POSITION STATEMENT

VHA 2010 Board Endorsed Position Statement

Medicare Locals

"Optimising health outcomes for all Victorians"

The Victorian Healthcare Association

The Victorian Healthcare Association (VHA) is the major peak body representing the interests of the public healthcare sector in Victoria. The VHA promotes the improvement of health outcomes for all Victorians from the perspective of its members that include public hospitals, rural and regional health services, community health services and aged care facilities.

1. Prefacing comments

The April 2010 National Health and Hospital Network Partnership Agreement (NHHN Agreement) and the papers *A National Health and Hospitals Network for Australia's Future* and *Building a 21st Century Primary Health Care Strategy* provide an opportunity to strengthen primary healthcare in Australia through the establishment of Medicare Locals. The policy goals outlined by COAG, and the agreed processes contained in these documents have guided the development of this discussion paper.

The VHA supports the introduction of Medicare Locals and believes their aims (if realised) will be beneficial to improving health and wellbeing outcomes for local communities. To ensure these goals can be met, it is fundamental that their structure, function, governance and boundaries are carefully planned in order to realise the short-term and long-term goals of the organisations.

2. The VHA Consultation Process

In developing this position statement the VHA has consulted widely with its members, including a working group that includes broad representation across the VHA membership. In addition, the VHA has worked closely with other key stakeholders - the Victorian Department of Health, General Practice Victoria (GPV) and State-wide Primary Care Partnerships.

The goal of this approach has been to achieve a position that, if implemented, will work for the Victorian health system, have broad-based support across all key stakeholders, and deliver demonstrable improvements for all Victorians. In particular, the VHA calls on the Victorian and Commonwealth Governments to ensure that any reform to primary healthcare delivers benefits to those communities and people who underutilise primary healthcare services, such as those experiencing socioeconomic disadvantage and those in rural and remote areas.

3. The VHA Position

3.1 Aims of Medicare Locals

The VHA supports and endorses the following aims of Medicare Locals, as outlined in clause B2 of the NHHN Agreement:

The creation of PHCOs will improve the delivery of GP and primary health care services at the local level and ensure local GP and primary care is better integrated and more responsive to the needs and priorities of patients and communities. PHCOs will aim to do this by:

(a) Improving the delivery of and access to GP and primary health care services at the local level to ensure there are fewer gaps in services, particularly for patients with chronic conditions and special needs;

(b) Working with local health care professionals, and engaging with the community, to ensure services work with each other so that patients will find it easier to navigate the local health system to find services they need; and

(c) Working with LHNs to assist with patients' transitions out of hospital, and where relevant into aged care, to ensure smoother transitions between service providers and greater coordination of services.

3.2 Medicare Locals Function

The following functions of Medicare Locals have been outlined in clause B26 of the NHHN Agreement to achieve the stated aims:

(a) Work with local health care professionals to ensure services cooperate and collaborate with each other so that patients can easily and conveniently access the full range of services they need;

(b) Facilitate allied health care and other support for people with chronic conditions, as identified in personalised care plans prepared by GPs;

(c) Identify groups of people missing out on GP and primary health care, or services that a local area needs, and better target services to respond to these gaps, for example, targeting gaps in GP services for aged care recipients;

(d) Work with LHNs to identify the best pathways between services, and to assist with patients' transitions out of hospital, and where relevant into aged care;

(e) Deliver health promotion and preventive health programs targeted to risk factors in communities, in cooperation with the National Preventive Health Agency, once it is established; and

(f) As needed in the execution of other functions, undertake population level planning and potential fund-holding roles in areas of market failure and where patient needs are not being met.

The VHA believes that the functions of Medicare Locals need some modification, as outlined below if they are to achieve the stated aims in Victoria.

3.2.1 Transparency

Further articulation of the types and breadth of services to be procured by Medicare Locals is required. Given that Medicare Locals are to hold funds, then effort must be made to ensure that commissioning and funding practices ensure transparency and collaborative working practices between service providers. The existing primary health system in Victoria is fundamentally based on partnership and collaboration, and this must not be lost in the implementation of Medicare Locals.

3.2.2 Service sustainability

The majority of funds to existing service providers must be channelled via direct Commonwealth funding to ensure the stability of the existing service system and provide a sound basis for cooperation and integration of the broader service system. The sustainability of existing service providers, particularly in rural areas, will be adversely affected by any function of Medicare Locals that undermines the stability of the existing workforce. Services purchased by Medicare Locals must be aimed at increasing service sector capacity for service coordination, addressing service gaps within catchment areas and health promotion and preventative programs.

3.2.3 Purchaser/provider roles

As Medicare Locals will be purchasers of defined services, the VHA has particular concerns regarding the stated function of Medicare Locals in the delivery of services. Being a provider of services has the potential to undermine trust and reduce cooperation between a Medicare Local and external agencies and may result in destructive competition between agencies in a particular region. The VHA believes there needs to be a separation of the purchaser and provider roles; it therefore believes clause B26e should be amended as follows:

> *e)* ***Procure, in its catchment area****, health promotion and preventive health programs targeted to risk factors in communities, in cooperation with the National Preventive Health Agency, once it is established*

Health promotion and illness prevention programs deliver benefits to the community by promoting positive wellbeing and reducing preventable illness. Health promotion strategies rely on active engagement with the community of interest. Consequently, such programs must be community informed and owned. There are services in Victoria with significant experience and expertise in delivering these programs, including community health services.

The Medicare Local would be best placed to take a leadership role in setting the health promotion agenda, leading health promotion initiatives, integrating health promotion into models of care, and developing specific health promotion resources. Health promotion activities identified within local and regional plans and delivered through community health services have been a feature of the Victorian primary healthcare system. The VHA believes that responsibility for *delivering* health promotion and preventative health programs should remain with the service sector, rather than the Medicare Local, except where no service provider is available within a particular catchment.

3.2.4 Equity-based priority setting

To achieve the stated aim of ‘regional service integration for more responsive service to address community needs’, the services requiring integration need to be identified and a definition of ‘needs’ agreed. The health of populations is largely determined by factors and conditions that lie outside the domains of the health system. Despite significant advancements in healthcare, rates of poor health and chronic disease continue to escalate alongside socioeconomic inequalities and disadvantage, often clustered in communities. To see real improvement in the health of populations, more comprehensive approaches to planning, such as population health planning and strategies that address the social determinants of health, are required. Therefore, the VHA encourages the implementation of Medicare Locals to not merely consider goals of efficiency and effectiveness, but to incorporate equity and social justice into priority setting mechanisms through a population health approach to planning.

3.2.5 Cross-sector collaboration

The VHA believes that improving the health outcomes of communities requires the action and engagement of stakeholders beyond the health sector. The cross-sector service collaboration required to improve health therefore requires broad engagement with a range of health and welfare services such as housing, homelessness or specialist services, as well as local government, to coordinate access and ease of navigation of a range of services that impact on health. Medicare Locals will therefore need to engage with stakeholders from sectors beyond health including housing, community services, education and employment. The role of Medicare Locals would then be to promote collaboration between a broad range of health, welfare and community service organisations and build capacity to enable improved service coordination.

3.2.6 Service coordination and care planning

The VHA is also concerned that Clause B26 describes the preparation of care plans for the delivery of services to those with chronic illnesses as being solely a role for GPs. In Victoria this role is currently effectively managed by a range of professionals, for example care coordinators or key workers in the Early Intervention in Chronic Disease program delivered through state funded primary healthcare services. In undertaking care planning the effective use of scarce health resources needs to be examined. This must include workforce usage and scope of practice.

The VHA believes that relying on GPs as case managers is a very expensive and inefficient model. The lack of certainty and articulation regarding service coordination evident in current Commonwealth policy announcements and the ongoing reliance on GPs as case managers is very limiting and of concern to the VHA.

The Victorian primary healthcare context currently demonstrates robust and effective service coordination models for a range of client groups. These operate at two levels: effective organisation coordination and client centre coordination. Victoria’s Primary Care Partnerships demonstrate successful multidisciplinary service coordination models at both the individual client level and

the organisation level. The development of service coordination tools (Initial Needs Assessments and Service Coordination Tool Templates) support effective, efficient and proactive use of resources to prevent, treat and manage the health outcomes of local communities.

At the individual level, effective service coordination to many clients has meant access to the right service at the right time in the right place through professional care coordination and case management, undertaken by a range of professionals. Ensuring clients receive a seamless and integrated response requires a multidisciplinary cross-sector, cross-organisational approach to developing appropriate systems and protocols.

These successful and effective approaches to the primary healthcare system must be used to build the primary healthcare system of the future. However, at present there is significant risk that they will be fractured through the reform process.

3.2.7 Electronic Health Records

The ability to provide effective and coordinated services to individuals and communities is inextricably linked to effective information management and communications technology. The implementation of an electronic health record and one national patient identifier, accessible to the individual and the team of professionals contributing to that person's care, is vital to achieving the goals of Medicare Locals. Instituting electronic health records requires not only enabling legislation and national protocols, but funding to support the required infrastructure at a local and regional level.

3.2.8 Additional Functions

The VHA believes the role of Medicare Locals needs further development in the following areas:

Table 1: Additional Functions

1	Strengthening and building the capacity of the existing health service delivery infrastructure, including information management and communications technology and capital infrastructure, with the aim of improving access, effectiveness, efficiency and sustainability of primary healthcare services and reducing preventable admissions
2	Identifying workforce issues and interaction between providers and workforce bodies e.g. Health Workforce Australia and respective training bodies
3	Identifying equity of access to a broad range of GP, allied health and related welfare services for those in greatest need (not just those with a chronic disease). The overuse of acute emergency services by patients with non acute illnesses/conditions is an example of the lack of access to affordable community GPs
4	The facilitating role of Medicare Locals in meeting gaps in service delivery is as a procurer of services, not as a services provider. As a procurer of services Medicare Locals must have clear, open, transparent, and contestable procurement processes
5	The role of Medicare Locals in planning is to reduce inequity in health outcomes through effective population health planning approaches. This should be based on the working definitions of population health and population health planning, and the framework developed by the VHA
6	Planning activities undertaken by Medicare Locals must link with existing effective planning mechanisms at a local, state and Commonwealth level. In Victoria this includes Municipal Public Health Planning and Primary Care Partnership Planning to ensure planning is consistent with projected growth areas, local needs and consideration of local community based service structures and networks
7	Community engagement to inform the quality of primary healthcare services and the transition between services. Medicare Locals must be required to go beyond high-level prevalence data to examine the underlying health needs of sub-populations within their communities, with an emphasis on social equity. Specific sub-populations such as newly arrived communities or the homeless need to be active participants in the design of services relevant to their health needs. Therefore, appropriate mechanisms for consumer/carer engagement need to be included.
8	Incorporating an evaluation function is necessary to enable evaluation of Medicare Locals' outcomes, to ensure this structure meets the short, medium and long term goals envisioned by the COAG agreement

To achieve sector wide planning and capacity building for the primary healthcare sector, there will need to be a national and jurisdictional network of Medicare Locals.

3.3 Governance

3.3.1 Governance Principles

To establish Medicare Locals as independent organisations that are able to deliver the functions outlined above, the following overarching governance principles must be adhered to:

Table 2: Governance Principles

1	The Boards of Medicare Locals need a broad range of skills including management, planning, financial management, procurement and health expertise to enable the effective governance of the functions described. Boards may require governance training to suitably develop their skills (B17, NHHN Agreement)
2	Best practice governance processes, including those relating to conflict of interest, will be required to effectively manage any real or perceived conflict that may arise in relation to the purchasing of services
3	The Boards of Medicare Locals must be constituted as new boards, rather than adapted from any pre-existing board or other kind of formal collaboration
4	Medicare Locals will need to form strong relationships with Local Hospital Networks (B18, NHHN Agreement)
5	A broad range of service providers should be engaged through organisational membership of the Medicare Locals, including those outside the health sector (B15, NHHN Agreement)
6	An accountability framework must be introduced that clearly establishes Medicare Locals' accountability to state and Commonwealth Governments. This would require performance standards and accreditation processes that cover governance, quality and safety, reporting, financial management and procurement, and performance management systems and protocols (B20, NHHN Agreement)

3.3.2 Membership

The ability of Medicare Locals to deliver on their stated functions is dependent on the engagement of key stakeholder groups. As such, it is important that the membership of Medicare Locals appropriately reflect their objective.

Membership of Medicare Locals should include:

- Primary health care providers
- General practice
- Women's health services
- Aboriginal health services
- Welfare providers
- Community service organisations
- Tertiary education providers
- Local government
- Local hospital networks
- Other community-based organisations

3.3.3 Governance Structures

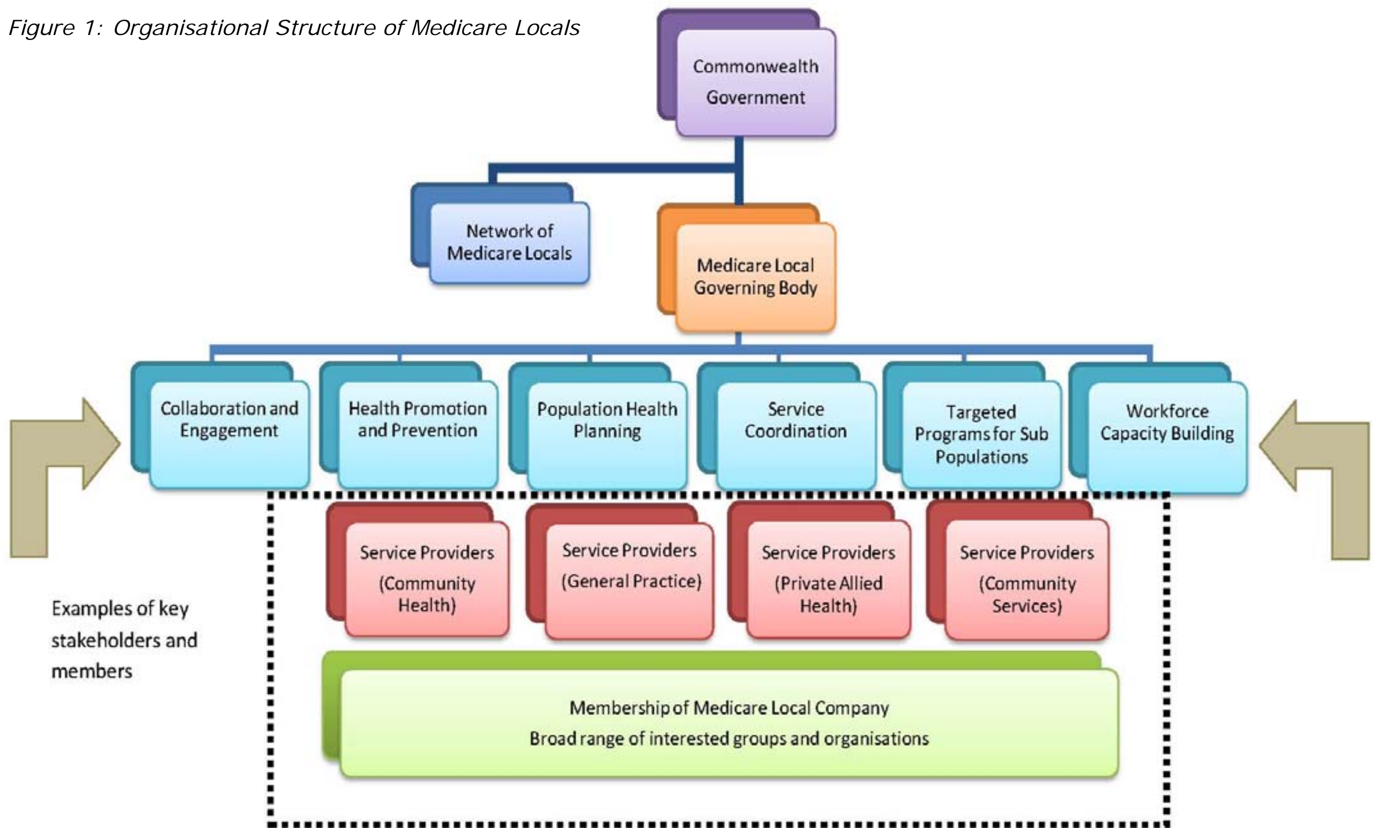
To ensure that Medicare Locals can meet these accountability benchmarks, effective registration and monitoring processes must be established.

In establishing Medicare Locals the VHA believes the following must be incorporated into their governance structures:

Table 3: Medicare Locals' Governance

1	Established as independent legal entities with strong links to communities and service providers. The legal structures that enable the corporate identity of Medicare Locals must support the organisation's ability to fulfil their functions. It is noted that if established as companies limited by guarantee, the capacity for government influence over the goals of Medicare Locals may be diminished. The VHA therefore supports corporate enablement through an amended Health Act 1997 (B15, NHHN Agreement)
2	Boards of between 6 and 9 directors
3	The majority of board positions should be elected by members and the remaining positions by transparent and robust selection processes based on best practice governance principles
4	The board should comprise an independent chair and at least 2 independent board positions, where independence is defined as no association with local service providers
5	The process for selection of the chairs should be a standard process applied across all Medicare Locals that uses a selection panel comprising external stakeholders
6	Boards should not include nominated stakeholder representative positions (other than Local Hospital Networks)
7	One place on each Medicare Local board should be reserved for a representative from Local Hospital Networks in the region (B18, NHHN Agreement)
8	Where clinical expertise is included on Boards this must be done so in such a way as to eliminate inherent conflicts of interest
9	Boards must adhere to the principles of best practice governance as published by the Australian Securities and Investments Commission (ASIC) and governance bodies such as the Australian Institute of Company Directors and Australian Centre for Healthcare Governance

Figure 1: Organisational Structure of Medicare Locals



3.3.4 Federal Governance

As Medicare Locals will have a role in the coordination of primary healthcare services, and act as a procurer of services, it is expected that their establishment and ongoing role will be subject to legislative oversight.

Further clarity is required regarding the Commonwealth Legislation that will enable the creation, oversight and funding of Medicare Locals. This must include articulation of the relationship between the National Performance Authority and Medicare Locals and the associated reporting and accountability requirements.

Figure 1 outlines the preferred organisational structure of Medicare Locals. The Board would have governance of a number of sub-committees to advance key aims and strategic objectives of Medicare Locals. The membership of a sub-committee would include the appropriate expertise to address its aim and this may include Medicare Local members, community representatives and/or clinical representatives.

The blue layer of Figure 1 represents some of the key functions of Medicare Locals. In implementing these functions it will be necessary to undertake broad engagement with stakeholders from across the primary healthcare, community services, and local government sectors. Processes that enable engagement will be essential to the successful implementation of programs by professionals independent of the corporate structure of Medical Locals.

A network of Medicare Locals will address sector wide planning and capacity building. Appropriate regulatory mechanisms will exist to monitor and manage the performance of Medicare Locals.

3.4 Boundaries

The VHA believes the boundaries established for Medicare Locals must include:

Table 4: Boundaries

1	LGAs as basic building blocks and where possible existing Primary Care Partnership boundaries. The use of LGAs as basic building blocks enables the use of municipal public health plans at the LGA level. At state borders, communities of interest must determine boundaries and where possible LGAs would remain the basic building block
2	Communities of interest: that is boundaries set according to the Medicare Local's ability to respond to local needs/priorities, logical geographic divisions and transit pathways
3	Consideration of local networks of service providers and community based organisations

3.5 Key Medicare Locals' Implementation Issues

The following issues must be addressed during the implementation of Medicare Locals:

Table 5: Implementation	
Governance of Medicare Locals	
1	The development of a uniform governance framework with clear structures and processes
Organisational Capacity	
1	Training and development for board and senior executives of Medicare Locals to enable effective governance and management of their key functions
2	A competency based framework for staff to ensure the recruitment of an appropriate workforce
3	An open and transparent workforce recruitment process
4	The development of a network of Medicare Locals at state/national level to promote professional development and response to sector wide issues and capacity building requirements
Performance	
1	Development of a performance framework with indicators covering the main domains of governance, including the functions of Medicare Locals
2	Specific indicators to measure performance in engagement with all key stakeholders including the community and service delivery organisations
3	Development of sector specific standards to be administered by a licensed accreditation provider (requiring evidence of continuous quality improvement)

4. Conclusion

The VHA is cognisant of the need to implement Medicare Locals in a timely and effective manner. The VHA is therefore committed to working with all stakeholders to ensure that their implementation is undertaken in such a way that builds on local strengths for the benefit of local communities.

Produced by the Victorian Healthcare Association (VHA). This document has been prepared by the VHA with input and feedback from VHA members. While this position statement aims to broadly reflect the views of the health sector in Victoria, it remains the position of the VHA and does not supersede any submission or position stated by any member agency. The VHA would also like to thank the VHA Medicare Locals Working Group. This group has contributed generously to the development of this position statement.

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