



## **Notes on the design of Medicare Locals**

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**Questions to ask about the design of Medicare Local in the local context**

<b>Structure</b>		<b>Process</b>		<b>Outcomes</b>
Medicare Local	Managerial coordination between agencies	Medicare Local	Managerial and operational	
<p>What kind of integration structure is it – a coordinating unit, lead agency, single organization?</p> <p>Will governance arrangements be likely to support effective integration?</p>	<p>What structure(s) link Commonwealth funded and State funded primary health care agencies, and Local Hospital Networks to each other?</p> <p>Is the structure(s) sufficiently formal to generate appropriate stability?</p> <p>Which primary health care sectors and services are included and which are not?</p> <p>Does the range of sectors and services reflect the needs of communities, clients and patients?</p>	<p>What techniques of coordination will Medicare Local have available to it (bureaucratic authority, market purchasing, network management)?</p> <p>What combination of functions will Medicare Local have?</p> <p>What issues will the combination of functions raise for agency cooperation and system integration?</p>	<p>What actions are likely to be required of agency management to support integration?</p> <p>What management systems will be required of agencies to support integration?</p> <p>How will appropriate multidisciplinary teams be formed and managed within and between agencies?</p> <p>Do the new arrangements imply changes to existing practices?</p>	<p>Is it likely that medical and other clinical needs of individuals can be met in the combinations required by clients and patients?</p> <p>Is it likely that social health needs of individuals can be met either alone or in combination with medical and clinical needs?</p> <p>Is it likely that the needs of disadvantaged populations can be met, for example in terms of availability, access, and appropriateness of services?</p> <p>Is it likely that the range of needs within the specific catchment population will be met?</p>

In the 2010-2011 budget the Commonwealth Government committed to establishing Medicare Locals, structures that were previously called Primary Health Care Organisations (PHCOs).

*The Australian Government, through the National Health and Hospitals Network, will provide funding to establish a network of Medicare Locals. Medicare Locals will be independent legal entities, with strong links to local communities, health professionals, service providers and non-government organisations. Medicare Locals will promote regional integration, one of the key building blocks in the National Primary Health Care Strategy.*

*Medicare Locals will make it easier for patients to navigate their way through the health system. They will improve the planning and coordination of services at the local level, support the delivery of a range of primary health care initiatives, including addressing service gaps and inequities, and improve collaboration between practitioners and service providers across the health system. Medicare Locals will also improve patients' access to after-hours primary care services (as described below under Access to After-Hours Primary Care) (Australian Government 2010).*

Medicare Locals will 'promote regional integration'. For this purpose their major functions will be planning, coordination of services, and facilitation of collaboration between practitioners (for example, multidisciplinary teams) and service providers (for example, collaboration between agencies). The functions that will be used to support service delivery, provide after hours primary medical care, and fill gaps are unclear, but may include fund holding.

The definition of primary health care is a key issue when operationalising the mandate for Medicare Locals. The national health reform agenda setting documents that provide a definition of primary health care all refer to the World Health Organization (WHO) definition derived from the Declaration of Alma Ata (World Health Organization and United Nations Children's Fund 1978) or the World Health Report on primary health care (WHO 2008). The Department of Human Services (2009) adapted the Declaration of Alma Ata definition of primary health care to the contemporary Victorian context to read:

*Primary health care is integral to the Victorian health system. Community-based, it seeks to protect, promote and develop the health of defined communities; and by addressing and managing individual and population health problems at an early stage reduces the need for more complex care. At the other end of the health care continuum, primary health care services can support rehabilitation and care at home.*

*Primary health care in Victoria should be provided by a range of suitably trained health practitioners, working collaboratively and in partnership with other sectors, to provide timely, appropriate, integrated and person-centred services and population health actions.*

*Primary health care services give priority to those most in need and address health inequalities; maximise community and individual self-reliance, participation and control, and use appropriate technologies. Primary health care in Victoria is underpinned by an understanding of the social, economic,*

*cultural and political determinants of health* (Department of Human Services 2009a:16).

Ovrevit (1993) argues that health system design should begin with the community's needs which define the services required, which in turn determine the details of how the system is organised. This process is implicit in the mandate for Medicare Locals. When trying to assess the likelihood of Medicare Local organisational arrangements achieving the desired outcomes Donabedian's quality framework is useful. Donabedian's framework (usually summarised as structure + process = outcomes) has been used as an evaluation framework for integration structures (Browne et al 2007).

In the table below a set of key questions about the potential organization of Medicare Locals are arranged under the headings of structure, process and outcome. After that is a brief discussion of some major bodies of theoretical and empirical work that lies behind the major questions. Because integration structures in health systems are working in complex contexts there are no formulae that guarantee success. Rather, success depends on how effectively the elements of the system and its relationship to its environment are assembled. The questions are intended to facilitate discussion between stakeholders at the local level. Additional key questions about the design of Medicare Locals may arise from local level discussion – reflecting the issue of 'fit' with environment.

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<p>What kind of integration structure is it – a coordinating unit, lead agency, single organization?</p> <p>Will governance arrangements be likely to support effective integration?</p>	<p>What structure(s) link Commonwealth funded and State funded primary health care agencies, and Local Hospital Networks to each other?</p> <p>Is the structure(s) sufficiently formal to generate appropriate stability?</p> <p>Which primary health care sectors and services are included and which are not?</p> <p>Does the range of sectors and services reflect the needs of communities, clients and patients?</p>	<p>What techniques of coordination will Medicare Local have available to it (bureaucratic authority, market purchasing, network management)?</p> <p>What combination of functions will Medicare Local have?</p> <p>What issues will the combination of functions raise for agency cooperation and system integration?</p>	<p>What actions are likely to be required of agency management to support integration?</p> <p>What management systems will be required of agencies to support integration?</p> <p>How will appropriate multidisciplinary teams be formed and managed within and between agencies?</p> <p>Do the new arrangements imply changes to existing practices?</p>	<p>Is it likely that medical and other clinical needs of individuals can be met in the combinations required by clients and patients?</p> <p>Is it likely that social health needs of individuals can be met either alone or in combination with medical and clinical needs?</p> <p>Is it likely that the needs of disadvantaged populations can be met, for example in terms of availability, access, and appropriateness of services?</p> <p>Is it likely that the range of needs within the specific catchment population will be met?</p>

Complex service systems such as health are considered to have multiple layers (or levels) that are described by Alexander (1995) as micro, meso and macro levels. In the Australian health system reform process integration at the micro level can be thought of as the packaging of services for a client or patient using, for example, multidisciplinary teams and care coordination arrangements (for example, Powell Davies et al 2008). Integration at the meso level requires creation and maintenance of the structures that connect diverse health and social care agencies and create the capacity to integrate care at the micro level (for example Browne et al 2007; Jackson et al 2008). Structures such as Primary Care Partnerships, Divisions of General Practice and the new Medicare Locals are meso level structures. At the macro level integration is found in the policies and programs that facilitate linkages in the health system creating their impacts through action at the meso and micro levels. Decisions by governments, published in the Council of Australian Governments (COAG) agreement and the Commonwealth budget, have established a macro level policy context for reform and system integration at the meso level. Medicare Locals, it was stated, '*will promote regional integration*' in primary health care (Australian Government 2010).

Armitage et al (2009) completed a systematic literature review of system integration in the health science and business literatures. They found diverse conceptualizations of what integration is and models for achieving it. There is no single model that will ensure system integration in primary health care (Ovretveit 1993; Alexander 1995; Jackson 2006). However, there are lists of qualities frequently associated with more effective structures (for example, Armitage et al 2009; Leutz 1999; Mitchell & Shortell 2000). The issue is deciding which qualities are going to be effective for any given structure operating in its particular context. The systematic literature review of comprehensive primary healthcare models, undertaken by Jackson et al (2006), found no systematic reviews of the effectiveness of the models discussed. Nevertheless, the design of the structures for integration have a major impact on what people in the system do (Galbraith 1995) and the relationships between organizations making up the system. Given that there are no reliable formulae for the design of these structures design decisions are based on informed judgment. Informed judgment is typically derived from the analysis of many case studies of integration structures in health often using extensive literature reviews (for example, Ovretveit 1993; Mitchell and Shortell 2000) and other sectors (for example Alexander 1995), and analysis of local contexts.

Structures to achieve integration goals need to be designed to 'fit' the context in which they are to pursue their goals (Alexander 1995:325). Mitchell & Shortell (2000) describe this as alignment. The context is in part created by policy but it is far more than that. The context is also made up by the organizations that exist and their mandates, policies in non-health sectors, existing institutional arrangements, history of organizational relationships, infrastructure, and resources, for example. The contexts in which Medicare Locals need to achieve their goals differ between states and territories (McDonald et al 2006), between rural and metropolitan areas and potentially between localities within metropolitan areas. The existing Victorian capacity and history is likely to provide a supportive context for the development of Medicare Locals.

There are still many decisions to be made about the emerging primary health care system. However, some key questions can be asked about the structures and process that will have a big influence on the outcomes achieved.

## **Structure**

### Medicare Local

*What kind of integration structure is it – a coordinating unit, lead agency, single organization?*

Alexander reports an analysis of a large number structures used to coordinate activity between organizations in the health and other sectors. He identified three ideal types of structures. Ideal types are mutually exclusive categories with distinct characteristics. Within each ideal type there can be a lot of variation but all examples show at least some of the characteristics. Alexander (1995) identified three ideal types of coordinating structures– coordinating units, lead organizations and single organizations.

*A coordinating unit* is an organization or organizational unit that exists to coordinate decisions and action and thus create and maintain a connected system (Alexander 1995:153). It has its own identity, budget and staff and has substantial independence in relation to the organizations participating in the system. It may exist as a defined unit within a larger organization (which could be a Medicare Local) or it may stand alone. If it is embedded in a larger organization it must have the influence to dissuade the larger organization from actions that make coordination efforts ineffective. A coordinating unit does not offer services and does not compete with members of the connected system it coordinates. Its ‘moral authority’ lies in it being an independent broker working for the benefit of the agencies it coordinates. Its power lies in having delegated authority and the capacity for influence in the chain through which funds flow.

*A lead organization* is one that, ‘in addition to its line functions, is responsible for coordinating the activities of all the other organisations’ (Alexander 1995:177). Coordination of the other organisations may be marginal to the lead organization’s main functional tasks. Maintenance of commitment and thence effectiveness can be a problem as the lead organization changes internally, the external coordination task changes, or a conflict develops between the interests of the lead organization and the coordination role. The difference between a lead organization and an embedded coordinating unit is the autonomy and influence of the structure responsible for coordination functions. In the framework agreed at COAG it is possible that Medicare Locals could be established to function as lead organizations.

*A single organization* coordination system occurs when most important functions are incorporated into one organisation. They are common outcomes of restructures of large organizations or of mergers. If Medicare Locals were designed as single organizations they would be very large bureaucracies. These types of coordination structures typically require a greater investment of political and material resources than the other coordination structures (Alexander 1995:194).

*Will governance arrangements be likely to support effective integration?*

The key questions are, will the governance arrangements be adequate to support external alignment of Medicare Locals with, for example, Local Hospital Networks and state primary health care services, and will it have the knowledge and skills to oversight a competent integration agency that achieves the outcomes in its mandate. Integration has 'costs' for agency managers and professionals that include additional tasks, and the acquisition of skills, knowledge and perspectives (Leutz 1999). The integration agency has to find ways of making the benefits exceed the costs if significant change is to be achieved for service system users.

### Managerial level coordination between agencies

*What structure(s) link Commonwealth funded and State funded primary health care agencies, and Local Hospital Networks to each other?*

Managers of organizations participating in an integrated system have the capacity to facilitate or inhibit integration. Reliance on informal relationships between agency managers is likely to be less effective than the use of formal structures with a mandate, 'rules of engagement', and appropriate membership, for example (Alexander 1995:322).

*Which sectors and services are included and which are not?*

Although the World Health Organization concept of primary health care was used in almost all the major documents prepared in the agenda setting phase of the reform process, the ways these were operationalised differed significantly. The COAG agreement states that Medicare Locals (previously PHCOs) will establish linkages with Local Health Networks and with relevant State funded services and that States will not support coordination structures that are additional to Medicare Locals. When the definition of whose needs and what needs require integration is narrowly defined the question of what happens to other needs and other people immediately arises (Leutz 199:84). Integration for some people can mean exclusion from services for others if integrations is defined narrowly. From a health systems perspective, if the varying health and social care needs of populations and individuals are to be addressed, different levels of integration are required (Mitchell & Shortell 2000). Leutz (1999) discusses three levels of integration: linkage, coordination and full integration.

The most basic level is 'linkage' which provides appropriate care for people with 'mild to moderate or new disabilities' in systems that serve whole populations. For example, when non-health professionals identify simple problems they know who to contact, when health professionals identify more serious issues they have effective referral systems available (Leutz 1999). The second level of integration is 'coordination' in which case managers work to coordinate care across acute and other systems to meet a client's bundle of needs. The third level is described as 'full integration' in which funds from multiple systems are pooled to create new services that meet complex individual needs better. Commissioning is an example of 'full integration' (Leutz 1999).

### **Process**

### Medicare Local

*What techniques of coordination will Medicare Local have available to it (bureaucratic authority, market purchasing, network management)?*

If people are to receive the care required to meet their needs there are likely to be many agencies and other support people required at different times. Acute and primary health care agencies, carers and clients all contribute in some way to the identification of needs, planning and organization of services, and their activities need to be coordinated (Ovretveit 1993:39; Leutz 1999)). It is beyond the capacity of any single agency to meet all needs in a complex system. Within the field of organizational studies problems like this can be analysed using the concept of organizational forms and the mechanisms they use for coordination (Powell 1990).

Single organizations of any size are typically established as formal organisations structured as bureaucracies. The characteristic methods used to facilitate people employed within the organization working in a coordinated way are setting work rules and exercising managerial authority. If people employed by different agencies are to coordinate activities their managers need to establish joint policies and protocols for this purpose. To achieve this a bureaucracy might, for example, establish a committee to advise on appropriate policies and protocols or develop them internally and consult on their feasibility. Critics of bureaucracy argue that *'services based on these principles are inflexible, slow, unresponsive to client need and not able to adapt to a fast-changing environment'* (Ovretveit 1003:41). These sorts of problems result in the use of other organizational forms, namely markets and networks, to maintain the benefits of bureaucratic organization but also to deal with its weaknesses.

Markets are exchange mechanisms between people and organization coordinated through price. The exchanges are controlled through contracts that specify what each will provide and receive, and the rules governing the relationship (Ovretveit 1993:42). Sometimes the exchanges and the rules are set in advance and at others competition is used to establish value. In mixed economies formal organisations (bureaucracies) operate successfully in the context of markets. Problems arise for system integration when competition is used inappropriately and it inhibits agencies sharing information and cooperating with each other for fear of being disadvantaged in the next competition. If Medicare Locals have purchasing or commissioning functions they will need to use market mechanisms with care to avoid discouraging cooperation between agencies that is necessary for system integration.

Networks are the third form of organization. Relationships are governed by *'trust, respect and shared values'* (Ovretveit 1993:43) that develop from repeated interactions over a period of time. Trust respect and shared values are the foundation of network coordination. Networks always co-exist with bureaucracy and market but are often informal and are not used to create the outcome of system integration. A network approach to system integration might involve establishing a structure (often called a partnership (Lasker et al 2001) or a network structure (Mandell 2000)) in which agency interdependencies are clear and their interactions achieve synergy (Lasker et al 2001). The process of managing these networks requires particular skills that differ in many respects from traditional bureaucratic practice (Isabella 2002; Lasker et al 2001). Medicare Locals may establish formal networks of agency managers (and perhaps practitioners in some instances) for the negotiation of the arrangements by which service provider bureaucracies are able to coordinate service

provision to communities and individuals at the levels of linkage and coordination described by Leutz (1999).

It is common for all three mechanisms of coordination to co-exist. It is also common for members of systems to be more skilled in the use of one mechanism of coordination than the others. When this happens they may accidentally fracture the relationships that are the foundation of an integrated system (for example, Larson 1992).

*What combination of functions will Medicare Local have?*

Policymakers often use a framework consisting of the following tasks: planning, coordination, purchasing, provision of services, and governance, to think about system structure and management.

*Planning.* Medicare Locals will strengthen the identification of needs and service planning in their region. These responsibilities will require population level planning as well as institution level planning.

*Purchasing.* Health purchasing is a specialized field of activity, typical of market forms of organization, and requires particular knowledge and skills. It can be used to shape the field of services provided and to enhance coordination between the purchaser and provider. Purchasing should be underpinned by population level planning. If regional level purchasing is introduced it makes sense for planning and purchasing to be undertaken by the same structure. However, putting coordination and purchasing together creates many risks for organizations that reduce their trust and willingness to cooperate and thence the capacity to create effective system connections. Purchasing arrangements would need to be thought through carefully to avoid making coordination between provider agencies ineffective.

*Providing.* Provision of services is frequently separated from purchasing of services. The purchaser has a stewardship role for population health and purchasing is based on the needs of the population. Provision of individual level services is based on the needs of individuals requiring care, and the provider's institutional mandate and interests. If an agency purchases services from itself and from other agencies a perceived conflict of interest in the purchasing process undermines trust and reduces cooperation between the purchaser and external agencies.

*Coordinating.* The mandate of Medicare Locals is to link service provision across their local area to establish an integrated system. This appears to be core business for Medicare Locals. There are a number of approaches to coordination each of which achieves different outcomes for individuals and populations or communities. Some approaches will provide integration that meets some needs and not others, or meets the needs of some people and not others. How they are used will need careful thought to avoid weakening the effectiveness of Medicare Locals system integration function.

## **Conclusion**

There are no formulae for the development of effective structures like Medicare Locals. Nor is the transportation of a model successful in another context likely to be successful without adaptation to a new context. Proposals can be evaluated to

ascertain their likelihood of success in local contexts. There is some evidence that can be used in the evaluation process, but wise judgement (the art of system design that needs to accompany the science) is also important. Judgement is especially important in relation to alignment with the environment and alignment with outcomes. In the design of organizations it is important that form follow function, and that processes are designed to achieve the desired outcomes. The appropriate approach to designing Medicare Locals is: clarify the outcomes to be achieved, how they might be achieved, who will play which role, and what structures are needed to support the people, organizations and processes that will achieve the outcomes.

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# NATIONAL HEALTH AND HOSPITALS NETWORK AGREEMENT

Council of  
Australian  
Governments

An agreement between

- the Commonwealth of Australia and
- the States and Territories, being:
  - ◆ the State of New South Wales;
  - ◆ the State of Victoria;
  - ◆ the State of Queensland;
  - ◆ the State of South Australia;
  - ◆ the State of Tasmania;
  - ◆ the Australian Capital Territory; and
  - ◆ the Northern Territory of Australia.

The objective of this Agreement is to improve health outcomes for all Australians and the sustainability of the Australian health system.

This Agreement sets out the architecture and foundations of the National Health and Hospitals Network, which will deliver major structural reforms to establish the foundations of Australia's future health system.

## Primary health care and Primary Health Care Organisations

1. All governments agree that GP and primary health care services are integral to an effective and efficient Australian health system, meeting the health care needs of Australians in the community to keep people healthy and out of hospital.
2. The Commonwealth Government will take full funding and policy responsibility for Australia's GP and primary health care services outlined in Schedule B from 1 July 2011.
3. GP and primary health care will be defined for the purposes of this agreement as those services outlined in provision B10, subject to the other provisions of Schedule B.
4. To better deliver on these new Commonwealth responsibilities, alongside existing Commonwealth investment in GP and primary health care, States agree to transfer funding and policy responsibility to the Commonwealth for the GP and primary health care services outlined in Schedule B.
5. The Commonwealth and the States will work together on system-wide GP and primary health care policy, because it impacts on the efficient use of hospitals and other State funded services, and because of the need for effective integration across Commonwealth and State funded health care services.

Primary Health Care Organisations (PHCOs) will be created as independent organisations with strong links to local communities and health professionals. They will improve access to services and drive integration across GP and primary health care services by coordinating services and working closely with LHNs to identify and address local needs.

## SCHEDULE B – PRIMARY HEALTH CARE AND PRIMARY HEALTH CARE ORGANISATIONS

### Objectives

- B1. Locating responsibility for improving the GP and primary health care system with one level of government aims to:
  - a. improve the efficiency of the health system and reduce pressure on hospital services;
  - b. reduce cost-shifting and blame-shifting; and
  - c. make it easier for patients to receive the services they need, improving patient outcomes and driving diversity and innovation in service provision.
- B2. 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.

### Primary health care transfer

- B3. In order to improve services in the community, address gaps in access to GP and primary care services and take pressure off hospitals, the Commonwealth Government will take full funding

and policy responsibility for Australia's GP and primary health care services, as outlined in this Schedule, from 1 July 2011.

- B4. To better deliver on these new Commonwealth responsibilities, States agree to transfer funding and policy responsibility to the Commonwealth for the GP and primary health care services outlined in provision B10.
- B5. In addition, the Commonwealth will move over time to increase its funding contribution to up to 100 per cent of the national efficient price for GP and primary health care-equivalent outpatient services, as outlined in provision A29(e).
- B6. In formulating GP and primary health care policy, the Commonwealth recognises the need for ongoing engagement and collaboration with States. In particular:
- a. the Commonwealth and States will work together on system-wide GP and primary health care policy, because it impacts on the efficient delivery of hospital services and other State funded services, and because of the need for effective integration across Commonwealth and State funded health care services;
  - b. the Commonwealth will prepare a state-wide GP and primary health care plan to be agreed bilaterally; and
  - c. in relation to the services where funding and policy responsibility is transferred to the Commonwealth:
    - i. where coordination is required for reasons of service planning or service integration, the Commonwealth and the relevant State will work together to develop an agreed implementation plan; and
    - ii. the Commonwealth will develop a policy framework for these services in consultation with the States.
- B7. States will continue to ensure the operation of transferred GP and primary health care services as outlined in provision B10, and the Commonwealth will not substantially alter delivery mechanisms for these services, without agreement by the relevant state or territory, for 5 years from 1 July 2011.

### **Responsibilities of the States**

- B8. The States will be responsible for:
- a. the ongoing operation of services funded by the Commonwealth, unless the relevant State agrees with the Commonwealth to divest this responsibility;
  - b. negotiating and agreeing with the Commonwealth for the delivery of relevant GP and primary health care services, where the Commonwealth agrees to provide those services through LHNs; and
  - c. contributing to the development of a system-wide plan for the provision of transferred GP and primary health care services, in collaboration with the Commonwealth, for the delivery of GP and primary health care services within their jurisdictions, as outlined in provision B6.
- B9. States will have continuing policy and funding responsibility for the following services which have been agreed as excluded from transfer to the Commonwealth:
- a. ambulance services;
  - b. existing public dental services;
  - c. health care for prisoners;
  - d. school and workplace primary care programs;
  - e. hospital avoidance programs that relate more specifically to patients who are predominantly being treated in acute care; and
  - f. specialist sexually transmitted infection services and general sexual health services.

## **Responsibilities of the Commonwealth**

- B10. Subject to the other provisions of this Schedule, the Commonwealth will take full funding responsibility, and policy responsibility, for the following categories of GP and primary health care services currently funded by State governments, from 1 July 2011:
- a. community health centre (CHC) primary health care services, such as generalist counselling, integrated care, GP and primary care coordination programs, including Indigenous and rural and remote primary health care services;
  - b. primary mental health care services which target the more common mild to moderate mental illnesses;
  - c. hospital avoidance programs that do not relate specifically to patients who are predominantly being treated in acute care;
  - d. primary and secondary prevention programs for early intervention and care coordination that focus on the management of patients with chronic disease in the community;
  - e. screening programs for cancer delivered in a primary health care setting;
  - f. immunisation; and
  - g. any further services to be agreed between the Commonwealth and one or more of the States.
- B11. The Commonwealth will be responsible for:
- a. undertaking planning for the provision of transferred GP and primary health care services. This will involve working with States to develop a system-wide plan as outlined in provision B6(b);
  - b. maintaining funding levels and indexation for transferred GP and primary health care services, as agreed with the States, unless they choose to divest responsibility as outlined in provision B8(a);
  - c. coordinating service provision to ensure service integration and improve the continuity of patient care, as outlined in provision B6(c)(i). This will usually involve consulting with States, PHCOs and other key stakeholders including clinicians.

## **Primary Health Care Organisations**

- B12. The Commonwealth Government will work with States and primary care stakeholders to establish PHCOs across Australia, with the first to be operational by mid 2011.
- B13. PHCOs will be the GP and primary health care partners of LHNs, and are integral to delivering the National Health and Hospitals Network.
- B14. PHCOs will deliver better integrated and responsive local GP and primary health care services to meet the needs and priorities of patients and communities.

## **Primary Health Care Organisation structure and governance**

- B15. PHCOs will be independent legal entities (not government bodies) with strong links to local communities, health professionals and service providers, including GPs, allied health professionals and Aboriginal Medical Services.
- B16. The Commonwealth and PHCOs will agree a service contract, in consultation with the relevant state or territory, as well as other relevant stakeholders, including health professionals.
- B17. PHCOs will operate with strong local governance, including broad community and health professional representation, as well as business and management expertise. Strong clinical leadership will also be a key feature.

- B18. PHCOs and LHNs will be expected to have some common membership of governance structures where possible. PHCOs' service contracts will require PHCOs and LHNs to work closely together.
- B19. PHCOs will establish a formal engagement protocol with local LHNs.
- B20. PHCOs will be subject to the performance monitoring and reporting requirements of the Performance and Accountability Framework outlined in Schedule D, and the governance arrangements for that framework outlined in Schedule E.
- B21. The Commonwealth will establish performance management arrangements for PHCOs. The Commonwealth will ensure States have opportunities to contribute and access information on the outcomes of these arrangements.
- B22. The Commonwealth and State governments will work together to create linkages and coordination mechanisms between PHCOs and other State services that interact with the health system, e.g. children at risk, people with serious mental illness and homeless Australians.
- B23. State governments will not establish duplicate GP and primary health care organisations, and to the extent that they already exist they will become part of arrangements for PHCOs as coordinating entities for GP and primary health care services, once an implementation plan has been agreed between the Commonwealth and the relevant state or territory, as part of the transfer of responsibility for funding of primary care outlined in provision B4.
- B24. In establishing PHCOs, the Commonwealth will work cooperatively with States to ensure, wherever possible, common geographic boundaries with LHNs as outlined in provision A7.
- B25. The final number and boundaries of PHCOs will be primarily a matter for the Commonwealth to resolve. However:
  - a. as a transitional matter to establish the new system, the boundaries will be initially resolved bilaterally between First Ministers by 31 December 2010; and
  - b. beyond this date, the Commonwealth will continue to consult with the States on PHCO structures and boundaries as changes are made.

### **Responsibilities of Primary Health Care Organisations**

- B26. PHCOs will be responsible for a range of functions aimed at making it easier for patients to navigate the local health care system and to provide more integrated care. They will:
  - 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.

## Attachment 2. Australian Government, Budget 2010-2011 Department of Health and Aging, Primary Health Care, Medicare Locals. May 2010.

### *Establish a network of Medicare Locals*

In 2010-11, the Australian Government, through the *National Health and Hospitals Network*, will provide funding to establish a network of Medicare Locals. Medicare Locals will be independent legal entities, with strong links to local communities, health professionals, service providers and non-government organisations. Medicare Locals will promote regional integration, one of the key building blocks in the National Primary Health Care Strategy.

Medicare Locals will make it easier for patients to navigate their way through the health system. They will improve the planning and coordination of services at the local level, support the delivery of a range of primary health care initiatives, including addressing service gaps and inequities, and improve collaboration between practitioners and service providers across the health system. Medicare Locals will also improve patients' access to after-hours primary care services (as described below under Access to After-Hours Primary Care).

The first Medicare Locals are expected to commence operations in mid-2011. In many instances and where possible, Medicare Locals may be drawn from Divisions of General Practice with the capacity to take on the roles and functions expected of Medicare Locals.

Over the next few years, Medicare Locals will replace the current Divisions of General Practice Network. Commencing in 2010-11, transitional arrangements will be put in place to support the network during the health reforms, and to ensure a smooth transition for programs and services to be delivered through the new Medicare Locals.

### *Divisions of General Practice program*

Pending the transition to Medicare Locals, the Australian Government, through the Divisions of General Practice program will continue to provide core funding to the Divisions of General Practice Network. The program provides a platform for the delivery of primary health care programs, and supports general practice to respond to the needs of local communities through the delivery of targeted initiatives. Funding is provided to the network under contractual arrangements to support a range of programs, including the General Practice Immunisation Incentive, the Australian Better Health Initiative, Workforce Support for Rural General Practitioners, and COAG initiatives to address diabetes, mental health, and drug and alcohol use.