



1. Introduction

This submission paper outlines the Victorian Healthcare Association's (VHA) position regarding the Department of Health and Ageing's draft boundaries for Medicare Locals (MLO).

1.1. The Victorian Healthcare Association

The Victorian Healthcare Association (VHA) is the major peak body representing the public healthcare sector in Victoria. Our members include public hospitals, rural and regional health services, community health services and aged care facilities. Established since 1938, the VHA promotes improvement of health outcomes for all Victorians, from the perspective of its members.

1.2. Current service context

The Victorian primary healthcare sector has evolved significantly over the past 10 years. This has led to increased integration, coordination and innovation in service delivery throughout Victoria and has been underpinned by the Primary Care Partnership (PCP) Strategy and the health sector, with a devolved form of governance.

Victoria has a strong history of state funded primary healthcare, structured through a network of over 100 community health services operating from approximately 250 sites. Thirty-seven of these services are independently managed and known as "registered community health services"; the remainder are auspiced by rural or metropolitan hospitals and public health services, known as "integrated community health services". These services plan and implement programs, services and projects according to local needs and funding agreements, with a particular connection to local communities. It is vital that the strengths of the current Victorian primary healthcare sector are developed through the reform process. The important functions that each key stakeholder plays should not be lost or ignored.

The VHA remains concerned that the roles of Medicare Locals continue to be unclear and there are many unanswered questions that surround their policy, implementation and performance framework. Similarly, development processes for Medicare Locals has been problematic at both a policy level and at a local agency level. Presently, it appears that this process will result in a transition for Divisions of General Practice; however it remains unclear as to what the benefits of this transition will actually mean for primary healthcare service agencies more broadly and their consumers.

1.3. The COAG reforms

The VHA acknowledges that the COAG reforms relating to health and hospitals build on many successful aspects of the Victorian health system. This is a vote of confidence in the Victorian health system and its workforce. The coming years provide an opportunity to build on the strengths of the Victorian system and continue to improve the services provided to local communities. It is hoped that further investments to support these health initiatives will flow in coming years. The VHA welcomes the mandate for formal bilateral agreement between federally-administered Medicare Locals (ML) and state-administered Local Health Networks (LHN).



2. The VHA's response – Medicare Locals

2.1. Form and function

The VHA welcomes the intention of the Federal Government to improve access to primary healthcare and promote service coordination and integration across Australia. The VHA has developed a Position Statement that outlines its position on the implementation of Medicare Locals in Victoria. These recommendations if followed would enable a workable solution for the Victorian health system. This document has broad-based support from key Victorian stakeholders.

Before it is possible to fully understand the implications of decisions regarding the boundaries of Medicare Locals, the form and function of these organisations must be comprehensively defined. Whilst the VHA has provided its position on Medicare Locals boundaries within this paper, the VHA views this discussion as premature until the form and function of these organisations is agreed upon. The VHA's position on the form and function of Medicare Locals is provided within the Position Statement.

The PCP Strategy, initiated by the Victorian Department of Human Services (now Department of Health), demonstrates the benefits of a collaborative approach. Many of these partnerships bring together health, social and welfare services to meet community needs, with a focus on Victoria's most vulnerable.

2.2. Medicare Locals

The VHA calls on the Federal Government to ensure that the implementation of reforms within the primary healthcare sector delivers demonstrable benefits to the Victorian community. In particular this must ensure improvement in access and health outcomes to those communities and individuals who currently underutilise primary healthcare services, such as those experiencing socioeconomic disadvantage and living in rural and remote areas.

The VHA highlights the important difference in terminology between primary care and primary healthcare. Medicare Locals must focus on a broad concept of primary healthcare that seeks to change the personal, social, political, environmental and economic determinants of health to create better health in communities, cities or regions. Consequently, these services will need to go far beyond the boundaries of traditional General Practice.

2.3. Principles for determining boundaries or catchment areas for Medicare Locals, including potential differences between metropolitan, rural and remote areas

Following member consultation, the VHA has developed the following key principles for the determination of Medicare Local boundaries:

- Adherence to the following existing regional boundaries:
 - Local Government Area
 - Victorian Department of Health regional catchments
- A focus on communities of interest, that is, boundaries set according to the Medicare Local's ability to respond to local needs/priorities, logical geographic divisions and communities of interest that cross state borders such as towns on the Victorian and NSW border, and transport routes
- Consideration of local networks of service providers and community based organisations



- Consider geography, population density and distribution, topography and natural population flow, such as transport routes that create communities of interest

Medicare Local boundaries must **not**:

- Act as a barrier or inhibitor to service coordination
- Be determined solely on the basis of population numbers within a specific area

2.4. Suggestions about the optimum number of Medicare Locals in a particular state, territory or region, including potential boundaries in each area

Following member consultation, the VHA believes that Victoria should have at a minimum 17 Medicare Locals established across Victoria. The following Medicare Local boundaries have been proposed by the VHA and its members:

Metropolitan Medicare Local Boundaries	
Number	Local Government Areas
1.	Melton, Brimbank, Wyndam, Hobson’s Bay, Maribyrnong
2.	Moonee Valley, Moreland, Melbourne, Yarra
3.	Hume, Whittlesea, Banyule, Nillumbik, Darebin
4.	Booroondara, Whitehorse, Manningham, Monash
5.	Knox, Maroondah, Yarra Ranges
6.	Port Phillip, Stonnington, Glen Eira, Kingston, Bayside
7.	Greater Dandenong, Casey, Cardinia
8.	Frankston, Mornington Peninsula

Rural Medicare Local Boundaries	
Number	Local Government Areas
9.	Corangamite, Moyne, Warnambool, Southern Grampians, Glenelg
10.	Moorabool, Golden Plains, Hepburn, Ballarat, Pyrenees, Ararat, Northern Grampians, Horsham, Yarriambiack, Hindmarsh, West Wimmera
11.	Gannawarra, Buloke, Swan Hill (with some relationship to Bendigo and interstate communities of interest in south-west NSW)
12.	Mildura (and interstate communities of interest in south-west NSW)
13.	Mitchell, Murrindindi, Strathbogie, Greater Shepparton, Moira
14.	Mansfield, Benalla, Wangaratta, Alpine, Indigo, Wodonga, Towong
15.	Baw Baw, Bass Coast, South Gippsland, Latrobe, Wellington, East Gippsland
16.	Greater Geelong, Surf Coast, Colac-Otway, Queenscliffe
17.	Macedon Ranges, Mount Alexander, Central Goldfields, Greater Bendigo, Loddon, Campaspe (and interstate communities of interest in south-west NSW)

The capacity for Medicare Locals to deliver to their stated function is dependent on the engagement of all key stakeholder groups. The VHA emphasises that local discussions between key partners around the appropriate geography for Medicare Locals is ongoing throughout Victoria. These discussions should be encouraged by the Department of Health and Ageing. The VHA is aware that divergent views to the above proposed boundaries between key stakeholders still remain. The VHA therefore cautions against making a final decision on boundaries until a



consensus view with all key partners across Divisions of General Practice, community health, other primary healthcare providers and acute health services in a local area and is achieved.

The VHA welcomes the significant work undertaken by Divisions of General Practice and key primary healthcare stakeholders in collaboratively seeking local agreements and solutions for Medicare Local implementation. The VHA commends these organisations on these important activities. However, the VHA is concerned that some Divisions of General Practice are progressing a Medicare Local model without support from key stakeholders in their local area. Such approaches may be disruptive to existing and future service arrangements and must be discouraged.

Consequently, the VHA believes that the approach of 'local solutions for local areas' should be applied across the state. Boundaries applied without local agreement will not achieve the collaborative outcomes listed within the COAG Agreement. Where there is clear crossover of issues and communities of interest, the VHA recommends the development of mechanisms that enable Medicare Locals to work cooperatively, rather than competitively.

The VHA is concerned about some of the proposed boundaries in the Department of Health and Ageing consultation document, particularly the large Hume catchment. The VHA believes this catchment should be separated into:

- o Mitchell, Murrindindi, Strathbogie, Greater Shepparton, Moira
- o Mansfield, Benalla, Wangaratta, Alpine, Indigo, Wodonga, Towong including capacity to cross borders with New South Wales.

The VHA also believe there should be consideration of crossing the South Australian border, as towns such as Mount Gambier have a strong travel relationship with areas such as Portland.

2.5. How boundaries might be defined in cross border areas

The VHA recognises the logistical and geographical issues of cross border areas, and believes that consideration of local factors on health care delivery must be recognised. It is imperative that these factors are managed at a local level, with support from all levels of government and service providers, rather than these state borders acting as a barrier to service integration. For example, these borders are currently an inhibitor to service integration in the areas of primary mental health.

2.6. Potential barriers or difficulties that will need to be addressed in establishing new boundaries and catchment areas for Medicare Locals

A key difficulty being faced in determining effective boundaries for Medicare Locals will be managing the needs of a diverse range of stakeholders, as well as the range of functions that Medicare Locals have been tasked with undertaking.

The COAG Agreement asserts that Medicare Locals will undertake population health planning, service integration, as well as service delivery. Because population health planning is a relatively new area, its concepts and principles are not well understood. The VHA, in collaboration with Monash University, has developed a position statement that provides best practice working definitions of population health and population health planning for the Victorian health system context. These definitions provide clarity regarding the concept of population health, with the potential to achieve consistency across services. The position statement also identifies four core components and eight best-practice principles that represent the activities required to implement



13 December 2010

a best-practice approach to population health planning. The VHA recommends that these be adopted when implementing Medicare Locals.

The VHA's position is that within Victoria there are many agencies well placed to provide services to communities across the state. The role of Medicare Locals as a service provider should therefore be through capacity building activities for the primary healthcare sector. They should therefore play a purchasing role rather than providing services for the community.

The role of population health planner and service integrator necessitates interacting with the health system at differing levels. The size of the community of interest or catchment for these activities therefore varies. Resolving these two issues creates a barrier to the implementation of Medicare Local boundaries and a clear strategy for overcoming this barrier is necessary. One of the key factors in the success of PCPs in Victoria is the ability to implement local solutions in the key areas of population health planning, integrated chronic disease management and service coordination. Therefore, decisions by Government cannot be made until a local consensus is also in place.

A secondary issue that must be addressed in the implementation process of Medicare Locals is ensuring that the important role that Divisions of General Practice currently play in supporting General Practice throughout Victoria is maintained within the new structure. This is a concern within the primary healthcare sector. In the enthusiasm to achieve the many gains afforded to the primary healthcare system by the proposed reforms the gains of the past 20 years must not be lost. It must be remembered that the General Practice workforce and their engagement is a key driver for achieving future change in the way in which services are provided to our communities.

3. Conclusion

The VHA believes that the primary healthcare reforms provide a valuable opportunity to develop the primary healthcare sector within Victoria. Service integration and improved population health approaches to planning are important drivers for improving the health outcomes of our communities. The VHA looks forward to working with all levels of government, and other interested stakeholders in supporting the implementation of these reforms.

Please contact me on (03) 9094 7777 to clarify any information in this submission.

A handwritten signature in black ink, appearing to read 'Trevor Carr', with a long horizontal flourish extending to the right.

Trevor Carr
Chief Executive Officer

