



NSW Association for Youth Health Inc (NAYH)

PO Box M178, Missenden Road NSW 2050
Ph: 02 9351 0956 Fax: 02 9351 0955
www.nayh.org.au

Email: eo@naah.org.au
ABN: 411 2093 2447
Funded by NSW Department of Health

Medicare Locals – Discussion Paper on Governance and Functions November 2010

About NAYH

The NSW Association for Youth Health¹ (NAYH, previously known as the NSW Association for Adolescent Health) is the peak body committed to working on behalf of the youth health sector in NSW to promote and advocate for the health needs and well being of marginalised and at-risk young people* aged 12 to 25 years.

NAYH works closely with the State's seventeen youth health services and the majority of the Association's work focuses on providing the youth health sector with support and training, government liaison and lobbying, policy and resource development, and community sector networking.

*For the purpose of this Paper, the term marginalised and at-risk young people includes the following groups of young people who are:

- socio-economically disadvantaged
- Aboriginal and Torres Strait Islander
- culturally and linguistically diverse;
- refugees
- homeless or at risk of homelessness
- gay, lesbian, bisexual and transgender
- living with a disability
- socially isolated
- living in regional and rural areas
- experiencing mental health problems
- experiencing alcohol or emerging drug and alcohol problems
- experiencing a dual diagnosis
- at-risk of, currently in or leaving out of home care
- in contact with the criminal justice system
- victims of crime
- living with a history of abuse, neglect and trauma
- experiencing family breakdown.²

¹ The NSW Association for Youth Health (NAYH) is the peak body for the health service providers committed to promoting the health and well being of young people aged 12 to 25 years in NSW. NAYH represents over 100 members who advocate for quality health care for marginalised young people whose health status and help seeking behaviours may be compromised by, for example, homelessness, poverty, mental illness, substance use, unemployment and/or disengagement from education.

² Silk, J. (1999) *Getting it Right Report*, NSW Association for Adolescent Health.

General comments

NAYH supports the decision by the Department of Health and Ageing to enable early community and public debate on the direct effects of health reform on the provision of hospital and area health based services in NSW.

In general, NAYH supports the attempt to harmonise boundaries and regions so that NSW Local Health Networks (LHNs) align closely with proposed Medicare Locals (acknowledging that the boundaries of Medicare Locals have yet to be formally announced). However, it is important to acknowledge that Medicare Locals (and other health agencies) will need to work, and plan, collaboratively with 'non health' partners – such as Community Services, Ageing, Disability and Homecare, various non-government organisations and Child Protective Services. These services operate with their own regional and organisational structures and it is important that Medicare Locals be supported to work with these partners.

However, we have several concerns which we hope will be addressed prior to the future implementation of any changes.

Partnership, planning, collaboration and service provision

The current discussion paper articulates in broad terms where various aspects of health, and health care, might be located within State, Local Health Networks and Medicare Locals.

NAYH supports the development and support of structures, partnerships, policies and programs which aim to reduce inequity in healthcare in Australia. Indeed, the creation of geographically oriented decision making bodies will go a long way to addressing the health inequities experienced by people living in Rural and Regional areas. Of particular concern to NAYH is how Medicare Locals would proactively engage with marginalised populations.

Identification of the health needs of local areas and development of locally focused and responsive services is essential to the planning and provision of effective primary health care services. Currently there are 17 Youth Health Services in NSW – the proposed future structure would have some Medicare Locals having responsibility for primary care in regions with multiple community based Youth Health Services, with some Medicare Locals working in differently resourced environments (without youth specific community health services).

Unfortunately, smaller population health survey data and other epidemiological evidence frequently “misses” analyses of populations who may experience considerable clinical need, but exhibit low clinical attachment in traditional primary health care settings. These populations include marginalised young people, but also includes people living with dual diagnosis and people who experience significant socioeconomic disadvantage.

Whilst real community participation, alongside the input of clinical led advisory groups, is to be applauded, NAYH has concerns that the planning for the health needs of marginalised populations will be done in a re-active, crisis based, manner.

In addition, the draft NSW Health Youth Health Policy clearly articulates the role of area based Youth Health Coordinators. The importance, role and function of these workers is unclear in the proposed arrangements. However, these workers could (and should) play a critical role in assisting Medicare Locals to plan and support the development of programs which encourage the appropriate use of primary health services by young people.

Recommendation 1: That further consideration be given to ensuring collaborative, partnership based approaches which target marginalised populations.

Recommendation 2: That further detail articulating communication and support relationships between Medicare Locals, Local Health Networks and other Commonwealth and State agencies be provided.

Governance Arrangements

NAYH has several concerns with the lack of detail currently attributed to the creation of the Medicare Locals. The discussion paper currently lacks critical detail on the selection process and creates the opportunity for a politically-driven appointment process. There is a critical need to ensure openness, transparency and accountability governance structures.

The discussion paper alludes to the role of 'Lead Clinician Groups' but does not articulate a constituency or function for these groups. In addition, it is unclear how Lead Clinician Groups, Governance boards and other 'decision makers' in the proposed structure will affect change in broader Primary Health care. It is unlikely that these groups will have the ability to restrict or direct individual primary health care providers – so a clearer description of the way in which workforce support (including training and opportunities for increased collaboration and communication) will impact on how primary health services are provided and accessed in local communities.

Recommendation 3: That further detail related to the creation and operation of the proposed Governance structures be made available for broad community consultation.

The currently described constitution of the Governance Boards has a strong focus on clinical participation, which presumably will reflect the importance of hospital (and hospital based) clinical activities. NAYH has strong concerns that unless the Youth Health (or broader community and population health) sectors are well represented on the Medicare Local governance boards; the important work of these programs will be effectively “deprioritised”.

Recommendation 4: That the Youth Health Sector (or broader community and population health sectors) be appropriately and meaningfully represented on each Medicare Local governance board.

Suggested additions to the role of Medicare Locals

- Medicare Locals should aim to equip clinicians and service users to work more effectively with marginalised populations, including young people, people experiencing homelessness and people who are engaged in problematic sex work. Medicare Locals, through training and support should build the capacity of the clinical workforce to better use tools such as brief intervention therapy consistently for people in these target groups.
- Medicare Locals should also support and improve capacity for opportunistic testing of highly prevalent illnesses in populations who have low rates of attendance to primary health care facilities.
- Medicare Locals should work to increase the confidence of clinicians working with unfamiliar diagnoses, by partnering them with more experienced clinicians, as has worked successfully in programs linking doctors who have HIV or infectious Syphilis notifications occurring within their practice.
- Medicare Locals should play a key role in ensuring (and promoting) the use of primary health care services by disadvantaged and/or marginalised populations. This should include a focus on ensuring that access to high quality, bulk-billing services is promoted for those who may experience financial difficulty in paying “gap” payments.