



# Forging New Links with the Community Services Sector to Build a Better Health Care System

Joint COSS response to the  
Department of Health and Ageing  
Health – November 2010

This submission has been coordinated by the Queensland Council of Social Service on behalf of the national COSS network:

Australian Council of Social Service (ACOSS)  
ACT Council of Social Service (ACTCOSS)  
Council of Social Service of NSW (NCOSS)  
Northern Territory Council of Social Service (NTCOSS)  
South Australian Council of Social Service (SACOSS)  
Queensland Council of Social Service (QCOSS)  
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Western Australia Council of Social Service (WACOSS).

### **About the COSS Network**

The Councils of Social Service (COSS) are the peak bodies representing the needs and interests of service providers and their clients in the non-profit social service sector in Australia. Our members comprise community service providers, professional associations and advocacy organisations.

We provide:

- independent and informed policy development, advice, advocacy and representation about issues facing the community services sector;
- a voice for all Australians affected by poverty and inequality; and
- a key coordinating and leadership role for non-profit social services across the country.

We work with our members, clients and service users, the non-profit sector, governments, departments and other relevant agencies on current, emerging and ongoing social, systemic and operational issues.

This submission involves policy analysis developed through consultation with our members and policy advisors in the states, territories and federally; from our experience working with people with disability, carers, the community sector and governments; and from our ongoing policy and advocacy work towards achieving social security for all Australians.

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## Executive Summary

This submission responds to the Australian Government's paper *Medicare Locals: Discussion Paper on Governance and Functions*. It does not individually address the questions posed in the papers. Instead, it focuses on the implications of health reform for the community services sector and the opportunities for government and the community services sector to work together to build a better primary health care system.

The community services sector has major role to play in making health care more accessible and responsive to people who are missing out on adequate health care. There is a need for:

- recognition of the critical role of the non-government health and community services sector in improving health outcomes;
- Improved linkages between the government and non-government health sector and community services and communities of interest to support population level planning and service delivery;
- A jointly agreed plan to develop and/or sustain these relationships;
- Support from Government agencies to develop the infrastructure required to deliver an improved health system that addresses the social determinants health;
- Flexible funding to respond to local needs and deliver services to disadvantaged and marginalized groups; and
- Monitoring and reporting focused on client outcomes.

## Recommendations

1. Incorporate a social model of health (including the social determinants of health and social justice concepts) in principles underpinning health reform and health care decision making. These principles should drive the funding, objectives and activities of Medicare Locals.
2. Medicare Locals develop comprehensive local health plans in collaboration between, Local Hospital Networks, NGO health and community services and local government.
3. Medicare Locals must consult with the community services on population-level planning; identify existing integrated planning processes; and work towards a more integrated planning system overall that incorporates the multiple factors that impact on health.
4. Promote a greater understanding of the role of the community services sector in improving health outcomes.
5. Invest in new approaches to the delivery of health care by:
  - Considering a range of health care delivery models such as community based and outreach services to meet the needs of disadvantaged and marginalised groups.
  - Improving processes for health services to identify and link with existing client co-ordination mechanisms.
  - Maintaining service integration where policy and funding responsibilities are shared across national, state and regional levels.
6. Recognise and support the lead role of Aboriginal and Torres Strait Islander community controlled organisations in the delivery of primary health care.
7. Develop and implement stigma reduction programs to improve the standard of health care delivery to disadvantaged and marginalised groups.
8. Deliver flexible and efficient funding processes with consideration of the following:
  - a. Provide Medicare Locals with flexible funding to broker alternative models to meet the needs of disadvantaged and marginalized groups. These funds should build the capacity of existing Health NGO services where they are proven to be effective.

- b. Medicare Local grants and acquittal processes are standardised as far as possible with those of the Health Departments in the States and Territory's to minimise red-tape and duplication.
  - c. Clear and transparent operational policies are developed to address the potential conflict of interest in the dual role of Medicare Locals.
- 9. Consider the role of Medicare Locals in primary health research and health workforce development.
- 10. Develop formal partnerships with NGO health and community service organisations to undertake joint policy, planning, and service delivery at the local level.
- 11. Develop and fund a jointly agreed plan to build the capacity and infrastructure of non-government health and community service organisations and communities of interest to engage with Medicare Locals and Government agencies.
- 12. Consider a range of options to build capacity to engage with communities and consumers including:
  - a. Build the health literacy of the community, by providing information and education about health conditions and local health services.
  - b. Fund capacity-building initiatives within local communities to support their active engagement and participation.
  - c. Consumer and community representatives are supported to participate, through travel re-imburement, mentoring, information and skills development.
  - d. Training and development for Medicare Local board members in the rationale, benefits and processes of community and consumer engagement.
  - e. Develop regional community and consumer engagement plans including rationale for engagement, objectives and strategies.
  - f. Consult with communities of interest and peak/statewide bodies to identify strategies to engage disadvantaged and marginalized groups.
  - g. Develop resources such as good practice guides to assist the development of regional plans.
  - h. Engage with peak bodies and Local Governments to map established interagency, multidisciplinary and specialized networks in the region/community.
  - i. Consult with these networks to identify any role in ongoing engagement processes.
  - j. Identify the need for new processes and infrastructure to build relationships within the community.
  - k. Identify a specific budget component for community and consumer engagement.
  - l. Identify specific positions with clear accountabilities for consumer and community engagement within the structure of Medicare Locals.
  - m. Include indicators relating to community and consumer engagement in the performance framework for Medicare Locals.
  - n. Establish common engagement frameworks and protocols with the consumer and community engagement structures with Local Hospital Networks.
- 13. Develop and implement meaningful and accessible performance monitoring and reporting processes including:
  - a. Consult with the non-government health and community services sector on the scope of, and process for, performance monitoring and reporting.
  - b. Healthy Communities reports contain information on health outcomes of the community, not only the health system.
  - c. Healthy Communities reports include measures of local health inequities and health outcomes for specific population groups, such as Aboriginal people.
  - d. The reports are made publically available in accessible formats and in a timely manner to enable people to make informed health care decisions.

## FORGING NEW LINKS WITH THE COMMUNITY SERVICES SECTOR TO BUILD A BETTER PRIMARY HEALTH CARE SYSTEM

### Introduction

This submission responds to the Australian Government's paper *Medicare Locals: Discussion Paper on Governance and Functions*. The focus of the submission is on the broad actions needed to forge links with the community services sector and build a better primary health care system to arrest and turn around the growing levels of health inequality that are experienced by the poor and disadvantaged in our community.

### 1. Role and function of Medicare Locals

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#### 1.1 Addressing health inequities

Data is readily available from many sources that indicate:

- Aboriginal and Torres Strait Islander people are less healthy, die at much younger ages, have more disability and a lower quality of life;
- People living in rural and remote areas experience higher levels of disease risk factors and illness than those in major cities;
- Disadvantaged Australians are more likely to have shorter lives;
- People with disability are more likely to have poor physical and mental health, and higher rates of risk factors such as smoking and overweight;
- Prisoners have significantly worse health, higher levels of disease, mental illness and illicit drug use;
- People from CALD backgrounds, refugees and refugee claimants have poorer health/mental health and limited access to health care;<sup>i</sup>
- People who are lesbian, gay, bisexual or transgender are often socially excluded, have higher tobacco and drug and alcohol usage and experience poorer health and mental health than the general population<sup>ii</sup>; and
- People who are homeless have poorer health than the general population for example, almost half of Brisbane's homeless population have a high mortality risk<sup>iii</sup>

Many people delay visiting or don't access primary health care services. The reasons are varied and include:

- Limited access to bulk billing general practitioners and inability to afford medication and follow up care;
- High co-payments for health services;
- Mistrust of health care providers and perceptions of discrimination and judgment;
- More pressing issues such as lack of housing or unemployment;
- Inflexible service delivery, for example for people with a mental health disorder or intellectual disability;
- Inflexible opening hours or location; and
- Difficulty in navigating the system.

This results in poor health outcomes for disadvantaged and marginalised people and high usage and health care costs at the acute end of the health care continuum.

Improved health is likely to come from the cumulative impact of complementary programs such as health and work, housing, and early childhood education. It requires action to address broader social, economic, cultural, environmental and political factors that shape the circumstances in which individuals are "born, grow-up, live, work and age" and that cause

health inequalities. Recognising that health is socially determined also means recognising that a social or community response to health is needed.

In order to effectively address the social determinants of health, it is crucial that Medicare Locals have a broad primary health care role that extends beyond a medical model of health. They must not only work to improve access to GP services, but also undertake broader population health and prevention activities in conjunction with the health and community services sector.

To improve access and equity, the health care system needs to:

- Work with services who are trusted by people;
- Recognise the interconnectedness between a stable and positive lifestyle and health by addressing multiple issues such as housing and employment;
- Increase investment in early intervention and prevention services and population health approaches
- Be accessible to the whole community including the disadvantaged and marginalised;
- Work within a multi-disciplinary and cross-sectoral approach; and
- Address affordability.

**Recommendation 1:**

Incorporate a social model of health (including the social determinants of health and social justice concepts) in principles underpinning health reform and health care decision making. These principles should drive the funding, objectives and activities of Medicare Locals.

As part of this 'joined-up' approach, it will be necessary for Medicare Locals to develop holistic, comprehensive local health plans in partnership with Local Hospital Networks, NGO health and community services and local government in order to deliver integrated, joined up care. The local health plans must address the needs of the local community and address the intersections between the different health settings and different providers.

Importantly, many health and community service organisations provide integrated services across prevention, early intervention, health promotion, primary care, social care, nursing care, advocacy and community development. It will be vital to maintain this service integration when policy and funding responsibilities may be shared across a national, state and regional level.

**Recommendation 2:**

Medicare Locals should develop comprehensive local health plans in collaboration between, Local Hospital Networks, NGO health and community services and local government.

*1.2 Population level planning*

Whilst consumer and community engagement is important to drive consumer control over health choices, a broader approach to engagement is required to understand community needs and identify models of health care that meet the needs of the whole population. Hence population level planning needs to incorporate community in a broad sense, through engagement with community services that are either already dealing with health issues and can provide access to the community, especially disadvantaged groups, to provide new services.

The role of Medicare Locals includes population level planning, identifying people who are missing out on primary health care or services and better targeting of services to respond to these gaps. To deliver more equitable distribution of services, population level planning needs to identify the characteristics and needs of local populations, with a focus on addressing disadvantage. Comprehensive population level planning includes demography, burden of disease, psycho-social, economic and environmental factor analysis. Some of this data will need to be sourced outside of the health sector. The community services sector generates data on groups that the health system may define as “hard to reach”. This data can assist in defining who is missing out on health services and why. The community service sector can also assist with local level validation of statistical data to provide a greater understanding of the factors affecting a community to inform effective responses.

To achieve real gains in health, the reform process needs to work towards a more integrated approach to planning with the factors which influence health outcomes such as: early childhood education and care, education, employment, housing, transport and community services. This requires a matrix approach to planning which interlays health care decision making with data on the social determinants. Geographical Information Systems (GIS) or social atlases includes a wide range of data (for example demographics, location, employment, education, socioeconomic and indigenous status) to identify the relationships between socioeconomic status, health status and health service utilisation<sup>iv</sup>.

The Australian Government needs to work towards a national approach to integrated planning which incorporates the social determinants of health. There are some examples of integrated planning processes which have developed through collaborative processes at the Local Government or regional level. Initially, in the absence of a nationally agreed approach to planning supported by multiple data sources and adequate infrastructure and skills, it will be important for Medicare Locals to tap into these existing processes.

**Recommendation 3:**

Medicare Locals must consult with the community services on population-level planning; identify existing integrated planning processes; and work towards a more integrated planning system overall that incorporates the multiple factors that impact on health.

*1.3 Role of the non-government health and community services sector*

Non-government health and community services provide a wide range of services to assist people with issues in their daily lives, and are an essential element of achieving good health outcomes in the community. They provide a holistic framework for the promotion and maintenance of good health within community settings, whilst responding to, and meeting the changing and diverse needs of local communities and priority population groups.

At the end of June 2009 there were nearly 11,000 businesses and organisations involved in the provision of community services in Australia. These include 5,809 not-for-profit organisations, 4,638 for-profit organisations, and 520 government organisations. Community service providers spent \$25.2 billion on direct services in 2008-09 with just over half expended by not-for-profit organisations. Commonwealth, state and territory government organisations contributed \$3.8 billion and provided a further \$9.5 billion in funding and payments to private organisations and self-employed contractors. In addition, community service providers spent a further \$4 billion on related or overhead community assistance. Over half a million people were employed by organisations providing community services and 325,440 volunteers assisted community services organisations during 2008-09<sup>v</sup>.

Community service organisations often receive funding from multiple sources and work with “communities of interest” as well as providing services to defined geographical areas. In its interaction with the health system the community services sector plays a critical role in prevention and early intervention, transition from hospital to the community; and joined up responses for people with complex and chronic conditions and long term care needs.

An effective primary care system requires close collaboration between health and community services to deliver person centred care. Despite this, there has been little engagement with the sector or discussion about its role in national health reform. The role of the community service sector in improving health outcomes needs to be more clearly defined and promoted.

**Recommendation 4:**

Promote a greater understanding of the role of the community sector in improving health outcomes.

*1.4 Investing in a range of approaches and settings for the delivery of health care*

To respond adequately to the full range of consumer needs, the primary health care system needs to mobilise a comprehensive range of resources and specialist support services across areas such as community mental health, drug and alcohol support; women’s health and sexual health, domestic violence; homelessness; housing; employment and income support services.

The particular needs of the Aboriginal and Torres Strait Islander population, people living in rural and remote areas, refugees and other culturally and linguistically diverse groups may also need to be addressed. This requires investment in training and development, comprehensive assessment tools, and co-ordination and referral pathways between health and community service organisations. Importantly, health reform needs to recognise and support the lead role of Aboriginal and Torres Strait Islander community controlled organisations in delivering health outcomes.

Key elements of health service delivery which meets the needs of disadvantaged and marginalised groups include:

- Trust and respect (relationship building)
- Flexibility (eg opening hours, location)
- Partnerships working (eg involving a range of organisations, pooled funding, engaging with communities of interest)
- User involvement (member helpers or volunteer trainees)<sup>vi</sup>
- Language skills and/or translation services

It also requires a range of service delivery options such as:

- alternative settings for the delivery of primary health care such as community based care and outreach services;
- specialised responses to meet the needs of specific population groups; and
- co-ordination of health and social services.

**Recommendation 5:**

\* Consider a range of health care delivery models to meet the needs of disadvantaged and marginalised groups.

\* Improve processes for health services to identify and link with existing client co-ordination mechanisms.

\* Maintain service integration where policy and funding responsibilities are shared across national, state and regional levels.

\* Recognise and support the lead role of Aboriginal and Torres Strait Islander community controlled organisations in delivering health outcomes.

Aboriginal and Torres Strait Islander community controlled health services provide leadership in Closing the Gap through integrated primary health care services. This leadership role needs to be recognised and supported.

**Recommendation 6:**

Recognise and support the lead role of Aboriginal and Torres Strait Islander community controlled organisations in delivering health outcomes.

*1.5 Stigma reduction to improve access to and quality of health services*

In delivering mainstream services to disadvantaged groups, discrimination or lack of understanding may impair access to, and the quality of, service delivery. This is particularly the case for people with a physical or intellectual disability; lesbian, gay, bisexual, transgender and intersex; Aboriginal and Torres Strait Islander people, and people from culturally and linguistically diverse backgrounds. Stigma reduction programs at the organisational and individual level will improve standards of health care delivery.

**Recommendation 7:**

Develop and implement stigma reduction programs to improve the standard of health care delivery to disadvantaged and marginalised groups.

*1.6 Flexible and streamlined funding*

- Brokerage funds

The needs of disadvantaged and marginalised groups will require Medicare Locals to have access to a pool of funds that can be delivered in a flexible way to support responses which meet the needs of disadvantaged and marginalised groups. As noted above, many health and community service NGO's provide services to marginalised and 'hard to reach' groups. In order to maximise value for money, existing services that are proven to be effective in servicing disadvantaged groups should be prioritised for funding.

- Streamlined funding and reporting processes

In funding services, particularly those provided by the non-government health and community services sector, it will also be important for Medicare Locals to minimise the administrative and compliance burden for NGOs by streamlining funding and reporting requirements. This will also require grants and acquittal processes to be standardised as far as possible with those of the Health Departments in the States and Territory's.

- Conflict of Interest

While we believe it will be necessary for Medicare Locals to have brokerage funds in order to fill the gaps in local health services, further consideration is needed to address the potential conflict that may arise between the dual role of Medicare Locals as both purchasers and providers of services, particularly in rural and remote areas.

**Recommendation 8:**

Provide Medicare Locals with flexible funding to broker alternative models to meet the needs of disadvantaged and marginalized groups. These funds should build the capacity of existing Health NGO services where they are proven to be effective.

Medicare Local grants and acquittal processes are standardised as far as possible with those of the Health Departments in the States and Territory's to minimise red-tape and duplication.

Clear and transparent operational policies are developed to address the potential conflict of interest in the dual role of Medicare Locals.

### *1.7 Additional roles*

In considering the future roles of Medicare Locals, a role in promoting research in primary health and facilitating research partnerships could potentially be adopted by Medicare Locals. Consideration will also need to be given to Medicare Local's roles in identifying workforce needs and building local workforce capacity. This will need to be undertaken as part of a comprehensive national health workforce plan.

**Recommendation 9:**

Consider the role of Medicare Locals in primary health research and health workforce development.

## **2. Structure of Medicare Locals (Governance and linkages)**

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### *2.1 Issues for the non-government health and community services sector*

This section identifies critical intersections between health services and the community service sector and proposes a range of strategies to work together to deliver better health outcomes for the whole population including disadvantaged and marginalized groups. In considering the issues, the community service sector has identified a range of unresolved questions that need to be considered and jointly addressed by government and the non-government health and community services sector if health reform is to make a difference to the people accessing services. These include:

- How will Non-Government Organisations (NGOs) be able to develop and maintain relationships (including funding relationships) with multiple Local Hospital Networks and Medicare Locals when most do not have the infrastructure to manage this?
- What is Government's role in supporting NGOs to develop mechanisms to facilitate communication, engagement and partnerships between community and health services?
- How will communities of interest, especially socially excluded communities, have a voice in the new health system?

- How will the service integration that many NGOs currently provide be maintained and improved when policy and funding responsibilities may be shared across the health and related sectors at a national, state and regional level?
- Will flexible funding be made available to support alternate models of health care delivery to meet the needs of disadvantaged and marginalised groups?
- How will health reform improve services for population groups that General Practitioners generally don't serve well (e.g. drug users, LGBT).
- Where will the population needs assessment, planning and health system management expertise come from in primary health care?
- How can primary health care services better link with existing networks at the local and regional level and case managers and care co-ordinators at the individual client level?
- How is the lead role of Aboriginal and Torres Strait Islander community controlled services recognised and supported in this reform process?

This submission provides a starting point for some joint strategies and approaches to resolving these issues.

## *2.2 Developing new relationships*

To improve access and equity, health services need to work in partnership with community based services that reach disadvantaged people and marginalized communities to develop alternative models of care in a range of settings. This includes groups perceived as “hard to reach”<sup>vii</sup>.

New and improved partnerships need to be forged at the organisational, local, regional, state and national level. Opportunities include:

- Linking Medicare Locals and community service organisations to undertake needs analysis and develop service delivery models to identify and meet the needs of disadvantaged and marginalised groups;
- Improved linkages between community service organisations, primary care providers and acute health care services to improve discharge planning;
- Better identification of, and links with, client case managers and care co-ordinators through the primary health care system.
- The development of multi-disciplinary and cross-sectoral models of care to meet the needs of clients with complex and multiple needs; and
- Ongoing engagement between Government agencies and community service organisations in the implementation of health reform.

There are some well developed multi-disciplinary and cross-sectoral networks and partnerships at local or regional levels that have been built up over time. To understand and meet the needs of disadvantaged and marginalised groups, it will be important for Medicare Locals and health services to identify and build on established partnerships as well as establish partnerships where none exist. Additionally, many people who access health services are already linked to care co-ordinators or case managers, especially clients with multiple and complex needs. Health services need to improve processes for identifying and linking with existing client co-ordination mechanisms.

Collaborative approaches require capacity, resourcing and tools to assist policy development, intersectoral planning and service delivery including:

- Acknowledgment of intersectoral collaboration as a legitimate and beneficial role;
- Equality of input and trust and respect between participants;
- Allocation of time to collaborate and plan;
- Integrated planning and client assessment tools;
- Referral pathways and information sharing;
- Co-ordination mechanisms; and
- Flexible funding to deliver person centred services.

The Australian and State governments need to recognise the key role of community service organisations and communities of interest in health reform at the policy, planning, and service delivery levels.

**Recommendation 10:**

Develop formal partnerships with NGO health and community service organisations to undertake joint policy, planning, and service delivery.

### *2.3 Capacity building, including infrastructure development*

A key challenge for the community service sector is to be able to develop and maintain relationships with multiple Medicare Locals when there is no infrastructure to manage this. There is limited infrastructure to support the community service sector to engage with health reform as the size, and structure of organisations vary. There is no natural alignment between the proposed boundaries of Medicare Locals and the structure and organisation of community service organisations. These links are critical if real change is to be realised through health reform. Without these links there is a risk that the reform process will fail to achieve improved outcomes.

As well as health reform, the Australian and State governments must also consider supporting non-government health and community services to develop new partnerships and linkages to deliver improved health outcomes for the whole population.

**Recommendation 11:**

Develop and fund a jointly agreed plan to build the capacity and infrastructure of non-government health and community service organisations and communities of interest to engage with Medicare Locals, and Government agencies

## **3. Interaction with patients and providers**

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### *3.1 Community and Consumer Engagement*

The achievement of healthier communities cannot be driven by the health system alone. It requires a broader understanding of the elements which contribute to ill health (the social determinants of health). By focusing on clinical health and business expertise, the opportunity to make real gains in health will be missed. There needs to be representation or influence outside of the health sector in the governance arrangements that provide an understanding of the interaction between health and non-health systems.

It is important that the difference between a “consumer” and the “community” is recognised in the development of any engagement strategy. As a first step, Medicare Locals need to identify the outcomes they are seeking from community and consumer engagement and

develop a plan that will suit the individual circumstances of each community or region. Whilst community engagement sub committees are one way of doing this, it risks isolating community and consumer engagement as a process rather than embedding community and consumer participation in health care decision making. A new culture of participation and engagement needs to be developed within the health care system. This requires a comprehensive change management strategy to support the implementation of a community and consumer engagement framework.

Consumer and community should be engaged as part of the governance structures of Medicare Locals. However it is also important to recognise that engagement extends beyond formal Board membership, and requires active participation in the planning, management and delivery of health services and the local and strategic levels.

Governing bodies working with local communities need leadership to effect change, an understanding of the issues affecting communities and a capacity to engage. In particular, governing bodies need the skills, knowledge and values to understand, and to speak for, people experiencing poverty and disadvantage. Mandatory training should be provided to members of Governing Councils in the rationale, benefits and processes of consumer and community engagement and the needs of people affected by poverty and disadvantage. A suite of resources for Medicare Locals could be developed to support community and community engagement. A “Good Practice Guide” would need to include objectives, principles and good practice examples that could be applied to the local level.

There is a risk that traditional community engagement processes will not reach marginalized and disadvantaged groups. These include strategies such as: websites, newsletters, liaison groups, community forums, online forums, focus groups and information in public areas. Other more formalised options include citizen juries and advisory committees. A UK study on engagement in development and planning indicated that respondents are “likely to be white, older, better educated middle class males<sup>viii</sup>”. Hence strategies to engage a wide range of groups that may be perceived as “hard to reach” are required as part of a community engagement plan. This will require Medicare Locals to have a comprehensive understanding of the local communities they serve and to consult with peak/state-wide bodies and communities of interest to determine the most effective evidence based strategies for meaningful engagement.

In engaging with communities, it will be important for Medicare Locals to tap into existing networks and structures. For example, there are many multi-disciplinary, cross-sectoral networks that are operating in some regions and communities. In addition there are speciality networks such as specialised homelessness services networks, and mental health, and youth networks. Medicare Locals need to engage with peak/state-wide bodies and Local Government to identify established networks and their role in ongoing community engagement. In the longer term, new infrastructure may need to be established to support regional and local engagement which better aligns with the established boundaries of Medicare Locals.

Community Engagement strategies need to be evaluated and learnings embedded into future processes. Indicators for successful consumer and community engagement need to be embedded in the performance agreements of CEO’s of Local Hospital Networks and Medicare Locals.

### **Recommendation 12**

Consider a range of options to build capacity to engage with community and consumers including:

- Build the health literacy of the community, by providing information and education about health conditions and local health services
- Fund capacity-building initiatives within local communities to support their active engagement and participation;
- Consumer and community representatives are supported to participate, through travel re-imbursement, mentoring, information and skills development.
- Training and development for Medicare Local board members in the rationale, benefits and processes of community and consumer engagement.
- Develop regional community and consumer engagement plans including rationale for engagement, objectives and strategies
- Consult with communities of interest and peak/statewide bodies to identify strategies to engage disadvantaged and marginalized groups.
- Develop resources such as good practice guides to assist the development of regional plans.
- Engage with peak bodies and Local Governments to map established interagency, multidisciplinary and specialized networks in the region/community.
- Consult with these networks to identify any role in ongoing engagement processes.
- Identify the need for new processes and infrastructure that meets the needs of the community/region.
- Identify a specific budget component for community and consumer engagement
- Identify specific positions with clear accountabilities for consumer and community engagement within the structure of Medicare Locals
- Include indicators relating to community and consumer engagement in the performance framework for Medicare Locals.
- Establish common engagement frameworks and protocols with the consumer and community engagement structures with Local Hospital Networks

## **4 Performance Monitoring and Reporting**

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### *4.1 Broader indicators of health*

The type of performance data collected needs to extend beyond clinical indicators to include non-clinical information on health status, service use and health outcomes along with information on the health of local communities. Health benchmarks also need to be developed to specifically address the needs of marginalized and disadvantaged groups including equity measures and whole of community health and well being indicators. In addition, Closing the Gap targets need to be incorporated in health performance monitoring and reporting.

The non government health and community services sector can inform the development of performance indicators through the National Performance Authority and Hospital and Healthy Communities reports.

In the longer term, analysis of health performance needs to include the correlation between non-health factors such as early childhood education and care, education, housing, transport, and the health of a population.

**Recommendation 13:**

Consult with the non-government health and community services sector on the scope of, and process for, performance monitoring and reporting.

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- <sup>i</sup> Australia's Health 2010. Australian Institute of Health and Welfare
- <sup>ii</sup> Australian Bureau of Statistics (2007). *Survey on Mental Health and Wellbeing*. (additional analysis)
- <sup>iii</sup> *50 Lives 50 Homes Survey Week Fact Sheet*. Common Ground USA June 7–11 2010
- <sup>iv</sup> Muecke, S. *Identifying Gaps in Primary Care Services: Reaching the Unreached*. Research Roundup. Issue 13. 2010
- <sup>v</sup> Community Services 2008-2009. Australian Bureau of Statistics. ACT 2010
- <sup>vi</sup> As above
- <sup>vii</sup> Flanagan S. Hancock B. *Reaching the hard to reach – lessons learned from the VCS (Voluntary and Community Sector)*. Department of Primary Care Clinical Sciences, University of Birmingham
- <sup>viii</sup> Good Practice Guide to Public Engagement in Planning and Development Schemes. Planning Aid England.