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Medicare Locals and the performance regime in Primary Health Care

A review of the policy context

Alison Gable & Michele Foster

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Biographies

Alison Gable is a Research Fellow with the School of Social Work and Human Services at The University of Queensland. An early career researcher, Dr Gable's interests have focused on the research of complex phenomenon, professionalism, interdisciplinarity and education.

Michele Foster, is an Associate Professor in the School of Social Work and Human Services, University of Queensland. Her research focuses on applied health policy and health services research, with an emphasis on management of complex conditions in primary health care, policy implementation and patient experiences. Aside from her current research which also includes an NHMRC funded CRE on quality and safety at the interface of primary and secondary care, she recently completed two projects on the role of allied health services in management of chronic disease and a project on primary care patient experiences of multidisciplinary team care. Dr Foster has published in the areas of health policy and health services research and disability and rehabilitation research. She was also a contributor to the World Health Organization's (WHO) first World Report on Disability and Rehabilitation (2011).

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Medicare Locals and the performance regime in Primary Health Care: A review of the policy context

Alison Gable & Michele Foster
Social Policy Unit
Faculty of Social and Behavioural Sciences
The University of Queensland
a.gable@uq.edu.au; fosterm@uq.edu.au

Abstract

Historically, the Australian Government's driver of performance in primary health care was dominated by the use of levers to effect change in General Practice. Accordingly, performance measurement directed at achieving population health outcomes has not received much traction and in its place, ad hoc strategies have been attempted. However, with the general trend to greater transparency and accountability and in an effort to address the challenges of chronic disease, Australia has more recently taken an alternative approach to performance management. This strategy has involved the establishment of Medicare Locals (MLs), a primary health organisation, targeted at the delivery of population health outcomes. A core responsibility of MLs is to provide data for a national system of public reporting on primary health care. The initiative marks a significant shift in thinking about performance measurement in Australia's health system. This paper examines the policy contexts that have underpinned this move from the use of levers to the use of outcomes as a means to improve the quality of primary health care. It ends with a reflection on the possible challenges, tensions and contradictions that may be encountered with the implementation of MLs.

Medicare Locals and the performance regime in Primary Health Care: Medicare Locals

Introduction

Health systems around the world are undergoing major transformation and change due to the economic and social costs of accelerating rates of chronic disease (Alemu et al., 2002; Martin, Peterson, Robinson, & Sturmberg, 2009). Reform in Australia mimics global trends of building capacity in primary health care to better deliver and monitor coordinated care to patients with complex health care needs, supported by clinical protocols and guidelines, integration of services and support for patient self-management (Wagner et al., 2001; Wagner, Austin, & Von Korff, 1996; Zwar et al., 2006). In the Australian context, there is a focus on building a comprehensive primary health care system, which extends beyond the traditional and predominant general practice approach and is exemplified by a better integration of general practice with other primary care services and within the broader health care system and a stronger emphasis on meeting a community's health needs and improving overall population health. Consequently, this involves new organisational governance arrangements, alongside revised funding arrangements and financial incentives, to encourage structural reform and changes in delivery systems and demonstrated improvements in performance. Most recently, there has been the establishment of a network of Primary Health Care Organisations (PHCOs), known as Medicare Locals (MLs), which form local governance networks. It is anticipated that MLs will have capacity to facilitate better integration of services, both within and across the primary health care sector, identify and monitor population needs, and undertake strategic planning to address gaps in service delivery and improve the patient journey (Australian Government Department of Health and Ageing [DoHA] 2010). The aims of this policy summary paper are to: summarise the policy context and describe the major reforms in primary health care; and describe the emergence of Medicare Locals and briefly outline some of the key issues related to this latest development in primary health care.

Policy context and background of Primary Health Care reform

Primary health care reform in Australia is being driven most recently by two key policy developments: The National Health and Hospitals Reform Commission's (NHHRC) report, *A Healthier Future for All Australians* (2009) and the Australian Government Department of Health and Ageing's first national primary health care strategy, *Building a 21st Century Primary Health Care System* (2010a). Both emphasise the need to enhance the capacity of primary health care to respond effectively to challenges of access and equity, cost, quality, efficiency and complexity of

need associated with chronic disease and demographic trends (NHHRC, 2009). General practitioners are considered to be well positioned to address the complex problem of chronic disease management (Harris & Zwar, 2007). However in Australia it has been proposed that several barriers exist to optimal practice. Harris and Zwar (2007) argue that this may be attributed to:

- the dominance of fee-for-service funding of general practice, encouraging reactive rather than systematic care;
- a lack of multidisciplinary patient care teams with many general practices;
- limited engagement between general practice and patient self-management education programs;
- underdeveloped information and decision support systems; and
- a lack of physical infrastructure within many practices to allow workforce diversification.

Numerous reforms have ensued in the area of primary health care since the introduction of Medicare in 1984 in response to concerns about efficiency, equity, the burgeoning cost of Medicare and quality, accountability and sustainability of a 'fee-for-service' sector (Swerissen & Duckett, 2002). These reforms have represented: general practice reform, delivery system reform, and major structural reform. They have addressed issues such as: professionalisation of General Practitioners (GPs); organisation and integration of general practice within the broader health care system; and general practice capability and capacity to manage complex care needs. Over time, the reform process has demonstrated a shift in government focus from initially strengthening of GPs' professional autonomy, towards changes in delivery and governance of general practice, with a clearer definition of the role of GPs (Weller & Dunbar, 2005) within a broader concept of primary health care and within the broader health care system (Coote, 2009). Concomitantly, these reforms have shown an increasingly stronger interest in targeting the needs of communities, not simply general practices, population health planning and performance (Sturmberg, 2011).

General Practice Reform

General Practice Reform Strategy

Major reform of Primary Health Care commenced in 1989, incorporating multiple initiatives directed at the professionalisation of general practice followed by a greater commitment to improving the quality of care and further definition of the role of GPs in Australia's primary health care system (Weller & Dunbar, 2005). In 1991, this manifested itself in the *General Practice Strategy* that drove substantial form in primary care general practice over the next decade. The Strategy included workforce distribution initiatives, recognition of postgraduate training, voluntary accreditation, establishment of professional divisions and finally remuneration strategies to "reward quality of

care.....and enhance the role of general practitioners beyond individual patient care"(Bollen & Saltman, 2000, p. 23) .In addition, the strategy was an attempt to overcome problems resulting from the separation of responsibilities for primary (Commonwealth) and community (States and Territories) care, towards a better integration of the system.

Vocational Registration for GPs was introduced by the Commonwealth in 1989 via practice accreditation by The Royal Australian College of General Practitioners (RACGP, 2010), as a strategy to improve the quality and cost effectiveness of health services (Blewitt, 1989). This was couched in incentive terms, directed at encouraging the professionalisation of general practice through registration to access higher fees made available through the Medical Benefits Schedule (MBS). The then Federal Minister for Communities and Health announced that:

> In the longer term, the Government expects general practitioners to be more willing to care for more complex conditions within their competence and to be more discriminating in their use of specialist referrals, prescribing and diagnostic tests. This should lead to reduced costs in the secondary and tertiary sectors and overall a much more effective use of health resources. (Blewitt, 1989, p. 18)

In1992 *Divisions of General Practice* were established with the aim of integrating the role and work of GPs within the broader health care system. Divisions were to provide locally relevant support for GPs, with the objective of improving the quality and access to care and the efficiency of services. The concept of divisions were driven by the Royal Australian College of General Practitioners (RACGP) and the Australian Medical Association (AMA) (Bollen, 1997), nevertheless it resonated with the Australian Government's desire to move away from the individualistic approach to health care and the inefficiencies of solo practices (Pegram, Sprogis, & Buckpitt, 1995). The Divisions were subsequently described as:

> "doctors working with doctors" to promote a "wellness culture" over an illness culture. The Divisions fill the gap between the Royal Australian College of General practice (which sets standards of professional competence) and individual GPs (who make decisions about what's best for each patient). (DoHA, 2004, p. 2)

The creation of regionally based Divisions with funding support from the Australian Government generated an infrastructure, managed by GPs, to serve as professional and administrative agencies (Pegram, et al., 1995; Swerissen & Duckett, 2002). The funding covered running costs through infrastructure grants as well as project grants for a wide range of community focused activities such as practitioner up-skilling, outreach services or programs to address chronic conditions (Pegram, et al., 1995). The organisations retained the discretion to decide how practices should meet the

objectives of government initiatives (Scott & Coote, 2007). In this respect, the introduction of the Divisions established a new focus on outcomes based funding. By 1998 the Australian Divisions of General Practice (ADGP) was formed as a representative national body, although this was not intended to take on a political role (Weller & Dunbar, 2005). However, in 2008 the ADGP reviewed its role and function and rebranded itself as the Australian General Practice Network (AGPN) in a strategy directed at convincing:

> government to see the Network as the provider of choice for new or expanded primary health care initiatives. This will lead to more secure, better resourced general practice sector with increased capacity to influence the future direction, management and funding of primary health care (AGPN, 2006, p. 5).

A review of the Divisions of General Practice (DoHA, 2004) was undertaken in 2003 and showed considerable difference across the Divisions in light of their focus and performance. As a result the government established a new national quality and performance system to hold the Divisions accountable for public funding, a system of peer review and ongoing audits. In addition, strong performances would receive additional funding and increased flexibility in reporting (DoHA, 2004).

The subsequent *National Quality and Performance System* was introduced in 2005 to ideally serve as regulatory framework to link accountability objectives to quality improvement processes (Gardner, Sibthorpe, & Lonstaff, 2008) An assessment of the implementation of the framework indicates that Divisions were applying it in a “traditional command and control approach to monitoring cost, activity and output data” (Gardner, et al., 2008, p. 8) rather than as a tool for improving processes.

In a response to a subsequent review of the health system (see the 2008 National Health and Hospitals Reform Commission discussed below) the RACGP commented that:

> The primary health care (PHC) sector in Australia is...governed from multiple points via centrally controlled, narrowly focused and frequently discontinuous programs. This creates major instability, inefficiency and frustration at every level, and impacts on workforce recruitment, morale and sustainability across all PHC disciplines...The creation of multiple specific purpose general practice entities with no overarching plan and little functional connection has been a feature of the last decade. (2009, pp. 1-2)

This suggests that the Divisions as primary health care organisations had come to represent a substantial, government funded, administrative network (Coote, 2009) but was less effective in positioning GPs within the broader health care system.

Better Practice Program 1994

The Better Practice Program (BPP) was an alternative funding model designed with an objective of alleviating the limitations of the MBS. This was an attempt by the Commonwealth to move from reliance on a fee-for-service approach to primary health care (Weller & Dunbar, 2005). However, the BPP was been argued to have contributed to the deskilling of GPs resulting in increased referrals to specialist doctors (Dugdale, 1997).

To be considered eligible for this supplementary funding, practices had to meet criteria drawn from the RACGP standards for accreditation. In return, the funding served as an incentive for practices to improve patient loyalty and therefore continuity of care as well as to shift practices to underserviced rural and remote areas (Dugdale, 1997). However the program emerged during an uneasy period of relations between the Federal government and the RACGP and the AMA (Bollen & Saltman, 2000). In addition, there were concerns with the fairness of the funding formula used to determine the payments (Dugdale, 1997) and as a result, uptake was slow and limited (Bollen & Saltman, 2000).

Despite the relative failure of the program and its eventual abandonment by the Federal government, Dugdale (1997) argued it marked an important shift in funding policy:

> The value of the BPP is not primarily its capacity to improve patient loyalty or encourage doctors to move to rural areas, although these things would have been valuable achievements. These explicit policy objectives are the acceptable clothing for a muscular new technology of government. The primary significance of the BPP is that a new set of public sector financial incentives has been instituted for governing general practice. (1997, p. 73)

Practice Incentives Program 1999

The Practice Incentives Program (PIP) was initiated in 1999 to encourage short and long term changes to general practice through a new form of blended payment. It was designed to complement fee-for-service by providing another funding stream for eligible practices which met quality and accreditation standards (Duckett & Willcox, 2011). The PIP provides incentive payments to accredited general practices and Aboriginal Community Controlled Health Services (ACCHSs), on the assumption that incentivising enhanced quality of care, in addition to fee-for-service, will facilitate improvements in health outcomes (Couzos & Delaney Thiele, 2011).

The PIP signified a pay-for-performance model of incentive funding, reflective of a general global shift in health policy, aimed at driving improvements in primary health care (Boxall, 2009; de Bruin, Baan, & Struijs, 2011; Mcloughlin, Leatherman, Fletcher, & Wyn Owen, 2001). This approach to public health management adopts a variety of strategies based on a similar premise that practitioners receive financial rewards when they are able to meet quality improvement benchmarks (Boxall, 2009).

The program is administered by Medicare on behalf of the Department of Health and Ageing (DoHA). Depending on the scheme, practices can receive a one-off sign-on payment per Standardised Whole Patient Equivalent (SWPE). In addition, GPs can earn a Service Incentive Payment (SIP) for implementing particular "cycle of care" set out by RACGP clinical guidelines. To be eligible for the supplementary payments, practices must first seek accreditation from the RACGP as the organisation given responsibility for establishing the Standards for General Practice (RACGP, 2010). Access to PIP payments is a key driver for practices to seek accreditation (ANAO, 2010). These guidelines, directed at improving the quality of care, serve as a "proxy for outcomes" (Cashin & Chi, 2011, p. 3).

In performance management terms, this provides a direct financial leverage on GP behaviour. Pay-for-performance strategies in health care face several challenges in their design. The following example of a PIP initiative directed at chronic disease, illustrates the tensions involved in its implementation and its unexpected consequences.

Example: PIP – Diabetes

In 1996, the Federal Government formally recognised Diabetes as a National Health Priority (Australian Institute of Health and Welfare & Commonwealth Department of Health and Family Services, 1997) triggering the development of policies and funding initiatives to address the management of this chronic disease. In July of 1998 a new form of blended payment for the treatment of patients with diabetes was introduced in the form of the Practice Incentive Program-Diabetes Incentive (PIP-DI) (Scott, Schurer, Jensne, & Sivey, 2009). By 2001 the government's strategy for the management of this chronic health problem was realised through a $76 million National Integrated Diabetes Program directed at financial incentives for GPs and General Practice Divisions to improve diabetes care (Miller & Valenti, 2009). This co-occurred with the release of new detection and management guidelines for Type 2 diabetes (Australian Centre for Diabetes Strategies, 2005) setting out expectations of good clinical practice.

Eligible practices receive a one-off sign-on payment of $1.00 per Standardised Whole Patient Equivalent (SWPE)[1]. This payment requires practices to maintain a register of patients, including an active system for recalling and reminding them as well as implementing a "cycle of care" (Medicare Australia, 2011, p. 2). The diabetes mellitus cycle of care involves the minimum requirements for the management of the disease as set out by the RACGP guidelines. These are annual reviews that include testing, reviews and evaluation of: blood pressure, weight, feet, eyes, blood sugar, blood lipids, urine, smoking, diet, physical activity, self-care education and medication (Royal Australian College of General Practitioners & Diabetes Australia, 2011).

[1] On average, a full-time GP has approximately 1,000 SWPEs annually (Medicare Australia, 2011)

In addition, the practice receives $20 per diabetic SWPE when at least two percent of their patients are diagnosed with diabetes mellitus and a cycle of care has been completed for at least 20 per cent of these patients. Each completed cycle of care with individual patients attracts a $40 Service Incentive Payment (SIP). In order to receive the quarterly payments, practices are required to substantiate claims for payments, provide accurate information for Medicare's ongoing audit program and advise the administrative organisation in writing of any changes to the practice arrangements (Medicare Australia, 2011). In 2009-10, practices received on average, $57,800 annually as PIP payments of which $10, 017 was attributed to the care of patients with diabetes (ANAO, 2010). Table 1 details the Federal Government's total annual expenditure on the PIP-DI, encompassing all three forms of payments (Roxon, 2011). To date there remains no reporting requirements for practices to account for how payments are used (Cashin & Chi, 2011).

Table 1: Annual Expenditure for the PIP-DI (Roxon, 2011)

2006-2007	$14.888m
2007-2008	$16.390m
2008-2009	$15.764m
2009-2010	$17.236m

A report by the Australian National Audit Office (2010) on the PIP indicates that the complex nature of the program can produce a number of problems. These include:

- barriers to accreditation, for example the high costs associated with the process, can be a problem for some types of practices trying to accessing the funding program;
- unintended consequences related to the use of SWPE to determine PIP payments, for example the rewarding of practices with higher number of patient visits rather than practices encouraging longer, individual consultations;
- problems in DoHA's use of take-up statistics rather than effectiveness measures to inform the government of the program's success in meeting its objectives;
- some concerns with the Medicare's capacity to provide DoHA with current practice information in order to assure the accuracy of payments or the eligibility for the program.

Saunders, Schattner and Mathews (2008) argue that the uptake of PIP-DI has been variable amongst GPs. Their research involving 22 GPs from a single division of practice indicated that every practice had a unique system in place to implement the diabetes SIP and there were suggestions that GP decision making was highly contextualised to local communities. Here they comment:

> One GP implemented the cycle only for patients who agreed to comply with the GP's requirement of quarterly visits. Two GPs stated that they would only claim the SIPs for their 'loyal' or 'faithful' patients, i.e. those seeing only one GP. Both of these GPs were in an area where patients commonly visit multiple practices.(Saunders, et al., 2008, p. 782)

Other barriers to the incentive program included concerns about patient attitudes, uncertainty about Medicare claims, lack of time, paperwork and difficulties getting colleagues on-board (Saunders, et al., 2008).

In addition, Australian research into the implications of the incentive payments on patient care suggests a number of forces might be at play. While there are some indications of enhancement in care based on the clinical guidelines (Georgiou, Burns, & Harris, 2004; Scott, et al., 2009) these improvements were also connected to contextual issues such as practice size, location or the availability of IT support (Georgiou, et al., 2004). Accordingly, while the research indicates improvements in the quality of care for patients with diabetes as a consequence of the policy, the GP uptake of the payment may be associated with such issues as the socio-economic status of patients or the internal supports or dynamics of the practice itself.

The design of the program has also created some disquiet as to possible unintended consequences. Young, Scott and Best (2010) raised several concerns. First, that the payments could induce practices to game the system, for example by only including those patients with well controlled diabetes. Second, the program's payment of outcomes is dependent on practice level data, which in turn requires investment in information management systems and the privileging of certain types of practices. Third, the multiple sources of additional funding being made available may create red tape processes that serve as disincentives to GP behaviour change (Young, et al., 2010).

In 2010, the PIP program included 13 incentives schemes to complement the MBS providing fee-for-service payments to GPs. Currently, 82.8% of general practice patient care is provided by doctors participating in the PIP (DoHA, 2011a) making it the largest government program directed at the reform of general practice (ANAO, 2010). However, a recent review of the PIP by The World Bank indicated that too little evidence is available to justify the $2.7billion spent on the program since its inception in 1998 (Cashin & Chi, 2011). The report (Cashin & Chi, 2011) indicated that the program design maintained several barriers likely to impact performance. First, its complex structure has rendered its monitoring difficult and payments to practices less transparent. Second, the scheme allows for practitioners to access incentive programs that have the greatest potential for reward. To this end, incentive programs directed at chronic conditions were less likely to be taken up, based on the required effort perceived by practitioners. Finally, the report argued that as no reports are available indicating trends in performance, the program has failed to exploit the potential of improved data collection for policy or service delivery.

Mcloughlin et.al (2001) argue that the unique structural conditions of health care funding in different countries set the context for how pay-for-performance models are implemented. In Australia, the authors believe that the overlapping roles of Commonwealth and State governments and the existence of a universal health scheme, creates a scenario where quality improvement requirements are negotiated and implemented in order to establish nationally consistent measures and benchmarks. This has meant that ideally, Australia is well positioned to maximise the impact of pay-for-performance funding through its capacity to access national datasets on quality of care measures (Mcloughlin, et al., 2001).

However, there is a surprising lack of evidence to indicate that pay-for-performance health care policies have a direct effect on the improvement of healthcare quality (de Bruin, et al., 2011) Indeed Boxall argues that "policymakers seeking to justify the widespread implementation of P4P [Pay for Performance] schemes in the health care sector based on the strength of the available evidence will find it a difficult task" (Boxall, 2009, p. 16).

The PIP, as an example of formula funding of general practice, has been argued to represent a neo-liberal mode of government (Dugdale, 2008) through its attempts to influence the GP behaviour via incentive payments. This is underpinned by quasi-market objectives promoting freedom of choice for both Doctors and patients to take up the program and thereby engage with the type of health care practices proposed by the government (Dugdale, 2008)

Reform of General Practice in Australia, initiated by the professionalisation of practice, the introduction of administrative, professional agencies and the use of incentive funding have formed the basis of GP performance management for almost 25 years. What follows is an account of efforts to reconsider the delivery of health services in Australia as a strategy to address a major economic challenge.

Delivery System Reform

Many of the reforms in the area of primary health care in Australia have been centred on achieving the optimal funding model for a 'fee-for-service' approach but also supporting the optimal model of care to achieve good population outcomes. The justification is based on the economic and social costs of accelerating rates of chronic disease (Alemu, et al., 2002). An ongoing criticism of the funding model for primary health care in Australia was that it generally encouraged episodic and short-term interactions between GPs and individual patients, rather than continuity of care, and was ineffective in driving broader population targets (Duckett & Willcox, 2011). Consequently, reforms have also drawn on a dominant discourse that constructs chronic disease as a burden and an economic challenge (Martin & Peterson, 2009). In 2002, a World Health Organisation (WHO) report argued that due to the aging population and the relative success in general health care, countries were now in a situation of having to address long-term demands on their systems. Accordingly chronic

disease was described as “the challenge of this century”(Alemu, et al., 2002, p. 29) and therefore in need of urgent resolution.

The WHO led the way with the development of the Innovate Care of Chronic Conditions (ICCC) framework (Alemu, et al., 2002) to initiate systemic reform of health care systems. The guiding principles of the framework include (Alemu, et al., 2002):

- evidence based decision making for policy-making, this includes the use of information about clinical processes of care and expected patient outcomes;
- a population focus, involving the prioritising of specific chronic conditions where treatment and support needs are well understood;
- a prevention focus, where patients are given information and skills to reduce health risks;
- a quality focus, to ensure resources are properly utilised and where practitioners are held accountable;
- integration, where boundaries between different levels of care and interventions are blurred; and
- flexibility/adaptability requiring surveillance and evaluation of the system in order to respond to changing contexts and situations.

In Australia it has been argued that the principles of chronic care management have been adopted as a “service template rather than as a conceptual framework” (Martin, et al., 2009, p. 10). Here there are concerns that an uncritical implementation of the model is “fraught with potential unintended consequences” (Martin & Peterson, 2009, p. 581) on the basis that the focus on prevention has its own social effects. Martin and Peterson (2009) make reference to tertiary level interventions directed at reducing the complications of chronic conditions, representative of the PIP, that have had consequences for widening health disparities or the failure of these preventative measures to ameliorate chronic disease.

Nevertheless, the urgency to better manage chronic disease and improve population health outcomes has generated a number of reforms in primary care in Australia amongst which are: the Coordinated Care Trials; and the Enhanced Primary Care (EPC) program. These prevention initiatives have focused on primary health care as the point of intervention and have adopted a particular discourse on chronicity emphasising the values of evidence based medicine. This has translated to prevention strategies utilising clinical disease protocols as a basis for “payment and decision making” (Martin & Peterson, 2009, p. 581).

Coordinated Care Trials 1995

The flexibility and capacity of the health system to respond to complex health needs became the focus for health reform in 1994 (Marcus, 1999) and 1995 (COAG, 1995). Although the Council of

Australian Governments (COAG) identified three categories of individual needed to be considered in change efforts, the coordination of health care for patients was to be at the hub of this transformation (Duckett, Hogan, & Southgate, 1995). The reforms were argued to be underpinned by COAGs' new attention to the delivery of an effective and efficient health care system in order to produce "better outcomes by becoming more people focused" (Duckett, et al., 1995, p. 4). The eventual strategy in the form of Coordinated Care Trials (CCTs), was also directed at positioning GPs to play "a central role as the architect of change, rather than simply being technicians in the process" (Silagy, 2000, p. 471). Finally, it was argued that the CCTs would " break down the barriers between Federal and State programmes and services" (Joyce, 1996, ¶5) in reference to the charges of cost-shifting that had plagued commonwealth-state relations (Marcus, 1999).

Health reform was directed at identifying evidence based strategies, services and approaches to the coordination of care that could be subsequently applied on a broader scale (Duckett, et al., 1995). The major premise underpinning the COAG reforms was that "that better coordination of the care of people with chronic or complex needs would reduce hospitalisation, and the savings could cover the costs of coordination" (Esterman & Ben-Tovim, 2002, p. 469).. Accordingly, Federal and State governments became the co-sponsors of 13 trials (Joyce, 1996; Marcus, 1999) directed at identifying innovative, cost effective services that would lead to improved outcomes. This was further extended to another five in 2002 (Anderson, 2004). The trials were able to draw on a pool of Commonwealth and State funding to buy services identified in individual care plans and to cover administration costs (Silagy, 2000). This was later boosted by funding from the Enhanced Primary Care program (see below) (Anderson, 2004).

However, the trials did not produce substantive evidence linking innovative coordination of care services to patient health outcomes, including savings from reduced hospital admissions (Esterman & Ben-Tovim, 2002; Silagy, 2000). This was attributed in part to the structure of the program imposing methodological limitations to the trials (Esterman & Ben-Tovim, 2002), but might also be attributed to the ambitious nature of the trials that would have to "show how to get the money, how to spend it, how to get the right co-ordinators, and how to deal with staff issues." (Duckett, et al., 1995, p. 8). In addition, it has been noted that barriers to GP involvement in the trials were also attributed to concerns about administrative demands and perceptions of loss of professional autonomy (Marcus, 1999; Silagy, 2000).

Enhanced Primary Care program 1999

The *Enhanced Primary Care* (EPC) program was introduced with the aim of encouraging the development of coordinated and multidisciplinary care (Swerissen & Taylor, 2008; Zwar, et al., 2006). It included specific payments for GPs to undertake health assessments and care planning, as well as patient centred case conferencing (Blakeman, Harris, Comino, & Zwar, 2001). The program

therefore offered financial incentive to GPs to work collaboratively with other health professionals to develop care plans for patients with chronic diseases and complex needs (Harris & Zwar, 2007).

However, the program experienced difficulties when it became evident that it had certain implications for the work of GPs. While doctors increased their take up of health assessments, this did not necessarily translate to engagement with a multidisciplinary team (Blakeman, et al., 2001). In addition there was some indication that the organisational and time requirements required of GPs served as barriers to case planning (Blakeman, Zwar, & Harris, 2002). In 2003 a report into the burden of policy initiatives, general practice administrative costs were estimated to be $13,100 annually per GP (Productivity Commission, 2003). Three programs, the PIP, vocational registration and the EPC accounted for over three quarters of those costs (Productivity Commission, 2003).

In response to this, the EPC was later revised in 2005 with new Medicare items to better streamline care planning and facilitate collaborative meetings. The Chronic Disease Management (CDM) items were once again directed at care planning and case conferencing and could have been the reason behind the increased use of ECP Medicare items between 2005 and 2009 (Steering Committee for the Review of Government Service Provision, 2009).

In 2005, as part of the National Chronic Disease strategy, it was argued that:

> Significant resources are being committed to chronic disease prevention programs with only a limited evidence-base that is being informed by a range of disparate health data collections at both Federal and State levels. This places serious limits on our capacity to target and track the impact of these investments. Current practice is neither sustainable nor efficient, and an alternative approach is required. (National Public Health Partnership, 2006, p. 5)

While the strategy to address these concerns were directed at the implementation of a surveillance system to be managed by the Australian Institute of Health and Welfare (AIHW) (National Public Health Partnership, 2006) to connect system performance to health outcomes, the proposal did not extend to the auditing of general practice.

The effects of the co-occurring reform efforts to address the management of chronic disease and the building of general practice capacity, have been considered to be still somewhat limited (Harris & Zwar, 2007). Harris and Zwar in 2007 argued that “although there is some evidence of improved uptake and trends in quality of care, there are few published data to demonstrate that the introduction of these initiatives have been associated with improved patient health outcomes” (p. 105). This suggests that despite a focus on evidence based medicine, clinical protocols and pay for performance funding, an unequivocal link to outcomes has proved problematic. Harris and Zwar (2007) propose that Australia’s lack of significant advancement in the management of chronic diseases is in:

> part due to the lack of systemic implementation of evidence based guidelines through audit and incentives...However, long-term widespread change requires a clear national strategy for primary health care, which, among other things, tasks our Divisions to develop a common clinical governance culture within general practice. (p. 106)

This would suggest that by the end of 2007, with a general election looming, there was recognition that health reform initiatives directed at changing GP behaviour to link the quality of care directly to improved patient outcomes, had not been achieved. In addition, the solution proposed was through some sort of possible re-deployment of the Divisions of General Practice as a strategy to re-culture with work of GPs.

Major Structural Reform

National Health and Hospitals Reform Commission

Soon after the 2007 election, Labor entered into an extensive process of consultation and information gathering directed at determining the systemic problems inherent in the health system. By February 2008, Prime Minister Rudd and his Minister for Health and Ageing, Nicola Roxon had announced the establishment of the *National Health and Hospitals Reform Commission* (NHHRC) with the objective of developing a "long-term health reform plan for a modern Australia" (February 25, 2008, p. 1). This was subsequently followed by the formation of a *National Preventative Health Taskforce* directed at ensuring that proactive health measures were included in future funding agreements between Commonwealth and State governments. Soon after, the Minister for Health and Ageing launched a *National Primary Health Care Strategy* directed at "better [tackling] the health challenges of the 21st century….the strategy will provide a road map for the future direction of primary care in Australia" (Roxon, June 11, 2008, p. 1).

Following its establishment in 2008, the NHHRC was given responsibility to deliver a report, *A Healthier Future for all Australians* (NHHRC, 2009). The report presented over 100 recommendations directed at the transformation of Australia's health system. Significantly, it was argued that:

> there is a lack of transparency and no clear leadership across the whole system. People do not find it easy to know which government to hold to account- or how to effectively hold them to account- for their access to health care and the quality of that care, and resent it when governments focus on shifting cost and blame rather than making things work….They want reforms put in place that will make out health system work well, but many are concerned about the ability of our governments to work effectively together to do so. (NHHRC, 2009, p. 146)

Unlike previous reform efforts, *A Healthier Future for All Australians* (2009) suggested major structural reform of the health care system. The NHHRC report included a recommendation that "the Commonwealth government take responsibility for the policy and public funding of primary health care services" (NHHRC, 2009, p. 102). The rationale that this would boost primary health care infrastructure and primary health care services, better able to establish continuous and coordinated care for people with complex health need as well as population health planning (NHHRC, 2009). In addition, the report recommended the establishment of PHCOs to support primary health care services in order to take on these broader roles. It was proposed that the new PHCOs, to be known as Medical Locals (MLs) would evolve from or replace the traditional Divisions of General Practice.

A core group of recommendations was directed at driving cultural change and a continuous culture of reform through quality performance and integration of clinical and corporates accountabilities (NHHRC, 2009, p. 125). In this case, cultural change necessitates greater attention to community engagement, valuing of the wider health professional workforce and encouragement of clinical leadership and decision making focused on evidence based practice and use of data and critical evaluation.

The report also addressed the necessity of accountability processes for reform of Australia's health system. Specifically, the Commission recommended that the COAG Reform Council should monitor and report on the performance of state governments against national reform agreements. It was proposed that there should be three measures of success in the health system: "measures of the performance of the health services, of the public's confidence in the health system, and of the satisfaction of those working in it" (NHHRC, 2009, p. 167).

Primary health care would be subject to a set of national standards and increased requirements for public reporting. This requirement for transparency was argued to be consequential as "Patients and the Australian community do not have sufficient information about the performance of their local hospital, general practitioners and other health care providers in the system" (Australian Government, 2010p. 56). Significantly, the Commonwealth government, as the majority funder of health services would be well positioned to "impose strong national standards……backed up by explicit financial rewards and penalties" (Australian Government, 2010, p. 57). With the exception of Western Australia, COAG agreed to the reform plan and its revision of Commonwealth and State roles and responsibilities (COAG, April 19 and 20 2010).

In 2010, then Prime Minister Kevin Rudd announced that the Commonwealth would fund up to 100% of the costs associated with primary health care in a strategy directed at ending the 'blame game'(March 3 2010). He commented that

> With the Australian Government paying more of the hospital bills, it will have the incentive to make sure people are treated through less expensive and

> more appropriate primary care services….By taking full funding and policy responsibility for primary care we can also reduce the number of hospital admissions that could be avoided through providing better care in the community" (Rudd, March 3 2010,¶118-124).

According to (Donato & Segal, 2010) this shift to a single funding governance structure creates the necessary context for the development of PHCOs and therefore the "efficient and equitable delivery of primary care" (Segal, 2008, p. 2). Here it was proposed that the split between Commonwealth and State funding responsibilities served to fragment the system sufficiently to impede the development of integrated and coordinated care. Donato and Segal (2010) argued that " the allocation of primary healthcare budgets on a needs-adjusted capitation basis is the key mechanism and financial driver for PHCOs to coordinate and manage the delivery of health services for its defined population" (p. 615). More specifically the authors suggested that the development of PHCOs in conjunction with the development of a single fund holder as well as clearer accountability requirements, would serve as a foundation for the implementation of a national quality and performance framework (Donato & Segal, 2010).

However resistance to the new funding arrangement required a re-negotiation with the States resulting in an amended COAG National Health Reform Agreement originally developed in 2008. In this 2011 agreement, the Commonwealth backed away from full responsibility for primary care, towards greater recognition of the States' role. The Agreement states that while the Commonwealth would maintain full funding and responsibility for aged care, it would have "lead responsibility for GP and primary care" (COAG, 2011, p. 4) requiring a partnership relationship with the States.

This relinquishment of full funding and therefore total policy control of primary health care marks a failure to achieve substantive structural change. Segal, Dalziel and Donato (2011) have argued that this:

> undermines the ability of the reforms to deliver benefits. It represents an expensive package but one that is likely to compound existing inefficiencies. Health financing is still to be directed to health services based on pre-existing professional and discipline and program boundaries. In the absence of capitated fundholding or third-party purchasing capabilities, Medicare Locals can only operate as advisory agents….Distortions which currently plague the health system will remain. The 'reforms' may rather further entrench distortions, for instance with the centrality of the general practitioner and medical model of health again privileged." (pp. 47-48)

The inability of the Rudd government to overcome inherent problems associated with the divisions of government responsibility for health has therefore been constructed by health economists as the major stumbling block for the transformation of primary health care through an alternative form of local governance over a clinically focused, general practice profession.

Medicare Locals - Local Governance Networks for Primary Health Care
Traditionally in Australia, a Division of General Practices operated as a type of PHCO (Scott & Coote, 2010). The aims of this kind of organisation is “to increase the influence of primary care professionals, and in particular general practitioners (GPs), in health planning and resource allocation, and in the health system more generally” (Smith & Goowin (2006) cited in Smith & Mays, 2007, p. 4) Accordingly, PHCOs as a form of professional network, have been employed by a number of countries (Donato & Segal, 2010; Smith & Mays, 2007) to reform health systems towards a greater focus on primary care. However there are substantive differences across countries as to PHCO’s objectives, roles and functions (Scott & Coote, 2010).These organisations have occupied an important part of the governance of primary health care, yet it is argued that they have been more influential in *adapting* general practice infrastructure than altering or contributing to clinical performance (Scott & Coote, 2010)

In 2010, COAG announced that it would introduce a new form of PHCO. These bodies would improve the “integration of services and [reduce] access gaps so that their local community can access care that meets local needs”(COAG, April 19 and 20 2010, p. 4). In an address to a Health reform summit, Nicola Roxon stated that the Government viewed these PHCO, to be known as Medicare Locals, as “the enablers, or coordinators…the glue that will help bring these often disconnected parts of the primary care system together” (Roxan, February 8, 2011, p. 5) and therefore of particular benefit for those people with chronic diseases.

In February 2011, the government released initial guidelines (DoHA, 2011b) for the establishment and operation of Medicare Locals. Organisations were invited to apply for the first group of 15 Medicare locals expected to begin operation from July 1, 2011. This initial group would be drawn from:

> high performing Divisions of General Practice, preferably working in partnership with other organisations.
>
> The subsequent groups of Medicare Locals will build on the expertise and capacity of existing primary care organisation, particularly partnerships between Divisions of General Practice and other primary health care organisations and services. (Prime Minister & Minister for Health and Ageing, February 22, 2011, p. 2)

Donato and Segal (2010) argue that PHCO’s serve as a meso-level organisational structure where GPs are assimilated into the governance of the primary health system. Here they describe the organisation as the vehicle for:

> coordinating primary and community services; coordinating and addressing population health issues; experimenting with a range of provider payment methods beyond fee-for service; effecting national quality assurance and accountability frameworks; and developing performance management and oversight of the quality of health service providers. (p. 615)

Accordingly, PHCOs as a new governance structure are positioned as another strategy for primary health care reform, better able to address major challenges (for example chronic disease and workforce projections). In addition and with respect to problems associated with the over reliance on fee-for-service payments to GPs, a:

> PCO [Primary Care Organisations] becomes the vehicle through which a range of blended provider payment methods can be experimented with and developed over time. Unless the reliance on fee-for-service and its implied clinical focus can be reduced, the capacity for delivery of preventative population health initiatives at the local level will be impaired. (Donato & Segal, 2010, p. 616)

In light of this, MLs have been constructed by some as the possible panacea for the complex of problems associated with Australia's health care system. The Council of Australian Governments (COAG) defined the key functions of the new PHCO as being " responsible for improving integration of services and reducing access gaps so that their local community can access care that meets local needs" (COAG, April 19 and 20 2010, p. 4).

By October of 2010 a discussion paper (DoHA, 2010b) was released by the Department of Health and Aging (DoHA) inviting submissions by the following month, on the governance and function of MLs. The paper proposed that the first group would evolve from high performing Divisions of General Practice able to demonstrate their capacity to take on additional functions and responsibilities. Five key objectives for MLs were detailed:

- Identification of the health needs of local areas and development of locally focused and responsive services including a stronger focus on prevention and early intervention;
- Improving the patient journey through developing integrated and coordinated services;
- Providing support to clinicians and service providers to improve patient care, particularly the better prevention and management of chronic disease;
- Facilitating the implementation and successful performance of primary healthcare initiatives and programs; and
- Being efficient and accountable with strong governance and effective management. (DoHA, 2010b, p. 5)

In addition, it was announced that MLs were to be Commonwealth funded, independent companies subject to the Corporations Act 2001 (DoHA, 2011b). Funding for the new organisations would therefore replace the Commonwealth's financial support of the Divisions. In the future, MLs will be required to gain accreditation from an approved agency. The Department of Health and Ageing have implemented a tendering process to develop a set of accreditation standards, support and training materials in preparation of this accreditation.

Furthermore, MLs are expected to be closely aligned to several government initiatives directed at primary health care reform (DoHA, 2011b). These include:

- instituting collaboration with Local Hospital Networks and local Lead Clinical Groups;
- supporting the development of e-health including "data provision to drive health system performance, service planning, monitoring and evaluation" (DoHA, 2011b, p. 5).
- advance primary health care services in response to local needs;
- support of health care infrastructure such as GP Super Clinics;
- [building] primary health care workforce capacity to meet local needs; and
- [implementing] Government reform initiatives directed at disease prevention and management, as well as access to services.

Once completed, 62 Medical Local organisations are expected to be in operation across Australia (Roxon, November 4, 2011). Eventually the Medicare Local network will receive approximately $171 million annually from the Commonwealth, to be distributed on a funding formula that takes into account community characteristics (DoHA, 2011b).

Applications for ML funding must meet six extensive selection criteria. Significantly, the operational arrangements are expected to provide a structure that "recognises the diversity of clinicians, services and health care recipients within the modern primary health care sector" (DoHA, 2011b, p. 15) indicating a move away from GP centric PHCOs, towards broader community and health professional representation (DoHA, 2011b). In addition, the selection criteria requires applicants to demonstrate expertise in data collection and analysis suggesting that MLs are positioned as agencies or repositories of information on local health concerns, GP practices and patient outcomes.

The work of Medicare Locals will be supported by the newly established Australian Medicare Local Alliance, which came into operation on 1 July 2012. In taking a national leadership role, the Alliance will also consult and work with general practice, allied health, health, aged and social care sectors in addressing strategies around preventive health and health promotion within the primary health care sector.

Medicare Locals will contribute towards and be subject to performance monitoring and reporting under the requirements of National Health Reform. "New reporting requirements will be centralised and standardised, focussing on achievement against new performance standards" (DoHA, 2011b, p. 11). Accordingly, each ML will be assessed against service and accounting reporting standards detailing access to and quality of service, finances, patient outcomes and/or experiences. Significantly, "these new performance standards will, over time, be linked to performance managements for Medicare Locals and be outcomes focussed" (DoHA, 2011b, p. 11). The newly established National Health Performance Authority (NHPA) will report on the performance of MLs through publicly available Healthy Communities reports.

National Performance Authority announcement 2010

As part of the Australian Government's transparency and public reporting agenda, a National Health Performance Authority (NHPA) has been established as an independent agency. The NHPA is responsible for compiling and synthesising the data from primary health care systems and will therefore provide locally relevant but also nationally consistent information about the performance of the primary health care system. The *Healthy Communities* reports will focus on areas of accountability for Medicare Locals as key middle level organisations in the primary health care system and be based on key indicators contained within the Performance and Accountability Framework (henceforth the Framework)[2] . The Framework released in May 2012 contains measures of safety, quality, access, efficiency, and financial performance. For MLs, performance will be measured initially against the domains of equity, effectiveness and efficiency. Although indicators for each of the domains will continue to evolve, the NHPA has identified a range of indicators[3]. The interpretation of performance information will take into account of the unique geographical, population and socio-economic elements of individual MLs.

Establishment of the NHPA as a statutory authority, has been underpinned by the National Health Reform Amendment (National Health Performance Authority) Bill 2011 (The Parliament of the Commonwealth of Australia, 2011). During the second reading of the bill, Roxon argued that it was legislation that would:

> form part of the new backbone of a modern, integrated, high performing health system...to create a National Health Performance Authority – the new watchdog for Australia's health system…This forms one critical element of a new health system – one that is sustainable, transparent, efficient, high performing and well resourced. (Commonwealth of Australia House of Representatives, March 3, 2011, p. 2192)

[2] http://www.nhpa.gov.au/internet/nhpa/publishing.nsf/Content/PAF
[3] http://www.nhpa.gov.au/internet/nhpa/publishing.nsf/Content/PAF~PAF-Section-6~PAF-Section-6-3#fig6image

However, by June of 2011 Victoria and Western Australia were expressing considerable concern with the potential of the new authority to identify underperforming hospitals (Dunlevy, June 3, 2011; Medew, June 8, 2011) which had the effect of delaying the creation of the authority. The bill was eventually signed in October of 2011 to establish the Authority.

Reflection

It is evident to date that realising a broader concept of primary health care, with a strong focus on population health and planning has been difficult to achieve in general practice settings, despite the wide range of reforms around funding, financial incentives and delivery system changes. It is reasonable to suggest that government reform efforts often sit uneasily with the GP community. A 1997 survey of GPs satisfaction and sense of fulfilment with their work and its influence on the quality of care for patients, indicates personal tensions between the need for reform and government efforts to remedy the problem. The authors argue that:

> GPs appear to be caught in a bind between wanting structural change to general practice to improve its viability and affirm its pivotal role in the health system, and resenting strategies of government and GP professional bodies which are designed to improve the status and functioning of the profession. (Bailie et al., 1998, p. 64)

It could be argued, that underpinning this tension is concerns with the professional autonomy of GPs and its connection to increased “rules, incentives and pressures to change how GPs work” (Lewis, Marjoribanks, & Pirotta, 2003, p. 46). While this challenge to autonomy often translates to significant pressure of doctors’ professional bodies on government policy development and implementation, it may also manifest itself in personal resistance to reform initiatives. Some of the uncertainties and tensions inherent in the ML approach include the extent of control that will be exerted over general practices and clinical decision-making both in terms of priority-setting and funding. These issues were raised by the AMA[4] in response to a Department of Health and Ageing’s discussion paper on the governance and functions of Medicare Locals (DoHA, 2010b).

Nonetheless, the formation of MLs as an alternative PHCO marks a new era in Australian primary health care governance. They have been described as the vehicle by which the major health policy reforms of the Rudd government can be realised (AGPN, 2009) In this respect MLs serve as an organisational structure directed at reforming primary health care, and its practitioners, in order to meet contemporary challenges faced by health care systems. Many of these challenges are related to determinants of health which extend into the social and structural domains and which the MLs will have to grapple with if they are to address key performance indicators around equity and effectiveness. In taking a population health planning focus, MLs are expected to develop a sound

[4] See https://ama.com.au/ama-response-medicare-locals-discussion-paper-governance-and-function

knowledge and ongoing monitoring of a community's health and the determinants of health (Sturmberg, 2011). Development of stronger partnerships between primary health care clinicians and other local community services, which traditionally have a focus on a broader concept of health and non-health determinants is also expected (Smith & Mays, 2007).

However, the feasibility and sustainability of such a broader community development approach in quite diverse geographical, population and resource contexts will require capital and infrastructure support. What incentives and funding will be provided to MLs and how this might be governed and allocated both at the ML level and within MLs, is unknown. It has also been argued that the particular structure proposed by the Government may well maintain "the prevailing disease and hospital centric orientation to health care, despite the desired shift towards a primary health care orientated health system" (Sturmberg, 2011, p. 528). Sturmberg (2011) proposes that the failure of the new structure to take into account epidemiology of illness and disease in combination with the focus on implementing policy initiatives and the control of how MLs will undertake their business, will serve as barriers to local responses to community contexts.

The *Health Communities* reports will be the main mechanism for reporting on performance of MLs in relation to a community's health and health outcomes, initially on the dimensions of equity, effectiveness and efficiency. The potential advantage of these reports lies in being able to identify and readily target determinants that improve performance in these areas, given they are likely to involve a complex combination of clinical (at the practice level), social (at the community level) and structural (at the political and systems levels) factors. The complexity of unraveling these factors and uncertainty about where to credit and target accountability is clearly evident. Further, there is a lack of clarity about government accountability, both to the MLs and communities, in the event of poor performance around these performance indicators and health outcomes of a community generally. Moreover, it is unclear what avenues will be made available for communities themselves to participate in decision-making and planning in light of these Reports.

Given that Australia has been gradually attempting to transform its primary health care system over the last decade towards the efficient and effective management of chronic disease, MLs serves as a potentially significant test-case of a new governance strategy.

Acronyms

ACCHSs	Aboriginal Community Controlled Health Services
ADGP	Australian Divisions of General Practice
AGPN	Australian General Practice Network
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
BPP	Better Practice Program
CCTs	Coordinated Care Trials
CDM	Chronic Disease Management
COAG	Council of Australian Governments
DoHA	Department of Health and Ageing
EPC	Enhanced Primary Care program
GPs	General Practitioners
ICCC	Innovate Care of Chronic Conditions
MBS	Medical Benefits Schedule
MLs	Medicare Locals
NHHRC	National Health and Hospitals Reform Commission
NHPA	National Health Performance Authority
PHC	Primary Health Care
PHCOs	Primary Health Care Organisations
PIP	Practice Incentives Program
PIP-DI	the Practice Incentive Program-Diabetes Incentive
RACGP	Royal Australian College of General Practitioners
SWPE	Standardised Whole Patient Equivalent
WHO	World Health Organisation

References

AGPN. (2006). A stronger network, a stronger voice. Canberra: Department of Health and Ageing.

AGPN. (2009). Connecting care: A blueprint for improving the health and wellbeing of the Australian population- the role and function of Primary Health Care Organisations. Canberra: Australian General Practice Network.

Alemu, S., Hua, F., Green, D., Narvaez, D., Penny, J., Pezeshkian, M., . . . Sefiwa, J. (2002). Innovative care for chronic conditions: Building blocks for action. Geneva: World Health Organisation.

ANAO. (2010). *Practice Incentives Program* Canberra, ACT: Attorney-General's Department Retrieved from http://www.anao.gov.au/uploads/documents/2010-11_Audit_Report_No5.pdf.

Anderson, R. (2004). Coordinated Care Trials 3. Retrieved February 6, 2012, from http://hpm.org/en/Surveys/CHERE_-_Australia/03/Coordinated_Care_Trials.html?p_i=0&showDetails=861&sortOrder=sortAsc&a=sh&lastSortBy=sortCountry&p_ft=coordinated+care&content_id=251&sortBy=sortCountry&p_c:253=253&lastSortOrder=sortAsc&pageOffset=0&language=en

Australian Centre for Diabetes Strategies. (2005). *National evidence based guidelines for the management of Type 2 Diabetes Mellitus*. Canberra, ACT: National Health and Medical Research Council Retrieved from http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/di7.pdf.

Australian Government. (2010). *A National Health and Hospitals Network for Australia's Future*. Canberra: Commonwealth of Australia.

Australian Institute of Health and Welfare, & Commonwealth Department of Health and Family Services. (1997). First report on National Health Priority Areas 1996. Canberra.

Bailie, R., Sibthorpe, B., Douglas, B., Broom, D., Attewell, R., & McGuiness, C. (1998). Mixed feelings: Satisfaction and disillusionment among Australian GPs. *Family Practice, 15*(1), 58-66.

Blakeman, T., Harris, M., Comino, E., & Zwar, N. (2001). Implementation of the enhanced primary care items requires ongoing eduation and evaluation. *Australian Family Physician, 30*(1), 75-77.

Blakeman, T., Zwar, N., & Harris, M. (2002). Evaluating general practitioners' views on the enhanced primary care items for care planning and case conferencing. *Australian Family Physician, 31*(6), 582-585.

Blewitt, N. (1989). Community services and health legislation amendment bill 1989 *House of Representatives Hansard, 2386*: Commonwealth of Australia.

Bollen, M. (1997). Recent changes in Australian general practice. *The Medical Journal of Australia, 164*(4), 212-215.

Bollen, M., & Saltman, D. (2000). A history of general practice in Australia *in General practice in Australia:2000* (pp. 3-39). Canberra: Department of Health and Aged Care.

Boxall, A. (2009). Research paper:Should we expand the use of pay-for-performance in health care? Canberra: Department of Parliamentary Services.

Cashin, C., & Chi, Y. L. (2011). Australia: The Practice Incentives Program (PIP) *Major developments in Results-Based Financing (RBF) in OECD countries*. Washington, DC: The World Bank.

COAG. (1995). Council of Australian Governments' meeting 11 April 1995.

COAG. (2011). *National Health Reform Agreement*. Canberra, ACT: Council of Australian Governments.

COAG. (April 19 and 20 2010). *Council of Australian Governments meeting communique*. Canberra: Council of Australian Governments.

Commonwealth of Australia House of Representatives. (March 3, 2011). *Parliamentary debates*. Canberra, ACT: Official Handsard.

Coote, W. (2009). General practice reforms,1989-2009. *Medical Journal of Australia, 191*(2), 58-61.

Couzos, S., & Delaney Thiele, D. (2011). The new "Indigenous health" incentive payment: Issues and challenges. *Medical Journal of Australia, 3*(1), 154-157.

de Bruin, S., Baan, C., & Struijs, J. (2011). Pay-for-performance in disease management: a systematice review of the literature. *BMC Health Services Research, 11*(272), 1-36. Retrieved from

DoHA. (2004). *Divisions of General Practice: Future dirctions: Government response to the report of the review of the role of Divisions of General Practice*. Canberra: Department of Health and Ageing.

DoHA. (2010a). *Building a 21st Century Primary Health Care System*. Canberra, ACT: Commonwealth of Australia.

DoHA. (2010b). *Medicare Locals: Discussion paper on governance and functions*. Canberra: Department of Health and Ageing.

DoHA. (2011a). 2010-2011 Annual Report. Canberra, ACT: Department of Health and Ageing.

DoHA. (2011b). *Medicare Locals: Guidelines for the establishment and initial operation of Medicare Locals & information for applicants wishing to apply for funding to establish a Medical Local*. Canberra: Department of Health and Ageing.

Donato, R., & Segal, L. (2010). The economics of primary healthcare reform in Australia- towards single fundholding through development of primary care organisations. *Australian and New Zealand Journal of Public Health, 34*(6), 613-619.

Duckett, S., Hogan, T., & Southgate, J. (1995). The COAG reforms and community health services. *Australian Journal of Primary Health-Interchange, 1*(1), 3-10.

Duckett, S., & Willcox, S. (2011). *The Australian health care system*. South Melbourne, Vic: Oxford University Press.

Dugdale, P. (1997). The Better Practice Program funding formula: A neo-liberal approach to funding general practice. *Australian Journal of Public Administration, 56*(3), 65-76.

Dugdale, P. (2008). *Doing health policy in Australia*. Sydney: Allen & Unwin.

Dunlevy, S. (June 3, 2011). Nicola Roxon threat as states rebel over health reforms, *The Australian*.

Esterman, A., & Ben-Tovim, D. (2002). The Australian coordinated care trials: success or failure? *Medical Journal of Australia, 177*, 469-470.

Gardner, K., Sibthorpe, B., & Lonstaff, D. (2008). National quality and performance system for Divisions of General Practice: Early reflections on a system under development. *Australian and New Zealand Health Policy, 5*(8), 1-8.

Georgiou, A., Burns, J., & Harris, M. (2004). GP claims for completing diabetes 'cycle of care'. *Australian Family Physician, 33*(9), 755-757.

Harris, M., & Zwar, N. (2007). Care of patients with chronic disease: The challenge for general practice. *Medical Journal of Australia, 187*(2), 104-107.

Joyce, L. (1996). Media release: Coordinated care trials get the green light: Department of Health and Ageing.

Lewis, J., Marjoribanks, T., & Pirotta, M. (2003). Changing professions: General practitioners' perceptions of autonomy on the frontline. *Journal of Sociology, 39*(1), 44-61.

Marcus, D. (1999). Current issues brief 11 1998-99: Coordinated care in an uncoordinated health system: The development and implementation of Coordinated Care Trials in Australia. Canberra: Parliamentary Library.

Martin, C., & Peterson, C. (2009). The social construction of chronicity - a key to understanding chronic care transformation. *Journal of Evaluation in Clinical Practice, 15*, 578-585.

Martin, C., Peterson, C., Robinson, R., & Sturmberg, J. (2009). Care for chronic illness in Australian general practice - focus groups of chronic disease self-help groups over 10 years: implications for chronc care systems reforms. *Asia Pacific Family Medicine, 8*(1), 1-14.

Mcloughlin, V., Leatherman, S., Fletcher, M., & Wyn Owen, J. (2001). Improving performance using indicators. Recent experiences in the United States, the United Kingdom, and Australia. *International Journal for Quality in Health Care, 13*(6), 455-462.

Medew, J. (June 8, 2011). National accord reached on hospital performance, *The Age*.

Medicare Australia. (2011). *Practice Incentive Program Diabetes incentive guidelines*. Canberra, ACT: Medicare Australia Retrieved from http://www.medicareaustralia.gov.au/provider/incentives/pip/files/2709-4-diabetes-incentive-guidelines.pdf.

Miller, G., & Valenti, L. (2009). Type 2 diabetes. In H. Britt & G. C. Miller (Eds.), *General practice in Australia, health priorities and policies 1998-2008* (pp. 171-184). Canberra, ACT: Australian Institute of Health and Welfare.

National Public Health Partnership. (2006). Blueprint for nation-wide surveillance of chronic diseases and associated determinants. Melbourne, Australia.

NHHRC. (2009). A healthier future for all Australians: Final report June 2009. Canberra: National Health and Hospitals Reform Commission.

Pegram, R., Sprogis, A., & Buckpitt, J. (1995). Divisions of general practice: A status review. *Australian Health Review, 18*(4), 78-94.

Prime Minister, & Minister for Health and Ageing. (February 22, 2011). Media release: Next steps to establish Medicare Locals. Canberra, ACT: Minister for Health and Ageing's office.

Prime Minister, & Minister for Health and Ageing. (February 25, 2008). Media release: National Health and Hospitals Reform Commission. Canberra, ACT: Minister for Health and Ageing.

Productivity Commission. (2003). General Practice Administrative and Compliance Costs. Canberra: The Productivity Commission.

RACGP. (2010). Standards for general practices. In The Royal Australian College of General Practitioners (Ed.), (4th ed.). Melbourne, Vic: The Royal Australian College of General Practitioners.

Roxan, N. (February 8, 2011). Address to the Australian Health Care Reform Alliance: Health reform summit. Canberra, ACT: Minister for Health and Ageing.

Roxon, N. (2011). Practice Incentive Program: Diabetes Incentive *House of Representatives Parliamentary Debates* (Vol. 117, pp. 114).

Roxon, N. (June 11, 2008). Media release: National Primary Health Care Strategy. Canberra, ACT: Minister for Health and Ageing.

Roxon, N. (November 4, 2011). Media release: 38 organisations named to drive primary health care reform. Canberra: Department of Health and Ageing.

Royal Australian College of General Practitioners, & Diabetes Australia. (2011). *Diabetes management in General Practice Guidelines for Type 2 Diabetes*. Sydney, NSW: Diabetes Australia Retrieved from http://www.racgp.org.au/Content/NavigationMenu/ClinicalResources/RACGPGuidelines/Diabetesmanagement/201107diabetesmanagementingeneralpractice.pdf.

Rudd, K. (March 3 2010). Better health, better hospitals: Speech to the National Press Club on the National Health and Hospitals Network.

Saunders, M., Schattner, P., & Mathews, M. (2008). Diabetes 'cycles of care' in general practice: Do government incentives help? *Australian Family Physician, 37*(9), 781-784.

Scott, A., & Coote, W. (2007). Whither Divisions of General Practice. An empirical and policy analysis of the impact of Divisions within the Australian health care system. *Medical Journal of Australia, 187*(2), 95-99.

Scott, A., & Coote, W. (2010). Do regional primary-care organisations influence primary-care performance? A dynamic panel estimation. *Health Economics, 19*, 716-729.

Scott, A., Schurer, S., Jensne, P., & Sivey, P. (2009). The effects of an incentive program on quality of care in diabetes management. *Health Economics, 18*, 1091-1108.

Segal, L. (2008). Health & Hospital Reform Commission discussion paper: A vision for primay care: Funding and other system factors for optimising the primary care contribution to the community's health.

Segal, L., Dalziel, K., & Donato, R. (2011). Economics-informed policy can drive better health but there are few gains without structural change. *Dialogue -Academy of the Social Sciences in Austraila, 31*(1), 44-50.

Silagy, C. (2000). Coordinated Care Trials *in General practice in Australia:2000* (pp. 470-491). Canberra: Department of Health and Aged Care.

Smith, J., & Mays, N. (2007). Primary care organizations in New Zealand and England: tipping the balance of the health system in favour or primary care? *International Journal of Health Planning and Management, 22*(1), 3-19.

Steering Committee for the Review of Government Service Provision. (2009). Report on government services. Canberra: The Productivity Commission.

Sturmberg, J. (2011). Primary health care organizations - through a conceptual and political lens. *Journal of Evaluation in Clinical Practice, 17*, 525-529.

Swerissen, H., & Duckett, S. (2002). Health policy and financing. In H. Gardner & S. Barraclough (Eds.), *Health policy in Australia* (2nd ed., pp. 13-48). Melbourne: Oxford University Press.

Swerissen, H., & Taylor, M. (2008). Reforming funding for chronic illness: Medicare-CDM. *Australian Health Review, 32*(1), 76-84.

The Parliament of the Commonwealth of Australia. (2011). *National Health Reform Amendment (National Health Performance Authority) Bill 2011*. Canberra, ACT: The Parliament of the Commonwealth of Australia.

The Royal Australian College of General Practitioners. (2009). Response to the interim report of the National Health and Hospitals Reform Commission.

Wagner, E., Austin, B., Davis, C., Hindmarsh, M., Schaefer, J., & Bonomi, A. (2001). Improving chronic illness care: Translating evidence into action. *Health Affairs, 20*(6), 64-78.

Wagner, E., Austin, B., & Von Korff, M. (1996). Organizing care for patients with chronic illness. *The Milbank Quarterly, 74*(4), 511-544.

Weller, D., & Dunbar, J. (2005). History, policy and context. In Department of Health and Ageing (Ed.), *General Practice in Australia: 2004* (pp. 2-31). Canberra: Department of Health and Ageing.

Young, D., Scott, A., & Best, J. (2010). For love or money? Changing the way GPs are paid to provide diabetes care. *Medical Journal of Australia, 193*(2), 67-68.

Zwar, N., Harris, M., Griffiths, R., Roland, M., Dennis, S., Powell Davies, G., & Hasan, I. (2006). A systematic review of chronic disease management. UNSW: Research Centre for Primary Health Care and Equity.