



**Australian  
General Practice  
Network**

*Delivering local health solutions  
through general practice*

## **Response to *Medicare Locals* Discussion Paper on Governance and Functions**

Australian General Practice Network

PO Box 4308

MANUKA ACT 2603

Telephone: 02 6228 0800

Facsimile: 02 6228 0899

[www.agpn.com.au](http://www.agpn.com.au)

Contacts:

David Butt, Chief Executive Officer

Leanne Wells, Executive Director, Policy and Business Development

**November 2010**



AGPN represents the network of 111 general practice networks as well as eight state based entities which cover Australia. More than 90 percent of general practitioners (GPs) and an increasing number of Practice Nurses and allied health professionals are members of their local general practice network. The Network is involved in a wide range of activities focused on improving the health of the Australian community including health promotion, early intervention and prevention strategies, eHealth and data management, health service development, chronic disease management, medical education and workforce support.

AGPN aims to ensure Australians have access to an integrated high quality health system by delivering local health solutions through general practice.

Australian General Practice Network  
PO Box 4308  
MANUKA ACT 2603  
AUSTRALIA

Telephone: +61 2 6228 0800  
Facsimile: +61 2 6228 0899  
Email: [agpnreception@agpn.com.au](mailto:agpnreception@agpn.com.au)  
Web: [www.agpn.com.au](http://www.agpn.com.au)

AGPN acknowledges funding from the Australian Government under the Divisions of General Practice Program.

## Introduction

The Australian General Practice Network (AGPN) is pleased to make this submission in response to the *Medicare Locals: Discussion Paper on Governance and Functions* released in October 2010. AGPN has outlined its views on this topic in previous submissions to the Department of Health and Ageing (DoHA) and especially through its blueprint for primary health care organisations (PHCOs) which can be accessed at:

[http://www.agpn.com.au/\\_data/assets/pdf\\_file/0013/21451/20091127\\_pap\\_Australian-PHCOs-Blueprint-FINAL-Graphic-designed.pdf](http://www.agpn.com.au/_data/assets/pdf_file/0013/21451/20091127_pap_Australian-PHCOs-Blueprint-FINAL-Graphic-designed.pdf).

This submission is structured in three parts:

- It contains AGPN's responses to the specific questions posed in the Paper relating to the function, governance and key interactions of *Medicare Local* primary health care organisations (PHCOs)
- It provides additional relevant information in the form of an overview of the various bodies of policy, legal and other technical work AGPN has commissioned or led itself in order to inform the transition of existing general practice networks (GPNs) to PHCOs
- It canvasses a number of strategic issues relating to the further policy development as well as organisational development required to support high-functioning PHCOs.

The views expressed in this submission have been informed by more than two years of consultation with member general practice networks including via twice-yearly meetings of Chairs and CEOs, various pieces of advice commissioned by AGPN which are summarised in part 3, the deliberations of the General Practice Network Leadership Group (GPNLG)<sup>1</sup>, AGPN's National Primary Health Care Consultative Group<sup>2</sup>, the development of the blueprint mentioned above and regular forums with the Network leadership facilitated by the state-based organisations (SBOs).

AGPN is the national organisation representing general practice networks (GPNs) which are made up of the 111 divisions of general practice which cover Australia. AGPN also represents eight state-based organisations (SBOs). GPNs are the community-based infrastructure which supports general practice to provide services in the community and into their homes. GPNs deliver local health solutions through general practice to ensure all Australians have access to high quality primary health care. GPNs aim to be in tune with their local communities and appreciate their communities' socio-health and socio-economic needs, which makes them a solid foundation for strengthening Australia's primary health care system, a characteristic recognised in the Government's commitment to introduce PHCOs by evolving them from, and building on, GPNs.

AGPN has long advocated for primary health care led reform and has participated actively and constructively in the major reviews conducted by the National Health and Hospitals Reform Commission, the National Primary Health Care Strategy External Reference Group and the National Preventative Health Taskforce. Our contribution to major health debates has been primarily informed by a 2005 Primary Health Care Position Statement and *Care That Puts People First*, a 2009 update of our original policy. A central proposal

---

<sup>1</sup> see <http://generalpractice.net.au/> for more information

<sup>2</sup> see <http://www.agpn.com.au/policy/policy-development/network-primary-health-care-policy-consultative-group> for membership and terms of reference

made in these policy statements has been for structures that regionally plan, organise, integrate and fund a wide range of primary health and social care. This policy stance follows evidence and trends elsewhere: countries at similar stages of economic development with health care systems organised around the tenets of primary health care produce better health outcomes for their populations. There is evidence that major service transformation requires highly organised primary health care. It is not surprising that strengthening primary health care and community-based care through some form of 'meso' level organisation that sit between micro levels of the system where clinical care for individual patients is delivered and the macro levels of the system where national policy, funding and public health infrastructure activity occurs has been a centre piece of health reform in many countries dealing with similar demand pressures as Australia such as Canada, the UK and New Zealand.

The announcement of *Medicare Locals (MLs)* is an opportunity to put in place a regional infrastructure that, provided it is funded and empowered appropriately, will be fundamental to implementing service improvements and better health outcomes for the community. The Network has consequently embraced this direction and believes that GPNs provide the best suited infrastructure on which to develop these new organisations.

## **Part 1: Response to Discussion Paper questions**

### **What will Medicare Locals do?**

As an overriding principle, AGPN strongly endorses the opening statement in the Discussion Paper on What will Medicare Locals do?

"Medicare Locals will retain, and expand, the functions and activities currently undertaken by the Divisions of General Practice – including general practice support and delivery of programs." (p4)

This is fundamental to the future of primary health care reform: the successes of the Network should not be lost in the transition, nor should the strong engagement with general practice. Rather this is the very foundation upon which MLs must be built.

#### **1. What features will Medicare Locals need to have in order to achieve their objectives (as outlined below):**

***a) Identification of the health needs of local area and development of locally focussed and responsive services***

***b) Improving the patient journey through developing integrated and coordinated services, including across the transitions between primary and acute and aged care.***

***c) Providing support to clinicians and service providers to improve patient care***

***d) Facilitation of the implementation and successful performance of primary health care initiatives and programs***

***e) Be efficient and accountable with strong governance and effective management.***

Many of the features that MLs will need to achieve the above stated objectives are interrelated and rely significantly on the authority, resources and capacity vested in MLs. These, as well as other key areas, are addressed below.

### *Capacity and authority*

First and foremost, MLs will need the power, authority, capacity and budgets to effect the change they are charged to achieve. This is fundamental to implementing the primary health care oriented, nationally unified and locally controlled health system – one of the stated intents of the National Health and Hospitals Network agreement between Australian governments. This includes adequate resourcing/funding and realistic expectations about what is possible both in the short and longer term. A key feature here is that MLs are implemented using a staged approach with goals that balance ongoing improvement over time with achievability.

### *Flexible funding and contracting*

While AGPN appreciates that MLs will need to be accountable to their funders and to the community, AGPN believes that to deliver on their objectives, PHCOs must be funded for success and sustainability. A key feature for MLs must be to have contracts and funding arrangements that are sufficiently flexible to address identified local need. Evolved GPNs must have the mandate to operate a 'full function' PHCO if they are to achieve their long-term objectives. Funding and contracts that are too restrictive and program-driven, as opposed to needs-driven, will stymie the ability of MLs to design programs and service models that address the specific needs of their local communities using services and partnerships that are available within their region. Currently the Network receives funds from an estimated 75 different programs through the Department of Health and Ageing (DoHA). This severely limits the ability to be flexible and responsive to need at the local level. AGPN strongly recommends that early in their lifecycle MLs have access to global budgets (linked to appropriate accountability arrangements) to ensure this flexibility and that, in the longer-term, they have significant purchasing/commissioning power in order to pursue lasting service reintegration and reconfiguration between general practice, community and social care services as well as sub-acute services to keep communities well and reduce hospital use.

### *Population health planning capacity and resources*

MLs will be required to undertake regional service planning and development. A key feature here is the ability of MLs to access reliable, accurate and up-to-date population health and service data for their local regions. Initially this may take the form of partnering with key agencies such as universities, public health units, area health services and the like. Over time however as MLs mature and further develop their capability, this could take the form of expert human resources located within the ML itself.

From the outset, MLs will need a mandate to access and use relevant, available data and the skills to turn the data into useable information for identifying and addressing local needs and service gaps. A key feature in this regard will be that MLs will need access to the skills (human resources) and technological systems to do this. Specific elements that will be required in this regard include:

- Resources to upskill existing and/or employ new personnel with epidemiology and health service planning knowledge and skills
- Strong partnerships with other sectors that may provide these skills and/or value add to those already in the ML
- Cooperation from state health and other agencies who hold data relevant to regional planning

- Knowledge management and IT skills and systems locally as well as continued national work on common definitions/standard data collection
- Identification of and access to available data sources eg. PHIDU, PHCRIS, ABS, AIHW; state/territory area health services; Commonwealth MBS/PBS; census data; local government data, clean local practice data etc. Access to data from LHNs as well as social/welfare service organisations will also be imperative.
- Access to qualitative data sources such as community views
- Development of a map of existing data sets with advice about how to use them
- The skills and ability to prioritise and allocate resources according to need at the local level.

### *Workforce*

Access to adequate health workforce will be a key prerequisite for MLs if they are to deliver on their proposed goals. Workforce will be required not only to deliver cross-sectoral service models but also to educate and train a broader range of PHC professionals and retain them in the primary health care setting. PHCOs must therefore have the resources to facilitate access to an adequate workforce. This could include:

- facilitating workforce recruitment and/or linking with workforce agencies to do so
- developing new service models, including virtual or remote models (such as telehealth)
- strategic partnerships around workforce development such as through regional training networks to be established by Health Workforce Australia.

PHCOs will also need to have robust communication systems in place to connect these different workforces across sectors. They will also need service delineation skills in order to frame services to the needs of the community and to ensure that the relevant services are available (eg. podiatry and nutrition services in a community with high diabetes levels).

### *Partnerships and community engagement*

Developing fruitful partnerships with other providers and sectors will be essential for MLs to deliver on their goals. Key links for MLs initially will be with PHC professionals, including general practice, as well as with LHNs and a range of community stakeholders including the ACCHO sector, the research community, non-government organisations, welfare services and so forth. Over time linkages may extend to non-health specific agencies such as educational, employment and town planning services so that MLs can increasingly develop and deliver services which also address the more fundamental social determinants of health.

Engaging with and, where relevant, building partnerships with these varied agencies will require significant skills and resources especially:

- Time. It takes substantial time to forge fruitful relationships and develop trust between partners
- Robust communication as well as change management skills. MLs will play a key role in facilitating cultural change to reduce barriers between different providers and sectors
- Other resources that support partnership and cross sectoral working/service delivery such as transport, technology, staff, shared protocols

Such cross sectoral partnerships will be a key feature of MLs in delivering on many of their proposed roles but especially in relation to assisting better integrated and coordinated care for patients. To further deliver on this goal, MLs will also need to have

in place mechanisms and systems that support engagement and communication across providers and that enable shared planning and connectivity. Such mechanisms and systems will include:

- Opportunities for broader health provider input into governance structures, both corporate and clinical
- The development of seamless clinical pathways and trans-sectoral models of care
- Integrated IT systems that connect different providers and that enable shared patient information (such as a shared EHR) and secure patient data transfer
- Capacity to drive cultural change through a shared commitment to patient safety and a more consumer focused approach.
- Funding levers at the ML level (as well as elsewhere) that can help address perverse financial incentives between public/private providers/sectors and that can instead promote team work and cross sectoral model.
- A strong understanding of what's required locally compared to what is currently available.
- The development of regional service directories
- Facilitation of central booking systems that can be used across services at the local level.
- The development of streamlined local referral processes and protocols

AGPN expects MLs to build on the Network's strong track record in this area of linkage and connecting across services.

#### *Governance structures*

Another key feature that MLs will need to have in place in order to deliver on their objectives are robust governance structures – both corporate and clinical – that accord with best practice not-for-profit governance (NFP) arrangements. More specific responses to questions relating to governance are provided in the following section '*What will Medicare Locals look like*' – commencing at page 13.

#### *Branding and marketing*

AGPN understands the Government's intention behind the naming of *Medicare Locals* as further promoting to the public the key role that the Federal Government plays in supporting improved health care in Australia. At the same time, AGPN knows from experience the importance of marketing services locally. AGPN suggests that a marketing and branding strategy is developed that incorporates the Government's intentions nationally, promotes MLs as a united, visible system of regional organisations, and enables MLs to be visible and meaningfully identified at a local level. This will be an important element in promoting the new structures to local communities and to other stakeholders that will work closely with MLs. In addition to funding for flexibility, success and sustainability and appropriate shifts in governance arrangements, a new brand will be an important strategy through which MLs can grow confidence and demonstrate their bona fides to stakeholders early in their lifecycle, including state governments who are being asked to transfer policy and funding responsibility of their services to this new system. Tactically, while it is important to retain the many strengths of GPNs, it is equally important to marry that with strategies that indicate that MLs are also different organisations with wider roles and responsibilities.

#### *The purchaser-provider split*

AGPN recommends that the commissioning and purchasing roles expected of MLs be clearly articulated. There appears to be some confusion among some stakeholders about the role MLs will have in this domain. However, like current GPNs, it is fully expected

that MLs will directly deliver services in their regions, particularly when there is market failure and no alternative provider. There is no impediment to MLs having dual purchasing and provision roles provided that these are separated both structurally and accountability-wise.

#### *Performance, standards and improvement*

A central characteristic of MLs must be consistent performance. AGPN believes that a performance development approach that is firmly embedded in quality improvement principles is the desired model. This will involve establishing clear standards across a range of corporate and clinical functions, combined with target performance indicators that will drive improvements. Benchmarking and shared learning opportunities should also feature in a transparent process of improvement. AGPN recommends:

- the development of PHCO-specific national standards against which all PHCOs are accredited
- the development of a performance measurement and development program that builds on the project initiated by AGPN in 2009 to support the Network in being proactive about improving and measuring performance. The program should include:
  - the development of appropriate population health and other indicators
  - the development and application of survey instruments to assess service user/consumer and provider experience and feedback
  - a pilot phase with the round one MLs
  - an on-line database, data analysis and reporting function to support the implementation of proposed indicators, including capability to benchmark and analyse each PHCO's performance over time.

#### **Are there other roles and functions Medicare Locals could potentially adopt?**

AGPN agrees in principle with the five key objectives for MLs as outlined in the discussion paper. AGPN believes however that the following roles could be additional to or help support the full implementation to the ML roles already outlined in the paper:

*A focus on prevention:* The Discussion Paper does not contemplate a lead role for MLs in advancing the Federal Government's prevention agenda, nor is it clear about the relationship between MLs and the National Preventive Health Agency. AGPN's strong belief is that the core business of MLs should be comprehensive primary health care which is inclusive of action and the development of capability and functions in areas such as health promotion. A broad model could involve the National Preventive Health Agency developing national initiatives with the MLs providing the regional implementation.

*Workforce development, orientation, local training and support:* This could include clinical placement coordination, supervision and training for a range of health professionals as well as the orientation and settlement of International Medical Graduates (IMGs) or other health professionals. A critical emerging partnership here will be between MLs and the regional training networks being established by Health Workforce Australia. It will be critical to growing and developing the primary health care workforce that these are fundamentally linked with MLs. This could include MLs auspicing or hosting training networks for students in their region. Further important links in this area are with Regional Training Providers and Rural Workforce Agencies.

*Research:* A key partner for MLs will be universities and the research community. There is therefore substantial scope for MLs to undertake, participate in and/or facilitate both clinical and health services research which can in turn help inform improved service delivery, quality care and evidence based practice.

*Linkages with medical specialists within the community:* Supporting private and public specialists to be able to participate in team-based integrated 'connected' care outside the hospital walls (as true consultants) may well be one of the most effective activities that MLs engage in.

*Broader scope and linkages:* Over time, there is opportunity for MLs to increasingly link with services that can begin to address the social determinants underlying health inequities in particular regions.

*Innovation and enterprise:* This could include the ability to access additional funding through non-government sources to respond to an expanded set of local needs. It may also include expansion of the ML to take on extended purchasing and commissioning roles.

*Facilitation of a 'centres of excellence' and knowledge network approaches in the ML network:* As MLs evolve it is likely that some specific skill sets may be more highly developed in certain regions. This could lend itself to MLs taking on extra roles in a "Centres of excellence" approach whereby certain MLs take the lead on a particular area of relevance to the ML Network overall. Examples include:

- organisational development, education/training and leadership
- corporate service/back office functions across the ML network
- research and training
- change management expertise.

Other roles that MLs could take a lead role in given their proposed linkages with other service providers and ability to communicate with and quickly mobilise a range of service providers on a regional basis include:

- disaster management and planning
- the implementation of local level eHealth solutions and connectivity across sectors
- standards and quality performance improvement development

### **What challenges will there be for Medicare Locals in performing the proposed roles and functions?**

The most significant challenge facing MLs is the matching of expectations of what they **might do** over time with the practical reality of what they **will be able to do** given budget constraints, and the continuing split in roles and functions in PHC between the Commonwealth and States (and hence the MLs and the State-run services). MLs should not be set up to fail – accountability for change and performance must be commensurate with capability: MLs need to be properly funded to ensure successful transition and increasingly effective operations. The capacity of MLs will be commensurate with the funding and resources available to them to fulfil the roles expected. While the intent behind ML policy is sound, it must be noted that, at this point and taking the current funding available for the Divisions of General Practice Program as a baseline, there is a modest level of increased 'core' funding combined with some equally modest targeted funding for program extensions in some areas such as after hours and mental health.

Strategies to mitigate this risk include:

- Identification of a 10 year vision for MLs and the maturity mapping which will be required to reach that point, including realistic expectations of capability and performance at July 2011, July 2012, July 2016 and July 2021 (an outline of this is included in the AGPN KPMG Transition Strategy and Plan 2010)
- Leading on from that, realistic performance indicators which will change over time, ensuring that MLs will not be 'sunk' at the first hurdle by completely unachievable outcome requirements or service expectations (like "fix mental health" or "guarantee access to after hours or allied health services")
- Policy directions and frameworks that enable (rather than limit or confound) MLs operating as full function primary health care organisations, including consistent policy drivers for both LHNs and MLs
- Adequate authority, power and funding (commensurate with responsibilities and accountabilities). This includes:
  - o Investment in transition support, organisational development and marketing and branding (in order to underpin local public education to explain the roles of MLs)
  - o Resources to employ/secure/broker the skills required to perform any and all functions required
  - o A level of resourcing that promotes and enables effective management, governance and oversight of desired roles
- A clear and unequivocal timeline and resource allocation plan from state health as to the intended transfer of services and over what period.
- Ability over time (commensurate with the above) to self-determine regional health care priorities and respond flexibly (moving away from prescriptive, program-based funding bases)
- Clarity about the supplementary resourcing that the Federal Government will apply to state transferred funds in order to bring up to a 'reasonable national service provision benchmark level' per allied health discipline/service per head of population.
- More detailed clarification about the 'required relationships' between MLs and LHNs in order to assist us to make appropriate decisions about regionalisation of delivery and decision making.

Time is also a particular challenge – both for establishment of MLs in terms of the due diligence and various other planning steps that need to be undertaken but also in terms of partnerships. While GPNs already have extensive local partnerships, there are a number of sectors that must be appropriately engaged in the formation and ongoing operations of MLs. Effective partnerships with a wider set of stakeholders will take time to build and, because MLs are fundamentally reliant on the engagement and support of multidisciplinary providers, services and local organisations that span various sectors (eg. the training sector, local government, Aboriginal Community Controlled Health Services), they are arguably more important to a GPN executing its ML formation plan than other domains of leadership and management. Expectations for ML performance based on such partnerships must allow for the time necessary to develop and build these relationships. Similarly boundaries of LHNs are not yet finalised thus making planning for

and linkage with these difficult at this stage. AGPN strongly emphasises the importance of taking a staged approach to ML establishment and evolution for these reasons.

A further key consideration is GP engagement. The formation of MLs will build on the well established infrastructure of GPNs. In addition, programs to be run by MLs at least initially, relate to GP services eg. after hours. While board composition, membership and the nature of programs and services undertaken by GPNs has broadened over time, GPNs have predominantly been governed by general practice and reflect the tradition and culture of Australian general practice. It is essential that GPs are fully briefed, consulted and, like others, have the opportunity to help shape a ML that retains the value of the current services it offers general practice as well as extends into a wider set of roles and responsibilities. Similarly, a governance model which evolves from GP networks in critical. As funding and roles broaden, so too should governance, membership and boards with the skills sets required to govern a 'full function' ML.

More specifically, challenges envisaged at this stage include:

- Ensuring access to an adequate health workforce
- Ensuring timely access to the data sets required for effective population health planning. Ensuring access to the skills and systems required to translate data into information for regional use to 'map and gap' health needs an inequities.
- Determining priorities (and the subsequent allocation of funds) among identified needs at the local/regional level
- Potential competition between national and local priorities in terms of service allocation
- Implementing cultural change in professionals working across different sectors and especially moving service providers away from a silo mentality
- Connecting and developing models of cooperative working between services that have not worked together previously/ Connecting services/developing models of care that connect services and service providers from different sectors eg public/private; community health/PHC etc.
- Developing mechanisms to ensure that local engagement with and support to health professionals, including GPs, is maintained within the larger framework and structure of a regional ML.
- Ensuring that MLs recruit staff with the appropriate skills sets as they evolve. In particular, skill sets required of staff in the establishment and transition phase are likely to be different to skill sets required by an ongoing operational and consolidation team.
- Promoting MLs to local communities and ensuring that communities understand what they are and how they can engage with them
- Determining the further transfer of services from state health to PHCOs over time
- Taking on increased areas of responsibility including extending support to other providers as well as GPs
- Addressing engagement and reach especially in those MLs that have a large geographic spread but have smaller populations
- Determining effective governance structures (both clinical and corporate) that enable community input as well as input from other key stakeholders such as LHNs, the ACCHO sector, non-health services etc.

AGPN believes that by building MLs from the Divisions Network, many of these challenges will be lessened as the Network has a significant track record in working with other agencies, linking services and developing innovative service delivery models tailored to the needs of their local communities. Even so, key areas such as access to population health data, ensuring adequate health workforce, undertaking a greater health service planning role engaging and partnering with new agencies are still challenges and should not be underestimated.

## **How should Medicare Locals and Local Hospital Networks work together?**

For MLs to engage effectively with LHNs, MLs must be given sufficient capacity, resourcing and authority so that both agencies can engage on a more equal footing. This cannot happen if PHCOs/PHC continues to be the 'poor cousin' to the acute sector. AGPN also considers that a decision as soon as possible about where final ML and LHN boundaries will be is important in order for PHCOs to start work on systematically engaging with the relevant LHNs. Once these structural steps have occurred, AGPN believes there are a number of other mechanisms that will support effective working between ML and LHNs:

- as a principle, AGPN does not support automatic cross membership between LHNs (as State-run statutory authorities) and MLs (as independent companies under the Commonwealth's Corporations Act 2001). See further detail below. Most of what needs to be integrated is operational hence strong cross-organisational linkages will be vital. at a clinical governance and service planning level AGPN suggests shared or cross committee membership on clinical governance committees between LHNs and MLs and/or shared clinical governance processes and planning between LHNs and MLs around areas of service overlap
- joint planning activities, based on information about identified local health needs, in which common areas to address in the region are agreed. This could include joint identification of need, clinical/referral pathways; the development of agreed patient transition protocols and pathways between sectors; implementation of hospital avoidance programs; the development of step-up/step-down models; development of effective, agreed intake/discharge planning processes
- at an operational level, effective engagement will be enhanced by:
  - shared communication, IT/IM and eHealth systems
  - access by MLs to LHN data which can help inform their regional planning processes
  - agreed standardised data reporting and coding systems
  - agreed shared clinical pathways
  - the inclusion of KPIs for LHNs and MLs that reflect reciprocal and effective engagement
  - there may also be scope for agreed shared workforce roles in certain areas
  - separate budgets and structures which clearly delineate funds available for LHNs in meeting their objectives from those available for MLs.

A further mechanism to assist MLs and LHNs work together is the General Practice Liaison Officer (GPLO) role. Having GPs inside the hospital system working to improve patient transitional care (referral and discharge) changes not only systems but can also help to progress a cultural shift with respect to building more effective, respectful working relationships across the acute-PHC interface. AGPN recommends that this role is funded, supported and expanded as a key function within every ML as a key mechanism to assisting effective linkage between MLs and LHNs.

## What will Medicare Locals look like?

COAG's National Health and Hospitals Network Agreement and policy documents from the Australian Government indicate that MLs will be independent companies limited by guarantee, regionally based, operate with strong local governance, have strong clinical leadership and work closely with Local Hospital Networks through various formal arrangements. AGPN supports all these characteristics. A company limited by guarantee is the most likely to meet the structural objectives for a ML and these may be developed either by establishing MLs as new companies or via amendments to the existing corporate vehicle of one or more GPNs. As public companies, MLs will have various reporting, disclosure and audit requirements and will be regulated by ASIC thereby ensuring funder confidence. In addition, this structure is appropriate to not-for-profit organisations and provides for a membership base – an important consideration when PHCOs are being built on existing organisations that have a membership-based model.

## What other broad principles or characteristics are important in establishing the governance arrangements for Medicare Locals?

A mature, best practice not-for-profit governance framework must be adopted by MLs from the outset. There is no single, universally accepted set of principles with regard to governance – much depends on the industry or sector in which the company operates, however the ASX Corporate Governance Council's Corporate Governance Principles and Recommendations are often referred to as a guide for good practice in the context of public sector or not-for-profit entities. In accordance with this guide, a fundamental principle is that MLs must be governed by skills-based – as opposed to representative – boards. Over time, MLs will be holding and be accountable for significant amounts of public funds and it is essential that both government funders and communities have confidence in both the strategic leadership and administration of MLs. There is often confusion between membership, governance and engagement and although these matters are related, it is essential that there is clarity around the fact that the board is only one level of governance and that its primary purpose is corporate governance – not membership engagement or partnership development. Broader stakeholder engagement strategies and clinical governance arrangements are therefore essential components of a ML governance framework.

AGPN believes a nationally consistent approach to membership, board composition and other structural and governance features is desirable, with local flexibility in application where appropriate. MLs must be supported by governance and engagement structures and arrangements that:

- reflect a skills based approach to corporate governance that encompasses the critical expertise required to govern entities of the nature of PHCOs
- allow each PHCO to form its governance arrangements in accord with broad criteria rather than have government-mandated board composition
- reflect a proportion of elected and appointed Directors to ensure optimum skill mix
- recognise primary health care clinical knowledge and knowledge of the primary health care industry as important parts of the skills matrix
- recognise the central role of the consumer and community through effective and visible consultative and engagement strategies to ensure ongoing input into ML strategic direction, decisions about planning and provision of services

- incorporate robust clinical governance arrangements that recognise the spectrum of health professionals working in primary health care (including medical, nursing, pharmacy and allied health professionals)
- facilitate partnerships with a wide range of agencies including private and public providers and services, health professional associations, community pharmacy, aged care providers, Aboriginal Community Controlled Health Services, other non-government organisations and education and training stakeholders
- are evolved from GP network governance, reflecting the fact that funding and other roles of MLs will broaden over time and that governance and membership need to similarly grow and adapt over time.

In addition to best practice corporate governance arrangements, good organisational governance must be guided by the existence and application of appropriate standards, performance development approaches and accountability frameworks that are firmly embedded in quality improvement principles as discussed at page 8.

### **What formal linkages are required between Local Hospital Networks and Medicare Locals to ensure good coordination of services in the community?**

The quality and extent of the relationship between MLs and LHNs will be a driver of regional health care improvement. As discussed earlier in this submission, there are several fronts on which the two organisations can work together to fulfil their roles of regional planner, coordinator, purchaser and deliverer of comprehensive primary health care solutions on one hand, and hospital and associated specialist services on the other. Points of linkage between MLs and LHNs must ideally occur at all levels within the regional health 'ecosystem' including at the governance, strategy and planning, operational levels. The principle of a level of shared accountability should also be considered, for example shared performance targets with shared incentives and penalties, and shared performance measures to the general public. Formal arrangements will be necessary and desirable at governance and operational levels (eg. MOUs), but informal arrangements should also exist.

AGPN notes that the Discussion Paper suggests that "to ensure formal linkages remain between Medicare Locals and Local Hospital Networks, Medicare Locals are expected to have some common membership of governance structures with Local Hospital Networks where possible and appropriate." Some have suggested this should translate into LHN "representation" on ML Boards. This is not a model which AGPN supports in either a practical or legal sense.

- First, MLs are to be established as public companies under the Corporations Act – Commonwealth legislation. That Act lays down the fiduciary and other responsibilities of Directors on such a Board. When a person is appointed to a Board under this Act, they are not there to "represent" anyone else but rather to act in the best interests of the company ie. the ML. So even if a person happens to be on the Board of a ML as well as a LHN, when they are functioning as a Director of a ML they must act in the interests of that company – not so as to represent the LHN
- Second, MLs and LHNs have very different roles and functions: MLs are independent companies funded to take responsibility for health needs planning, ensuring the delivery of services targeted to best meet needs, and in some cases direct service provision. LHNs are State statutory authorities responsible to the State Minister for the management of local hospitals. There is not a direct

correlation between what one does in primary health care, on the one hand, and what the other does in hospital care on the other hand.

It is noted that governance occurs at various levels and does not simply refer to the corporate board of a company or statutory authority. AGPN considers that some common membership of governance should therefore be required at governance levels below that of the company Board.

**What is needed to ensure that the structures and governance arrangements for Medicare Locals are flexible enough to deal with future changes in the health care system, including potentially different roles and responsibilities for primary health care?**

While the broad roles and functions for MLs are set out in the NHHN Agreement and various other Government documents, there remain a number of service domains (community health promotion and population health programs, drug and alcohol treatment services, child and maternal health services, community palliative care and specialist community mental health services) where Commonwealth responsibility for policy and funding is yet to be negotiated. At the policy level, this leaves a fundamental question unanswered which has significant bearing on the ultimate roles and responsibilities of MLs: what domains of comprehensive primary health care are in scope? At a systems and planning level, a clear statement from governments that outlines a 2-5-10 year outlook for MLs is required in order for MLs to forecast and plan across the short, mid and long-term.

At an organisational and governance level, it will be important that MLs do not take a heavily prescriptive corporate path and adopt a flexible, outcomes-based governance approach. In particular, MLs will need to test and adapt their governance models to meet changing circumstances. This should include flexibility of membership, and consultative and partnership arrangements to accommodate evolving roles and responsibilities.

**What other types of internal governance structures are needed to support the Board and the operations of the Medicare Local?**

As a general principle, AGPN believes that internal governance structures for MLs should not be prescribed. However, and in accord with good practice company governance, an audit and risk committee as well as a clinical governance sub-committee of the board should be required by the ML's constitution.

In the formative stages, a wide set of partnerships and strategic alliances with stakeholders, including community and consumers, will be necessary. At a minimum, AGPN anticipates the need for:

- a change management steering committee to govern and support formation and transition to the ML
- technical and implementation groups specific to first stage ML programs and initiatives to provide expert advice, engagement and instruction
- a community/consumer advisory mechanism to provide advice and propose solutions on local needs, concerns and changes in community contexts
- a PHC provider advisory group.

In terms of ongoing governance, in addition to the board, board subcommittees and advisory committees, with the community and key stakeholders such as LHNs and the

Aboriginal Community Controlled Health Sector involved at this level, will be important in order to add a broader industry perspective to ML strategy and policy.

### **Who should the members of Medicare Locals be?**

Various options for ML membership have been canvassed by DLA Phillips Fox in their advice to AGPN. Each has particular strengths and weaknesses and can be expected to be of varying appeal to different stakeholders. The four membership options considered by DLA Phillips Fox can be summarised as follows:

- membership drawn from the community, with the potential of additional restricted membership categories for other stakeholders
- individual membership offered to all primary health care providers/professionals in the MCL catchment. Providers could be grouped into categories (eg. GPs, allied health) to manage impacts on governance. Potentially other individuals and organisations could be offered a class of membership without voting rights
- organisational membership is offered to all general practices, allied health practices, Aboriginal medical services, NGO providers of health care and other community based practices in the catchment. Potentially other stakeholders (eg. individual providers, local government, LHNs, education providers) could be offered a class of membership without voting rights
- organisational membership is offered to major organisations that have a significant and relevant stakeholder base or constituency of their own, such as community health services, community mental health services, Aboriginal medical services, NGO peak bodies and relevant education and training organisations.

AGPN does not support a national or prescribed approach to membership. The model for ML membership needs to strike a balance between inclusion, accountability and practicality as well as community and provider ownership. Network members have actively considered the second and fourth options as outlined by DLA Phillips Fox as the most viable, however the views remain mixed. A shift to organisational membership exclusively is a marked shift away from the membership model that currently characterises GPNs whereby individual GPs have an organisational voice and vote. As flagged elsewhere in this response, a transitional approach to membership and governance changes alongside the evolution of the ML's role may be pragmatic. In many cases the existing GPNs would initially be auspicing members, especially during the first years of evolution. AGPN recommends the second and fourth membership options, or a combination of the two. This is a simple structure that will best suit the purpose of MLs and accommodate relevant membership.

### **How should membership be structured to ensure Medicare Locals focus on the health needs of their local community?**

In addition to the above comments, AGPN believes that a single class of membership is advisable and that different classes of membership, each with different rights, only be adopted when such an approach is essential to distinguish the manner of engagement of various key stakeholders or to effect transition. Reflecting the multidisciplinary nature of primary health care service delivery, AGPN recommends that specific strategies are required to facilitate the engagement of nursing and allied health groups in ML governance given most do not currently have an established regional provider network similar to general practice.

## **What rights should members have and should they be able to influence the governance or the activities of Medicare Locals?**

There are a number of decisions reserved to members at law under the Corporations Act. These include approval and repeal of the company's constitution, approval of a change of the company's name, approval of a change of company type and removal of directors and many of these require a special resolution passed by at least 75 per cent of the votes cast by members entitled to vote on the resolution.

There are other potential decisions that could be reserved to members however as a general principle AGPN believes that, perhaps with the exception of decisions regarding new members to the ML, the matters reserved for decision by members of a ML should be limited to those specified in the Corporations Act, unless there are compelling reasons to do otherwise. A great number of decisions reserved to an AGM may risk 'paralysing' the ML due to the timeframes, administration and expenses involved in convening lengthy, business-laden AGMs and could place directors in a position of having responsibility without power (which in turn may create difficulties in attracting and retaining appropriately skilled and experienced board members). While AGPN appreciates that how decisions about MLs are taken is a sensitive issue given the number of organisations with a stake in how the ML is formed and operates, AGPN believes that matters of members rights on the one hand, and effective stakeholder consultation and engagement on the other hand, should not be confused, and that it will be imperative on all MLs to have highly visible, structured and genuine arrangements for stakeholder, community and consumer engagement embedded in their overall governance framework.

## **What aspects of clinical governance should Medicare Locals be responsible for?**

MLs will require robust clinical governance systems in order to:

- ensure quality and safety in primary health care services MLs provide (in circumstances where the ML has a service arm involved in direct service provision) as well as models of care or care pathways they may introduce, advocate and/or fund
- support effective service planning that delivers access to well coordinated quality care that aligns with clinical standards and guidelines and is predicated on effective care pathways
- engage clinicians and lead/coordinate continued quality improvement in primary health care clinical practice across the jurisdiction.

AGPN recognises and supports the clarification provided by the Commonwealth that MLs will not become directly involved in clinical decision making about individual patients, however, we note they may facilitate practitioner education and development by providing opportunities for practitioners to participate in peer discussion and review activities related to direct patient care and specific incidents of care.

In order to achieve these objectives clinical governance at the ML level will need to be focused on fostering and further developing:

- clinical effectiveness
- an effective workforce
- effective risk management
- consumer participation in service planning and evaluation.

Across these domains and with specific regard to key objectives for clinical governance within ML recommended above, clinical governance within ML will need to address:

- priorities and strategic direction
- planning and resource allocation
- culture
- organisation
- performance
- continuous improvement of quality
- roles and responsibilities
- continuity of care.

Effective clinical governance will demand clinical leadership and for patient/consumer participation and feedback to be actively sought and considered. To reflect the multi-disciplinary nature of effective primary health care and to ensure the engagement of primary health care professionals across disciplines, clinical governance structures will need to include clinical leaders with expertise in medicine, nursing, pharmacy and allied health, relevant to primary health care practice. To accord with best practice and ensure a focus on consumer perspectives they will also require consumer representation.

### **What is required to ensure appropriate linkages between Medicare Locals' clinical governance and Local Lead Clinical Groups?**

There remains much ambiguity about the role of Local Lead Clinical Groups. As these groups appear to sit outside the MLs and LHNs, they cannot take on the responsibility for the clinical governance functions of either body, as these need to be core responsibilities of the LHNs and MLs. Hence their role appears to be an advisory, coordinating role – an admirable and desirable function but one which needs to be set up in such a way to ensure a balanced approach. In other words, a Lead Clinician Group dominated by specialists and with a token GP or allied health professional would not achieve the rebalancing of the system towards a stronger primary health care approach, as has been signalled by government. Attention to membership of these groups therefore needs to be carefully considered based on first determining what functions they are to perform.

It is important to ensure that health professionals from the primary and hospital sectors work together to promote models and pathways of care that support best possible patient experiences and best possible health outcomes. While all MLs and Local Hospital Networks should be required to ensure partnership at a clinical governance level, the exact mechanisms through which they do so are likely to be most effective if they are established with consideration of the local context and in response to identified needs which are likely to be the initial focus of collaborative work. Such arrangements may potentially include memorandums of understanding, joint standing advisory groups, professional networks or specifically appointed working groups.

Supporting effective partnerships between MLs and Local Hospital Networks at a clinical governance level will require sufficient resourcing of partnership activities and forums. It will be most effectively realised if it is supported by a broader culture of open communication between the two organisations and approaches to strategic and service planning that involve consultation and collaboration with the other organisation.

### **How will Medicare Locals interact with patients and providers?**

**How can communities best be supported to fully participate in the activities of Medicare Locals? What can Medicare Locals do to facilitate stronger community participation in local primary healthcare service planning and delivery?**

It will be critical to the capacity of MLs to achieve their objectives that they are strongly engaged with local communities and that they actively support community participation in local primary health care service planning and delivery. Through effective engagement with community members and consumers, MLs will be able to better understand and meet local needs and mobilise existing community networks and capacity. Such engagement will support greater community trust and 'buy-in', greater transparency and accountability to the community and ultimately, facilitate improved health outcomes.

AGPN believes that to facilitate meaningful community engagement and participation MLs should be required to develop and implement robust community engagement strategies based on principles of good practice in community engagement. Such strategies should comprise multiple mechanisms for community engagement matched to the local context and should develop and extend over time as both the community and the ML become more adept at meaningful engagement.

To effectively support meaningful participation, mechanisms used to engage with the community will need to be relevant to the geographic and cultural specificity of the ML population. Due to the need for community-appropriate approaches it is not recommended that all MLs are required to employ the same community engagement strategy.

While one community engagement strategy cannot be expected to meet the needs of all MLs, to ensure a minimum standard of community engagement is achieved there may be value in supporting Medicare Locals to employ a common minimum set of specified approaches. In particular, consideration should be given to requiring MLs to employ a common approach to ensure that they support meaningful participation in decision-making at a strategic planning and development level as this is essential to ensure meaningful community participation in the 'big picture' direction taken by the ML - including the approach taken to community engagement.

To support MLs and the community in meaningful engagement AGPN believes that further investment will be required to:

- support the community and specific community members to develop the capacity to participate meaningfully in ML planning and service or program implementation and evaluation. Individuals and community organisations may require additional resources, knowledge, and skills to participate in particular ways. AGPN believes that this development should be actively facilitated by the ML at the regional level, although there may also be a role for national training, education and networking initiatives.
- ensure ML have the capacity to support meaningful community engagement. AGPN is currently working with a small advisory group and a community development expert to develop a community engagement framework and toolkit to support MLs to further develop their community engagement approaches and to foster a commitment to robust community engagement more broadly across the health sector. In a proposal to the Commonwealth Government to support the effective transition of the current General Practice Network to a national network of MCs, AGPN has sought funding to support further capacity building for MLs in community engagement through the development of resources, education and training.

To assure quality and drive performance improvement in relation to community engagement, AGPN believes that national standards and performance frameworks for MLs should address community engagement and participation.

Through their role in supporting quality improvement in primary health care services, MLs also have an opportunity to advocate and support general practice and other primary health care services/providers to develop and implement meaningful consumer engagement strategies. The relationships MLs have or will develop with local primary health care providers and the role they will play in supporting system change and quality improvement across provider organisations, means they are well placed to support service providers to enhance their community engagement and community responsiveness. AGPN believes that MLs should be actively encouraged and supported to drive a greater focus on consumer participation in health service design and delivery and a culture of commitment to community engagement across the primary health care system, including through appropriate resourcing and access to data that demonstrates performance in this area.

### **What kinds of information would be appropriate to provide in Healthy Communities Reports?**

MLs must be accountable to the Australian Government and the local community for measurable outcomes over which they have influence and for which they have been given sufficient responsibility, authority and resources to influence. This should occur through a comprehensive national performance, improvement and business excellence framework: however this framework needs to be realistic about what is achievable with the limited resources available.

It is unclear from the discussion paper and from previous Commonwealth references to Healthy Communities Reports whether they are intended to comprise an element of this accountability framework and will act as a public report on the performance of MLs or whether their primary purpose is to provide a more general picture of health within the local community.

There is value in Healthy Communities Reports that provide stakeholders, including the general public, with a comprehensive picture of health behaviours, outcomes and service access within each ML catchment. AGPN believes that there is also potential value in structuring these reports to provide a public report of ML performance against key performance indicators. As the way that such performance is reported can significantly impact on stakeholder perception of MLs this should be the subject of careful consideration and it will be critical that Healthy Community Reports clearly distinguish between those areas of community health status that MLs have responsibility for and are resourced to influence and those they are not. Further, to support meaningful interpretation of any performance measures reported through Healthy Communities Reports, this should be couched within easy-to-interpret analysis and discussion that highlights key influencers on such measures within that jurisdiction.

To support public access to a comprehensive picture of population health and local primary health care services, Healthy Community Reports will need to report against key indicator measures for the following categories at the local or jurisdictional level. To support an assessment of change over time and ML performance reports will need to present trends over time for these key indicators:

- population health outcomes
- population health behaviours in relation to key health risk factors
- access to primary health care services, including timeliness of access to GP services and after-hours GP care, prevention initiatives and chronic disease management support

- health system integration and coordination, including through measures of patient experience of quality of care and its coordination and, potentially, measures of 'avoidable' hospital presentations and admittance.

To ensure a focus on health equity, key indicator measures should be assessed with regard to specific sub-population groups.

While there are existing data sources that can provide an initial foundation to support measures of key indicators in each of these areas, supporting a comprehensive picture of community health and Medicare Local performance is likely to require additional data sources, including potentially, practice and service-level data. This will require the establishment of additional mechanisms to gather quality data that is reported in a nationally-consistent way. The need for, and benefits of, additional data sources should be considered with a focus on minimising the need for services, practices and practitioners to dedicate additional administrative time to data collection and reporting.

These are major undertakings and a clear plan of requirements, including funding implications, needs to be established.

## **Part 2: Other Relevant Information**

As the critical role to be played by the Network in primary health care reform has become more apparent, AGPN and the Network have continued to support the planning and development work necessary to establish high performing MLs. This has included:

- commissioning Carla Cranny and Associates to provide independent expert advice on potential boundaries for PHCOs. The resultant report is currently being used by the Commonwealth as the foundation of broader stakeholder consultation around PHCO boundary mapping.
- commissioning KPMG to develop a transition strategy and plan for the evolution of the Network to PHCOs. This comprehensive strategy: details key strategic and organisational issues to be considered in transitioning existing general practice network infrastructure into a new level of operation; provides a guide to the practical steps involved in transition and establishment of PHCOs based on GPNs; and recommends transition support tools, resources and activities that will be key to a timely and effective Network-wide transition process. The strategy has currently been provided to the Network as a consultation draft and is serving as the basis of future planning
- commissioning DLA Phillips Fox to provide independent legal advice on PHCO legal structures, membership and governance
- commissioning an independent public health consultant with substantial experience in both the United Kingdom (UK) and Australian health systems to provide advice on leadership and organisational development in the Australian context based on learnings from the UK experience of primary health care reform
- engaging stakeholders at national, state-based and, in many instances, regional levels to ensure they are fully briefed about the primary health care system changes proposed by the Commonwealth and that they are consulted and engaged regarding the Network's plan to respond to these

- adapting a performance development project begun by AGPN in 2009 to support the Network in being pro-active about improving and measuring performance, to suit the PHCO context. Working in consultation with a stakeholder advisory group an external expert commissioned by AGPN has drafted performance indicators suitable for PHCOs. Further work in engaging the wider primary health care community, developing key survey instruments, establishing collection and analysis systems for these indicators is required.
- the initiation of work to develop a community engagement framework in conjunction with community development expert, Dr Jim Cavaye, to support PHCOs to establish and implement robust consumer and community engagement strategies. This work is occurring in partnership with an advisory group of external stakeholders.
- hosting leadership development master classes for current and emerging Network leaders to begin supporting them to develop as transformational leaders for change. A further leadership master class series is planned for 2011.

AGPN is willing to share these documents with the Department on a commercial-in-confidence basis on request.

### **Part 3: Other strategic considerations**

In conclusion, AGPN would point out the following strategic issues for consideration by Government. Our responses to the consultation questions touch on these matters to some extent however these are particular issues relating to policy context/vision, the full scope of ML role and responsibility and the scale of change management required that AGPN would like particularly to stress:

#### **Policy vision and 'full function' PHCOs**

AGPN has strongly supported the concept of a single primary health care-oriented health system that is nationally unified through policy and funding arrangements, and locally delivered. The establishment of primary health care organisations in the form of MLs is critical to this goal. In a November 2010 communique<sup>3</sup> CEOs and Chairs of our member organisations restated their commitment to the reasons to act on health reform and to embracing the formation of MLs and set out the principles required to drive reform and the urgent need for the Federal Government to empower and enable the Network to form MLs. However, while the broad policy intent and role envisaged for MLs is clear, the scope of comprehensive primary health care and the full range of programs and services that will flow through and to MLs over time remains unclear in the intergovernmental agreements reached to date. This has a significant bearing on the ultimate roles and responsibilities of MLs. A 2-5-10 year outlook for MLs is required in order to MLs to forecast and plan across the short, mid and long-term.

After more than two years of discussion, debate and planning, members of the general practice network are primed, ready and eager to implement its plan for PHCOs and to work with the Government to establish the regional mechanisms through which one

---

<sup>3</sup>

[http://www.agpn.com.au/\\_data/assets/pdf\\_file/0004/32593/20101104\\_med\\_ChairsCEOs-communique.pdf](http://www.agpn.com.au/_data/assets/pdf_file/0004/32593/20101104_med_ChairsCEOs-communique.pdf)

national health system can be delivered locally. To achieve the reform timetable and intent, the Network needs a mandate to ensure that evolved GPNs can operate as 'full function' PHCOs and a commitment that MLs will be funded for success and sustainability.

That means the Network has to be funded to achieve the effective reorientation of the health system envisaged by the Government as demonstrated by changes such as:

- hospital care is seen as a backup to primary care, not the other way round
- services are delivered as close as possible to the patient and their families - who are acknowledged as being truly in control of their health outcomes in chronic disease
- care is delivered to whole people - not different services for different parts of the body
- providers deliver education, not advice
- services have a culture that 'every door is the right door', rather than having 'intake' procedures aimed at controlling demand and limiting supply
- 'hospital avoidance' does not start at the hospital door, but starts many months before arrival and many kilometres distant
- there is no longer 'hospital in the home' or 'hospital outreach programs', but instead have 'GP in the home' and 'GP inreach into hospital' programs
- each patient can identify a 'medical home' where they know the care they need can be accessed, and which is accountable for their health
- patients with chronic disease can identify all members of their health team: there is informational consistency between all providers who care for a patient
- there is no longer any need for lowest-common-denominator services targeted at the disadvantaged and hard to reach groups - as accessible care is routinely provided holistically to all in the community.

### **Network configuration**

Currently 111 GPNs exist in a system that includes state-based organisations and AGPN as a national peak body. The paper does not canvass the future configuration of the Network. There are two relevant considerations. The first is the future role and function for these state and national level entities that, together with the local GPNs, have comprised the national network since 1998. Networks offer innovation, the opportunity to exchange knowledge and skills, the flexibility to respond to changes in the environment and more efficient operation. Given the desire for consistency of performance, involving a focus on networks and systems, AGPN believes that, over time, there is a need for national and state entities to support MLs to perform effectively and efficiently. This should involve provision of leadership and representation as well as standard setting, capacity building and monitoring roles. AGPN also believes that, particularly in the formative years, there are a number of functions such as planning, government liaison, stakeholder consultation, member support across a range of initiatives and programs including ML transition, and member representation that will require leadership and coordination at the national and state levels.

The second is the number of MLs and the configuration and approaches to delegation they adopt regionally. It is apparent from public statements made by the Minister and expert modelling, particularly that done by Carla Cranny and Associates on which the Government has based its public consultation on ML boundaries, that Australia can expect to see around 50 -70 MLs. While this reflects both policy objectives and key design criteria that MLs must have the size and scale required to have capable organisations with the critical mass and skills required to lead change and reform in the sector, to hold budgets and to manage the risks associated with commissioning and service provision in high need communities, there are two main issues:

- a key consideration is to not 'trade off' the practice engagement and community connectedness that is one of the unique characteristics of current GPNs. Whatever their final size, MLs will need to work with local services, communities and particular communities of interest to set priorities and address gaps. To this end, AGPN recommends that, in some regions, a 'hub and spoke' organisational configuration will be required to ensure MLs have appropriate outreach capacity to conduct local needs assessments, build effective relationships and practical partnerships, support providers and practices and offer services. Regions where this style of configuration might be contemplated were canvassed in the Cranny consultancy. In this context, some guidance may be required around the level of autonomy such outposts have eg. can they hold funds in their own right?
- a further consideration is that of 'forced mergers' between GPNs in order to form the ML once decisions about boundaries are made. The evidence is that 'forced mergers' are generally less successful and can impact negatively on the productivity of organisations in the short to medium term especially when the merging entities do not see themselves as a good fit and have both communities of interest and cultures that are vastly different. Sound local leadership and support for appropriate planning and facilitation will mitigate this prospect.

### **Support for Transition, Establishment and Performance**

From global experience and the extensive health literature on 'meso' level organisation formation, transition and reorganisation, we can anticipate and plan for a number of challenges. High quality management and infrastructure support is needed. Foremost among these is the realisation that a key change enabler is the quality of system leadership at the local level to manage demand, develop new care models, forge new partnerships, involve the public and establish new forms of organisation and governance. As the Cronin review points out, in implementation of primary health care reforms, the human dynamics of change are at least as important as structure, accountability and the management of the task. This requires investment in change management and leadership and organisational development. Transitioning the Network to a system of high performing MLs will require significant and fast-paced change to both build the capacity, capability and credibility to meet expanded roles as well as the Government's timeframes and other imperatives. As an initial down payment, AGPN has proposed a Transition and Establishment Support Fund to deliver actions such as:

- transition and organisational development guidance, support tools and templates
- Network capacity development in key areas eg. marketing and branding, world class community/consumer engagement
- development of organisational standards and a performance and development strategy to drive continued quality improvement
- development of a PHCO leadership development scheme

- a transition support team of specially recruited experts operating in the field to advise on the required organisational development steps
- an assessment of round one MLs against a set of draft industry-specific standards. This will provide the first wave with a systematic framework against which to determine where they need to focus attention and to develop an understanding of what additional supports may be required to ensure MLs can obtain accreditation at a specified future point. In addition, an examination and evaluation of various aspects of ML development and establishment and be done in conjunction with lead primary care research centres.