

13 December 2010

Assistant Secretary
Policy Development Branch
Primary and Ambulatory Care Division
MDP 1002
Department of Health and Ageing
GPO Box 9848
CANBERRA ACT 2601

cc. General Practice Network Leadership Group

Dear Mr Dennis

Medicare Local Boundaries

I am writing to provide you with a response from the Divisions of General Practice Network to the second stage consultation on proposed Medicare Locals boundaries. In addition to this nationally coordinated response, you will have also received individual responses from state-based organisations (SBOs) and general practice networks (GPNs).

This brief submission comments on the high-order principles that should prevail in finalising boundaries, the overall number of proposed Medicare Locals and the implications of these for the manner in which Medicare Locals are structured and organised in their communities. We do not comment on each Medicare Local region, only where there is a recommended change in boundary that is of a substantive nature or where there are impacts that we believe the Government should be aware.

Principles for decision making

The Network notes the proposed boundaries build on those outlined in the Cranny Report. The Network particularly supports the efforts by the Commonwealth and State/Territory governments to align Medicare Local and Local Hospital Network (LHN) boundaries. A robust and strategic relationship between these two pillars of the Australian health system is an essential pre-requisite for health reform objectives to be taken forward. Aligning boundaries, while not always possible, can help facilitate that outcome and is an important principle. Evidence of patient flows from both primary and secondary care and the requirement that Medicare Locals have sufficient economies of scale are also important criteria that should inform final decisions on Medicare Local boundaries.

While consideration has been given to cross-border arrangements around the NSW, Victorian and Queensland borders, AGPN recommends that these not be introduced at this early state of development, with the exception of the APY lands spanning the Northern Territory and South Australian borders and where existing cross-border conventions already exist (ie. between Victoria and NSW). Consideration of workable cross-border arrangements could be considered in the period following establishment.

It is also important that health reform related measures across the board are working together to advance health reform, and that decisions taken in one area do not confound or put at risk the success or direction of decisions taken in another. This is an additional principle and, on this basis, we have made firm recommendations for boundary changes based on the locations and catchments for the e-Health lead trial sites (GP Access in New South Wales and GPpartners in Queensland in particular). To minimise risk to those trials, it is imperative that the community catchment for these trials is maintained as far as is possible.

Number of Medicare Locals

The functions envisaged for *Medicare Locals* include identification of local health needs, development of locally focused and responsive services, provision of support to clinicians and service providers and implementation of primary health care initiatives and programs. These functions support the overall aim of better organised, better coordinated and better integrated primary health care services for local communities.

In order to fulfil these functions it will be important for these new organisations to have sufficient size and scale to be able to influence systems, models of care and practice, to provide practical support for primary health care networks in local communities and to partner effectively with LHNs and other services that serve regional populations. This approach is consistent with global trends towards primary health care-style organisations covering larger populations in order to provide the critical mass and resources required for effective needs assessment, funding, service development and workforce support functions on a regional level.

The proposed number of Medicare Locals is broadly consistent with earlier modelling and estimates by AGPN in our 2009 blueprint for primary health care organisations. However, the geography covered by some Medicare Locals is expansive and, in many cases, contains distinct communities of interest which will necessitate 'hub and spoke' structural arrangements in some areas. While medium to large scale Medicare Locals are the preferred overarching model, sub regional structures such as branch offices or service centres are also likely to be required to:

- address the challenges of the distances between communities in regional, rural and remote Australia
- respond to the primary health care service gaps and workforce needs of growth areas on the fringes of major cities
- serve particular communities of interest and high need disadvantaged communities
- ensure successful and effective community and provider engagement, particularly in ensuring that current engagement with general practice is maintained and where possible enhanced.

A network of branch offices and/or service centres will enable Medicare Locals to engage with local communities, support local primary health care and community networks and to tailor services and support programs to meet the needs in these diverse communities. This approach will ensure Medicare Locals remain connected and engaged with local communities, are large enough to perform the required roles and manage funds efficiently and effectively and will preserve the valued infrastructure of the Network.

Hub and spoke arrangements would have the following broad delineation of responsibilities and configuration:

- the primary focus of the 'hub' would be on the management of the Medicare Local
- the primary focus of the 'spokes' would be on engagement and service delivery to general practice and other primary health care providers and, in many cases engagement and direct service delivery to the community. 'Spokes' would essentially take one of the following two forms:
 1. Medicare Local branch offices in major regional towns that are the service hub for surrounding rural and remote communities. These branch offices would have the capacity to attract and manage funds to address gaps in local primary health care services as a direct service provider or form a consortium with other groups to develop innovative services for disadvantaged or high need groups. Branch offices would also undertake community consultation, local and regional needs assessment and planning, support local provider partnerships and networks and to host regional teams that offer outreach services where it is cost effective to do so.
 2. Service centres where local or visiting clinical teams and some practice support services are based in rural and urban settings that have significant workforce or access issues or in high need or disadvantaged communities where highly targeted or specialised effort and engagement is required.

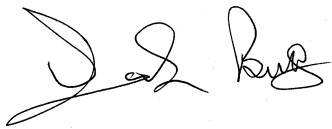
Recommended boundary changes and other impacts

AGPN has taken a systems perspective in our response. The attached table provides a summary response state-by-state, specifically indicating where major or substantive boundary changes are recommended and why. Where relevant, impacts of implications of particular proposed boundaries are discussed. AGPN would refer you to individual responses coordinated by the SBOs for more detailed analysis and for minor recommended boundary adjustments at the LGA or level.

Thank you for the opportunity to provide a further round of comments on the proposed Medicare Locals boundaries. AGPN is happy to provide further advice and looks forward to working closely with the Government to take the Medicare Local formation forward.

Please do not hesitate to contact myself on (02) 62280816 or Leanne Wells on (02) 62280854 if you or your staff require any further information.

Yours sincerely



David Butt
Chief Executive Officer