Diabetes Australia

20/12/2013

M/s Kerry Flanagan
Acting Secretary
Department of Health
GPO Box 9848
CANBERRA ACT 2601

Dear M/s Flanagan

Re: Medicare Local Review

Thank you for your correspondence dated 2 December 2013 inviting a submission to the current review of Medicare Locals.

Please find attached Diabetes Australia's submission.

Should you require any additional information please do not hesitate to contact me.

Yours sincerely

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Chief Executive Officer

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Patron – Her Excellency Ms Quentin Bryce AC Governor-General of the Commonwealth of Australia

unite for diabetes
Diabetes Australia is a member of the International Diabetes Federation

Submission to the Medicare Local Review

Diabetes Australia is pleased to provide this submission to the Review of Medicare Locals (ML's).

Diabetes is the nation's fastest growing chronic disease and the major threat to the health and productivity of Australia in the 21st century.

Following the report from the National Health and Hospitals Commission, Diabetes Australia supported the establishment of ML's to strengthen the primary health care system across Australia. However, the implementation has been problematic.

Medicare Locals are a structure without a strategy.

Too much of the time, focus and funding of ML's to date has been on structures and administration. There has been insufficient focus, funding and effort on plans and strategies, and implementation and action. There has been little alignment with national health priorities like diabetes to strengthen the prevention and management of the growing chronic disease epidemic.

Diabetes Australia supports ML's as a structure, but we must now ensure that national health priorities like diabetes are addressed systematically by every ML, and this should address prevention and management.

We believe most ML's are performing well against the objective of planning and coordinating services locally and increasing access to afterhours GP services. However, there is little national consistency or coordination being demonstrated in regard to national health priorities such as diabetes. It remains unclear to the community what national plans or targets are being applied to ML's.

While the ML structures are useful – national strategy and direction is required to ensure every ML has a clear local plan, and implementation, to address the prevention and management of all types of diabetes in each ML population.

Performance and accountability

The establishment phase for ML's has been over many years and for many ML's it is still early days. Efforts have primarily been directed towards population surveys and service identification. Much of this was to repeat surveys and processes conducted previously under earlier structures. There has been some genuine consultation about specific issues in many MLs but there remains too much inconsistency and variability between approaches in different ML's. It is still unclear what the function of the Australian Medicare Local Alliance is in acting as a gateway for major national organizations, and whether they have a role to play in coordinating efforts on key health priorities.

The inclusion of NGO's in ML thinking and planning has been inconsistent. While real connections have been made in some areas where processes have been inclusive and broad, some ML's have looked at NGO's as competitors rather than partners and providers. Often there is very little engagement or communication with NGO's about what ML's are planning, doing or achieving.

For Diabetes Australia, building an integrated approach to prevention and management of all types of diabetes has proved difficult as this has required separate discussion and negotiation with 61

Medicare Locals all with different priorities and approaches. A particular missed opportunity has been the linkage of all ML's to the National Diabetes Services Scheme database to help them identify every person with diabetes in their ML. Instead ML's have conducted or repeated population estimates rather than connect to the best actual register of people diagnosed. This applies also for women with gestational diabetes and the National Gestational Diabetes Register as a sub register of the NDSS.

ML's have lacked consistency around reporting and accountability.

Alongside local innovation and responsiveness by ML's, a nationally consistent approach should be implemented across all ML's to ensure consistent reporting, accountability and engagement with NGO's and local communities.

What gets measured gets managed!

All ML's need to have a plan for the prevention and management of diabetes that is comprehensive, meaningful to their local population and service partners, and can be implemented. These plans should set targets (e.g. every person with diagnosed diabetes has a management plan; ensure every person with diabetes has their eyes checked in accordance with NHMRC guidelines;) and should address prevention of all of the major complications of diabetes as well as preventing people with prediabetes from developing type 2 diabetes. The targets should be measureable and enable transparent reporting to the community and stakeholder organisations.

The Minister for Health has recently announced a new diabetes task force to lead the development of a new National Diabetes Strategy. Diabetes Australia produced its own framework for a national strategy which is attached. The framework sets out five prevention goals essential for this national strategy, which should be central to the work of ML's:

- Prevent complications – through optimal management and earlier diagnosis
- Prevent more people from developing type 2 diabetes
- Reduce the impact of diabetes in pregnancy for women and children
- Reduce the impact of diabetes in Aboriginal and Torres Strait Islander people
- Strengthen prevention through knowledge and evidence.

If ML's are tasked with taking on action across these five goals, real national results are achievable.

National targets should be set around screening, prevention of type 2 diabetes in the high risk, prediabetes population, prevention of diabetes complications and avoidable hospital admissions, and all ML's should be required to publicly report against their achievement in their local populations. National targets should be set for identifying and managing diabetes in pregnancy and for pre-pregnancy programs and post pregnancy programs. National targets should be set for addressing prevention and management of diabetes in indigenous populations in each ML.

Innovation, duplication and scale

Many ML's have invested significant resources to develop new services and programs rather than coordinating and linking with existing programs. This often leads to duplication of effort, and the introduction or replication of less evidence based programs.

Diabetes management programs have not been a priority for all ML's, despite the impact of this disease in all communities across Australia. Diabetes management programs are often locally devised, and are often delivered on a small scale in sections of the community rather than systematically ensuring access for all people with diabetes in the ML.

We know that the size of the diabetes epidemic will require a consistent, evidence based, national approach. Unless ML's are guided by a national strategy, they will be unable to implement programs on a scale that will actually have any impact.

We need a national action plan and national coordination to address the major national health and productivity problem of diabetes in the 21st century. Expertise needs to be shared and programs based on evidence to ensure resources aren't wasted or duplicated on programs that may be popular locally, but aren't based in best practice or best outcomes.

ML's s should be required to respond to a national framework of best practice self management and structured diabetes management programs and should not duplicate programs developed by NGO's. ML's should look more to partner in service delivery.

GP's as the cornerstone of primary health care

General Practitioners play an integral role in coordinated, multidisciplinary diabetes management and are the first point of call for most patients entering the health system.

Evidence from primary care collaboratives and many sources is that resources need to be provided around the GP, data needs to be gathered and utilized, a range of health professionals needs to be integrated into a team (diabetes educators, podiatrists, optometrists, psychologists and others), coordination must be provided, and the person with diabetes and their family needs to be at the centre.

The opportunity for ML's was to strengthen these essential elements of good care by providing infrastructure, coordination, and connection to allied health services and specialist Diabetes Centres. There is little evidence to date that ML's have fulfilled this opportunity.

Many ML's have developed health directories within their ML's to assist health professionals/GPs and clients to access diabetes services. But often these do not integrate with statewide services and supports, particularly those provided by NGO's.

Summary

Diabetes Australia supports strengthening of the primary care system and a clearer focus for the primary care system on the prevention and management of diabetes. ML's were developed as a new, stronger structure for primary care but structure must be aligned with plans, strategies and actions or it is just bureaucracy. Diabetes Australia does not recommend the dismantling of ML's, but the focus for the future must be on requiring every ML to implement a plan for the prevention and management of all types of diabetes that is relevant to its population and aligned with a national strategy. These plans must have targets and action must be measured and publicly reported.