Submission by

Australian Healthcare & Hospitals Association

on

Medicare Locals: discussion paper on governance and functions

November 2010

Contact: **Prue Power**
Executive Director
Australian Healthcare & Hospitals Association (AHHA)
PO Box 78
Deakin West ACT 2600

0417 419 857
02 6162 0780
ppower@aushealthcare.com.au
www.ahha.asn.au

Contents

1. Introduction 3
2. AHHA role 3
3. Name – Medicare Locals (MLs) 4
4. Primary Health Care (PHC) 4
5. Establishment of Primary Health Care Organisations 5
6. Boundaries 6
7. Function of Primary Health Care Organisations 7
8. Governance of Primary Health Care Organisations 10
   8.1 Corporate governance 10
   8.2 Clinical governance 11
9. Funding and performance of Primary Health Care Organisations 12
10. Local Hospital Networks 12
11. eHealth and data collection 13
12. Evaluation 13
13. Conclusion 14
14. Summary of AHHA recommendations 15

AHHA Submission

This submission is the Australian Healthcare & Hospitals Association (AHHA) response to the ***Medicare Locals: discussion paper on governance and functions*** (referred to as the Paper). In addressing the Paper, our response provides page references to assist clarity.

The AHHA response includes a Background to the reforms and this Discussion Paper at Appendix 1.

1. Introduction

The AHHA believes that the NHHN reforms (summarised at Appendix 1) deliver significant funding and structural changes for public hospitals and primary healthcare and represent a strong and positive foundation to further reform.

On 3 March, the AHHA welcomed the Government's newly announced proposals for health system governance and supported the plan to shift clinical input and financial decision-making closer to the community through local networks of health providers.

However, the AHHA pointed out then, and still argues that there are some structural gaps in the proposals both at the national (oversight) and local (service delivery) levels; in particular, how will the proposals ensure equity of access and quality health care for consumers and a mechanism to ensure service integration and coordination.

In the short-term (over the next four years) the manner in which the reforms are implemented will be critical to addressing these and other gaps, harnessing provider and community support and ensuring their future evolution.

2. AHHA role

The Australian Healthcare and Hospitals Association (AHHA) is the independent peak membership body and advocate for the Australian public healthcare system and a national voice for universally accessible, high quality healthcare in Australia.

The AHHA represents providers in the acute, community, primary and aged sectors. Our members include all the public sector primary care services that are proposed for funding and policy transfer from the states to the Commonwealth as well as in the hospital sector.

The Association has expertise in coordinating the views of a wide range of stakeholders and would be pleased to work with Governments in relation to the proposed reforms. Given the AHHA's pivotal role, the Association is in a position to establish and facilitate a robust networking structure between the LHNs and MLs to foster communication for national, state and local regional service engagement. It is critically important that communication is fluid, open and engaging so as to give these reforms the best opportunity for success.

It must be noted that the Australian General Practice Network (AGPN) is not the only national peak body in this space. To date, the AGPN has been the only organisation meaningfully engaged in consideration and development of the future of primary health care. As a membership body, the AHHA and its stakeholders perceive a lack of broader engagement with organisations that are currently doing the work of coordinating care across regions and a range of settings.

<u>Recommendation 1</u>

That the Australian Healthcare and Hospitals Association (AHHA) be recognised, in all further consultation processes, as the peak body representing public sector primary and community health. The AHHA is the only

independent membership body and advocate for the Australian public healthcare system and represents providers in the acute, primary, community and aged sectors. Our members include the public sector primary care services proposed for funding and policy transfer from the states to the Commonwealth. The Association has expertise in coordinating the views of a wide range of stakeholders and would be pleased to work with Governments in relation to the proposed reforms.

3. Name – Medicare Locals (MLs)

In the 2010-2011 budget the Commonwealth Government formalised its commitment to establishing primary health care organisations (PHCOs) but renamed them Medicare Locals (MLs).

The AHHA strongly believes that the name is inappropriate in relation to the proposed function as originally conceived in the national reform agenda. The name indicates that the function will be dominated by medical and related services (ie. any services payable under Medicare) and it is highly likely that the community will view these organisations in this way.

The name excludes the large range of other services traditionally provided by the PHC sector, for example allied health services, aged care and disability. This interpretation is further reinforced with the controversial proposal, delineated in the Discussion Paper and referred to below, to limit applicants for PHCOs to Divisions of General Practice (DGPs) only.

Throughout this submission we continue to refer to the organisations as Medicare Locals (MLs) for clear reference to the paper, in spite of our concern regarding this name.

Recommendation 2

The AHHA recommends that the name Medicare Locals be overruled in favour of returning to Primary Health Care Organisations (PHCOs) or something more representative of the range of services they cover rather than the source of funds (Commonwealth).

4. Primary Health Care (PHC)

The fact that the definition of primary health care (PHC) is not clarified in the context of the reform agenda has the potential to jeopardise the future direction of the reforms. It appears that the Government is using "primary health care" as a proxy for general practice. This definitional issue is fundamental and requires resolution before finalising the transfer of services and the role and function of Medicare Locals (MLs).

The immediate impact is:

- confusion over the definition of services currently being delivered in the primary and community care sectors, including out-of-hospital specialist care (not recognised in the NHHN), leading to lack of national consistency in relation to services being transferred from states and territories to the Commonwealth; and
- significant lack of clarity in relation to the role and function of MLs. The AHHA is seriously concerned that the Paper is using PHC as a proxy for General Practice, reinforcing the fear among health organisations that MLs will operate as DGPs by another name rather than genuinely new forms of primary health care organisations (PHCOs) (page9 para5).

When determining the role of the proposed PHCOs, the AHHA urges all Australian governments to adopt the internationally recognised definition from the World Health Organization (WHO) agreed at the Declaration of Alma Ata (World Health Organization and United Nations Children's Fund 1978).

For example, the Victorian Department of Human Services adapted this Declaration (2009) in the Victorian context as follows:

> *Primary health care is integral to the Victorian health system. Community-based, it seeks to protect, promote and develop the health of defined communities; and by addressing and managing individual*

and population health problems at an early stage reduces the need for more complex care. At the other end of the health care continuum, primary health care services can support rehabilitation and care at home.

Primary health care in Victoria should be provided by a range of suitably trained health practitioners, working collaboratively and in partnership with other sectors, to provide timely, appropriate, integrated and person-centred services and population health actions.

Primary health care services give priority to those most in need and address health inequalities; maximise community and individual self-reliance, participation and control, and use appropriate technologies. Primary health care in Victoria is underpinned by an understanding of the social, economic, cultural and political determinants of health (Department of Human Services 2009a:16).

Recommendation 3
The AHHA recommends that the definition of *primary health care*, in the context of the national reform agenda, be clarified and resolved by all jurisdictions as a matter of urgency as this is fundamental to:
- an orderly and consistent transfer of services to the Commonwealth from the states and territories; and
- clarifying the role and function of MLs.

5. Establishment of Primary Health Care Organisations

The AHHA contends that selection for MLs should be open to all relevant organisations and be based on merit. This is a critical issue. Unless this occurs, the reform will not be genuine (rather business as usual) and a huge opportunity will be lost.

Although the Paper (page1 para6) states that the establishment of MLs will need to take account of existing regional and PHC infrastructure as well as partnership arrangements established and operated by the states and territories, the Paper does not provide details of which bodies are being referred to or how they will be taken into account. The reader may assume that they are Divisional State-Based Organisations, Community Health Centres, Aboriginal Controlled Community Health Organisations, Sexual Health Centres, Primary Care Partnerships and other related organisations in the public, not-for-profit and private sectors.

It should be noted that most of the current linkages across the primary and community care sectors, and with acute and aged care agencies, are with a diverse range of services operating in the primary and community care sector. However, the Paper mentions these as 'complementary' to DGPs and that MLs should 'draw on', rather than absorb, the range of skills and expertise of these bodies.

This appears to be strong clarification that the proposed approach excludes these organisations and has the potential to result in a GP focused network to the detriment of a team approach which utilises the full range of allied health services and which is the ultimate purported goal of the national reform agenda.

A GP dominated body will be influenced by the remuneration system available to GPs, which will be further reinforced if the organisations are called 'Medicare Locals' (cf. Recommendation 2 above). There is evidence to show that GPs, through DGPs, are unlikely to support any service change that could negatively impact on their income, resulting in them not providing services to 'unprofitable' population groups and/or limiting non-GP based choices for service delivery. This system does not foster a population health approach to PHC.

On the other hand, non-DGPs have better experience in running true primary care organisations and also running real health businesses. Few DGPs have a track record with health service provision, leading to a significant risk, both in terms of business capacity and also conflict of interest. What is clear in the Paper is that none of these non-DGPs will be given the opportunity to form a ML. This is of significant concern to the AHHA.

Furthermore, there appear to be no clear criteria for identifying the DGPs that will form MLs. It is intended that the first group of MLs will be established in 2011 (expected to be around 15) and will evolve from high

functioning DGPs. The second group will be established in 2012, evolving from DGPs that demonstrate capacity to take on additional roles and functions.

If this process is to continue, it is imperative that Divisions provide objective evidence of relevant achievements and why they should form the foundation MLs. Empirical work must be undertaken to specify and assess the key factors, structures, performance indicators and expectations of the MLs, rather than relying on anecdotal contributions through this open submission process. At the same time, gaps in their activities must be identified in order to inform the process and powers needed by MLs to be more successful than the best DGPs (page4 para1).

This approach raises further questions in relation to ongoing funding of DGPs and State-Based Organisations that are not in the first group. The AHHA understands that all Divisional funding will cease at 30 June 2011. Given the declared intent that the first group will act as a 'benchmark' for the second group, it is logical that some funding would have to continue. The AHHA is seeking confirmation of plans for Divisional funding.

Recommendation 4

The AHHA recommends that selection for MLs should be open to all relevant organisations (including DGPs) and be based on merit according to agreed selection criteria and that sufficient funding be allocated for establishment and capacity building purposes.

6. Boundaries

The AHHA notes that, while the number of entities has not yet been determined, LHNs are in the process of being developed by each jurisdiction, due for completion before the end of December 2010. The boundaries of MLs, on the other hand, will be resolved bilaterally between First Ministers in the same timeframe.

The AHHA would prefer MLs and LHNs be combined in order to ensure a smoother patient journey across all healthcare settings. There is little or no evidence to prove that the needs of hospitals would subsume primary and community care needs if LHNs and MLs were amalgamated.

However, in the meantime, the AHHA supports the principle stated in the NHHN Agreement that LHNs will have common geographic boundaries with MLs, to facilitate purchasing of patient services and coordination of care at the local level. It will be critical to establish infrastructure and systems that build, foster and maintain close connections between providers in these entities.

It is currently being argued that one ML could service 2-3 LHNs and that larger MLs will be established either at the outset or via amalgamations over time. In the view of the AHHA, this would severely jeopardise the proposed local functionality of MLs. Large MLs would be more likely to be purchasers of programmatic funding with less flexibility to account for local needs on the basis of population health planning.

It is critical that the LHN and ML boundaries (where they have a geographic focus) define natural catchments, to provide funding stability and a 'critical mass'. The debate on boundaries must take into account the maxim that form should follow function. The population coverage required to allow the ML to have appropriate critical mass will depend upon the purpose. For example, if it is for health needs assessment it will be one thing, if it is to appropriately work with LHNs it could be another and if it is to 'manage' PHC it could be different again. It will also be determined by local circumstances, acknowledging that there is no intention for more than one ML to operate in the same geographic area. It should be noted that the Membership section in the Paper could give a different impression in its statements about the initial group of members setting up the ML, but the interpretation is unclear.

It must be noted that rural and remote MLs will have challenges that far exceed those of their relatively well-resourced metropolitan counterparts. Their challenges, among others, will be to address major gaps in primary care services and disparities in the distribution of health professionals; to support the existing health workforce; and to integrate primary care with specialist services, Local Hospital Networks, aged care and mental health services.

Recommendation 5
The AHHA recommends:

- adherence to the principle stated in the NHHN Agreement that LHNs will have common geographic boundaries with MLs to ensure maximum potential for coordination of patient care; and
- LHN and ML boundaries (where they have a geographic focus) define natural catchments, to provide funding stability and a 'critical mass'.

7. Function of Primary Health Care Organisations

The Commonwealth Government envisages the network of MLs to:

> *Be independent legal entities, with strong links to local communities, health professionals, service providers and non-government organisations. MLs will promote regional integration, one of the key building blocks in the National Primary Health Care Strategy. Medicare Locals will make it easier for patients to navigate their way through the health system. They will improve the planning and coordination of services at the local level, support the delivery of a range of primary health care initiatives, including addressing service gaps and inequities, and improve collaboration between practitioners and service providers across the health system. Medicare Locals will also improve patients' access to after-hours primary care services* [Australian Government Budget 2010-2011, Department of Health and Aging, Primary Health Care. Australian Government, Canberra].

The NHHN Agreement further details the function of MLs as operating in a "nation-wide network of primary health care organisations…to better connect hospitals, GP, allied health, aged care and Indigenous health services making it easier for patients to get the treatment they need, including after hours". A key aspect of their initial role will be to "fill gaps in access to services after hours". However, they will "progressively take on a broader role" to "underpin the delivery of PHC services at the local level – by supporting them to improve access to health services in the community and improve integration with Local Hospital Networks and aged care services" as well as "providing health promotion and preventive health programs targeted to risk factors in communities" [A National Health and Hospitals Network for Australia's Future: page 63].

The Discussion Paper states that MLs will be responsible for "making it easier for patients and service providers to navigate the health care system" (page1). They will "support health professionals to provide more coordinated care, while maintaining the important role that general practice plays in the PHC sector. MLs will facilitate improved access for patients and encourage greater integration between the PHC, hospital and aged care sectors".

The Paper goes on to state that MLs will play a major role in achieving the objectives of the NHHN, helping to 'drive' the reform program (page3), but these are optimistic assertions when there is no detail on how such objectives are to be achieved. No evidence or mechanisms to achieve these goals have been delineated or even mooted. The Paper also states that "a key role will be undertaking local health planning, identifying gaps in services at the local level, examining opportunities for better targeting of services and establishing formal and informal linkages with the acute and aged sectors" to "drive more efficient use of resources" (page4).

Taking all these descriptions into account, in summary, the proposed functions of MLs are:

- regional integration including coordinating services at the local level to secure improved access to primary, acute and aged care services including after-hours services;
- service planning including addressing gaps and inequities;
- to support the delivery of a range of primary health care initiatives (see discussion about lack of definition above);
- to improve collaboration between practitioners and service providers; and
- to provide health promotion and preventive health programs targeted to risk factors in communities.

However, the Paper is silent on mechanisms to achieve these functions, relying instead on suggesting that MLs will operate, at least initially, as DGPs currently do, that is, a collection of programs being loosely managed

rather than setting in place fundamental step-change reform from the start. Statements on page 6 and 7 illustrate this: "MLs initial role in direct service delivery will be based on the existing responsibilities and arrangements of DGPs, such as for the provision of allied health services and psychological services" (page7 para1) and listed dot points (page6 para3). The Paper indicates that MLs may take greater responsibility for direct management of PHC services over time but does not discuss the competency and capacity levels needed to achieve this.

The mechanisms that would be used to support service delivery, provide after-hours primary medical care and fill gaps are unclear. The Paper refers to fund-holding as one possible mechanism (page 6 last dot point), but it should be noted that the NHHN Agreement only allows for fund-holding "in areas of market failure and where patient needs are not being met" [NHHN Agreement clause B26(f)].

In addition, the illogical way in which the NHHN proposes to carve up primary and community care services has the potential to cause even more confusion for providers and consumers. For example, the artificial split for hospital avoidance programs into those for acute care patients versus others will be difficult to manage as most patients in the target group admitted to hospital have an acute exacerbation of a chronic disease.

In addition, it is not clear who will manage and fund patient care where a seamless interface between hospital and home is required, such as in community and home-based rehabilitation, palliative care and mental health care.

Nor is there any coherent strategy to manage hospital demand within the NHHN.

In the context of proposed functions discussed above, the Paper discusses five "key objectives" (page5). The AHHA's discusses these in detail below.

Identification of health needs of local areas and development of locally focused and responsive services

According to the Paper, the Commonwealth anticipates that "local population health and service plans will be developed over time". The AHHA contends that this should be the initial function of MLs on the basis that health system design should begin with the community's needs which define the services required, in turn determining the details of how the system is organised [Ovreveit J, Coordinating community care: Multidisciplinary teams and care management: Open University Press, Buckingham].

In the absence of a strong tradition in Australia for undertaking such work, MLs will need considerable financial and professional support to build the required capacity and skill-sets. Currently, the vast majority of available health planning expertise resides in state and territory health departments and regional areas. The AHHA argues that MLs must explicitly harness this expertise and will require considerable development money for capacity building.

There is also an assumption in the Paper that the geographic population covered by an ML is the same as the population using GPs in that geographic area. This may be the case in more regional and remote settings but not in the metropolitan environment where experience suggests a significant variation between these two populations (estimated at 70%-90%), with the lower-socio-economic groups being the most transient and therefore, more vulnerable to service gaps.

Recommendation 6

The AHHA recommends that the Commonwealth:

- ensures local population health and service plans will be an initial function of MLs; and
- involves the expertise of the states and territories in population health planning and agrees to purchase this expertise to inform the creation of MLs and to ensure a consistency of approach throughout the network.

Improving the patient journey through developing integrated and coordinated services

It is arguable that this function is the most critical for MLs. The Paper states the MLs and Local Hospital Networks will need to work closely together to ensure integration and coordination of services (page4 para3) and recognises, in rhetoric, the imperative for service integration as a major driver and beneficiary of the proposed reforms. However, it has never been clear how the NHHN Agreement would encourage or facilitate greater coordination of care and the Paper does not assist in clarifying what mechanisms will be used to foster and/or fund this critical function.

The Paper refers to MLs 'support[ing] the coordination and integration of primary care services transferred to the Commonwealth' (page4 para5). This implies that they will either hold the funding for these services or the policy levers will be in some other guise. If this is the case, how will the states and territories influence service delivery decisions? If MLs do not hold the funds, then how will they be able to achieve the function?

The Paper states that MLs will also have a role in coordinating aspects of General Practice. Again, it is unclear as how this will happen and whether all GPs are covered or just those that volunteer to become members of MLs (page4 para6). There is no evidence that DGPs currently work well with GPs (corporate or traditional) who don't participate in Divisional activities. This begs the question: will GP engagement with MLs be mandatory? If not, how will system-wide reform be effected?

One of the most significant questions on which the paper is unclear is the extent to which MLs will have *responsibility* for integrating care and providing a 'navigation' service to their populations across acute and aged care along with improved coordination of primary health services.

The AHHA believes greater coordination of care can be achieved by funding the MLs and LHNs to foster and approve, against national guidelines, care pathways and other models of care that support the whole patient journey. These models of care would link primary and community-based care with hospital care, particularly for the management of chronic disease (such as diabetes and heart conditions). The regional entities would foster the local development of models of care, building on the many existing public sector 'networks', to better manage more common acute episodes such as hip replacements and heart attacks or service challenges such as the provision of emergency surgical services. As there appears to be complete absence of mechanisms that will be used to facilitate patient coordination and integration, the AHHA argues that a selected number of pilot sites be established to test the above proposal on models of care.

Recommendation 7

The AHHA recommends that:

- the Commonwealth Government negotiates with state and territory governments to establish an agreed number of pilot sites to test the operation of the new entities. Suitable sites would have a full range of services including cross-border flows;
- as part of the pilot, the Commonwealth fund a project to develop some 'real-life' case studies for key consumers and target groups. These would include modelling their current experiences of the health system and the 'ideal' experience that helps determine the roles and structures for MLs. Case studies would include:
  - Consumer with mental illness
  - Indigenous consumer
  - Rural consumer
  - Aged consumer
  - Consumer with complex chronic conditions
  - Healthy episodic consumer; and
- the regional entities should foster the local development of models of care, building on the many existing public sector 'networks', to better manage more common acute episodes such as hip replacements and heart attacks or service challenges such as the provision of emergency surgical services.

The Paper correctly states that one area where MLs and LHNs will need to cooperate is in ensuring appropriate clinical pathways to assist coordination and integration of patient care between different settings.

The AHHA supports Clinical Pathways and Practice Guidelines in providing clinicians with the best available evidence on treatment for specific conditions. The system-wide adoption of known best practice within our health care system would also significantly improve quality and reduce preventable errors. Incorporating nationally consistent pathways and guidelines into standard health service practices and making them available electronically will ensure that consistently high quality care is provided to all patients by:

- providing an evidence-based benchmark for clinical processes that supports the configuration of services, local commissioning and clinical practice across all care settings while facilitating localisation of the content promoting usability and adoption; and
- addressing clinical governance (page11) by providing a national benchmark for clinical guidelines while allowing the development and sharing of local guidelines and care pathways.

In this context, the Paper proposes that pathways will be developed collaboratively between MLs, LHNs and Lead Clinician Groups (LCGs) (page4). However, this raises more questions than it solves in relation to how such pathways are to be developed and enforced, assuming consensus. There is also no recognition of the need to generate the evidence at a national level utilising a specific Research and Development Strategy incorporating research, training and evaluation on which to base the clinical pathways.

Recommendation 8

The AHHA recommends:

the system-wide adoption of known best practice within our health care system on the basis that incorporating nationally consistent pathways and guidelines into standard health service practices and making them available electronically will ensure that consistently high quality care is provided to all patients; and

the establishment of a national Research and Development Strategy in order to achieve the above, incorporating research, training and evaluation on which to base the clinical pathways.

Provide support to clinicians and service providers to improve patient care

This is the area where DGPs have struggled to engage with GPs other than those willing to participate. Therefore, the question is, what powers will MLs have to hold GPs and other primary care providers to account and involve them in the coordinated system?

Facilitation of the implementation and successful performance of primary healthcare initiatives and programs

Comment as above.

Be efficient and accountable with strong governance and effective management

See section below.

8. Governance of Primary Health Care Organisations

As the core component of these reforms is premised on effective local governance, it is clear the fundamentals of good corporate and clinical governance are essential to the success of these reforms.

Clinical and corporate governance operate in parallel in addressing the organisation's structures, systems and processes to ensure quality, accountability and proper management of operations and service delivery.

8.1 Corporate governance

The ML Boards (as well as LHN Governing Councils) will be expected to provide strategic oversight and monitoring of the organisation's financial sustainability, occupational health and safety, compliance, effective risk and clinical governance and consumer empowerment with appropriate separation from management's day to day responsibilities.

As discussed in other sections of this response, there are significant expectations placed upon MLs as to their role in the reformed health system and very little specification on the mechanisms they will have to operate.

For example, the section on membership (page 10-11) implies that they will be organic and grow over time and could look different in different places. Whilst local flexibility is critical it should be within a nationally specified framework. The ability, as currently proposed, for any initial group to be the company members and therefore drive the company seems very vague, open to corruption and a compromise in not wanting to upset current Divisional structures. This is equally problematic with the explicit barring of certain foundation members, including corporate general practices.

It appears that reform will be an 'opt-in' process for those who want to be on board, whether they are already modelling what the reformed system should look like or are keen to be at the vanguard. There is no mention of how those organisations and individuals will be selected.

There is also no mention of how those who are resistant to change will be engaged/compelled to participate in the reforms. If there is no compulsion for the whole system to move in the same direction (for example, through using sanctions), the reform will not result in the systemic effects that are expected.

Therefore, the composition of the Board needs greater clarification. This is also necessary as most Divisional Boards are very introspective and GP dominated.

The AHHA believes that there should be national guidelines which clearly specify the composition of ML Boards. There should be a fixed number of Board members with a limit on the number of GPs. MLs must also have designated positions for consumers and a member the Local Hospital Network (including state-wide networks) in their catchment area.

There also needs to be greater specification of the responsibilities of the key officers, e.g. Chief Executive, Financial Director, Medical, Nursing and Allied Health Directors (page 10 para1).

The question is: how will 'transparency' and 'engagement' deliver results? More detail is required on what 'strong governance' looks like. Board Directors will require training, support and professional development so that they understand and are appropriately prepared for their corporate responsibilities and the current and upcoming challenges shaping the health system.

Recommendation 9

The AHHA recommends:

- national guidelines which clearly specify the composition of ML Boards. There should be a fixed number of Board members with a limit on the number of GPs. MLs must also have designated positions for consumers and a member the Local Hospital Network (including state-wide networks) in their catchment area. A limit should be placed on the number of GPs; and
- the need for greater specification of the responsibilities of the key officers, e.g. Chief Executive, Financial Director, Medical, Nursing and Allied Health Directors

8.2 Clinical governance

The approach to clinical governance in the Paper is non-specific and yet attention to clinical governance is imperative in ensuring a systematic approach to maintaining and continually improving the quality of patient care in order to safeguard high standards. Implicit in clinical governance is transparent responsibility and accountability for standards.

A mechanism to formally include clinical governance in the functionality of MLs must be incorporated from their commencement. The Paper tends to assume that those involved will be well-intentioned but the AHHA contends this is not sufficient in developing a reform structure.

In addition, reference throughout the document to the 'Local Lead Clinician Groups' implies that they have already been determined but the AHHA believes that this has not yet occurred. The proposed composition of the Local Lead Clinician Groups is also unclear as well as their relationship between the boards of both the MLs and the LHNs.

Recommendation 10

The AHHA recommends the incorporation of a formal clinical governance mechanism from the inception to ensure:

- transparency in relation to responsibility and accountability for standards;
- a systematic approach to maintaining and continually improving the quality of patient care in order to safeguard high standards; and
- clarity around the composition and role of Lead Clinician Groups.

9. Funding and performance of Primary Health Care Organisations

The Paper has stated nothing with regard to the funding structures and expected performance monitoring of the Medicare Locals themselves (as distinct from primary health care as a whole). In her speech to the Australian General Practice Network Forum on 4 November, Hon Nicola Roxon MP made mention of work underway to identify a funding formula for Medicare Locals in addition to separate work to establish a performance framework for the organisations.

The AHHA is deeply concerned that the development of these two key elements of the functioning of Medicare Locals is proceeding without broader engagement and consultation with the primary health care sector. The risk is that the models derived for funding and performance management are based solely on the current funding model for existing DGPs which, as we know, is limited to general practice and has no remit for coordination of health services in addition to the other functions specified for Medicare Locals.

Recommendation 11

The AHHA requests that the Commonwealth Government engage directly with a range of other stakeholders, including the AHHA, in development of the funding and performance measurement frameworks that will apply to Medicare Locals.

10. Local Hospital Networks

The Paper is vague about how MLs will work *with* Local Hospital Networks to improve service integration (page4 para7), while implying MLs will have a role in the actual coordination of health services across the spectrum of delivery settings. This needs considerably more clarity and the AHHA suggests that the MLs (in the first instance) are not best placed to undertake this work.

Although the AHHA understand the Commonwealth will not intervene in matters concerning governance of LHNs or the negotiation and implementation of LHN Service Agreements, the NHHN Agreement envisages that the states and territories can manage the delivery of relevant GP and primary health care services where the Commonwealth agrees to provide those services through LHNs. The AHHA supports this concept. There should be nothing in the legislation that would prevent LHNs from participating in primary and community care. LHNs should be able to participate in funding from the 100% primary care pool, not just the hospital ABF pool. The Discussion Paper is silent on this point.

In this context, there is no reason to prevent LHNs from taking on the role of a ML in the form of Local or Regional Health Network.

The AHHA views the future of PHC at the turning point. It can either be business as usual or we can agree on a bigger vision for the most appropriate functioning of PHC organisations which are not isolated from LHNs. The worst outcome would be a parallel system of primary and hospital delivery systems that achieves none of the intended service integration.

Recommendation 12
The AHHA recommends that LHNs should be encouraged to participate in primary and community care utilising funding from the 100% primary care pool, not just the hospital ABF pool and should not be prevented from taking on the role of a ML in the form of Local or Regional Health Network.

11. eHealth and data collection

The Paper is strangely silent on the introduction of e-health, despite the fact that the NHHN will need a sophisticated electronic health information system to underpin its activities. For example, the requirements for measurement and reporting, activity-based funding and integration of patient care between LHN and ML services will be substantial. Currently, this infrastructure does not exist. Unless this infrastructure is built, opportunities presented by the NHHN could be lost.

Funding in the Commonwealth Budget (11 May 2010) which provided $467m (over 2 years) to implement a person-controlled Electronic Health Record is only a small, though important start to implementing the National E-Health Strategy.

The successful implementation of e-health however also requires a range of specialised human resources. These include:

- clinicians who understand these technologies and can apply them to clinical practice;
- information technology professionals with in-depth knowledge of both the business and clinical needs of the health system;
- health information management professionals with knowledge of e-health technologies;
- planners who know how to utilise health information systems to address system management issues; and
- specialists in process re-engineering and change management.

Recommendation 13
The AHHA recommends explicit consideration of the information and communication technology needs of MLs and LHNs as part of the specification of their roles and responsibilities with direct reference to the National E-Health Strategy.

12. Evaluation

A significant oversight in the whole reform agenda is the lack of an evaluation program. Without a systematic method for collecting, analysing and using information to answer questions about the effectiveness and efficiency of the multiple elements of the reform program, how will we know if they have been successful, particularly in terms of patient outcomes?

The community will want to know if the programs they are voting for and funding are actually having the intended effect, and when they are not, that there are mechanisms to remedy the situation.

In the context of interaction with patients and providers, it is imperative that quality and outcome indicators, along with access measures, are incorporated into a formal evaluation program from the outset. This goes to the core of what MLs should be doing in terms of improving the quality of primary health care services, particularly through their stated core responsibility of local population planning (page13 para4).

Recommendation 14
The AHHA recommends the inclusion, at the outset, of a systematic method for collecting, analysing and using information to answer questions about the effectiveness and efficiency of the policies and projects inherent in the reform program, particularly in terms of patient outcomes.

13. Conclusion

AHHA's assessment is that MLs as set out in this document are in danger of being DGPs by another name – and they will struggle with the same problems faced by the Divisional program over many years. There is nothing in the Paper to suggest that they are genuinely reformed primary health care organisations.

Consequently, AHHA has little confidence that MLs will be able to adequately address the issues around primary health care that lead to fragmented care and overuse of the public hospital system. On this basis AHHA would feel very reluctant to see funding transferred to the Commonwealth for the bulk of what states and territories currently provide in the primary/community health space, let alone the continued (and possibly expanded) funding of primary health care organisations that perpetuate the patchy Divisional model.

AHHA | PO Box 78 | Deakin West ACT 2600
p: 02 6162 0780 | f: 02 6162 0779 | e: admin@ahha.asn.au | w: www.ahha.asn.au

14. Summary of AHHA recommendations

AHHA role

Recommendation 1

That the Australian Healthcare and Hospitals Association (AHHA) be recognised, in all further consultation processes, as the peak body representing public sector primary and community health. The AHHA is the only independent membership body and advocate for the Australian public healthcare system and represents providers in the acute, primary, community and aged sectors. Our members include all the public sector primary care services proposed for funding and policy transfer from the states to the Commonwealth. The Association has expertise in coordinating the views of a wide range of stakeholders and would be pleased to work with Governments in relation to the proposed reforms.

Name – Medicare Locals

Recommendation 2

The AHHA recommends that the name Medicare Locals be overruled in favour of returning to Primary Health Care Organisations (PHCOs) or something more representative of the range of services they cover rather than the source of funds (Commonwealth).

Primary Health Care

Recommendation 3

The AHHA recommends that the definition of *primary health care*, in the context of the national reform agenda, be clarified and resolved by all jurisdictions as a matter of urgency as this is fundamental to:

- an orderly and consistent transfer of services to the Commonwealth from the states and territories; and
- clarifying the role and function of MLs.

Establishment of Primary Health Care Organisations

Recommendation 4

The AHHA recommends that selection for MLs should be open to all relevant organisations (including Divisions of General Practice) and be based on merit according to agreed selection criteria and that sufficient funding be allocated for establishment and capacity building purposes.

Boundaries

Recommendation 5

The AHHA recommends:

- adherence to the principle stated in the NHHN Agreement that LHNs will have common geographic boundaries with MLs to ensure maximum potential for coordination of patient care; and
- LHN and ML boundaries (where they have a geographic focus) define natural catchments, to provide funding stability and a 'critical mass'.

Function of Primary Health Care Organisations

Recommendation 6

The AHHA recommends that the Commonwealth:

- ensures local population health and service plans will be an initial function of MLs; and

- involves the expertise of the states and territories in population health planning and agrees to purchase this expertise to inform the creation of MLs and to ensure a consistency of approach throughout the network.

Recommendation 7
The AHHA recommends that:
- the Commonwealth Government negotiates with state and territory governments to establish an agreed number of pilot sites to test the operation of the new entities. Suitable sites would have a full range of services including cross-border flows;
- as part of the pilot, the Commonwealth fund a project to develop some 'real-life' case studies for key consumers and target groups. These would include modelling their current experiences of the health system and the 'ideal' experience that helps determine the roles and structures for MLs. Case studies would include:
    - Consumer with mental illness
    - Indigenous consumer
    - Rural consumer
    - Aged consumer
    - Consumer with complex chronic conditions
    - Healthy episodic consumer; and
- the regional entities should foster the local development of models of care, building on the many existing public sector 'networks', to better manage more common acute episodes such as hip replacements and heart attacks or service challenges such as the provision of emergency surgical services.

Recommendation 8
The AHHA recommends:
- the system-wide adoption of known best practice within our health care system on the basis that incorporating nationally consistent pathways and guidelines into standard health service practices and making them available electronically will ensure that consistently high quality care is provided to all patients; and
- the establishment of a national Research and Development Strategy in order to achieve the above, incorporating research, training and evaluation on which to base the clinical pathways.

Governance of Primary Health Care Organisations

Recommendation 9
The AHHA recommends:
- national guidelines which clearly specify the composition of ML Boards. There should be a fixed number of Board members with a limit on the number of GPs. MLs must also have designated positions for consumers and a member the Local Hospital Network (including state-wide networks) in their catchment area. A limit should be placed on the number of GPs; and
- the need for greater specification of the responsibilities of the key officers, e.g. Chief Executive, Financial Director, Medical, Nursing and Allied Health Directors

Recommendation 10
The AHHA recommends the incorporation of a formal clinical governance mechanism from the inception to ensure:
- transparency in relation to responsibility and accountability for standards;
- a systematic approach to maintaining and continually improving the quality of patient care in order to safeguard high standards; and
- clarity around the composition and role of Lead Clinician Groups.

Funding and performance of Primary Health Care Organisations

Recommendation 11

The AHHA requests that the Commonwealth Government engage directly with a range of other stakeholders, including the AHHA, in development of the funding and performance measurement frameworks that will apply to Medicare Locals.

Local Hospital Networks

Recommendation 12

The AHHA recommends that LHNs should be encouraged to participate in primary and community care utilising funding from the 100% primary care pool, not just the hospital ABF pool and should not be prevented from taking on the role of a ML in the form of Local or Regional Health Network.

eHealth and data collection

Recommendation 13

The AHHA recommends explicit consideration of the information and communication technology needs of MLs and LHNs as part of the specification of their roles and responsibilities with direct reference to the National E-Health Strategy.

Evaluation

Recommendation 14

The AHHA recommends the inclusion, at the outset, of a systematic method for collecting, analysing and using information to answer questions about the effectiveness and efficiency of the policies and projects inherent in the reform program, particularly in terms of patient outcomes.

Reform – principles and objectives

The AHHA believes sustainable reform of the Australian health system requires adherence to four core principles:

- Preservation of the universality and scope of the national Medicare system.
- A transparent and binding funding agreement between Commonwealth and states/territories incorporating clear accountability for expenditure and service delivery.
- A governance structure incorporating:
  - national bodies to develop Australia-wide standards and performance indicators to ensure high quality care and efficient delivery of services which meet the needs of the community and provide information from which to analyse outcomes for evaluation and public reporting purposes;
  - regional entities with influence over the allocation of funding within the region and the authority to develop, monitor and improve delivery of services.
- Implementation of mechanisms to ensure improved coordination of the patient journey between hospitals, primary / community care and private specialty facilities.

In the National Health and Hospitals Reform Commission Report (2010) the case for health reform was argued on the basis of:

- problems arising from a fragmented health system with a complex division of funding responsibilities and performance accountabilities between different levels of governments;
- increase in demand for, and expenditure on, health care;
- unacceptable inequities in health outcomes and access to services;
- growing concerns about safety and quality;
- workforce shortages; and
- inefficiencies.

In March 2010, the Prime Minister (Kevin Rudd) announced a comprehensive set of reforms based on the NHHRC report plus outcomes from a community and industry consultation program. Subsequently, agreement was reached with Premiers and Chief Ministers of states and territories (with the exception of WA) at the Council of Australian Governments (COAG) meeting in April to establish the National Health and Hospitals Network (NHHN) as the vehicle to implement the reforms.

The reforms had three primary objectives:

- building a sustainable foundation for services by reforming funding and governance;
- providing better access to integrated care designed around the needs of patients plus a greater focus on prevention, early intervention and care outside hospitals;
- increasing investments in hospitals, infrastructure and workforce (specifically doctors and nurses).

It is the second objective (above) that is primarily the subject of the Discussion Paper on Medicare Locals. By improving access to GP and primary health care (PHC), the NHHN's aim is to 'take pressure off hospitals' [A National Health and Hospitals Network for Australia's Future: Chapter 6].

Consistent with this goal, the Commonwealth Government is committed to taking responsibility for funding of all GP and PHC services in Australia from 1 July 2011 and to move, over time, to fully funding up to 100% of those hospital outpatient services that are better characterised as PHC. At the time of writing, PHC services delivered by states and territories are being identified for 'relevancy' before being transferred to the Commonwealth.

The Commonwealth Government aims to achieve this commitment through a range of actions including establishing a network of Primary Health Care Organisations ($291m); providing GP advice and services after hours including establishing the national Health Call Centre Network; coordinating care for people with diabetes ($449m); building 23 new GP Super Clinics plus 425 upgrades to existing services; supporting practice nurses in GP clinics ($390m); and supporting delivery of GP and PHC services in hospital emergency departments in rural and remote areas.