AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | info@ama.com.au
W | www.ama.com.au
42 Macquarie St Barton ACT 2600
PO Box 6090 Kingston ACT 2604

10/222

Ms Jane Halton
Secretary
Department of Health
MDP 84
GPO Box 9848
CANBERRA ACT 2601

Dear Ms Halton

Review of Medicare Locals

Thank you for the invitation to provide a submission to the Australian Government's Review of Medicare Locals. We welcome the opportunity to contribute to this important review of their role and performance.

The attached submission, which has also been emailed to MLreview@health.gov.au, outlines the AMA's concerns with the performance of Medicare Locals. It includes feedback from general practitioners on their Medicare Local.

Thank you for the opportunity to raise these issues.

Yours sincerely

Dr Steve Hambleton
Federal AMA President

19 December 2013

Australian Medical Association Submission to the Review of Medicare Locals

Background

The AMA acknowledges the need for an overarching structure of Primary Health Care Organisations (PHCOs) (e.g. Medicare Locals) to improve the integration of health services within primary health care, as well as the interface between primary care and hospital settings. They can also play a key role in ensuring that services are tailored to meet the needs of local communities.

General practice is the first point of call in the health system for most patients and this GP-led model of care delivers good outcomes for patients, while also being cost effective. GPs are acutely aware of existing gaps in access to care and the impact on patients from badly designed or poorly integrated health care services. For these reasons, it is essential that a PHCO model builds on what works by supporting general practice in caring for patients. This means that GP leadership and input is vital to the success of any PHCO in targeting service gaps, supporting continuity of patient care and facilitating access to needed services.

Unfortunately, the former Government took a contrary approach to the design and implementation of Medicare Locals (MLs). There has been a deliberate effort to down play the role of GPs and many MLs have failed to communicate effectively with general practice, or engage with them in a meaningful way. The performance of MLs against their objectives has been patchy and there appears to be little evidence of improvement on the former divisions of general practice structure that they have replaced – despite significant additional funding.

To inform our submission, the AMA conducted a survey of 1,212 GPs and a report on the results of this survey is included at attachment A.

Role of Medicare Locals and their performance against stated objectives

From the outset, MLs appeared to struggle to communicate with general practice. Initial advice on their role and responsibilities lacked clarity, and feedback from AMA members at the time was that MLs had little understanding of their own role and function, nor the role of general practice. Our recent survey findings confirm that this remains a significant problem.

According to GPs, engagement is problematic, with notification of meetings or information/consultation sessions often given at short notice and arranged for during work hours. This often prevents GP from attending. The AMA's own survey shows that only 26 per cent of respondents agreed that MLs provide them with useful information and only 17 per cent agreed that they engage with and listen to them about the design of needed health services. A majority of survey respondents (61 per cent) do not agree that MLs value or recognise the input of local GPs.

Given the above, it should come as no surprise that the AMA GP survey found that less than 30 per cent of GPs agreed that MLs had improved the delivery of primary care overall and should be retained.

Performance of Medicare Locals in administering existing programmes, including after-hours

<u>After hours care</u>

For the most part, MLs undertook at least initially to provide GPs with the same or similar level of funding as they were getting under the Practice Incentive Program (PIP) for after hours (AH) care. The AMA supported this approach.

Unfortunately, it has become clear that the implementation of AH funding has generally increased red tape and compliance costs for general practice. It has also disenfranchised GPs previously committed to providing AH GP care.

During 2013, MLs attempted to implement onerous contracts and new reporting requirements for GP AH services. Although the AMA worked with the Australian Medicare Local Alliance (AMLA)

to develop a more reasonable contract template, it remains problematic and a number of MLs have ignored it.

Overall, there is no doubt that when compared to the former PIP arrangements, general practices now face an increased red tape burden. This is confirmed by our GP survey, with 44 per cent of respondents agreeing that the contracts have increased red tape and compliance costs.

Some MLs contracted consultants to identify gaps in AH care. However, we understand from GPs that these consultants often failed to engage with stakeholders. The reliability of recommendations arising from these processes is questionable, especially as not all information about the extent of existing AH services would have been readily identifiable.

The AMA does not have access to data on whether the new funding arrangements for AH services have improved access to care for patients. Our own survey suggests that it has not, with only 24 per cent of GPs agreeing that effective arrangements to support access to AH GP care have been put in place.

The AMA believes that the former PIP funding should be restored, with supplementary programs developed to target identified gaps in service delivery at the local level.

Other Medicare Local Programs

According to our GP survey, there is significant dissatisfaction with the level of access for patients under a number of programs that are run by MLs:

- Access to Allied Psychological Services (ATAPs) – more GPs disagree than agree that MLs provide easily accessible ATAPs;
- Personally Controlled Electronic Health Record (PCEHR) support – only 43 per cent of GPs agree that MLs provide effective support to practices for establishing the PCEHR; and
- Timely patient access to allied health services in residential aged care facilities (RACFs) – only 38 per cent of GPs agreed that MLs have effective programs in place to support RACF patients to access allied health services.

The AMA believes that a PHCO structure works best when it targets hard-to-reach patient groups and addresses gaps in service delivery. However, our survey highlights that Medicare Locals appear to be going beyond this remit with 50 per cent of respondents reporting that existing services are being duplicated. Examples of this would include some AH services, immunisation and diabetes programs. This approach wastes scarce health resources and is disenfranchising local GPs who have invested their own capital and perceive that they face unfair competition from an organisation that should be working to support and assist them in caring for patients.

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

From the outset, there was a concerted effort by the former Government and the Department of Health to dilute the role of GPs in the governance arrangements for Medicare Locals. Relevant guidelines limit the number of GPs that can be recruited onto the Medicare Local board and this can result in poor service design. GPs understand local health needs and excluding or restricting high-level GP involvement neglects this knowledge, which is crucial to identifying service gaps, funding priorities, required support services and strategies for improving the coordination and integration of patient care.

As noted earlier, our GP survey confirmed that MLs have insufficient regard for GP input and involvement.

Ensuring Commonwealth funding supports clinical services, rather than administration

The AMA understands that the Department of Health has implemented a range of guidelines governing the operation of Medicare Locals and has stringent reporting requirements. While the AMA acknowledges the need for accountability, the right balance needs to be struck. We

saw this trend start when the former divisions of general practice were in operation where the Department insisted on excessive reporting – even on relatively minor funding programs. There is no doubt that this diverts precious resources away from clinical care and towards paperwork and bureaucracy and this trend needs to be reversed.

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

The proper design of services require strong GP input and leadership. The current Medicare Local model is designed to deliberately constrain the level of GP input and leadership, and while ever this is the case, the AMA does not have confidence that MLs can meet this objective. Instead, we have seen the use of high-cost consultancy firms that have no understanding of local health needs. Our GP survey supports this view, with many GPs clearly believing that the information flow from MLs is poor and that GP input is not valued. Further, 72 per cent of survey respondents do not believe that MLs have improved the delivery of primary care overall and 50 per cent believe that MLs duplicate existing general practice services.

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

There appears to be some interaction between LHNs and Medicare Locals, although little evidence of any practical outcomes. The AMA is aware that a very small number of Medicare Locals have been working to develop improved care pathways with LHNs as well as implement hospital avoidance programs. However, this work seems quite limited and still in its early stages.

Tendering and contracting arrangements

As noted earlier, the funding of GP after hours services by MLs has been extremely problematic. Some tenders sought to redefine the requirements of a AH service and most MLs offered onerous terms in after hours contracts. The processes adopted were unfair in many cases and a number of MLs displayed a distinct unwillingness to negotiate more reasonable arrangements with general practices or even listen to their concerns in the first place.

Way forward

A strong and well-coordinated primary care system delivers very good health care outcomes for the community and can take pressure off the hospital system. A well-designed network of PHCOs is critical to this objective, provided they are established in a way that supports general practice and recognises at the same time the need to collaborate with other health professionals and other parts of the health system. This review should recommend reforms that focus on the establishment of a network of PHCOs that are:

- GP-led and locally responsive;
- focus on supporting GPs in caring for patients, working collaboratively with other health care professionals;
- not overburdened by excessive paperwork and policy prescription
- focus on addressing service gaps, not replicating existing services; and
- better aligned with Local Hospital Networks, with a strong emphasis on improving the primary care/hospital interface.

The AMA also recommends that ML branding be dropped as it does not reflect the true purpose of a PHCO, nor do the public understand what MLs actually do.

These key features are further discussed in the *AMA Position Statement Medicare Locals – 2011*, which is attached at Attachment B.

Please find attached:

- **Attachment A**: AMA GP member survey on Medicare Locals report; and
- **Attachment B**: *AMA Position Statement Medicare Locals – 2011*.