



Victorian Healthcare Association

SUBMISSION

*Submission to Department of Health and Ageing Medicare
Locals Discussion Paper on Governance and Functions*

22 November 2010

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1. Introduction

This submission paper outlines the Victorian Healthcare Association's (VHA) position regarding the Department of Health and Ageing Discussion Paper on Medicare Locals (MLO) Governance and Functions (the discussion paper).

1.1. The Victorian Healthcare Association

The Victorian Healthcare Association (VHA) is the major peak body representing the public healthcare sector in Victoria. Our members include public hospitals, rural and regional health services, community health services and aged care facilities. Established since 1938, the VHA promotes improvement of health outcomes for all Victorians, from the perspective of its members.

1.2. Current Service Context

There are over 110 public hospitals in Victoria which provide a broad range of services including inpatient and outpatient medical and surgical services, rehabilitation, mental health, aged care and primary healthcare services.

Victoria has a proud history in primary healthcare, structured through a network of over 100 community health services operating from approximately 250 sites. These services plan and implement programs, services and projects according to local needs and funding agreements, with a particular connection to their local communities. The Victorian primary healthcare sector has existed within a dynamic and vibrant policy environment for the past 15 years which has led to a range of initiatives that are currently bearing significant outcomes for communities. These initiatives have resulted in improved service integration across the continuum of care, with subsequent benefits to patients and communities.

This policy landscape incorporates a broad range of stakeholders and programs, and has included public sector primary healthcare which includes community health services provided by independent organisations and those auspiced by public health services and hospitals, Primary Care Partnerships (PCPs), the Hospital Admission Risk Program (HARP), early intervention in chronic disease (EiCD), mental health, housing and other community sectors. In transferring policy and funding responsibility to the Commonwealth Government it is important that the linkages across and between sectors are not diminished or restricted and the momentum achieved over the last 15 years is not lost.

In particular, the VHA calls on the Victorian and Commonwealth Governments to ensure that primary healthcare reform delivers benefits to those communities and people who underutilise primary healthcare services, such as those experiencing socioeconomic disadvantage, those in rural and remote areas.



1.3. Prefacing Comments

The VHA believes the implementation of MLO has the potential to provide significant improvements to the health of individuals and communities through improved service coordination and system planning. Achieving these goals however is dependent upon ensuring MLO implementation builds upon what is working effectively within local health systems and support increased partnerships and collaboration.

1.4 State Government Engagement

The VHA believes all state governments are key stakeholders in the delivery of health services who must be effectively and consistently engaged in the roll out of MLO in their state. The VHA believes the current approach fails to achieve the required level of engagement. The VHA calls on the Commonwealth Government to embark on an engagement process that incorporates local service delivery contexts in a meaningful and comprehensive manner to achieve the benefits and mitigate the risks of transitioning to MLO.

2. Victorian Peak Body Joint Statement

Stakeholders representing Victorian primary healthcare groups, General Practice Victoria (GPV), Statewide Primary Care Partnerships (SPCP), Municipal Association of Victoria (MAV) and the Victorian Healthcare Association (VHA) support the following statement regarding the discussion paper regarding MLO. Each stakeholder will submit their individual response incorporating this statement.

Victoria has a well established history of collaboration across the primary health care sector. We are looking to use MLO as an opportunity to further the positive results of collaboration and the direct benefits to the client and carer.

Victoria is pleased that in the document the Commonwealth has acknowledged the differences within each jurisdiction by stating that the establishment of MLO,

“Will need to take account of existing regional primary health care infrastructure, partnership arrangements, including those established and operated by states and territories, while considering opportunities to build on elements that are currently working well.”

In order to achieve the overarching outcomes of the reform vision, we believe that the purpose and scope of MLO should be a bilateral decision i.e. a state by state agreement. In addition we believe the following points are fundamental to the success of implementing MLO in Victoria:

- Clarity of roles of State and Local governments especially as health planners (state and local) within our system and how the regional planning function of MLO is proposed to fit with them.
- The purpose and function of MLO as system reform requires strong underpinning of policy and significant investment.
- Clarification of the governance structure for MLO. The appropriate structure should be put in place for the ultimate role of MLO. If an



organisation is initially established to fulfil a limited role and is intended to take on a much broader role in the future it risks creating the need for another major restructure.

- Quantify the resources available to achieve the objectives
- The development of a protocol agreement between MLO and Councils that addresses the fundamentals of how to effectively plan and work together. This is supported by local government, who are key stakeholders in the planning and service delivery of primary health care and related services in Victoria.
- A requirement that MLO be not-for-profit entities. (The discussion paper describes this on page 9 as an expectation rather than a requirement)
- Clarification regarding the conflict of interest that may exist within MLO if they play both a purchaser and provider role.

Victoria's current primary healthcare structures have facilitated the development of valuable and inclusive partnerships between a broad range of sectors and a very diverse range of services. Victoria's experience over the past decade demonstrates that inclusive, broadly based and cross-sector partnerships can improve the health and wellbeing of targeted communities, via comprehensive and coordinated strategies.

3. Summary

The Victorian primary healthcare sector is becoming increasingly concerned regarding the policy framework within which the Commonwealth Government will enact primary healthcare reform. The VHA calls for clear and strong leadership at a national policy level across the continuum of comprehensive primary healthcare. The Commonwealth Government must articulate the scope of the MLO policy to ensure the system is improved through these changes.

Based on the policy direction provided to date, the benefits of MLO to the Victorian community and the health system are unclear. The national implementation process being canvassed does not provide evidence that MLO will improve existing primary healthcare partnership, funding allocation and service coordination processes.

The VHA believes the MLO policy could be strengthened by:

1. Providing clear policy direction to all MLO that best practice community consultation processes will be required by government
2. Clearly demonstrating how the Federal Government will avoid MLO acting as another layer of bureaucracy that may stymie innovation
3. Providing a strong demonstration of how MLO will positively impact on health inequities, the social determinants of health and vulnerable communities
4. Ensuring that all key stakeholders, as well as general practice, are engaged and included within the implementation of MLO

Existing state-based service systems and mechanisms must be the foundations of MLO in order to fully realise its potential to improve the health outcomes of communities. The proposed implementation plan fails to articulate how this will occur, which poses risks to the implementation of MLO in Victoria.



3.1. Meeting Needs of Local Communities

Local community needs must be addressed through the implementation of MLO. If the MLO policy is not structured to meet state needs, fragmentation will occur within the health system and key stakeholders will be excluded from the policy initiative, which will jeopardise the important linkages between the primary healthcare sector and the community sector. This will result in limited capacity for MLO and related policy initiatives to appropriately impact upon the health and wellbeing of populations and the broader determinants of health.

3.2. Building on Expertise

State governments across Australia currently undertake a range of planning activities. Much of the expertise regarding population health planning resides within state health departments. The VHA believes a role must be established for state governments to support the planning activities of MLO to leverage this expertise. Failure to do so will create duplication and inefficiency.

The VHA believes the most effective and appropriate system administrators of primary healthcare funding are state governments, who undertake the system planning role for acute health. Informed by the planning intelligence from MLO along with system-wide knowledge from the acute health system, state governments can play a significant role in the allocation of primary healthcare service funding, in line with Commonwealth policy priorities and KPI's.

3.3. Defining Primary Healthcare

The policy, as currently framed, fails to clearly provide a cohesive definition for what is considered primary healthcare, primary care and general practice. This gap is problematic because it means differing components of the primary healthcare sector will be interpreting the policy in differing ways, resulting in further fragmentation on the ground. While the VHA acknowledges further information provided by DoHA in this discussion paper, many gaps remain regarding the role and scope of MLO and the lack of clear definitions, making it difficult to determine the framework or context within which policy will be implemented. Until the role and purpose of MLO is further refined, the scope for sectors that will engage in MLO will remain unclear and, therefore, the capacity of the policy will remain indistinguishable.

In addition, the VHA notes the interchangeable use of primary care and primary healthcare in the health reform documentation. These terms have significant differences in meaning and MLO must focus on a broad concept of primary healthcare that seeks to change the personal, social, political, environmental and economic determinants of health to create better health in communities, cities or regions. Consequently, these services will need to go far beyond the boundaries of traditional Divisions of General Practice.

Victoria's primary healthcare services – predominantly community health services – often work with the most vulnerable and disempowered members of our community. This well-established primary healthcare service system is unique to Victoria and should be nurtured. To ensure its continued viability, this sector requires flexible funding that supports innovation to design creative programs and further



improvements in care coordination to integrate services across the care continuum. The focus of healthcare delivery needs to shift from treating individual illnesses to a holistic, person-centred approach that provides access to multidisciplinary teams of healthcare professionals, client management plans and a focus, where appropriate, on self-management of chronic illness. A stronger primary healthcare sector will enable a more effective health system overall and improving these services in rural Victoria will address existing disadvantage and inequity.

4. What will MLO do?

4.1. What features will MLO need to have in order to achieve their objectives:

4.1.1 Identification of the health needs of local areas and development of locally focused and responsive services

The identification of local areas' health needs and the development of locally focused and responsive services is a process that requires significant workforce expertise in population health planning and service development. A range of these functions are currently undertaken within Victoria across state and local government and within the primary health sector. A collaborative approach across PCP's has also seen a range of other stakeholders engage in these important activities in recent years. The knowledge, workforce and expertise to support these functions currently sits across a range of agencies. The processes that MLO use to undertake this role therefore must be collaborative, open and utilise the existing planning process and knowledge base.

A clear definition is also required of the service gaps that MLO are seeking to fill. It is unclear if the aim is to provide a universal system or to address the gaps affecting the most vulnerable in our communities. Such policy-setting priorities must be made at a national level to ensure coherent and consistent approaches within MLO. The VHA suggests that MLO will have the most effective outcomes if they focus on meeting the needs of vulnerable communities.

To create a national system of local area planning the Commonwealth Government must provide a mandated cohesive framework to guide the planning process. The model outlined in this discussion paper has the potential to lead to divergent approaches and therefore, fragmentation across the health and social sectors. This will limit the ability to compare and contrast the health status of a particular region - thus limiting the quality and applicability of outcomes.

The COAG Agreement asserts that MLO will undertake population health planning, service integration, and service delivery. Because population health planning is a relatively new area, its concepts and principles are not well understood. The VHA, in collaboration with Monash University, has developed a position statement (attached) that provides best practice working definitions of population health and population health planning for the Victorian health system context. These definitions provide clarity regarding the concept of population health, with the potential to achieve consistency across services. The position statement also identifies four core components and eight best-practice principles that represent the activities required to implement a best-practice approach to population health planning. The VHA recommends that these be adopted when implementing MLO.



4.1.2 Improving the patient journey through developing integrated and coordinated services, including across the transitions between primary and acute and aged care

The Victorian primary healthcare context currently demonstrates robust and effective service coordination models for a range of client groups. Victorian PCP's demonstrate successful multidisciplinary service coordination models at 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 has given many clients 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 must be used to build the primary healthcare system of the future.

A review by KPMG of Victorian service coordination processes found that *"service coordination delivers a number of benefits....earlier identification of client needs, better management of waiting lists, improvements in service navigation and coordination and greater operational efficiency...all for a relatively small investment"*. However, there is currently significant risk that they will be fractured through the reform process.

The features and leanings of PCP in Victoria are therefore fundamental to the successful implementation of MLO within Victoria. There is a risk that the achievements to date for the Victorian community will be lost if the structures already in place are not incorporated in the transition to MLO.

4.1.3 Providing support to clinicians and service providers to improve patient care

The VHA has successfully implemented its clinical governance in community health project over a four-year period. This collaborative project successfully led to the increased profile, uptake and quality of clinical governance across Victoria's 100 community health centres. The key feature of this project was that it was sector-led but centrally supported. Using such approaches, MLO have the ability to support the diffusion of best practice across the primary healthcare system. The structures required for such projects include sector engagement mechanisms, project support funding and methodologies that enable projects being sector-led with collaboration and coordination of outcomes.

4.1.4 Facilitation of the implementation and successful performance of primary health care initiatives and programs

The ability of MLO to drive change within the primary healthcare system is dependent on the system-wide levers that are managed by government and the ability of MLO to work in partnership with the primary healthcare sector.



The PCP's in Victoria have supported changes in practice through collaborative approaches, based on trust and shared goals driven by state government priorities. There is a need for bottom-up change initiatives and drive by individual MLO and services providers and top-down approaches through system-wide policy initiatives driven by government. Individually, MLO will have very little ability to initiate and maintain change, unless there is a financial or policy benefit for agencies to participate.

4.1.5 Be efficient and accountable with strong governance and effective management

An accountability framework must be introduced that clearly establishes MLO 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)

4.2. Are there other roles and functions MLO could potentially adopt?

Prior to MLO taking on any additional roles and functions, it is important that those roles already identified need to be established and functioning effectively. Identification of additional roles should occur in consultation with state and local government to fill gaps across the health system without duplicating existing roles and functions. This may also require analysis of differing contexts across Australia.

4.3. What challenges will there be for MLO in performing the proposed roles and functions?

There will be a range of challenges for MLO in performing their proposed role and functions.

4.3.1 Priority Setting

A key challenge for MLO will be deciding their priorities. MLO goals are currently stated without any indication of the priority of these goals or the potential for them to be achieved based on the evolution of MLO. Consequently, the VHA believes the Commonwealth must define the short, medium and long-term goals of MLO. This will ensure the right stakeholders are engaged at the right time with an understanding that goals will evolve as relationships across and between sectors are established.

4.3.2 Building on Existing Structures

A key outcome required of the MLO policy is the integration of primary healthcare services with acute and sub acute health services, with the aim of creating a continuum of care that benefits consumers while creating system efficiencies. One issue the VHA believes needs highlighting is the number of community health services in Victoria that are integrated with a public health service or hospital. This approach should be maintained, where suitable, and is particularly important in rural areas to facilitate the best use of scarce resources and expertise. To be successful MLO must build on this and other existing service delivery structures that are in place across the system.



MLO will require clear discussions with all local stakeholders including service providers, PCPs, Divisions of General Practice, local and state government to ensure that service system strengths are maintained. This will require a degree of local customisation to implementation and in some instances bilateral approaches. Failure to implement such an approach will lead to significant challenges for MLO in implementing their roles and functions and in achieving their stated goals.

Partnership and collaboration will be fundamental to the success of MLO and a failure to fully support local contexts will lead to unnecessary competition, which will undermine collaboration.

4.3.3. Conflict of Interest – Service Provision

The significant conflicts of interest that exist where MLO is planner, funder and service provider will pose significant challenges. The ability to engender collaboration across the primary healthcare sector will be limited in such a context.

Being a service provider has the potential to undermine trust and reduce cooperation between MLO and external agencies and may result in destructive competition between agencies in a particular region. The VHA believes there needs to be a separation between the purchaser and provider roles. The VHA believes that responsibility for delivering programs should remain with the service sector, rather than MLO, except where no service provider is available within a particular catchment.

There is a well-developed service delivery sector in Victoria. There is therefore no reason within the Victorian context for the development of new service providers through MLO. Such an approach is considered counter to the goals of MLO.

4.4. How should MLO and Local Hospital Networks work together?

The relationship between MLO and LHN will be critical for ensuring effective service coordination and pathways. Implementing such approaches will depend on the relationships developed at appropriate levels between the two organisations. The most appropriate solutions and working relationships will be developed through the establishment of working groups on specific issues.

A joint approach to population health planning should be undertaken between LHNs and MLO to support an integrated approach to planning across regions. This should involve the use of consistent planning frameworks and joint engagement of local communities.

5. What will Medicare Locals look like?

5.1 What other broad principles or characteristics are important in establishing governance arrangements for MLO?

The VHA recommends that MLO boards be skill-based. To establish MLO as independent organisations that deliver the functions outlined for MLO, the following overarching governance principles must be adhered to:



Table 1: Governance Principles

1	The Boards of MLO 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 MLO must be constituted as new boards, rather than adapted from any pre-existing board or other kind of formal collaboration
4	MLO 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 MLO, including those outside the health sector (B15, NHHN Agreement)
6	An accountability framework must be introduced that clearly establishes MLO 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)

5.2 What other types of internal governance structures are needed to support the Board and the operations of the Medicare Local?

To ensure that MLO can meet these accountability benchmarks, effective registration and monitoring processes must be established. The VHA believes the following must be incorporated into MLO governance structures:

Table 2: MLO Governance

1	Established as independent legal entities with strong links to communities and service providers. The legal structures that enable the corporate identity of MLO 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 MLO may be diminished. The VHA therefore supports corporate enablement through an amended Health Act 1997 (B15, NHHN Agreement)
2	Boards of between six and nine 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 MLO with a selection panel comprising external stakeholders



6	Boards should not include nominated stakeholder representative positions (other than LHNs)
7	One place on each MLO board should be reserved for a representative from LHNs in the region (B18, NHHN Agreement)
8	Where clinical expertise is included on Boards it must 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

5.3. What formal linkages are required between Local Hospital Networks and MLO to ensure good coordination of services to the community?

The VHA applauds the COAG agreement to introduce a devolved governance model for LHNs nationwide. Within such a framework, local service delivery models and solutions remain in place to strengthen the health system. The Victorian example of local Boards of Governance facilitates innovative models of health service delivery to communities of interest and community-based decision making. This decentralised governance model of health service delivery benefits local communities, particularly rural communities where it enables the continued vibrancy of small, local health services.

The VHA supports the LHN model that will be implemented in Victoria and is confident that this model is suitable for the Victorian health system structure to meet the needs of best practice governance. Under this model, the Victorian Government will remain the public hospital system manager and the single purchaser of public hospital services in Victoria. Each LHN will have a professional Governing Council/Board and Chief Executive Officer responsible for direct management of its hospital services. The VHA supports this model for the current Victorian service structure, including governance arrangements for small rural health services, where boards will continue to operate.

However, having designated positions on boards for LHNs is problematic because:

- Directors are supposed to come to their organisation to act in the best interests of that organisation with principal responsibilities of compliance and performance, and this ideally means having independence without constraint (not representing positions from outside the organisation).
- LHNs will have their own responsibilities that will likely 'straddle' sections of boundaries ultimately set for MLO.
- As such, geographical overlays potentially mean a number of 'consultative' engagements would be needed to maximise service efficiencies between the two organisational systems.

The linkage between the two separate legal entities should be formalised through a system of joint consultative sittings where memorandum of understanding principles are clearly determined with absolute transparency. This would ensure that MLO and LHNs have a rigorous platform to work from when engaging on matters of mutual interest.



5.4. Legal structure and internal governance - What is needed to ensure that the structures and governance arrangements for MLO are flexible enough to deal with future changes in the health care system, including potentially different roles and responsibilities in primary health care?

A shared understanding of the language and concepts implicit within the MLO strategy is vital to encourage shared purpose and goals across all stakeholders. Development of such an understanding will lead to integrated and collective action that can achieve real health improvements for populations.

The following issues must be addressed during the implementation of MLO:

Governance of MLO	
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 MLO 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	Development of a network of MLO 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 MLO
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)

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 MLO. 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.





5.5. Membership - Who should the members of MLO be?

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

Membership of MLO should include at a minimum:

- 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

5.6 How should membership be structured to ensure MLO focus on the health needs of their local community?

In order to effectively undertake their role and functions the VHA believes MLO should have one class of organisation-based membership. Such a membership strategy aligns closely with the purpose, functions and roles of MLO. Organisational membership moves the organisation closer to a structure that focuses on the outcomes of health services and thus the health needs of local communities.

5.7 What rights should members have and should they be able to influence the governance or the activities of MLO?

If MLO are established as companies limited by guarantee the members should have those rights afforded under the Corporations Act.

5.8 Clinical governance - what aspects of clinical governance should MLO be responsible for?

The discussion paper demonstrates a level of confusion between governance responsibilities and clinical governance, resulting in further uncertainty regarding accountability structures for MLO.

As the VHA believes that MLO should not be service providers, their role in clinical governance should be building capacity of the service provider sector. This will require leadership around how service providers develop effective clinical governance systems within their organisation.

A clear understanding of the difference between governance and clinical governance needs to be established. The VHA would caution that confusion regarding these two issues is evident within the paper.



Enabling effective local clinical governance structures to be developed will require MLO to play a leadership role in the establishment of local clinical networks that appropriately engage the workforce across healthcare professionals.

Through its Clinical Governance in Community Health Project, the VHA has developed resources to be deployed locally to support local clinical governance systems. These resources were developed through centralised leadership groups that trailed resources and supported sector-led innovation. Such approaches should be supported through MLO, as this supports local responsibility and shared knowledge building.

5.9 What is required to ensure appropriate linkages between MLO' clinical governance and Local Lead Clinician Groups?

Effective engagement with all sectors must be established in the implementation of Local Lead Clinician Groups. There remains a degree of uncertainty about how these groups will be established and the purpose of the groups. Further details are required regarding the role and function of these groups before a detailed response can be provided.

6. How will MLO interact with patients and providers?

6.1. How can communities best be supported to fully participate in the activities of MLO?

Effective engagement with communities will be essential to ensuring MLO are able to fulfil their role and functions, especially their population health planning functions. Best practice approaches to engagement must be implemented. The VHA believes that such approaches must go beyond consumer representation on the board or a consumer representative committee to include comprehensive engagement processes throughout planning processes. These must particularly look to engage sub-populations that under-utilise primary healthcare services.

6.2. What can MLO do to facilitate stronger community participation in local primary health care service planning and delivery?

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 MLO to engage with a range of health and welfare services such as housing, homelessness, specialist services and local government, to coordinate access to a range of services that impact health. The role of MLO would be to promote collaboration between a broad range of health, welfare and community service organisations and build capacity to enable improved service coordination.

6.3 What kinds of information would be appropriate to provide in Healthy Communities Reports?

Effective reporting on a range of population health and local primary healthcare service access indicators needs to be included within Healthy Communities Reports. Healthy Communities Reports should include indicators regarding:

- Population health outcomes
- Population health behaviours in relation to key health risk factors



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- Access to primary healthcare services (although these should be carefully considered so as to not create perverse incentives within system performance)
- Health system integration and coordination

These indicators should be measured across whole and sub-populations. Effective measures of both health system outcomes should also be established.

As new information technology systems are established, new data should be incorporated into the reports.

7. Boundaries

The following principles should be applied to forming Medicare Local boundaries:

- Department of Health regional catchment and Local Government Area boundaries, with inherent flexibility for cross-border relationships, should be used
- Focus on communities of interest, that is boundaries must be set according to MLO ability to respond to local needs/priorities, logical geographic divisions and transit pathways
- Consideration of local networks of service providers and community-based organisations

Medicare Local boundaries must **not**:

- Act as a barrier or inhibitor to service coordination
- Focus only on population number, but also consider geography, population density and distribution, topography and natural population flow, such as transport routes that create communities of interest

The capacity for MLO to deliver to their stated function depends on the engagement of all key stakeholder groups. The VHA emphasises that local discussions between key partners around the appropriate geography for MLO is ongoing throughout Victoria. These discussions should be encouraged by DoHA. The VHA is aware that divergent views to proposed boundaries between key stakeholders remain. The VHA therefore cautions against making a final decision on boundaries until a consensus view with all key partners across Divisions of General Practice, community health, other primary healthcare providers and acute health services is achieved.

The VHA welcomes the significant work undertaken by Divisions of General Practice and key primary healthcare stakeholders in collaboratively seeking local agreements and solutions for MLO implementation. However, the VHA is concerned that some Divisions of General Practice are progressing the MLO model without support from key stakeholders in their local area. Such approaches may be disruptive to existing and future service arrangements and must be discouraged.

A key difficulty in determining effective boundaries for MLO will be managing the needs of a diverse range of stakeholders, and the range of functions that MLO have been tasked with undertaking.

Consequently, the VHA believes that the approach of 'local solutions for local areas' should be applied across the state. Boundaries applied without local agreement will not achieve the collaborative outcomes listed within the COAG Agreement. Where



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there are overlapping communities of interest, the VHA recommends the development of mechanisms that enable MLO to work cooperatively, rather than competitively.

The VHA recognises the logistical and geographical issues of cross-border areas, and believes that local factors affecting healthcare delivery must be recognised. It is imperative that these factors are managed locally, with support from all levels of government and service providers, rather than these state borders acting as a barrier to service integration. For example, these borders are currently an inhibitor to service integration in primary mental health.

The role of population health planner and service integrator necessitates interacting with the health system at differing levels. Therefore, the size of the community of interest or catchment for these activities varies. Resolving these two issues creates a barrier to the implementation of MLO boundaries and a clear strategy for overcoming this barrier is necessary. One of the key factors in the success of PCPs in Victoria is the ability to implement local solutions in the key areas of population health planning, integrated chronic disease management and service coordination. Therefore, decisions by government cannot be made until a local consensus is also in place.

The important role that Divisions of General Practice currently play in supporting General Practice throughout Victoria must be maintained within the new MLO structure. This is a concern within the primary healthcare sector. In the enthusiasm to achieve the many gains afforded to the primary healthcare system by the proposed reforms, the gains of the past 20 years must not be lost. It must be remembered that the General Practice workforce and their engagement is a key driver for achieving future change in the way in which services are provided to our communities.

8. Other Comments

The VHA believes effective mechanisms for engaging with key stakeholders should be incorporated into the establishment of MLO. As the state government will remain a key stakeholder within the health system, through its system management role, effective mechanisms for state governments to engage with MLO across a state will also be required. As the service delivery contact within Australia varies considerably, state-based discussion forums will also be beneficial. The VHA therefore believes state-based general practice organisations should be supported to become state-based MLO support agencies. This will retain the significant knowledge and expertise already held within these organisations and support independent and local discussions between MLO and state governments.

Please contact me on (03) 9094 7777 to clarify any information in this submission.

A handwritten signature in black ink, appearing to read 'Trevor Carr', is written over a horizontal line.

Trevor Carr
Chief Executive Officer