



Contributions of Medicare Locals to promoting health and increasing health equity

Never Stand Still

Medicine

Research Centre for Primary Health Care and

Marilyn Wise
Associate Professor, Healthy Public Policy
Centre for Health Equity Training Research & Evaluation
(CHETRE)

Purposes of Medicare Locals

Stated

- to improve access to GP and primary health care services
- to provide more integrated and connected care for patients across the health and aged care system

+ Unstated

- to contribute to promoting, protecting, and maintaining the health of the population
- to contribute to increasing health equity

functions

- identify health needs of defined populations
- develop locally focussed, responsive services
- improve patient journeys through integrated, coordinated services - create networks of relevant agencies
- provide support to clinicians and service providers to improve patient care

- facilitate the implementation and successful performance of primary health care initiatives and programs:
 - improve access to after hours primary care
 - improve access to mental health primary care
 - deliver more primary care to older Australians
 - flexibly meet the needs of patients with chronic conditions
 - improve Aboriginal and Torres Strait Islander peoples' access to primary health care

and

- provide strong governance
- effective, efficient management
- account for progress and outcomes

change creates opportunities

- a focus on contributing to improving the health of populations within defined geographic boundaries
 - in addition to the prescribed roles and functions, the opportunity/necessity to focus on
 - health equity
- and
- health promotion

why are these important?

- health of Australians (life expectancy) has improved for everyone over last two decades

but

- still significant differences between highest socioeconomic quintile, the middle three quintiles, and the lowest quintile

what is health equity?

- a measure of having brought health differentials to the lowest levels possible through the provision of:
 - equal access to available care for equal need;
 - equal utilisation for equal need; and
 - equal quality of care for all.
- an outcome of the equal distribution of opportunities for health in a society and community

why is this of concern for Medicare Locals?

Access to general practice

- 85% of the population attend at GP at least once a year (on average 6.5 times per annum)

AIHW. The contemporary primary health and community care sector in Australia: a descriptive analysis paper. AIHOW. April, 2001.

Patterns of use of primary health care vary:

- low in adolescents and young males, and high in patients over the age of 74
- higher among low income groups tend to use primary health care services more but use is less in remote rural communities
- rural patients who suffer from chronic illness report that their condition and lack of access to appropriate transport limits their access to primary health care more than other patients.

Fitzgerald M, Pearson A, McCutcheon H. Impact of rural living on chronic illness. Australian J of Rural Health 2001; 9: 235-240.

Difficulty getting after hours care without going to emergency room

- Proportion of patients reporting very/somewhat difficult getting care on nights, weekends, or holidays without going to ER

Australia	59%
Canada	65%
France	63%
Netherlands	33%
New Zealand	38%
UK	38%
US	63%

Source: 2010 Commonwealth Fund International Health Policy Survey in Eleven Countries

Health checks by educational status (HIPS Study 2009)

			Low educational status	High educational status	Total
GP visits for a health check in past 3 months	Yes	N %	123 49.0	146 62.9	269 55.7
	No	N %	120 47.8	76 32.8	196 40.6
	Unsure	N %	8 3.2	10 4.3	18 3.7
Total		N %	251 100.0	232 100.0	483 100.0

Barriers to preventive care in disadvantaged practices

Patient	Practitioner/practice	System
Language, culture, literacy	Workload – demand on GPs and other practitioners – time available	Access to referral
Openness of patients to disclosure of risk factors & barriers	Practitioner attitudes	Cost, transport, location, availability, waiting time, delay in entry into programs, coordination of entry/referral
Knowledge and attitudes	Effectiveness of referral services	Waiting times for public services
Priority given to health vs other pressures	Access to bulk billing	Workforce availability
Social factors – family stress, unemployment	Funding for staff to undertake preventive work and health promotion	Location of services
Co-morbidity – depression, other physical conditions (mobility)	GP based funding	
	Workforce knowledge & skills	

what can be done to improve the access of disadvantaged groups – in order to improve health equity?

Access = availability, price, accommodation, location, acceptability

- Reduce cost to consumers
 - Increase availability – after hours, appointments...
 - Involve non-medical staff in service delivery
 - Ensure services are culturally appropriate
 - Ensure practice (including reception) is culturally safe
 - Employ culturally skilled providers
 - Increase continuity of care, including reminders for follow up and re-screening (for example)
 - Provide outreach services
 - Offer support through telephone and home visits
 - Monitor accessibility through audit and patient feedback
 - Monitor quality of care through continuous quality improvement systems
-
- Assess the system of health care delivery: Wagner Chronic Care Model with an equity lens
 - Aspire to develop and provide a fully-integrated community-based service, including primary health care, and a range of community-defined services and activities (Bromley on Bow)

and what about health promotion?

- significant differences in prevalence of common risk behaviours, chronic conditions, and deaths from chronic disease among people in lowest socioeconomic quintile and those in higher ses quintiles:
 - regular tobacco smoking
 - obesity

 - depression
 - type 2 diabetes
 - chronic respiratory diseases
 - cardiovascular disease
 - severe disability

 - diabetes mortality
 - cardiovascular disease mortality



Patients' health literacy and doctor/patient communication

- patients with inadequate health literacy were more likely to report worse communication in the domains of
 - general clarity
 - explanation of condition
 - explanation of processes of care
- Schillinger D, et al, 2004
- patients with lower health literacy
 - ask fewer questions of physicians in observed medical encounters (Katz et al, 2006; Beach et al, 2006)
 - are more likely to be perceived by physicians as desiring a less active role in their care and self management (Beach et al, 2006)

Health promotion – what has been proven to be effective in primary health care?

- brief intervention – smoking, alcohol, CBT for psychological problems
- preventive screening and follow up + reminders (cervical screening, immunisation, breast screening, and for some, routine preventive health checks)
- structured self-management plans, combined with education and follow up - for people with chronic diseases – diabetes, asthma, cardiovascular rehabilitation
- quality use of medicines
- build health literacy – cultural appropriateness, relevance, comprehensibility, and appropriate communication methods/skills/levels
- cultural safety – people, systems, and places



and

partnerships and advocacy to influence social determinants of health

education, employment, income, housing, transport, food security, peace, and health care
+ respect, autonomy, inclusion, and political power

in addition to working with individual patients, doctors and all health professionals can help by

- working with communities;
- use evidence and influence to advocate for change within the health sector and in other sectors;
- promote the generation of research;
- work through their professional organizations (locally, nationally, globally) to initiate and support the social change that is necessary if everyone is to have an equal opportunity to become and stay healthy.

British Medical Association. Social determinants of health: what doctors can do. UK: BMA, 2011

Medicare Locals: direct opportunities

- governance – the Board and other decision-making groups/bodies established to conduct the business of the organisation
 - who is appointed?
 - how do items ‘get on to the agenda’?
 - what processes are used to deliberate upon and decide on priorities and investment/disinvestment?
 - what criteria are used to decide on priorities?



and

- strategic planning – based on health needs and priorities of the population – with particular focus on marginalised groups
 - engage communities in planning
 - set goals and targets for health and equity outcomes
 - use a planning framework that recognises change is incremental

Intervention
impact
measures

Health literacy

Measures include:

- Health related knowledge
- Attitudes
- Motivation
- Behavioural intentions
- Personal skills
- Self-efficacy

Social action and influence

Measures include:

- Community participation
- Community empowerment
- Social norms
- Public opinion

Healthy public policy & organisational practice

Measures include:

- Policy statements
- Legislation
- Regulation
- Resource allocation
- Organisational practices

Intermediate
Health
Outcomes
(modifiable
determinants
of health)

Healthy lifestyles

Measures include:

- Tobacco use
- Food choices
- Physical activity
- Alcohol and illicit drug use

Effective health services

Measures include:

- Provision of preventive services
- Access to and appropriateness of health services

Healthy environments

Measures include:

- Safe physical & social environments
- Supportive economic and social conditions
- Restricted access to tobacco & alcohol

Health and
Social
Outcomes

Social Outcomes

measures include:

- Quality of life
- Functional independence
- Equity

Health Outcomes

measures include:

- Reduced morbidity
- Disability
- Avoidable mortality



As well

- workforce – build knowledge, skills, of current workforce in acting to reduce inequalities in health care design and delivery and to promote health;
- workforce – employ a diverse workforce – to mirror the population being served
- workforce – invest in continuous development and reward progress in promoting health and reducing inequity

and invest

- in action to reduce inequity and to promote health;
- in research to evaluate and build new knowledge;
- in collaboration with universities and other institutions contributing to improving access to health care, reducing health inequity, and promoting health.

finally

partnerships

- lie at the heart of Medicare Locals, themselves, as networked organisations

and

- at the heart of effective action to create equal opportunities for access to the determinants of health and to health in the populations being served

partnerships are built on

Clear definition of need:

- why do the organisations and groups need to work together?
Is working together necessary for each organisation and group to achieve its own goals – as well as shared goals?
- how will the partnership affect the ability of each of the organizations to conduct their core business?
- what benefits is each wanting from the partnership – that can only be achieved by the partnership?

Medicare Locals

offer exciting opportunities to work in new ways to provide high quality, universally accessible primary health care to communities and populations.

Seizing the moment will be important – because doing what we've always done will (albeit with new partners) won't achieve the changes in health and health equity that are, now, within our reach.

Although it is important to think about and decide 'what to do' one of the greatest opportunities is to change how decisions are made – to develop and use processes that respectfully and seriously engage the groups who have been marginalised in decision-making. That is the greatest opportunity and the greatest challenge if the past is any guide to the future.