

General practices' perspectives on Medicare Locals' performance are critical lessons for the success of Primary Health Networks

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BRIEF REPORT

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ABSTRACT

Background

Under a health reform after two decades, Primary Health Organisations (PHOs) in Australia were changed from Divisions of General Practice (DGP) to Medicare Locals (MLs). Following a review of Medicare Locals, in July 2015 Primary Health Networks (PHNs) replaced Medical Locals to potentially improve outcomes through supporting primary care and enhancing integration.

Aims

The aim of this paper was to gather front-line staff's perspectives on MLs and identify any lessons applicable to PHNs.

Methods

A national purposive sample of 22 high-performing general practices representing all Australian states and territories was selected for semi-structured, face-to-face interviews, and a thematic analysis conducted.

Results

Fifty-three interviews were conducted: participants comprised 19 general practitioners (GPs), 18 practice managers (PMs), 15 practice nurses (PNs), and one community pharmacist. Most participants reflected on the difference between the DGP and MLs. Themes that emerged included ambiguity, community needs, professional development and education, communication and support, duplication in services and ignoring existing ones, recruitment and retention, and engagement and involvement.

Conclusion

Those MLs that did well continued in an expanded way the work DGP were doing beforehand and made a seamless transition. PHNs will need to build on the strengths of previous PHOs, and create locality structures and processes that maximise the potential for clinical engagement. They will actively guide the dialogue between related microsystems: to achieve this they will have to be clinically led, change management organisations.

Key Words

Primary health care, healthcare reform, Australia, general practice, family practice, health services needs and demand

Implications for Practice:

1. What is known about this subject?

Government-commissioned reports evaluated Medicare Locals and provided recommendations that form the basis of the current primary healthcare reform.

2. What new information is offered in this report?

This report provides perspectives of general practices on Medicare Locals and offers lessons learned for primary health networks.

3. What are the implications for research, policy, or practice?

PHNs will build on the strengths of previous PHOs and create locality structures and processes that maximise the potential for clinical engagement.

Background

In July 2011, 108 Divisions of General Practices (DGPs) were gradually replaced by 61 Medicare Locals¹ (MLs) after two decades of success in Australian primary care.² The MLs were thought to be an opportunity for coordinated, multidisciplinary primary health.³ In December 2013, the Minister for Health asked Professor John Horvath, Australia's former Chief Medical Officer to conduct a review of MLs. Based on a review of their functioning (by Ernst & Young), financial audit, and stakeholders' submissions and interviews, Prof Horvath produced a report with 10 recommendations concluding that establishing Primary Health Organisations (PHOs) would potentially improve health outcomes.⁴ In May 2014, based on these recommendations, the Australian Government announced that Primary Health Networks (PHNs) would replace MLs effective from July 2015.⁵

Method

We gathered the front-line staff's perspectives on MLs. A national purposive sample of 22 high-performing general practices representing all Australian states and territories was selected for semi-structured, face-to-face interviews. From April 2013 to December 2013, 53 interviews were conducted: participants were 19 general practitioners (GPs), 18 practice managers (PMs), 15 practice nurses (PNs), and one community pharmacist. All interviews were audio recorded, transcribed, and analysed using a thematic approach. This project was granted ethics approval from Flinders University Social and Behaviour Ethics Committee. Selection criteria, interview schedule, data analysis, and limitations to this study were addressed elsewhere.^{6,7}

Results

When we asked general practice staff about the organisational support from MLs (the meso-level in the system), most participants reflected on the difference between the DGP and MLs. During the transition from DGP

to MLs, most participants perceived the loss of support, involvement and engagement that they used to experience from their DGP. Participants reflected that this was because MLs had not consulted the GPs, did not work with the existing providers, and started their own services competing with the existing ones resulting in the duplication of services with less uptake from the local community. Some of the participants used to be on the boards of DGPs and did not continue with MLs, which led to less engagement.

Geographic catchments of MLs did not address the different needs of the communities which was more obvious in rural settings. Unaddressed needs included training, aspects of patients' culture, and access to hospitals. The dynamics of MLs were different. General practice staff used to know the relevant DGP person for any required help, "*worked as a family*", and thought that the MLs were overstaffed with no clear role to support general practice staff and created paperwork hurdles. Participants stated that DGPs were more supportive and more grassroots in their approach to address local general practice needs. General practice staff thought MLs had become more political rather than caring about primary care. Although the DGPs had less funding, they had "*goodwill*". Due to their frustrations, some participants wrote to the Commonwealth and state health departments without success. On the optimistic side, participants mentioned that the support from MLs would improve with time and had started to observe small changes. Some of the participants had positive views about MLs; those who entered general practice after the abolition of DGPs or who were ML board members.

"They have been just godsend to me. They have lots and lots of different courses and I attend as many as I possibly can."
PM, urban

"They've been particularly supportive around, around things like... around the IT aspects. Such as, making sure the Clinical Audit Tool is installed on the relevant computers."
GP, urban

Ambiguity

"Yeah, no one knows what the Medicare Local does... They just, they get lots of money from the government... And they seem to be a bit more community focused, but I don't see any benefit to us... you don't see things sort of projecting out into the general practices that are sort of... not like the old days, you know, there were so many things going on." PM, urban

"All this humungous funding that was used to create and to support and to pay salaries and to create infrastructure for these Medicare Locals is actually money, which is not going into rebates for patients...." PM, rural

Community needs

"We were terribly disenfranchised when our Medicare Local came on the scene and our Division disappeared. We had been very privileged to have a very strong, very high-performing DGP in this area; very supportive of its practices, and unfortunately we got put into an urban Medicare Local that really didn't understand, So, they're really not that engaged with us." GP, rural

"The bottom line is Medicare Local is less local than it was before." GP, rural

Professional development and education

"...so we had a DGP locally and they put on a lot of education for nurses; they were really, really good, but now that they've got Medicare Local they function from (urban setting). So, that's quite a long way away and it's in the city. So, some of the education that they provide is difficult for us to get to..." PN, rural

Communication and support

"... the more money that has been funded into the Medicare Local the less, the less support... what used to happen with the DGP they would come to us, they would ring us, they would be on top of us all the time, and, and it was always helpful." PM, rural

Duplication in services and ignoring existing ones

"...And they already contracted a service, which comes in competition with us... They tried to promote their own diabetic educators and ah no one attended their sessions. The result was, duplication in services, for which they found they had no uptake from the local community.... And instead of continuing to support these programs, they reinvented these wheels again." PM, rural

Recruitment and retention

"They get somebody here that's good for a few months and you think, 'oh, this is fantastic,' but then they're gone! They're only on a six-month contract or whatever... and then they've gone and then you've got nobody for awhile. They haven't replaced them, or they replace them with somebody who doesn't know what they're doing, or you know.... You don't seem to get any, any continuity of support." PM, rural

Engagement and involvement

"We had at least three of our doctors on the board there, working in the Division. Our staff did lots of stuff with them, in general. So, we thought they were fantastic and then we went to a Medicare Local, who was just at the other end of the scale..." PM, rural

"...They have not consulted us on a lot of things" GP, rural
"I think that the biggest things, the biggest challenge will be for Medicare Locals to convince general practice that it, it has a role, which will enhance what they got before." GP, urban

Discussion

Lessons for PHNs: A basic building block of health care is the clinical microsystem formed when a clinician or a team of care providers interact and exchange information with patients, and general practice is a key primary care component of that microsystem.^{8,9} The Australian Government's Department of Health is the macrosystem and between them is the mesosystem. A key function of a meso-level system is to actively guide the dialogue between related microsystems to achieve desired outcomes.

In primary care the mesosystem is represented by primary health care organisations (PHOs). In Australia, initially these were DGPs, followed by MLs, and now PHNs.¹⁰ In line with many other countries, the Australian mesosystem reform aims to improve clinical outcomes, efficiency, and integration, primarily to be achieved through commissioning and enhancing primary care. Commissioning is a process of identifying population health needs, designing, and securing appropriate services. If this is done effectively, previous concerns with respect to duplication of services and direct competition will become redundant. It also provides clarity of purpose for PHNs which was another criticism of MLs.

The achievement of the desired outcomes will require changes across the microsystem. Additional concerns from our interviews focused on the loss of local context and lack of engagement. The risk of both is high. There were 108 DGPs, 61 MLs, and now there are 31 PHNs. The reduced number and associated increasing geographical spread of each PHN necessitates the formation of locality structures to maintain both local context and engagement. A clinical council (and community advisory group) per LHN has been mandated as a structure for clinical input and advice to the PHN Board. PHNs need to go much further and

deeper. Even DGPs experienced significant numbers of general practitioners who were sceptical.¹¹

More recently, international experience has found clinical engagement and more importantly achieving high levels of buy-in to be a critical success factor.^{12,13} Strategies to achieve these have included provision of regular education events, identifying early wins from either a patient or clinical perspective, multi-faceted communication strategy, agreeing referral pathways and protocols, sharing comparative data, facilitating peer review, and provision of financial incentives. Where such buy-in has been achieved, there is evidence of achieving practitioner-determined outcomes as well as system-level outcomes. In the United States, there are examples of independent practitioner associations or medical groups holding the equivalent of a commissioning budget achieving improved outcomes and cost effectiveness through enabling high quality primary care, appropriate use of specialist services, and alternatives to hospital admission.¹⁴ This is not dissimilar to objectives set for PHNs.

Conclusion

The general practice perspectives have been expressed by clinicians working in high-performing clinical microsystems and were predictable. The perceived failure of many MLs was a matter of design. Those MLs that did well continued, in an expanded way, the work DGPs were doing beforehand and made a seamless transition. PHNs need to build on the strengths of previous PHOs, by creating locality structures and processes that maximise the potential for clinical engagement. They have to actively guide the dialogue between related microsystems by being clinically led, change management organisations.

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CONFLICTS OF INTEREST

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Flinders University Social and Behaviour Ethics Committee.
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