Dear Ms Faichney

The Australian College of Mental Health Nurses has a strong interest in the review of Medicare Locals. Mental health nurses work within primary care settings in a variety of ways, as employees and contractors of Medicare Locals, as private practitioners, and as members of the general practice team. Mental health nurses who manage acute and community mental health services are also impacted by changes in primary health care. For these reasons, the ACMHN is making a submission to the review of Medicare Locals.

**The role of MLs and their performance against stated objectives**
The ACMHN advocates for the rights of all people to equitable and effective health care services, and endorses the Alma Ata Declaration 1 on primary health care (PHC) as a means for attaining a level of health that will permit people to lead a socially and economically productive life. The Australian primary health care system should be supported and enabled to place the individual at the centre of care, increase accessibility, encourage community participation in planning and operation, focus on illness prevention and health promotion, and support a multisectoral approach. With ever increasing health care costs and an ageing population, it is undeniable that the primary health care system must be further developed to reduce the reliance on more expensive tertiary health care services.

The ACMHN is supportive of the concept of primary health care organisations that provide coordination and support to existing primary health care services, and assist in addressing gaps in primary health care. We believe Medicare Locals can play an important role in strengthening primary health care services in Australia, particularly in providing better integration with other parts of the health system and social services. These goals are reflected in the five strategic objectives of Medicare Locals which are to:

- Improve the patient journey through developing integrated and coordinated services;
- Provide support to clinicians and service providers to improve patient care;
- Identify the health needs of local areas and development of locally focused and responsive services;
- Facilitate the implementation and successful performance of primary health care initiatives and programs; and
- Be efficient and accountable with strong governance and effective management.

The ACMHN is cognizant that there are Medicare Locals that are more mature than others and that many have a strong track record against their objectives. We are concerned that many Medicare Locals have yet to achieve their stated objectives. We also acknowledge that given variability of Medicare Locals there will be some to which our comments below do not apply.

**Tendering and contracting arrangements**

The experience of ACMHN and our members has been that Medicare Locals have created additional bureaucratic processes without a commensurate increase in service delivery improvements. The processes put in place by Medicare Locals are not suited to the scale and capacity of health professionals and organisations providing primary health care. The ACMHN notes that the Medicare Locals are responding to the requirements of the Department of Health. The balance between accountability and compliance with requirements compared with service delivery and flexibility has favoured the former at the expense of the latter.

This has been most apparent in the tendering and contracting processes run by Medicare Locals for their ATAPS and MHNIP programs. Individual nurses and allied health professionals have been required to apply to deliver services under these programs by submitting a tender. This in itself is a positive development as it provides the opportunity for a wider pool of health professionals to provide services to disadvantaged people. However, the requirements of some Medicare Locals have been onerous on the health professionals. Tendering processes run by Medicare Locals appear to have been based on large scale procurement exercises, more appropriate to high value contracts with large organisations.

The Medicare Local Accreditation Scheme is another example where there has been an over emphasis on accountability and compliance compared with delivering services. All health professionals who are contracted or sub contracted by Medicare Locals to deliver ATAPS services have been asked to become accredited against the National Standards for Mental Health Services. They have been informed that this would cost in the order of $3,000 - $5,000. This is a significant financial impost on sole practitioners, which could result in health professionals opting to withdraw from this program, reducing services for consumers. This requirement is also impractical and inappropriate. While there
are guidelines to assist private office based mental health services to implement the standards, there is no tool or process available to undertake this accreditation. Accreditation against the National Standards for Mental Health Services is available to hospitals and large health services but this process is not suitable for the majority of ATAPS providers. While the ACMHN and other professional bodies agree that processes to promote the safety and quality of clinical services is important, there must be a balance between the compliance costs, appropriateness of requirements and relative risk to the public.

**Ensuring Commonwealth funding supports clinical services, rather than administration**

While the ACMHN is not in a position to estimate the cost of the bureaucratic processes that we have described above, it is logical to conclude that Medicare Locals have had to put significant resources towards meeting their compliance requirements that might otherwise have been spent on supporting direct clinical services.

At the same time, it is important to acknowledge that Medicare Locals have to meet the requirements of their funding. For example, each mental health program has different requirements in terms of funding reporting, service reporting and managing providers. We also acknowledge that some Medicare Locals appear better able to use their funding to maximise clinical services, while maintaining appropriate systems to administer these services.

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

Primary health care involves a diverse array of services, organisations and health professionals. The ACMHN acknowledges the pivotal role the general practitioner plays as a part of the primary health care team. Each health professional brings a unique and valuable contribution to the managed care of people in the primary health care setting, and they all contributing to the solid foundation of primary care. It is the opinion of the ACMHN that while the general practitioner is critical, they alone do not form the foundation of primary health care. All participants in the primary health care landscape should contribute to the functions and governance of Medicare Locals.

**Processes for ensuring that existing clinical services are not disrupted or discouraged by ML programs**

The ACMHN believes there needs to be greater transparency in Medicare Locals’ decisions to run mental health programs. We are concerned that the needs of the community are not being given sufficient weight compared with other factors. The Mental Health Nurse Incentive Program (MHNIP) is one such case. This
program is currently delivered by around 33* Medicare Locals. Medicare Locals are uniquely positioned to enable access to the MHNIP. We believe some Medicare Locals decided not to continue the MHNIP when they transitioned from Divisions of General Practice. More recently, some Medicare Locals have indicated that they will not apply to join the MHNIP because it is not financially viable for them. Other Medicare Locals who currently run the MHNIP have indicated that they may not continue the program in the future because the funding isn’t sufficient. It is concerning that the financial viability of a program appears to be the primary consideration, and the needs of the local community for services is secondary. Given the Medicare Locals objectives, community needs and filling gaps in primary care should be the primary consideration.

**Conclusion**

The ACMHN fundamentally supports the concept of primary health care organisations to develop and strengthen primary health care services in Australia. We strongly advocate that all Australians have the right to access high quality mental health care and this includes in primary health care settings. We have been disappointed that the establishment of Medicare Locals has not resulted in significant progress in developing accessible and flexible primary mental health care. Based on our experience, it appears that there has been an over emphasis on compliance and accountability requirements at the expense of flexible, innovative and high quality clinical services. We hope that this review will address this issue and result in improvements to Medicare Locals.

Yours sincerely

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* Department of Health information is that there are 33 Medicare Locals / Divisions of General Practice as registered MHNIP organisations.