



**Submission to
the Department of Health and Ageing**

**Medicare Locals
Discussion Paper on
Governance and Functions**

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GPSA Feedback on the Commonwealth's Medicare Locals Discussion Paper

Generally, the language in the Discussion Paper is broad and leaves room for further interpretation, and provides only limited information about what will be done. The following observations are provided as feedback and recommendations for potential approaches to a more structured conceptual design and attempt to provide a response to the questions posed in the Paper.

Achieving collaboration between service providers

Throughout the document there is reference to collaboration among service providers to achieve the health reform objectives. The way the discussion paper is presented, it appears that success is heavily dependent on the goodwill, commitment of resources, capacity and capability of services providers to collaborate.

As the paper suggests a significant change management undertaking, change management should be acknowledged as a major plank of the reforms, and a clear plan to resource the change process should be identified. The paper should also acknowledge that there will be a need to incentivise and compensate collaboration and the changes to clinician behaviour that will be required, so that funding to Medicare Locals will enable such change to be achieved.

Defining eligible organisations to establish Medicare Locals

Page 1 refers to the first group of Medicare Locals evolving from and building on 'high functioning' Divisions of General Practice, but makes no reference to what defines 'high functioning' Divisions. This is particularly problematic, given that the only evidence basis that the Commonwealth currently has in relation to Division performance is strictly limited to compliance with the reporting requirements associated with contracts with DoHA. As compliance alone is not a measure of performance or functional capacity or capability, further detail in relation to this is essential to understanding which Divisions can consider themselves eligible for consideration amongst the 'first group'.

Ensuring better care in non-acute settings

Page 2 refers to challenges and priorities facing the health system and includes a point about patients using hospital resources 'who could be better cared for in non-acute settings'. While we agree with this, if it is tending toward a strategy, there needs to be acknowledgement for the establishment support required to appropriately equip non-acute settings to take on this role. Further, the assumption that there is capacity in non-acute settings to fulfil this role needs to be tested.

If Medicare Locals are to be expected to develop or expand capacity in non-acute settings, this should be clearly identified in conjunction with acknowledgement of the establishment funding that will be required as part of the funding package to Medicare Locals in the early years. The establishment or expansion of health services providing direct patient care should not be considered as part of the transition funding package for setting up Medicare Locals.

Improving access to general practice and primary health care services

Page 3 raises the notion of ‘improving access to responsive, integrated and coordinated GP and primary health care services’, which then leads to questions as to how Medicare Locals will be able to effectively influence the way in which GP services are delivered, as the funding for GP services will not sit within Medicare Locals. We assume that the opening statement on page 4 is attempting to address this by including ‘general practice support’ in the functions that Medicare Locals will retain. If this is the case, how will this be different to what Divisions do now and what leverage will Medicare Locals have with general practice that will ‘improve’ on what Divisions currently do?

Coordinating care

On page 3, the final paragraph discussing coordination of care does not seem to acknowledge how patients tend to access and use the health system, particularly in relation to episodic care, and the practitioner response to that. This requires patient and practitioner input to test the assumptions being made about patient expectations in relation to health practitioner response to their identified needs.

Ensuring clinically appropriate settings of care

Page 4 raises the issue of ‘clinically appropriate settings’ of care. If Medicare Locals are to be involved in making determinations about clinical appropriateness, including the setting for care, there is a significant clinical governance role that will need to underpin the functional operations of a Medicare Local. The paper needs to discuss the implications of clinical risk and requirements for Medicare locals to effectively manage this risk through strong clinical governance.

What is currently described leans toward a case management type of role for Medicare Locals, which needs to be clearly defined if Divisions are to be considering future options to evolve into Medicare Locals. This is a very different role to the one which Divisions have previously performed, and has significant implications if Medicare Locals are to have a role in approving the use of publicly-funded health services for individual patients.

Ensuring a common approach to primary care services

Page 4 discusses that Medicare Locals will ‘ensure a common approach to the full range of primary care services’. This is only made possible if the MLs have direct control over all primary care services. Such a situation cannot exist with a network of private practitioners, unless there are incentives for integration between practitioners. The paper needs to include how the Government plans to equip Medicare Locals to be able to forge the formal linkages between providers that are necessary for this to be achieved.

Coordinating access to after-hours GP services

The statements on page 4 relating to coordination of local face-to-face after hours GP services assumes that there are GPs willing to provide these services. The paper needs to identify that additional incentives will be built into the current system to engage GPs for his purpose. A description is required as to how the circumstances be different to the current system so that Medicare Locals are equipped to either purchase or directly provide these services.

Ensuring integration and coordination across primary and acute care services

Page 4 discusses the need for Medicare Locals and Local Hospital Networks to work closely together to ensure integration and coordination of services across primary and acute care. Parameters for such collaboration need to be identified for this to occur. Further detail about this is essential to Divisions understanding requirements for transitioning to undertake the role of a Medicare Local.

Applying population health data for decision-making

Page 5, point 1, refers to the use of population health data for decisions and processes based on evidence, but does not identify where such data will be sourced, nor does it indicate what incentives will drive the provision of this data by private providers to Medicare Locals in order to use it for this purpose. The use of population health data is a significant assumption that seems to be at the very core of Medicare Locals' roles and functions. Clarity around this issue is essential.

Developing clinical pathways

Page 5, point 2, refers to collaborative work between Medicare Locals and Local Hospital Networks to develop clinical pathways, but does not describe how requirements for collaboration will be formalised and enforced. Such collaboration appears to be a critical success factor for the health reforms, and as such, should warrant further prescription around this.

Monitoring provider performance

Page 5, point 3, implies that there will be some form of mechanism, either contractual or otherwise, to enable Medicare Locals to monitor and provide feedback on provider performance. This makes a significant assumption that private practitioners will agree to receiving assistance from Medicare Locals to meet safety and quality standards. The benefits to incentivising providers to agree to this will need to be tied to contractual arrangements.

We understand that, as stated in the National Primary Health Care Strategy, 'The Australian Government will use its position as the majority funder of health and hospital services in Australia to impose strong national standards for primary health care performance' (key priority area 4)... with new targets backed up by explicit financial rewards and penalties'. It is unclear how this 'carrot and stick' approach will be implemented.

There is still no detail on the development of the new performance and accountability framework, and the role of the Medicare Local in this system is unclear. This framework is to be developed by Senior Officials and agreed and adopted at CoAG with no input from the primary care sector. Negotiations will need to be undertaken with Clinicians if they are to be willing to undergo such monitoring within the system.

Therefore, alternative arrangements may need to be considered where providers choose not to participate in performance monitoring. This is particularly of issue if the assumption extends to GPs, where the funding for the majority of services provided by GPs will not be under the control of Medicare Locals.

Page 5, point 5, is particularly problematic in relation to the expectation that Medicare Locals will 'encourage improved clinical governance, performance reporting and the adoption of safety and quality standards and clinical practice. 'Encouragement' alone will not enable the Medicare Local to deliver on this. Further, how will such 'encouragement' be measured? Incentives to providers, both financial and non-financial, will need to be aligned with the objective in order for the Medicare Local to deliver results. This is the same challenge currently facing Divisions of General Practice. The paper needs to describe how things will be different.

Structuring Medicare Locals

One of the key questions in relation to the legal structure and governance for Medicare Locals is about who will be the members of these new organisations. It is disappointing that the paper does not address this issue, as it is highly relevant to necessary preparations for forming a Medicare Local, and impacts on Divisions' ability to forge partnerships that might be required to assemble proposals for consideration by the Government to establish Medicare Locals.

The discussion on page 10 still leaves this issue open to speculation and interpretation and then makes suggestions that private organisations as well as private health care providers could be members of these organisations. The risks associated with allowing membership of the same groups or individuals that the Medicare Locals would potentially contract for delivery of services do not appear to have been considered. Further, the voting rights of individual members versus organisational members need to be considered.

The needs of indigenous people receive scant mention, and this is within the context of governance arrangements. Considerations for the needs of special populations are far-reaching and complex, and must be accounted for within the design of Medicare Locals. The potential to further fragment services for indigenous people is significant if Medicare Locals are to operate separately to ACCHSs.

GPSA believes that any process of establishing Medicare Locals should secure and progress the many gains already forged by the community controlled health sector. It will be important in the changing environment that the development of Indigenous organizations capacity to deliver appropriate health services to Indigenous communities is continued. There should be a governance requirement that any Medicare Local planning, prioritizing and service delivery will seek to decrease inequalities for Indigenous Australians and that Indigenous people should be effectively involved in the governing processes that are responsive to the community.

Notional representation of indigenous people through governance arrangements will not be sufficient to ensure that the needs of this population are met through 'improving access to responsive, integrated and coordinated GP and primary health care services'.

There is a question on page 11 that reads, 'what rights should members have and should they be able to influence the governance and activities of Medicare Locals'? Under common law, members would be able to influence governance and activities of Medicare Locals if Medicare Locals are Companies Limited by Guarantee. Is the Government intending to create special provisions for Medicare Locals that will differ from this?

Page 13 poses questions about community participation. This can be achieved through various configurations, including membership, participation at Board level, advisory or reference groups that report directly to Boards, requirements for community engagement in service planning, etc. The Government needs to establish clear expectations and requirements around this issue.

Boundaries

Geography and size will determine the level of capacity a ML has to implement the reform agenda. Any decisions on boundaries will need to reconcile between the ability to engage with and service communities as a function of their size and any infrastructure and capacity for planning and implementing key initiatives and programs.

As stated in GPSA's submission to the yourhealth website in response to the Carla Cranny Report, the SA Divisions of General Practice agree that three metropolitan and two rural independent Medicare Locals be established in South Australia. In determining the boundaries for metropolitan MLs this submission takes in to consideration the three proposed State Local Hospital Networks (LHNs) - in the northern region (Lyell McEwin Health Service, Gawler and Modbury Hospitals); central region (The Queen Elizabeth Hospital and Royal Adelaide Hospital), and southern region (Flinders Medical Centre, Repatriation General Hospital and Noarlunga Health Service).

There is acknowledgement of the need for alignment between boundaries of Medicare Locals and Local Hospital Networks. However, areas that are currently being identified by the State as rural, more logically fit within a metropolitan Medicare Local response. In particular, the following areas require consideration:

- The northern boundary for Metropolitan Adelaide needs to align with the Adelaide Statistical Boundary (north of Gawler). The State currently is not including Gawler within plans for a northern metropolitan LHN boundary, although it is recognised and funded by the Commonwealth as a metropolitan area. The Adelaide Northern Division of General Practice currently services the Gawler area and expects that Gawler would be part of a northern metropolitan Medicare Local being planned for that area.

The GPs in the region also expect to be included in the metropolitan Medicare Local and see no benefit in inclusion with the rural Medicare Local. Their reasons for this include the nature of their practice since the loss of rural status by the Commonwealth; they no longer

practice rural medicine; they see a short term life for their service to the hospital at the end of the current contract; they have stated there is no common links with the Barossa and the rapid population growth excludes them from consideration as a rural location. Most pointedly in August of this year the Gawler East, Gawler South and Evanston Park areas were classified and gazette as a metropolitan region.

- The southern metropolitan boundary for a Medicare Local needs to account for areas with service utilisation of the Flinders Medical Centre. The State's plans currently indicate some these areas as part of the rural LHN, which does not reflect current access and patient flows to metropolitan hospital services, and do not align with the current plans for a southern metropolitan Medicare Local.

These issues indicate that there may be a need to be somewhat flexible in allowances for the detailed boundary delineations that do not perfectly align between Medicare Locals and LHNs. This is particularly true for areas that the State is currently treating as rural that are likely to be drawn into metropolitan boundary areas over time.

Plans for the rural Medicare Locals cover northern rural SA (including current Division boundary areas for Eyre Peninsula, Yorke Peninsula, Flinders and Far North, Mid North and the Barossa) and southern rural SA (including current Division boundary areas for the Riverland, Adelaide Hills, Murray Mallee and the Limestone Coast).

The SA Divisions understand that work commissioned by AGPN proposes that the Riverland and Limestone Coast regions become part of Medicare Locals in other states. SA Divisions do not support this proposal, as it is not consistent with efficient consumer flows or accessible pathways to care. SA Divisions also do not support the view that the Barossa region becomes part of a metropolitan Medicare Local.

The following key principles have informed the SA Divisions' current position:

- Ensuring and optimising the best possible health outcomes for all communities.
- Local General Practice positioned at the forefront of primary health care.
- Maintaining strong engagement of clinicians and community in local service delivery reforms and improvements, considering local health needs.
- Maintaining local responsiveness and innovation, within the framework of a wider Medicare Local.
- Building a collective capacity from regional locations yet ensuring low levels of inherent bureaucracy.
- Contributing local input to influence collective actions, and adding value to activities through strong, sustainable collaborations.

Timeframes and Consultation Issues

The preface to the discussion paper outlines the need for careful consideration on a broad range of issues. GPSA has been and continues to be concerned about the lack of detail and clarity on key issues, particularly as the timeframe for first round implementation draws closer. Divisions in South Australia have been working hard to pre-empt the Governments thinking on key issues in order to progress planning.

With Medicare Local functions not clarified, structure and clinical governance not yet specified and boundaries and catchment areas still to be determined by COAG in December, the timeframe from allocation of first adopters to transition from existing structures is not appropriate, especially for a number of Divisions who expect to move towards one entity from current separate legal and membership structures. What is also not recognised in this discussion paper is that it takes time to build relationships for effective multidisciplinary teams around new governance structures.

Additional cost to transition

There appear to be key aspects to the reform plan which will require significant administrative capabilities and investment on the part of Medicare Locals that will require additional funding. These are not limited to:

- Medicare Locals will be required to have a formal engagement protocol with a LHN, additional resources, funding and support for that Medicare Local must be provided.
- In the development of Health Community Reports the Commonwealth will work with 'GP and other primary health care stakeholder groups and the National Preventative Health Agency to develop the report structure and to identify what data is already available and what will be needed to be developed over time' (Delivering better health and better hospitals, page 47) – how will this work be funded?
- The health reforms present considerable challenges in terms of change management and the system changes needed to support it are many and require adequate funding.
- Scheduled eHealth initiatives for primary care will need additional support so that health care providers existing information systems are aligned with the new eHealth environment.