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Medicare Locals: the first six and next twelve months

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Acknowledgements

This report was written by Jennifer Doggett on behalf of the AHCRA Executive.

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Contact details

This report is produced by the Australian Health Care Reform Alliance (AHCRA), a coalition of over 30 peak health groups (professional and consumer) working towards a better health system for Australia's future.

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Executive summary and recommendations

Medicare Locals (MLs) are intended by the Federal Government to be vehicles for fostering reform and improvement of the primary health care sector in each of 62 catchments.

The need for MLs (or similar organisations) was identified by the National Health and Hospitals Reform Commission and their current role reflects (to a large extent) a shared understanding among most key stakeholders on the problems with Australia's current approach to primary care. A small but growing body of literature on primary care meta-organisations also supports their role. Importantly no other organisations are in place to systematically improve the primary health care system.

AHCRA undertook this project to obtain a clearer picture of the current and future roles of MLs within the health system, during this critical implementation stage. We found that up to February 2012, their energies have been directed into establishing organisational and governance structures and building support among both their previous GP constituency and the broader primary health care sector.

Their key areas of activity up to this time, as defined by MLs, align closely with those required by DoHA, although there are some differences in the focus and interpretation of the DoHA guidelines. For example, many have a greater focus on consumer engagement and on the provision of services than is required by their agreement with DoHA. Most see their relationships with other stakeholders in their community as their main vehicle for driving change and so are currently focussed on developing and strengthening their local networks. All are either undertaking or planning to undertake a needs analysis of their local areas, which will form the basis of population health planning. However, not all MLs articulated in detail how this process would occur.

All the MLs interviewed expressed a strong commitment to improving access to services but had a less strong commitment to reducing inequity, partly because of perceived barriers to making a difference in this area. Some are playing a role in prevention and chronic disease management but this is not yet a major emphasis for most. Similarly, there is less of a focus overall on quality, safety, performance and accountability, although some MLs are building on previous activities in these areas to achieve positive outcomes. Integration with allied health professionals is starting (or in some cases continuing) although there has been less progress in other areas, such as in promoting efficiency, increasing coordination and integration, partly due to constraints on their influence in these areas.

Overall, AHCRA believes there are many positives in the progress to date of MLs. However, there are also some early signs of developing problems that need to be addressed in order for MLs to maximise their potential. The MLs themselves have also identified a number of barriers to them achieving their goals, which may also need to be addressed. If these factors can be addressed, in the context of a supportive funding and policy environment, AHCRA believes MLs can play a significant role in driving positive and long-term changes within Australia's primary care sector.

Recommendations

Recommendation 1: The Federal Government should develop a clearer shared vision for the future of primary health care and support this with policy and funding changes to give the MLs the levers to foster change effectively.

Recommendation 2: The Government should commit to a continuation of funding for MLs for ten years (subject to reasonable performance).

Recommendation 3: Action towards achieving equitable access should be included as an (initial) key performance measure for MLs, taking into consideration the constraints on their ability to achieve gains in this area. This should be extended to indicators about improving equity once MLs have matured.

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Recommendation 5: MLs (through the Australian Medicare Local Alliance) should liaise with experts in population health data (such as the AIHW) to establish an agreed framework for the collection and dissemination of data on their local communities.

Recommendation 6: MLs (through the Australian Medicare Local Alliance) should pro-actively seek opportunities to use the population health data collected to collaborate with other organisations on population health issues.

Recommendation 7: A framework for engagement between MLs and the Australian National Preventive Health Agency should be developed.

Recommendation 8: Key indicators on prevention activity should be included in the agreed set of performance indicators (recommended above)

Recommendation 9: Performance indicators should reflect the need for MLs to engage with consumers, carers and communities at all levels of their operations.

Recommendation 10: Coordination and integration of services at the local level should be included as key performance indicators within the performance framework agreed by government and MLs (as above)

Recommendation 11: MLs (through the Australian Medicare Local Alliance) should engage with the IHPA and the NHPA to ensure new hospital funding arrangements do not undermine the goals of MLs.

Recommendation 12: Maintaining GP engagement should be included as a key performance measure for MLs.

Recommendation 13: The development of multi-disciplinary services should be included as a key performance measure for MLs over the medium to long term.

Recommendation 14: MLs and other stakeholders should have the opportunity for input into the set of performance indicators against which their performance is going to be measured.

Recommendation 15: MLs should develop a framework for sharing their experiences so that they can learn from others' successes and failures.

1. Introduction

Medicare Locals (MLs) form a key component of the Federal Government's current health reform agenda, especially in primary health care, and are seen as critical to the success of a number of their stated aims of health care reform, such as "*better access to services, improved local accountability and transparency, greater responsiveness to local communities and provide a stronger financial basis for our health system into the future"* [1]

However, for organisations that will play such a key role in the health sector, AHCRA is concerned that there appears to be no shared understanding of the details of this role and that there is significant confusion among stakeholders about the aims of MLs and how these will be achieved. AHCRA considers this lack of clarity extends not only to stakeholders outside of the sector, such as politicians and senior bureaucrats, but also to many within the primary health and health care sectors, including health professionals and consumers.

This report aims to answer the question *'What will Medicare Locals do and how will they do it?*' It is an analysis of interviews in early 2012 with nine Medicare Local CEOs or senior managers about their early progress, the strategies they are already using and their planned objectives and approaches to primary health care reform in their area. The report also covers those MLs' establishment processes, and also what they see as the enablers and the constraints on their effectiveness over the longer term. Lastly, we provide some analysis of the interview findings against both the stated aims of the program as well as against AHCRA's key criteria for health reform, and make recommendations about improving the effectiveness of MLs.

1.2 The Australian Healthcare Reform Alliance

The Australian Health Care Reform Alliance (AHCRA) is a coalition of over 30 peak health groups working towards a better health system for Australia's future (see Appendix 3). AHCRA was formed in 2003 and since then has worked actively to influence the development and implementation of the health reform agenda in line with the agreed principles of AHCRA's health professional and consumer member organisations (see www.healthreform.org.au/principles).

AHCRA is supportive of moves toward a more equitable health system that is centred much more on prevention and primary health care, is supportive of a more multi-disciplinary and integrated primary health care sector and is person-centred with strong consumer participation. AHCRA sees potential for MLs to facilitate change towards such a vision.

See www.healthreform.org.au for more information about AHCRA's position on primary health care reform.

1.3 Context

Australia's health system is facing a number of challenges. These include: an ageing population; increased rates of chronic disease; the development of new treatments and technologies; and rising health care costs. There is significant fragmentation in the system, and also some major

[1] The National Health Reform Agreement 2011

gaps and inequities in access to health services and unequal health outcomes among population groups. In particular, Indigenous Australians and have lower levels of access and shockingly poorer health outcomes than average while people living in rural and remote areas have much worse access and outcomes than average.

The Commonwealth Government's health reform process started with the establishment of the National Health and Hospitals Reform Commission (NHHRC) that undertook a comprehensive review of most of Australia's health system (it was directed to exclude private health insurance). In 2009 the NHHRC made 123 recommendations for health system reform. While the Government ultimately did not accept all (or even a majority) of the Commission's recommendations, its findings have had a significant influence on the current health reform agenda.

The NHHRC identified the importance of the primary care sector in achieving all of these reform goals. In fact, its Final Report stated, *"primary care services should be the axis or pivot around which we seek to develop a person-centred health system"* [2].

It noted that although performing above OECD averages, Australia was now slipping down the list. In particular, the report acknowledged that in many ways Australia's existing health system is provider-centric, rather than patient-focussed stating that "*it is usually the patient who must find a way of seeing multiple health professionals while navigating across various locations, rather than health professionals functioning as a team practicing together and providing care around the whole needs of a person*"[3]

In relation to the organisation of primary care, the report recommends the establishment of comprehensive primary health care centres and services to provide "*a 'one stop shop' approach so that patients can get access to an expanded range of services……at more convenient times through extended opening hours*".[4] The NHRRC also noted that there was good evidence of the benefits *'from an efficiency and health outcomes perspective, to build a strong primary health care sector, provided this is not done at the expense of adequate support of specialist and referral care.*[5]"

1.4 Primary Health Care Policy

The recommendations of the NHHRC were influential in forming the Government's approach to primary health care reform, which is outlined in the documents
Building a 21st Century Primary Health Care System: Australia's First National Primary Health Care Strategy, Primary Health Care Reform in Australia: Report to Support Australia's First National Primary Health Care Strategy and Improving Primary Health Care for All Australians.

[2] The National Healthcare and Hospitals Reform Commission *Final Report: A Healthier Future for all Australians* 2009 Chapter 4
[3] The National Healthcare and Hospitals Reform Commission *Final Report: A Healthier Future for all Australians* 2009 Chapter 1
[4] The National Healthcare and Hospitals Reform Commission *Final Report: A Healthier Future for all Australians* 2009 Chapter 4
[5] National Health and Hospitals Reform Commission (2009), The Australian health care system and the potential for efficiency gains: A review of the literature, Background Paper.

These documents identify four major problems with Australia's current primary health care system:

- workforce shortages/misdistribution
- the difficulty many consumers have in navigating the system
- gaps in services in many areas
- an insufficient population health focus.

The Primary Health Care Strategy outlines the Government's approach to primary care reform and states that the overall aim of the reform agenda is to shift health services from hospitals to primary care. This involves a number of initiatives, including:

- the establishment of Medicare Locals
- GP Superclinics (funding for 60 so far has been approved)
- establishing an after hours GP hotline
- a pilot of coordinated care for people with diabetes
- funding for primary care infrastructure upgrades.

1.5 Government directions

Despite the above, the Government has initiated a very modest level of reform of primary health care. It has chosen the establishment of Medicare Locals (at the expense of the more narrowly focussed Divisions of General Practice program) to be the vehicles for gradual reform. It is unaccompanied by any other significant policy or funding changes, although to be fair, its diabetes block funding proposal for general practice was a positive move but was diverted into a trial after pressure from the medical organisations.

1.6 Medicare Locals' roles

The document *Improving Primary Health Care for All Australians* outlines the role of MLs as follows:

- They will work closely with Local Hospital Networks to make sure that primary health care services and hospitals work well together for their patients.
- They will plan and support local after hours face-to-face GP services.
- They will identify where local communities are missing out on services they might need and coordinate services to address those gaps.
- They will support local primary health care providers, such as GPs, practice nurses and allied health providers, to adopt and meet quality standards.
- They will be accountable to local communities to make sure that services are effective and of high quality.

The role of MLs is described in more detail in the document Medicare Locals: Guidelines for the establishment and initial operation of Medicare Locals & Information for applicants wishing to apply for funding to establish a Medicare Local.

2. Project methods

The project involved interviewing nine of the new Medicare Locals that were perceived as having made most progress to date (see Appendix 2 for a list). All of these MLs were established in the first tranche, e.g. from July 2011 apart from the Southern Adelaide-Fleurieu ML which is part of Tranche 2. Some external parties (including a primary health care academic and the Consumers Health Forum of Australia) were also interviewed to assist in providing a broader context for the report.

AHCRA acknowledges that this is only a small-scale initiative with a small number of MLs and using a variety of interviewers (mostly AHCRA executive members). The findings are therefore limited by the small sample size and should be read in this context.

3. Findings

This section outlines the main findings of the ML CEO interviews. It describes their overall approach to driving change, their short and longer-term objectives and their ongoing key areas of activity. It also notes the constraints identified by the CEOs.

3.1 Role of MLs in fostering change

The MLs interviewed identified the following ways in which they could foster change:

- **relationship building** (bringing stakeholders together, communicating, developing and fostering strong relationships, acting as a 'network of influence' and enabler, empowering others)
- **engagement** (building on existing stakeholders – GPs, to include as many people as possible in informing the development and implementation of health programs, increasing input from consumers)
- **collaboration** (supporting collaborations, decreasing fragmentation and duplication of services in the region
- **meeting consumer needs** (identifying and targeting areas of need, improving coordination of services)
- **advocacy** (evidence-based advocacy for more primary-care focussed health system, uniting primary care clinicians in a single voice to be a more powerful advocate for change)

Case study – efficiency and prevention
Hunter Urban ML – web-based pathways to support primary care clinicians

HealthPathways is a collaborative, jointly funded, initiative of the Hunter New England LHD and the Hunter Urban Medicare Local that commenced in late 2011. This project targets efficiency by supporting the referral of the right patients with the right information to public outpatients. It also aims to support clinicians in preventive care and provides a good example of how MLs can bring providers together to improve coordination of services and care. HealthPathways involves the development of web-based pathways to support primary care clinicians in the Hunter region in the assessment, management and referral of patients. Currently there are 22 localised pathways on the website, 14 nearing completion and another 47 in development. Each pathway is developed by a development team of relevant medical specialists, GPs, and other providers. The feedback on the pathways so far from clinicians has been very positive. So far there have been 143 clinicians involved in pathway development and since the recent launch there have been 680 visitors to the site. More information about this project is available at **www.healthpathways.org.au**

Overall, MLs see themselves as supporting and facilitating change primarily through the relationships they establish with other stakeholders. This was expressed by one ML as a 'network of influence'. It is through the networks that MLs develop that they will ultimately be able to fulfil their goals and effect change within the primary health care sector. Many of the people interviewed commented that, as MLs do not currently have financial or other levers to compel stakeholders to change how providers currently operate, their influence must come from the relationships they build in their communities.

3.2 The first six months' priorities

Most of the MLs reported that they had spent the first three to six months of operations in establishing basic organisational and governance structures and in change management, including appointing Boards, appointing staff, locating and (in some cases) moving offices and other tasks associated with transitioning from one or more Divisions of General Practice to an ML. Those who have retained much of their structure and governance arrangements from a single Division have had to undertake less change management than those whose evolution involved coalitions of several organisations, shifts in boundaries and major governance changes.

Those MLs which had established basic governance and organisational structures were moving into the next stage of their development, a process referred to by one CEO as having "just come off the 'L' plates and have moved onto the red 'Ps'". However, there were a couple of MLs further along the implementation process, including one which described itself as "fully operational" These MLs cited some early specific achievements:

- building of communication networks and strengthened community engagement with GPs, members and community
- assessment of after-hours services in the region and identification of major gaps

- obtaining funding from the Commonwealth to extend the hours of a local health centre for Aboriginal and Torres Strait Islanders.

3.3 Next 12 month priorities

Most MLs interviewed identified a range of priorities for the next twelve months, many of them reflecting their initial need to build strong relationships with their members and stakeholders. The specific priorities identified included:

- **community/stakeholder consultation** (setting up forums to identify needs and priorities, surveys, establishing advisory groups)
- **primary health care assessment** (including working with other stakeholders and identifying gaps in services and communities with poor access in the region)
- **primary care planning** (developing a primary health care plan for the region, completing a strategic plan for the ML, developing a joint health service plan in conjunction with the LHHN)
- **governance** (appointing board members, advisory committees and clinical governance committees)
- **specific areas of focus** (implement or expand an after-hours program, health promotion and prevention, recruiting new allied health professionals as ML members, building and e-health infrastructure to support better communication within the primary health care sector).

Case study – integrated care
Barwon ML – a local IT referral network for care providers

This is a local IT system created by Barwon ML which has subsequently recruited 95% of allied health practitioners locally to be able to receive electronic referrals direct from GPs and communicate back to them with their case notes and findings. This increases the involvement of allied health practitioners in people's care and hence provides consumers with more multi-disciplinary care supported by optimum communication between providers.

3.4 Long-term objectives

The longer-term objectives defined by the nine MLs covered a range of issues, including some specific to their regions and others that are more general. Among the generic objectives there was a strong focus on:

- community engagement (e.g. developing and implementing a genuine consumer engagement framework) and
- population health planning, with the goal of ultimately improving consumers' experience of health care.

Specific long-term objectives defined by the MLs interviewed also included:

- to improve the patient journey
- to address gaps in service delivery with an emphasis on those with traditionally poorer access to services
- to support clinicians
- to deliver services (implementation of primary health care programs)
- to support clinicians (including developing lead clinician groups)
- to bring together primary health care professionals and organisations to deliver high quality primary care services
- to achieve efficient management and good governance.

These predominantly (and sometimes explicitly) reflect both the strategic objectives and the activities prescribed by the Department of Health and Ageing.

Case study – access and equity
Metro North Brisbane ML – filling the gaps in dental

Metro North Brisbane ML employ liaison officers who engage with primary care service providers to promote integration of services. For example, the Medicare Local has engaged with a range of private dentists who have agreed to provide dental services under the government's Chronic Diseases Dental Scheme, and now maintains a list of such dentists. GPs referring consumers to a suitable dentist can now do so easily through the Medicare Local's Team Care Coordination program (that coordinates care for people with chronic and complex care needs).

3.5 Key areas of activity

Once established, the MLs interviewed identified the following ongoing key areas of activity:

- Developing and strengthening relationships with other health care providers in the community, such as local hospitals and indigenous health services. This can occur at all levels of organisation, including the Board.
- Identifying and addressing gaps in service delivery in the local area through a range of mechanisms, for example, online surveys, public forums and data analysis.
- Developing e-health systems to support the sharing of information among care providers (for consenting patients).
- Working with local health organisations to develop resources to support improved care.
- Consulting with local organisations and the community to establish genuine consumer engagement.

Case study – health promotion/consumer education/collaboration
Hunter Urban Medicare Local – the Understanding Pain project

This was a joint initiative between the Hunter Urban ML and the Hunter Integrated Pain Services (John Hunter Hospital). This project focussed on the development of a short educational video posted on YouTube. This was designed as a tool for clinicians to use in patient consultations. The script is based on current evidence and peer-reviewed research into chronic pain and was developed by a multidisciplinary team. The YouTube clip has had over 70 000 views since it was launched and has received positive feedback from leading health bodies internationally.

4. Analysis and discussion

Early progress

It is still very early days in the development of MLs, and any analysis or critique of the initial work of these nine MLs (out of a planned 62) has to be acutely aware of this fact. Thus far, most of the MLs interviewed have had to focus their time and energy in establishing their organisational and governance structures. Given that most have evolved from Divisions of General Practice, this has involved building support among existing members (mainly GPs) while also engaging a broader constituency (such as allied health professionals) and creating a shared vision for the organisation. While in some ways it may have been a short-cut by Government to establish MLs on the back of existing Divisions, in some places this has caused considerable organisational problems as Divisions attempt to evolve into organisations with markedly different memberships and roles. This process appears to be occurring successfully, albeit if slowly in some case.

MLs' visions

In general this project did reveal a high level of enthusiasm and drive within the MLs to achieve their aims. There was a genuine commitment to both genuine reform and to ongoing quality improvement of the primary health care sector. However AHCRA notes that the visions expressed by most MLs are focussed more on short-term rather than longer-term objectives. Despite this many of the MLs interviewed saw themselves as actively working towards establishing primary health care as the centre of the health system, as described by the NHHRC. AHCRA strongly supports this gradual shift in the focus of health care, as evidence shows that a primary health care-focussed health system delivers both more equitable and efficient care.[6] It will require MLs to plan more explicitly for this though.

However there was no mention by MLs of their roles duplicating those of any other organisations. In reality of course there are no other organisations in Australia that are

[6] See AHCRA's Briefing Paper on primary health care reform at www.healthreform.org.au

established and funded specifically to improve and reform the primary health care system. There are significant problems at his level, illuminated by the comprehensive NHHRC review in 2009. of the Australian health system both illuminated the problems at eh primary health care level, and indeed recommended that such organisations be established to drive reform. AHCRA agrees with the NHHRC that that little meaningful reform will occur in this sector without the leadership and the clinical and consumer engagement to drive reform that such local organisations can provide.

Activity: current and planned

The following tables provide a summary of reported ML activities against both the objectives specified by DoHA and against the National Primary Care Strategy.

Table 1: ML activity vs. DOHA specifications

DoHA-specified activities	**ML reported activities in the first six months**
Coordinating primary care services	Some level of activity reported (such as after hours care) – mainly inherited projects from Divisions.
Identifying and addressing local needs	All MLs interviewed reported undertaking needs analyses of local communities.
Undertaking local health planning	Planning only just starting as the above needs analyses are completed.
Prevention and chronic disease management	Some level of activity reported on chronic disease management – mainly inherited projects from Divisions. Limited action on prevention thus far.
Driving efficiency	Only one specific activity reported (HealthPathways case study above). Efficiency not articulated as a main focus by most of the MLs interviewed and it is not clear to what extent MLs can impact on current incentives for cost shifting, service gaps and duplication.
Improving access via better coordination and integration	Some specific projects planned or being undertaken to increase access for targeted groups.
Increasing consumer access to information	All articulated a strong commitment to responding to consumer needs. However the majority did not provide specific examples of activities in this area.
Improved transparency, performance and accountability	All are developing governance and organisational structures to support improved transparency and accountability.

Table 2: ML activity vs. National Primary Health Care Strategy

PHC Strategy objectives	ML reported activities
Access to care	Some specific projects planned or being undertaken to increase access for targeted groups.
Patient centred-care	All articulated a strong commitment to responding to consumer needs. However none identified specific activities to increase consumer access to information.
Focus on prevention	Limited action on prevention thus far although articulated as a longer-term goal by some.
Integration and coordination	Some activities (such as improving after hours care, inherited from Divisions) focusing on integration and coordination at the local level and future activities and collaborations planned.
Safety and quality	This was not identified as a key focus by the MLs interviewed.
Health information management	Information management identified as an enabler to allow ML to achieve other objectives (e.g. chronic disease management)
Local flexibility	All MLs expressed a strong commitment to meeting specific local needs and were undertaking preliminary community consultations to identify these.
Workforce planning and retention	Workforce issues identified as an important factor influencing MLs. Workforce needs assessed as part of community needs analysis.
Sustainability	This was not reported by MLs as a key focus.

As noted above, it is important not to judge the performance of MLs too quickly as they need time to develop organisationally and develop relationships with broader primary health care field. However the above analysis clearly shows that the MLs interviewed so far are mostly focusing on population health planning and coordination (especially around after-hours services), as well as continuing some of the predecessor Divisions' activities, e.g. on chronic disease management. They have yet to engage to any extent around prevention, addressing inequities or driving efficiencies. Only a few yet are planning concrete strategies to improve consumer engagement or information.

While the MLs interviewed all reported relationship building as a key focus in their developmental stage, it is difficult to predict their eventual impact as these relationships are still in the early stages of development and their potential for driving change is not clear.

AHCRA does note that MLs are expected to play a mixture of roles (e.g. from quality improvement to fostering structural change in local service system to service delivery etc.), but the balance of these (as in Divisions) already does and will probably continue to vary from area to area based on both context but also organisational choice. This is inherent in any locally focused arrangement and will be both its strength (being locally flexible) and potentially its weakness (being diverted by local powerful but minority interests, or poor implementation). However, this does point to the need for a strong support for MLs to minimise this variation. The role of the Australian Medicare Local Alliance will be crucial here to facilitate the sharing of lessons and expertise and for MLs to work collaboratively when necessary to achieve common aims.

It is also important to recognise that MLs are only one vehicle for reform and in order to achieve their objectives they will also require support from and collaboration with a broader range of organisations, professionals and stakeholder groups as well as a more favourable policy and political environment.

However, to ensure MLs can maximise their potential to drive change within the primary health care sector, any emerging problems or issues need to be identified and addressed. This section identifies a number of barriers (and other issues affecting MLs long term performance) and makes recommendations on how they can be addressed.

The following table summarises the enablers, barriers and challenges to achieving the goals of primary care reform, as identified by the MLs interviewed.

Table 3: Enablers, barriers and challenges to success as perceived by MLs

Enablers	Barriers	Challenges
Community engagement Flexible funding Good relationships with stakeholders Inclusiveness (GPs, other health providers, consumers) History of positive collaboration Good existing relationships with GPs e-health capacity Solid governance structures Independence from Government	Workforce shortages and maldistribution Fee-for-service payment systems Funding systems for collaborating NGOs Inadequate overall funding Multiple sources of funding Onerous reporting requirements Few (if any) levers to effect change Conflicting expectations from professional groups	Juggling competing interests Selling the aims of the ML to internal stakeholders Lack of alignment between ML and Local Hospital Network boundaries Short timeframes for delivering objectives Removal of the Divisional SBOs High (possibly unrealistic) expectations from stakeholders Lack of clarity about the role of MLs Genuine consumer engagement with few dedicated resources

AHCRA believes that the barriers and challenges identified above will need to be addressed in order for MLs to achieve their stated goals.

AHCRA considers there are three absolutely critical barriers from the above that need urgent attention by the Federal Government:

- the lack of clarity about the long term vision for primary health care
- MLs' lack of power to change current policy settings (e.g. around predominance of fee-for-service arrangements), and
- MLs' lack of funding levers to foster change.

These factors, and a broader range of issues raised by this project, are described below in more detail with accompanying recommendations.

4.1 ML vision

AHCRA notes that there is a divergence between stakeholders on the vision for MLs, particularly in terms of equity, integration and the multidisciplinary nature of primary health care in the future. Currently, these are all concepts supported by MLs but there is a lack of clarity in how they are defined and, in many cases, a lack of well-defined strategies to achieve them. AHCRA believes this is a crucial flaw in the reform program and that the Federal Government needs to be much clearer about the shape of the primary health sector that it is encouraging.

AHCRA also believes that MLs need to be seen as a long-term (ten years minimum) project if they are to achieve their stated goals. Changes in population health status cannot be assessed in the short term and it is unrealistic to expect MLs to operate within a short-term funding environment and at the same time be focussed on long-term outcomes. The vision for MLs needs to reflect this perspective, which needs also to be supported by a government commitment.

Recommendation 1: The Federal Government should develop a clearer shared vision for the future of primary health care and support this with policy and funding changes to give the MLs the levers to foster change effectively.

Recommendation 2: The Government should commit to a continuation of funding for MLs for ten years (subject to reasonable performance).

4.2 Equity

The national primary care policy and strategy documents (discussed above) clearly state that reducing inequities in access and health outcomes are central goals of the Government's reform agenda. MLs have a critical role to play at the local level in this through identifying population groups at risk and developing and implementing targeted strategies. When asked specifically about equity, most of the ML CEOs interviewed noted their organisation's strong commitment to improving health equity and integration in their region.

However, a number noted that the factors that impact upon health equity (such as payment systems) are outside of their influence and that therefore this goal will be difficult to achieve. These included the continuation of current fee-for-service structures, workforce mal-distribution and MLs' limited capacity to address the social determinants of health (as noted in the table under 'challenges' above). A number of MLs also noted that they would need to partner with relevant organisations, such as Aboriginal health services and Local Hospital Networks, in order to achieve any change in this. The need for robust consultation processes, evidence-based strategies and joint service planning were all highlighted in responses to this question.

For AHCRA, the current inequities in access and outcomes are key and serious flaws in the system, and AHCRA certainly expects that addressing these would be central agenda items for reform and hence for MLs. AHCRA is encouraged by the focus on equity expressed by the MLs interviewed but is concerned that the words 'equity' or 'equitable' (or their equivalents) hardly appear at all in the stated objectives of the MLs or expressed goals. This raises the question of the degree of awareness and commitment of the MLs to genuinely addressing the issue.

AHCRA does not wish to judge too early but it certainly would be concerned if MLs' commitment and actions on this issue were not significantly more prominent in the next year.

Recommendation 3: Action towards achieving equitable access should be included as an (initial) key performance measure for MLs, taking into consideration the constraints on their ability to achieve gains in this area. This should be extended to indicators about improving equity once MLs have matured.

4.3 Population health

Many MLs were only just starting to undertake their population health planning work. While this is to be expected in their first six months of operation, AHCRA is concerned that in some cases, MLs did not appear to have a good understanding of this process. Population health planning will be critical to the ability of MLs to take a population-based approach to primary care and to fulfill key objectives such as improving equity of access among their patient population. AHCRA sees this role as crucial as it will provide a common and illuminating resource for the first time in most areas to providers and the community alike. It will be a critical springboard in fostering initiatives aimed at addressing inequities and gaps. AHCRA hopes that the population health planning role will continue to grow and become more sophisticated as MLs evolve and that this will be reflected in their evaluation by DoHA.

It is also important that the data on population health being collected by MLs is used to achieve maximum benefits. If collected comprehensively and systematically, this data will open up new opportunities for MLs and other health organisations to improve the planning, delivery and evaluation of health policies and programs across Australia. AHCRA understands that DoHA is preparing national guidelines for population health planning and hopes that these will be comprehensive enough to support a more robust and consistent approach to population health nationally.

Recommendation 4: Specific training and assistance in population health planning processes should be provided to MLs, where required (for example by the Australian Medicare Local Alliance).

Recommendation 5: MLs (through the Australian Medicare Local Alliance) should liaise with experts in population health data (such as the AIHW) to establish an agreed framework for the collection and dissemination of data on their local communities.

Recommendation 6: MLs (through the Australian Medicare Local Alliance) should pro-actively seek opportunities to use the population health data collected to collaborate with other organisations on population health issues.

4.4 Prevention

AHCRA, along with many other commentators (including the NHHRC) believes that a much stronger focus on prevention is crucial in order to minimise the impact (both on the community and on health care costs) of increasing rates of chronic disease. The DoHA objectives note an increased focus on prevention but early actions of the MLs did not include any/many initiatives on this focus. There is also no clear direction within the primary care policy documents (such as

Australia's First National Primary Health Care Strategy) of how MLs should work with the new Australian National Preventive Health Agency (ANPHA). AHCRA, along with many other commentators on the Australian health system (including the NHHRC), believe that a stronger focus on prevention is important in order to minimise the impact of chronic diseases on the community. Although the involvement of MLs in preventive health may evolve, AHCRA is concerned that this area may be seen as a secondary or minor focus of MLs' role (reflecting the relatively modest approach by all governments currently to preventive health).

Recommendation 7: A framework for engagement between MLs and the Australian National Preventive Health Agency should be developed.

Recommendation 8: Key indicators on prevention activity should be included in the agreed set of performance indicators (recommended above).

4.5 Consumer/community engagement

AHCRA believes that consumer and community engagement are central to creating a more person-centric and equitable health system and hence to the role of MLs, in particular in the planning and delivering of health services. The MLs interviewed for this project general expressed a strong commitment to increasing consumer engagement in all aspects of their work although many felt they were under-resourced to do this properly.

While most MLs identified the need to engage with the community as the key to their success, they also commented on the lack of funding for consumer and community engagement and the difficulties involved with undertaking community consultation on a shoestring budget. The Consumers Health Forum who expressed the view that consumer engagement should not be seen as an additional task requiring discrete resources but should be a normal way of operating challenged this view. Resolving these two views will be important to sustain genuine community/consumer engagement in the future of MLs. However, AHCRA was highly encouraged to note that there appears to be considerably more focus by some MLs on community and consumer engagement than existed in their predecessor Divisions.

Recommendation 9: Performance indicators should reflect the need for MLs to engage with consumers, carers and the community at all levels of their operations.

4.6 Integration/coordination

Many MLs commented on the fact that they had been charged with achieving a more integrated and coordinated health system, an outcome which several generations of health ministers and senior health bureaucrats had been unable to achieve, despite the policy and funding levers at their collective disposal. While some MLs felt that this was an unrealistic system-wide aim for MLs, others also expressed the view that achieving improved levels of integration and coordination may be more possible at the local level, where there is greater capacity to build trust among organisations to foster and achieve real change than at the level of Health Ministers Council and COAG.

Additionally, a number of MLs have (in their previous life as Divisions) a history of attracting funding from other areas, such as state governments. They felt that in the future MLs would be

looking to increase their funding base and potentially become fund-holders for many local services, thus giving them greater influence over how these were delivered.
With reform occurring in other sectors of the health system, such as hospitals, it is vital that MLs engage key bodies outside of primary care in order to understand the changes taking place and the implications they may have for MLs and primary health care. For example, the shift to activity-based funding within the public hospital sector also raised concerns that hospitals could become more output-focussed and move away from working with MLs and other stakeholders on demand-management programs and preventive care.

There are some examples of links being established between MLs and hospitals at the local level, for example, the Chair of ACT ML also serves on the Local Hospital Network Board. Engagement with the new Independent Hospital Pricing Authority (IHPA) and the National Health Performance Authority (NHPA) may be important in ensuring that hospital funding arrangements do not undermine the overall goals of MLs and health reform more generally. AHCRA believes that local integration and coordination is a central role for MLs and needs to be seen as a high priority.

Recommendation 10: Coordination and integration of services at the local level should be included as key performance indicators within the performance framework agreed by government and MLs (as above)

Recommendation 11: MLs (through the Australian Medicare Local Alliance) should engage with the IHPA and the NHPA to ensure new hospital funding arrangements do not undermine the goals of MLs.

4.7 Engagement with GPs and other health professionals.

There was a strong focus on ongoing GP engagement among the MLs interviewed and an acknowledgement that GPs remain a core part of the reform process. While most of the MLs felt that they had already established strong relationships with GPs in their former roles as Divisions, many explicitly mentioned their focus on retaining this engagement as they evolve into MLs. Some MLs felt that there was a risk that some of their GPs may not be supportive of the broader role taken on by MLs. They were concerned that without the engagement and support of the majority of GPs in their region, the goals of the ML would be compromised. AHCRA acknowledges the importance and challenge of retaining strong GP support while moving towards engaging other health professionals and stakeholders in the ML. How MLs are able to manage this tension in order to achieve a more comprehensive and coordinated approach to primary health care will be the key to their success.

There was a range of avenues through which MLs were already working to integrate allied health professionals into the primary health care system better. As might be anticipated at this early stage, they were focussed on knitting individual allied health practitioners and practices in with GPs. This is an encouraging sign and AHCRA hopes that MLs would gradually foster stronger engagement of allied health practitioners as well as more development of multi-disciplinary services (rather than networks of independent separately-housed practitioners).

Recommendation 12: Maintaining GP engagement should be included as a key performance measure for MLs.

Recommendation 13: The development of multi-disciplinary services should be included as a key performance measure for MLs over the medium to long term.

4.8 Aboriginal health

AHCRA believes that improving the poor health status of Australia's indigenous people should be a goal of all sectors of the health system and that MLs can play an important role in achieving this goal, along with other key bodies, in particular those specifically targeting Aboriginal Australians. Most of the MLs interviewed did not mention Aboriginal health as a key focus, raising questions about whether they would have a significant role in reform of Aboriginal health. However, there some examples of positive activities in this area such as the Hunter Medicare Local which has developed a partnership with Awabakal Aboriginal Medicare Service to improve health outcomes for members of the Hunter's Aboriginal community. The ACT ML also has a representative of the local Aboriginal Health Service on its Board.

AHCRA hopes that Aboriginal health will become a priority for all MLs, in particular those with significant indigenous populations, so that they make a positive contribution to closing the current health gap between indigenous and non-indigenous Australians.

4.9 Performance management

The question of evaluating the performance of MLs also raises some issues for the future of MLs. The Government has said that MLs will be assessed against indicators outlined in the Healthy Communities Reports, which do not exist yet. The new National Health Performance Authority has only recently (May 2012) released its accountability framework and finalised specific performance indicators. Therefore, MLs from Tranches 1 and 2 were, to some extent, operating in a vacuum when they developed their strategic plans, unsure of the specific outcomes against which they will be measured. This uncertainty was heightened by the broad nature of the vision the government has articulated for primary health care. While a detailed analysis of the accountability framework is outside the scope of this paper, AHCRA is concerned about some issues relating to the performance indicators for MLs, in particular the lack of focus on equity and access in the short term. AHCRA is also concerned that MLs and other key stakeholders, such as consumers, have not had the opportunity to provide feedback on these indicators.

One longer-term issue is how the Government will deal with the likely variable performance of MLs. Like Divisions, there will probably be significant variability in the range of MLs' performance. This will raise the need to ensure the high performers share their knowledge and expertise throughout the network and to manage the under-performance of MLs in the way that best meets community needs. It is not yet clear how performance management for MLs will work and how the Government will approach using funding to drive performance within this sector.

Recommendation 14: MLs and other stakeholders should have the opportunity for input into the set of indicators against which their performance is going to be measured.

Recommendation 15: MLs should develop a framework for sharing their experiences so that they can learn from others' successes and failures.

5. Conclusions

AHCRA believes that MLs have the potential to make lasting positive changes to primary care in Australia. However, in order to achieve their stated aims they need to be based on a clear vision, agreed among all stakeholders, and be seen as a ten-year project to have a realistic chance of delivering positive outcomes. They will also require support from stakeholders plus the policy and funding levers to drive change over this period.

Given that focus of health reform has been heavily (far too heavily in AHCRA's view) on hospitals to date, it is vital that stakeholders in this area work together to support MLs achieve a more primary care-oriented health system. AHCRA believes this is achievable but would like to see a stronger focus on a number of issues as MLs move on from this initial developmental stage. These include access and equity, support for multidisciplinary integrated services, prevention and strengthening consumer participation. We acknowledge that currently MLs are limited in their ability to drive change. We believe that MLs can grow their capacity and create opportunities but that the Government needs to give them substantially strong policy and funding levers in order to really equip them for the scale of the job they have been given. Ideas of how this might happen are already emerging in a range of quarters, e.g. the roles suggested for them by the National Advisory Council on Dental Health, and by DOHA to assist in rolling out the eHealth records system.

AHCRA has made a number of recommendations that we believe will help support MLs to achieve their goals and address some of the current identified barriers. We believe that if these barriers are addressed and with continued engagement among stakeholders at the local, state and national levels, MLs can play an important role in achieving lasting positive changes within our primary health care sector.

Feedback

AHCRA welcomes feedback on this study, which it sees as a preliminary and small-scale analysis of the role(s) being undertaken by MLs as they move through the early stages of their development and implementation. AHCRA hopes that others will follow this up in a more rigorous way at regular periods to shed light on the work and progress of the new vehicles in the primary health care system.

APPENDIX ONE

AHCRA's vision and principles

Vision

A health system that assists individuals to be healthy and delivers compassionate and quality health care to all.

Principles

Access

- Health care is a right and should be available on the basis of need not the ability to pay.
- All should have access, in a timely manner, to services that maintain and support health and offer quality health care to those in need.
- Revenue from taxation should be used to fund health care services that provide equity of access and outcomes.

Primary Health Care

- Modern health care systems should be designed to optimise the utilisation of health promotion and preventive strategies and those that allow early diagnosis and treatment to minimise the development of chronic disease.
- Health care systems should provide support so that individuals and can optimise their own health.

Community Engagement

- Health care systems must be built on a partnership between the Australia Community and consumers.
- Health care policy must be grounded in and measured against community values; and changes to the health care system must be derived from the Australian community to ensure that they are informed and ready to embrace change.

Equitable Outcomes

- Inequity and injustice in the delivery of health care are undermining Australia as a nation and must be reversed.
- The appalling health status of Australia’s Indigenous community must be addressed urgently.
- An equitable health care system will ensure that those with special needs, including, for example, people with disabilities and those whose access to healthcare is restricted by cultural, linguistic or geographic factors enjoy health outcomes equivalent to that of the general community.

- Social determinants (from poverty to the state of the environment) impact on the health of an individual or community. Investment to address these determinants must be built into Australia's planning for healthcare.

Workforce

- Australia must have a policy that extends beyond 'self sufficiency' to see us not only capable of training the health professionals needed to care for our community but also able to contribute to the health of our region of the world.
- Health workforce planning should result in the development of professionals who can provide quality services in a culturally sensitive manner to cater for the diversity that characterises modern Australia.

Efficiency

- Health care reform must remove the jurisdictional inefficiencies associated with the divided health care responsibilities of our State and Federal governments.
- Health care should be based on the best available evidence and delivered by the most appropriately skilled health professional.

APPENDIX TWO

Medicare Locals interviewed as part of this project

	State
Western Sydney Medicare Local	NSW
Hunter Urban Medicare Local	NSW
Metro North Brisbane Medicare Local	Qld
Gold Coast Medicare Local	Qld
Barwon Medicare Local	Vic
Inner East Melbourne Medicare Local	Vic
Inner North West Melbourne Medicare Local	Vic
ACT Medicare Local	ACT
Southern Adelaide – Fleurieu Medicare Local	SA

NB: All the above are Tranche 1 MLs, apart from Southern Adelaide-Fleurieu ML which is Tranche 2.

In addition to the MLs (above) AHCRA also obtained input and feedback from the following organisations:

- Consumers' Health Forum of Australia
- UNSW - Centre for Primary Health Care and Equity
- Australian General Practice Network

APPENDIX THREE

AHCRA's Members

Allied Health Professions Australia
Audiology Australia
Australian College of Midwives
Australian College of Nurse Practitioners
Australian Council of Social Service
Australian Federation of AIDS Organisations
Australian Health Promotion Association
Australian Healthcare and Hospitals Association
Australian Nursing Federation
Australian Rural Health Education Network
Australian Women's Health Network
Australian Wound Management Association
Chiropractors' Association of Australia
Chronic Illness Alliance
Continence Foundation of Australia
Country Women's Association of Australia
CRANAplus
Doctors Reform Society
Health Care Consumers' Association (ACT)
Health Consumers Network
Health Consumers of Rural and Remote Australia
Health Issues Centre
Health Reform South Australia
National Council For Intellectual Disability
National Public Hospitals Clinicians Taskforce
National Rural Health Alliance
Paramedics Australasia
Public Health Association of Australia
Public Hospitals, Health and Medicare Alliance
Royal College of Nursing Australia
Services for Australian Rural and Remote Allied Health
Tasmanian Medicare Action Group
The College of Nursing (NSW)
Victorian Medicare Action Group

APPENDIX FOUR

References

The following are the main Federal Government documents, which outline the policy context for MLs, their objectives and goals.

Building a 21st Century Primary Health Care System: Australia's First National Primary Health Care Strategy

Primary Health Care Reform in Australia: Report to Support Australia's First National Primary Health Care Strategy

Improving Primary Health Care for All Australians.

Medicare Locals: Guidelines for the establishment and initial operation of Medicare Locals & Information for applicants wishing to apply for funding to establish a Medicare Local