Medicare Locals

Background

In its paper *Building a 21st Century Primary Health Care System – Australia's first national primary health care strategy*, the government announced its intention to better integrate and coordinate the range of organisations and service providers operating within primary health care, and to better link primary health care and other sectors.

Under *Building Block 1, Regional Integration*, the Government committed $290 million over 4 years to the establishment of a network of primary health care organisations across Australia known as Medicare Locals. In October 2010, the Government issued a Discussion Paper with some details of the functions and governance of the Medicare Locals but with a lot of gaps and no further public information is available at this point. AMA responded to the Discussion Paper and AMACGP further considered the matter in February 2011. More recently, the Government has issued Guidelines for the establishment of Medicare Locals which disclose their latest thinking in response to the submissions from affected parties.

Reason for position statement

The task of integrating and coordinating the range of organisations and service providers operating within primary health care, and to better link primary health care and other sectors, is a key task which can be done well or badly, efficiently or inefficiently and in a manner supportive of the General Practice workforce or not supportive.

At one extreme, if well done, it could provide great benefits to GPs and patients and at the other extreme, it could waste a lot of valuable resources and demotivate the GP workforce.

The Government has made a decision to tackle these vital tasks via the establishment of 50-75 Medicare Locals. AMA acknowledges the Government's right to do this and the Government's belief that, along with other reforms such as the Local Hospital Networks, these can be positive reforms to the health system. The AMA has a range of views about how these reforms can be more effective which are set out below.

1. AMA position

1.1. The AMA acknowledges the potential reach of Medicare Locals. Medicare Locals have the potential to impact on aged care services, mental health outcomes, chronic disease management, indigenous health services and services to the disadvantaged.

1.2. Medicare Locals need to be introduced in a way which is consistent with the AMA's overall health vision and which is respectful of the existing role of the General Practitioner and other community based Specialists. They should be introduced in an orderly fashion and seek to maximize positive relationships and partnerships at all levels.

1.3. General Practitioners are the highest trained practitioners in the primary health care setting and have a key role in the coordination and management of care for patients providing 120 million services each year. Medicare Locals can be useful to GPs by supporting them in carrying out their role and assisting them in accessing allied health services in the community.

1.4. Given the potential for Medicare Locals to consume precious health resources, they need to be organized in an efficient manner with contestability and transparency as key considerations

2. Governance

2.1. Local doctors must be represented on the Boards of the Medicare Locals and on all the key committees established by the Board.

2.2. Boards should be skills based with a preponderance of medical members with appropriate Board training and possessing the appropriate skills. Other members of the Board would include local community members, business people, persons with financial expertise etc possessing the appropriate skills.

2.3. Board membership should be by individuals rather than organisations.

2.4. Only health practitioners who are registered with the Australian Health Practitioners Registration Authority and who work within the boundaries of the Medicare Local should be eligible for membership.

2.5. Financial membership would be necessary in order to vote on matters relating to the formation of the Board.

2.6. The process of selecting the Boards of Medicare Locals must be transparent and free of political interference or patronage. A nominations committee made up of financial members of the Medicare Local should be formed to make recommendations for appointments to the Board. Board appointments should be staggered to avoid the loss of corporate knowledge.

2.7. Associate memberships should also be available but persons with this category of membership would be ineligible to vote.

2.8. Government must not mandate common Board memberships between Medicare Locals and Local Hospital Networks but where this does occur, it should be allowed with common members being independent directors of each company. Medicare Locals should have equal status to Local Hospital Networks and it is important to avoid possible conflicts of interest through common memberships.

2.9. The Boards of the Medicare Locals must have the power to select and dismiss the Chief Executive Officer of the Medicare Local and all the usual powers of a Board.

3. Functionality

3.1. The main functions of Medicare Locals are:

3.1.1. To enhance the role of the GP in delivering services to patients
3.1.2. To identify gaps in local service provision and assist GPs to fill those gaps
3.1.3. To assist GPs in their role of co-ordinating care between acute care, aged care, other community primary care providers (inc State based) and the general practice care setting.
3.1.4. To assist GPs in streamlining the transition of patients from one care sector to the other
3.1.5. To facilitate communications with other specialists by various mechanisms including e-health capabilities
3.1.6. To support GPs in their teaching and training roles and with continuous quality improvement at the practice level

3.2. Medicare Locals have a key role to improve indigenous health and the health of other disadvantaged groups and this should be included in the Company Objects.

4. Accountability

4.1. The primary accountability of a Medicare Local is to its members. Secondary accountability is to the local community and the Federal Government.

4.2. The Board structure of the Medicare Local must ensure accountability to the membership. For example, there must be transparency in the performance of Medicare Locals. Medicare Locals must develop performance indicators against which they can be measured. Performance indicators should reflect the ability of the Medicare Local to find and remedy gaps in primary care for the community and in establishing the clinical needs of the community.

4.3. Boards must be careful that the information requirements imposed on GPs and other health practitioners are not excessive. The Board should put limits around the cost and time taken for collecting data and reporting by GPs

5. Coordination mechanisms

5.1. Better coordination between the GPs, other community primary care including state based primary care services, acute care and aged care is a key task and must be led by the Board with follow through by senior management and ultimately at all levels of the organisation

5.2. Medicare Locals and Local Hospital Networks should be regarded as organisations of equal status and should receive funding sufficient to enable them to function as equals. Just as GPs recognize the importance of the acute sector, the acute sector should recognize the key complementary role of General Practice

5.3. Key coordination mechanisms include the development of strong communication links, development of systems and protocols to facilitate e-health and IT connectivity between all sectors and the minimization of red tape

6. Fundholding

6.1. A key foundation of Medicare, supported by both sides of politics, is universal access to patient rebates for the provision of medical services initiated by patients as needed.

6.2. AMA supports the continuation of these arrangements and rejects any move to divert rebate entitlements as bundled payments to General Practitioners or to Medicare Locals to fund the provision of GP or Specialist medical services. The same applies to PBS entitlements.

6.3. The AMA has specific policies in relation to fundholding which continue to be relevant to this initiative.

7. Boundaries

7.1. The boundaries established for Medicare Locals are for the purpose of funding and administration only and must not be used to restrict access to clinical services or as an effective barbed wire fence against historical or natural referral patterns

7.2. The boundaries should be flexible and adaptable to reflect local considerations and patient flows and must follow and improve patient flows that already exist

8. National body

8.1. There is no requirement for a national coordinating body to disburse program funds or provide political representation for Medicare Locals. Such a body would require substantial funding of its own which detracts from service provision and reduces the capacity of Medicare Locals to support GPs in the field

8.2. If Medicare Locals feel there is a need for coordination for other reasons, it should be funded and organized by the Medicare locals themselves and the responsibility could rotate between Medicare locals to avoid a concentration of power within in one body

9. Vigilance

9.1. There is potential for Medicare Locals to develop in ways which are inimical to good health provision and it is essential that the profession be vigilant against this and draw such developments, if they occur, to the attention of Government.

9.2. Examples of such developments would include Medicare Locals evolving into powerful fundholding bodies purchasing GP services directly for a population group, interference in the GP clinical care role as opposed to support, interference in the fee for service aspect of General Practice, rationing, proliferation of bureaucracy etc.

9.3. The Government should review the operations of Medicare Locals not more than three years after their implementation and at regular intervals thereafter to ensure they are performing in a manner which is consistent with their broad objectives. This review should have strong representation from the medical profession