RURAL DOCTORS ASSOCIATION OF AUSTRALIA

Ms Kerry Flanagan
Acting Secretary
Department of Health
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Dear Ms Flanagan

Thank you for the opportunity to provide a submission to the review of Medicare Locals. I enclose a submission from the Rural Doctors Association of Australia (RDAA).

RDAA is a strong advocate for coordinated primary health care in the rural setting with the rural generalist practice at the centre of all primary care arrangements. However, efforts to build strong, coordinated primary health care services in rural and remote Australia are often impeded by a significant shortage of GPs and other health professionals.

RDAA has been concerned about the establishment of a national network of Medicare Locals. Many of our concerns have centred on the transition from organisations performing a more limited scope of roles as Divisions of General Practice to undertaking a myriad of complex, higher level roles as Medicare Locals. RDAA believes that Medicare Locals have been allocated a number of responsibilities that have been too challenging for this relatively early stage of their development. After hours services are a key example.

The potential scope of the work of Medicare Locals is both diverse and far-reaching. If all of these roles are undertaken efficiently, effectively and transparently for the benefit of all communities within the reach of a Medicare Local, there will be worthwhile outcomes for patients and appropriate support for GPs. If they are not, valuable health dollars could be wasted, the gap between the health of people living in rural and remote areas compared to people living in metropolitan areas could widen and the GP workforce – particularly in rural areas – could be disheartened and discouraged.

Medicare Locals in their current form are bureaucracies that consume significant amounts of health funding, much of which supports the functioning of offices, and the salaries of managers, project officers and support staff rather than service delivery. This expenditure on administrative costs is duplicated across 61 regions.

In many rural areas, Medicare Locals have yet to prove their worth or relevance to GPs. Many rural GPs report limited engagement and still do not understand the role and purpose of these organisations. Others report positive relationships and are optimistic about what they can achieve in partnership with their Medicare Local.

RDAA believes that there is some potential for Medicare Locals to be an active and positive component of delivery of primary care, but their work should always build on the strengths of existing primary health care services, particularly those provided through general practice. We also believe that Medicare Locals should never operate as fund-holders.

RDAA has some concerns about the short time frame for submissions to be lodged to this review and the constraint of a three-page submission, which perhaps gives the impression of a cursory review process. RDAA believes GPs and other health professionals should have been able to provide confidential feedback, perhaps through a national online survey, to obtain a better picture of what is happening on the ground within each Medicare Local catchment area.

If you require any further information, please do not hesitate to contact me on (02) 6239 7730.

Yours sincerely

Jenny Johnson
Chief Executive Office

RDAA SUBMISSION TO THE REVIEW OF MEDICARE LOCALS

INTRODUCTION

Medicare Locals were established in 2011 to work with GPs and other primary health care providers to ensure all Australians, regardless of where they live, can access effective primary health care services. Two years later it remains unclear to many rural doctors exactly how Medicare Locals will benefit their patients, their practices and their communities.

RDAA's submission to the review of Medicare Locals draws on the experiences of members who are practising at the coalface of rural medicine. Some are closely engaged with their Medicare Local and are optimistic about the benefits this type of organisation can deliver. However, others report that Medicare Locals have considerable work to do to gain the respect and support of rural GPs, and to demonstrate their relevance.

SUBMISSION

The extent to which Medicare Locals have recognised and supported general practice as the cornerstone of primary care in governance structure and service delivery

RDAA believes that governing Boards of Medicare Locals require strong leadership from GPs, including rural medical representation where the boundaries of Medicare Locals extend beyond metropolitan areas. While this has occurred in some regions, this has not been the case in others. Medicare Locals that do have GPs closely involved in its management structure tend to be Medicare Locals that have evolved from larger Divisions of General Practice.

Many rural GPs are still waiting to see how Medicare Locals will engage their practices, and what role they will play in population health, continuing professional development, preventative medicine, health workforce and clinical service delivery. One member reported that, in his area, there is "no support for GPs as the leader of the health team". Another member indicated that, "if the whole enterprise collapsed we wouldn't miss most of their services." This sentiment was echoed by a number of members.

A number of RDAA members are represented on the Boards of Medicare Locals and have been committed to working towards getting the best outcomes for their communities.

Some rural GPs report that programs have been developed within their region without adequate consultation, and that these programs tend to centre on servicing the needs of the largest regional centre, neglecting the needs of smaller rural communities. This illustrates one of the problems which many Medicare Locals face in meeting the needs of communities that are both geographically and demographically diverse.

Obviously it is early days for Medicare Locals, particularly for those Medicare Locals established under the third tranche of this program. So while the expectations of some GPs as to what Medicare Locals should be doing may be unrealistic at this stage, their feedback highlights the significant work some Medicare Locals need to do to build constructive relationships with general practice.

Many members have raised the issue of conflicts of interest in the governance structure of Medicare Locals and the potential risks associated with Medicare Locals being managed by a select few with self (or local) interests. There is a real potential for a conflict of interest where the Medicare Local is a fund holder and also becomes a service provider.

For example, many health professionals sitting on Medicare Local Boards will have a private practice, or be affiliated with a private practice that may wish to seek funding from Medicare Locals. Requiring the CEO or Board of a Medicare Local to make decisions about allocating funding to a Board member is less than ideal. Where funding is allocated to one practice over another practice in circumstances where someone who works at, or is affiliated with, the successful practice is a member of the Medicare Local Board, there will inevitably be a perception of bias. This will undermine the credibility of the Medicare Local and damage its relationship with local health professionals.

The work of Medicare Locals has the potential to have a significant impact on the ability of smaller rural communities to access primary and secondary health care. If funding decisions are made by Medicare Locals that affect the viability of rural practices in smaller rural communities, these communities stand to lose the principal providers of primary health care, afterhours services and hospital-based services.

There is significant variation between Medicare Locals in the range and quality of services that support general practice. Some members report that their Medicare Local has maintained worthwhile services and continuing professional development activities previously established and run by the Division of General Practice. However, in other areas these previously effective programs have stalled, and been replaced by a focus on E-health issues.

Ensuring Commonwealth funding supports clinical services, rather than administration

The expenditure of health dollars on Medicare Locals as duplicated bureaucracies that focus on administrative processes rather than service delivery is a major concern for RDAA and the same concern has been expressed to us by many of our members.

The transfer of responsibility for providing funding assistance for afterhours services to Medicare Locals has resulted in a previously transparent and centrally administrated process now being duplicated across 61 bureaucracies, with associated employment costs for project and administrative officers. Many practices feel that the new arrangements require them to deliver the same services for less money once the costs of managing the red tape associated with the new arrangements are taken into account. This includes hours of staff time to negotiate simple maintenance of a pre-existing outpatient and/or afterhours payment.

RDAA recommends that the previous arrangements where afterhours incentives were administered through the Practice Incentives Program be reinstated in order to address these issues. Funding could still be provided to Medicare Locals to identify and fill gaps in the availability of afterhours services.

To date, Medicare Locals have not necessarily been able to deliver cost-effective, integrated and more coordinated services, particularly in isolated rural settings.

There is a need to consider partnerships with State Health Departments and Local Hospital Networks. For example, a more effective model for primary health care co-ordination in smaller rural communities might be to employ 3 or 4 relatively junior staff from the regional hospital to provide these services, rather than have the Medicare Local fund expensive, FIFO services.

The reporting requirements for Medicare Locals, and for general practices receiving funding from Medicare Locals, is a drain on the resources of the practice and can act as a deterrent to ongoing GP participation. Some Medicare Locals run 30 to 40 individual programs, with each of these programs requiring a report on a departmental template every 3 to 6 months. This reporting burden must consume a significant percentage of their funding. A considerable amount of staff time must be spent completing these reports.

Tendering and contracting arrangements

For many RDAA members, the difficulties in tendering and contracting arrangements with Medicare Locals are illustrated by the negotiations around contracts for afterhours services.

For many rural practices, the dialogue about the new after hours funding arrangements was their first point of contact with Medicare Locals. Unfortunately, this process was marked by uncertainty, poor communication, and last minute and heavy-handed negotiations, all of which generated a significant amount of angst.

The initial after hours funding contracts were unnecessarily onerous. Following protests by a number of stakeholder organisations, these were subsequently withdrawn and revised. However, the new contract template only became available three weeks before the implementation of the new arrangements, and after practice staff had spent considerable time and money going through the initial contracts and seeking legal advice. This generated even more frustration.

A common complaint from members was that Medicare Local staff did not appear to understand the myriad of different service delivery models for effective afterhours care that have been developed over time to suit the needs of rural communities. Members also felt that Medicare Local staff did not appreciate or fully understand a practice's responsibility to balance meeting the afterhours health care needs of their communities with the need to provide a safe workplace, reasonable hours and adequate remuneration.

In some cases Medicare Locals did not recognise existing afterhours services as 'working well' on the basis that they did not adhere to a rigid interpretation of the guidelines for funding after hours arrangements (ie the service was not operated as a clinic that was open to anyone who walked in off the street). In some smaller rural communities, this service delivery model is not viable on a number of levels and poses a risk to doctors who may well end up working alone at night in the practice. While the majority of practices that previously received afterhours PIP payments eventually signed short term contracts with Medicare Locals, RDAA believes the real test of the new arrangements will come once these contracts expire and negotiations for longer term contracts commence.

Practical interaction with Local Hospital Networks

Rural GPs in many areas are still waiting to see how Medicare Local services will coordinate with the Local Hospital Networks.

To be effective, Medicare Locals and Local Hospital Networks need to share responsibility for health outcomes, particularly in rural areas where the same doctors often provide both primary and acute care. This is a challenge because different funding streams and a shrinking health budget encourage cost shifting rather than cooperation, and participation in a "blame game" which in turn creates gaps in services.

Conclusion

Medicare Locals are still very new organisations, with some only established 18 months ago. In view of this, it is not surprising that the performance of Medicare Locals is quite variable across the country. Some Medicare Locals arose from the amalgamation of a number of Divisions of General Practice, and experienced a difficult transition period.

The former Divisions of General Practice experienced some of the same challenges facing Medicare Locals. The performances of Divisions were also quite variable and the issues surrounding governance faced by Medicare Locals also applied to the Divisions.

It is unfortunate that the first interaction that many Medicare Locals had with rural GPs involved negotiating afterhours funding agreements. The transfer of responsibility for this funding to Medicare Locals was controversial, with many rural GPs perceiving that these payments could potentially be eroded over time. A transition process marked by clarity, stronger consultation and reasonable timeframes rather than uncertainty, short deadlines and antagonism would have allowed for to establishment of more productive relationships with GPs.

Medicare Locals need to be more locally focused to effectively improve access to primary care and grow their relationships with GPs, particularly in rural areas. It is critical that they separate out their planning and provider functions, and demonstrate their relevance to general practice.

RDAA also recommends that the administrative costs associated with operating Medicare Locals be minimized and that they cease to operate as fund-holders.