



22 November 2010

Assistant Secretary Policy Development Division Branch
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Via E-mail: medicarelocal@health.gov.au

**AUSTRALIAN
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Dear Madam/Sir,

Re: Medicare Locals Discussion Paper on Governance and Functions

The Australian Federation of AIDS Organisations (AFAO) is the national federation for the HIV community response. AFAO's members are the AIDS Councils in each state and territory; the National Association of People Living with HIV/AIDS (NAPWA); the Australian Injecting & Illicit Drug Users' League (AIVL); the Anwernekenhe Aboriginal and Torres Strait Islander HIV/AIDS Alliance (ANA); and Scarlet Alliance, Australian Sex Workers Association. AFAO advocates for its member organisations, promotes medical and social research into HIV/AIDS and its effects, develops and formulates policy on HIV/AIDS issues, and provides HIV policy advice to Commonwealth, State and Territory Governments.

AFAO's perspective on this Inquiry

AFAO welcomes the opportunity to comment on the Medicare Locals Discussion Paper on Governance and Functions. We support the aims behind the establishment of Medicare Locals, including to create more locally responsive and flexible services, to better support health practitioners and patients, and to improve integration and accountability across the health system. AFAO agrees that the establishment of Medicare Locals will need to take account of existing regional primary health infrastructure, including, for example, HIV prevention, care and support services delivered by state/territory AIDS Councils and other community organisations. We see the establishment of Medicare Locals as potentially providing an opportunity to better integrate services, including between primary health care, hospital, aged and community sectors.

However, we are concerned that the fundamental foundation of Australia's successful national strategy and partnership response to HIV - involving the active engagement of government, community agencies and affected communities - be preserved. From AFAO's perspective, it is essential to identify and address aspects of the proposed arrangements that may unintentionally risk the jeopardisation or dismantling of that partnership. These risks arise in two main areas:

1) the redistribution of responsibilities for implementation of the HIV and other BBV Strategies across a much wider range of agencies; and

2) fragmentation arising from HIV/BBV community organisations having to liaise and negotiate contracts with up to seventeen program purchasing agencies rather than a single state government department as is currently the case. We believe that the cornerstone of the current HIV partnership must be maintained and state/territory AIDS Councils should retain their lead/key role in HIV prevention, care and management.

1. PREVENTION and HEALTH PROMOTION

According to the Discussion Paper¹, Medicare Locals will have a specific role in:

- coordinating local face-to-face after hours GP services;
- working with local GPs and other health professionals to ensure that these services are available in local communities;
- encouraging better prevention of disease; and
- supporting better coordination of mental health services in the future

A sustained focus on targeted prevention strategies has been pivotal to Australia's HIV response, as has the collaborative partnership between federal and state governments, communities at risk of HIV, health professionals and academic/research bodies. Due to the often contentious nature of the debate around HIV – which necessarily involves detailed public discussion intimate sexual behaviour and of illicit drug use, this partnership has been essential to the delivery of effective programs across the nation. AFAO members, including state/territory AIDS Councils, NAPWA, AIVL, ANA, and Scarlet Alliance, have played lead roles in this work. We are keen to ensure that the HIV sector continues to be adequately resourced to be able to continue actively engage in the partnership, and that funding structures do not adversely affect delivery of services.

Structural challenges in HIV and BBVs prevention and health promotion

Currently, AIDS Councils and most other community-based HIV organisations are funded directly by State/Territory health departments. AFAO believes that any changes to the funding structure whereby community based organisations would negotiate their funding from the various Medicare Locals may well disrupt capacity to provide effective prevention programs. Disruptions that may occur include:

1) Governance and funding complexities

State/territory AIDS Councils may need to enter into contractual arrangements for funding with multiple Medicare Locals within their state/territory, as opposed to single state/territory health departments. Community organisations would need to redirect significant resources to develop and manage a wide range of contracts for essentially the same work – currently funded overwhelmingly by the state and territory governments. AIDS Councils would also need to be involved in multiple governance structures.

2) HIV program vulnerabilities in local contexts

Work in HIV and other BBVs prevention is at times contentious. AFAO believes that the current structure in which state/territory AIDS Councils and other community HIV organisations are responsible to state/territory health departments and the respective Minister provides a degree of political support and protection for the contentious programs needed which Medicare Locals, as independent business entities, would be unlikely to provide. Such a change may have an impact on, for instance, the desirable

¹ Page 6

location of needle syringe outlets or the effectiveness of AIDS Councils to run important but potentially controversial interventions, even where such interventions relate to National HIV Strategy Priority Actions and Priority Populations.

3) **Fragmented messaging and/or increasing costs**

Different Medicare Locals may expect state/territory AIDS Councils to focus on different preventative health messages and interventions, some of which require direct and forthright language and/or explicit graphics illustrating safe sexual or injecting practices. This could result in a significant increase in costs and resources, and/or 'dumbing-down' of HIV resources and campaigns to meet the lowest common denominator, in order to accommodate the variety of demands of distinct Medicare Locals.

4) **Inadequate expertise**

Expertise in developing and providing targeted HIV prevention and health promotion programs is much more limited than for more common health issues, such as diabetes or obesity. Thus, it may be impractical for individual Medicare Locals to develop adequate expertise to oversee implementation of the National HIV Strategy action plans together with planning and program design for local prevention initiatives regarding HIV and other BBVs. The current concentration of expertise in policy and program development in national and state community organisations and State/Territory health bureaucracies is an effective way of maximizing the value of fairly scarce resources, thereby contributing to its cost effectiveness. The success of Australia's response to HIV in most program areas is testament to the efficacy of this arrangement.

5) **Challenges to prevention services and their possible reduction**

We are concerned that the decentralisation of planning and program design for HIV and other BBVs may lead to proposals to move prevention services, such as needle and syringe programs (NSPs), to sub-optimal locations. Recent attempts by some state jurisdictions and local government bodies to move sex worker establishments to industrial areas despite potentially serious health and safety ramifications are clearly driven by prejudicial attitudes to sex work and to sex workers. It is possible that prejudicial community views regarding provision of services targeting HIV priority populations may surface with decentralisation of HIV/BBV prevention services at a local level. Such an approach to funding and resourcing local HIV and other BBV prevention services would be undesirable, and would potentially compromise consistent and coherent implementation of national HIV and other BBV strategies and associated action plans.

On balance AFAO believes that funding and coordinating prevention services at the level of a Medicare Local would not be efficient and would potentially compromise crucial elements of Australia's partnership response to HIV prevention. State/territory health departments should continue to control state/territory-wide planning and program design for HIV and other BBVs.

Recommendation:

That State/territory health departments continue to carry primary responsibility for managing state-wide planning and program design for HIV and other BBVs

Delivery of HIV and BBVs prevention

As noted above, success until now in responding to HIV has been due to the collaboratively developed National Strategies and their nationally consistent implementation through the Partnership involving affected communities, health care workers, and state/territory and

commonwealth governments. Indeed, the Sixth National HIV Strategy focuses on the need to continue the partnership approach that has characterised Australia's successful HIV response.² It is important that implementation of the Medicare Locals initiative not undermine other fundamental aspects of the national health reform agenda, and that prevention strategies be supported by structural frameworks. Consideration of the role and function of Medicare Locals must have regard to ensuring that key national health strategies, including the National HIV Strategy and the other BBV and STI strategies are effectively implemented.

In particular, it is crucial to recognise that community-based organisations deliver important peer-to-peer education and support, community development and education, as well as preventative programs such as needle and syringe programs (NSPs). Disruptions that may arise if Medicare Locals were to become responsible for delivery of HIV and BBVs prevention would include:

Lack of effectiveness of prevention and health promotion programs

The National HIV Strategy explains that it is essential to involve affected communities in the HIV response because it ensures that policies and programs:

- are effective
- are informed by the experiences of those with HIV and affected communities
- are responsive to need
- take into account the full range of personal and community effects of policy directions.³

State/Territory AIDS Councils are constituted by and for affected communities. Over many years of work in the area, these organisations have established trust with these communities and are in fact regarded as a part of those communities. These community based organisations are therefore best placed to deliver HIV and other BBVs prevention programs.

While primary health care providers have important roles to play in HIV testing, and the treatment, management and care of people living with HIV, they tend not to be expert in delivery of targeted prevention and health promotion for priority populations such as gay men, injecting drug users and sex workers. Community organisations can best provide tailored interventions for affected communities such as peer education, NSPs and counselling, as they are trusted by affected communities. These complementary roles in the prevention, management and care of people among communities affected by HIV should continue, with state/territory AIDS Councils being principally responsible for HIV prevention and health promotion.

Sexual health clinics currently provide a safe and anonymous alternative to having sexual health tests in general practice. We have had the opportunity to view ACON's submission to this inquiry and endorse ACON's views in relation to sexual health clinics. We agree that the current high rates of testing for HIV and high rates of STI screening among those communities most at risk of HIV is reliant on access to safe, sensitive and anonymous testing such as that currently provided by sexual health clinics.

Recommendation:

That state/territory-based AIDS Councils, NAPWA, AIVL, ANA, Scarlet Alliance and other community-based HIV/AIDS-sector organisations continue to lead HIV and other BBVs prevention, care and support.

² Sixth National HIV Strategy, 1.3, p5

³ Ibid

Potential Opportunities

Despite these misgivings, AFAO sees opportunities for improved HIV prevention, management and care with the establishment of Medicare Locals. These include:

1) **Greater collaboration between health providers**

The introduction of Medicare Locals presents an opportunity to improve collaboration between GPs, allied health workers and HIV organizations. This could be modelled on the HIV partnership established prior to the development anti-retroviral treatments (ART) from 1996 during which time collaboration between GPs and other health care professionals became routine. This model is now being applied in other areas as the interrelationship of HIV and Ageing becomes clearer, with collaboration becoming increasingly common between GPs, gerontologists, aged-care providers and cardiovascular and renal specialists.

Medicare Locals may initially have a significant impact on health outcomes by improving primary health care services for people living with chronic illnesses and the elderly. This may include improving the early diagnosis of chronic disease and access to effective services such as allied health, patient education and social supports. The improved management of chronic diseases such as diabetes and cardio vascular disease and coordinated care for the elderly, will potentially benefit all people living with chronic conditions including people living with HIV, many of whom also live with other chronic diseases or are likely to be consumers of multiple health services.

2) **Additional funding**

The establishment of Medicare Locals could allow for additional funding for HIV and other BBVs prevention, care and support services. Under such a scenario, central state/territory funding would remain in place, but Medicare Locals, in consultation with local services, may allocate additional funds to target particular gaps. This would reflect the aim of Medicare Locals to be responsive and flexible to local needs, while retaining important state/territory health department functions and roles.

3) **Better integration of the HIV response within broader health care**

Currently, prevention and health promotion programs for HIV and other BBVs have tended to be separate from broader prevention strategies, such as for mental health. A more integrated, holistic approach to prevention encompassing other important areas of health, spanning across national and state preventative health strategies, would likely lead to improved HIV prevention, care and management.

2. **STRUCTURE/COMPOSITION OF MEDICARE LOCALS**

The Discussion Paper explains that Medicare Locals will continue to support primary health care providers – a role currently performed by Divisions of General Practice.⁴ We welcome the establishment and maintenance of strong links with a broader range of primary health care stakeholders in a more structured and consistent manner, across private and public sectors, including:

- general practice (including GPs and practice nurses);
- other health professionals (allied health providers, nurses, medical specialists);
- health and non-health service providers (across the community health, Indigenous health, hospital, aged care, health education and training sectors);
- community pharmacies;

⁴ Medicare Locals, Discussion Paper on Governance and Functions, 2, p9

- non-government organisations; and
- consumers and community representatives.

In the early years of HIV, AFAO and many of our member organisations established innovative engagement and collaboration with key GPs, including:

- 1) routinely involving them in design of HIV prevention, care and support programs and facilitating delivery of these through their practices;
- 2) providing authoritative and accessible information on treatments (often well in advance of publication of targeted resources);
- 3) working with GPs and hospital specialists to improve and better 'problem-solve' patient pathways, and provide access to primary and secondary/tertiary services.

AFAO believes that Medicare Locals should have strong mechanisms for community and consumer participation and that consumer representatives be included on the Boards of Medicare Locals. It is also crucial that the Boards of Medicare Locals include individuals with prevention and health promotion expertise. We also believe that Medicare Locals should engage with community based organisations through other mechanisms, including, as suggested, advisory committees and consultative forums.

Recommendation:

That the boards of all Medicare Locals include designated membership of a community member and also by a person with demonstrated expertise in community-level prevention and health promotion.

Gay, lesbian, bisexual and transgender people (GLBT), people living with HIV, injecting drug-users, and sex-workers may have particular health needs. People among these populations can experience discrimination in mainstream health care settings and fail to disclose critical information because of mistrust of primary health care services. Medicare Locals should seek to improve awareness of GLBT health issues among their memberships, including strategies to improve access to health care and services available for GLBT people. There are broader issues to consider in relation to lesbian, gay, bisexual, transgender and intersex Australians and AFAO endorses the submission provided by the National LGBT Health Alliance in this regard.

3. FURTHER CONSULTATION

AFAO is keen to engage in discussions about the establishment of Medicare Locals. We would encourage the Government and DoHA to undertake further consultations that engage all affected stakeholders to facilitate the clarification of key elements of Medicare Locals. We would particularly encourage consultations with health consumers/users and their representative organisations, including state/territory AIDS Councils, NAPWA, AIVL, Scarlet Alliance and the ANA.

4. CONCLUSION

AFAO welcomes the establishment of Medicare Locals to improve health outcomes for the Australian population. We support the Government's aim of making it easier for patients and service providers to navigate the health care system. The structural change will ensure better integration of the primary health, acute and aged care sectors.

At the same time, the successful structure of the current HIV partnership must be retained, with community-based organisations - particularly state/territory AIDS Councils - retaining primary responsibility for delivery of HIV prevention, care and support programs across their respective jurisdictions.

Yours sincerely

A handwritten signature in black ink that reads "Don Baxter". The signature is written in a cursive, slightly slanted style.

Don Baxter
Executive Director
Australian Federation of AIDS Organisations