

COAG and the States

The outcomes of last month's COAG meeting involving the Premiers and the Prime Minister made clear that the State of Victoria will be retaining a very significant role in the delivery of primary health care over the coming years.

The Commonwealth had intended to make "a single level of government responsible for both the majority of the cost of a visit to the hospital and all of primary care" arguing that this would "put in place a clear and powerful financial incentive to take pressure off hospitals."¹ The agreement signed at the COAG meeting does commit the Commonwealth to take full funding and policy responsibility for general practice and primary health care services (as outlined in provision B10)², but the transfer of primary care to the Commonwealth is not as simple as that.

The COAG agreement also

- commits the Commonwealth and the states to developing an agreed implementation plan for services transferred to the Commonwealth. (B6, p.22)
- says that the states will continue to operate transferred GP and primary services... and that the Commonwealth will not substantially alter delivery mechanisms, without agreement by the relevant state, for 5 years from 1 July 2011. (B7, p.22)
- says that 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" (B23, p.24)³

It is significant that the Commonwealth is continuing to acknowledge the crucial place of general practice in the primary care system and seeking to strengthen the infrastructure and arrangement of general practice (including by effectively making the employment of practice nurses a standard arrangement throughout Australia). General practice seems to be at the heart of the responsibilities outlined for PHCOs in the COAG agreement (and reproduced in both the final Primary Health Care Strategy and the latest National Health & Hospitals Network report). GPV, AGPN and divisions have all advocated for this recognition in whatever changes are made to the health system.

But it is equally significant that the government is seeking to widen the remit of the PHCOs to cover all of primary health care; and that the state retains an active role in the negotiations, following the April COAG agreement. It is clear that divisions will need to continue to work with local partners just as GPV needs to continue to work with the state on the development of arrangements for PHCOs.

Establishment of PHCOs

The number of PHCOs across Australia is expected to be roughly half the number of current divisions. The budget announcements confirm that the first PHCOs will start operations from 1 July 2011 and the remainder of the PHCOs will be operating from 1 July 2012. There is no funding for divisions allocated beyond this date. AGPN has reported that the government will allocate current divisions' core funding of \$82m/year over four years to PHCOs, with additional funding both

¹ Commonwealth of Australia, April 2010, A National Health and Hospitals Network: Further Investments in Australia's Health, p.43.

² Council of Australian Government, National Health and Hospitals Network Agreement, Schedule B – Primary Health Care and Primary Health Care Organisations, provision B4.

³ See Appendix for Responsibilities of PHCOs, named "Medicare Locals" in the Budget.

for their development and for extra programs.⁴ It is difficult to tell whether funding for all the current programs is included, especially given pending reviews and/or cessation of some current Divisions Network contracts (e.g. ABHI PCIP, Collaboratives).

Work on the development of PHCOs should be based on clarity about what is to be included in the PHCOs' responsibilities. This suggests that detailed work can only occur after the agreement between the State and Commonwealth on each state's primary health care policy, implementation plans, etc. (This is one of the questions we are putting to senior state and commonwealth bureaucrats at our state forum).

Detailed work on the development of PHCOs may also need to be based on agreement between the states and Commonwealth about boundaries for the PHCOs, which is not scheduled for completion until of 31 December 2010.

Longer-term

The plan for the long term will require even more negotiation. The latest NHHN report says

Subject to final agreement with the states, Medicare Locals may play an increasing role in delivering services currently funded by states but set to transfer to the Commonwealth through the Government's reforms. The Commonwealth and the states have already agreed to roll any primary care coordination functions into Medicare Locals to reduce duplication. States have agreed to align related programs with Medicare Locals as much as possible...

Where possible, Medicare Locals will be drawn from those Divisions of General Practice that have the capacity to take on the roles and functions expected under the new arrangements...⁵ (p.40)

In some parts of Australia, divisions have assumed a major role in delivering state-funded primary care services. But in Victoria, where there is a sizeable community health sector this has not been necessary. For example, the budget for 15 independent community health agencies in just one of the three Melbourne metropolitan DH regions (North West Metro) is approximately \$185m with more than 1,900 FTE staff employed.⁶

The papers do not make it clear whether PHCOs are expected to become at some time the funding source for the whole Victorian primary health care sector, but clearly it would be a major change if the funding for all these services were to be channelled through the PHCO. There also seems to be some confusion in the documents about whether the PHCO would be allocating the funding to service deliverers or would itself be "delivering services." This is an important issue because it goes to the relationship between the PHCO and the service delivery sector, as well as to the question of whether an agency that allocates funding can also allocate funds to itself to deliver services.

Role of PHCOs

The reason for changing to a national network of PHCOs rather than maintaining a General Practice Network is that PHCOs are expected to have a very different role (as has been widely discussed in the reform deliberations, although it does not seem to be reflected in the list of activities in the COAG agreement, most of which quite closely resemble divisions' roles).

⁴ There is \$290.5 million in new funding for Medicare Locals, in addition to \$180.0 million in contractual funding for Divisions being redirected to Medicare Locals following the completion of existing contracts. Budget paper no. 2 Budget Measures 2010-11 – Part 2 Expense Measures p.228
<http://www.budget.gov.au/2010-11/content/bp2/html/index.htm>

⁵ Commonwealth of Australia, 2010, A National Health and Hospitals Network for Australia's Future: Delivering better health and better hospitals, p.40. Available through www.yourhealth.gov.au

⁶ Community Health and Women's Health Services in Victoria's North-West Metropolitan Region, December 2009, 'Much to offer – Committed to the wellbeing of our communities – response to NHHRC's *A Healthier Future for all Australians*.' www.healthnorth.org.au/news/550/

Part of the reason for change is obviously to widen the focus to include all of primary health care although this would not require so drastic a change from divisions to entirely new organisations. No doubt the negotiations between the Commonwealth and the states will clarify the roles to be adopted by PHCOs, including the key issue of whether PHCOs will hold and allocate funding for services. The nature of the role will determine the governance and membership structures and, as the AGPN-commissioned report on membership and governance points out, the PHCOs will be new organisations.⁷

There continue to be very different interpretations of the vision for PHCOs, ranging from their being larger, more efficient divisions, carrying on 'business as usual' with a capacity-building approach (albeit with different governance and membership and more emphasis on integration and coordination), to organisations with system design and management functions, which would plan, purchase and regulate.⁸

The question of whether at some time PHCOs will be responsible for the allocation of all primary health care funding for their areas is important because if they are to do this their governance must be quite different from that required by an organisation that receives funds to implement programs and services.

GPV has expressed reservations in submissions (following consultation with divisions) about PHCOs delivering services if they also hold funds to allocate to primary health care services. But if PHCOs do not hold funds and contract with agencies how will they have levers to influence what agencies do? Will they continue to be organisations using capacity-building and partnership approaches, just like divisions? The latest NHHN report appeared to suggest that this is the case, when it described Medicare Locals as "supporting GP and primary health care providers, integrating services" (p.43).

The lack of clarity in the Commonwealth's papers about the roles of PHCOs provides an opportunity for Victorian divisions to set out what they think those roles should be. This is an essential precursor to the negotiations that will ensue between divisions and their local stakeholders and between GPV, peak bodies and the Victorian Department of Health over the coming months and years.

GPV, divisions and the Health Department have all acknowledged that all parts of the primary care system need to work together and coordinate more effectively if we are to achieve better patient care, deliver improved chronic disease care, prevention, help to reduce the increasing rate of preventable hospital presentations and admissions, and create acceptable arrangements for access to care. Divisions have done significant work to bring together aspects of general practice and the state-funded parts of the primary sector (although this has not been DoHA's highest funding priority). The Health Department has also formally acknowledged that general practice is the primary point of health care for the majority of the community and is the gateway into the broader health system.

A structure that brings together general practice (where more than 80% of the population access at least one service each year) and other parts of the primary care system could offer great potential for improvement.

The Victorian Minister for Health has proposed a Roundtable to discuss what Victorians should be asking for in the development of PHCOs. GPV will have a seat on this roundtable, so it is important for divisions to give us their view of what PHCOs should be focusing on, and for what they should be accountable.

⁷ DLA Phillips Fox, 'Report to the AGPN: Advice and recommendations for structure, membership and governance of Primary Health Care Organisations' Emailed to divisions by AGPN, See p.59-60.

⁸ For example, Hal Swerissen has continued to argue for the latter in his presentation at the National Primary & Community Health Network, 10/5/10.

Roles and responsibilities of primary health care organisations

Extract from *A National Health and Hospitals Network for Australia's Future: Delivering better health and better hospitals*, pp. 64-5.

Medicare Locals will be responsible for better integrated care, making it easier for patients to navigate the local health care system. For example, they will:

- >> Facilitate allied health care services and other support for people with chronic conditions, as identified in personalised care plans prepared by GPs.
- >> 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.
- >> 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.
- >> Support the delivery of targeted Australian Government programs, such as immunisation, after hours services and mental health.
- >> Work with Local Hospital Networks to assist with patients' transition out of hospital, and where relevant into aged care.
- >> Deliver health promotion and preventive health programs targeted to risk factors in communities in cooperation with the Australian National Preventive Health Agency, once it is established.

As independent organisations that reflect the full spectrum of GP and primary health care providers, Medicare Locals will be uniquely placed to ensure that patients within a community receive the services they most need. For instance, a Medicare Local, in consultation with local GPs, might identify that there are a large number of diabetics in a particular area – and organise a roster of allied health professionals such as nutritionists and diabetes educators to provide sessional services to different GP clinics in that area.

The planning and management of an individual patient's care will remain the responsibility of their GP. By identifying and helping to fill gaps in service delivery, Medicare Locals will be able to complement services provided by GPs. They could also ensure that when patients leave hospital, they have a usual GP to go to for follow up care, and if they don't, put them in touch with one.

A core function of Medicare Locals will be to enhance the capacity of GPs to manage the care of people with chronic conditions, by providing them with a complementary array of services, so that a patient's experience is less fragmented and more satisfactory. One aspect of this is the critical role Medicare Locals will play in improving access to primary mental health care, through the delivery of the Access to Allied Psychological Services program and its expansion (described in chapter 13).

Medicare Locals will have strong links to local communities, health professionals and service providers, including GPs, allied health professionals and Aboriginal Medical Services. They will be expected to work with universities and education and training providers to support the education of health professionals in communities.

The first Medicare Locals will commence operations by mid 2011, with the rest to be rolled out by mid 2012.

Appendix 2

GPV's Activities on Health Reform 2008-2010

Since early 2008, GPV has been involved in a variety of health reform related activities including representation, advocacy and stakeholder engagement, including submissions to:

- the National Health & Hospitals Reform Commission,
- the External Reference Group for the National Primary Health Care Strategy,
- the Preventative Health Strategy, and
- AGPN's policy positions on primary health care and PHCOs

GPV submissions are available at www.gpv.org.au/resources.asp?cat=23&subcat=38

GPV has engaged Victorian divisions in discussions about health reform through State Forums for Chairs and CEOs in June 2008, May and September 2009, and in multiple consultation papers (see the [GPV website](#)), and kept divisions informed about developments and invited input through the GPV e-bulletin and a dedicated [Health Reform](#) section on our website.

Continuing Activities

- In August 2009 GPV convened the GPV Health Reform Response Working Group to discuss the implications of health reform for divisions and inform the GPV board's deliberations in formulating a Victorian response.
- On 27 April 2010, the GPV Chair and CEO, with the Chair and CEO of the Victorian Healthcare Association (VHA) met with Victorian Minister for Health Daniel Andrews, at his request.
- Continued liaison with
 - Victorian Department of Premier & Cabinet senior advisors
 - Senior Dept of Health officers including Secretary, Fran Thorn
 - other SBOs and AGPN,
 - other primary care players in Victoria including the VHA, MAV and PCPs.
 - Members of the Victorian General Practices Issues Group and the Victorian Primary and Community Health Network

Joint Advocacy

In February 2010, GPV and VHA made a joint submission on health reform, focussing on the roles of PHCOs, to Commonwealth Minister for Health and Ageing Nicola Roxon, the Victorian Ministers for Health (Daniel Andrews), and Mental Health (Lisa Neville) and Victorian Premier John Brumby.

The joint submission is available for download from the [GPV website](#).

CEO Stakeholder Engagement

GPV CEO Bill Newton has presented on GPV's approach to health reform in Victoria and planning for PHCOs at a variety of forums, including:

- Gippsland Region Health Reform Forum
- Northern Mallee PCPs Forum
- PCPs Chairs Executive
- Allied Health Peak Organisations
- VHA Primary Health Care Consultation
- MAV Forum
- Victorian General Practice Issues Group
- Western Melbourne Health Reform Forum
- Community Health Centre CEOs