

# **Divisions of General Practice Program Transitioning to Medicare Locals Issues**

## **Frequently Asked Questions December 2011**

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These Frequently Asked Questions have been developed to provide Divisions of General Practice (Divisions) with information regarding the transition from the Divisions of General Practice network to Medicare Locals. This document will be updated from time to time to include additional questions and issues as they arise.

Note: The Australian General Practice Network (AGPN) Forum website, accessible by its members, provides general legal advice on company obligations in regards to the capacity to continue as “a going concern”. In regards to the lapsing of the Divisions of General Practice Program (DGPP) on 30 June 2012, and the introduction of Medicare Locals, questions in relation to solvency in the context of a declaration or resolution are addressed on the website.

Version 4: December 2011

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## Document History

This table is to record the document's history as major changes are made. As each version is drafted and submitted, the version number and changes made will be appropriately recorded.

Version No.	Date	Description of Revision
1	8 June 2011	<i>FAQs: Version 1 - Published</i>
2	July 2011	<ul style="list-style-type: none"> <li>• Inclusion of new FAQs sections: <i>Transition Arrangements</i> (FAQs 3); <i>Subcontracting</i> (FAQs 9); <i>Assets</i> (FAQs 14), <i>Liabilities</i> (FAQs 15); <i>Insurance</i> (FAQs 16); <i>Intellectual Property</i> (FAQs 17); <i>Confidentiality</i> (FAQs 18)</li> <li>• Renumbering of: <ul style="list-style-type: none"> <li>- <i>DGPP Core Funds</i>, FAQs 4</li> <li>- <i>Program Funds</i>, FAQs 5</li> <li>- <i>Redundancies</i>, FAQs 6</li> <li>- <i>Transition Funding</i>, FAQs 7</li> <li>- <i>Medicare Locals Core Funding</i>, FAQs 8 (replacing <i>Funding Formula</i>)</li> <li>- <i>Staff Entitlements</i>, FAQs 10</li> <li>- <i>Leasing Arrangements</i>, FAQs 11</li> <li>- <i>Accreditation</i>, FAQs 12</li> <li>- <i>Reporting</i>, FAQs 13</li> <li>- <i>Other Issues</i>, FAQs 19</li> </ul> </li> <li>• The inclusion of FAQs: 3.1-3.2, 8.2 – 8.4, 9.1-9.2, 14.1 - 14.4, 15.1 - 15.2, 16.1, 17.1 - 17.3, 18.1 - 18.2, 19.7 – 19.11</li> <li>• Update of FAQs 1.2, 2.1, 2.2, 4.1-4.6, 5.1, 13.2, 19.1 – 19.11</li> <li>• Deletion of FAQ 3.7</li> </ul>
3	November 2011	<ul style="list-style-type: none"> <li>• The inclusion of FAQs: 4.9, 4.10 12.3 – 12.6, 13.1, 13.3, 14.6 - 14.7, 17.4</li> <li>• Update of FAQs: 2.1, 2.2, 3.1, 3.2, 4.2, 4.5, 4.6, 4.8, 5.1 - 5.3, 7.1 – 7.2, 8.1, 9.1-9.2, 12.2, 14.1 – 14.2, 19.1 – 19.11</li> <li>• FAQ 13.1 moved and updated to 13.2</li> <li>• Deletion of FAQs: 7.4 – 7.5</li> </ul>
4	December 2012	<ul style="list-style-type: none"> <li>• Renumbering of: <ul style="list-style-type: none"> <li>- <i>General</i>, FAQs 1</li> <li>- <i>Transition Arrangements</i>, FAQs 2</li> <li>- <i>DGPP Core Funds</i>, FAQs 3</li> <li>- <i>Program Funds</i>, FAQs 4</li> <li>- <i>Redundancies</i>, FAQs 5</li> <li>- <i>Transition/Establishment Funding</i>, FAQs 6</li> <li>- <i>Medicare Locals Core Funding</i>, FAQs 7</li> </ul> </li> </ul>

		<ul style="list-style-type: none"> <li>- <i>Subcontracting</i>, FAQs 8</li> <li>- <i>Staff Entitlements</i>, FAQs 9</li> <li>- <i>Leasing Arrangements</i>, FAQs 10</li> <li>- <i>Accreditation</i>, FAQs 11</li> <li>- <i>Reporting</i>, FAQs 12</li> <li>- <i>Assets</i>, FAQs 13</li> <li>- <i>Liabilities</i>, FAQs 14</li> <li>- <i>Insurance</i>, FAQs 15</li> <li>- <i>Intellectual Property</i>, FAQs 16</li> <li>- <i>Confidentiality</i>, FAQs 17</li> <li>- <i>Other Issues</i>, FAQs 18</li> <li>• The inclusion of FAQs: 1.2, 3.2, 4.4, 6.3, 13.5-13.6</li> <li>• Update of FAQs: 1.1, 2.2, 3.3, 3.5, 3.9, 3.11, 4.1, 6.1- 6.2, 6.4, 7.4, 8.1, 11.1-11.2, 13.1, 18.2, 18.6, 18.8- 18.10</li> <li>• Deletion of FAQs: 1.1 – 1.2, 2.1, 4.2 – 4.3,</li> </ul>
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## General

### **1.1 The boundaries include regional names for each Medicare Local. Will there be any flexibility for potential service hubs in a Medicare Local to have their own region-specific name?**

As part of the funding agreement, all Medicare Locals are required to adopt common branding which includes the catchment name specified by the Department. The adoption of the Medicare Local branding establishes a strong identity and a platform from which Medicare Locals can communicate key messages and facts to their stakeholders and the public.

### **1.2 Can a Medicare Local also be a service provider?**

Under the Government's National Health Reforms, individual practitioners will continue to be responsible for their individual patients' care, and patients will continue to receive the health care they require from their individual primary health care providers.

Medicare Locals will work collaboratively with GPs and other primary health care service providers in their area towards meeting the primary health care needs of their local communities. Medicare Locals will work with local primary health care providers, Local Hospital Networks and communities to ensure that patients receive the right care in the right place at the right time.

A particular role for Medicare Locals will be to identify where there are service gaps and where patients are missing out on services and to support and coordinate services to help address these service gaps.

Medicare Locals will have a critical planning, co-ordination and integration role and will, for the first time, bring all parts of the primary healthcare system together so that patients are best served. While some Medicare Locals will undertake service provision, this is not the primary function of Medicare Locals.

## Transition arrangements

### **2.1 What is the status of Divisions after 30 June 2012?**

All DGPP Core Funding will cease on or before 30 June 2012. Further information on how this will impact Divisions is provided under *DGPP Core Funds* (see Q3).

Following cessation of DGPP Core Funding, Divisions may choose to continue operating as entities using alternative funding sources.

### **2.2 Can Divisions be subcontracted to continue to provide services on behalf of the Medicare Locals?**

It will be a requirement of Divisions which receive Commonwealth funding in 2011-12 to work with Medicare Locals as they are established to ensure continuity of service, and to collaborate with Medicare Locals to ensure effective transition of all Department of Health and Ageing funded programs.

There is no formal role for Divisions to act as the service delivery arm of a Medicare Local. Where a Division within a Medicare Local catchment area has the capacity to provide the services, a Medicare Local may wish to subcontract a Division to provide direct services during the transition period in 2011-12.

From 1 July 2012, Medicare Locals must move towards subcontracting arrangements that are contestable and demonstrate efficient use of Commonwealth funding. However, Medicare Locals funding cannot be used to underwrite the ongoing operational costs of Divisions. Further information on sub-contracting arrangements is provided under *Sub-Contracting* (see Q8).

## **DGPP Core Funds**

### **3.1 Can a Division use DGPP Core Funds to prepare for the new Medicare Local environment?**

Divisions may use DGPP Core Funds to prepare for the new Medicare Local environment, whether they are successful or not, in their application to become a Medicare Local. The Department acknowledges that there will be additional costs associated with the preparation of ITA documentation, consultations with stakeholders, strategic planning and development activities with prospective partners during this application/preparation phase. Where a Division has been advised that they are successful in their application for Tranche 2, they may use DGPP Core Funds associated with establishment costs for the Medicare Local, with the intention that the DGPP Core Funds are repaid, once available, from Transition/Establishment funding (see Q6).

Any use of DGPP Core Funds must seek to minimise disruption to the provision of programs and support services, i.e. activities must not be curtailed by the use of the funds for application/preparation activities. Those Divisions which plan to use DGPP Core Funds must include this intention in their Annual Budget or have already been granted prior approval from the Department. Where relevant, Divisions must identify the quantum and purpose of these funds as notes to the Annual Budget or request for approval.

The Department expects that there will be no “mixing” of Funds between Divisions and Medicare Locals. As both these Funds will be the subject of separate arrangements with the Department, they must be maintained, and accounted for, separately.

### **3.2 In the case of a Tranche 3 Medicare Local being established on 1 July 2012, is it expected that a Division will be reimbursed costs associated with the establishment of the Medicare Local considering that the Division will no longer be funded under the DGPP?**

Under current arrangements, it is not expected that Tranche 3 Medicare Locals will have access to funds until after 1 July 2012. Where a Division forming a Tranche 3 Medicare Local has used DGPP Core Funds to prepare for the establishment of a Tranche 3 Medicare Local, the Department anticipates that there will be no requirement to reimburse Funds to the Division. Reimbursement from the Medicare Local in this case would result in a retrospective underspend by the Division which would then need to be either transferred to the Medicare Local or repaid to the Department.

Where a Division has used Member's or non-Commonwealth funds to prepare for the establishment of a Tranche 3 Medicare Local, then reimbursement to those funds can occur once transition/establishment funding has been provided.

### **3.3 What types of expenditure can a Division use DGPP Core Funds for in applying to become a Medicare Local?**

DGPP Core Funds can be used by Divisions to assist with reasonable costs associated with:

- the preparation of, and planning involved in, the Medicare Locals ITA application, including population and health service planning, governance models etc;
- meetings with partner organisations to discuss the ITA and/or wind up;
- member and community consultation costs;
- strategic planning meetings;
- engagement of external consultants or contractors to assist with the preparation and development of an ITA application; and
- legal/accounting costs associated with the planning for a Medicare Local or the wind-up of the Division (this does not include legal/accounting activities which AGPN has undertaken on behalf of the network – see Q3.5).

Successful Medicare Local applicants will be provided with separate funding to support their establishment, which may include transition activities (see Q6).

### **3.4 What types of expenditure is a Division able to use DGPP Core Funds for if they do not wish to become a Medicare Local?**

DGPP Core Funds can be used by Divisions to assist with reasonable costs associated with:

- member and community consultation costs;
- engagement of external consultants or contractors to assist with the preparation and development of an ITA application; and
- legal/accounting costs associated with either the planning for a Medicare Local or the wind-up of the Division (this does not include legal/accounting activities which AGPN has undertaken on behalf of the network – see Q3.5).

### **3.5 What types of expenditure is a Division unable to use DGPP Core Funds for in relation to preparing for the new Medicare Locals environment?**

In addition to Clause 4.8 of the Deed for Multi-Program Funding (the Deed), DGPP Core Funds cannot be used to:

- undertake transition/establishment activities for which AGPN is already funded on behalf of the Divisions network (under the National Transition Project) eg. governance support, organisational development and enhanced function support tools etc. More information about the National Transition Project is available at [www.agpn.com.au/medicarelocalstransition](http://www.agpn.com.au/medicarelocalstransition);
- meet the operational and/or establishment costs of a Medicare Local; and
- meet legal or other costs (including damages) to settle unfair dismissal grievances and/or settle other claims brought against the Division or Medicare Local.

### **3.6 How is the transition to a Medicare Local going to affect DGPP Core Funding if a Division (or a consortium of Divisions) has been successful in applying to become a Medicare Local?**

From 1 July 2011 until 30 June 2012, Core Funding to Divisions under the DGPP will progressively cease as Medicare Locals are established. The Department will work with Medicare Locals and affected Divisions to determine an appropriate transition strategy. Generally, once a Medicare Local is operational no Division in the catchment will receive DGPP Core Funds. Time-limited funding will be only available in specified instances (outlined below in Q3.7).

### **3.7 How is the transition to a Medicare Local going to affect DGPP Core Funding if a Division has been unsuccessful in applying or does not wish to become a Medicare Local and a Medicare Local is established in their area?**

The priority of the Australian Government is the continuity of service delivery, particularly during the transition phase to the new Medicare Locals environment. Where a Division is unsuccessful in applying or does not wish to become a Medicare Local then funding provided by the Commonwealth will cease on or before 30 June 2012.

As Medicare Locals become operational and are able to deliver services in a catchment, DGPP Core Funding will cease to Divisions in that catchment. Where a Medicare Local is established but not able to immediately deliver services, then time-limited DGPP Core Funding may be provided to Divisions in the catchment. It is a requirement of funding in 2011-12 for all affected Divisions to work with the Medicare Local in their catchment during this transition phase to ensure continuity of services and an effective transition of all services and programs to the Medicare Local. This requirement has been articulated in the form of a new clause to funding arrangements which includes a termination provision which will be effected once the Division is advised that a Medicare Local is fully operational.

### **3.8 What happens to any Unspent and Uncommitted DGPP Core Funds if a Division has been successful in applying to become a Medicare Local?**

It is expected that requests to retain DGPP Core Funds by the Medicare Local will be treated on a case by case basis, having regard to the level of funds available as well as anticipated activities and commitments. The Department will consider options to deal with the Funds as the situation arises.

### **3.9 What happens to Unspent and Uncommitted DGPP Core Funds if a Division has been unsuccessful in applying or does not wish to become a Medicare Local?**

Where a Division is unsuccessful in applying or does not wish to become a Medicare Local, Unspent and Uncommitted DGPP Core Funds will be dealt with on a case by case basis. In accordance with Clause 34 of the Medicare Local Deed, the Department may approve Unspent and Uncommitted DGPP Core Funds to be transferred to the respective Medicare Local.

### **3.10 Can a Division, which is not becoming a Medicare Local, use Unspent or Uncommitted DGPP Core Funds to assist with the wind-up of the organisation?**

Where a Division, which is unsuccessful in applying or does not wish to become a Medicare Local, chooses to deregister the business, the Division may seek approval from the Department to use Unspent and Uncommitted DGPP Core Funds to assist with the deregistration costs.

The Department is not obliged, under the Deed, to meet deregistration costs. The Department will consider such requests on a case by case basis, including requests to meet deregistration costs which may be in excess of the amount of Unspent Core Funds available.

### **3.11 What will happen to DGPP Core Funding for Divisions affected by Tranche 2 Medicare Locals?**

For Divisions that will transition to become a Tranche 2 Medicare Local, either as a single entity or as the lead organisation of a consortium, DGPP Core Funding will cease on execution of the Medicare Local Deed for Funding (no later than 31 March 2012).

For Divisions that are either non-lead organisations in a Tranche 2 Medicare Local consortium or not becoming a Tranche 2 Medicare Local but otherwise affected by the establishment of a Medicare Local in their catchment, DGPP Core Funding will cease by 31 March 2012. The Department will write to these Divisions individually advising them of the arrangements.

## **Program Funds**

### **4.1 How is the transition to a Medicare Local going to affect Program Funding?**

All Program Funding currently delivered by Divisions will be transferred to the Medicare Local. The continuity of service provision will be a priority during this period (Clause 24 of the DGPP Deed for Multi-Program Funding refers).

As Medicare Locals become operational, existing program funding to Divisions will be re-directed through Medicare Locals. Over time, this will be absorbed into a single funding agreement.

The timing of the transfer of programs currently managed through Divisions will depend on individual circumstances. The program transfer process will be undertaken by the Department on a case by case basis as Medicare Locals have the capacity to undertake the delivery of programs. Medicare Locals and affected Divisions are encouraged to discuss the timing and preferred method of transfer before advising the Department (see Q4.4)

As part of the ITA process, applicants were required to demonstrate their capacity to ensure the seamless transfer of programs and services from existing Divisions of General Practices operating within the local area to the Medicare Local (refer to Objective 4.4 in the *Guidelines for the establishment and initial operation of Medicare Locals and Information for applicants wishing to apply for funding to establish a Medicare Local 2011*).

### **4.2 What happens to any Unspent and Uncommitted Program Funds if a Division has been successful in applying to become a Medicare Local?**

It is expected that requests to retain Program Funds by the Medicare Local will be treated on a case by case basis, by the relevant Program Area within the Department, having regard to the level of funds available as well as anticipated activities and commitments. The Department will consider options to deal with the Funds as the situation arises.

#### **4.3 What happens to Unspent and Uncommitted Program Funds if a Division has been unsuccessful in applying or does not wish to become a Medicare Local?**

Where a Division is unsuccessful in applying or does not wish to become a Medicare Local, the Department's relevant Program Area will consider options for dealing with Unspent and Uncommitted Program Funds which may include all surplus funds being repaid to the Commonwealth or alternatively, in accordance with Clause 34 of the Medicare Local Deed, the Department may approve for Unspent and Uncommitted DGPP Core Funds to be transferred to the respective Medicare Local.

#### **4.4 What will be the actual process for transferring Programs from a Division to a Medicare Local?**

The transfer process for Programs will depend on the arrangements of the Division and Medicare Local, in agreement with the Department. Please note that Program transfer takes considerable time and early notification to the Department of the intention to progress Program transfers is important. There are two main methods for transferring Programs:

##### *1. Termination of the Division's Deed and offer of new Program schedules under the Medicare Local Deed.*

This method involves terminating the Division's Deed and all current Program Agreements under it by a Deed of Mutual Termination (or more than one if more than one Division is involved) with an agreed effective date. Each Division is responsible for their final reporting, including audited financial statements for each Program, for that portion of the year that they received funding before the effective date. Each Division is also responsible for the transfer of Unspent and Uncommitted Funds and Assets to the Medicare Local, or as otherwise directed by the Department in the Deed of Mutual Termination.

Subsequent to the termination of the Division's Deed, the Medicare Local will be offered one schedule under the Medicare Local Deed for each Program. The Medicare Local will be responsible for reporting on that portion of the year still remaining from the effective date of the schedules (usually the day following the date of effect of the Deed of Mutual Termination).

##### *2. Novation of the Division's Deed to the Medicare Local.*

This method involves each relevant Division signing a Deed of Novation with the Medicare Local and the Department agreeing to the transfer of all rights and obligations under the Division's Deed and all current Program Agreements under it, to the Medicare Local on an agreed effective date. The Deed of Novation will also transfer Unspent and Uncommitted Funds and Assets to the Medicare Local, or as otherwise directed by the Department, and the Medicare Local will be entitled to receive payments (subject to acceptance of the deliverable) under the Division's Deed and Program Agreements. In effect, the Medicare Local agrees to take on the responsibilities of the Division/s including the remaining reporting requirements of the Division/s under the Division's Deed and Program Agreements.

## **Redundancies**

The Department expects program continuity to be a key priority during the transition phase until 30 June 2012. To enable program continuity, the Department would envisage that as many staff as appropriate will transfer from Divisions to the Medicare Locals or Affiliated Organisations within a reasonable period of time. This will also ensure retention of corporate

knowledge as well as maintain existing relationships. In most instances, it is expected that program staff who transfer to the Medicare Local will continue in the same or similar roles, previously occupied within the Division.

It is the responsibility of an employer to make employees aware of the fixed nature of any project/program activities funded by the Commonwealth. Employment of staff on a permanent basis for the purposes of undertaking Commonwealth funded project/program activities is a business decision for the employer and not a matter for the Department or Commonwealth. Accordingly, in such situations, responsibility for provisions for redundancy vests in the employer. Divisions are expected to ensure that they comply with all relevant State/Territory and Commonwealth legislation and awards when determining redundancy responsibilities (see Q9.1).

### **5.1 Can DGPP Core Funds be used to provision for redundancy?**

The Commonwealth does not have any obligation to allow Divisions to use or set aside Commonwealth Funds to make provision for redundancies. While there is no Commonwealth obligation to provide for redundancies, the Department will consider such provisions on a case by case basis.

The Department expects that redundancy provisions arising during the transition to Medicare Locals will be the **exception**, and applicable in only a small number of cases. Clause 4.4 of the Deed stipulates '*Funds for the Program must not be set aside or used for the purposes of redundancy payments **unless agreed in writing in advance** by the Deed Manager*'. This clause clearly provides the Deed Manager with the authority to consider requests from Divisions relating to redundancy payments for DGPP personnel.

Note that Medicare Local Funds (either Core or establishment/transition) cannot be used to pay for redundancies for DGPP personnel.

### **5.2 What is the process for seeking approval to provision for a redundancy?**

In order for the Division's request to provision for a redundancy to be considered they must submit a Business Case including the provision of **independent legal advice** justifying the quantum and basis for the entitlement of the relevant individual to a redundancy payment.

This advice should include, at a minimum, the following details:

- Name of the person
- Position held
- Length of service
- Program(s) the person is or has been working on
- End date of funding for the Program
- Reason for the redundancy
- Proportion/percentage of each program, the person is attributed to i.e. Commonwealth program funded activities or other
- Award or Contract/Agreement under which they are employed
- Provision for redundancy under the Award or Contract/Agreement
- Whether the person is an employee or contractor
- Employment status - full or part time
- Commencement date and current end date of contract/agreement
- Confirmation that there is no other suitable employment available within the Division/SBO for this person

- Future provisions such as how long the person would be excluded from working in the new organisation (i.e. in the Commonwealth, this is usually 12 months) and if this covers employment as a consultant, non on-going or permanent in a Medicare Local structure.
- Expected redundancy amount.
- Details as to how the redundancy will be met, and if required, what proportion of the costs the Division is seeking approval for by the Department (including the relevant program/s).
- If the Division is seeking Departmental approval to use Commonwealth funds to support the redundancy, information must be provided as to the degree in which the relevant program/s will be affected and whether service provision or activity will need to cease altogether. In this case, dates will need to be supplied.

Any requests received will be considered on a case-by-case basis by the Program Manager in conjunction with the relevant State or Territory Office. If the Program Manager supports the request, approval of the recommendation is sought through the Deed Manager. The Deed Manager will consider the request from the Program Manager and advise accordingly.

Divisions are not permitted to budget for redundancies in their 2011-12 Annual Budget unless the above process has been followed. If the Business Case is approved, the Division will be requested to submit a budget revision.

The requirement for a Business Case to provision for redundancies is also applicable to State Based Organisations.

## **Transition/Establishment Funding**

### **6.1 What is transition/establishment funding and how does it differ from DGPP Core Funds which can be used to plan and/or prepare for the ITA?**

Transition/establishment funding will be provided to Medicare Locals to assist with costs associated with the establishment of the Medicare Local.

Reasonable costs associated with planning and preparation of the ITA documentation etc (see Q3.3), on the other hand, are accrued by the Division prior to transitioning to a Medicare Local. Those Divisions which are unsuccessful in applying to become a Medicare Local cannot continue to accrue costs associated with the planning and preparation involved with transitioning to a Medicare Local once they have been advised that their application has been unsuccessful.

Medicare Locals may use transition/establishment funding to assist with costs associated with the establishment of Medicare Locals, which could include the elements such as:

- New constitutions;
- Board;
- CEO and staff recruitment;
- Relocation or set up of new premises;
- Equipment;
- Websites development and IT infrastructure;
- Financial and HR systems;

- Asset and debt management;
- Member and community consultations;
- Branding; and
- Communications and marketing.

This will depend on the individual requirements of Medicare Locals. Details will be negotiated between the Department and preferred applicants following finalisation of the selection process.

**6.2 If a Division becomes a Tranche 3 Medicare Local at the end of the Deed (30 June 2012) will transition/establishment funding still be available?**

Yes.

**6.3 Can a successful Tranche 3 Medicare Local have access to transition/establishment funding before 1 July 2012?**

It is currently not possible to provide Tranche 3 Medicare Locals with transition/establishment funding prior to 1 July 2012. The Department will endeavour to provide transition/establishment funding as soon as possible after 1 July 2012.

**6.4 Will there be funding for due diligence and additional legal and audit costs involved either in a transition or winding down scenario?**

Medicare Locals may use transition/establishment funding to assist with costs associated with the establishment of Medicare Locals, such as legal costs. Details will be negotiated between the Department and preferred applicants following finalisation of the selection process. Reasonable use of DGPP Core Funds may be used to assist with the costs of winding up (see Q3.3 and Q3.4).

## **Medicare Locals Core Funding**

**7.1 How was the Medicare Local core funding formula developed?**

The key considerations in developing the funding formula were equity, viability, and consideration/recognition of local characteristics that may impact on a Medicare Local's operation (e.g. remoteness). The formula takes into account the key demographic and geographic characteristics of each Medicare Local, including rurality, socio-economic status, Aboriginal and Torres Strait Islander populations, low English speaking proficiency, and aged related profiles.

**7.2 Will Medicare Locals be provided with flexible funding to address local primary health care issues?**

From 1 July 2012, the Government will provide flexible local funding through the Regionally Tailored Primary Health Care Initiatives through Medicare Locals Fund (the Fund). Over time, the Fund will consolidate funding provided to Medicare Locals and other primary health care organisations for the delivery of a range of primary health care initiatives including after-hours general practice services, rural primary health services, workforce support for rural GPs and support for aged care recipients to access general practice and allied health care services.

The Fund will provide Medicare Locals with greater flexibility to respond to evolving priorities, as identified by Medicare Locals in conjunction with their local communities. The

Department will work with the primary health care sector to develop guidelines to underpin the operation of the fund.

### **7.3 Will Medicare Locals need to employ fully qualified planning and research experts to undertake service planning and gap analyses?**

Medicare Locals will be independent companies limited by guarantee. Employment of personnel for planning and research purposes will be a business decision for Medicare Locals in determining how best to identify and meet the needs of local communities.

### **7.4 How will Medicare Locals be supported to have an increased role in population health planning?**

The Department is intending to provide support to Medicare Locals in their data analysis and population health planning role.

The Department will also work closely with the established Medicare Locals to further determine the data and support required.

## **Subcontracting**

### **8.1 Whilst Medicare Locals are not permitted to fund the operations of Divisions, can Divisions be subcontracted to continue to provide services on behalf of the Medicare Local?**

As mentioned previously, where a Division within a Medicare Locals catchment area has the capacity to provide services, a Medicare Local may wish to subcontract a Division to provide direct services during the transition period in 2011-12. However, from 1 July 2012, Medicare Locals must move towards subcontracting arrangements that are contestable and demonstrate efficient use of Commonwealth funding.

Funding provided to Divisions under sub contractual arrangements for service delivery must not be used to underwrite the ongoing operational costs of Divisions. It would be expected that a minimal administrative overhead would be included in any subcontract, whether a Division or any other organisation is tendering for the work. However, the Department does not expect to see the full administrative and staffing costs currently associated with the operations of a Division to be included in any subcontract. Divisions and Medicare Locals must note that Medicare Local Core Funding cannot be used for governance costs of Divisions (or any other organisations) in subcontracting arrangements with Medicare Locals. The intent of this is not to prohibit or restrict Divisions or other organisations from being subcontracted by a Medicare Local, but to ensure that Divisions/organisations which are subcontracted are competitive in their bids and that the Medicare Local achieves value for money.

### **8.2 What is a sub contract for the purposes of the Medicare Locals Deed for Funding?**

Under the Medicare Locals Deed for Funding, Clause 8 provides for a Medicare Local to subcontract another organisation to undertake the performance of a program or part thereof on behalf of the Medicare Local.

Where a Medicare Local outsources service delivery to another organisation, such as a Division or a locum service, those organisations would be considered sub-contractors. However, health practitioners then contracted by those organisations to perform services

required would not be considered subcontractors, unless they are in turn given responsibility for that part of the Program Agreement.

The subcontracting arrangements do not generally apply where the Medicare Local is purchasing services from an independent contractor to assist it to meet its functions under the Medicare Locals Deed for Funding (e.g. analysing data or the evaluation of a project).

The Medicare Local will be required to seek approval from the Department to subcontract the performance of a particular Program or part thereof, in accordance with Clause 8 of the Medicare Locals Deed for Funding.

If the Department is satisfied with the proposed subcontracting arrangements for delivery of the Program in question, approval will be granted. The Commonwealth may impose any terms and conditions it considers appropriate when giving its approval.

## **Staff entitlements (leave, length of service)**

### **9.1 What happens to staff entitlements if a Division has been successful in applying to become a Medicare Local?**

This is a business decision for the Division and/or Medicare Local and should be addressed in individual transition arrangements identified by successful Medicare Locals. Divisions and Medicare Locals should seek their own legal advice regarding their obligations under transmission of business arrangements.

## **Leasing Arrangements**

### **10.1 What happens to a Division's current leasing arrangements if a Division has been successful in applying to become a Medicare Local?**

Divisions should make appropriate enquiries as leasing arrangements are a business decision for the Division and/or Medicare Local. It may be appropriate, in some instances, to novate leases to the Medicare Local which will operate in the former Division's geographical area, but this will be a matter for discussion between the Division and the Medicare Local.

### **10.2 What happens to a Division's current leasing arrangements if a Division has not been successful in applying or does not wish to become a Medicare Local?**

Divisions should make appropriate enquiries if it is envisaged that the cessation of DGPP funding may lead to the wind-up of the Division, as this is a business decision for the Division.

## **Accreditation**

### **11.1 What happens to a Division's accreditation status if they have been successful in applying to become a Medicare Local?**

Accreditation by an agency approved by the Commonwealth and against standards approved by the Commonwealth will be a condition of funding under the new funding arrangements for Medicare Locals. In the event that a successful Division's accreditation lapses prior to

July 2012, the new Division/Medicare Local is not required to seek reaccreditation or an extension of their existing accreditation.

The ITA program guidelines describe the initial operation and establishment of Medicare Locals – including the requirement to become fully accredited by an accreditation agency approved by the Government. Further advice on the accreditation requirements for Medicare Locals will be provided in the first half of 2012.

### **11.2 Does a Division need to maintain accreditation if they have been unsuccessful in applying or do not wish to become a Medicare Local?**

It is a requirement that all Divisions not transitioning to become a Medicare Local maintain their accreditation status during the current term of the Deed (Clause 7 of the Deed). Failure to maintain accreditation status may result in the Department deferring, reducing or not making payment of Funds or may result in termination of the Deed and repayment of Funds.

### **11.3 Do Medicare Locals need to be accredited?**

Medicare Locals will need to be accredited. The Deed for Funding between the Commonwealth and each Medicare Local requires the Medicare Local to comply with accreditation requirements as directed by the Commonwealth. That is, each Medicare Local agrees to register with an accreditation agency approved by the Commonwealth and achieve full accreditation within 12 months, upon receiving a written request from the Commonwealth.

### **11.4 What will Medicare Locals accreditation involve?**

The Department will be working closely with stakeholders over the next 6-12 months to develop and implement a new accreditation framework for Medicare Locals.

This will include development of appropriate accreditation standards, assessing and approving organisations to undertake assessment of Medicare Locals against the standards, developing and promulgating and processes for monitoring and reviewing the quality of assessment procedures and ensuring ongoing compliance with standards across the accreditation cycle.

The Department anticipates that a set of Standards will be developed, in consultation with stakeholders, which detail specific requirements for continuous quality improvement, governance, financial management and clinical governance arrangements for Medicare Locals.

### **11.5 When will Medicare Locals need to achieve accreditation by?**

The Department will implement the new accreditation framework for Medicare Locals from July 2012. The Deed for Funding between the Commonwealth and each Medicare Local requires the Medicare Local to register with an accreditation agency approved by the Commonwealth and achieve full accreditation within 12 months, upon receiving a written request from the Commonwealth.

### **11.6 Will there be interim accreditation arrangements for Medicare Locals?**

The Department will not be implementing interim accreditation arrangements for Medicare Locals.

## Reporting

### **12.1 What are the final reporting requirements for Divisions under the DGPP?**

Divisions will be required to complete a final report and provide an Audited Financial Statement for the DGPP. This may be in the format of the 2011-12 Twelve Month DGPP report, where applicable (i.e. for those Divisions receiving funding until 30 June 2012), or an equivalent report for the Division's 2011-12 funding period under the DGPP (i.e. for those Divisions affected by Tranche 2).

All Divisions are obliged to ensure they meet their full reporting commitments under the current DGPP Deed whether they are:

- a lead or consortium Division for a Medicare Local;
- winding up or ceasing business as a result of a Medicare Local being established in their catchment; or
- affected by a Medicare Local but not part of the consortium.

Each Division must satisfy all of their reporting obligations under the DGPP Deed (for Schedule 2 and 3 as well as any other Program Schedule).

### **12.2 What happens to a Division's 2011-12 12 Month Report for DGPP Core Funding (which is due 30 September 2012) if a Division is affected by a Tranche 2 Medicare Local?**

For Divisions either becoming a Tranche 2 Medicare Local or affected by a Tranche 2 Medicare Local and will no longer receive DGPP Core Funding, it is expected that, in lieu of the 2011-12 Twelve Month Report due on 30 September 2012, these Divisions will submit their 2011-12 Six Month Report as their final report. An Audited Financial Statement will also be required at this time for these Divisions.

These Divisions may also be required to provide a report on the key achievements and challenges during the DGPP.

All final reporting requirements and timeframes for these Divisions will be confirmed by the Department as Tranche 2 Medicare Locals are established.

### **12.3 What happens to a Division's 2011-12 12 Month Report for DGPP Core Funding (which is due 30 September 2012) if a Division is affected by a Tranche 3 Medicare Local?**

For Divisions that are either successful as a Tranche 3 Medicare Local or otherwise affected, these Divisions must provide their 2011-12 Twelve Month Report, which is due on 30 September 2012, as per the terms of the current Deed. As Divisions will have transitioned to the Medicare Locals environment by this date, appropriate provision is expected to be made to retain sufficient funds and staff to complete and submit the final deliverable, in particular those Divisions which are not becoming a Medicare Local. If Divisions require alternative reporting arrangements, a request will need to be submitted to the Department for consideration and approval prior to 30 September 2012.

## Assets

### **13.1 What happens to a Division's Assets (including real property) which were purchased using Commonwealth Funds if they are successful in applying to become a Medicare Local?**

In respect to the DGPP Deed, an Asset refers to:

- Items identified in Item H of a DGPP Program Schedule; or
- An item of tangible property purchased or leased either wholly or in part with the use of Commonwealth Funds with a value of \$5,000 or more, inclusive of GST. This does not include Program Material. The minimum value for registering an Asset under the Medicare Local Deed is an item with the purchase value of \$5,500, inclusive of GST.

Clause 19 of both the DGPP and the Medicare Local Deeds deals with Assets, including maintaining an assets register for the organisation (being the Division or the Medicare Local). Generally where a Division will transition to become a Medicare Local, then all of the Assets currently owned by that Division (as per their Asset register) which were purchased using Commonwealth Funds will transfer to the Medicare Local. Where one or more Divisions transition to a Medicare Local in a given catchment, then the Commonwealth-funded Assets of all Divisions will transfer to the Medicare Local and any surplus or duplicate Assets will be dealt with under Clause 19 of the respective Deed for Funding. That is, the Assets will be identified and approval for disposal and retention of the proceeds by the Medicare Local or the Division will be sought from the Department. No assets are to be disposed of, either by a Division or a Medicare Local, without prior written approval from the Department.

A Medicare Local may seek approval from the Department to donate any fully depreciated Assets or Assets with a low or minimal value and in reasonable working order, to a nominated charity. In accordance with Clause 19 of the Medicare Locals Deed for Funding, the Medicare Local is required to seek prior approval from the Department before selling or otherwise disposing of Assets.

As with Clause 29.5 of the Medicare Locals Deed for Funding which states that the Participant must not acquire or lease any Asset from a Related Party, non-arms length transactions (i.e. giving Assets to organisation employees or contractors) would also not be permitted.

In regards to the transfer of Real Property, such situations will be dealt with on a case by case basis once the transfer process from Division to Medicare Local is underway.

### **13.2 What happens to a Division's Assets which were purchased using Commonwealth Funds if they are not successful in applying or do not wish to become a Medicare Local?**

Clause 19 of the Deed deals with this. Generally where a Division will not transition to a Medicare Local, then the Assets currently owned by that Division (as per their Asset register) which were purchased using Commonwealth Funds will transfer to the Medicare Local that will assume responsibility for that catchment. If there are more than two Medicare Locals assuming responsibility for that catchment, then the transfer of Assets will be considered on a case by case basis (based on factors such as geographical size and population). Any surplus or duplicate Assets will be dealt with as set out under the terms of the Deed (as above).

Where a Medicare Local has advised it does not need the Assets, similar to the advice provided in 13.1, a Division may seek approval from the Department to donate any fully depreciated Assets or Assets with a low or minimal value and in reasonable working order, to a nominated charity. In accordance with Clause 19 of the DGPP Deed, the Division is required to seek prior approval from the Department before selling or otherwise disposing of Assets.

As with Clause 29.5 of the DGPP Deed, which states that the Participant must not acquire or lease any Asset from a Related Party, non-arms length transactions (i.e. giving Assets to organisation employees or contractors) would also not be permitted.

### **13.3 How will the Medicare Local know what Assets a Division has so they can be transferred?**

It is a requirement of the Deed that Divisions maintain an Asset register (Clause 19.2) and that upon request, they must provide a copy to the Department. Medicare Locals may request a copy of the Asset register from Divisions in their catchment, or in some circumstances, the Department will request a copy and provide this to the Medicare Local. Transfer of the Assets to the Medicare Local will be on either a date agreed between the Division(s) and the Medicare Local or, if there is any disagreement, a date advised by the Department.

As required under the DGPP Deed, Divisions are required to work cooperatively with the Medicare Local to ensure the continuity of services.

### **13.4 Can a Division keep their Assets if they have entered into a subcontracting arrangement with a Medicare Local?**

As the ownership of Assets that a Division previously held under a funding agreement with the Department will have been transferred to a Medicare Local, agreement will need to be reached in the event of a subcontracting agreement being entered into between the Medicare Local and the Division in order that services continue. Medicare Locals need to be aware of their obligations in respect to Assets under their Medicare Local Deed for Funding (Clause 19). It is not expected that Divisions will need to purchase new assets under a subcontracting arrangement with a Medicare Local. The Medicare Local may allow the Division to continue to use the Assets, as long as they are only used for the purposes of delivering Commonwealth funded programs. At the expiry of any subcontracting arrangement, the Assets will be returned to the Medicare Local, or if surplus or duplicate, dealt with as set out under the terms of the Deed (as above).

### **13.5 What happens with the transfer of an Asset which has been purchased using a combination of DGPP Core or Program Funds and the Division's own funds?**

It is expected that any Asset, purchased using a combination of DGPP Core or Program Funds as well as the Division's own funds, would be transferred from the Division to the Medicare Local with the Division being reimbursed its proportion contributed of the depreciated cash value.

Alternatively, upon agreement of the Medicare Local, the respective Division and the Department, the depreciated cash value may be transferred to the Medicare Local in lieu of the Asset itself, minus the proportion of the depreciated value that the Division contributed.

### **13.6 Can a Division transfer the depreciated cash equivalent of an Asset to the Medicare Local rather than the Asset?**

Generally, the Department expects that, wherever possible, the actual Asset will transfer from the Division to the Medicare Local. Depending on the circumstances of individual Divisions and Medicare Locals and the requirements of the Medicare Local with respect to an Asset, the Department may give consideration to allow for the transfer of the depreciated cash value in lieu of the Asset itself.

For instance, where an Asset is of a fixed nature and therefore it is not practical to transfer the Asset (i.e. a fixed Asset such as cabling/telephone lines), the Department will give consideration to allowing the depreciated cash value of the Asset to be transferred to the Medicare Local in lieu of the Asset itself. This will be determined on a case by case basis by the Department and with the agreement of both the Division and Medicare Local.

Where an Asset is of a fixed nature and has been purchased using a combination of DGPP Core or Program Funds as well as the Division's own funds, then, as outlined above, the depreciated cash value may be transferred to the Medicare Local in lieu of the Asset itself, minus the proportion of the depreciated value that the Division contributed.

### **13.7 If the Assets are transferred to a Medicare Local and the Medicare Local has no need for the Asset, can the Medicare Local dispose of the Assets and use the funds for program delivery?**

As outlined in Clause 19 of the Medicare Locals Deed for Funding and above, a Medicare Local must obtain prior agreement in writing from the Commonwealth before selling or otherwise disposing of an Asset.

As such, if the Medicare Local wishes to retain the proceeds from the sale of an asset(s), they must seek written approval from the Department. Any requests for approval must outline the purpose for which the proceeds will be used (Clause 19.3). If approved, these proceeds will be considered to be Funds under the Medicare Local Deed for Funding and must be included in the Annual Plan and Budget and future financial reports. Details for the Deed Manager can be found in the Item I in Schedule 1 – General Provision of the Medicare Locals Deed for Funding.

### **13.8 Is a Division still required to report or deal with assets that depreciate to below \$5,000 (GST inclusive)?**

Assets are dealt with under Clause 19 of the DGPP Deed. A Division is required to continue to include all assets originally purchased or leased with Commonwealth Funds over \$5,000 (GST inclusive) on the Assets Register. Where an asset is valued and depreciated to below \$5,000 (GST inclusive) or fully depreciated, a Division will still be required to report on this asset.

### **13.9 What is the process for approving the Assets Register before assets are transferred to the Medicare Local, sold or otherwise disposed?**

As part of the final reporting requirements under the DGPP Deed, a Division will be required to ensure their Assets Register is current and that all Assets are recorded and appropriately valued and depreciated where necessary.

In accordance with Clause 19.2 (f) of the DGPP Deed, a Division must include information on the Assets Register on the Program to which the Asset was acquire, the date of purchase or lease, the purchase or lease price, Asset description including a serial number, Asset location, the proportion of the DGPP Core or Program Funds used to create or acquire the Asset, the Depreciated value of the Asset and where appropriate, details of an approved Asset disposal including the sale price. A Division is also required to maintain appropriate and current insurance for all Assets. A copy of the current Assets Register must be provided to the Department for approval together with the final reporting documentation.

## **Liabilities**

### **14.1 What happens to a Division’s liabilities if a Division is successful in applying to become a Medicare Local?**

Where a Division will transition to become a Medicare Local then all of the liabilities payable by that Division must either be paid or transferred to the Medicare Local(s) that will assume responsibility for that geographic area. The transfer of liabilities, including staff leave and entitlement provisions will be subject to a number of factors including negotiations between the Division and the Medicare Local. In determining the transfer of such provisions, the Department encourages Divisions to seek independent legal advice if appropriate. Other liabilities, including outstanding invoices, creditors etc, will generally be paid by the Division before transitioning to a Medicare Local.

### **14.2 What happens to a Division’s liabilities if a Division is not successful in applying or does not wish to become a Medicare Local?**

Where a Division will not transition to become a Medicare Local then all of the liabilities payable by that Division would have to be paid during any winding-up process (if applicable).

## **Insurance**

### **15.1 What about insurance if a Division transitions to a Medicare Local?**

As per the terms of the current Deed Clause 26, where a Division has a ‘claims made’ insurance policy then there is a requirement to maintain a policy in like terms for seven years after the Program Agreement is terminated or expired. Medicare Locals will be required to maintain appropriate insurance policies and, as a normal incident of business, would be expected to provision for any residual insurance requirements that arise from the Deed.

## **Intellectual Property**

### **16.1 What happens with Intellectual Property when Program Materials are transferred to a Medicare Local?**

Where Program Material produced under the Deed is transferred to a Medicare Local then the Intellectual Property may transfer as well. It is a matter between the Division(s) and the Medicare Local, as separate legal persons, to deal with any subsisting Intellectual Property in any Program Material that is transferred. In any transfer of Intellectual Property to the Medicare Local, Divisions are advised to provide for the Commonwealth’s licence to use,

copy, modify and exploit the Program Material, as outlined under clause 17.2 of the current Deed.

**16.2 Does the Department need the agreement of the Division to transfer Intellectual Property to the Medicare Local?**

As the Intellectual Property in any Program Material rests with the Division who created it, permission to transfer the Intellectual Property, in Program Material, to a Medicare Local rests with the Division. The Commonwealth's licence to use, copy, modify and exploit the Program Material, as under the terms and conditions of the current Deed, should continue to apply following the transfer of any Intellectual Property to a Medicare Local.

**16.3 Is there potential for Divisions to inadvertently breach the requirements of Clause 17 of the Deed by transferring Intellectual Property to the Medicare Local?**

Under Clause 17.2, a Division grants to the Commonwealth a perpetual, irrevocable, etc., licence to use, copy, etc., Program Material. It follows that in any dealings a Division has with its Intellectual Property in its Program Material, it should be mindful of and may need to accommodate, the Commonwealth's continuing interest in the Program Material.

**16.4 Is the Division required to provide DGPP or program data to the Medicare Local at their request?**

As outlined under Clause 17.5, any Program Material (including data) developed by a Division for the purposes of and using Commonwealth Funds for the DGPP or programs will be made available freely and at no cost to the Divisions Network and the Commonwealth.

At the request of the Medicare Local, a Division within that catchment is obliged to provide any DGPP or program data to the Medicare Local. Alternatively, where necessary, the Commonwealth will seek provision of any DGPP or program data.

## **Confidentiality**

**17.1 How will Medicare Locals access any Confidential Information that the Division has, without breaching the Deed?**

Clause 27 of the Deed has the effect that the Commonwealth has the authority to allow Divisions to disclose Confidential Information to other parties, where that Confidential Information relates to the Deed, or a Program Agreement, or a Program.

Following a request for a Medicare Local to access that Confidential Information which is held by a Division, the Department will consider the request and provide notice in writing to both parties.

**17.2 Will agreement need to be sought from individuals whose confidential information transfers to a Medicare Local?**

Before Personal Information of any individual is considered by a Division for transfer to a Medicare Local, as a practical matter, it should be very clear that the information is actually required for the activities of the Medicare Local.

If it is, then the Division should closely consider its obligations, in the particular circumstances, under the *Privacy Act 1988* and clause 28 of the Deed, to ensure the proposed transfer of Personal Information is not in breach. If in doubt, the Division should secure the

consent of the individual concerned, before their Personal Information is disclosed to the Medicare Local.

The Medicare Local must advise the client upon receipt of their personal information and ensure the client is fully aware of the purpose for which the Medicare Local has obtained this information from the Division.

## **Other Issues**

### **18.1 Are there plans to direct funding through the Australian National Preventive Health Agency to Medicare Locals given the greater role seen for Medicare Locals in population health planning and preventive health?**

The Australian National Preventive Health Agency (the Agency) has been established to assist in driving the prevention agenda, including by providing evidence-based advice to Health Ministers, and supporting the development of evidence and data on the state of preventive health in Australia and the effectiveness of preventive health interventions.

The Agency's work program is currently guided by its annual operating plan and five year strategic plan. Current priorities for the Agency comprise (i) management of the social marketing campaigns aimed at obesity (Measure Up; Swap it, Don't Drop It), harmful use of alcohol and tobacco use; and (ii) driving the preventive health agenda through development of research priorities and targeted funding of these priorities.

At this stage, there are no plans to direct funding through the Agency to Medicare Locals. It is anticipated that the Agency will work closely with Medicare Locals to support preventive health efforts at the local level, however the exact nature of this relationship and the work that will be undertaken has not yet been defined.

Any changes to the role of the Agency, including as a funder of Medicare Locals, would likely need to be considered by all Health Ministers in the context of the Agency's strategic and operational plans.

### **18.2 What is the current timeline for the development of system-wide policy and state-wide planning for GP and primary health care to be developed under the National Health Reform Agreement (NHRA) and will the initial drafting process be led by the Commonwealth or the states/territories?**

The NHRA as agreed with all states and territories (refer Schedule E) provides that:

*The Commonwealth will develop by December 2012 a national strategic framework to set out agreed future policy directions and priority areas for GP and primary health care, informed by bilateral work on state-specific plans for GP and primary health care, with state-specific plans to be completed by July 2013.*

The Commonwealth (DoHA) will lead the development of system-wide policy and state-wide planning for primary health care, consistent with the Commonwealth's designated lead responsibility for GP and primary health care in the National Health Reform Agreement.

The work to be undertaken involves two connected tasks:

- the development of a national strategic framework for GP and primary health care by December 2012;
- bi-lateral state specific plans for primary health care by July 2013.

### **18.3 When will there be more detail about local Lead Clinicians Groups (LCGs) and what is the process for development of Lead Clinicians Groups?**

On 29 September 2011, the Government released the Australian Government Policy Position for LCGs. The Policy Position is available on the yourhealth website, [www.yourhealth.gov.au](http://www.yourhealth.gov.au).

The policy has been informed by a comprehensive consultation process, involving States and Territories, key stakeholder groups, clinicians, consumers and the public. There has been significant interest in the development of this initiative, with more than 115 organisations and over 390 individuals participating in multiple consultations, including: the public release of a discussion paper and subsequent position paper; meetings; interviews; workshops; and roundtable discussions.

Following a competitive Expression of Interest process and a robust assessment, the final membership of the National LCG was announced on 29 September 2011. Membership is multi-disciplinary and spans healthcare sectors including, but not limited to, hospitals, general practice, aged care, mental health, allied health, rural and remote and Indigenous healthcare. More detail on the National LCG can be found at [www.yourhealth.gov.au](http://www.yourhealth.gov.au).

The Commonwealth will continue to work with jurisdictions to establish local LCG arrangements in each State and Territory. Where appropriate and feasible, LCGs will build upon and complement, rather than duplicate, current and effective clinical engagement initiatives within States and Territories.

### **18.4 Are Lead Clinicians Groups intended to focus on clinical risk issues for Medicare Locals, or for independent and public Primary Health Care Services in the catchment?**

The establishment of LCGs is designed to enhance the engagement of clinicians both at national and local levels. Better opportunities for the engagement of clinicians will improve the communication between health care managers and their clinical colleagues, ultimately deliver better coordination of patient care between hospitals and primary care settings, and promote collaboration across health sectors to identify better ways to deliver services.

Local LCGs will advise on local implementation of guidelines and standards, and consider and provide advice to Local Hospital Networks and Medicare Locals on matters such as; integration of patient-centered care pathways across local healthcare sectors; and improving coordination of care between hospitals, aged care and the community; to best meet the needs of the local community. Their mandate will be broader than a focus on clinical risk issues for Medicare Locals alone, and will include consideration of mechanisms to improve health service delivery at the local level.

### **18.5 What will the relationship be between Medicare Locals, the LHN and the National Health Performance Authority (NHPA)?**

The National Health Performance Authority (NHPA) will monitor and report on the performance of every Local Hospital Network (LHN), every hospital – both public and private and every Medicare Local. The Hospital Performance and Healthy Communities

Reports will be prepared by the NHPA and delivered in line with the Performance and Accountability Framework (the Framework).

The Framework, which is to be agreed by the Council of Australian Governments (COAG), sets out the initial performance indicators that the NHPA will report against and the processes for determining appropriate performance criteria to assess LHNs and Medicare Locals.

The NHPA will identify high-performing organisations to facilitate sharing of innovative and effective practices, and will also identify poorly performing organisations to assist with performance management activities.

It is envisaged that the indicator set for LHNs and Medicare Locals will progressively be revised by the NHPA and Health Ministers.

The NHPA will be an independent statutory authority established under the *National Health Reform Act 2011*.

#### Relationship between LHNs and Medicare Locals

- The co-ordination of acute and primary health care is central to national health reform, which requires Medicare Locals to work with LHNs to integrate services and improve the health of local communities.
- The collaboration of LHNs and Medicare Locals through formal engagement protocols, including common membership of governance bodies where possible, will be critical in establishing joint planning of health services and integrating the delivery of care. This will enable health and hospitals to be better aligned enabling patients to move smoothly through the health system and ensure patients receive services in the most appropriate setting. Wherever possible the Commonwealth will work cooperatively with States and Territories to ensure common geographic boundaries between Medicare Locals and LHNs, including where States and Territories introduce arrangements for cross-border LHNs.

#### Relationship between LHNs and the National Health Performance Authority (NHPA)

- The NHPA will be an independent authority that will increase accountability through improving access to clear and transparent health information that is reported in a way which is nationally consistent and locally relevant.
- The NHPA will produce Hospital Performance Reports that will illustrate how LHNs and public and private hospitals are performing. The performance of Medicare Locals will be reported in the Healthy Communities Reports (see above).
- These reports will be nationally comparable, publicly reported and available for everyone to access. These reports will be used over time to drive improved performance across healthcare services.
- The Framework will set the initial performance indicators that the NHPA will report against and the processes for the determining appropriate performance criteria to assess LHNs and Medicare Locals.

#### Relationship between Medicare Locals and the NHPA

- The National Health Performance Authority will monitor and report on the performance of Medicare Locals through the Healthy Communities Report. The Healthy Communities Reports will be prepared by the National Health Performance

Authority and delivered in line with the Performance and Accountability Framework (the Framework).

- Where the NHPA identifies poor performance by a Medicare Local that plans and coordinates primary care services provided by a State or Territory, the relevant State or Territory will be consulted before the NHPA issues its final report.

### **18.6 What is the expected timeframe for the Performance and Accountability Framework to be developed and implemented?**

The Performance and Accountability Framework (the Framework) is currently being finalised and is expected to receive COAG endorsement in the near future.

However, it is envisaged that the Framework will be a living document that will need to be updated as the NHPA and its role in the health performance reporting system matures.

### **18.7. Will there be a set of shared Key Performance Indicators for Medicare Locals?**

Medicare Locals will be subject to the performance monitoring and reporting requirements of the Performance and Accountability Framework (the Framework) to be agreed by the Council of Australian Governments (COAG). The Framework will set out the initial performance indicators that the NHPA will report against and the processes for determining appropriate performance criteria to assess LHNs and Medicare Locals. Each Medicare Local's performance against the indicators will be reported through the Healthy Communities Reports.

The indicators will focus on access to services, quality of service delivery, financial responsibility, patient outcomes and/or patient experience. Performance indicators will be few in number and supported by data which is timely, comparable, administratively simple, cost effective and accurate.

Where practical, the NHPA will seek to meet its data requirements through existing national data collections, such as those held the AIHW, ABS or the states.

### **18.8 Will Medicare Locals be required to provide data regarding primary health care services within their catchment area?**

The Strategic Objectives for Medicare Locals are set out at clause D33 of the National Health Reform Agreement. One Strategic Objective is: "identifying the health needs of their local areas and development of locally focused and responsive services." This will include having appropriate expertise in data collection and analysis, strategies and referral pathways to:

- provide input into population health profiles;
- undertake population health needs assessment and planning;
- actively participating in the Performance and Accountability Framework;
- analyse primary health care service gaps and identify strategies to improve health outcomes and the quality of service delivery;
- conduct joint service planning with Local Hospital Networks and other appropriate organisations; and
- facilitate a reduction in inappropriate or inefficient service utilisation and avoidable hospitalisations.

For the purpose of streamlining the data reporting obligations of Medicare Locals under the PAF, existing data sources and existing data pathways will be used as much as possible.

However, while the NHPA will seek to source data from existing data sources held by the Australian Institute of Health and Welfare, Australian Bureau of Statistics or the states, there may be some requirements for data to be sourced from Medicare Locals.

### **18.9 How will Medicare Locals be supported to promote evidence based practice and what systems will be used to monitor actual practice against guidelines and benchmarks?**

Medicare Locals will be expected to expand on the activities of Divisions of General Practice in supporting general practitioners. Medicare Locals will also provide support to practitioners across the spectrum of primary health care service provision, to enable them to provide best practice care.

The Medicare Local National Body will support Medicare Locals to achieve their objectives and to operate effectively and efficiently. In addition, the National Body will be required to establish relationships and communication pathways across the primary health care sector, creating an opportunity for consultation and information exchange across the Medicare Local network, general practitioners, allied health professionals and consumers.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) was established on 1 July 2011 as a permanent independent body and will recommend priorities for action and disseminate knowledge and advocate for safety and quality. The ACSQHC will expand on its current role in order to develop national clinical safety and quality standards, and report against these standards. In September 2011, the ACSQHC released a consultation paper on practice-level indicators for primary health care. The indicators will be designed for voluntary inclusion in quality improvement strategies at the local practice or service level.

In addition, Medicare Locals will be subject to the performance monitoring and reporting requirements of the new Performance and Accountability Framework, agreed by Health Ministers' on 7 June 2011 and soon to be considered by COAG.

The Performance and Accountability Framework will introduce clear and transparent reporting to provide Australians with information about the performance of their health and hospital services in a way that is nationally consistent and locally relevant.

The Framework will include design principles for the Healthy Communities Reports. These Reports, to be published by the National Health Performance Authority, will include performance assessments for each Medicare Local against new service and financial reporting indicators which will focus on access to services, quality of service delivery, financial responsibility, patient outcomes and/or patient experience.

It is anticipated that the Framework will be publicly released once COAG approval is obtained.

### **18.10 How will clear lines of accountability be established for the clinical and client based work undertaken by Medicare Locals?**

Patients will continue to receive the health care they require from their individual primary health care providers. Medicare Locals will help address the primary health care needs of their communities, and help ensure the range of primary health care services needed by their communities are available and work effectively for patients.

When performing their role, Medicare Locals will need to reflect clinical and community perspectives and therefore will need to have transparent and visible processes for external engagement. These processes may include the use of advisory groups or sub groups of the Board.

**18.11 Will reporting requirements for Medicare Locals be outcomes based?**

Through the Healthy Communities Reports the NHPA will report on access to services, quality of service delivery, financial responsibility, patient outcomes and patient experience within each Medicare Local.