

The Royal Australian College of General Practitioners

Submission to Department of Health and Ageing:

Medicare Locals

Discussion Paper on Governance and Functions

24 November 2010

1. Introduction

The Royal Australian College of General Practitioners (RACGP) thanks the Department of Health and Ageing (DoHA) for the opportunity to contribute to discussions regarding the functionality and governance of the soon to be established "Medicare Locals".

The RACGP is the specialty medical college for general practice in Australia, responsible for defining the nature of the discipline, setting the standards and curriculum for education and training, maintaining the standards for quality clinical practice, and supporting general practitioners in their pursuit of excellence in patient care and community service.

Discussion within this submission is made in response to the discussion paper titled *Medicare Locals, Discussion Paper on Governance and Functions*, issued by the Australian Government on 2 November 2010, which can be viewed at: <http://www.yourhealth.gov.au>.

2. Overview and response to discussion paper

Australia's current health system can be considered as high performing and when compared with overseas health systems. However, there are some population groups who continue to experience issues in accessing primary health care services. Past deficiencies in national health policy and strategy have led to a growing mismatch between the level and complexity of community needs, and the capacity of general practice and primary healthcare to proactively plan for and meet those needs.

Given such disparities in accessibility and current funding arrangements, the RACGP believes that equity and fairness is paramount and recognises that significant reform to the current health system is crucial to improve much needed integration of primary care services and better access to these services.

International evidence demonstrates that effective health care systems are person-focussed and based on strong integrated primary health care foundations with accessible, quality general practice at the centre of the system. Strategies to achieve the vision of future general practice will involve realigning primary healthcare policies, functions, structures, and funding to match projected community health needs, enhance quality of care, and increase equity.

Professional organisations can contribute to health system reform through development of a shared vision of the future of general practice and its relationship with the wider primary health care system, including identification of the practical strategies required to reach that vision.

The College notes that Primary Health Care Organisations (PHCOs) are an important component of national health reform and, in principal, agrees with the objectives of PHCOs. The RACGP welcomes the Government's commitment to work with the profession and key stakeholders regarding the establishment of the PHCOs, and is committed to the integration of quality primary health care, facilitated by general practitioners with strong clinical leadership.

Reform in primary healthcare must involve:

- recognising, supporting, and enhancing the role of general practitioners in primary healthcare and the health system
- creating integrated local clinical networks with cross sector and community engagement, and strong pathways between community and hospital based services
- redistributing system resources to increase scope and capacity in general practice and primary health care, with priority given to areas of greatest community need
- investing in teams, technology, advanced skills training and teaching
- defining, embedding, and rewarding a strong focus on quality and health outcomes
- establishing all primary health care disciplines as sought after career destinations
- progressing voluntary enrolment with provider of choice for at risk people and groups.

In relation to health reform more broadly, if common healthcare is to be achieved at a local level between the primary healthcare and hospital sectors, a formal, structured and meaningful relationship between the PHCOs and Local Hospital Networks (LHNs) needs to be established and maintained. Progression towards a more collaborative approach by PHCOs and LHNs will cultivate and foster an integrated culture of mutual understanding, cooperation, and respect between both sectors.

3. RACGP response to consultation paper

The College's response centres on the following questions as posed by the consultation paper:

1. What will PHCOs do?
2. What will PHCOs look like?
3. How will PHCOs interact with patients and providers?

3.1 What will PHCOs do?

The RACGP believes that the overall success of PHCOs will be dependant on how effectively they interrelate with primary healthcare professionals, local communities, and service providers. Given the objectives of the PHCOs as outlined in the Government's discussion paper, it is expected that PHCOs will assist health providers in the coordination care, improve access to services, and foster better integration of care between primary health, hospitals, aged care, mental health and allied health services.

The College also understands that PHCOs will provide patients with greater access to information about available services with their specific region.

3.1.1 Key features

The RACGP is of the view that PHCOs should encourage better access, greater equity in health care, greater coordination of services and meaningful local community engagement.

Essentially, PHCOs should utilise the information learned from existing relationships with local service providers and communities to help shape their development. Drawing upon these relationships will ensure that Medicare Locals are able to provide patients with seamless primary healthcare which is accessible, coordinated and well integrated which meets the needs of the local community.

Given that general practice has demonstrated that it delivers high quality preventive care, health promotion¹²³ and chronic disease management⁴, the RACGP believes general practitioners are in an ideal position to provide strong clinical governance and leadership to the teams working within PHCO framework. The evidence suggests that general practice has a proven track record in providing primary health care with superior clinical care over both secondary and tertiary care in terms of effectiveness and efficiency in terms of general patient health outcomes and patient satisfaction.

As discussed in Section 3.2.3 of this submission, a key feature of PHCOs should be strong linkages between PHCOs and LHNs. Ultimately, without mandated and robust links with the LHNs for planning, service delivery, innovation and measurement/data collection, the reformed national healthcare system will just be another fragmented and dysfunctional dual systems approach.

3.1.2 Roles and functions

It is anticipated that the roles and functions of PHCOs will evolve over time. However, it is generally expected that they will facilitate engagement between health, other sector services, NGOs, local government and local community groups and create an integrated “support platform” for the local community, particularly those who are disadvantaged. PHCOs should integrate local health service planning, coordination and delivery, population health, teaching and research functions.

Key priority areas include:

- Improving patient access to primary healthcare and reducing inequity through organisation and coordination
- Better managing patients with chronic conditions
- Increasing the focus on prevention, with targeted strategies tailored to the region
- Improving patient safety, healthcare quality and healthcare delivery
- Closing the gap.

Ideally, PHCOs will assist general practitioners and other healthcare providers in the provision of:

- Accessible, clinically-culturally appropriate, timely and affordable healthcare
- Patient centred healthcare, supporting health literacy and self management
- More preventive focussed healthcare including health lifestyles

¹ Ferrante JM, Gonzales EC, Pal N, Roetzheim RG. Effects of physician supply on early detection of breast cancer. J Am Board Fam Pract 2000;13:408-14.

² Campbell RJ, Ramirez AM, Perez K, Roetzheim RG. Cervical cancer rates and the supply of primary care physicians in Florida. Fam Med 2003;35:60-4.

³ Roetzheim RG, Gonzalez EC, Ramirez A, Campbell R, van Durme DJ. Primary care physician supply and colorectal cancer. J Fam Pract 2001;50:1027-31

⁴ Macinko J, Starfield B, Shi L. The contribution of primary care systems to health outcomes within Organization for Economic Cooperation and Development (OECD) countries, 1970-1998. Health Serv Res 2003;38:831-65.

- Well integrated and coordinated continuity of care and complexity
- Safe, high quality care, improving via research and innovation
- Improved information management, and efficient use of e-Health
- Flexible healthcare that evolves and responds to local community needs
- Quality working and training environments and conditions to attract, retain new and existing workforce
- Fiscally sustainable, efficient and cost effective healthcare.

To meet the key objectives as outlined by the Government in their discussion paper, the College believes that PHCOs should perform a range of roles and functions which include but are not limited to:

- Identifying health needs of the population
- Identifying gaps in services
- Understanding how people interact with health services
- Understanding the health literacy of the population
- Population health planning at a local level
- Supporting the delivery of preventive health and health promotion programs
- Supporting service coordination
- Forecasting
- Addressing fragmentation in aged care and after hours care
- Attracting relevant resources and primary healthcare professionals
- Improving patient care and safety of health services
- Meaningful and ongoing engagement with local communities, local service providers, and consumers in regard to planning, delivery and evaluation of health services and governance arrangements.

Essentially, PHCOs should identify regional gaps in primary health care planning, support existing services, and manage additional funds to fill these gaps. PHCOs should assist existing service providers to improve the patient journey through the integration of care and increased preventive health strategies.

3.1.3 Aboriginal and Torres Strait Islander health

The College notes a lack of emphasis on Aboriginal and Torres Strait Islander health in the discussion paper, and advocates for an increased focus and investment in indigenous health.

Whilst it can be argued that the PHCO focus on chronic disease would include indigenous Australians, a generic mainstream policy around chronic disease will only serve to increase inequalities of access and outcomes. The RACGP believes that PHCOs must specifically tackle inequalities and chronic diseases in indigenous communities in collaboration with community controlled and other Aboriginal and Torres Strait Islander health services. Such programs and initiatives would be achieved through a collaboratively built bottom-up approach, with indigenous communities taking the lead.

From a policy perspective, the College believes that there should be specific recognition of Aboriginal and Torres Strait Islander health in the following PHCO key objectives as identified by the Department:

- Initiatives aimed at identifying healthcare needs in local areas
- Implementation and successful performance of primary healthcare programs.

3.2 What will PHCOs look like?

When establishing the governance arrangements for PHCOs, the College is of the view that the fundamental objectives of PHCOs should, for both general practice and primary health care, recognise and consider:

- Profession led Standards
- Quality of care
- Practice education and training
- Quality Improvement.

3.2.1 Legal Structure and Governance

The College notes that the National and Hospital Network Agreement states that PHCOs will be independent legal entities and not government bodies. Given this, it is imperative that PHCOs adhere to all legislative requirements with functional, transparent, and accountable governance structures.

Appropriate funding arrangements are a key component when considering the establishment of PHCOs. It is pertinent that the Government recognise that PHCOs will have varying needs which are dependant on geographical location, and the socio-economic status of population groups. Therefore, it is essential that the Government adequately funds all PHCOs so they are able to effectively perform their roles and functions.

The College also believes that PHCOs should be afforded room to form governance arrangements according to outcome focussed criteria agreed to between the profession and the Government, allowing flexibility in each region to tailor governance arrangements to the region's needs.

3.2.2 Board Membership

Members appointed to PHCO Boards should ideally be from a cross section of both the public and private sector and will need to possess a range of skills which include:

- Management
- Financial management
- Health planning
- Health expertise
- Consumer engagement experience.

As previously noted, the College does not believe that the precise composition of the Board should be mandated by the Government, and instead a principled approach should be employed.

Notwithstanding the above, membership of the PHCO Boards must include a strong general practitioner presence, who are clinical leaders in primary healthcare.

Furthermore, the College recommends that governance arrangements include a formal mechanism for consideration of indigenous health. Such a mechanism could be achieved via a number of strategies, including an Indigenous Health Committee – which would include Aboriginal and Torres Strait Islander representatives – reporting to the PHCO Board.

3.2.3 PHCO and LHN linkages

As PHCOs will be independent companies limited by guarantee, and the LHNs will be governed by Ministerial appointment via a Governing Council, the College is of the view that a simple cross membership is insufficient.

The RACGP recommends that a functional cross-governance link is negotiated that supports:

- shared planning
- mutual reporting
- some shared responsibilities regarding regional patient issues.

The College believes that if common healthcare is to be achieved at the local level, a formal, structured and meaningful relationship between the PHCOs and LHNs need to be established and maintained. It is anticipated that progression towards a more collaborative approach by PHCOs and LHNs will cultivate and foster an integrated culture of mutual understanding, cooperation and respect between both sectors.

3.3 How will PHCOs interact with patients and providers?

Flexible PHCOs that meet the needs of local communities should be developed through a 'bottom up' strategy, where health leaders and communities are engaged and fully involved in the design implementation of the regional model.

If properly delivered, such an approach will ensure that providers and patients are involved in the development of the PHCO from the outset, and each PHCO will employ a provider/patient interaction strategy appropriate to the region.

Notwithstanding the above, the RACGP believes that outcome focussed provider/patient interaction criteria should be established, that would at a minimum include:

- strategies to include providers and the community in PHCO planning and direction
- broad provider and community consultation strategies
- targeted strategies aimed at engaging and obtaining input from local clinical leaders.

However, if poorly designed, the introduction of a regional system will generate additional layers of bureaucracy, expense, and red tape. Therefore, when exploring options for regional structures, it is vital that there is ongoing and meaningful consultation with the profession at both a national and local level.

4. Other comments

4.1 Concerns regarding after hours medical care

The RACGP remains concerned regarding the Government's plans to remove the responsibility for the provision of access to after-hours medical care from general practice, replacing the current arrangements of medical care with a telephone medical advice service, run by PHCOs. We urge the Government to not withdraw existing PIP funding for after hours care from general practices until the profession has been properly consulted regarding the details of the proposed scheme.

Current proposals will result in a 2 year gap between the withdrawal of Tier 1 funding for general practices and the introduction of Medicare after hours medical care co-ordinated by Medicare Locals (from 2013). Unless these issues are addressed, patient access to after hours care may be negatively impacted.

4.2 Terminology - “Medicare Locals”

The RACGP notes that despite ongoing feedback and concerns raised by the profession, the consultation paper refers to PHCOs as “Medicare Locals”. The College does not agree with this terminology, and believes that it will be misleading and confusing for the general public and patients. The proposed “Medicare Locals” are not affiliated with Medicare, nor are they even Government organisations – as stated in the consultation paper.

To avoid confusion, it is proposed that the terminology of PHCO is used, which is more consistent with terminology used for the hospital LHNs, and more indicative of the role of these regional organisations.

4.3.1 Consultation

The RACGP notes that 2 weeks was initially provided to the profession to respond to this discussion document. Meaningful consultation involves providing adequate timelines to digest discussion and proposals, and provide a considered response to possible strategies.

The timelines afforded for the “Medicare Local” discussion document were not sufficient, and the College notes that short consultation periods are the same as no consultation.

To ensure that PHCOs are properly designed and implemented, there must be meaningful and ongoing consultation with the profession. Therefore, the RACGP trusts that this is the first discussion paper as part of a broader consultation strategy regarding the design and implementation of PHCOs.

5. Concluding comments

The College recognises both the unsustainability of our current health system and the associated challenges facing governments in reforming that system – including the functional, structural, financial, and governance reforms required to ensure effective, equitable, sustainable health care in the decades to come.

It is recognised that this means major change for every discipline, every service, and every sector.

The RACGP accepts and welcome changes that increase the discipline’s responsibilities in close collaboration with other primary healthcare professionals and our communities, including responsibilities for local population health planning, demonstrable high quality performance, and improved equity of access to health services and health outcomes.

In accepting these responsibilities, the College expects that reforms to general practice and the primary healthcare system preserve, recognise, and appropriately reward the discipline's proven quality characteristics (i.e. whole person, continuing, comprehensive, coordinated care). It is also expected that reform builds on what already exists, and aims to integrate, not fragment, responsibilities, care, and services.

To achieve successful reform, the Government must meaningfully engage with general practitioners, general practice groups, primary healthcare professionals, and communities of interest, about best ways forward, leading to the development of strategies to achieve the outcomes for primary healthcare that our communities need.