5.6 Implementation considerations

It has not been within scope for this Review to define an implementation roadmap. Without a detailed options analysis and understanding of preferred option this would be difficult to complete.

The recommendations and future options outlined in this report provide a number of policy considerations for the DH as well as areas of further analysis and planning. These include:

No	Area	Consideration
1	Aligning components of the Review and defining a preferred option	Aligning components of the Review and consolidating analysis and recommendations across all three into a consistent future direction for PHOs. This should include selecting a preferred future option (future responsibilities, focus and role as well as any changes to structural design) and the completion of a detailed design incorporating resolution of any Commonwealth and State/Territory policy implications. It should also include the planning related to the rebranding of MLs.
2	Understanding levers to affect change	Understanding the available levers to implement the future direction and any associated implications. For example the ability to adjust the governance of MLs may be limited due to the current configuration as independent companies limited by guarantee with a Board. There may be the ability to apply further conditions on core funding to adjust the governance, but this would be dependent on MLs and the transition/timing of current funding arrangements. Funding or regulation may be other levers available. In terms of funding this may be based on conditions placed on funding received - Core, Program or Flexible, enhanced contracting arrangements, or the phasing out of funding streams. In terms of funding it may be necessary to explore the impact of specific conditions placed on funding, for example, if they are perceived as restrictive to a company limited by guarantee under the Australian Competition and Consumer Commission. Regulatory options within the current Government context may also be explored.
3	Future models and numbers of PHOs	Depending on the preferred option this may vary. However, analysis should be completed to determine what the optimum future number and configuration of PHOs. This should include the hub/spoke concept outlined in this section.
4	Chronic disease management – PHO pilots	Analysis and prioritisation of Chronic Disease at national and regional levels, with the potential to select 2 or 3 pilot areas.
5	Future funding options	Enhancement of future funding models, including detailed analysis of programs suitable for further devolution to PHOs, ongoing streamlining of the funding/contracting mechanisms for PHOs and the development of future funding models. Streamlining should include the adjustment of reporting and

No	Area	Consideration
		broader contractual requirements to ensure a focus on the right outcomes and reduce the process-based reporting burden on PHOs. Future funding models should have an increasing focus on funding based on outputs and outcomes for a defined population as well as options around the ability to pool funding across 'commissioners' (public and private) of services.
6	Performance management framework	Alongside these funding considerations, the ongoing development and refinement of the performance management framework and KPIs related to PHOs. This should be increasingly output and outcome-based. Lessons may be learnt here from other areas of the DH.
7	Commissioning	Commissioning, as defined in this Report, and how to enhance commissioning capability and capacity within the DH and across the broader system.
8	Peak Body funding	Analysis of current DH funding for Peak Bodies and the requirement for and cost/benefit of current arrangements.
9	State/Territory impacts	The potential impacts of future direction on each State/Territory health system as well as the required engagement to support any changes. This may include State/Territory (and broader stakeholders) in the detailed future state design.
10	Access to data	The changes required to enable PHOs access to more comprehensive population-based datasets across Primary and Secondary Care including NHPA, MBS, PBS, IHPA, and NHCDC datasets.
11	Health professional engagement	The requirements and approaches to retaining GP and other health professional engagement throughout any changes to the current configuration.

These are all key considerations and recommendations of this Review. Certainly any change to the current design will require a long-term commitment to and significant effort around Commonwealth policy design and implementation.

6 Appendices

6.1 Appendix A – Stakeholder interview list

EY would like to thank all those who have participated and contributed to this Review.

No.	Organisation	Date
1	[redacted]	15/01/14
2	[redacted]	15/01/14
3	[redacted]	16/01/14
4	[redacted]	10/12/13 and 14/01/14
5	[redacted]	15/01/14
6	[redacted]	30/12/13
7	Department of Health, NSW	13/01/14
8	Department of Health, Queensland	06/01/14
9	Department of Health, Victoria	28/01/14
10	Metro North Hospital and Health Service	14/01/14
11	[redacted]	14/01/14
12	[redacted]	14/01/14
13	[redacted]	17/01/14
14	[redacted]	16/01/14
15	South Eastern Sydney Local Health District	13/01/14

6.2 Appendix B – Supporting definitions

The following appendix provides additional detail in terms of definitions related to the concepts outlined in the full report. These include PHC, Commissioning and Market failure.

6.2.1 *PHC Definitions*

Although there are a number of definitions of PHC currently in use, the following definition (endorsed by the Australian Health Ministers' Council in 1988 and widely used since then) provides a useful reference point:

"*Primary health care seeks to extend the first level of the health system from sick care to the development of health.*

It seeks to protect and promote the health of defined communities and to address individual problems and populates health at an early stage. Primary health care services involve continuity of care, health promotion and education, integration of prevention with sick care, a concern for population as well as individual health, community involvement and the use of appropriate technology."[11]

PHC is not to be confused with 'Primary Care' or 'General Practice'. By way of comparison:

- General Practitioners (GPs) – an individual medical practitioner who provides a range of medical services.
- General Practice – Incorporates GP medical services, but also includes broader clinical services provided by practice nurses.
- Primary Care – incorporates General Practice, but also includes primary/community health care nurses, early childhood nurses and community pharmacists.[12]
- PHC - incorporates primary care, but also includes a comprehensive range of generalist services by multidisciplinary teams that include not only GPs and nurses but also allied health professionals and other health workers, such as multicultural health workers and Indigenous health workers, health education, promotion and community development workers.

In addition to these distinctions, it is important to note that:

- Non-inpatient care (treatments and diagnostics) is tending to move rapidly away from traditional hospital settings into a community or PHC setting.
- The continuum of care and care pathways are increasingly dominated by the care that is provided outside of hospitals and in an individual's living environment.

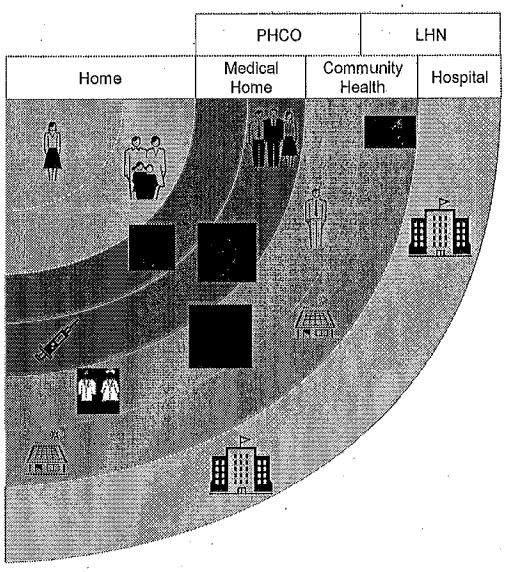
6.2.2 *Contemporary General Practice*

Building on this definition, the Patient Centred Medical Home (PCMH) is increasingly being seen as the model for contemporary General Practice. Pioneered the in USA, PCMH involves General Practice as the cornerstone of PHC working with a multidisciplinary team to provide a broad range of preventive, chronic care and acute care services, with mature forms integrating medical and psychosocial services[13]:

[11] http://www.phcconnect.unsw.edu.au/phcweb.nsf/page/What+is+PHC

[12] http://www.phcconnect.unsw.edu.au/phcweb.nsf/page/What+is+PHC

[13] Adapted from the Patient-Centred Medical Home (Dr Tony Lembke)



The models vary, but the 'medical home' acts as the hub of care, which is coordinated by a primary care provider in conjunction with the multidisciplinary team and with specialist input where required. The teams form and reform according to the patient needs and include nurses, allied health professionals and specialists. The aim is to deliver care as close to an individual's home as possible. There is evidence from multiple settings and several countries that this model of General Practice can improve quality of care, outcomes and satisfaction, as well as reduce errors.[14]

In this model, the role of a GP varies across the spectrum of types of primary health care services. For example they are likely to lead the service in traditional and extended General Practice or Primary Care Medical Homes, but not necessarily in more comprehensive models, which are likely to have a broader population responsibility, greater focus on equity and prevention and community based programs. [15]

6.2.3 *Contemporary PHC*

As outlined contemporary PHC is characterised by the importance of:

- A focus on positive wellbeing over absence of disease;
- Communities and individuals controlling health service planning as opposed to health professionals;
- Major focus on health through equity and community empowerment as opposed medical solutions for disease eradication;
- Health service provision by multi-disciplinary teams as opposed to individual medical doctors;
- Health improvement strategies via multi-sectorial collaboration as opposed to medical interventions.[16]

[14] Rosenthal Thomas C, MD; "The Medical Home: Growing Evidence to Support a New Approach to Primary Care"; Journal of the American Board of Family Medicine, October, 2008; Vol.21, No.5

[15] Powell Davies, G, McDonald J et al (2009) Narrative Review of Integrated Primary Health Care Centres/Polyclinics, APHCRI

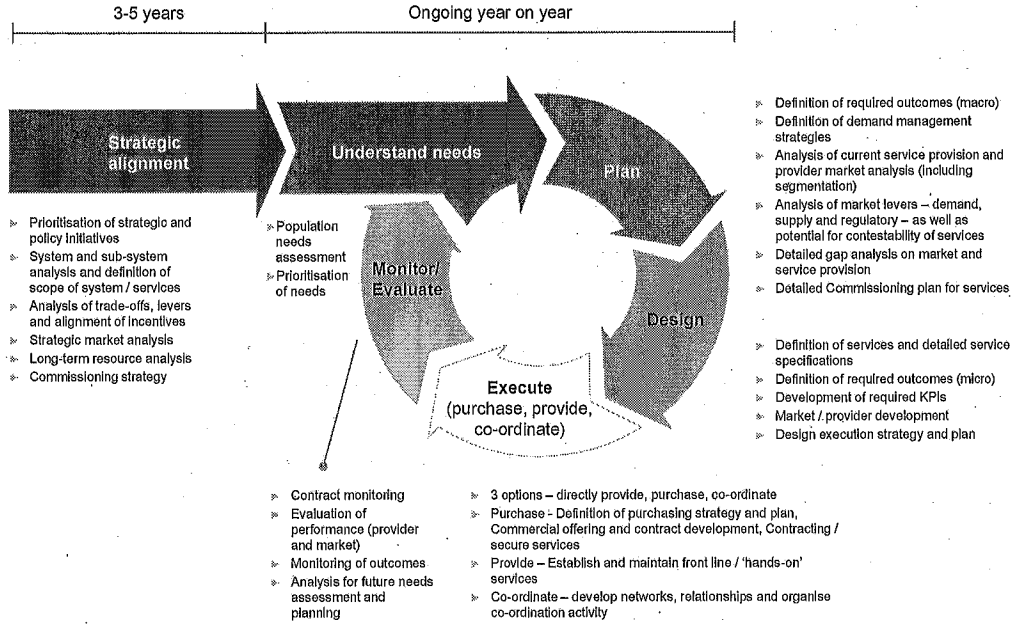
[16] http://www.phcconnect.unsw.edu.au/phcweb.nsf/page/What+is+PHC

6.2.4 *The key role - commissioning*

There are many definitions of commissioning and many terms to describe similar processes/frameworks or specific components of them. For the purposes of the future role and potential options the following definition has been applied:

"*A holistic framework for delivering strategic policy initiatives as well as designing, delivering and performance monitoring initiatives to most effectively and efficiently meet the needs of a defined population within the resources available*"

The following diagram provides an overview of the end-to-end framework (overleaf):



It is important to note that this commissioning framework includes three mechanisms for delivering initiatives – purchasing, providing or coordinating services. For clarity the purchasing and providing of similar sets of services by the same commissioner should be at a minimum.

Within this context, it is important to distinguish between a primary commissioning role and a secondary commissioning role:

- *Primary commissioners* – Apply the framework (defined above) in the context of holding and controlling the total funds for a defined population. Primary commissioners tend to commission on a macro level. Primary commissioners should not provide services.
- *Secondary commissioners* – Apply the framework (defined above) in the context of commissioning services / programs within a defined set of funds and to deliver against requirements of a primary commissioner. Secondary commissioners may use any of the three mechanisms for delivering initiatives although provisions should be only in exceptional circumastances.

6.2.5 *Defining market failure*

It has not been within scope to fully define market failure as part of this Review, but consideration of a workable definition helps frame the future role of PHOs as providers of absolute last resort.

There are many definitions of market failure, reasons as to why markets fail - competition, externalities, public goods, information asymmetry – as well as discussion on whether market failure can be applied to healthcare services if they are considered a public good.

Put simply market failure can mean no or limited supply of services of an appropriate quality where there is recognised demand for them.

Important points within this definition include:

- Assessing market failure is not a simple undertaking.
- Limited supply can refer to capacity (none or not enough) or to capability (quality - efficiency and effectiveness of delivery).
- Ineffective / inefficient delivery of services is also market failure.
- Consistent monopoly service provision within a market can also be market failure.
- The impact of market failure should be assessed against the failure of Government-led intervention in the market.
- Market enablement is a key approach to addressing market failure and should not be discontinued if a decision is made to 'plug a gap' in the market and provide a service.

6.3 Appendix C – Bibliography

No.	Document	Source	Date
1	Annotated bibliography with implications for Medicare Locals for National Medicare Local Evaluation	Gawaine Powell Davies – Lit Review.	Nov 2013
2	Literature List - List of articles and reports included	Gawaine Powell Davies – Lit Review.	Nov 2013
3	Characteristics of articles and reports included	Gawaine Powell Davies – Lit Review.	Nov 2013
4	Key Learnings from the literature	Gawaine Powell Davies – Lit Review.	Nov 2013
5	Framework for development of Primary Health Care Organisations in Australia: Parts 1 and 2	Carla Cranny and Dr Gary Eckstein	May 2010
6	Framework for development of Primary Health Care Organisations in Australia: Part 3	Carla Cranny and Dr Gary Eckstein	May 2010
7	A Healthier Future for all Australians: Final Report	National Health and Hospitals Reform Commission	June 2009
8	Primary Health Care Reform In Australia: Report to Support Australia's Frist National Primary Health Care Strategy	Commonwealth of Australia: DoHA	2009
9	Building a 21st Century Primary Health Care System: Australia's First National Primary Health Care Strategy	Commonwealth of Australia: DoHA	2010
10	National Primary Health Care Strategic Framework	Commonwealth of Australia	April 2013
11	National Health Reform Agreement	Council of Australian Governments	2011
12	DH - Invitation to ML review	Department of Health	Nov 2013
13	The Value of the Divisions Network: An Evaluation of the Effect of Divisions of General Practice on Primary Care Performance	Anthony Scott and Bill Coote Melbourne Institute Report - No. 8	Mar 2007
14	National Evaluation of Medicare Locals - First Interim Report	EY, UNSW, Monash Uni	Sep 2013
15	National Evaluation of Medicare Locals - DRAFT Final Report	EY, UNSW, Monash Uni	Dec 2013
16	Social Health Atlas of Australia - Data by Medicare Locals	Public Health Information Development Unit	Oct 2013
17	Medicare Locals & Schedules Matrix	Department of Health	
18	Medicare Locals by tranches	Department of Health	
19	2011-12 ML 6-month reports; 12-month reports; and annual plans	Department of Health	2011-12
20	2012-13 ML 6-month reports; 12-month reports; and annual plans	Department of Health	2012-13
21	2013-14 ML annual plans	Department of Health	2013-14
22	AUSTRALIA: THE HEALTHIEST COUNTRY BY 2020 National Preventative Health Strategy_2009	Preventative Health Taskforce	June 2009
23	Medicare Locals - Aggregated national data	AML Alliance	Dec 2013

No.	Document	Source	Date
24	Response to the Medicare Local Review - Medicare Locals in Australia. Driving efficiency and productivity through integrated and coordinated primary health care	AML Alliance	Dec 2013
25	Reclaiming a population health perspective - Future challenges for primary care	Nuffield Trust in partnership with NAPC	April 2013
26	Transforming our healthcare system - Ten priorities for commissioners	The Kings Fund	April 2013
27	Improving integration of care: A discussion paper for Medicare Locals	AML Alliance	June 2012
28	Market Failure and Medicare Locals	AML Alliance	Nov 2013
29	AML Alliance Annual Report 2012-13	AML Alliance	
30	AML Alliance 2012-15 Strategic Plan	AML Alliance	Aug 2012
31	High Level Scoping Study Part 2: Environmental Scan. Clinical Engagement and Cross-Sector Collaboration Project	AML Alliance	Dec 2012
32	AML Alliance response to the Review into the Personally Controlled Electronic Health Record System	AML Alliance	Nov 2013
33	AML Alliance response to the Australian Government's National Commission of Audit	AML Alliance	Nov 2013
34	Sentinel Sites Evaluation: A place-based evaluation of the Indigenous Chronic Disease Package 2010-2012	Department of Health	Mar 2013
35	General Practice Engagement with Medicare Locals - Membership	AML Alliance	Nov 2013
36	Patient Centred Medical Home – Discussion paper	AML Alliance	Dec 2013
37	ML health profiles: Avoidable deaths and life expectancies in 2009-11	National Health Performance Authority	Dec 2013
38	Except from the submission to the senate enquiry into the factors affecting the supply of health professionals in rural areas	RDAA	Dec 2011
39	Regionally Tailored Primary Health Care Initiatives through Medicare Locals Fund Discussion Paper	RDAA	Jan 2012
40	After Hours services in rural and remote Australia – position paper	RDAA	Aug 2013
41	Purchaser/Provider and Managed competition: Importing Chaos?	Andrew Street	April 1994
42	The relationship between size and performance of PCOs in England	Wilkins, Bojke, Coleman, Gravelle	2003
43	Making integrated care happen at scale and pace	Kings Fund - Chris Ham and Nicola Walsh	March 2013
44	Primary Health Care Commissioning Framework	AML Alliance	June 2012

6.4 Appendix D – Document control

Changes history:

Version	Date	Author/Editor	Comment/Change
v0.1 – 0.3	03/02/2014	EY	Initial drafts. Issued for first internal review
v0.4	05/02/2014	EY	Updated with internal review comments. Issued as a working draft for discussion to DH for review.
v0.5	12/02/2014	EY	Updated with comments from the DH, issued for final internal review.
v0.6	14/02/2014	EY	Updated with internal review comments. Final draft issued to DH.
v1	28/02/2014	EY	Updated with comments on the final draft and issued as final.

Reviewed by:

Role	Date
EY Engagement Partners	04/02/2014 and 14/02/2014
DH Review team	11/02/2014 and 27/02/2014

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