



Municipal Association of Victoria

**Response to
National Health and Hospital Reform Commission**

Interim Report:

“A Healthier Future for all Australians”

March, 2009

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The MAV congratulates the NHHRC on its Interim Report and the many excellent recommendations across the major themes, and has encouraged Victorian councils to provide feedback to the detailed questions in the on – line survey.

In addition, the MAV would like to make some comments about the main areas of involvement and concern for local government.

1. Primary Health Care

Reform direction 2.1: that : the Commonwealth should assume responsibility for all primary health care policy and funding.

The MAV supports the case for the importance of and need for reform of the primary health care sector, but has concerns over some of the specific proposals.

1.2 Maternal and Child Health (MCH) Services

Victoria has a universal maternal and child health program, very similar to the one being proposed nationally, provided in partnership between the State and local government (since 1917). Although the report suggests that there would be a transfer of funds from the State to Commonwealth for such programs, there is no mention of local government, which in fact funds, on average, 50% of the costs of providing the MCH services in Victoria.

Thus the MAV would seek clarity with the Commonwealth about the continuance of local government's role in Victoria as a funder and provider of MCH services. Unless local government is directly involved with the Commonwealth government in a negotiated partnership agreement (as has been the case with the state government) it is unlikely to be interested in continuing as a funder of such services.

1.2 Comprehensive Primary Health Care Centres

Reform direction 2.2: The Commonwealth should encourage and actively foster the widespread establishment of Comprehensive Primary Health Care Centres.

The proposed governance and operational structure are critical elements of any reformed primary health care system. The Interim Report does not really address how a mixture of public and private services would operate in comprehensive care centres (CPHCC), other than the implementation should involve all local stakeholders and that consortia would need to involve current medical and allied health providers and community participation in planning. Although it is suggested that capital grants will act as an incentive, there is also likely to be significant additional personnel time and legal costs associated with consortia planning, establishment and on – going management arrangements. Incentives should also address such costs. There are also other models of linking like services in progress, for example the children's services hubs, and in Victoria, the co-location of maternal and child health services include a range of options including community health centres and children's services hubs.

Previous experience with co-located services suggests that physical co-location alone is not in itself sufficient to provide integration across services, nor necessarily improve the client experience, and that the management structures and processes are important in changing attitudes and practices. Not all services needed by an individual can be in one location, nor is the one location necessarily the best setting for some services, and thus incentives for the development and maintenance of virtual teams, alliances and protocols are as important as co-location.

1.3 Voluntary enrolment

The Interim Report proposes offering voluntary enrolment for young families and people with chronic and complex conditions with a single primary health care service to improve continuity and coordination of care and access to multidisciplinary care. While this would potentially be beneficial, it is not clear what the limits and protections of user choice would be. For example, a family may choose to use a different physiotherapist than the one located in the practice, particularly initially, when people are already likely to have a history with different providers. Also, will those who choose not to enrol, be excluded from using the practices who have entered the enrolment model? Where is the responsibility for promoting the advantages of voluntary enrolment to service users going to lie – with individual practices competing for patients or with a national education campaign?

2. Home and Community Care (HACC) services

The interim report acknowledges the importance of HACC services in both preventing inappropriate hospital admissions (through proposed agreements with the Primary Health Care Centres) and their essential relationship with the sub – acute and rehabilitation services in restoring people to better health and independent living. Local government is both a funder and provider of many of the HACC services in Victoria, and the MAV has advocated the importance of these linkages between HACC and other State health programs (e.g.: HARP; Post Acute Care, rehabilitation services). In response to the aged care reforms being considered by COAG, the MAV proposes that the strengths of the Victorian system be maintained through a trilateral agreement between the Commonwealth, Victorian and local government. From the Victorian council perspective, it would be preferable not to have different community care systems for people over and under 65 years old. There are already perverse examples in the smaller rural communities where the same home care workers have to be registered with three different employers, who are providing HACC, CACP and Veterans' Home Care.

Reform direction 6.5: We support consolidating aged care under the Commonwealth by making aged care under the Home and Community Care (HACC) program a direct Commonwealth program.

The MAV supports the need to streamline and simplify individuals gaining access to the level and type of community care services needed to meet their needs, and for HACC and other aged care services to be planned in conjunction. Many of the current boundary problems between the two programs could be resolved by an improved joint Commonwealth/State/local planning framework. Care co-ordination and case management should be available for those needing it in HACC services as well as for those requiring the higher levels of packaged care. The interim report suggests changes to extend the range of package values and provide more options for individuals to choose their own care, which could include continuing to purchase some of the HACC provided services, but with better consideration for administrative efficiencies in the purchasing arrangements.

Research undertaken by the MAV in 2002 for the Myer Foundation, into models of care for high needs clients, indicated that the Commonwealth's practice of planning and allocating aged care packages at a regional rather than local level has led to a proliferation of aged care package providers in Victoria. At that time, up to 24 providers could be operating in one municipality, often purchasing home care services back from the council as part of the package for a client. Victorian local government suggests that a key reform direction for the Commonwealth should be the consolidation of a sustainable, co-operative service system, to redress the fragmentation which has occurred in part due to the weight given to the application of competition policy in package allocation. This would be enhanced by transparent joint planning processes between the three spheres of government, including sharing data on supply, utilisation and demand down to the local area level.

The Interim Report makes a point of building on existing system strengths. The MAV would argue that the provision of HACC services by councils in Victoria is a strength that should not be lost in the proposed national reforms. HACC services are part of the local social fabric, often supplemented by council provided community transport and meeting facilities, and the knowledge and capacity to link to social and physical activity programs. Being a HACC provider and having staff expertise in aged care, has facilitated councils' capacity to plan for their ageing communities and undertake integrated positive ageing strategies. With over 6,000 workers, the costs to councils of getting out of these services would be extensive, and councils also contribute over \$110 million from their own revenue sources (2006/7 Grant commission data) to their costs of providing community care services. Victoria has had a long tradition of local public sector services and communities are used to, and value this.

Reform direction 6.6: We propose developing and introducing streamlined, consistent assessment for eligibility for care across all aged care programs.

The MAV supports consistent and streamlined assessment processes, but is concerned about the apparent lack of consistency in the arguments about which level of government should manage aged care, or what elements constitute aged care. The Aged Care Assessment Program is administered by the States, with links to acute and sub acute health services as well as residential and community care. There doesn't appear to be a recommendation in the report that it should also be managed by the Commonwealth.

3. Service co-ordination and population health planning

Reform direction 2.6: We believe that service co-ordination and population health planning priorities could be enhanced at the local level through the establishment of Divisions for Primary Health Care, evolving from or replacing the existing Divisions of General Practice. These divisions will need to be of an appropriate size to provide efficient and effective coordination.

Victoria has attempted to address service co-ordination in primary care services and planning through the creation of Primary Care Partnerships. This model has required significant resourcing to get it established and sustain participation, and has presented some difficulties in aligning catchments and boundaries to suit the scale of different health and related services.

The interim report's proposal to establish Divisions of Primary Health Care, raises significant governance issues regarding the role and participation in a regional body by a range of public and private organisations, whose representatives often cannot commit their own organisation through another decision making structure. This is of particular concern for local government, given its legislative and electoral mandate for municipal planning and development. The relationship with other population planning processes also needs to be established, as in Victoria, the Health Act 1958, and the new Public Health and Wellbeing Act 2008, require councils to prepare a four year Municipal Public Health Plan, linked to a State Public Health and Wellbeing Plan.

4. Conclusion

There are strong arguments for greater national consistency and leadership in the reform of Australian health services, particularly in health promotion, funding, quality, addressing inequity, workforce registration, planning and development. The MAV is most willing to participate in dialogue regarding the reforms, however, is not convinced that some of the proposals for changes in primary care and aged care in the Interim Report will deliver real improvements in Victoria.