



AMA response to Medicare Locals discussion paper on governance and functions

Introduction

AMA has supported the need for reform to Australia's health system particularly the issue of responsibility for public hospitals and the linkages with other parts of the health system such as primary care and aged care in particular. On the primary care side, the Government believes Medicare Locals will enhance services to patients. The Government has said Medicare Locals are the mechanism to improve these linkages and to improve the level of health resources available to patients with chronic and complex care needs and to improve the integration of care and these are reasonable intentions at least.

Our usual preference would be for less bureaucratic mechanisms than are suggested in the discussion paper. We represent doctors who like to behave in an efficient manner, responsive to the needs of their patients, to be independent and accountable to their patients and free, to the maximum extent possible, of bureaucracy and red tape. We understand government likes to create entities in which it can repose powers and charge these bodies with particular responsibility for implementing government policy.

Over time, these bodies may perform their tasks well or poorly, may evolve into organizations much more powerful than originally intended, may involve more bureaucracy and wasteful resourcing than originally intended. The challenge is to establish Medicare Locals in a way that they are most likely to achieve their objectives and least likely to evolve in unintended ways which are inimical to good health service provision.

In doing this, we are not saying the current health system is performing poorly or that doctors have been doing an inadequate job. On the contrary, we think General Practitioners in particular are doing a great job. However all systems can be improved and GPs are the first to acknowledge it.

Good reform should be about supporting doctors in providing health care to patients, not removing them and substituting with lesser skilled health professionals. The key focus of Medicare Locals should be to support the central role of general practice by providing a greater range of allied health services for doctors to refer patients as part of their care. This would enable them to provide better care to patients but also to extend their linkages back into the acute care and aged care sector from which they have been increasingly isolated.

Good reform is not about creating all sorts of parallel primary care services, each worthy on their own, but not achieving their full potential because they are not coordinated within the main primary care relationship with the General Practitioner.

The role of the GP

It was not the intention of the discussion paper to acknowledge the contribution of the General Practitioner but nor should it have been so dismissive of their contribution. The paper states that Medicare Locals will play a significant role in providing a ‘sustainable foundation’ for health and hospitals. The paper says the reforms are about organizing and coordinating care around the needs of the patient and contrasts this to the un-coordinated and poorly integrated episodic care that arises when health care delivery is dictated by funding models and not patients’ health care needs. These are unfortunate references which do not acknowledge the efforts of GPs and the strengths of the fee-for-service system.

The foundation of the health system is not a bureaucratic coordinating body but the General Practitioner, the highest skilled health professional with very broad scope of practice in the GP setting. General Practice has the confidence of the Australian people over a long period of time and there are 120 million reasons each year to verify this is the case. General Practitioners understand the patients’ needs better than anyone including government and they also understand how the system fails patients and why.

We do not accept that General Practice is fragmented as stated at the beginning of the paper. General Practitioners have done a very good job at delivering coordinated care to patients but have been weighed down by under-resourcing, red tape and bureaucratisation without which they would have done more.

Nowhere does the discussion paper properly acknowledge the role and contribution of the GP. Where it mentions them, it is to give equal weight to nurse practitioners and other primary care providers who are not holistically trained to provide independent care of the whole patient in the primary care setting as are GPs.

The scope of Medicare Locals

There are a number of references to referred specialist medical care in the discussion paper. “Medicare Locals will drive more efficient use of our health resources – by encouraging the delivery of primary care, ambulatory and acute care in the centers that are most able to safely and effectively provide them” (page 4) “By building on the good work in supporting providers by Divisions of General Practice, Medicare Locals will see greater levels of interaction and integration across the full primary care system (including nursing, allied health, specialists and pharmacy) (page 5). The paper also states that Medicare Locals will improve patients’ access to services “by improving the co-ordination and integration of care both within the primary sector and across other sectors of the health care system.”

These references to the inclusion of referred specialist medical services occur within a document that is overwhelmingly expressed to apply to primary care services, understood as those services in the first line of health care delivery. We remain very unclear about what the intended interaction will be between Medicare Locals and other non-acute health care services including ambulatory care, sub-acute care and other community-based health services.

The paper is silent on the possible future relationship between primary care and the non-acute and ambulatory settings, services and providers which are an essential part of the continuum of care outside of hospital, particularly in the diagnosis, treatment and management of patients with chronic disease. The paper is silent on the possible enhanced access to care by other specialists providing medical services to patients in the community through co-location with primary care services and/or through telemedicine.

As a result, many specialist groups other than general practice are questioning the extent to which they should engage with the concepts in the discussion paper. They are concerned to ensure that their involvement in any such arrangements remains their choice and that these services continue to be remunerated under a fee-for-service arrangement, as per the concerns of GPs. They are also concerned to ensure that any involvement of Medicare Locals in brokering such arrangements for referred specialist medical services does not in any way impinge on, restrict or dictate the nature of clinical care they provide to individual patients.

These issues are too important to be left to the delphic touch and oblique references they have received in the discussion paper. It is necessary for the government to come out more clearly on this issue and provide a specific and separate process of consultation and consideration of these issues for the other relevant medical specialist groups to consider and provide input to.

Key issues

While the paper has been developed at leisure, the responses must be provided in an absurdly short timeframe casting doubts on the genuineness of this consultation process. In the limited time available, we make the following key points:

1. The most important objective of Medicare Locals is to support and enhance the GP role and not to diminish, sideline or substitute it. That is the first challenge.
2. The second challenge is to improve the coordination between the acute care sector, the aged care sector and General Practice.
3. The third challenge is for Medicare Locals to be efficient so as to provide the maximum level of resources for the provision of care, not the organization and administration of care.

4. The fourth challenge is to ensure there is a clear separation between the role of the Medicare Local and the role of the GP. We agree with the 5th dot point on page 8 of the Discussion Paper that the role is to support GPs, not get involved in clinical decision making about individual patients. The GP is responsible to the patient for their comprehensive health care needs. The Medicare Local is responsible to the Government for supporting and enhancing the ability of the GP to provide that care.
5. General Practitioners provide 120 million services each year to Australians of all ages and health status. People look to GPs for their health care needs to be met either directly or on referral and no other health practitioners have the breadth or depth of understanding of how the patients see the system and how the system responds to patient need. Patients would expect GPs to be able to continue to provide these services for them in genuine private practice on a fee-for-service basis unencumbered by the activities of Medicare Locals.
6. If Medicare Locals do not have strong GP representation on the governing bodies and on all the key committees established within the Medicare Local, they will be denying themselves the opportunity to receive the best informed and most comprehensive advice on the gaps in the system. Also, if GPs see their representation on the Medicare Locals substantially eroded from the levels available on Divisional bodies, they will become disengaged and Medicare Locals cannot work with a disengaged GP workforce. Professor Ham, CEO of the Kings Fund, in addressing the recent AGPN National Forum in Perth, stated that strong clinical leadership is essential for successful primary care organizations, as are clinical champions with vision and persistence. This is the fifth challenge.

In addition there are some challenges expressed in the negative. We do not want Medicare Locals to:

1. Be allowed to evolve into the role of a fund-holder which purchases services on behalf of patients. Patients can do that perfectly well on their own and fund-holding is inimical to the philosophy of Medicare to which Governments of both persuasions have sworn fidelity. Patients can access appropriate health services and the government provides a rebate to assist them in accessing those services. Fund-holding turns this on its head and gives power to the fund-holder, not the patient. It emphasizes caps on expenditure and therefore on the services supplied to patients.
2. Create massive service expectations out in the community which cannot be met. Medicare Locals need to tap into community needs but they are also directed by government in the performance of their role and funded by Government. While they may in the long run be able to access other funds, community expectations should not be allowed to run ahead of government preparedness to pay. Even the name, with its association to Medicare, falsely gives the impression of a limitless health benefit scheme available to them.

3. Spread themselves too thin in the first instance. The challenges at the bottom of page 6 of the discussion paper are already substantial. Medicare Locals must pace themselves and stage their objectives or they risk getting no runs on the board.
4. Focus disproportionately on programs aimed at prevention at the expense of programs aimed at supporting health care provision.
5. Impose red tape on GPs through onerous reporting activities or compliance activities. The opposite should be the case. Medicare Locals should look to ways to alleviate current red tape requirements which are already onerous.

What will Medicare Locals do?

There is a tension in the discussion paper between the role of the Medicare Local as a coordinator of add-on services to the basic health transaction between the GP and the patient and its role as an emerging service provider and budget holder. The paper moves between the two. Many of the envisaged services are non specific State services which will now be transferred to the Commonwealth. At present such services are provided for larger populations than may exist within the Medicare Local. It is not clear how responsibility will be shared among all Medicare Locals and who will have overall responsibility for the service, whether the service will be directly managed within the Medicare Local or provided on a contracted basis.

We have no clear idea from the paper of the relevant State and Territory services it is proposed to transfer. We have no idea how that will be achieved and we have no idea from the paper of the attitudes of the various States and Territories to the transfer. We know separately it is opposed in some States.

The paper states that Medicare Locals ‘will have strong community engagement and transparent reporting’. This sounds attractive but further to any information that is publicly reported on Medicare Locals and the health outcomes in a community, there is no mechanism for accountability to respond to concerns of local communities. A community which is not satisfied with the activities of a Medicare Local appears to have little or no redress. In addition, as the paper says, Medicare Locals are directly accountable to the Federal Government.

The five key objectives of Medicare Locals listed in the paper are:

1. Identification of the health needs of local areas and development of locally focused and responsive services
2. Improving the patient journey through developing integrated and coordinated services
3. Provide support to clinicians and service providers to improve patient care

4. Facilitation of the implementation and successful performance of primary health care initiatives and programs
5. Be efficient and accountable with strong governance and effective management

In our view, objectives 2,3 and 5 are the most important and the ones on which it is necessary to get runs on the board as early as possible. These are the core activities and responsibilities in our view.

Objective 1 is also clearly important but it may best be tackled when all the Medicare Locals are established and the State and Territory primary care services to be transferred to the Commonwealth are identified and transferred. This would not prevent early work to identify ways to better support General Practitioners in the care of the mentally ill which is a clear priority area. The implementation of the Government's election commitment to provide an extra 20,000 specialist psychiatry sessions on a fee-for-service basis each year through Medicare Locals and the requirement to report on the performance of mental health services would be priorities for implementation.

Under both objective 3 and 4, there are aspects which imply some control over General Practitioners in the delivery of health care services and we believe this should not be the case. The paper states that, in relation to safety and quality standards of service delivery, Medicare Locals will 'monitor and provide feedback to providers on their performance.' It further states that Medicare Locals will deliver the government's reform program objectives through their direct engagement in ... delivering more primary care services to older Australians and flexibly meeting the needs of patients with chronic conditions.'

GPs would not expect Medicare Locals to have any involvement in matters related to standards of care or the delivery of care and would not see them as well placed or qualified to engage in such activities.

What we want is

1. The Government to specifically determine that objectives 2,3 and 5 are the initial priority objectives.
2. Objective 1 is a key objective but should not be implemented until all Medicare Locals are established and State and Territory services transferred and settled with the exception of mental health as discussed above.
3. The Government to rule out the evolution of Medicare Locals into fund-holding or health service purchasing bodies
4. The government to specifically report on the level of bureaucratization and red tape involved in Medicare Locals as a key performance objective.

What will Medicare Locals look like?

We think this is the most disappointing aspect of the paper.

The Discussion Paper provides almost no clarity on how we reconcile the twin statements that they will be independent legal entities with the statements that they will be accountable to their communities and to government.

There is already a long list of requirements imposed by the Government. Medicare Locals 'are expected to play a central role in delivering the reform program objectives'. Medicare Locals 'will be a conduit for reform initiatives through...delivering more primary care services to older Australians and flexibly meeting the needs of patients with chronic conditions.'

Having regard to the Government's normal approach to these issues, it is likely that there will be strong central control over all the activities of Medicare Locals. Although not stated in the paper, it would seem likely that if Medicare Locals are established by the Commonwealth, without specialized legislation, under the Commonwealth Corporations Act 2001, they will also fall within the Commonwealth Authorities and Companies Act 1997. The Commonwealth would be the sole shareholder in the companies and would have almost total control over their activities. This should have been made clearer in the paper.

We are not in a position to know who the members will be, what the significance of that will be, who will be on the Board, who will appoint the Board, who will elect the Chair of the Board, how the Board will set its priorities etc. It has taken years for arrangements for the Divisions of General Practice to evolve reasonable working arrangements, albeit with varying degrees of success. Medicare Locals on the other hand will need to come up with answers very quickly. What we do know is it would be essential to have GPs within the Medical Local boundaries strongly engaged through membership and representation.

The discussion paper conveys the impression that all these issues will be resolved at the local level and through rational processes the correct mix for each Medicare Local will emerge. We think this is quixotic and that in reality they will be resolved by strong central mandate to ensure uniformity and appropriate representation and governance.

It is clear that Medicare Locals will be accountable to the Government but it is less clear how Medicare Locals will be fully accountable to local communities. If a dispute arises about how the resources on the Medicare Local should be spent, the Commonwealth position will prevail. It would have been useful if the paper had provided some commentary on these points because they are critical issues and they should not be hidden from view.

These arrangements will be difficult to manage. If the Department proposes to manage the affairs of up to 75 Medicare Locals down to this level, it will become hopelessly bureaucratic and slow. In addition, it is indicated in the Discussion Paper that the population covered by a Medicare Local may vary from 100,000 to 1,000,000 people. This will give rise to very large differences in capability and resources between the Medicare Locals to the detriment of the small Medicare Locals. For the larger ones, it will be difficult for them to know their communities to the level desired.

An alternative is that the Government will establish a central funding body under the Commonwealth Authorities and Companies Act 1997 which could in turn establish Medicare Locals as standard companies under the Commonwealth Corporations Act 2001. While the Commonwealth would no doubt exercise strong controls over the central funding body, it could exercise less control over the Medicare Locals as such.

Whatever the situation, there should be strong representation from General Practice on the Board because they are the key health providers with the most experience in the delivery of services to patients. GPs more than any other health practitioner understand patient needs and system faults and gaps. It should be a requirement that General Practice is strongly represented on all the structures and committees established within the Medicare Local. Recent UK reforms to move from Primary Care Trusts to GP-run primary care organizations is a direct response to problems which arose because there was insufficient local GP engagement and involvement in the management and running of primary care in the NHS.

The paper states that Medicare Locals should not become involved in individual patient care decisions. To give effect to this, there should be specific protections given to General Practitioners and other medical practitioners from interference in clinical decision-making by Medicare Locals. Given the General Practitioner is the most highly trained and the only health practitioner able to diagnose, manage and prescribe unconditionally, there should be protection of the central role of the GP also.

We understand there will be an opportunity to comment on boundaries later but we note that it is a very important issue and that some States and Territories have pre-determined the issue in their Local Hospital Network considerations, leaving only limited options for Medicare Locals.

Our key requirements in this area are:

1. Doctors must be involved in the delivery of health care in their local area free of political interference.
2. Local doctors must be represented on the Board of the Medicare Locals and on all the key committees established by the Board.
3. The process of selecting the Boards of Medicare Locals must be transparent and free of political interference or patronage. For example, GP representatives could be nominated by local doctors.
4. The Boards of Medicare Locals must have the power to select and dismiss the Chief Executive Officer of the Medicare Local.
5. There must be transparent and public reporting by the Board on their decisions and the reasons for them.
6. Medicare Locals and Local Hospital Networks should share boundaries wherever possible but recognizing that the boundary should be used for administrative purposes and should not be used to restrict access to health care for any person living outside it.

7. As suggested in the paper, Medicare Locals should establish formal linkages with Local Hospital Networks, which may include common membership of governance structures where possible and appropriate.
8. Medicare Locals should be similar in both size and financial resources and small enough to ensure an understanding of local issues and to allow meaningful engagement with local communities and local health professionals. The range contained in the discussion paper should be narrowed where possible.
9. Specific protection should be given to the independence and autonomy of medical practitioners in providing services to patients free from third party interference.
10. Specific protection should be provided for the central role of the General Practitioner. Other health resources should be made available to patients through the GP and without eroding the central role of the GP in maintaining comprehensive and holistic care of the patient

How will Medicare Locals interact with patients and providers?

This section states that ‘under the National Health and Hospitals Network Agreement, Medicare Locals will be required to have strong links to local communities...’ There is no similar requirement for strong links with local doctors and there should be.

In relation to clinical governance issues, a key issue will be compatible boundaries. Desirably, a Medicare Local should not have to relate to more than one hospital network and vice versa. In addition, there may be sense in establishing Medicare Local Lead Clinician groups to relate to the Local Hospital Network Lead Clinician Groups at a similar professional level.

Aboriginal representation on Medicare Locals

Medicare Locals have the potential to integrate Indigenous health services and referral pathways, and identify where particular services are needed, so that primary health care services (both Indigenous specific and mainstream) have a greater capacity to provide *comprehensive* primary care.

In the context of the new health system arrangements, it should be a fundamental performance requirement for Medicare Locals that they:

- facilitate the establishment of, and maintain, integrated networks of health and other support services for Indigenous people in the region. Those services should be suitable to meet the complex physical, social and emotional conditions that Indigenous people in the region experience. The support services should also be suited to addressing the range of social determinants of health for Indigenous people in the region, and
- successfully support and facilitate the journey of Indigenous people through these networks.

To ensure that these services and facilitated pathways are appropriate and successful, it is essential that each Medicare Local has strong and permanent representation in decision-

making from local Aboriginal communities in the Medicare Local region, and Aboriginal community controlled health services in the area. Aboriginal and Torres Strait Islander communities and representative bodies will then be active partners in regional planning of primary health care.

Further consultation

The Government's discussion paper has been a useful contribution to the debate but it is clear there are still many issues which need to be considered further and after that, be the subject of further consultation.

We recommend the Government engages in a further round of in-depth consultations this year.

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