Submission to Medicare Locals (ML's) Review

The ML's role and their Stated Objectives:

The main role of Medicare Locals (ML's) was to expand the community coverage in primary care provision undertaken by their predecessors i.e. the Australian General Practice Network (AGPN), whose focus had been somewhat inward looking.

Sixty-one (61) ML's were created upon a national localised basis, whose operations were spread over three separate initial start-up times:-

- 1st third commenced – 1 July 2011
- 2nd third commenced – 31 December 2011
- 3rd third commenced – 1 July 2012

Each selection seems to have been based on priorities given to those AGPN divisions which were more advanced in a community engagement sense.

It is in this sense that one would naturally judge the progress achieved along these lines as to be expected, and should be compared according to those time frames.

However we consider their five Department of Health (DOH) contracted responsibilities to be appropriate to their aim to achieve a more beneficial primary health care service. The detail is left for them to develop, in accordance with local needs.

As was expected, there has been some resistance to the change by elements within the GP's but this seems, in the main, to be dissipating at the grass root level and a desirable level of team work is becoming apparent.

This is becoming increasingly so as much outstanding work by the leading ML's become more widely known about, amongst the community.

Medicare Locals Key Objectives (as per the DOH contract) **:-**

Objective 1. Improving the patient journey through developing integrated and coordinated services.

(Note: This will require partnerships with hospital and community based health providers and community organisations.)

Objective 2. Provide support to clinicians and service providers to improve patient care.

Objective 3. Identification of the health needs of local areas and development of locally focused and responsive services.

Objective 4. Facilitation of the implementation and successful performance of primary health care initiatives and programs.

Objective 5. Be efficient and accountable with strong governance and effective management.

Objective 1 is the key component in having primary care coordinated in a collaborative way not only within itself, but also with the public and private hospital systems and the community generally.

The task of this objective is to open out the existing silo style structure of the health system as a whole which has prevented the integrated delivery of health services and also led to much duplication across activities.

There has also been a need for improved patient care and attending to the increasingly excessive public and private cost of it by early intervention with preventative measures.

The truth of this assessment is amply demonstrated by such conclusions progressively being recognised, for example, within the advanced community consultation draft of the "**Strategic Framework for Integrated Care of the Older Person with Complex Health Needs**" recently issued by NSW Health's Agency for Clinical Innovation.

The key component of this study, which involves all levels of care and wellbeing, is the concept of integration of all services relevant to each patient.

A relevant point of this review is that the Medicare Locals are designed to play a vital role in resolving this key integration issue both within primary care and with the hospitals, patients, and other involved entities.

This fundamental element in achieving an integrated service became increasingly apparent to the ACI group working on this timely project.

This framework document is now open for community comment by mid February 2014; the framework is available for download at:

http://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0005/204377/ACI_draft_framework_for_integrated_care_of_the_older_person_with_complex_health_needs.pdf

Most of the other issues raised in the Review seem to be automatic requirements for any proficient health system or part thereof. We are not positioned to comment on their progress.

However it is suggested that the third term be reviewed:-

"*Recognising general practice as the cornerstone of primary care in the ML functions and governance structures*"

This is not considered to be appropriate. It is not a part of the ML contract with the Department of Health (as above), and I suggest it is not specifically proposed within the terms of this overriding provision:

"Improving the patient journey through developing integrated and coordinated services"

This will require partnerships within ML's with hospital and community based health providers and community organisations including consumers. This has been happening in a number of ML's.

The purpose of moving from the former AGPN structure to ML's was in fact to advance from the existing siloed situation so that all affected parties would be seated at the same table in a genuine partnership, and be able to concentrate on the long overdue policy of advancing the nationwide health reform program in a collaborative manner suited to their local situations.

It is appreciated that this is a complex issue along with many others.

I note the review extends to March next year.

I, in company with consumer interest associates, would appreciate the opportunity to discuss these within the review process at a mutually convenient time.

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