

ABORIGINAL HEALTH COUNCIL OF WA



SECTOR MEETINGS ON MEDICAL LOCALS IN WA

DISCUSSION & NEGOTIATIONS FOR ACCHO
ENGAGEMENT IN THE ROLLOUT OF MEDICARE
LOCALS HELD AT THE RENDEZVOUS HOTEL ON
14 & 15 APRIL 2011

This is a detailed report of the Medicare Locals discussion in the afternoon session of the State Sector Annual Planning Day held on 14 April. The report also presents a detailed record of the discussions which took place on Friday 15 April between the GP Divisions, the ACCHO sector and the DoHA on ACCHO engagement and views on particular policy issues with respect to the establishment of Medicare Locals in WA.

THE AFTERNOON SESSION OF THE 14 APRIL STATE SECTOR ANNUAL PLANNING DAY

Introduction and Background

The Department of Health and Ageing organised a facilitator to work through a number of issues in two separate sessions with the Aboriginal Community Controlled Health Organisation Sector and with the WA GP Network stakeholder group.

The stimulus for these facilitated sessions was recognition that the ACCHO sector had expressed a range of mounting concerns about the lack of engagement they had experienced during the period when Medicare Local (ML) proposals by Divisions of General Practice had been invited by the Australian Government.

There was concern also about confusion, mis-information and the apparently 'rigid' interpretation of the Australian Government's Medicare Locals application guidelines by the Divisions of General Practice.

The sector was not prepared to support any proposals largely due to the lack of engagement and denial of opportunities to participate and contribute to the thinking about important considerations such as the number of MLs and geographical boundaries each ML would cover in WA.

There was also some confusion about how the ML policy might affect current and future funding for ACCHS and a reluctance to trust and accept the various reassurances which were being provided. This was largely because it appeared that there were different messages depending on 'who spoke to whom'.

During the 2011 State Sector Conference which had been held over the prior two days, there were three presentations which specifically addressed ML policy developments. These presentations and the messages conveyed to Conference delegates was then viewed in context with various statements and affirmations from officials in and from the Department of Health and Ageing in Canberra, even during the Conference itself.

The most recent focus and confusion about the ML policy during and since the Conference event had left sector stakeholders with a very much heightened sense of urgency and concern about how the ML policy would eventuate in WA.

At the same time, the GP Divisions who have been involved in responding to the Invitation To Apply (ITA) guidelines from the DoHA had been developing their proposals based on their unique interpretation of the guidelines, the various messages and statements they had received from Canberra and from within the context of their own 'world view' as largely a sector comprised of GPs.

Thursday 14 & Friday 15 April ACCHO and GP Divisions sector meetings on Medicare Locals in WA

The recognition that the lack of support for their proposals from the ACCHO sector had begun to impress the GP Division sector and they had been encouraged to get to terms with the fact that they needed to sort this problem out very quickly.

As a sector, the GP Divisions are under threat because the Divisions are to be abolished and their functions (some of them at least) are to be absorbed into new MLs. For this reason, it appears that many of them have assumed that this part of the policy rollout was mostly about 'them' and that there was no requirement for them to take a highly consultative or partnering approach with other sectors such as the ACCHO sector.

Given the degree of concern and mounting hostility, the DoHA took the opportunity presented by the State Sector Planning Day post Conference event to invest in a facilitator supported series of focused discussions to find a constructive way forward for both sectors.

The plan was for the facilitator to:

1. Spend a few hours during the morning of Thursday 14 April with the GP Division stakeholder group; followed by
2. A similar session with the ACCHO sector participant group attending the Planning Day; and finally
3. A facilitated joint meeting between the two sectors scheduled for the following day on Friday 15 April aimed at reaching an agreement on the way forward from this point.

Pre Facilitated Session Discussions

The participants took the opportunity to have some discussion amongst themselves prior to the arrival of Nicole O'Keefe, State Manager of the Department of Health and Ageing's State Office in WA and the event facilitator Ms Kari Kristiansen.

Vicki O'Donnell, Chair of AHCWA and CEO of the Derby Aboriginal Health Service opened the session and the first order of business was to bid a formal farewell and say thanks to Ernie Dingo for his MC role in the Conference and the morning session of the Member's Planning Day.

A few key aspects of MLs discussed. There were:

- AHCWA Principles for engagement;
- ML boundaries;
- Funding Policy;
- Governance Policy; and
- General discussion.

AHCWA Principles for Engagement

Sue Christophoulos from AHCWA outlined a draft framework which had been prepared by AHCWA to guide involvement of ACCHS in the development of applications for Medicare Locals in WA. The points encompassed in the draft framework are copied below:

1. The Aboriginal Health Council of WA (AHCWA) and all Aboriginal community controlled health services (ACCHSs) within the proposed ML area will be invited to a face-to-face meeting within two weeks of receiving the 'Invitation to Apply', with the meeting funded and organised by the GP Divisions involved.
2. The Aboriginal Health Council of WA and all ACCHSs within the proposed ML area will be invited to be on the organising committee for the development of the application.
3. The application will include a statement of recognition that AHCWA's preferred option is for a Statewide Aboriginal Primary Health Care Organisation.
4. The application will include a statement of support for the concept of Aboriginal community control of primary health care services for Aboriginal people.
5. The application will include a commitment to ensuring that ACCHSs are appropriately resourced and supported to provide ongoing comprehensive primary health care to Aboriginal people.
6. The application will include a commitment to supporting the development of ACCHSs in areas where they currently do not exist, and to using the resources of the ML to support this.
7. The application will include the framework for a governance structure which will give Aboriginal people and their organisations genuine priority setting and decision making powers within the ML.

Boundaries

Initially, commonwealth planning was to have a ML per population number, but in WA, the population outside the metropolitan area is only big enough in overall number terms to attract one ML if the guidelines are followed. This would mean that there would be one ML for the entire state of WA outside of Perth itself, the South West and whatever arrangements might be determined for the Wheatbelt region. The sector doesn't believe this is feasible and thinks that this would disadvantage the workability of regions.

The sector view is that there should be three MLs outside of Perth, noting that the Wheatbelt are opting out of being involved in a ML along with the southern regions of the state.

There needs to be discussion around the boundary solutions for WA.

There is also the question as to how we ensure that the Wheatbelt region gets the voice they need for the Aboriginal people who live there. They are disadvantaged because they have no AMS. Chris Renshaw proposed that AHCWA speak for the Wheatbelt region's needs at this stage.

A question was posed from the Bega health service, asking if, because BEGA only serves Kalgoorlie, it could appropriately represent Aboriginal people in the entire Goldfields region. It was pointed out that Bega is situated in Kalgoorlie, but that its constitution is that it is a regional service. It is only its resources which restrict its clinic operations to a single site in Kalgoorlie.

Funding Policy

Thursday 14 & Friday 15 April ACCHO and GP Divisions sector meetings on Medicare Locals in WA

The policy framework for the distribution of funds was also discussed and it was proposed that funding distribution decisions should be put through the Regional Aboriginal Health Planning Forum system already established.

Governance Policy

It was stressed that there needs to be some care given to policy wording. For example, ML governance should consider Aboriginal interests and not simply AMS representation. There was also the view that the sector should be advocating for a policy of Aboriginal representation on ML governance boards.

Ron Richards addressed the Members at this point. He said that his reading of the document was that government were calling for specific expertise criteria for people sitting on the governance boards of MLs and on this basis it may be unlikely that Aboriginal community people would qualify as it appeared to be weighted in favour of members who were GPs.

General Discussion

Glenda Humes, CEO of the South West Aboriginal Medical Service pointed out that this largely undirected group discussion was making

“Huge intellectual jumps around the discussion right now because some people here know very little about the ML policy at this point in time, whereas others have had the benefit of having been involved in many discussions”.

Chris Larkin, CEO Kimberley Aboriginal Medical Service Council said he thought this was

“A great leap of faith for us. I am reminded of Sandy Davis’ comments to Members in the morning session. I think people here now are all still piecing this together with varying degrees of information. I am concerned that at this point in time, Members are ‘jumping around’ on issues because they haven’t been well enough informed”.

Chris Renshaw reminded that participants that:

“The sector doesn’t yet have a position and that this is what the facilitated session this afternoon was intended to help us with. We should listen to what they have to say and work through that process”.

Both Danni Brown and Chris Renshaw offered comments about the teleconference with Canberra officials a few weeks ago. They agreed the main message was that if we put something on the table they will pick it up and look at it but if we put nothing up, they will assume we don’t have a position.

Wayne Johnson from Bega expressed the view that the reality is we are trying to ‘buy a place at the table’ for a policy solution which is being developed almost exclusively with mainstream concepts in the best interests of doctor and whitefellas.

Chips Bin Kali asked for clarification of whether or not AHCWA had put up any proposals via the Technical Team. Vicki confirmed that they had not. She also advised that AHCWA had sent a letter

stating that the sector does not agree with them going ahead without consultation with sector. The GP Divisions have put up applications for the first round of invited applications because the government said it would only look at their proposals in this round. Therefore, the GP Divisions have put up proposals knowing they have not been done with any collaboration with our sector.

Chris Renshaw said that he recalled that in April 2010 there had been a meeting in Perth with Canberra officials and that there had been a working group set up to put forward a proposition. This was sent to Canberra and it was also sent out to every ACCHS.

The Facilitated Session

At this point Nicole O'Keefe arrived with facilitator Kari Kristiansen and Vicki introduced them and handed the proceedings to Kari.

Karri Kristiansen explained that the job for this afternoon was to work toward a clear understanding of strongly held views and to see if the Members can develop a consensus.

She called upon Nicole to summarise the main points about the ML policy. Nicole's summary was:

- There are going to be MLs – no doubt about it;
- In first wave of applications, the Divisions of General Practice who chose to respond to the ITA will be merged into new MLs and as such will no longer exist as separate GP Divisions. Those who chose not to put up an application will cease to exist altogether;
- This accounts for a lot of the anxiety amongst the GP Division sector;
- ACCHS funding is quarantined and won't go into or through the MLs;
- ACCHS will stay in the existing format and they are secure;
- Providing services is not core business for MLs but there will be some 'migration' of existing services from the GP Divisions on a needs basis to ensure continuity for service users;
- The core role of the MLs is purchasing services rather than providing them;
- MLs will determine how primary health care funding is directed and how they can allocate funding in the future to get services happening where they are most needed;
- As an example, mental health funding for primary health won't go through Nicole's office any longer for distribution decisions and administration. In future, these funds will go to the relevant MLs who will be best placed to determine how best to distribute the funding within the area they are responsible for;
- The current ACCHS funding position is very secure and your outlook for the future is even better;
- The second wave of proposals will provide an opportunity for Divisions and ACCHS to develop joint proposals;
- In respect to the skill criteria for ML board membership, proponents must include in their proposals the governance framework and skill sets they believe will be best suited;
- The governance framework Ron Richards was referring to when he made his comments had come from a GP Division proposal and not from the commonwealth policy. Therefore, it was simply the view from one party as to what a ML board should look like.

Chris Renshaw asked if it was a given that any proposal put would need to demonstrate that it had support from the ACCHS sector.

In response to this, Nicole stated that there will be selection criteria and weightings. She said her office has advised Canberra strongly that when applicants claim partnerships with other sectors that these are tested properly in the application and selection process.

Nicole took the opportunity to address the obvious concern amongst the Members present about the word 'quarantine.' She said they hadn't realized how Members might interpret this word and that she regrets if this has caused people to be alarmed. The meaning is really that the money you are getting is protected for you just as it is now.

Chris Renshaw offered that perhaps the sector's time and energy would be best spent in deciding how to influence Aboriginal health funding distribution decisions made by the MLs in the future.

Nicole reminded participants of the fixed realities in this situation. She said:

- To be successful, a proposal will have to demonstrate how it fits in with and has 'real and testable' support from the stakeholders in the area it is going to serve;
- You need to work out how to be savvy in the context of the fixed realities and aim for deal making not deal breaking.

As the facilitator, Kari set the scene for preparation for the following day. She affirmed that the ideal approach for tomorrow is to not to be anxious and worried as this will convey the wrong message. Rather, she urged participants to be strong and clear about what they want to see happen and how they want to be involved in developments from this point forward.

She also reminded participants that DoHA do not want the ACCHS sector to be blindsided by primary health care reform:

"To the contrary they want you to flourish".

Kari also encouraged the group to:

- Get into a key stakeholder position in the evolution from this point on;
- Be savvy and smart;
- Consider the reality that the GP Divisions have a lot more to be anxious about than ACCHS right now because a lot of them will be de-funded soon. Not one ACCHS will be affected by this in terms of ongoing existence and core funding;
- Remember that your sector is powerful, you have expertise and authority. I advise you to use this as a tool and not as a weapon;
- Also remember that Nicole is true to her word; and
- Go in for making deals not breaking them.

In terms of the Governance Framework for Applications, a participant confirmed that in the invitation to apply (ITA), the wording from government states that the governance committee should be skills based and that there should be between seven and nine directors/members. These are pretty much the only givens thus far.

It was pointed out that the ITA does not say anything specific about the actual skills. A GP Division might put up the skill sets they think are the right ones but they will do that from the perspective of a doctor's 'world view'.

The ACCHO sector on the other hand would put up something a bit different in terms of relevant skills as this would be based on their own unique 'world view'.

Kari said:

"The issue for your sector is how you can support best practice and that the way of doing business is going to be good for Aboriginal people. For example, your sector would quite rightly put forward a strong argument that expertise in Aboriginal health and culture is a skill set of equal importance to a medical or any other field of expertise or qualification".

Chris Renshaw noted that his health service was asked to support a GP Division proposal. He said that they were unable to support it because it contained three 'deal breaking' elements. One of them was that it was doctor centric and another was that it was not at all friendly to Aboriginal community concerns. He said that in responding to these views, the Division had said it was 'already stipulated and pre-ordained' what the governance composition must be in the ITA and that they were simply complying with that.

In response, it was offered that here again, this was the GP Division's own interpretation of what the ITA implied. Your sector would be entitled to quite a different interpretation.

Karri noted Glenda's objections about being asked to support a proposal in a written letter and for that to be construed as 'consultation'.

Kari reiterated that:

"The proposals put forward will live and die on their merits. Your sector may see proposals you don't agree with and the whole point is to influence this so they get it right. Any proposal will be tested on the basis of the claims they make. If the proponent claims to have your support and your support is actually not there, this will influence the merit and success of that proposal".

Again, Kari urged Members to make tomorrow a 'deal making dialogue'. She suggested that the messages should be:

- This is who we are;
- This is what we do;
- This is what we believe; and

Thursday 14 & Friday 15 April ACCHO and GP Divisions sector meetings on Medicare Locals in WA

- We would like to have a negotiation with you.

She affirmed that DoHA had invested in this process for today and tomorrow to position the ACCHS sector and the GP Divisions to be able to do good business with each other and get an agreed process going forward so it is good for WA, for primary health care and for Aboriginal health.

You need the process to go well beyond the “this is our proposal and we consulted/tick the box” approach. You are looking to get an agreed process which is about genuine joint work, partnerships and shared outcomes to be embodied in proposals which get approved.

“Don’t be militant. Rather, be fair and just in negotiation”.

In terms of principles, it was affirmed that there is no requirement in the ITA for there to be an Aboriginal person on the governance committee of a ML, nor is there a requirement for any of the sector’s stated principles to be observed.

On this point, Kari posed the question to the participants:

“So how do you see yourselves tomorrow moving from the current situation to where you want to be?”

It isn’t my position, or Nicole’s, to advocate for your position to the Divisions tomorrow. Your job is to think about how to have your principles and wishes built into the way forward through negotiation”.

Vicki O’Donnell stated that the sector isn’t talking about ITAs as such. Rather, we are talking about key principles around how our sector works with the GP Divisions.

Kari responded by saying:

“So that is your side of the fence. I’m here to tell you that they are seeing things from their side of the fence.”

Vicki offered that:

“The Divisions had put up a steering committee model but they did not come and talk to us. I would be happy to stand up tomorrow to tell them the key principles we think should be in place for how we are consulted and that we don’t want to be told what to do”.

Graeme Cooper expressed the view that:

“Unless these principles are met we can’t do business”.

At this point, Nicole O’Keefe reminded the Members that the next lots of submissions are due 19 July 2011. She said:

“There isn’t time for gradually building a foundation of consultation based on agreed guiding principles anymore. This is one of those fixed reality issues now. Tomorrow IS about the ITA. It is time for business negotiations and your sector will need to make a big shift forward in thinking to make

tomorrow a success. There is no real point in trying to take the process back in time as there is no time left to do that”.

Karri suggested an approach for tomorrow:

- The sector is in the box seat on the ITA right now;
- You could ask them to share with you their principles around entering into a process with you to develop a bid;
- Keep in mind that they need to win these tenders;
- Also remember that they need your support to achieve that outcome;
- They want to do business with you;
- The sector is in a position of strength.

Des Martin offered that:

“In Chris Pickett’s presentation to the Conference, he made it clear it was a skills- based board in their view. It just seems that for our people, the goal posts keep shifting. There has been some mis-communication here and we are struggling with this. We have been denied an opportunity to date and they are here now to talk with us only when they have no other choice and they need us now. It is difficult not to be angry”.

Kari responded:

“I can clearly sense disappointment on your part and also understand why people here right now feel the way they do and are finding it hard to let some of this go and move onto the main game for tomorrow”.

She also said that she could equally sense the pressure on the GP Division side of all this.

She said that this was exactly the reason Nicole’s office had helped get this process today and tomorrow on track so that the parties do finally come together in good spirit before the deadline.

She said:

“The reality is that you are going to feel sensitive about your names being used to prop up proposals they want to get up.

They are going to feel very sensitive if they can’t make deals with you because they can’t find a way to work it out with you”.

Chris Larkin, CEO of the Kimberley Aboriginal Medical Service Council (KAMSC) said:

“I am reminded that Kim Snowball said the Department of Health and Minister for Health won’t sign off on initiatives unless they know the Aboriginal health sector feel content with it. We don’t need you to lecture us on how to deal with angry sensitive people. I think we know how to do that”.

Vicki O’Donnell offered a way forward at this stage and the key steps are summarised below:

- Declare that we want to sit down and negotiate through this process;
- Tell them about the principles that are crucial to our sector;
- Tell them the ML boundaries we would like to see in place;
- Tell them how we want to see the steering committee arrangements;
- Discuss the governance arrangements and see if we can get agreement on a model we can support;
- Clarify our interpretation of the skills base criteria for the governance boards;
- Discuss and agree some funding principles and how the Regional Aboriginal Health Planning Forums are a key part in funding distribution decision making processes in our view; and
- See if we can get a bit of clearing of the air to put the reasons our sector are annoyed out on the table so these things can get addressed and put aside.

At this point, Ron Richards said that he had been looking closely at the ITA document on the governance skills criteria issue and in light of the conversation here today, it is clear that there is another interpretation available. He said:

“The ITA details say that the governance skills base must reflect the skills and expertise aligned with the community and service providers. This gives your sector a lot more room to negotiate a different model that what the GPs have come up with from their own world view”.

Nicole O’Keefe said:

“The GP sector has been introverted and self interested due to their own pressures. They know they haven’t done it right. They are coming to the realisation of this fact and now they want to engage in meaningful conversation so they can work out how they can better address the ITA to make sure their proposal has a governance model which does reflect the local community and providers of services.

Boundaries are negotiable. They should be based on a partnership approach and your views on what your sector thinks are the most viable boundary arrangements need to be made clear to them. You don’t have to be ‘beholden to’ the boundary definitions the AGPN thinks would work best”.

Phil Matsumoto, BRAMS Chairman asked if the boundaries were calculated based on population size. Nicole advised that her State Office has provided a perspective to Canberra on this issue and that she believes the concerns about viability in the WA context were better understood now.

She also counseled the participants that she thought it wouldn’t be productive to use the meeting tomorrow to get deeply involved in a dense and detailed discussion on any specific issue such as boundaries. She said she thought the risk would be that the time would be spent arguing/negotiation over detail on only one issue and that the opportunity to agree a way forward for the ‘whole thing’ would be lost.

In closing the session, it was clarified for the benefit of the participants that:

- Ongoing resourcing of ACCHS will not be changing and that the core funding will not go through the MLs;

- The way the Australian government funds GP Divisions is changing. These Divisions will be abolished and their functions will 'morph into' the first round of the new MLs; and
- In the first round of applications, high performing GP Divisions had been invited to put forward their proposals for where and how they would like to see the functions of their previous Division to be taken up into a ML;
- Other Divisions who were not invited in the first round were able to apply in subsequent rounds;
- All of the proposals will be assessed according to their merit against the selection criteria outlined in the ITA. Criteria such as the level of support from stakeholders within an area to be covered by a proposed ML will be properly assessed and 'tested' for validity;
- A proposal which claims to have support from other stakeholders – such as the ACCHS and others – but where that support cannot be backed up in reality would have less probability of success;
- The GP Divisions understand this aspect better now;
- Tomorrow should be a productive way of making sure the WA stakeholders do manage to put forward good quality proposals which will stand up to the scrutiny of the selection process and testing of the various statements and claims contained in the proposals.

The Parking Lot

As facilitator, Kari had stated from the outset that specific issues people wanted some answers for would be listed as being put into 'the parking lot' for now. This was to ensure they didn't get forgotten but that they didn't take up the time needed to focus on the main agenda for the session.

Issues in the parking lot were:

1. Alternative models; and
2. Transition Issues.

The matter of alternative models referred to boundary issues in the main. These were briefly discussed and were agreed to be an issue to be negotiated after tomorrow for the proposals which would eventually go forward from WA.

In terms of the transition Issues, participants were concerned about what would happen with some of the services which GP Divisions had been funded to provide during the changeover process itself. In some cases there are Allied Health services run by some GP Divisions and those services are provided within ACCHS in some cases.

Participants were very concerned to ensure that these services would be maintained through appropriate arrangements.

It was confirmed that whilst the role and responsibilities of the new MLs did not encompass the function of being actual service providers, there were many service programs currently being provided by various GP Divisions.

Thursday 14 & Friday 15 April ACCHO and GP Divisions sector meetings on Medicare Locals in WA

It was affirmed that these would be 'migrated into' the relevant ML for the time being to ensure the services continued to operate smoothly. The goal for the ML would then be to ensure that the funds for the services go to the most appropriate provider.

End of Session

Vicki O'Donnell thanked the facilitator and Nicole O'Keefe. She closed the session and also offered that the ACCHS CEOs would meet together and discuss more detailed plans on how best to put their positions forward at the meeting on Friday 15 April.

THE FRIDAY 15 APRIL NEGOTIATIONS MEETING

Introduction and Background

The intention for this joint meeting session on Friday 15 April 2011 was the conduct of a facilitated discussion/negotiation between the Aboriginal Community Controlled Health Organisation (ACCHO) sector and the GP Divisions/Network sector in relation to shaping the Medicare Local primary health care reform policy within the Western Australian context.

This joint meeting had been preceded by a facilitated meeting of ACCHO sector delegates the previous day (the afternoon of Thursday 14 April) to discuss the Medicare Local issues in preparation for today's proceedings.

The same facilitator assisted preparatory discussions at a separate session working with the GP Division sector during the morning of Thursday 14 April.

The intention behind the separate preparatory meetings was to bring each sector to a clearer understanding of the other's perspective and needs and to develop their propositions for negotiation with each other today.

The Medicare Locals Policy and the WA Context

The Australian Government announced the creation of new primary health care organisations across Australia – now to be called Medicare Locals – as a key element in the National Health Reform program.

The Department of Health and Ageing (DoHA) released an Invitation to Apply (ITA) package in 2010 and the intention is:

1. For a first round of applications from existing high performing GP Divisions to be lodged by the closing date of 5 April 2011;
2. For a second round of applications from other GP Divisions and eligible organisations and groups to be lodged by the closing date of 19 July 2011;
3. According to the published information, the Australian Government intends to have the first tranche of new Medicare Locals (15 is the target number) established by July 2011 so they can commence their development period;
4. During which time a second tranche are to be selected and be formalised by January 2012;
5. A third tranche are to be formalised by July 2012.
6. The existing GP Divisions will cease to function and be de-funded from 1 July 2012.

The boundaries for the first round of Medicare Locals were set by the DoHA following consultation after their 2010 Discussion Paper. In the Western Australian context, the boundary issue is one of a number of contentious matters because population size has been used in an effort to ensure sustainability. At this point in time, the translation of this in WA has dictated that outside of the four Medicare Locals in the Perth metropolitan area and one for the southern land division, the entire balance of the state is designated to have one single Medicare Local (referred to locally as the 'Big North').

On the basis of the 'Big North' boundary definition, the WA GP Network and relevant GP Divisions have worked solidly for several months on the development of a proposal for a single Medicare Local.

ACCHO Sector Perspectives on the Medicare Local Process in WA

The ACCHO sector is not currently supporting any Medicare Local proposals within WA because they feel they have been largely excluded from meaningful participation as important primary health service providers and advocates for Aboriginal health interests; and have received confusing and at times less than helpful information from various sources.

Leading up to the State Sector Conference hosted by the Aboriginal Health Council of WA on 12 and 13 April this year, the ACCHO sector had become increasingly concerned and frankly frustrated by the pace of the Medicare Local developments and the relative exclusion of their sector.

At the Conference, the leader of the GP Division group submitting a proposal for a Medicare Local for the 'Big North' in WA did a presentation to delegates on the subject of the Medicare Locals. He conveyed the views of his constituents and these are summarised below:

- The ITA guidelines did not stipulate any particular consultation with or participation from the ACCHO sector or services was necessary;
- The guidelines also dictated that the decision about the 'Big North' boundary had been taken and therefore was essentially 'a given';
- The board of a Medicare Local was to comprise between seven and nine 'experts' and as such would not require any particular stakeholder groups – such as the ACCHO sector or local Aboriginal communities - to be represented; and
- The Medicare Local policy was a concern to the current GP Divisions who would be de-funded next year and for this reason, their focus during the development of the proposal had been relatively 'internal';
- Their sector didn't see any particular threats from Medicare Locals to ACCHS.

Another presenter at the Conference extrapolated what he could from what has been said (and not said) in writing and verbally by the DoHA and the Federal Ministers for Health and Indigenous Affairs in relation to the funding formula for the Medicare Locals.

This speaker's messages were very discouraging for the sector in relation to the veracity of the as yet unknown formula or the adequacy and fairness of the funding for primary health care for Aboriginal people. It was pointed out that the funding formula was intended to be applied to operational funds for the Medicare Locals across Australia as opposed to the actual funds for financing primary health care. The speaker rejected this caution, preferring to hold his personal view that the same formula developed for Medicare Local administration funds distribution would be applied to actual primary services funding in the fullness of time.

One powerful message this speaker did convey to the Conference – and one which resonated clearly with all delegates – was that the Medicare Locals policy was likely to be the most profound reform to

primary health care in Australia in the lifetimes of many of the delegates present and on this basis, it would be crucial to 'get it right' the first time around. He went on to also say that:

"If they get it wrong, we will probably be stuck with it for two or three decades because it is a very robust system and no governments would ever contemplate successive rounds of fundamental changes".

This was perhaps the strongest and most enduring 'take home' message for Conference delegates on the subject of primary health care reforms and Medicare Locals evolution in WA. As such, the 'head of steam' within the ACCHO sector which had been building over the course of several months had a lot more pressure added during the course of the Conference.

The Starting Point for Today's Meeting for Each Sector

The separate preparatory sessions with each sector appeared to have had a profound effect.

The GP Division sector had come to the realisation that they need the participation and support of the ACCHO sector to a much greater degree than they had assumed from the outset by adhering to their own unique interpretation of the ITA and associated Guidelines.

The ACCHO sector delegates had 'let go' a good deal of the 'pent up steam pressure' the previous day and had begun to absorb the reassuring messages repeatedly provided by the facilitator and DoHA State Manager that:

- ACCHS funding is safe and secure and will not be channeled through or controlled by the Medicare Locals;
- The DoHA does not wish for the ACCHO sector to be threatened or disadvantaged by the advent of the new Medicare Locals. To the contrary, the DoHA wants the ACCHS to "flourish";
- The likelihood of a Medicare Local proposal succeeding where a stated claim of support from the ACCHO sector does not stand up to scrutiny is very low;
- The ACCHO sector is not facing any particular threat from Medicare Locals and in fact could stand to benefit in the future;
- Services currently provided by the Divisions which are shared with or used by ACCHS will be migrated into Medicare Locals pro-tem so there is no break in continuity or reduction in service levels;
- The GP Divisions on the other hand are facing the certainty of de-funding and as such are working under a great deal of pressure to ensure that their core business is migrated smoothly into the new Medicare Locals and that service continuity is not lost;
- There is an obligation upon proponents to engage genuinely with the ACCHO sector; and
- To a significant extent, ACCHO sector participation and support is needed and desired. As such, the ACCHO sector is in a more comfortable position and has some leverage for the meeting today.

At the time of the meeting today, the status for the parties is:

- The GP Division sector have the view that they followed the ITA and associated Guidelines in good faith;
- They are looking for an expedient way forward for their proposals and are reasonably open to ideas and agreements for suitable ACCHO sector participation from this point;
- Their appetite for going back over the work, re-doing significant elements of the proposals and engaging in lengthy and complex consultations and technical work is limited due to the effort that would take and the time constraints;
- The ACCHO sector is still fairly skeptical about what they perceive to be a lack of a genuine desire to collaborate and consult – rather, they perceive they are being engaged at ‘the last minute’ because the GP Division proponents have finally accepted they need ‘testable’ support from their sector;
- They have had to quickly develop a ‘deal making’ negotiation strategy for future participation which will position their sector to influence on issues such as the boundaries, governance inclusion, consultation and decision making and alignment in the future with established mechanisms such as the Regional Aboriginal Health Planning Forums;
- They are essentially more ‘relaxed and confident’ about their negotiating position than they were 24 hours prior, because most of the major threats concerning them had been addressed to a satisfactory level the previous day.

Opening the Joint Meeting Proceedings

Des Martin, CEO of AHCWA introduced Phil Matsumoto, Chairman of the Broome Regional Aboriginal Medical Service (BRAMS) who stood in for Vicki O’Donnell, Chair of AHCWA (absent at this point).

Phil welcomed all attendees to the joint meeting. He also welcomed Nicole O’Keefe, State Manager of the DoHA in WA and OATSIH and the session facilitator Kari Kristiansen.

Phil’s message was:

“When we are discussion things, the opportunity for people to talk should be heard and we don’t want anyone being talked down to. We need a fruitful outcome from today”.

He handed over to the facilitator at this point.

Kari offered that Phil had indeed spoken wise opening words and said that it was everyone's job to make sure we have good communication occurring here today. She affirmed that everyone is here today in good faith, with professional goodwill and ready for good dialogue.

She asked for comments through the facilitator so she could assist the group to manage the dialogue in a fair and balanced way and advised that there would be roving microphones to help support discussions from around the room.

Kari acknowledge Nicole's commitment to progress on the Medicare Locals policy in WA through creating the opportunity for focused discussion amongst each sector yesterday and for this joint meeting to be supported through a facilitation process today.

She pointed out that some of the things which come up in discussion over the next few hours may not be able to be resolved today. This may be because it isn't known by anyone present, cannot be known at this stage and/or needs more consideration/discussion outside this process today.

She said she was very conscious that there are many established relationships amongst the delegates from both sectors and that today is not at all about meeting and talking for the first time. Rather, it is based on understandings and relationships already in existence in some form.

To commence the session, Kari clarified who the representative speakers would be for each sector and the DoHA:

- Nicole O'Keefe, Marilyn West, Jillian Abraham (works with GP Divisions in DOHA), Louise O'Neil (OATSIH) and Anna from the Primary and Ambulatory Care Division in the DoHA in Canberra. Nicole said she would speaking on behalf of DoHA and would call on relevant members of the DoHA team to address technical/details and aspects;
- AHCWA have nominated Chris Renshaw, CEO Puntukurnu Aboriginal Medical Service (PAMS) to lead discussions on behalf of the ACCHO sector.
- Chris Picket will be lead speaker for GP Division sector.

She asked each representative to speak over a ten minute period on the broad statement of intent for their sector:

Nicole O'Keefe

- Welcome and thank you for time and energy and commitment;
- DoHA is here to help with clarification and technical information to support you;
- We are not here to own or dominate this discussion;
- We come together with respect for each other's values and principles and the strong commitment from each party;
- We are keen to see where the common ground is and where there are mutually beneficial opportunities to work together.

Chris Pickett

- Chris was asked to step forward to address the room but he declined to do so, stating that he meant no disrespect, but that he felt strongly that he should speak from the table where he was sitting with his colleagues;
- Thanks for the opportunity to get together;
- To be honest this is not my ideal way of talking - I thought we would sit around a table and sort it out;
- The workshop format is probably OK but I think it would have been better to sit around and talk;
- We need to talk about key issues: governance of Medicare Locals, communications from here on, and the critical one – how negotiations proceed around boundaries;
- We have a government report which shows a big Medicare Local boundary in WA covering most of the state;
- We hope we can find a way to set in place a structure for ongoing discussion similar to the ones we have with the Regional Aboriginal Health Planning forums and other processes.

Chris Renshaw

- We see this as a beginning, not the end;
- Today should be about mutual respect;
- Our sector is a major provider for Aboriginal people. We have a pretty proud history;
- We put a lot of store in the planning forum network;
- Key issues for us for today are governance and boundaries for the Big North proposal - we take it there is a high degree of flexibility in terms of what governance models can look like and we are very keen about that;
- Consultation processes – we want to be engaged in consultation and planning about models;
- We don't want to look back – we want to go forward;
- If we can nail these issues today, we will be a long way towards getting stuff off the ground asap;
- So lets' have a good respectful conversation.

At this point, Kari also welcomed Melissa Vernon (WACHS) and Michael Bradley (Derbarl Yerrigan) as observers.

Discussion and Resolutions on Medicare Local Governance

Karri invited discussion on Medicare Local governance and clarified that the key issues expressed by the groups were the routine operations governance and the processes involved when bidding for primary health care funding.

She pointed out that the ITA conveys the Australian Government's expectations and suggested to the meeting that they use these as the basis for how to interpret them jointly and also to explore the opportunities to reach some agreement on working together.

DoHA stated that the ITA guidelines address governance broadly in that they expect Medicare Locals boards will be essentially skills based. They believe the ITA is broad guidance only and that it is not prescriptive or intending to be prescriptive. For example, it suggests the skills sets of finance, legal, community and health knowledge but does not go so far as to say the skills would be limited to these or even that these are mandatory.

ACCHO stated that they:

- Do not see the governance issue as big a headache since things had become clearer to them over the last 24 hours;
- Are keen for appropriate participation on Medicare Local boards;
- Interpret the guidelines on skills for board members to mean that community, cultural and health knowledge is a recognizable skill set;
- Believe that Aboriginal directors would contribute to the overall governance board skills base in the same way as individuals with other special areas of expertise such as medicine or financial management;
- See appropriate Aboriginal directors on Medicare Local boards as being there on the basis of their expertise and not simply as broad representatives of the community and/or the ACCHO sector.

GP Divisions stated that they:

- Don't think within our current thinking there is anything in what you have suggested we would have a difficulty with;
- Believe it is only right to have Aboriginal representative on a Medicare Local board from our perspective;
- Have thought about it in absence of being able to have discussions with sector representatives over recent months;
- Envisage there will be a position protected for an Aboriginal health representative on the boards;
- Want to see a broad spectrum of involvement, for example an individual with Allied Health expertise would add value in a primary health care context;
- See no reason why a community representative from a consumer body could not also be an Aboriginal person and on this basis, there could be several Aboriginal people involved and not simply one representative only;
- Believe all the directors of a Medical Local should be there for the benefit of providing governance of the Medicare Local itself and not simply to represent another organisation or interest group;
- Believe that organisation membership of the Medicare Local is a requirement and that this could involve relevant ACCHS, CUCRH, Rural Health West, GP Practices and other corporate entities involved in the region. All of these members would all have the right to vote in board directors. However, we are specifically proposing that there would be at least one position which would be 'protected' to ensure an Aboriginal person fills it;

- Understand that the context of Medicare Local governance is not about representation of any and all sectoral interests. Rather, it is to be a governance structure which is best for directing business in the best way for our patients.

Chris Renshaw summarised the key constructs on a whiteboard at this point, depicting a proposed steering committee as a precursor to the eventual board of directors during the developmental stage. The ACCHO would be a key participant and contributor within the developmental steering committee structure and terms of reference. In terms of the core skills, he listed as given the legal, clinical, financial areas of expertise and then offered that regional considerations should guide the balance of skills and expert knowledge to compliment a board and ensure it is relevant to a particular region. For example, a region may have 40% of its total population made up by Aboriginal people. Furthermore, that population may very well consume around 80% of the health services provided. This reality must, in their view, be reflected in the Medicare Local board composition overall. In fact, much the same way as it would work in a metropolitan region with a mix up 'Applecross like suburbs in the mix'.

Chris Pickett responded in general agreement with the views expressed. He said:

"You are on the mark generally. The use of health status, burden of disease and services consumption is an important group of considerations. For this reason, we think it is less value to have Aboriginal representation and much more valuable if there are suitably skilled people (Aboriginal and non Aboriginal) on the board with the skills to understand the health issues.

I also think we should look at the structure which supports and defines the board – the constitution and rules, planning and decision making mechanisms and the like. If we are talking about whole populations, then the Forums – or bodies like the Forums - may need to 'morph into' a concern for the whole population so they are not Aboriginal specific. Perhaps the Forums should be enshrined within the structural governance arrangements".

Chris Renshaw asked if it was possible to agree that we take into account the population and consumption profile when considering the governance participation for a regional area. In terms of the Pilbara example, he offered that there are many experienced and skilled Aboriginal experts and that representation of the main users of many health services would be an added bonus.

Karri suggested it would be appropriate right at this point to clarify the key steps in the process/machinery. She asked if the meeting would be willing to explore the 'journey' toward someone becoming a director and also reminded the group that they needed to be aware of managing their time here today so they can address the key issues of concern. She invited Chris Pickett to outline the thinking on this question from the GP Division perspective.

Chris Pickett summarised their thoughts:

- There needs to be an adequate transition period;
- We understand the thinking is to allow from twelve months to two years;
- There would be work toward the establishment of a board in around a year;

- The steering committee would work out a constitution, membership mechanisms, invitations to join, nominations for board positions, selection/voting for director selection (an open and democratic process amongst the members).

Karri sought feedback on general agreement from the meeting that:

“A membership base must reflect region profile dimensions. This will form the fertile and rich base from which comes the director nominees/applicants and selections. This is the architecture and the glue which holds it all together. From there the processes of governance, the meetings, notifications and so on would stem. There is a lot of work there, but this is the not-for-profit journey. How the Aboriginal ‘protected/designated’ position would be reflected in the constitution also needs to be worked out”.

Chris Renshaw offered that the rules of operation would be developed by the proposed steering committee. He also pointed out that the Regional Aboriginal Health Planning Forums are not incorporated bodies. He said it may be possible/desirable to write into rules that all members of Forums would be invited into the membership base. The key is the steering group needs to be a very active and truly representative group of people to get it all worked out as everything will hinge on it.

Chris Pickett shared the view that so far, the key assumption has been that the GP Divisions will be ‘morphing’ into Medicare Locals, but that there may also be a range of options. For this reason, the GPO Divisions believe there is a need for something completely new. He said:

“We don’t see this just migrating the existing Divisions into the new model, or that the Medicare Locals are simply GP Divisions with a different name. Rather, we see something new – starting with a really clean sheet. On this basis then, we see that there are two issues. One issue is the development of the new entity as we have been talking about. The other important issue for us in the short term is that the Divisions are being defunded in July 2012. Our regions can’t afford to lose the services provided by the divisions at the present time, so the service structure needs to be protected during the changeover. In many areas, there is no private sector capacity to pick things up and fill in gaps in our Pilbara and Kimberley regions. We are very anxious to treat this as a priority and no doubt your sector would also agree with the importance of what is at stake here”.

Chris Renshaw agreed that the ACCHO sector is concerned about protecting these services, especially as the ACCHS use them for Aboriginal people. He said:

“We are interested in how you see that going forward”.

Chris Pickett responded and said:

“The actual Medicare Local process for these sorts of issues won’t roll out immediately, because these things will take time to develop and put into place. Every contract for services will eventually go through the Medicare Local. So we are dealing in transition phase here only. There are still discussions to be had about if they will be allowed to ‘run out’ as they are at the present time and form, or if existing providers are expected to hand them over formally to the Medicare Local so they can be immediately sub contracted them straight back to ensure they keep operating smoothly. Existing service providers and

networks have to be 'leaner and meaner' and prove themselves in the longer term to attract the contacted work from the Medicare Locals".

Chris Renshaw also shared the views that:

"The networks we work with at end of the day will have nothing to do with existing GP Divisions, so we agree with you that things will really be very new. We also agree that business continuity is at stake for the short term until all the longer term processes and arrangements get worked out. One option could be for the former GP Division to form an incorporated body so it can 'bid to' the Medicare Local and contract for work. Under such an arrangement, the interim services we are all concerned about for the time being would go to the relevant GP practices automatically. Alternatively, they could be formally outsourced under a contract to a variety of suitable providers. There is no conflict of interest or risk to our sector with this, as we all share the concern that the services simply continue to take place under a secure arrangement. The risks we would all be concerned about are that service collapse and the funding goes back into the government's coffers unused. The businesses that currently provide the services (GP Divisions) do it pretty well and I imagine we would support retention of this business under the best possible short to medium term arrangements".

Karri asked DoHA (Marilyn) how it could pan out in other ways. She said:

"DoHA wouldn't disagree with anything said. There are different models available and the Medicare Local model selected will ultimately be defined through the ideas in the applications and the selections made which will take all these issues into account. But over time, it is certain that the money currently tied up with these existing services will go through the Medicare Local in a formal manner. In the short term however, the intention is to retain the services in some business continuity arrangement. It is just that the exact details have not been prescribed for how these interim arrangements will take shape".

Chris Pickett stated:

"What I have put forward is the model we (our three GP Divisions concerned about the North West regions) have proposed. Our boards involved in our proposal wanted to ensure we had a clear proposition on this aspect. Let's not put under the table the fact that a model has been put forward by us. We felt was crucial, because it is certain the funding arrangements change in 2012 for Divisions. There is a lot at stake and we thought it best to put our thinking - as clearly as possible - on the table to get response and feedback.

Karri said at this stage, that she could see that things were getting clear about this aspect and she sought and received affirmation from the participants.

Chris Renshaw stated that:

"Around the governance aspect, just so we are really clear: as a sector, in principle, we don't support the proposal which has been developed, although we do support some of the things behind it. The governance arrangement was one of our issues and I think we are comfortable with this now".

Thursday 14 & Friday 15 April ACCHO and GP Divisions sector meetings on Medicare Locals in WA

Chris Pickett said on behalf of his constituents that they would like to know more about what other issues the ACCHO sector are in agreement with

Chris Renshaw affirmed that the ACCHO sector was very much in agreement with:

“The proposed Medicare Local steering committee arrangements, as a precursor to leading to a full governance model as depicted on the whiteboard have the full support of the ACCHO sector”.

Chris Pickett stated that they hadn't contemplated a steering group in this way. He said that:

“We would want to ensure our GP Divisions are well represented on this to ensure the wind up of their various business arrangements was secured and that continuity arrangements are covered”.

Karri affirmed for Chris Pickett and the GP Divisions participants that they have some internal winding up/transition and business continuity issues needing to be worked out and that these issues and concerns were clearly acknowledged and accepted by the wider group at the meeting.

She also pointed out that in spite of the wind up and transition matters; there is also still the matter of the creation of a new entity. She reframed Chris Pickett's thinking on behalf of the GP Divisions group that the issues and arrangements with respect to both of these outcomes are intertwined and can't be separated, and that they must be linked into the proposed steering committee intended to craft the way forward for the new organisation. She reiterated and asked for feedback on :

“Chris Renshaw's proposed steering committee is about creation of the new model and entity. Do you see the ACCHO sector being involved in all the transition details?”

Chris Renshaw responded that the ACCHO sector understands the cross over issues and that a lot of it is internal business concern primarily for the GP Divisions most affected by the changeovers. He acknowledged that the ACCHO sector needs to be engaged because they have a keenly vested interest in how it all ends up. Mainly, they want to be part of planning the new entity and the various approaches and decisions. In terms of the 'transition stuff', he said that they have a stake in the outcomes and that they are happy to be of assistance. In summary, he said:

“Our major concern is that the new models and proposals are developed out of a process we have been able to have an inadequate part in. We might leave the room when you are thrashing out your internals – would that be OK?”

Chris Pickett said:

“That sounds OK and your position is understood. We would like to enshrine the Regional Aboriginal Health Planning Forums somehow into the new arrangements as a vehicle to advise the Medicare Local about population health, primary care services planning, priority health issues and service provider views. Medicare Locals are meant to be small organisations that conduct commissioning/purchasing for health services and to undertake planning and consultation. The Medicare Locals themselves are not the 'main game', and as such, must not consume resources. We believe on building on existing forums as key

advisor linkages, because we don't see the Medicare Locals themselves growing large enough to take control of that entire planning and expertise agenda".

On that note, Chris Renshaw then asked:

"If funds available we would see the Medicare Local referring specific Aboriginal primary health care funding initiatives and programs to the Regional Aboriginal Health Planning Forum which would serve as the key advisor. We would also see that working for service planning. Each region develops a joint service plan and puts up well researched and documented plans based around agreements on roles and responsibilities for various organisations to be involved. What I hear you saying, is the 'new look forum' would advise on all regional health planning and priorities. I'm not sure how our sector would respond to that prospect, other than to say that they would need time to digest it and consider all the issues involved".

Chris Pickett in response:

"There is no reason why your forums can't continue as they are. But we are also looking at forum model which advises on primary health care across the board and not just from an Aboriginal perspective. People 'doing' primary health care are the ones who can bring substance about primary health care for local planning and responding in ways which are very close to the community. A strong body underpinning a Medicare Local is a good thing in our view".

Chris Renshaw agreed:

"If a special advisory group like you are suggesting underpins a Medicare Local, we would see the RAHPF being a key component of that arrangement. But we would stress that we wouldn't envisage our forums would be 'morphing' into the bigger/broader advisory group. We wouldn't want to risk that our forums might be 'watering down' in terms of our Aboriginal health focus".

At this point, Terry Brennan, CEO of the Geraldton Regional Aboriginal Medical Service (GRAMS) offered his view that:

"A primary health care advisory group is what we need in our regions. I would like to be able to be part of a joined up broader primary health care forum. However, I would fight to death to not lose our Regional Aboriginal Health Planning Forum as it stands at the present time, although I could see it easily aligning with a broader forum which brings in all other elements such as aged care. I don't think we can sort this out in fine detail today but we hopefully are getting close to some common ground".

Chris Renshaw then offered that:

"The proposed steering committee is the 'glue' in my view and as we have proposed today, we are very much a part of. If you are comfortable with having a group like this - with our sector having an integral part to play in its structure and terms of reference - we have the basis for going forward jointly from today. It would also be a framework for your sector for sorting out your internal transition stuff and it will enable us to participate in those issues to some extent because we have a stake in the continuity

Thursday 14 & Friday 15 April ACCHO and GP Divisions sector meetings on Medicare Locals in WA

outcomes for the services currently being provided by the Divisions. We have a much bigger stake in creating the new 'thing' and our participation would be well and truly covered if we use the steering committee structure we have talked about today".

At this point, there was a question from a participant from the GP Division sector. The statement/question was:

"I think we feel confused at this point. Are we talking about our Divisions proposal or are we now talking about something new and different?"

Chris Renshaw responded:

"We don't support any proposals put up in round one."

When asked why, Chris Renshaw responded:

"Because were not consulted at all. That is why we are here today."

Clarification was sought at this point because it appeared to be understood by the participants that the ACCHO sector only had objections to the proposal for the 'big north'.

Des Martin, CEO AHCWA said:

"We have no objection to the metropolitan area proposal as long as Derbarl Yerrigan are engaged in the discussions. The sector's position on the South West Medicare Local model is that there is no support because there was no consultation. We would support any proposal which the South West Aboriginal Medical Service is engaged in and supporting. What we are asking for the Wheatbelt region is that AHCWA are engaged in consultations for any proposals for that region."

Glenda Humes, CEO of the South West Aboriginal Medical Service (SWAMS) stated:

"A signed letter of support does not mean that there has been consultation."

To summarise the discussions at this point prior to a break, Kari offered:

- We have reached agreements in principle and in broad terms about the governance of Medicare Local development processes;
- This involves setting up a steering committee which might include a 'can do engine room' group of people to work out transition management arrangements and work through the development of the constitution, rules, director appointment processes and management mechanisms for the Medicare Local under its own board;
- The ACCHO would be involved through the proposed steering committee.

She asked for feedback if this summary was accepted by both sectors.

- Chris Renshaw indicated agreement to the summary from the ACCHO sector; and

- Chris Pickett stated that the GP Division representatives would need time to consult with their broader constituent base. He said it wasn't an issue of disagreeing with the general thrust and principles of the summarised position, but rather the fact of the matter for them is that they have a 'live' Medicare Local proposal lodged with DoHA at the present time. He also offered that there could be more discussion about this at today's meeting.

Break/Resumption

Kari asked if it was now possible to tie up ends on the broad agreements on governance.

Chris Renshaw offered:

- Side talks during the break have clarified the transition processes a bit more;
- All business from the former GP Divisions will migrate into Medicare Locals;
- So the Medicare Local will start out its new life as a default service provider to ensure service continuity is protected;
- In the future however, the services would probably be outsourced;
- Our sector doesn't have a problem with that;
- Existing funding for the ACCHS is going to be quarantined as per the advice we have been given over the last few days - and we want that as a clear statement of policy so there cannot be any further confusion about it;
- Any new dollars specifically for Aboriginal health initiatives and programs would go through the Medicare Local but we want a policy to be enshrined within the governance rules that they refer to the Regional Aboriginal Health Planning Forums processes for advice on plans, priorities, strategies and allocation arrangements for funds.

Kari invited a response from the GP Division sector to see if there was a broad level of consensus on the governance resolutions put forward today. Chris Pickett summarised their position:

- We don't anticipate a Medicare Local would be a service provider in terms of its core function;
- We see its only roles would be as a commissioner/purchaser of services;
- We would see the Medicare Local outsourcing the current services we are concerned about – these are the ones currently funded through and provided by the GP Divisions at this point in time;
- In the initial transition stages, we envisage that the Divisions would have novated contracts or some such arrangement to the Medicare Local;
- In terms of Medicare Local governance generally, we have agreed to address the discussion we have had;
- An element of the steering committee's business would be done through a transition group already established;
- But we would look at a new subcommittee to oversight new developments of the Medicare Local with ACCHO sector participation.

Kari put the position forward that there was consensus in broad terms on the processes for developing governance structure and mechanisms for Medicare Locals and sought final affirmation of this statement from both sectors. Chris Picket asked to clarify one particular point – that being that the steering committee’s focus would be the constitution of the new entity.

Resolutions:

- 1. A governance steering or subcommittee with ACCHO sector representation would be established. Its core function would be to develop and oversight the implementation of a governance structure, a corporate constitution and board director appointments process for new Medicare Locals;**
- 2. The GP Division sector have established a business continuity/transition group to deal with transition of business issues between the outgoing GP Divisions and the new Medicare Local and this would continue its work and be linked with the new steering or subcommittee dealing with governance developments for the new entity;**
- 3. Funding for existing services delivered through GP Divisions to be transitioned through the business continuity/ transition working group;**
- 4. ACCHS core and current funding will continue to go directly from the DoHA/OATSIH to the ACCHS and not through the Medicare Locals;**
- 5. Future new funding for primary health care initiatives or programs fully or partly targeting Aboriginal people would be dealt with by the Medicare Locals (through commissioning/bidding procedures to be developed) who would seek advice and guidance from the relevant Regional Aboriginal Health Planning Forums;**
- 6. There was general agreement that a Medicare Local might establish a broad primary health care advisory forum from its membership base and that the Regional Aboriginal Health Planning forums could/would be linked in as a key component of such a forum but would not be subsumed or lose their unique identity or exclusive focus on Aboriginal health.**

Discussion and Resolutions on Medicare Local Boundaries

Kari put forward the proposition that the remainder of the time could be spent dealing with either funding or boundary issues.

It was agreed by both sectors that the high level concerns about primary health care funding for ACCHS had been satisfactorily addressed over the last 48 hours. On this basis, both sectors agreed that the time would be best spent addressing the boundary issues.

Kari invited opening position statements from the sector representatives in terms of their views on Medicare Local boundaries:

- The ACCHO alternative position to the 'big north' boundary is that there should be a Medicare Local for the Pilbara/Kimberley regions, the Central and Goldfields regions including the Lands (Tristate arrangements to be worked out) a solution for the Wheatbelt should be developed through AHCWA representation of Aboriginal interests in that region;
- WA GP Network advised that the GP Divisions aligned with the South West and Wheatbelt region proposals were not present for this meeting and that they don't believe they are able to respond to the ACCHO sector position;
- Chris Pickett reiterated that they put forward their proposals based on directions by DoHA in terms of boundaries and also took into account the views from our Divisions in terms of how the boundaries could work. He also advised:
 - ⇒ They looked to the New Zealand experience with setting up primary health care organisations and there was clearly a message from this that they aren't viable without a large enough population base;
 - ⇒ Our situation in WA is that the 'big north' covers 28% of land mass but only has a total population of about 220,000 people;
 - ⇒ There is the risk of loss of economies of scale relative to the bureaucracy needed to run each Medicare Local;
 - ⇒ For this reason, our thinking is that a small, lean central corporate arrangement with local offices set up in the key regions would work best;
 - ⇒ Some key skilled staff position holders (eg the Medicare Local accountant) might also be based out in a regional office as not every core position would need to be in the central office necessarily;
 - ⇒ We are very keen to have sufficient a lean bureaucracy;
 - ⇒ The challenge is to make the Medicare Local 'truly local' but still lean and efficient;
 - ⇒ We don't see any value in creating more than one Medicare Local for the 'big north' area.

The question Kari posed to DoHA on behalf of the meeting was:

"Is there any real scope for us to influence boundary decisions?"

DoHA's response was that the matter is being reviewed and that process will be completed by end of April. So it does appear that there is still a small window of opportunity to provide input to the Department through State Office. The ultimate decision is also subject to the COAG decision making process which may or may not be completed by the end of April. At this point in time, the Australian Government is working towards a decision and announcement on boundaries by the end of April.

Chris Renshaw pointed out that the ACCHO sector were left with the clear understanding from the meeting with Mark Booth at the end of March that things were open in terms of boundaries.

Nicole O'Keefe affirmed that that was indeed what was stated by Mark Booth. The ACCHO position has been conveyed to the Department in Canberra and the WACHS position will also find its way into the

process. There is also the second round of applications due on 19 July. This means that there are many 'threads' to this issue and different parties are making their views known and conducting various conversations. All this will inform the decision making.

Chris Pickett asked that if there are conversations with AHCWA and WACHS about boundaries, why there wouldn't be a conversation with the GP Divisions as well.

Nicole advised that there was no reason at all and the situation was open to many conversations and viewpoints. Her purpose here was simply to help the meeting understand that many conversations are going on and all the views will feed into influencing the decision about boundaries.

The meeting was reminded that in formal terms, the deadline targeted for a decision/announcement on boundaries is the end of April. Therefore, time constraints need to be kept in mind if any party plans to try to influence things from this point on.

Chris Larkin, CEO of KAMSC stated that WA Department of Health Director General Kim Snowball had assured the Conference two days ago that the state's position was that decisions would be made through the COAG process. This was confirmed as correct.

Chris Pickett pointed out that the GP Division sector had not been invited to be part of a process to discuss boundaries with the state or federal departments. He asked what the process is and who they needed to talk to. He said again that they had done a great deal of work, in good faith, adhering to the criteria and guidelines put out by DoHA. He stressed the substantial commitment of time, energy and money the sector had devoted to putting forward a complying proposal and also stated:

"Now we find we have less than two weeks to work up a submission on other boundaries. This is too rich. We feel like we are becoming whipping boys in this".

Kari looked to DoHA representatives for a clear statement to clarify the process to give certainty to the players in light of this statement.

A DoHA Canberra representative:

- Affirmed that they are talking with the WA government about their position on boundaries;
- Stated that they would like to hear all views on boundaries by end of April;
- Affirmed that it is up to Premiers and Ministers ultimately as to timing of decision and announcement.

Melissa Vernon from WACHS stated:

- "The WA government position will come through the Minister for Health and Director General of the Department together;
- They want the process to continue to sort this issue out;
- They aren't wedded to the April deadline;

Thursday 14 & Friday 15 April ACCHO and GP Divisions sector meetings on Medicare Locals in WA

- The conversation about the boundaries only started very recently (end of March when Mark Booth visited);
- If boundaries had already been decided by the DoHA for the ITA guidelines, this is not the state's position
- The WA DoH wants to make sure the boundaries are right for WA;
- They will link in to the COAG decision making processes.

Melissa also offered that she is a contact for anyone wanting to put a view forward to the WA Department of Health on the matter.

Kari invited further comment from DoHA:

- Either sector is welcome to talk to us so we can carry those views forward to Canberra;
- It isn't necessary to document a 'huge business case' on this aspect;
- Just a short outline of your reasoning and recommendation would suffice.

DoHA reiterated that the Commonwealth position is that there has been no final decision on boundaries for Medicare Locals other than guidelines suited to the first round applicants for the ITA.

Terry Brennan asked:

"Does that mean that the submission from our colleagues in several GP Divisions based on the 'big north' boundary is dead in the water?"

DoHA stated:

That this was not the case at all;

First round applicants will be assessed **on merit relative to existing boundary parameters**. Second round applications will be assessed **on the basis of ultimate boundary decisions**.

Kari asked the DoHA how the process would go if the WA government decision making via the COAG doesn't align with the Commonwealth's current decision timeline for the end of April in respect of the boundaries for Medicare Locals.

DoHA affirmed that they want the boundary issues resolved asap so the second round processes can be very clear about boundary decisions.

Melissa Vernon reiterated at this point:

"The state has not been involved in Medicare Local developments. The boundaries suggested in the first round ITA guidelines and the decision deadline of the end of April for final boundary determinations have been imposed by the Commonwealth and the state are not involved in that. Therefore, the state is not agreed to necessarily be bound by the Commonwealth's view about boundaries."

Kari offered a summary of the discussions thus far:

“While the state and the commonwealth work out their respective issues, your two sectors should ensure that both the commonwealth and the state know your views. Therefore, you should get on and put forward your own submissions. Does this help you Chris Pickett?”

Chris Pickett responded:

- No it doesn't;
- Our view on boundaries is what our submission is based on and we don't change that;
- The idea about putting up another view on boundaries in a two week timeline is a nonsense;
- Who would we work with and talk to in that timeline?
- Our current submission is based on known information and was done as a complying (with official ITA and guidelines) proposal in good faith;
- We don't resile from it;
- Primary health care is a very complex business and changing our view on boundaries would require a lot more work and consultation.

Kari confirmed that the GP Division position is respected and that they were not under any obligation to submit another proposal based on different boundary configurations.

A GP Division representative made the statement:

“We will have wasted six months of work and effort.”

Chris Renshaw stated at this point:

- There is a submission in for the 'big north' area – that is a given;
- Our view is to walk away from this meeting today with a consensus about how we will work together based on the boundary ideas for the second or third tranche submission;
- If we assume for a moment that the state and commonwealth agree on our sector's perspective on boundaries, then we will work together on a another proposal;
- If they do agree on your submission, we will be stuck with it, but from today, we still have a process in principle for how we are going to work together to develop the new entity on this basis;
- From AHCWA's perspective, we will simply take up our right and put our own view forward as you have;
- After that, we will all learn about the outcome of your submission and once we know, we will either work with the decision, or work together on a slightly different boundary context;
- Either way, what we have agreed on today about the governance development arrangements to be applied for either model.

Chris Pickett reiterated the time and effort necessary to develop a proposal in a ten week time line (to July). He also affirmed that it was his recommendation to their board that they not make another submission into this process until they receive definitive information from the commonwealth about

exactly what the parameters are. On this basis, we won't further invest in a second round submission process without such clarification.

Resolutions

- 1. The GP Division proposal for the 'big north' Medicare Local stands on its merits;**
- 2. If it succeeds, the two sectors will work together as agreed today on establishment of the governance of the new entity;**
- 3. If it doesn't succeed, the two sectors will work together on a proposal for alternative boundary configurations;**
- 4. The GP Division sector requires absolute clarification on all parameters for any subsequent proposal.**

Discussion and Resolution on Communication

Kari asked if the participants were satisfied about communication and forward planning arrangements going forward. She also clarified that:

- Where no AMS existed, AHCWA would represent Aboriginal interests;
- Derbarl Yerrigan were to be involved in metropolitan arrangements; and
- SWAMS were to be involved in arrangements for the South West;

Terry Brennan suggested that:

- We should go out with a plus on communication;
- Today, we have talked openly and politely which is great;
- We should make a commitment that we continue to talk together on anything to do with Medicare Locals from this point on:
- Whatever we or the Divisions sector hear from privileged access to information, we discuss with each other so we are all keeping informed together.

Kari welcomed these ideas and suggested such an approach would remove the likelihood of ongoing misunderstanding and create freedom to share/talk. She asked for more detail on how this would take place in reality.

Chris Renshaw offered that the ACCHO sector do acknowledge spending time and resources on something and then having the goalposts shift at last minute it is not good. He suggested:

- We have a task force approach - there is an actual AHCWA task force for communications across the sector;
- We conduct joint meetings to talk about boundaries a bit more - especially to see if we can't find a bit more middle ground from here;

- If we keep working together we may find solutions we haven't thought of yet.

Kari requested clarification if this taskforce was to be a precursor to the proposed steering committee for governance. She suggested that the first task would be to ensure there is a vehicle for sector planning and engagement with the Divisions sector. She pointed out that WAGPN has a taskforce for Medicare Locals on a whole of state basis and asked if the two groups would be vehicles for cross communication.

Chris Pickett stated that the WAGPN taskforce is fine from a whole of state level and AHCWA will want to work with this. However, he said that they don't see that as being a suitable vehicle for us to work with sector in respect to our 'big north' submission in particular.

He also took the opportunity to clarify that WAGPN represents statewide sector interests and not Divisions themselves because they are independent.

Kari affirmed that this was understood by all participants.

On that note, Terry Brennan pointed out that the ACCHO sector was set up on a similar manner. Therefore, each ACCHS will deal directly with the division people on relevant issues in a local region/area. AHCWA make sure that information is flowing to our individual services and boards.

Terry also stated that he felt a bit annoyed on behalf of GP Division and our own sector. Chris Pickett and their team put in a lot of work and we have had a lot of anxiety. We have managed to work things out a lot more today and that is good. But the fact is that a lot of this conflict and anxiety was unnecessary.

Des Martin also offered that:

- Today has been great;
- We are closer and understand each other better;
- My own understanding is better than it was;
- This issue is bigger than us - it is about our communities and us ensuring that as health providers going forward we get it right;
- AHCWA are the members (we are them and they are us);
- We work on behalf of our members not as well as, or in spite of them;
- Communities and local people's interests are paramount; and
- We believe in bottom up approach and the Regional Aboriginal Health Planning Forums are central to this principle in practice.

Chris Renshaw offered that:

"From our point of view we are about done and we are supportive of the way of moving forward. There is a lot for us to go away and think about now".

Chris Pickett also offered:

"I think we are done. The ITA deadline should go for six weeks from the anticipated announcement on boundaries. In final comment, too many mistakes made trying to roll out programs before they are well thought through and all the key information provided to all concerned. We would appreciate that message getting back to Canberra because they need to hear it."

Resolutions

- 1. The GP Divisions and others concerned with the 'big north' proposal will communicate directly with relevant ACCHS on developments;**
- 2. SWAMS and Derbarl Yerrigan will be kept informed by the relevant Divisions and others on developments concerning their regions;**
- 3. AHCWA will ensure relevant information is disseminated throughout the ACCHO sector;**
- 4. AHCWA and the WAGP Network will ensure they continue to communicate on developments on a whole of state basis.**

Meeting Close

Kari expressed thanks to all participants today.

Des Martin made the closing comments. He thanked Nicole and her team, the Canberra representatives and the GP Division colleagues for coming to sit and talk with us.

"I know that over last ten months there have been testing times. But we have been able to come together today and get some progress. We need you skills and talent for the future."