children 0-6 years and is highly regarded by families. The service is provided by Victorian councils and contacts approximately 97 per cent of all families in the community.
- Important that MCHS be part of and integrated with wider primary care and network of family and children's services.
- Given long history and 50/50 funding arrangements in Victoria, the MAV would be seeking joint State /Local government negotiations with the Commonwealth over the funding, management, location and implementation issues.

Immunisation – babies and school children

- In Victoria, under the Public Health and Wellbeing Act 2008 (and its predecessor), councils are required to coordinate immunisation services for children in their municipality.
- Nationally, local government provides 18 per cent of preschool immunisations, but in Victoria it administers approximately 50 per cent of preschool immunisations and nearly 100 per cent of school-age immunisations.
- Victorian local government significantly contributes to one of the highest coverage and lowest cost immunisation services in Australia.
- Victorian councils (in 2004) contributed between 61% and 83% of the overall cost of delivering immunisation services.
- This contribution by Victorian local government was estimated to save the Commonwealth and Victorian Governments \$7.8 million a year for infant/preschool immunisations and a further \$5.7 million a year for school-age immunisations.
- The MAV would have concerns about efficacy of an immunisation program relying entirely only on a GP mode for delivery, and would want to be involved in discussion about models and funding for Victoria in delivering immunisation.
- NHHRC is recommending that a national program would work with some of the existing state service models in a flexible implementation process, and it would be this process that local government in Victoria would need to be advocating for and engaged with over the five year implementation period.

2. Service co-ordination and population health planning priorities should be enhanced at the local level through the establishment of Primary Health Care Organisations (PHCO), evolving from or replacing the existing Divisions of General Practice

- The proposed structures are based on larger populations than most single LGAs - more sub-regional than local.
- Links between LGA role in local population health planning and wellbeing plans, mandated under the State Public Health and Wellbeing Act 2008, and the health prevention strategy and regional primary health care planning, need to be established.
- Similar issues regarding governance and accountability will arise for LGAs in the proposed new Primary Health Care Organisations as have been there in the Primary Care Partnerships in Victoria. It is not simple for an elected level of government to be also represented and accountable within a different organisational structure.
- The MAV does not support a “quasi” regional level of government being established for health administration in Victoria, given the mandates and authorities of State and local government, and the track record of effective sub-regional and regional co-operative associations.
- The role of proposed PHCO in planning, priority setting and funding primary care services needs to be established.

3. Consolidating aged care under the Commonwealth Government by making aged care under the Home and Community Care Act (HACC) a direct Commonwealth program.

- Local government is the largest public sector provider of HACC services in Victoria. Nearly 40% of the joint Commonwealth/State allocations go to councils and councils also contribute an additional \$110 million pa (2006/7) on the local community care services they provide.
- For Victorian councils, it is the re- defining of the current joint Commonwealth /State Home and Community Care Program (HACC) as a Commonwealth aged care program, more tightly integrated vertically with the assessment process and care subsidies used in residential care, which is likely to have significant impact on the current role as a planner, funder and provider of local community care services.
- Some of the concerns about the proposal to vertically integrate aged care services from low level community care to residential care include:
 - For the majority of older people who remain living in their homes and community throughout their later life, the key service links are the strong horizontal linkages between local HACC services and the prevention, primary, acute and sub acute care services as well as to the myriad of local recreational, transport and social support services necessary for living in the community. Many of these services are also provided by councils and the linkages depend on integrated local policy and planning and local knowledge. Only a small percentage of older people ever use residential care.

- Preserving the ground work and links between local Positive Ageing Plans, health promotion, prevention strategies and HACC.
- Whether HACC is to be absorbed as a program under the Aged Care Act, or new community care legislation – concern about the suitability and emphasis of Aged Care Act and its suitability for HACC services.
- How the Commonwealth government structure can manage national objectives and outcome consistency without losing local knowledge and innovation, and manage the large HACC program in each state, in terms of the numbers of providers and relationships, and continue a co-operative planning and a service development, quality improvement approach rather than the more centralized planning and purchasing currently used in the Commonwealth aged care program.
- Before the HACC Program was initiated in 1985, Victoria already had strong community care services through local councils, district nursing services across Victoria, community health centres and large nongovernment organisations. Preserving this consolidated and stable public sector HACC service delivery platform in Victoria is critical to achieving integrated service delivery for clients. The degree of integration across the HACC sector in Victoria is more effective when compared to the fragmentation which has come from the Commonwealth method of allocating packaged care to multiple agencies with small number of clients across many different municipalities.

Attachment One – Note MAV Position put to COAG in 2008

- The MAV would reiterate the issues raised in the earlier discussion regarding COAG reforms to aged care funding (2008)
 - It is agreed that there is a need to work through options for improving planning for integration of community care e.g. Community Aged Care Packages/EACH, with the core HACC program. Victoria may well be able to achieve this in a different way to other states.
 - State government to continue a role in policy and program planning and resource allocation and distribution in Victoria (consider other models under which the current federal government has incorporated state expertise and implemented National Partnership arrangements through the States e.g. Early Childhood reforms and Commonwealth Regional and Economic Development Consultative Committees. These are managed in Victoria for the Commonwealth by the State).
 - Operational model for HACC in Victoria will not be compromised, and continue to be based on State/local partnership and local government planning and service delivery platform.
 - Local government agrees to maintain effort on additional funding, in the case that councils choose to continue in their current HACC service provision roles in any “reformed “ system.
 - Commonwealth needs to increase the annual funding escalator to appropriately match cost movement in the HACC program.
 - Commonwealth /State/Local Government Agreements to apply for a reasonable time period e.g. 10 years, to provide certainty and continuity for both clients and staff.

Note re reference to term ‘Local’

The Commonwealth reports on health reform refer frequently to “local”, however the text makes it clear this mainly refers to some sort of regional configuration. Given the experience in many Commonwealth programs where both planning and data are at a regional rather than local government area level, MAV questions the use of local when regional is meant, and argues that all service planning and data should build on LGAs as the minimum base unit.