Ms Jennie Roe  
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Medicare Locals Branch  
Department of Health and Ageing  
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By email: pcprojectsCoord@health.gov.au

Dear Ms Roe

**Regionally Tailored Primary Health Care Initiatives through Medicare Locals Fund**

The AMA welcomes the opportunity to comment on the discussion paper “Regionally Tailored Primary Health Care Initiatives through Medicare Locals Fund”. This submission is directed at the following key areas:

a) Medicare Locals role  
b) Medicare Locals National Body  
c) Funding arrangements

**Background**

General practice is the central hub of Australia’s health care system. GPs provide over 120 million services a year caring for the preventive health, acute care, aged care, treatment and health management needs of patients.

The AMA supports health reforms that improve regional integration and increased investment in health infrastructure, and structural and financial improvements to the primary health care system. In order to drive improvements and greater integration in primary health care and to ensure that services are better tailored to meet the needs of local communities we support the key priority areas listed which are:

- improving access  
- better managing of chronic conditions;  
- increasing the focus on prevention; and  
- improving the quality, safety and accountability of primary health care services.

The AMA has acknowledged the scope for Medicare Locals to impact on primary health care services. This impact could be positive if Medicare Locals are effectively governed and managed with strong GP representation at all levels of the decision making process, actively engage in consultation with local health service providers, and do not seek to usurp the role of GPs. On the other hand there is potential for them to be another layer of health bureaucracy, draining scarce healthcare resources.
During the latter part of 2011 the AMA visited all but one of the first 19 Medicare Local districts announced by the Government and spoke extensively to GPs in each area. The overwhelming feedback was that GPs did not feel there had been adequate consultation about the design and implementation of Medicare Locals and as a result there was little understanding about the role of Medicare Locals and the services they will provide.

**Medicare Locals role**

The medical profession has profound reservations about the introduction of Medicare Locals, with the AMA Federal Council in May 2011 calling for the roll out of Medicare Locals to be deferred, pending a peer reviewed evaluation of the first tranche of 19 as announced by the Commonwealth.

This concern is a reflection of Government’s limited consultation on the purpose, formation and governance arrangements of Medicare Locals. It also reflects the reluctance of the Government to properly consider the failings in other countries, such as Britain, Scotland and initially New Zealand, of the very primary health care organisations on which Medicare Locals are modelled. There is also a lack of clarity about how Medicare Locals will interact with GPs, and how they will continue to support GPs who want practical programs that will support them in caring for their patients.

With support for the delivery of primary health care services being the central plank of the operations of Medicare Locals, the AMA supports a governance structure for Medicare Locals that ensures a significant presence of local GPs on the Boards and all key committees established by the Boards.

The AMA has concern about the potential for Medicare Locals to develop in ways that are inimical to good health provision. An example of such a development would include Medicare Locals evolving into powerful fund holding bodies purchasing GP services directly for a population group. Experience overseas has demonstrated the failings of such models with patient care being rationed, selective enrolment (cherry picking), substitution of services, interference in the doctor patient relationship and clinical decisions and restricted patient choice.

Despite the strategic objectives of Medicare Locals, as outlined in the discussion paper, there is a prevailing concern within the profession that Medicare Locals, rather than supporting GPs and other primary health care providers, will attempt an oversight or “watchdog” role over their performance (as suggested under heading 2.4 and 3.2 with references to “meeting quality standards” and “deliver safe, high quality services” and “improve the delivery safety and quality of health services”).

The AMA believes this type of role is inappropriate considering most general practices are already subject to voluntary accreditation processes and General Practitioners are also subject to the registration requirements of the Medical Board of Australia. In addition

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they must meet the education standards required by the Royal Australian College of General Practitioners (RACGP) and/or the Australian College of Rural and Remote Medicine (ACRRM) to practise as Specialist General Practitioners. Medical practitioners also have the AMA Code of Ethics and Medical Board of Australia codes to guide them in what is expected of them in caring for their patients and the community.

The AMA would reject any move by Medicare Locals to require the implementation of processes or measures that would interfere with a GP’s autonomy, clinical discretion, and service delivery.

The AMA believes the core role of Medicare Locals must be to support GPs in providing comprehensive, quality care to patients and that this should form the first of the key roles as listed under 2.4 in the discussion paper.

**Medicare Locals National Body**

The AMA opposes the creation of the Medicare Locals National Body because it redirects funding away from frontline service provision and creates an additional and unnecessary administrative layer. The Department of Health and Ageing (DoHA) should be well equipped to convey Commonwealth priorities to Medicare Locals and to ensure that Medicare Locals deliver on their contracted obligations under funding agreements.

Medicare Locals are independent entities and they will be much bigger than the divisions of general practice they are replacing. They should be capable of working with other Medicare Locals, and engaging with the Government. There is no need for a third party to negotiate on their behalf or develop top down policy proposals.

The AMA is concerned that the Medicare Locals National Body will seek to generate national policy and program solutions for primary health care and that the DoHA will become overly reliant on this process, as opposed to working with independent key stakeholders, including peak representative bodies such as the AMA. We have already seen evidence of the Government relying heavily on the non-representative advice of the Australian General Practice Network (AGPN) in developing and progressing its Medicare Locals policy.

It is the AMA view that, if the Government wishes to continue to pursue the formation of a Medicare Locals National Body, it should be subject to a sunset clause. Once the establishment period has been completed there should be no need for any national body. Each Medicare Local should be able to stand on their own merit and the Department of Health and Ageing should be responsible for ensuring that Medicare Locals are performing as expected, and where necessary take corrective action.
Funding arrangements

Establishment of flexible funds

The AMA recognises that the Government’s decision to consolidate the existing 159 health and ageing programs into 18 larger flexible funds will potentially reduce the administrative costs involved in running the different programs. Any savings derived from this consolidation process must be ploughed back into service delivery to ensure that the benefit to the community is maximised.

The AMA also recognises the funding flexibility that the consolidation of programs into the Regionally Tailored Primary Health Care Initiatives through Medicare Locals Fund is intended to create and that this may result in greater innovation and the potential for more effective direction of funding. However, this will be dependent on having appropriate guidelines in place to govern these processes and ensuring meaningful engagement with clinicians at the local level.

Funding terminology

The terminology used to describe Medicare Locals funding, namely ‘core’ and ‘non-core’ is inappropriate. Funding identified as ‘non-core’ (ie in this case as support for services for patients) suggests it is not central to the purpose of Medicare Locals and thus subject to removal. Better terminology is required to describe what is essentially funding for administrative and operation costs versus funding for primary health care initiatives and services that support patient care.

The following additional comments are made re ‘core’ and ‘non-core’ funding, using the terminology of the discussion paper for the purpose of clarity only.

‘Core’ funding

The discussion paper states the purpose of ‘core’ funding is to meet the establishment and ongoing operational costs of Medicare Locals. However, it fails to provide information on how much of, or what percentage of, the available $1.5 billion (over the next four years) in the fund will be utilised for ‘core’ funding. The AMA wants clarity around the level of funding that will be directed to setting up and running the Medicare Locals. This amount needs to be made public to ensure transparency and make clear what the cost of Medical Local set up and operations should be.

Clarification as to how funding will be allocated to each of the Medicare Locals is required. The guidelines for the operation of the fund need to include information about which factors, and the weightings given to each, that will be taken into account when allocating funds. Factors for consideration might include:

- Population size
- Breadth of jurisdiction
- Population demographics, including socio-economic information
- GP workforce and that of allied health providers
In addition, information is required about what control measures will be imbedded in this process to ensure funds are allocated fairly based on population needs.

The AMA does not support any allocation of ‘core’ funding for the establishment and ongoing operation of the Medicare Locals National Body. Any funding utilised for this purpose is funding that could be better spent identifying gaps in services and supporting local GPs and allied health providers in delivering the services the community needs.

‘Non-core’ funding

The ‘non-core’ funding is identified as being for the delivery of a range of primary health care initiatives and services. The discussion paper also highlights that the ‘non-core’ funding may be paid to other organisations to support and assist Medicare Locals in meeting their strategic directions. Clarification is needed as to the types of organisations and for what purposes this ‘non-core’ funding might be provided.

The AMA appreciates the flexible nature of the fund but seeks reassurance and accountability as to how the funding will be used.

The AMA’s firm view is that ‘non-core’ funding should only be used for the delivery of primary health care initiatives, identified in consultation with key stakeholders as being health care priorities for the community, that support GPs to care for their patients in collaboration with other primary health care providers when clinically necessary.

To protect against funds being used for political expediency, for example, there must be clear parameters met when determining the funding allocation. Parameters for consideration might include whether the initiative, program or support service

- will meet an identified need
- is ranked a priority by the majority of GPs and other primary health care providers
- will produce beneficial and sustainable outcomes
- has a body of evidence to support the measure.

The discussion paper talks about operational efficiency and the AMA has no objection to Medicare Locals being required to operate efficiently, or to maximise available funds to support services. Any strategies for meeting these objectives should properly consider the impact on locally established health care services. Medicare Locals must not seek to achieve short term efficiency gains where these may compromise the long term sustainability of successful local primary health care services. For example, the AMA is deeply concerned that unless Medicare Locals continue to support GPs in providing after hours services the viability of those services will be threatened and may cease operation.

We welcome that flexible funding will allow the redirection of savings or under-expenditures from operational or ‘core’ funding to program or ‘non-core’ funding, but
stress that this must go towards supporting services for patients as identified are required by local GPs.

The AMA does not support the reverse of the above, that is, the application of program or ‘non-core’ funding in 2011-12 to 2012-13, in addition to operational or ‘core’ funding expenditure being directed towards Medicare Local infrastructure activities that are in reality costs related to the establishment and operation of Medicare Locals.

The AMA is pleased that the Government has indicated additional or supplementary funding may be available where there is a demonstrated need. The devastation of fires, floods and storms in recent years certainly produced situations where allocated funding was unable to meet the exceptional need. Delays in obtaining additional funding, however, is devastating for those in need, and the AMA would like clarification of the processes that will be in place to request additional funding and to respond to such requests in a timely manner.

Fund priorities

The AMA does not support the use of funds for purposes that are already addressed by other mechanisms such as accreditation and professional registration. Nevertheless, the AMA is supportive of Medicare Locals’ obligation to ensure that when contracting with allied health care providers those providers are adequately trained and qualified to deliver the service. The AMA is also supportive of Medicare Local programs that support primary health care sector providers to implement best practice processes and procedures.

Guidelines

The guidelines for the Regionally Tailored Primary Health Care Initiatives through Medicare Locals Fund must provide clear direction as to how funds are to be allocated and the criteria for assessing the need, support for and appropriateness of funding allocations.

Yours sincerely

Dr Steve Hambleton
President