



**Submission to the
Department of Health Review of Medicare Locals**

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The role of MLs and their performance against stated objectives

The effective and efficient provision and coordination of primary health care services is a critical component of a comprehensive health system which can significantly improve health outcomes and reduce overall health care costs and out-of-pocket expenses. This requires a formal coordination and development structure for primary care and MLs have provided a good starting point for this. In line with this view, the AHHA supports the objectives under which MLs were established, and notes that there are emerging examples where MLs have demonstrated good practice in meeting these objectives.

The performance of MLs should be considered in the context of the relative youth of the organisations particularly those which were part of tranche 2 and 3, established only 24 and 18 months ago respectively.

The Divisions of General Practice (GP), as the predecessors of MLs, had the disadvantage of representing only one facet of primary health and community care, but the advantage of clarity in mission: representation at regional level of the practical interests of the general practitioners, albeit at varying levels of competency and success. The transition to MLs addressed the disadvantage by bringing together a local body from the variety of primary health care practitioners in the region. However, achieving the MLs' objectives has been problematic – while they have influence, they do not have service delivery funds of sufficient scale to drive the creation of planned services, or the provision of financial incentives for integration; nor do they do have any statutory powers, and support from the various levels of government has been mixed.

In some MLs, an advocacy role has been adopted, which, while it may appropriately support local need, may be perceived to be inconsistent with their mandate from the Commonwealth. Additionally, while many MLs view the planning/needs assessment role as core business, delivering on this objective has proved to be challenging. Clarity around this objective and its purpose in the system, in agreement with other levels of government, is required. It must also be recognised that while there will always need to be a process of informing priorities, this cannot be achieved by interested local stakeholders alone.

The performance of MLs in administering existing programs, including after hours

The effectiveness of MLs in administering existing programs has been variable, as was the case with the predecessor GP Divisions. This variability results from the systemic weakness in contracting out the governance of regional primary health care to an NGO formed from the local interested primary health care practitioners, without providing these organisations with the means (funding and power) necessary to provide that governance. As a result, some have operated as well-funded local advocates, rather than effective program administrators. The program-driven nature of much of the MLs' work has not encouraged design flexibility and has tended to focus on reporting outputs or inputs, rather than outcomes.

Recognising general practice as the cornerstone of primary care in the functions and governance structures of the MLs

Ensuring a role for general practice as the cornerstone of primary care within the functions and leadership of MLs will cement in principle what is already the case in practice in the great majority of MLs. There is, for example, quite significant GP engagement in the boards of MLs. However, while general practice is a critical component of primary care, the AHHA contends that it must be seen as part of the overall mix in primary care, not as the predominant feature. One of the positive benefits of MLs over GP Divisions was the broadening of scope to engage non-GPs; a move away from this would be a retrograde step in our view. Further, a GP-dominated body would potentially be influenced by the remuneration system available to GPs, who may be unwilling to support service changes that could negatively impact their income, thus limiting non-GP based service delivery options. Exemplifying this is the recent lack of support for new prescribing pathways for allied health professionals.

Ensuring Commonwealth funding supports clinical services rather than administration

The clinical and administrative expertise of MLs enables an important role in population health planning and in addressing inequities in health service access and health outcomes. However, the diversity of the environments in which they operate (including geography, population size and characteristics, local government and local hospital network structures) requires flexibility and innovation in organisational structure and service delivery.

More devolved authority is essential to making the most of the Commonwealth's investment in ML infrastructure. The challenge is to ensure that MLs realise their potential to contribute to better integrated and coordinated care – something which may not yet be the case across all MLs. However, some administrative infrastructure is required to ensure that patients are able to access the appropriate services for their needs, in a connected manner, particularly where their needs are complex (eg for chronic disease management and for the very elderly) or where they are in some way marginalised (eg Indigenous, mental health, homelessness). Without some coordinating infrastructure, simply pushing funding towards clinical services will not address the existing problems many people experience in obtaining joined up, accessible services, as clinicians are neither best placed, resourced or cost-effective to undertake the coordination role. Likewise, it will not address over-servicing in the MBS, PBS and diagnostic areas. While use of ML infrastructure to promote delivery of coordinated mental health, Aboriginal health and aged care programs has largely been positive, the AHHA does not support this as a mechanism to ensure Commonwealth oversight of delivery.

The challenge is to design an administrative infrastructure which is efficient and effective. The blunt application of funding cuts will not necessarily ensure optimal use of funds. Evaluation of current ML arrangements is required. An area which warrants investigation is the reporting burden– the AHHA supports simplifying reporting and reducing duplication, ensuring that the reporting requirements better reflect risk (and dollars invested). Likewise a simplification of funding arrangements would be beneficial in reducing administrative burden.

In terms of clinical focus, the AHHA suggests that particular attention should be paid to supporting well targeted programs that ensure accessibility for those who are disadvantaged, people with mental illness and in aged care facilities, and for after-hours services. Service planning and system improvement works most effectively if undertaken through authentic and genuine relationships with health equity populations (Aboriginal and Torres Strait Islanders, refugees and asylum seekers, those experiencing homelessness, people with mental illness for example). This element of the work of Medicare Locals should be strengthened and supported through the development of credible engagement accountability mechanisms.

Assessing processes for determining market failure and service intervention, so existing clinical services are not disrupted or discouraged

If the proposed shift in resource allocation within MLs toward service delivery eventuates, discipline will be required in conceiving and providing services that recognise and complement the primary health care constituency that comprises their membership. An allocation of Commonwealth funds to provide expanded and more diverse primary health care services will be a welcome initiative if done with local sensitivity, and ensuring that Commonwealth resources are not being applied to build services in competition with existing NGOs, for example, Aboriginal Community Controlled Health Organisations and community health services, unless there is service failure, rendering communities without access to service.

Unfortunately, the establishment of MLs, and the subsequent flow of Commonwealth funding to them has perversely encouraged some market failure, in that it has allowed the states and territories to further reduce or close some community health services, thus increasing the market gap. Partnerships to optimise the use of federal and state resources should be the key mandate for Medicare Locals. This requires joint catchment planning, setting of desired outcomes and measurement to determine progress. Collaborative effort and shared responsibility/accountability for achieving these outcomes and reporting against these outcomes in a transparent manner is required.

It should also be noted that there are a range of specialist services in the community that are neither linked into MLs or into LHNs. Care coordination services provided by nurses or allied health practitioners and incorporating care planning along the lines of the evidence based Flinders Model, exemplifying an approach that is not likely to arise within the market, is worthy of consideration.

Evaluating the practical interaction with Local Hospital Networks (LHNs) and health services, including boundaries

The AHHA contends that integration across allied health, primary health and hospitals should be supported by strong policy and incentives. The current disconnect across these sectors is problematic to efficient resource utilisation, and the contribution of MLs to improving this is yet to be fully realised. This must be part of an evaluation of the ML arrangements. However the evaluation must also take into account the evolution of a system that for a number of MLs only commenced mere months ago. It must also be recognised that while it is good in principle to align MLs with Local Government Areas and LHNs, some flexibility is needed given the size and population of some regions, and the impact of cross border arrangements.

It would be sensible if the evaluation of MLs also took into account the success or otherwise of other regional level infrastructure in delivering on similar objectives to those of MLs. For example, in Victoria, the Primary Care Partnerships model shares similar objectives and its roles and contributions should be assessed alongside those of MLs, including consideration of their role in working with the state health department in planning and rolling out statewide initiatives (eg in service delivery, training, testing new models of care).

In some locations, there is some evidence to suggest that the established services of local health districts and community health agencies may be better placed to manage the funds and provide ML-type programs because of long-established and well-functioning relationships with other health providers. There may also be greater support and participation by GPs and other health professionals for the programs. The AHHA is aware of duplication of some administrative functions across MLs and these regional level services, including human resources, public relations, community engagement and GP services.

Tendering and contracting arrangements

Tendering and contracting arrangements must be subject to robust probity and competition arrangements, without becoming overly inflexible and bureaucratic such that MLs become driven by process rather than outcomes. The review currently being undertaken should examine the over-reliance on large (and expensive) consultancy firms to deliver advice on matters which might equally have been informed by smaller and not-for-profit entities with strong credentials in health policy work at lower cost to the system. Some attention should also be given to the reliance of some MLs on their stakeholders and partners for the supply of consultancy services – probity, integrity and independence of advice should be a feature of all tendering and contracting arrangements entered into by MLs and their national alliance, particularly where Commonwealth funds are being used. The AHHA is aware of situations where ML Board members are also suppliers of services to the ML under contract, potentially raising conflict of interest issues.

Attention also needs to be paid to the mechanism for funding distribution to MLs. Is there appropriate Commonwealth scrutiny in place where funds are disbursed from the Commonwealth via the national alliance of MLs? In determining a way forward, some clarity is required as to whether MLs are a formal part of the health system, thus subject to the rigour of government funding and acquittals but able to avail themselves of assured funding flows, or whether they are genuinely not-for-profit entities that must engage with government and the community, and garner financial and other support, subject to the particular scrutinies applied to not-for-profit agencies, in the same way as other not-for-profit agencies are required to act.

Other related matters

While the AHHA views as desirable that the Boards of Medicare Locals have autonomy and independence from all levels of government to make informed decisions, in the best interests of their community, in relation to the range of programs and services they provide, it is important that the Commonwealth retains an overall view of the success or otherwise of its investment in primary health care. The absorption of advice and program accountability into the functions of the line departments such as the Department of Health is preferable to the current arrangements where responsibility is transferred to a variety of proliferating agencies, for whom the objectives are sometimes unclear (for instance, is the purpose of public reporting to better inform consumer choice, improve clinician or hospital performance, improve health outcomes, ensure fiscal responsibility, or a mix of some or all of these?).

To ensure some clarity around program accountability for MLs, the Commonwealth government must provide overarching governance arrangements and take direct responsibility for performance, in order to ensure value for taxpayer investment. Without this level of control within the Commonwealth line agency, the opportunity cost will be a loss of 'administration': planning, data collection and contribution into the planning exercises of state and Commonwealth governments. More coherent arrangements for ML data development, collection and reporting are also required, and should be the subject of consideration within a broader review of national health data collections by the several competing agencies in this space. Ensuring robust national collections of primary health care relevant data that can be viewed at regional level is far more important than any contribution that MLs could be contracted to provide. In particular, difficulties accessing Medicare data need to be addressed by the relevant Commonwealth agencies, and work should be undertaken to develop a national minimum data set for primary health.

Further genuine reform may be achieved by bringing state-funded population and community health together with MLs. The finalisation of bilateral National Primary Health Care Strategic Framework implementation plans must also be a priority for the Commonwealth, states and territories.