

Review of Medicare Locals

**Report to the Minister for Health and
Minister for Sport**

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Table of Contents

Executive Summary	ii
Background	ii
Methods	ii
Findings and discussion	ii
Implementation	iv
Recommendations	v
1 Introduction	1
1.1 Background	1
1.2 Medicare Locals	2
1.3 Terms of Reference	3
1.4 Methods of the Review	3
2 Key Findings	4
2.1 Recognition of the need for an organisation to reduce fragmentation	4
2.2 The ‘Medicare Local’ name is inappropriate and confusing	4
2.3 LHN boundary alignment and engagement is essential	4
2.4 General practice has a critical role	5
2.5 An absence of a clear purpose for Medicare Locals compounded by variability across the country	5
2.6 One model does not fit all	6
2.7 Selective engagement across sectors	6
2.8 Commonwealth funding for a lead change agent for Medicare Locals	6
2.9 Facilitators and purchasers of health care	7
2.10 Implementation of after hours incentive payments	7
2.11 Improving financial performance	8
2.12 Reporting and performance monitoring	8
3 Discussion and Recommendations	9
3.1 Patient outcomes can be improved through better integration of health care	9
3.2 General practice engagement is paramount	10
3.3 Vision and design principles	10
3.4 Achieving an effective and efficient PHO	12
3.5 Funding and purchasing role	13
3.6 Performance information and monitoring	14
3.7 Implementation risks and strategies to deal with these	15
4 Concluding Comments	16

Executive Summary

Background

The Minister for Health asked me to conduct a review of Medicare Locals to consider all aspects of their structure, operation and functions, and to provide advice on future directions.

The Australian health care system consists of universal access to the PBS, the MBS and the public hospital system; reflecting the pattern of illness and the medical knowledge of the time they were established – 40 years ago.

While the system has remained as a frozen snapshot of that moment when episodic care prevailed, today's health care needs are very different. The burden of disease has shifted to chronic illnesses - which call for a continuum of care – and fundamental changes in the health care workforce have emerged to deal with these.

It is axiomatic that form should follow function. Organisational structures and funding in health need to align with the clinical outcomes that are expected today – in 2014.

This is my Report on the Review.

Methods

To inform my conclusions and recommendations I considered: a review on the functioning of Medicare Locals conducted by Ernst & Young; an independent financial assessment of Medicare Locals performed by Deloitte Touche Tohmatsu; over 270 stakeholder submissions; and, information gathered from interviews with key stakeholders.

Findings and discussion

Patient outcomes can be improved by an organisation that reduces fragmentation of care

It is clear that many patients continue to experience fragmented health care that negatively impacts on individual health outcomes and increases health system costs. There is a genuine need for an organisation to be charged with improving patient outcomes through working collaboratively with health professionals and services to integrate and facilitate a seamless patient experience. While there are a few high performing Medicare Locals, a great many are not fulfilling their intended role. To be effective, boundary alignment with Local Hospital Networks (LHNs) is critical for engagement; and flexibility is required to accommodate local circumstances – a 'one size fits all' approach will not work.

The name Medicare Local is confusing and without contextual meaning. I have considered what such organisations could appropriately be called and conclude that Primary Health Organisations (PHOs) is more appropriate. This name reflects a focus on primary health care and captures a broader wellness perspective.

The role of general practice is paramount

GPs have reflected on disempowerment because of Medicare Local governance structures that have generally failed to appropriately involve and engage GPs. It is essential GPs have a significant presence within the corporate structures of PHOs. Broader and deeper GP involvement can be achieved through establishing local Clinical Councils. I see these Councils as influencing inter-sector collaboration, developing and monitoring integrated care pathways, and

Review of Medicare Locals

identifying solutions for service gaps. GPs need to buy-in to PHOs and see benefits from their involvement.

A clear vision and purpose is a critical success factor

I found lack of clarity in what many Medicare Locals are trying to achieve, with considerable variability in both the scope and delivery of activities. This has resulted in inconsistent outcomes across Medicare Locals, dispirited stakeholder engagement, poor network cohesion, and reduced sector influence. This lack of clear purpose has perpetuated a sense of confusion and relevance with service sectors, governments and the community.

PHOs must be patient focused. To achieve this, PHOs should work collaboratively with GPs, LHNs and other providers to establish care pathways that facilitate appropriate and innovative health care to ensure better patient experience and outcomes. PHOs should be designed on a series of principles that facilitate their establishment as effective and efficient organisations, including strong skills based Boards, clear performance expectations, flexibility to respond to their regional and local context, and broad and meaningful engagement across sectors.

The AML Alliance appears to have struggled to understand its role and fulfil its mandate, particularly in relation to building the capacity of the network and addressing jurisdictional-specific supports. It appears to have adopted a stronger role as a national programme coordinator. I have been unable to see the need for a national body funded by the Commonwealth. There are existing national bodies, such as the National Health and Medical Research Council (NHMRC) and the Australian Commission on Safety and Quality in Health Care that could provide PHOs with the clinical expertise and share innovations, successes and failures across PHOs.

An effective and efficient PHO

There is an opportunity to implement a new system of regional PHOs to reduce fragmentation of services and improve integration between health professionals, by establishing clinical pathways of care that arise from the needs of patients (not organisations), that will necessarily cross over sectors to improve patient outcomes. These would represent a fundamental restructure, with new PHO entities established to replace Medicare Locals. These entities would align with LHNs, be selected through contestable processes, and have contracts with the Department of Health that contain clear performance expectations.

The scale of PHOs should be such that they would have significant leverage and influence within their region and more broadly within their jurisdiction, less organisational variability and increased purchasing power. The increased scale is also designed to improve administrative efficiency by consolidating all corporate, financial and administrative functions. These efficiencies will free up a higher proportion of funding for frontline services.

The exact number of PHOs should be decided following discussions with state and territory governments to ensure effective alignment with LHNs and other service sectors, and careful consideration of jurisdictional regional characteristics. I anticipate far fewer PHOs compared to the current network of 61 Medicare Locals. At the local level, Clinical Councils and Community Advisory Committees would be responsible for ensuring each PHO is accountable and relevant, working to identify local health care needs and gaps in services and implement local pathways and explore innovative solutions to improve health outcomes.

Review of Medicare Locals

Increasing leverage as facilitators and purchasers

Medicare Locals have adopted a variety of approaches to discharge their responsibilities, including as coordinators or facilitators of services, purchasers, and/or direct service providers. I found it particularly concerning that a number of stakeholders described to me instances where Medicare Locals established services in direct competition to existing services. I consider this to be outside the Medicare Local mandate. The role of PHOs should be restricted to facilitators and purchasers and not to directly deliver service, except where there is demonstrable market failure, significant economies of scale or absence of services and patient care would be compromised.

To maximise the return on investment in PHOs, the Commonwealth may utilise PHOs to a greater extent to administer both flexible and programme funding. This will provide PHOs with increased leverage to effectively engage with the primary health care sector, LHNs and jurisdictions, and further support local decision-making to deliver greater benefits to patients.

It is critical that lessons learned from the activities of Medicare Locals inform the establishment of PHOs. I encountered widespread frustration in how the Medicare Locals 'after hours' programme has been handled. The Government should consider reviewing the appropriateness and effectiveness of the current delivery strategy. A review would garner considerable support and contribute to goodwill from general practice. It would also inform the implementation of other programmes in this sector.

Improving financial performance

The Deloitte audit into Medicare Locals did not identify significant issues or uncover any fraud. A number of anomalies were identified in their findings including: variability in expenditure on administration, varying levels of funds allocated to frontline services, inconsistencies between planned and actual budgets, cross programme funding, and variable accounting practices. These all point to the mixed financial capabilities across Medicare Locals. Many of these issues can be overcome through having fewer, larger organisations with consolidated corporate functions to improve efficiency and obtain economies of scale.

To enable PHOs to perform effectively, reporting requirements and processes need to be pruned and streamlined, with a major focus on measureable outcomes. I am advised the Department of Health has been engaged in a significant grants reform process and enterprise technology solution agenda to address these issues. Aligning PHO performance reporting to LHN outcomes and national priorities will go a long way to ensure a real sense of purpose and collaboration within local health care services.

Implementation

Large regional PHOs should be selected through contestable and transparent processes that support the establishment of cost effective entities.

The setting up of these PHOs will need an effective strategy to ensure all stakeholders are properly informed, and are involved in establishing the different parts of the PHOs relevant to their roles. This should ensure the positive relationships and goodwill essential to their success.

Review of Medicare Locals

Recommendations

The following recommendations support the establishment of an organisation to improve health outcomes through integrating and coordinating health services.

Recommendation 1: The government should establish organisations tasked to integrate the care of patients across the entire health system in order to improve patient outcomes.

Recommendation 2: The government should consider calling these organisations Primary Health Organisations (PHOs).

Recommendation 3: The government should reinforce general practice as the cornerstone of integrated primary health care, to ensure patient care is optimal.

Recommendation 4: The principles for the establishment of PHOs should include:

- contestable processes for their establishment;
- strong skills based regional Boards, each advised by a number of Clinical Councils, responsible for developing and monitoring clinical care pathways, and Community Advisory Committees;
- flexibility of structure to reflect the differing characteristics of regions;
- engagement with jurisdictions to develop PHO structures most appropriate for each region;
- broad and meaningful engagement across the health system, including public, private, Indigenous, aged care and NGO sectors; and
- clear performance expectations.

Recommendation 5: PHOs must engage with established local and national clinical bodies.

Recommendation 6: Government should not fund a national alliance for PHOs.

Recommendation 7: The government should establish a limited number of high performing regional PHOs whose operational units, comprising pairs of Clinical Councils and Community Advisory Committees, are aligned to LHNs. These organisations would replace and enhance the role of Medicare Locals.

Recommendation 8: Government should review the current Medicare Locals' after hours programme to determine how it can be effectively administered.

The government should also consider how PHOs, once they are fully established, would be best able to administer a range of additional Commonwealth funded programmes.

Recommendation 9: PHOs should only provide services where there is demonstrable market failure, significant economies of scale or absence of services.

Recommendation 10: PHO performance indicators should reflect outcomes that are aligned with national priorities and contribute to a broader primary health care data strategy.

1 Introduction

The Minister for Health asked me to conduct a review of Medicare Locals (the Review) to consider all aspects of their structure, operation and functions, and to provide advice on future directions. This is my Report which is presented to the Minister for consideration. It contains my findings, discusses key themes and issues and offers 10 recommendations.

1.1 Background

Australia has a high quality health system that performs well by world standards. Compared to the Organisation for Economic Co-operation and Development (OECD) averages, Australia's expenditure on health is below average; life expectancy at birth is two years higher; the infant mortality rate is lower; and rates of chronic, non-communicable, disease mortality (including cancer, cardiovascular diseases, chronic respiratory conditions and diabetes) are lower. In addition, Australia's smoking rates are amongst the lowest in the world.

However, the health system does face major challenges:

- lower life expectancy and poorer health outcomes for Aboriginal and Torres Strait Islander peoples, people living with severe mental illness, people living in rural and remote Australia, and people in lower socio economic circumstances;
- new technologies and medical advances support longer life, combatting and managing what were previously fatal and debilitating conditions meaning the health system is increasingly having to manage increasing life expectancy but not necessarily healthy years;
- significant funding and capacity pressure is being felt across the entire health system associated with the increasing prevalence of non-communicable diseases, including an increasing number of people living with multiple chronic conditions; and
- unwarranted variations in clinical practice between clinicians, services and geographic locations is leading to variable patient outcomes and poor quality care.

Despite the dynamic and ever-changing health and health care environment, the three pillars of the Australian health care system – the Pharmaceutical Benefits Scheme (PBS); Medicare (Medicare Benefits Schedule), which facilitate access to GP and specialist medical services and subsidised pharmaceuticals; and universal access to free public hospital care – have remained relatively unchanged for over 40 years (reflecting the pattern of illness and the medical knowledge of the time they were established). Further, the mixed public/private health system with delineated roles and responsibilities split across Commonwealth and state/territory governments has strengths but can also complicate opportunities for a unified and systematic response to challenges at hand.

While the system has remained as a frozen snapshot of that moment when episodic care prevailed, today's health care needs are very different. The burden of disease has shifted to chronic illnesses - which call for a continuum of care – and fundamental changes in the health care workforce have emerged to deal with these.

It is axiomatic that form should follow function. Organisational structures and funding in health need to align with the clinical outcomes that are expected today – in 2014.

For many individuals, the health care services they access and the quality of care received depends on where they live, and the service providers involved, as much as their clinical needs

Review of Medicare Locals

and circumstances. Patients, particularly those with complex conditions that require multiple integrated services have either been left to navigate the health system on their own or, even when supported by their GP, have been affected by information gaps, fragmented services and duplication of clinical interventions. To deliver improved value to patients and carers, the health care system must move from an episodic, siloed system to an integrated, coordinated, patient-centred system, that facilitates access to appropriate, cost-effective health care, when and where patients need it.

Australia is not alone in seeking to maintain strong population health outcomes in the face of current and expected future challenges. International evidence indicates health systems with a strong primary health care approach improve health equity and produce better health outcomes at a lower cost.¹ A number of countries have established structures to support the primary health care sector to better engage, integrate and facilitate patient care – in particular at the interface with the acute care sector. The governance, structure and funding arrangements for these organisations differ significantly and in some instances the organisations have significant purchasing and commissioning roles. Experience from the UK, Canada and New Zealand has shown that a decentralised regional approach can drive improvements in the quality of care and facilitate a more efficient and integrated health care system. In most countries these approaches have evolved over time as learnings take place. System change takes time, and for most of these countries, effective primary health care organisations are continually evolving entities.

1.2 Medicare Locals

As part of the Council of Australian Governments' (COAG) National Health Reform Agreement (2011), the Commonwealth Government agreed to fund Medicare Locals to improve coordination and integration of primary health care in local communities, address service gaps, and make it easier for patients to navigate their local health care system. Medicare Locals are expected to fully engage with the primary health care sector, communities, the Aboriginal Community Controlled Health Service (ACCHS) sector, and Local Hospital Networks (LHNs). Their establishment was built on the foundations of Divisions of General Practice (DGPs).

Medicare Locals were established as not-for-profit companies in three 'tranches' in July 2011 (19 Medicare Locals), January 2012 (18) and July 2012 (24). The Commonwealth also established the Australian Medicare Local Alliance (AML Alliance) in July 2012 as the peak body to support the network of 61 Medicare Locals.

The Department of Health is generally the principal funder of Medicare Locals, with funding provided under a Deed for Funding (the Deed) amounting to over \$1.8 billion (GST exclusive) over five years (2011/12 to 2015/16) through the *Regionally Tailored Primary Health Care Initiatives through Medicare Locals Fund*; and, around \$800 million (GST exclusive) over five years (2011/12 to 2015/16) through 31 current Programme Schedules. The number of programme schedules across Medicare Locals is variable and ranges from four to 13.

The Department of Health funds the AML Alliance to around \$4 million (GST exclusive) per annum to coordinate and support state functions and assist Medicare Locals achieve their objectives. This funding is committed until June 2016. The AML Alliance also receives additional programme funding of around \$31.8 million (2013/14 and 2014/15) to support the national roll out of programmes through the network (such as Closing the Gap initiatives) and broader workforce, immunisation and capacity development.

¹ World Health Organisation 2008, The World Health Report 2008: Primary health care, (now more than ever). (<http://www.who.int/whr/2008/en/> accessed 1 February 2014)

Review of Medicare Locals

The government of the day mandated in-depth reporting of processes. The Deed is common to all Medicare Locals with programme schedules that specify reporting requirements. Reporting is generally six monthly, however the type and quantity of information varies according to each schedule. A Medicare Locals Accreditation Scheme is being implemented to ensure Medicare Locals adhere to best practice organisational management and service delivery processes. The National Health Performance Authority (NHPA) is responsible for reporting on the outcome performance of Medicare Locals in Healthy Communities Reports that detail performance against a Commonwealth-state agreed Performance and Accountability Framework.

1.3 Terms of Reference

The Minister for Health announced on 16 December 2013 Terms of Reference for the Review to consider:

1. The role of Medicare Locals and their performance against stated objectives.
2. The performance of Medicare Locals in administering existing programmes, including after-hours.
3. Recognising general practice as the cornerstone of primary care in the functions and governance structures of Medicare Locals.
4. Ensuring Commonwealth funding supports clinical services, rather than administration.
5. Assessing processes for determining market failure and service intervention, so existing clinical services are not disrupted or discouraged.
6. Evaluating the practical interaction with Local Hospital Networks and health services, including boundaries.
7. Tendering and contracting arrangements.
8. Any other related matters.

He subsequently appointed me to consider the information gathered and provide independent advice to the Government.

1.4 Methods of the Review

The Review incorporates four distinct and independent components, all of which I have considered in forming my conclusions:

- *A review on the functioning of Medicare Locals:* Conducted by Ernst & Young (EY) this review provided analysis and opinion on current Medicare Locals operations and potential future governance options.
- *An independent financial audit of Medicare Locals:* Undertaken by Deloitte Touche Tohmatsu (Deloitte), the audit provided an assessment of Medicare Locals compliance to their Deed and financial performance.
- *Stakeholder submissions:* The Department of Health invited selected stakeholders to make submissions to inform the Review. Over 270 submissions were received. Over half of these submissions were unsolicited, highlighting the significant interest in the Review.
- *Interviews with key stakeholders:* I personally held interviews with a number of key stakeholders and opinion leaders.

Administrative support to the Review was provided by the Department of Health.

2 Key Findings

Overall, I found there to be considerable agreement across a number of themes relevant to the Terms of Reference for the Review.

2.1 Recognition of the need for an organisation to reduce fragmentation

It is clear that many patients continue to experience fragmented and disjointed health care that negatively impacts on health outcomes and increases their health costs. This fragmentation is in part an artifact of the health system operating in silos arising from its orientation towards the episodic health care that was needed at its inception 40 years ago. It now represents a significant systemic failing in both the primary health care sector and the wider health care system and undermines health system productivity. There is a genuine need for an organisation to be charged with addressing this problem within the primary health care sector, and with patient experience and outcomes in mind, across the secondary, acute, public and private, sectors (siloes) that comprise our health system.

Medicare Locals were a response to this issue of fragmentation and some have been quite successful in integrating care for patients and improving the effectiveness of primary health care services. However, overall their effort has been mixed, associated with an absence of a focused mandate and variations in their interpretation of roles. Whether it is a refocused Medicare Local, or a new organisation, there is unanimous support for an entity to be tasked with working to improve service integration and reduce fragmentation to deliver improved health outcomes and ensure the health system is more productive.

2.2 The 'Medicare Local' name is inappropriate and confusing

I found three general themes relating to the name 'Medicare Locals':

- the name fails to appropriately reflect the intent and activities of the organisations;
- there is no functional relationship between Medicare Locals and 'Medicare'; and
- the general public frequently confuses Medicare Locals for Medicare Offices.

This last issue is an ongoing problem for Medicare Locals, with members of the public frequently turning up at their front door expecting to have their Medicare claims addressed. I observed signs on the doors of Medicare Locals advising they were not a claims office.

A number of submissions, principally from Medicare Locals, supported continuing with the Medicare Local name and branding. Indeed, there was some evidence of natural traction associated with the name. However, such arguments were overwhelmingly outweighed by a mounting stakeholder sentiment that a name change is essential to better reflect the strategic intent of these, or alternative organisations, moving forward.

2.3 LHN boundary alignment and engagement is essential

The relationship between Medicare Locals and LHNs is undoubtedly one of the most important to address health system productivity, to enable the shift of health care away from high cost hospital services towards increasingly appropriate, lower cost, primary health care solutions.

The original intent of the National Health Reform Agreement appears to have sought this collaboration, however relationships were not mandated and boundary negotiations resulted in Medicare Local and LHN misalignment.

Review of Medicare Locals

I found that Medicare Locals, having been established as 61 separate organisations, lacked the power and moral authority to effectively engage and negotiate with LHNs, let alone jurisdictions. There are undoubtedly instances where Medicare Locals and LHNs have proactively engaged and successfully collaborated. However, both the extent and scope of engagement has varied significantly. For example, I found energetic engagement at senior levels which, unfortunately, was not replicated at the grass roots level. Relationships that pre-date Medicare Locals appear to be one of the key facilitators for productive engagement, highlighting that Medicare Locals as entities are not sufficient to achieve traction and leverage with LHNs.

The lack of alignment has hindered governance, shared purpose and collaboration, and stymied effective strategies to integrate care, for example hindering multi-disciplinary clinical engagement to create locally relevant clinical health care pathways. Alignment of geographical boundaries is a necessity for clinical alignment and to support patient flows, as most submissions and stakeholders agreed. In some jurisdictions creative approaches may be required to achieve alignment.

Furthermore, I found a disproportionate number of staff were involved in corporate and reporting functions in each of the 61 incorporated entities. Problems were emerging because of inability to recruit sufficiently skilled staff in these areas, which could be overcome by significantly reducing the number of these companies (say to 1, 2 or 3 per state jurisdiction); while pursuing the local agendas via pairs of Clinical Councils and Community Advisory Committees.

2.4 General practice has a critical role

Clearly, the transition to Medicare Locals from DGPs with restrictions on Board membership and with a mandate for broader engagement beyond general practice has affected relationships with GPs. GPs have felt disempowered through governance structures that have generally failed to appropriately involve and engage them. In some Medicare Locals, relationships with GPs have further been eroded through Medicare Locals pursuing an operational focus centred on practice nurses and practice managers rather than engaging the GPs themselves.

General practice is critical for a high performing, cost effective, primary health care system to orientate health care away from expensive hospital services. It is paramount that relationships with general practice are rebuilt and GPs are appropriately engaged. There needs to be GP buy-in at both the governance and operational levels and for them to be able to see benefit of their involvement.

2.5 An absence of a clear purpose for Medicare Locals compounded by variability across the country

I found lack of clarity in what many Medicare Locals are trying to achieve, with considerable variability in both the scope of activities performed and catchment delivery strategies. This has resulted in inconsistent outcomes across Medicare Locals, dispirited stakeholder engagement, poor network cohesion, and reduced sector influence. I found at the time of commencement that many Medicare Locals themselves did not have a clear or consistent understanding of what to do, and other entities did not know what to do with them. This lack of clear purpose perpetuated a sense of confusion and relevance with service sectors, governments and the community.

To some extent, this finding is not surprising. The original mandate for Medicare Locals was relatively broad and provided Medicare Locals with considerable flexibility. Such flexibility became increasingly important with increased flexible funding, which resulted in Medicare Locals

Review of Medicare Locals

pursuing a diverse range of activities. In many instances, this resulted in duplication of effort, in particular around jurisdictional initiatives and state-based population health planning and, of concern, there are instances where Medicare Locals are regarded as competitors rather than collaborators.

Variability within the context of flexibility to respond to local issues is acceptable. However, variability in intent and performance is not. Some described variability as a product of immaturity, but I think it has more to do with a lack of clear purpose and associated agenda to accomplish something.

2.6 One model does not fit all

Considering the vast range of environments in which Medicare Locals operate together with disparities in performance, I conclude that a single organisational model is not suitable for all circumstances and environments. For example, I found in some rural and remote areas, Medicare Locals provide limited additional value, particularly where established provider and service relationships exist or where there are few private primary health care providers.

It is apparent that some model differentiation is required to improve community responsiveness. The catchment spread and resource intensity would be different depending on the primary health care provider market, workforce dynamics and LHN service distribution.

2.7 Selective engagement across sectors

Our health system is a complex mix of public and private providers, indeed the primary health care sector is dominated by private providers. I consistently heard that Medicare Locals have avoided engagement with private hospitals and the private health insurance industry. Failure to engage the private sector or incorporate equitable provisions for private patients in planning and activities is a lost opportunity and further compounds fragmentation.

Patients discharged from private hospitals are generally unlikely to see any contribution from Medicare Locals to improve their transition into the community or meet their ongoing health care needs. Additionally, privately practicing community specialists and allied health professionals who play a significant role in ensuring patients can be appropriately cared for in the community, must be engaged by Medicare Locals. Increasingly we are seeing health insurers seeking to provide selected interventions and support frameworks for patients in the community. Moving forward, organisations such as Medicare Locals cannot afford to ignore the opportunities for innovative integration with the private sector.

2.8 Commonwealth funding for a lead change agent for Medicare Locals

The uncertainty surrounding the role of Medicare Locals can be extended to the AML Alliance. Despite the AML Alliance receiving considerable funding from the Department of Health to perform the role of lead change agent for the national network many stakeholders reflected they experienced limited engagement. The AML Alliance appears to have struggled to fulfil its mandate particularly in relation to building the capacity of the network and addressing jurisdictional-specific issues.

I support the view that national bodies are best generated by the members they serve. In the current network space it appears to me that the greatest need is around the consolidation of system-wide functions and the evaluation and dissemination of good practice, and that numerous existing clinical and professional bodies could fulfil this role.

Review of Medicare Locals

The need for effective engagement with state/territory governments is paramount and key to fostering increased productive engagement with LHNs. Rationally, a smaller number of empowered organisations could engage in conversations and negotiations with state/territory governments that are more effective, targeted and authoritative.

I can see no rationale for continuing to provide government financial support to the AML Alliance. If the membership of the Alliance deems it adds sufficient value to their activities then it should seek funding through appropriate membership fees and other charges.

2.9 Facilitators and purchasers of health care

There is considerable variability in the approach to service delivery across the Medicare Local network including as coordinators or facilitators of services, purchasers, and/or direct service providers. Medicare Locals have not had clear direction on how to approach the implementation of their multiple programme schedules.

Tranche one (July 2011) Medicare Locals appear to have started with more of a purchasing intent, but over time this has eroded into a greater focus on direct service delivery. The majority of Medicare Locals utilise a combined approach to services delivery, which adds to the confusion among providers about their purpose. A number of stakeholders described to me instances where Medicare Locals established services in direct competition to existing services. This has further eroded relationships with general practice.

Significantly, I identified stakeholder support for Medicare Locals to facilitate and/or purchase services to meet local needs, but not for them to provide services. Without exception, I have heard that Medicare Locals should only be services providers when there is demonstrable market failure, where services do not exist or where there is insufficient access to services (i.e., performing a gap filling role). I note the importance of organisations being service providers in some remote locations in order to get a seat at the table to effectively engage 'local' stakeholders, but even in these situations, services should complement and add value to existing services rather than compete.

2.10 Implementation of after hours incentive payments

A common theme among stakeholders is frustration associated with the implementation of the Medicare Locals' after hours programme. Issues raised included: service contract complexity and conditions; excessive additional reporting burdens for general practices; and, instances where Medicare Locals established services to operate in direct competition with existing general practices or duplicated state-funded services.

Each Medicare Local approached the task of funding after hours services differently. Some adopted a mock-Practice Incentive Payment methodology, others used simple grants, and others applied regional approaches that negated the need for specific practice support (i.e., via Medical Deputising Services). Some national or jurisdictional corporate service providers struggled to keep up with the different after hours solutions in each catchment.

I consider the timing of the transition of this programme to Medicare Locals to be a significant issue, with the majority of Medicare Locals enmeshed in establishment activities while at the same time attempting to implement a complex and controversial reform. For many Medicare Locals this was their first significant attempt at purchasing and, with the benefit of hindsight, given the sensitivities attached to the issue it was probably not an ideal starting point. The outcome for some catchments appears to have been further damage to GP goodwill, something that organisations tasked with strengthening primary health care cannot afford. It is within this

Review of Medicare Locals

context that I consider it reasonable to reflect on the appropriateness and effectiveness of the current delivery strategy.

2.11 Improving financial performance

The Deloitte audit into Medicare Locals did not identify significant issues or uncover any fraud. However, a number of anomalies were identified in their findings. There is evidence of variability in expenditure on administration, with 40 Medicare Locals spending more than 25 per cent of their core funding on ‘running’ costs.² Also discovered were varying levels of funds allocated to frontline services, inconsistencies between planned and actual budgets, cross programme funding, and variable accounting practices (i.e., cash management, interest revenue, capital asset management). This all points to mixed financial capabilities across Medicare Locals.

I believe the variability of administration costs suggests that many Medicare Locals are below the minimum efficient size to deliver value for money to the Commonwealth. It is therefore preferable to have fewer, larger organisations to improve efficiency and obtain economies of scale.

I note that Deloitte made recommendations regarding Department of Health contracting and reporting requirements and that Medicare Locals consistently state that their reporting obligations under the current Deed are excessive both in quantity and frequency. I am advised that a grants reform process is underway in the Department of Health with an enterprise technology solution that is intended to address most of these issues.

2.12 Reporting and performance monitoring

Reporting requirements mandated by the Government at the establishment of Medicare Locals resulted in a complex and often burdensome situation. Reporting requirements were directly related to single programme schedules, which made programme integration more difficult and added to the complexity of reporting. Performance measures were input and process driven not outcome focused. Reporting has become more complicated as an increasing number of programs were devolved to Medicare Locals.

Going forward, the use of process measures should be minimised, replaced by major health outcome measures that should be used as dashboard indicators. In an environment where organisations are not responsible for service delivery, complex accreditation processes need not apply and normal business standards and service related contracts with the Department of Health should be used. The rollout of eHealth across primary health care and other sectors and the use of population data in cooperation with LHNs and state health authorities in the long term, should provide more meaningful tools to measure health improvements and performance more generally. This would further benefit from developing a national primary health care data strategy that includes indicators of integration.

² I note the audit was on the 2012/13 financial year and that core funding is now included within the Medicare Local Flexible Fund.

3 Discussion and Recommendations

It is my considered opinion that there is a demonstrable need to reduce fragmentation and improve integration across the health care system, using clinical pathways across sectors to improve individual patient outcomes. Our health system is generally designed for episodic care, when nowadays many illnesses are chronic and complex, requiring multiple integrated and coordinated services centred on the ongoing needs of patients. To enable this, we need organisations that can work in partnership with the broader health system and facilitate better integration, coordination, access and care pathways. Medicare Locals were a response to this challenge. However, in their current form, as a national network, I do not regard them as appropriate or effective to successfully achieve these outcomes.

There are a number of design elements that I consider essential for any organisation intended to reduce fragmentation and improve the integration of patient care across the entire health system.

3.1 Patient outcomes can be improved through better integration of health care

Many of people I spoke to as part of this Review held the view that without addressing fragmentation – both within the primary health care sector, and more broadly across the health care system – patient care will continue to be compromised and the health system investment will not be maximised. The solution proffered is that a small number of regional entities is required to link up the parts of the health system to allow it to operate more effectively and efficiently. Such entities must focus on improving patient outcomes through collaboratively working with health professionals and services to integrate and facilitate a seamless patient experience. In their current form, Medicare Locals cannot fulfil this role. They are constrained by their lack of clear purpose, variability, conflicts of interest (provider vs. purchaser) and lost goodwill with general practice. New entities in this space must have a clearer purpose and role, and focus on being system enablers.

I have considered what such organisations could be appropriately called. Many ideas have been presented to me, but I keep coming back to Primary Health Organisations (PHOs). I believe the name needs to reflect the organisations' focus, which is the primary health care sector, as the starting point for integration, as this is the 'shop front' of the health care system. Such a name should inspire professional ownership within that sector, provide a sense of place within the broader health system and be understandable for patients, carers and the broader community. The PHO name also aligns with common international nomenclature, which would assist Australia to engage in dialogue internationally on lessons learnt.

For PHOs to be effective, it is critical that their boundaries (or rather those of their Clinical Councils and Community Advisory Committees) are aligned with LHNs, while reflecting relevant local and community needs. This will facilitate collaborative working relationships and reduce duplication of effort.

Recommendation 1

The government should establish organisations tasked to integrate the care of patients across the entire health system in order to improve patient outcomes.

Recommendation 2

The government should consider calling these organisations Primary Health Organisations (PHOs).

Review of Medicare Locals

3.2 General practice engagement is paramount

Any attempt to improve integration in the primary health care system requires general practice to be front and centre. I appreciate that the original intent of Medicare Locals was to broaden the net of professional engagement within the primary health care sector, but this appears to have come at the expense of GP goodwill. This goodwill needs to be rebuilt if any future organisation is to be successful. Comprehensive professional engagement is still required, however it must be recognised that GPs are by their nature the first authoritative point of contact for primary health care, they start the patient on their care pathway and remain critical to their ongoing care.

To this end, I consider it essential that GPs have a significant presence within the corporate structures of any future primary health care entity. My preference is for locally relevant Clinical Councils to be established that have a significant GP presence and broad clinical membership, including from LHNs. These Councils would interact directly with the PHO Board. I see these Councils as having influence in inter-sectoral collaboration, developing and monitoring integrated care pathways, and identifying solutions for service gaps. Participation on Councils should be voluntary. The voice and opinions of the Council will directly inform the deliberations of the PHO Board on matters such as, local and regional priorities, investment strategies, and primary health care professional and business support needs.

Recommendation 3

The government should reinforce general practice as the cornerstone of integrated primary health care, to ensure patient care is optimal.

3.3 Vision and design principles

I put forward the following as an overview of PHOs.

Patients with chronic diseases such as cardiovascular disease and respiratory disease do not receive optimal care in many instances due to the fragmentation of services. The role of the PHO is to work with GPs, private specialists, Local Hospital Networks (LHNs), private hospitals, aged care facilities, Indigenous health services, NGOs and other providers to establish clinical pathways of care that arise from the needs of patients (not organisations) that will necessarily cross over sectors to improve patient outcomes.

The PHOs may well perform an important facilitating role in undergraduate and vocational medical and other clinical training.

Evidence shows this will reduce unplanned hospital emergency department presentations, admissions and re-admissions and patients will benefit from better health care in the community rather than having to use hospital services inappropriately.

Not all regions across Australia are equally serviced. The role of the PHO is to work with the GPs, Commonwealth and state health authorities, LHNs, and communities to identify gaps in health services and work in partnership with these organisations to source the appropriate services.

PHOs will provide practice support to strengthen general practice to improve patient care, including assisting general practice with the adoption of electronic health records.

The success of PHOs will be known through a small number of outcome based indicators.

Review of Medicare Locals

There are a number of design features that will facilitate the establishment of effective and efficient PHOs.

PHOs should:

- be companies incorporated under the *Corporations Act 2001* and selected through contestable processes;
- have skills based Boards – without restriction on membership – advised by Clinical Councils and Community Advisory Committees through mandated Memorandums of Understanding (MOUs) and Standard Operating Procedures (SOPs) to ensure transparency and define roles and responsibilities;
- establish a Clinical Council and a Community Advisory Committee in each LHNs (or clusters of LHNs) with which they are aligned as ‘operational units’:
 - Clinical Councils with a significant GP presence and involving primary health care professionals, public/private hospital clinicians, should be established to ensure ongoing local clinical engagement within PHOs. Councils, aligned with LHNs provide a direct link between clinicians and the Board for effective local decision-making, particularly in terms of liaising with LHNs and developing clinical care pathways.
 - Community Advisory Committees, based on the same catchments as Clinical Councils, will provide a community voice into the Board decision-making and activities, particularly in regard to service gaps.
- have ongoing engagement with national and local clinical bodies to ensure consistency and evidence based decision-making;
- operate at a sufficient size to achieve benchmarked economies of scale;
- have clear performance expectations tied into their Commonwealth contracts, with outcomes based performance indicators aligned to national and local priorities;
- engage state and territory jurisdictions to develop structures that are most appropriate for each jurisdiction and region; and
- engage broadly across health sectors, including public, private, and NGO sectors.

I do not see the need for a national body for PHOs. A membership driven peak body to support the corporate needs of PHOs is best left to emerge, if required, without the investment of the Commonwealth. There are existing national bodies, such as the National Health and Medical Research Council (NHMRC) and the Australian Commission on Safety and Quality in Health Care that could provide PHOs with the clinical expertise, share innovations, successes and failures of PHOs. It may be that jurisdictional PHOs see more merit in networking at a state level to leverage greater integration. Regardless, decisions around support should be left to PHOs.

Recommendation 4

The principles for the establishment of PHOs should include:

- contestable processes for their establishment;
- strong skills based regional Boards, each advised by a number of Clinical Councils, responsible for developing and monitoring clinical care pathways, and Community Advisory Committees;
- flexibility of structure to reflect the differing characteristics of regions;
- engagement with jurisdictions to develop PHO structures most appropriate for each region;
- broad and meaningful engagement across the health sector, including public, private, Indigenous, aged care and NGO sectors; and
- clear performance expectations.

Recommendation 5

PHOs must engage with established local and national clinical bodies.

Recommendation 6

Government should not fund a national alliance for PHOs.

3.4 Achieving an effective and efficient PHO

I have identified an option that I believe should deliver the Minister improvements in patient outcomes by establishing new regional Primary Health Organisations (PHOs). These regional PHOs would replace the existing national network of Medicare Locals and the AML Alliance.

PHOs would be selected through a transparent competitive tender process and contracted to the Department of Health with explicit obligations and performance expectations, consistent with the vision and design principles outlined above and guided by national priorities. Medicare Locals and other interested parties would be welcome to make a submission to operate a PHO.

Individual PHOs would be responsible for determining appropriate organisational and operating structures consistent with the above design principles, but tailored to regional circumstances. At the local level, Clinical Councils and Community Advisory Committees would be responsible for ensuring the PHO is accountable and relevant. They will work to identify local health care needs and gaps in services and implement local pathways and innovative solutions to improve health outcomes. In addition, PHOs could use out-posted staff or engage third parties (through competitive tender) to act on behalf of, and be accountable to, the PHO and support the needs of Councils and Committees. Where feasible these arms of the PHO should be co-located within existing services (such as LHNs) to facilitate integration on the ground.

The scale of PHOs would be such that they would have significant leverage and influence within their region and more broadly within their jurisdiction to foster more equitable engagements with LHNs. In turn this scale is designed to improve administrative efficiency by consolidating all corporate, financial and administrative functions. These efficiencies will free up a higher proportion of funding for frontline services.

The exact number of PHOs should be decided following discussions with state and territory governments, to ensure effective alignment with LHNs and other service sectors, and careful consideration of jurisdictional regional variations. It would be expected that most states would have at least one metropolitan and one rural PHO, with the potential for single PHO's in

Review of Medicare Locals

Tasmania, the ACT and Northern Territory. The end result is that there would be far fewer PHOs compared to the current network of 61 Medicare Locals.

PHOs would deliver:

- greater local GP involvement through Clinical Councils – increasing the recognition of the central role of general practice as the cornerstone of integrated primary health care;
- increased capacity to strengthen relationships and work collaboratively with jurisdictions and LHNs to develop patient care pathways and address gaps in service delivery;
- effective local engagement and accountability through Community Advisory Committees and increased engagement and opportunities for the private sector, corporate general practice, across the entire aged care sector, the Indigenous community and NGOs;
- stronger, more focused organisations that can attract highly skilled corporate and operational staff including financial and management skills; and
- administrative efficiencies meaning more funding goes to frontline services.

Recommendation 7

The government should establish a limited number of high performing Regional PHOs whose operational units, comprising pairs of Clinical Councils and Community Advisory Committees, are aligned to LHNs. These organisations would replace and enhance the role of Medicare Locals.

3.5 Funding and purchasing role

To maximise the return on investment in PHOs, it may be possible for the Commonwealth to provide PHOs with increased flexible and programme funding. Opportunities exist to devolve further responsibilities from the Department of Health or other agencies to PHOs. The advantage of this approach is two-fold, first additional funding through PHOs will increase their authority and leverage to effectively engage with the primary health care sector, LHNs and jurisdictional governments; and second, local decision-making is likely to deliver greater benefits to patients and a higher return on Commonwealth investment.

It is important that lessons from the activities of Medicare Locals inform the establishment of PHOs, to this end I believe that the Government should review the Medicare Locals' after hours programme to assess the appropriateness and effectiveness of the current delivery strategy. Medicare Locals were tasked too early with this sensitive programme reform, and it resulted in many of them having to learn their purchasing/commissioning skills by experimenting on after hours GP services.

The purchasing role of PHOs will be greatly aided by deregulating the contracting platform across the Commonwealth. There is scope to learn from the complex contractual effort deployed for Medicare Locals where programmes were increasingly devolved, each with a unique set of reporting and administrative requirements. This complexity has had an administrative impact on the amount of resources available for frontline services. The Department of Health's grants management reforms has the potential to make doing business easier. Within this context, I believe that there may be merit in further transitioning programme funding to flexible funding that requires PHOs to deliver on key performance indicators. This would make PHOs truly responsible for local needs, allow regionalism to flourish and reduce administration drain on both sides of the contractual agreement.

Review of Medicare Locals

PHOs, once they are fully established, would be well placed to facilitate and/or administer a range of Commonwealth funded programs, working with LHNs and other local entities to link up the system. Teaching in such an environment would enable future practitioners to work most effectively in this future paradigm.

There is no need for PHOs to directly deliver services, except where there is demonstrable market failure, significant economies of scale, or absence of services. The exact parameters for this definition would need to be worked out. PHOs should be providers of last resort and their decision to directly provide services should require the approval of the Department of Health.

Recommendation 8

Government should review the current Medicare Locals' after hours programme to determine how it can be effectively administered.

The government should also consider how PHOs, once they are fully established, would be best able to administer a range of additional Commonwealth funded programmes.

Recommendation 9

PHOs should only provide services where there is demonstrable market failure, economies of scale, or absence of services.

3.6 Performance information and monitoring

To enable PHOs to perform effectively, reporting requirements and processes need to be streamlined, with a focus on measureable outcomes. Aligning PHO performance reporting to LHN outcomes (such as avoidable hospitalisations and re-admissions) and national priorities will go a long way to ensure a real sense of purpose and collaboration within local health care services.

The primary health care sector does not have access to significant data to inform decision-making. Most of what we know about interventions in this sector is based on fee-for-service data via Medicare. Little is known about the outcomes achieved, costs and interactions at the patient and practice level, or access trends. There are some great examples of shared information or linked data, but these only occur in pockets and are often constrained by administrative, collaborative and/or legislative factors. The eHealth agenda will have the potential to harness practice information resources and improve service planning thereby contributing to a more robust primary health care data set. PHOs need to be at the forefront of enabling the eHealth agenda, supporting professional adoption needs, applying clinical pathways and demonstrating the power of information for care coordination.

Regardless, PHOs will require a repository of reliable quantitative data to inform performance judgements. These data would be best shared through the development of interoperable systems that can extract and exchange output and outcome information. Such a system of exchange would reduce reporting burden and allow for more efficient and effective performance monitoring. The establishment of Medicare Locals failed to identify preferred data systems, and unfortunately many developed or purchased systems in isolation of the network and at great cost. There is merit in identifying system preferences for PHOs to ensure that they can communicate effectively with the Department of Health via a standardised exchange portal. It is important that the primary health care sector starts to contribute more robust data to better inform our understanding of the broader health system.

Recommendation 10

PHO performance indicators should reflect outcomes that are aligned with national priorities and contribute to a broader primary health care data strategy.

3.7 Implementation risks and strategies to deal with these

Large regional PHOs should be selected through contestable and transparent processes that support the establishment of cost effective entities. Commonwealth funding to Medicare Locals would need to be rolled back and appropriate processes will need to be in place to minimise impacts on patient care – ensuring continuity of care for individuals.

Although reducing the number of organisations could also be perceived as limiting or eroding local relevance and/or autonomy, particularly in high performing Medicare Local catchments where relationships with local stakeholders are well established; the goodwill of stakeholders could be effectively channeled through membership of Clinical Councils and Community Advisory Committees. These structures would present an opportunity to capture the enthusiasm of existing Medicare Local stakeholder and advocates, and also those disenfranchised GPs who are keen to play a part in a new and invigorated organisational agenda.

Finally, there is the potential for reform fatigue to erode positive relationships and goodwill, a PHO narrative is needed that clearly articulates the value proposition for patients, GPs, primary health care providers and the broader community.

The setting up of these PHOs will need an effective strategy to ensure all stakeholders are properly informed and involved in establishing the different parts of the PHOs relevant to their roles. This should ensure the positive relationships and goodwill essential to their success.

4 Concluding Comments

This Review has highlighted the potential to improve health outcomes through establishing PHOs to better integrated health care services.

Some Medicare Locals have achieved a great deal, however as a national network, they have failed to present a compelling argument to continue in their current form. PHOs will build on the strengths of Medicare Locals, but by avoiding unnecessary corporate bureaucracy and duplication – a greater proportion of funding should be targeted to frontline services.

General practice will have a key role in PHOs and, through Clinical Councils, a greater say in the governance and strategic direction of their local primary health care systems and development of integrated care pathways. Similarly, local communities, through Community Advisory Committees, will have greater engagement to shape health services.

The future for primary health care is bright.