Chapter 4

Medicare Locals—history and implementation

Establishment

4.1 The establishment of 61 Medicare Locals across Australia was one of the key reforms under the National Health Reform Agreement (NHRA). The NHRA formed the basis for the then Labor Government's implementation of the recommendations made by the National Health and Hospitals Reform Commission (NHHRC).

4.2 Formed in 2008, the NHHRC was created 'to provide advice on performance benchmarks and practical reforms to the Australian health system which could be implemented in both the short and long term'.[1] The NHHRC's June 2009 report provided the foundation for the NHRA and health funding announced by the Labor Government in 2011.

4.3 Medicare Locals were a key element of a strengthened primary care system which focused on integration of services and joint Commonwealth and State government planning for service delivery and access.[2]

4.4 Under the NHRA, the Commonwealth Government had responsibility for the establishment of the Medicare Locals.[3] The Medicare Locals were funded with $1.8 billion over five years from 2011-12 to 2015-16.[4]

4.5 A lengthy consultation process led by the Department of Health and Ageing was conducted prior to the establishment of the Medicare Locals. Groups who participated included:

- Australian General Practice Network;
- state and territory health departments;
- individual Divisions of General Practice;
- medical bodies (including the Royal Australasian College of Physicians and the Royal Australian College of General Practitioners);

---

1 National Health and Hospitals Reform Commission, Terms of Reference, http://nhhrc.org.au/terms-of-reference/.

2 *A National Health and Hospitals Network for Australia's Future*, Government publication, 2010, p. 5.

3 Council of Australian Governments, *National Health Reform Agreement*, 2011, p. 6. http://webarchive.nla.gov.au/gov/20140801015609/http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nhra-agreement.

4 *Review of Medicare Locals – Report to the Minister for Health and the Minister for Sport*, Professor John Horvath AO, 4 March 2014, p. 2.

- the Australian Medical Association;
- allied health professional groups such as the Pharmacy Guild;
- intellectual disability groups;
- Aboriginal and Torres Strait Islander health organisations and other stakeholders in the sector.[5]

4.6 Following a competitive application process, 61 Medicare Locals were established in three tranches: 19 Medicare Locals were established from 1 July 2011; 15 Medicare Locals commenced from 1 January 2012; and the remainder from 1 July 2012.[6]

4.7 Also operational from 1 July 2011 was the after hours GP helpline, which by August 2011 had received over 20 000 calls. Medicare Locals were funded to also improve access to after hours care or more specifically to:

> …to review the after hours primary health care needs of their region and address urgent gaps in care, ensuring that communities across their region have suitable after hours services in place.[7]

4.8 Medicare Locals are non-profit companies which are principally funded by the federal government and which operate independently. Each Medicare Local has a Deed for Funding through which government funding is allocated and which specifies program schedules and reporting requirements.[8] Medicare Locals are also able to source additional funding through state government grants or fundraising activities.

Purpose

4.9 Medicare Locals were part of a renewed focus on primary care, 'to work with the full spectrum of General Practice, allied health and community health care providers and improve access to care and drive integration between services'.[9]

4.10 The task of Medicare Locals, including their relationship to GPs, was explained further as:

> While GPs remain at the centre of primary health care and responsible for individual patient care, Medicare Locals will be responsible for developing

---

5 *National Health Reform Process and Delivery Publication*, Government Publication, September 2011, pp 17–18, http://webarchive.nla.gov.au/gov/20140801015101/http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nhr-progress-delivery, (accessed 7 November 2014).

6 *National Health Reform Process and Delivery Publication*, Government Publication, September 2011, pp 17–18.

7 *National Health Reform Process and Delivery Publication*, Government Publication, September 2011, p. 18.

8 *Review of Medicare Locals – Report to the Minister for Health and the Minister for Sport*, Professor John Horvath AO, 4 March 2014, pp 2–3.

9 *National Health Reform Process and Delivery Publication*, Government Publication, September 2011, p. 16.

> strategies to meet the overall primary health care needs of their communities. They will ensure the primary health care services needed by their communities work effectively for patients, through developing collaborative arrangements between health service providers in their area. They will also plan and support local after hours face-to-face GP services.
>
> Medicare Locals will work closely with Local Hospital Networks and the new front end for aged care to deliver better integration and smoother transitions for patients across the entire health care system...
>
> A stronger primary health care system will be supported by joint planning with states and territories and Medicare Locals to improve the delivery of primary health care services in the local community.[10]

4.11 Funding was also allocated for the Australian Medicare Local Alliance, a peak body for the 61 Medicare Locals. The Alliance's role was to 'lead, coordinate and support' the Medicare Locals. [11]

Activities of Medicare Locals

4.12 Medicare Locals were designed to take an active role in identifying gaps in primary health care and improving service delivery. For example:

> Medicare Locals will be responsible for improving primary health care service delivery at the local level, to reduce service gaps and improve access to high quality integrated care centred around patients' needs. For instance, a Medicare Local, in consultation with local GPs, might identify that there are a large number of diabetics in a particular area – and organise a roster of allied health professionals such as nutritionists and diabetes educators to provide sessional services to different GP clinics in that area.
>
> Subject to final agreement with the states, Medicare Locals may play an increasing role in delivering services currently funded by states but set to transfer to the Commonwealth through the Government's reforms. The Commonwealth and the states have already agreed to roll any primary care coordination functions into Medicare Locals to reduce duplication. States have agreed to align related programs with Medicare Locals as much as possible.[12]

4.13 The submission from the Australian Medicare Local Alliance sets out the strategic objectives of the Medicare Locals:

- improving the patient journey through developing integrated and coordinated services;
- providing support to clinicians and service providers to improve patient care;

---

10 *National Health Reform Process and Delivery Publication*, Australian Government, September 2011, p. 16.

11 Australian Medicare Local Alliance (In Liquidation), *Submission 82*, p. 1.

12 'A National Health and Hospitals Network for Australia's Future' Government publication, 2010, p. 40.

- identifying the health needs of their local areas and development of locally focused and responsive services;
- facilitating the implementation of primary health care initiatives and programs; and
- being efficient and accountable with strong governance and effective management.[13]

4.14 The operating model of the Medicare Locals to achieve these objectives is also set out by the Alliance, in the figure below.

Figure 1—Medicare Locals operating model[14]

Primary Health Networks

Policy change

4.15 Medicare Locals were mentioned only briefly in the August 2013 Coalition health policy, *The Coalition's Policy to Support Australia's Health System*. The policy notes that 'We [the Coalition] will also review the Medicare Locals structure to ensure that funding is being spent as effectively as possible to support frontline services rather than administration.'[15]

4.16 During the leadership debate in 2013, in answer to a question by a member of the audience, the then Opposition Leader, the Hon Tony Abbott MP made a promise that no Medicare Locals would be closed should the Coalition form government.[16]

4.17 However, on 16 December 2013, the new Minister for Health, the Hon Peter Dutton MP announced a review into the Medicare Locals to be conducted by Professor John Horvath AO.[17] A media release on 16 December 2013 quoted the Minister for Health as saying that the purpose of the review was 'reducing waste and spending on administration and bureaucracy, so that greater investment can be made

---

13 Australian Medicare Local Alliance, *Submission 82*, p. 6.

14 Australian Medicare Local Alliance, *Submission 82*, p. 6.

15 *The Coalition's Policy to Support Australia's Health System*, Liberal and National Parties, August 2013, http://lpaweb-static.s3.amazonaws.com/13-08-22%20The%20Coalition%E2%80%99s%20Policy%20to%20Support%20Australia%E2%80%99s%20Health%20System.pdf, p. 3.

16 The Hon Tony Abbott MP (Opposition Leader), *People's Forum 2*, transcript, ABC News 24, 28 August 2013.

17 Health Minster the Hon Peter Dutton MP, Media release, *Medicare Locals review: Australia's former Chief Medical Officer Prof John Horvath AO will oversee the Australian Government's review of Medicare Locals*, 16 December 2013, www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2013-dutton025.htm.

in services that directly benefit patients and support health professionals who deliver those services to patients.'[18]

4.18 The review recommended that the Medicare Locals be closed and a new network of 'Primary Health Organisations' be established.[19]

4.19 While the review was completed in March 2014, it was not until the 2014-15 Budget that the government announced all Medicare Locals would cease operation on 30 June 2014 and a new network of Primary Health Networks (PHNs) would be established.

The Review of Medicare Locals

4.20 The Minister for Health announced the terms of reference for the Review of Medicare Locals (the Review) on 16 December 2013, and at the same time invited stakeholder comment:

> Stakeholders have been invited to comment on various aspects of Medicare Locals' functions including:
>
> - The role of MLs [Medicare Locals] and their performance against stated objectives
> - The performance of MLs in administering existing programmes, including after-hours GP services
> - Recognising general practice as the cornerstone of primary care in the ML functions and governance structures
> - Ensuring Commonwealth funding supports clinical services, rather than administration
> - Processes for ensuring that existing clinical services are not disrupted or discouraged by ML programs
> - Interaction between MLs and Local Hospital Networks and other health services, including boundaries
> - Tendering and contracting arrangements
> - Other related matters[20]

4.21 Professor Horvath, the former Chief Medical Officer, was appointed to conduct the Review. In his work he was assisted by the Department of Health, and he drew upon work conducted by two consultants:

---

18 Health Minster the Hon Peter Dutton MP, Media release, *Medicare Locals review: Australia's former Chief Medical Officer Prof John Horvath AO will oversee the Australian Government's review of Medicare Locals*, 16 December 2013.

19 Professor John Horvath AO, *Review of Medicare Locals – Report to the Minister for Health and the Minister for Sport*, 4 March 2014, Executive Summary, p. v.

20 www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2013-dutton025.htm.

> A review on the functioning of Medicare Locals: Conducted by Ernst & Young (EY) this review provided analysis and opinion on current Medicare Locals operations and potential future governance options.
>
> An independent financial audit of Medicare Locals: Undertaken by Deloitte Touche Tohmatsu (Deloitte), the audit provided an assessment of Medicare Locals compliance to their Deed and financial performance.[21]

4.22 In addition to the consultant reports, Professor Horvath stated that he also '…personally held interviews with a number of key stakeholders and opinion leaders'.[22]

4.23 Professor Horvath wrote: 'The Department of Health invited selected stakeholders to make submissions to inform the Review. Over 270 submissions were received. Over half of these submissions were unsolicited, highlighting the significant interest in the Review.'[23] The submissions were not published either on the Department of Health's website or as supporting documentation with the Review.

No information on Review process

4.24 The Review findings were provided to the government on 4 March 2014.

4.25 The committee has been able to obtain very little information about the process and methodology used to conduct the Review. What information the committee has been able to gather has come from public hearings.

4.26 The committee heard that those Medicare Locals who were asked for input to the Review were restricted in what they could provide. Ms Kathryn Stonestreet, CEO of the Southern NSW Medicare Local told the committee:

> We were asked to give an opinion and I think we had to keep it to three pages—it was short—in terms of what Medicare Locals are, our achievements and the potential issues. All Medicare Locals could participate plus other organisations like the AMA and such.[24]

4.27 The Northern Adelaide Medicare Local published its three page input to the Horvath Review on its website.[25] The small font size, dot points, pages crammed with information and the need for 15 pages of attachments clearly indicate that the three page limit imposed by the Horvath Review was inadequate to explain the achievements of a Medicare Local.[26]

---

21 Professor John Horvath AO, *Review of Medicare Locals – Report to the Minister for Health and the Minister for Sport* 4 March 2014, p. 3.

22 Professor John Horvath AO, *Review of Medicare Locals – Report to the Minister for Health and the Minister for Sport*, 4 March 2014, p. 3.

23 Professor John Horvath AO, *Review of Medicare Locals – Report to the Minister for Health and the Minister for Sport*, 4 March 2014, p. 3.

24 Ms Kathryn Stonestreet, CEO Southern NSW Medicare Local, *Committee Hansard*, 16 September 2014, p. 5.

25 Northern Adelaide Medicare Local, www.naml.com.au/about-us.

26 Northern Adelaide Medicare Local, www.naml.com.au/about-us.

4.28 It seems that other Medicare Locals did not have the opportunity to provide input to the Review. Mrs Brenda Ryan, CEO, Goldfields-Midwest Medicare Local (GMML) in Western Australia told the committee that the GMML was not consulted.[27] Similarly Mr Paul Hersey, CEO, Perth South Coast Medicare Local (PSCML), Western Australia, was not approached by the Review.[28]

4.29 However Mr Hersey contributed to the Deloitte audit and he believed that the PSCML was one of six Medicare Locals, out of a possible 61 Medicare Locals, involved in the audit. Mr Hersey noted that there had been no major issues identified in the PSCML audit, however he was concerned about the timing of the audit and believed that the audit results should be viewed in context:

> My main concern with the Deloitte process was that it looked at a point in time. It was always firmly in the rear-view mirror and by the time the audit took place it looked at the 2012-13 financial year, which was when Medicare Locals had just been established. With any issues that Deloitte raised with me, a typical conversation would be, 'That may have been the case at that point in time, whereas this year we are doing things differently.' Deloitte acknowledged that throughout.[29]

4.30 The work of the audit was described by Mr Mark Booth, Department of Health, as 'essentially a basic audit' with six Medicare Locals involved in a more intensive 'side visit'.[30]

4.31 A number of organisations have advised the committee that they made submissions to the Review of Medicare Locals, including the Consumer Health Forum of Australia (CHF)[31] and the Australian Medical Association (AMA).[32]

Committee comment

4.32 With limited information available publicly, and no detailed discussion of methodology in the Review report, it is difficult to understand the Review's recommendations. Similarly, without the transparency that would have been achieved by the publication of the consultancy reports and the 270 submissions, the Review's assertions that the Medicare Locals are "flawed" cannot be tested.

---

27 Mrs Brenda Ryan, CEO Goldfields-Midwest Medicare Local, *Committee Hansard*, 10 October 2014, p. 12.

28 Mr Paul Hersey, CEO South Coastal Perth Medicare Local, *Committee Hansard*, 10 October 2014, p. 12.

29 Mr Paul Hersey, CEO South Coastal Perth Medicare Local, *Committee Hansard*, 10 October 2014, p. 12.

30 Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division, Senate Community Affairs Legislation Committee, *Supplementary Estimates*, 22 October 2014, p. 34.

31 This submission was provided to the committee upon request.

32 This submission is available on the AMA website: https://ama.com.au/submission-australian-government-review-medicare-locals

Government response

4.33 Prior to the Budget being handed down, communities believed that despite the findings of the Review no Medicare Locals would be closed.[33] These views were based on a firm public statement by the now Prime Minister that no Medicare Locals would be closed should the Coalition form government.[34] For example, the Northern Adelaide Medicare Local Board Chair, Dr Nick Vlachoulis published a media release on 23 April 2014 to reassure staff and consumers that the Medicare Locals would continue:

> Recent rumours that Medicare Locals will be axed as part of the Federal Budget is purely speculation, says Northern Adelaide Medicare Local (NAML) Board Chair, Dr Nick Vlachoulis.
>
> "NAML has a contract with the Commonwealth for Medical Local funding through to June 2016 and Tony Abbott said prior to the election last year that Medicare Locals would not be closed" Dr Vlachoulis said. Dr Vlachoulis highlighted that the majority of staff employed at NAML are frontline health workers who provide services and programs directly to the community.[35]

4.34 The 2014-15 Budget announced that all 61 Medicare Locals would be closed and a new smaller system of PHNs would be established.[36]

4.35 The Department of Health has stated that the cost of establishing the Primary Health Networks will be drawn entirely from departmental resources. The government has not clarified what will happen to any remaining funding from the $1.8 billion allocated over five years for the support of the current 61 Medicare Locals. The Budget Papers explain:

> The Government will refocus primary care funding by replacing Medicare Locals with Primary Health Networks from 1 July 2015. The Primary Health Networks will establish Clinical Councils, with a significant GP presence, and local Consumer Advisory Committees that are aligned to Local Hospital Networks, to ensure primary health care and acute care sectors work together to improve patient care.[37]

---

33 Northern Adelaide Medicare Local Media Release, *Media speculation around Medicare Locals*, 23 April 2014, www.naml.com.au/media-centre/latest-news.

34 The Hon Tony Abbott MP (Opposition Leader), *People's Forum 2*, transcript, ABC News 24, 28 August 2013.

35 Northern Adelaide Medicare Local Media Release, *Media speculation around Medicare Locals*, 23 April 2014, www.naml.com.au/media-centre/latest-news.

36 The Horvath Review refers to Primary Health Organisations, but the Government has opted for the alternative name 'Primary Health Networks'.

37 2014-15 Budget, Budget Paper No. 2: Budget Measures 'Establishment of Primary Health Networks', p. 129.

Committee comment

4.36 The committee believes that without more information about the processes and methodology used by the Review, and without the publication of the consultancy reports and the 270 submissions, the Review's findings cannot be subjected to proper scrutiny.

4.37 The evidence the committee has heard, and the few submissions the committee has seen that were made to the Review, raise a large number of questions. Further, the committee is concerned by the disparity of the evidence it has heard of the achievements of Medicare Locals and the highly critical and negative findings the Review made about the work of the Medicare Locals.

The costs of implementing Primary Health Networks

Introduction

4.38 This section focuses on the impact of the government’s decision to close Medicare Locals, the loss of frontline services already reported to the committee and the confusion surrounding the tender process to establish the PHNs.

Closure of Medicare Locals

4.39 In the 2014-15 Budget the government announced:

> The Government will refocus primary care funding by replacing Medicare Locals with Primary Health Networks from 1 July 2015. The Primary Health Networks will establish Clinical Councils, with a significant GP presence, and local Consumer Advisory Committees that are aligned to Local Hospital Networks, to ensure primary health care and acute care sectors work together to improve patient care.
>
> The cost of this measure will be met from within the existing resources of the Department of Health.[38]

4.40 The effect of this decision is that funding will cease for Medicare Locals on 30 June 2015. By that time, the government's intention is that PHNs will have been selected through a tender process and be ready to operate from 1 July 2015.

4.41 The committee has heard much evidence regarding the wind up of the Medicare Locals and the tender process for the PHNs. Issues which emerged consistently in evidence included:

- concerns over the permanent loss of important frontline services delivered by Medicare Locals;
- loss of healthcare professionals as they seek alternative employment due to uncertainties over the future of programs run and contracts managed by Medicare Locals;
- the up to $112 million cost of closing Medicare Locals; and

---

38 Budget Paper No. 2: Budget Measures – Health. www.budget.gov.au/2014-15/content/bp2/html/bp2_expense-14.htm.

- confusion about the role and timeline for the tender for PHNs and the late provision of the boundary information.

4.42 Whether Medicare Locals participate in the tender for PHNs, or continue without government funding, or close entirely, it will be important that vital services are not lost, that the good work of Medicare Locals in population health, closing gaps in services and better integration of primary care is not lost in the process.

Loss of services provided by Medicare Locals

4.43 The closure of Medicare Locals and the establishment of a smaller number of PHNs does not in any way guarantee the retention of the diverse range of services provided by the Medicare Locals. Valuable work that is likely to be lost in the transition includes:

- service delivery programs, particularly preventative health and mental health programs;
- the creation of a health care support model which includes consumers, GPs and allied health professionals working together;
- networks and relationships with NGOs, state governments and service providers; and
- community goodwill and support.

This is by no means a complete list.

4.44 Mr Phil Edmondson, CEO, Tasmania Medicare Local, told the committee that it had taken two years for the Tasmanian Medicare Local to build up its place in the community.[39] Mr Edmondson outlined the details of 11 of the projects the Tasmanian Medicare Local works on currently, however he explained that this is a small sample of the 'more than 200 current contracts with Tasmanian health service providers and agencies to deliver joined up primary healthcare services'.[40] Dr Judith Watson, Chair of the Tasmanian Medicare Local explained the work that had been done to secure the community's trust and through collaboration with stakeholders:

> What Medicare Locals were always intended to be about was major system business change, primarily to bolster the power of the primary sector to keep people well and out of hospital—the most economical and sustainable use of the health dollar and better for all Australians. We will be doing this by changing the way in which primary and tertiary sectors interact to service the health needs of the communities, by changing the way in which primary health providers work, communicate and engage to provide the best possible care to all of their communities and by changing the expectation, utilisation and understanding of what communities can and should expect from their primary care system. None of these things happen

---

39 Mr Phil Edmondson, CEO Tasmanian Medicare Local, *Committee Hansard*, 4 November 2014, p. 11.

40 Mr Phil Edmondson, CEO Tasmanian Medicare Local, *Committee Hansard*, 4 November 2014, pp 2–3.

> overnight; indeed, it takes many years of intensive effort of trust and collaboration to achieve many of the changes necessary to effect such changes in balance and focus. We must now make the most of this opportunity to do our best to preserve the service continuity within our state.[41]

4.45 A key part of the work undertaken by Medicare Locals is to 'provide better services, improve access to care and drive integration across GP and primary health care services'.[42] An example of the success of Medicare Locals in this area was provided to the committee by Ms Kathryn Stonestreet, CEO, Southern NSW Medicare Local:

> General Practice in Tuross
>
> Tuross Head Surgery is a general practice owned and operated by SNSWML [Southern NSW Medicare Local]. Opened in March 2010, the thriving practice now has more than 1,500 regular patients and three GPs supported by a practice nurse and three receptionists, as well as regular visits by allied health professionals.
>
> The story was very different in 2009 when Tuross Head residents had been without a GP in their town for two years. Recognising this significant gap in primary health services for a community of 2,500 people with an ageing population, limited transport options, and a significant year round visitor population, SNSWML applied for Federal Government funding to establish and operate a general practice in the seaside village. The application for $210,000 was successful and 12 months later Tuross Head Surgery was open for business.[43]

4.46 Witnesses expressed strong concerns that with the cessation of funding for Medicare Locals on 30 June 2015, and the uncertainty created by the establishment of new PHNs, continuity of services was at risk. Mr Paul Hersey, CEO South Coastal Perth Medicare Local, explained his concerns about whether the transition would allow for existing services and contracts to continue:

> My concern about the transition to Primary Health Networks is that this service continuity needs to be maintained. People accessing services are the most vulnerable in the community and, in many instances, if these types of programs are not available, people will simply not access the healthcare system, which would obviously have a detrimental impact on the individual and, down the line, on the acute care system.
>
> I have gone on the record previously indicating my support for the concept of Primary Health Networks and the opportunities presented through larger organisations, GP-centricity and an ability to take an equal seat at the table

---

41 Dr Judith Watson, Chair, Tasmanian Medicare Local, *Committee Hansard*, 4 November 2014, p. 1.

42 Australian Government, *A National Health and Hospitals Network for Australia's Future – Delivering better health and better hospitals*, report, 2010, p. 33.

43 Answer to question on notice, Kathryn Stonestreet, CEO Southern NSW Medicare Local, 16 September 2014.

> with state health and other state-wide bodies. However, my concern in my area is about ensuring a smooth service transition and, in my own case, running a Medicare Local that hopes to transition to a service delivery organisation to continue to be able to deliver those services in spite of losing in excess of $3 million in core funding.[44]

4.47 The Partners in Recovery Program is another example of a program at risk due to the change from Medicare Locals to PHNs. Mr Darren Carr, CEO of the Mental Health Council Tasmania explained the community benefits of the Partners in Recovery Program:

> Partners in Recovery is an excellent program. It has made a difference here in Tasmania. In particular, it has made a difference for the people who are at the pointy end of the triangle, so to speak—the people who are the most unwell and are falling through the gaps of current services… Due to eligibility criteria differing from program to program and service to service, consumers who have complex needs and needs that perhaps involve multiple service providers often fall through the gaps. Partners in Recovery has helped…make it far less likely and has helped those people deal with multiple service providers.
>
> My father died of cancer five years ago. Dealing with multiple service providers, as he was dying, was complex and difficult for our family—never mind the fact that I have worked in the cancer field, have a brother who is a doctor and a mum who is very involved. Even then, it was difficult. For people with a severe illness who do not have those fantastic supports…Partners in Recovery has helped those people enormously. We are seeing some great outcomes from Partners in Recovery.[45]

4.48 At Senate Community Affairs Legislation Committee Supplementary Estimates, the Department of Health was unable to give any reassurance that Partners in Recovery would not suffer under the closure of Medicare Locals:

> Mr Booth: The Medicare Locals exist until 30 June [2015] and then Primary Health Networks take over. There are a number of areas, in terms of transition, in a number of services which come to an end at the end of that particular period or, as in the case of Partners in Recovery, where the contract goes for a further year and lead agencies in that area are Medicare Locals…The answer is that we are working closely with Medicare Locals and Partners in Recovery consortia to look at how we deal with that. Our key aim with Medicare Locals, in working with them over the next six months, is to ensure that service delivery is prioritised and that there is no reduction in service delivery that they need to do. We would certainly make sure that was happening, as far as we could, with Partners in Recovery.

---

44 Mr Paul Hersey, CEO, South Coast Perth Medicare Local, *Committee Hansard*, 10 October 2014, p. 11.

45 Mr Darren Carr, CEO, Mental Health Council of Tasmania, *Committee Hansard*, 3 November 2014, p. 11.

> Senator WRIGHT: So at this stage you are working with them closely, but there is no answer for those organisations.
>
> Mr Booth: Not yet. As we are doing with a number of different areas, we are working with the Medicare Locals; we are working with the consortia to work out the transition period.[46]

4.49 Department of Health officials have emphasised that funding for Partners in Recovery will continue beyond the closure of Medicare Locals, until 30 June 2016. However when pressed on this subject, officials disclosed that the lead agencies of the majority of the 48 Partners in Recovery Regions are Medicare Locals which are facing closure one year earlier in June 2015.[47] In fact, an answer to a question on notice demonstrates that 73 percent of Partners in Recovery Regions have Medicare Locals as their lead agency.[48] This means that that nearly three-quarters of the Partners in Recovery programs being delivered across the country are at risk due to the government's decision to close Medicare Locals.

4.50 Ms Alison Fairleigh, Area Manager Townsville, Mental Illness Fellowship NQ, described the effect on the community of the uncertainty around whether the services currently organised by Medicare Locals would continue:

> The establishment of the smaller number of PHNs in place of the 61 Medicare Locals is creating nervousness within the sector. In particular, the closure of Medicare Locals with no transitional arrangements for rural staff creates an environment of uncertainty. There is also lack of clarity regarding the role and responsibilities of the new PHNs. The current extent of change—for example, to the funding of drug and alcohol services, to disability services, to preventative health initiatives and to primary health care—along with the current uncertainties about funding cuts and short-term contracts, is making effective practice difficult for providers, impacting on clients who are continually transitioning from one service to a new one. Change needs to be rolled out slowly so that people can learn new systems and adapt, but the current level of change from both state and federal governments is overwhelming, having a detrimental impact on consumers. Continuity of care is essential for recovery and wellness.[49]

4.51 The loss of services provided by Medicare Locals will impact on the most vulnerable in the Australian community, including Aboriginal and Torres Strait Islander Australians. Medicare Locals who spoke to the committee told about their work identifying gaps in services, consulting with Aboriginal communities, and

---

46 Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division, Department of Health, *Senate Community Affairs Legislation Committee Supplementary Estimates*, 22 October 2014, pp 35–36.

47 Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division, Department of Health, *Committee Hansard*, 8 October 2014, p. 70.

48 Department of Health, *Answer to Question on Notice 12*, 8 October 2014 hearing.

49 Ms Alison Fairleigh, Area Manager Townsville, Mental Illness Fellowship NQ, *Committee Hansard*, 21 August 2014, p. 11.

building networks and services. For example Mr Vahid Saberi, Chief Executive Officer of the Northern NSW Medicare Local told the committee about work his Medicare Local had undertaken to ensure emergency healthcare services to Aboriginal communities:

> …in many of these Aboriginal settlements, the ambulance does not go in without police escort. During and after hours they have no health professionals, so the community is left without any health skills at all during or after hours. They were talking about a trauma that had happened in the community and that they could not respond. It took the ambulance an hour or an hour and a half to get there. So we started the process of doing first aid in Aboriginal communities, which has been a fantastic program. We subsequently are working with the Commonwealth Bank for them to be part of this process. We have 13 Aboriginal communities where we have run first aid and we are moving them into mental health first aid. We are using that group to really start doing other things in the community. Subsequent to that, there was a call from a mainstream community in Coraki saying, 'We would really like this as well.' Now we are doing it in small towns.
>
> So a small visit resulted in a movement now of building resilience and capacity in communities. Now the ambulance service has come on board and said, 'We can make some of these people first-aid responders in this community.' That link is so important for us to be able to understand the reality of our region and respond—and there are lots of programs like that.[50]

4.52 In South Australia, other Medicare Locals, such as the North Adelaide Medicare Local, have worked to ensure that Aboriginal stakeholders are included in the Medicare Local service process. Ms Debra Lee, Chief Executive Officer of the North Adelaide Medicare Local, told the committee:

> …We ensured that our organisation had a broad and responsive membership base. We set up initially seven membership consortium groups, all of whom were focused around what we knew to be our community population health issues. They were: mental health, palliative care, general practice, older persons in aged care, medical specialists, Aboriginal health, carers and consumers. And, in the last few months, we have expanded those to include disability and childhood, as two new MCGs [Membership Consortium Groups].
>
> Our MCGs ensure that we have the broadest possible input from all of our stakeholders, service providers, organisations and community, which directly feeds our strategic direction and our needs-assessment analysis. We support them to meet and discuss; we simply ask them to each prioritise

50 Mr Vahid Saberi, Chief Executive Officer Northern NSW Medicare Local, *Committee Hansard*, 15 September 2014, p. 27.

what they see as being their top three priorities for primary health in their specific areas.[51]

4.53 Some examples of services provided to Aboriginal and Torres Strait Islander Australians by Medicare Locals, and which are now at risk due to the closure of the Medicare Locals include:

North Coast New South Wales Medicare Local[52]

North Coast NSW Medicare Local co-ordinate a range of Aboriginal health programs and services across the North Coast including:

- Bulgalwena General Practice
- Jullums Lismore Aboriginal Medical Service
- Care Coordination and Supplementary Services (CCSS)
- Closing the Gap

Southern New South Wales Medicare Local[53]

- Aboriginal health services including:
- Koori health checks (free health checks in a local general practice)
- Koori Diabetes Days (free diabetes monitoring and treatment)
- Koori Boois (Mums and bubs clinic and playgroup)
- School clinic visits (clinic style health check services for Aboriginal school students)
- Butt out Boondah (tobacco cessation and support)
- Deadly Dads (promotion of fatherhood and grandfatherhood)
- Living strong (healthy lifestyle programs)
- Coordinated Care and Supplementary Services (chronic medical condition management)

Barwon Medicare Local[54]

Aboriginal health services, including:

- Closing the Gap
- Indigenous Chronic Disease (providing support to the health sector and better access to health care by Indigenous Australians)

---

51 Ms Debra Lee, Chief Executive Officer North Adelaide Medicare Local, *Committee Hansard*, 9 October 2014, p. 12.

52 Mr Saberi, North Coast Medicare local, *Committee Hansard*, 15 September 2014, p. 26; and www.ncml.org.au/index.php/programs-services (accessed 19 November 2014).

53 www.snswml.com.au/our-health-programs.html (accessed 19 November 2014).

54 www.barwonml.com.au/health-professionals/clinical-services-support (accessed 19 November 2014).

- Indigenous PIP (a gateway service to which patients can access services through the Closing the Gap program)

Goldfields-Midwest Medicare Local[55]

- the Closing the Gap (CTG) program which provides on the ground support to clients and assistance to GPs and allied health services to reduce barriers to health care;
- encouraging further use of Telehealth for specialists, general practices, residential aged care facilities or Aboriginal medical services and increase the delivery of health services across the region.

4.54 It is instructive to consider the range of services which are at risk as a result of the government's decision to close Medicare Locals. Appendix 8 illustrates a selection of the services detailed to the committee during its public hearings and included in submissions.

Medicare Local services at risk

4.55 The committee heard evidence from numerous Medicare Locals explaining the confusion resulting from the government's announcement of the closure of Medicare Locals from 1 July 2015. Critically, many Medicare Locals argued that the long term damage to communities would be exacerbated by the uncertainty surrounding the continuation of many services provided exclusively by Medicare Locals.

4.56 During this inquiry the committee received oral evidence from 14 of the 61 Medicare Locals about the valuable services they provide to their communities. Appendix 8 breaks down that information by state to demonstrate the far reach of the likely cuts to Medicare Local services. While this is not an exhaustive list, it provides a snapshot of the valuable programs that are at risk due to the government's decision to close Medicare Locals.

Committee comment

4.57 The scale of the change the government is proposing becomes evident upon reading the long list of complex and essential programs currently being either provided or coordinated by the 14 Medicare Locals consulted in the course of the committee’s inquiry.

4.58 The committee is greatly concerned that the way in which the government is managing the closure of Medicare Locals that will result in important community healthcare services being cut. Given the uncertainty created by the closure of Medicare Locals, the committee is concerned that communities will be left in the dark as to what services will be provided by PHNs. The committee is also deeply concerned by the rushed transitional arrangements as discussed earlier in this chapter,

---

55 Mrs Brenda Ryan, CEO Goldfields-Midwest Medicare Local, *Committee Hansard*, 10 October 2014, pp 10–15.

given the department's inability to guarantee continuity of important healthcare services around Australia.

4.59 The uncertainty and lack of clear information surrounding the closure of Medicare Locals and the establishment of PHNs is already eroding the work done by the Medicare Locals. The result is likely to be that PHNs will have to duplicate the groundwork work already done by the Medicare Locals. In essence, the government's broken promise not to close Medicare locals will push back by several years the establishment of innovative and integrated primary health organisations. The government has provided no certainty that the roles and services provided by Medicare Locals will be reproduced by PHNs.

Loss of healthcare professionals

4.60 The uncertainty over continuity of contracts and services has already had a negative effect on communities. Several Medicare Locals advised the committee that skilled health professionals had left their communities, simply because their employment was not guaranteed with the change to PHNs. This was particularly noticeable in evidence from witnesses from regional and rural areas.

4.61 Mrs Nancy Piercy, CEO, Murrumbidgee Medicare Local, told the committee that her Medicare Local had already lost professional staff due to the uncertainty surrounding the move to PHNs. These are staff providing frontline services:

> Yes. Two psychologists on Friday and one exercise physiologist yesterday: it is front-line staff we are losing. It is just the uncertainty. We are still very positive within our organisation. We are keeping positive that, depending on the boundaries, we will have a role to play somewhere but we cannot give them a guarantee that we will be a service provider and the job is going to be there. Definitely a lot tell me they are applying and have had interviews in Melbourne. The last ones went to Sydney to Brisbane.
>
> The opportunity for employment in rural areas is not good. Wagga is not bad but that is only a third of the population of our area. It is the smaller areas where we have been able to recruit, particularly allied health professionals, on a part-time basis. We do employ a lot part-time because the services are only needed for smaller communities. We have primary care nurses working over 54 small communities doing care coordination. They live out there and provide to four or five different communities. They are the ones who are asking: 'What will happen to us? Is it in scope with the primary health network for the type of work we are doing to be commissioned? Who is going to be our boss? Who is going to organise services across 54 tiny rural communities with no hospital in them?'[56]

4.62 Mrs Brenda Ryan, CEO of the Goldfields-Midwest Medicare Local also raised the issue of staff leaving as a result of the uncertainty in 2015:

> The uncertainty of the future at the moment is concerning with many health professionals considering their options moving into 2015. The late

56 Mrs Nancy Piercy, CEO, Murrumbidgee Medicare Local, *Committee Hansard*, 2 October 2014, p. 27.

> announcement of the boundaries caused some concerns for subcontractors and staff alike. To lose staff at this point in time would be problematic to service communities for the future. The board of the Goldfields-Midwest Medicare Local is highly concerned with maintaining service continuity at the current level. The pressure of reduction in funding has not only put more uncertainty into the mix, but there are many of our staff undertaking two or three roles, which we recognise is unsustainable and untenable.[57]

4.63 Ms Alison Fairleigh, Area Manager Townsville, Mental Illness Fellowship NQ explained that the uncertainty for staff and professionals also had a massive negative effect on users of the services. In the case of mental health patients who are already vulnerable, the effect of the uncertainty and the severing of their relationship with mental health professionals could be disastrous:

> …at the consumer level there is a fear about what is going to happen and who is going to be here to provide the service. You have Medicare locals providing allied health staff within the huge region…occupational therapists, social workers and psychologists who move not just within the Townsville and Mackay areas but right out to, for example, Flinders Shire and the Hughenden area. Nobody knows if they are going to have a job past the end of the Medicare locals. They are employed by the Medicare locals to provide the allied health services and they cannot guarantee their clients that they are going to be here to continue that service past 30 June 2015.
>
> That is an awful feeling for somebody, for example, who is living with a mental health issue…Are they going to be retraumatised by having to sit down with a brand new clinician and start going through the process: 'This happened to me when I was 15. This is why I have this issue.' That is a very traumatising process. We know that, for any person who suffers from mental ill health, continuity of care is essential as part of that recovery process. To have a really negative experience with a medical appointment…can set a person back in their recovery significantly…Medicare locals have been able to do that through the provision of umpteen number…of allied health people in this area. Their jobs are now in jeopardy and we do not know what is going to happen to them past 30 June.[58]

Costs of closing Medicare Locals

4.64 The closure of Medicare Locals will result in the loss of staff, contracts, program experience, and community goodwill. While it is difficult to quantify the loss of community goodwill, staff and healthcare services, the committee has been given

57 Mrs Brenda Ryan, CEO, Goldfields-Midwest Medicare Local, *Committee Hansard*, 10 October 2014, p. 10.

58 Ms Alison Fairleigh, Area Manager Townsville, Mental Illness Fellowship NQ, *Committee Hansard*, 21 August 2014, p. 12.

figures relating to the wind up costs of 10 Medicare Locals. These are detailed in the table below.[59]

59 As some staff work part-time, employee numbers in the following table and footnotes may vary with the staff numbers being higher than the FTE numbers.

Table 2—Wind up costs of Medicare Locals (a sample)

Medicare Local	FTE	Wind up costs
Southern NSW Medicare Local	Not supplied	$1.7 million[60]
Central Queensland Medicare Local	72	Not supplied[61]
Murrumbidgee Medicare Local	102	$1 million[62]
Bayside Medicare Local	55	$800 000[63]
Barwon Medicare Local	55	$2 million[64]
Loddon Mallee Murray Medicare Local	40	$1.3 million[65]
Country North Medicare Local	75	$1.9 million[66]
North Adelaide Medicare Local	65	$2.2 million[67]
Central Adelaide and Hills Medicare Local	60	$1.2 million[68]
Goldfields-Midwest Medicare Local	47.8	$900 000[69]
South Coast Perth Medicare Local	81	Just under $1 million[70]

---

60 Ms Kathryn Stonestreet, CEO, Southern NSW Medicare Local, *Committee Hansard*, 16 September 2014, p. 3. The Southern NSW Medicare Local has about 150 employees.

61 Mrs Jean McRuvie, CEO Central Queensland Medicare Local, *Committee Hansard*, 30 September 2014, pp 2–3. The Central Queensland Medicare Local has about 94 employees.

62 Mrs Nancye Piercy, CEO Murrumbidgee Medicare Local, *Committee Hansard*, 2 October 2014, p. 26. The Murrumbidgee Medicare Local has more than 100 private contractors and 120 employees.

63 Dr Elizabeth Deveny, CEO Bayside Medicare Local, *Committee Hansard*, 2 October 2014, p. 27. The FTE count for the Bayside Medicare Local depends on whether both Commonwealth funded services and state funded services are included.

64 Mr Jason Trethowan, CEO, Barwon Medicare Local, *Committee Hansard*, 6 October 2014, p. 2. The Barwon Medicare Local has 85 employees.

65 Mr Matthew Jones, CEO, Loddon Mallee Murray Medicare Local, *Committee Hansard*, 7 October 2014, p. 46. The Loddon Mallee Murray Medicare Local has just over 60 staff, including part time staff. 50 per cent of staff are mental health clinicians.

66 Mr Kim Hosking, CEO Country North Medicare Local, *Committee Hansard*, 9 October 2014, p. 19. The Country North Medicare Local has around 100 employees.

67 Ms Debra Lee, CEO North Adelaide Medicare Local, *Committee Hansard*, 9 October 2014, p. 19. The North Adelaide Medicare Local has about 70 employees.

68 Mr Chris Seiboth, CEO, Central Adelaide and Hills Medicare Local, *Committee Hansard*, 9 October 2014, p. 19.

69 Mrs Brenda Ryan, CEO, Goldfields-Midwest Medicare Local, *Committee Hansard*, 10 October 2014, p. 11. At 30 May 2014, the FTE for the Goldfields-Midwest Medicare Local was 66.6. As at 10 October 2014 the FTE had fallen to 47.8.

70 Mr Paul Hersey, CEO, South Coast Perth Medicare Local, *Committee Hansard*, 10 October 2014, p. 11.

Tasmania Medicare Local	Not supplied	Over $3 million[71]

4.65 Mrs Jean McRuvie, CEO of the Central Queensland Medicare Local, told the committee that the Department of Health had appointed McGrathNichol to assess the contingent liabilities of the Medicare Locals:

> [McGrathNichol] have been appointed to work out what the contingent liabilities will be, because we have core contracts that go to 2016, and the department is breaking that contract. They are liable under contract law to meet reasonable costs for breaking the contract. Reasonable costs could be the cost of a lease. You might have taken the lease on a building. It could be redundancies for staff. It could be any agreement that you have got with a third party. They need to look at that.[72]

4.66 Mr Phil Edmondson, CEO Tasmanian Medicare Local, told the committee that the alternative, working to improve the Medicare Locals, would surely be an more cost-effective approach:

> What are the costs of a process that arguably may well have been achievable, in our view, in large part with respect to the recommendations in the Horvath review, by some simple rewording of contracts? A few new clauses requiring some changes to the way in which things were happening and advice about perspectives on what was considered to be good versus bad performance may well have allowed organisations like ours to make any changes that were required with some very simple, straightforward and highly progressive activity at the local level, without the need for this major sort of 'throw everything up in the air-everything to the wind' type of approach, which seems to have grown legs.[73]

4.67 The committee tried unsuccessfully over three further hearings[74] and numerous questions on notice to obtain from the Department the total cost for the closure of all 61 Medicare Locals. Finally, three weeks after first being asked the question, the Department provided an answer, once again frustrating the committee by providing a highly qualified response:

> The Department is not yet in a position to know the cost of winding up those Medicare Locals which need to be wound up.
>
> The Department asked Medicare Locals to determine the types of liabilities and categories that could arise resulting from the termination of the

71 Mr Phil Edmondson, CEO, Tasmanian Medicare Local, *Committee Hansard*, 4 November 2014, p. 12. The Tasmanian Medicare Local as 150 staff. Wind up costs are estimated to be higher for this Medicare Local due to it having $60 million of additional work through the federal government's Tasmanian Health Assistance Package.

72 Mrs Jean McRuvie, CEO Central Queensland Medicare Local, *Committee Hansard*, 30 September 2014, pp 2–3.

73 Mr Phil Edmondson , CEO Tasmanian Medicare Local, *Committee Hansard*, 2 October 2014, p. 11.

74 Including during hearings of the Senate Community Affairs Legislation Committee for Supplementary Estimates.

> Medicare Local Program, to identify all resources allocated to each of those categories, and to provide those figures to the Department.
>
> As a result of this exercise an estimate of $112 million of liabilities was identified against all categories that might be in scope for consideration. This figure, which was committed under funding agreements put in place under the previous Government, represents the outer limit of the claims which might eventually be made by Medicare Locals.
>
> The actual cost of the changeover from Medicare Locals to Primary Health Networks (PHNs) is expected to be significantly less than this amount.
>
> The Department intends to have more detailed discussions with each individual Medicare Local to finalise claims for reasonable costs in early 2015 after the outcome of the approach to market and subsequent announcement of the successful PHN operators.[75]

The PHN tender process

4.68 There have been a range of uncertainties created by the government's management of the PHN tender process. These uncertainties have created genuine concerns amongst existing Medicare Locals. The committee received evidence of the four following concerns about PHN tender:

- uncertain tender timeline;
- lack of tender process details;
- delayed release and configuration of PHN boundaries; and
- the elusive definition of "market failure".

4.69 On 28 November the Minister for Health released the Invitation To Apply (tender) for the PHN Program, almost a month after the originally scheduled release date. Applications for the PHN Program will close on 27 January 2015.[76] The Department of Health will hold four industry briefings on the PHN Program tender process on 5, 8, 10 and 11 December 2014 in Sydney, Perth, Melbourne and Brisbane respectively.[77] The committee notes that this arrangement leaves potential applicants little time to finalise and submit their tender for the PHN Program.

4.70 The committee reserves comment on the PHN tender documents. Evidence provided to the committee has centered on the confusion surrounding the tender process. The committee considers that this evidence of flaws in the government's PHN tender process raises doubts regarding any outcome of the tender process following the close of applications.

---

75 Answer to Question on Notice 4, 2 October 2014 hearing.

76 Department of Health website, 'Primary Health Networks – Latest News', www.health.gov.au/internet/main/publishing.nsf/content/primary_health_networks

77 Department of Health website, 'Primary Health Networks – Latest News', www.health.gov.au/internet/main/publishing.nsf/content/primary_health_networks

PHN tender timeline

4.71 Public information about the timeline for the closure of the Medicare Locals and the establishment of the PHNs has been minimal and often contradictory.

4.72 For example, the first detailed information about the implementation was in the 'Establishment of Primary Health Networks Frequently Asked Questions', published on 11 July 2014. This document advised the tender process would commence in late 2014.[78] The Department of Health advised the committee on 2 October that the 11 July version of this document was the most recent version,[79] however the committee has since become aware of a version released on 15 October which supplies some minimal updated information.[80] The Department of Health's website includes a page called 'Establishment of Primary Health Networks: information session' dated 10 July 2014 and reviewed 15 August 2014 which has a timeline for PHN implementation:

> Overview
>
> - March 2014: Medicare Local Review provided to Government
> - May 2014: 2014-15 Budget Announcement
> - June – July 2014: Information Sessions with key stakeholders
> - >December 2014: Invitation to Apply
> - 1 July 2015: PHNs commence[81]

4.73 Mr Saberi, Chief Executive Officer of the Northern NSW Medicare Local, described the timeframes for the transition to PHNs as he understood it at the committee's hearing on 15 September:

> There is an invitation to apply. That will be released in November [2014]. One of the suggestions we have made is that maybe [the Department of Health] can do an expression of interest before the invitation to apply, because if there is only one organisation that is going to apply it would be much easier just to transition them. Writing an ITA [invitation to apply] is quite disruptive and a long process. So if our region stays the same and there was an expression of interest and we were the only applicant for it—if there were two or three that is fine—it would work well to just work with us and transition. It would save a huge amount of money, time and relationships and so forth.
>
> …So, the ITA is in November. That closes before Christmas. The results are in February, and then March-April-May or April-May-June [2015] will

---

78 Department of Health, *Establishment of Primary Health Networks – Frequently Asked Questions*, Version 1.2, 11 July 2014, p. 3.

79 Ms Mary McDonald, Acting Deputy Secretary, Department of Health, *Committee Hansard*, 2 October 2014, p. 48.

80 See appendix 6 for a copy of the 15 October version of the FAQ.

81 www.health.gov.au/internet/main/publishing.nsf/Content/phn_presentation

be a transition period. That is the intended time frame we have been informed of.[82]

4.74 The clearest picture of the timeframe for the closure of Medicare Locals and the establishment of the PHNs can be found on the website of the Tasmanian Medicare Local. On a page written after briefings provided by the Department of Health, Mr Phil Edmondson, CEO of the Tasmania Medicare Local provides the following timeline:

- 30 June 2014 - Closure of AML Alliance
- July 2014 - Number of PHNs and boundaries announced
- 1 Nov 2014 - Request for Tender (RFT) issued; industry briefings
- Nov-Dec 2014 - Applicants respond to RFT (six-week period)
- Jan-Feb 2015 - Applicants assessed
- Apr-June 2015 - Establishment of new Primary Health Network: service transition commences
- 30 June 2015 - Medicare Local funding ceases: service transition completed
- 1 July 2015 - PHN becomes operational[83]

4.75 Mr Edmondson told the committee at its hearing on 4 November that he had heard informally from the Department of Health that the tender for the PHNs would be released towards the end of November 2014, however this advice was not provided in writing.[84] Asked what formal advice had been provided by the Department, Mr Edmondson explained that:

> The only formality is in respect of the words that are on the [Department of Health's] website, and if you read that you will have everything that Medicare Locals have in terms of a defined time line and information.[85]

4.76 During Senate Estimates hearings, Department of Health officials were only able to provide a "hopeful" date for the release of the tender rather than anything certain:

> We are aiming to have the tender out towards the end of this year. We are working through process at the moment and policy. At the moment, aiming

82 Mr Vahid Saberi, CEO, Northern NSW Medicare Local, *Committee Hansard*, 15 September 2104, p. 26.

83 www.tasmedicarelocal.com.au/about-us/primary-health-networks.

84 Mr Phil Edmondson, CEO Tasmanian Medicare Local, *Committee Hansard*, 4 November 2014, p. 4.

85 Mr Phil Edmondson, CEO Tasmanian Medicare Local, *Committee Hansard*, 4 November 2014, p. 12.

toward the end of this year and hopefully the end of November is what we have been saying.[86]

Uncertainty surrounding the tender process

4.77 The practicalities of the tender process for PHNs also appear to be unresolved. During Senate Estimates hearings on 22 October 2014, the officials from the Department of Health advised that they were still working through the following parts of the tender process arrangements:

- Areas of the Department that would participate in assessing the proposals.[87]
- Whether the Department will be able to adequately assess the proposals and finalise the tender process between the receipt of proposals sometime in January and early April. The Department indicated that three months (April–June) is needed for a PHN to become functional.[88]

4.78 While the tender documents have now been released, the committee notes that the time for tendering coincidences with the end of year period and this may impact on organisations' ability to prepare applications.

Boundary information

Missed timelines

4.79 At the public hearing on 16 September, Dr Carlson, Moruya General Practitioner; and Chair, Southern New South Wales Medicare Local (SNSWML), told the committee that a key problem with the Medicare Locals preparing to tender for the PHNs was that there was no boundary information available. The Department of Health had earlier advised that the information would be released in July 2014. The date was then extended to August. Dr Carlson told the committee:

> We have been informed that it is sitting with the minister now. There has been a recommendation. The longer it goes the harder it is to form those partnerships. For example, say we were going to partner with Illawarra-Shoalhaven. If we want to do that in a collegial fashion and merge with that ML, which is another high-performing ML, that will take us time with the boards to look at the vision and the governance structure, and that is only half the picture. Then we have to collaboratively come up with a vision for the primary health network and how we are going to address the ITA

---

86 Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division, Department of Health, *Senate Community Affairs Legislation Committee Supplementary Estimates*, 22 October 2014, p. 38.

87 Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division, Department of Health, *Senate Community Affairs Legislation Committee Supplementary Estimates*, 22 October 2014, p. 38.

88 Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division, Department of Health, *Senate Community Affairs Legislation Committee Supplementary Estimates*, 22 October 2014, p. 39.

> [invitation to apply] and performance measures that they have stated in that. They will be less likely to do that.[89]

4.80 At the time Dr Carlson spoke to the committee, the boundary information for the Medicare Locals had not been published. After significant delay, the boundary information was released on 15 October 2014 after a decision by the Minister for Health over the final boundaries.[90]

4.81 Despite the delay of over three months, the Department released the PHN Program tender documents on 28 November 2014.

Boundary configurations

4.82 The government's PHN boundary decision reduced the number of primary healthcare organisations from 61 Medicare Locals to 30 PHNs. The Department explained that the figure 30 had come from the findings of the Review.[91]

4.83 Patient flows were also part of the consideration for the PHN boundaries. However, the Department indicated at Estimates that cross-border patient flow issues would be a matter to solve on the ground rather than at the boundary planning point:

> [The Department of Health] did look at patient flows and we were very aware of patient flows that go across boundaries in a number of areas in the country. I think it is fair to say that the intent for the PHNs and one of the strong drivers we have is the establishment of the clinical networks at a lower level. The purpose of the clinical networks is to assist the patient pathway to improve outcomes for patients at the ground level. We would expect that if there were significant cross-boundary issues then the clinical councils would cooperate with each other and the PHNs would cooperate in looking at those issues. Boundaries are always going to be an issue.[92]

4.84 However, from the evidence provided at Estimates, it appears that thorough consultation with state and territory governments was not a consideration of setting the PHN boundaries. An example of this lack of consultation prior to the release of the boundaries is demonstrated in the following exchange on the Queensland PHN boundaries:

> Senator McLUCAS: Was Queensland Health made aware of the PHN boundaries before they were announced?

---

89 Dr Carlson, Moruya General Practitioner; and Chair, Southern New South Wales Medicare Local, *Committee Hansard*, 16 September 2014, p. 6.

90 Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division, Department of Health, *Senate Community Affairs Legislation Committee Supplementary Estimates*, 22 October 2014, p. 29.

91 Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division, Department of Health, *Senate Community Affairs Legislation Committee Supplementary Estimates*, 22 October 2014, p. 29.

92 Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division, Department of Health, *Senate Community Affairs Legislation Committee Supplementary Estimates*, 22 October 2014, p. 30.

> Mr Booth: No.
>
> Senator McLUCAS: No?
>
> Mr Booth: We had discussions with state and territory governments around boundaries because we needed to look at hospital flows, but the boundaries that were released last week were all released to everybody at the same time. There was no prerelease to any party whatsoever.
>
> Senator McLUCAS: But consultation with the states has occurred?
>
> Mr Booth: We talked to states, as we do on a whole series of things, and they had opinions and views. We needed to talk to them about the hospital flows.[93]

4.85 The reduced number of PHNs is particularly dramatic when considering Australia's larger and more sparsely populated states. For example Western Australia will experience a reduction from eight Medicare Locals to three PHNs. One Western Australia PHN boundary in particular, "Country WA", has an enormous geographical area (approximately 2.5 million square kilometres) with a diverse set of health care issues across a small and often isolated population. Boundary maps for the Medicare Locals and the PHNs are at appendix five. Senator Smith expressed concerns over the reduction in the number of PHNs for Western Australia during Budget Estimates:

> In all honesty, I was surprised to see that Western Australia would have one organisation outside the Perth metropolitan area. I owe it to myself as a regional Western Australian senator to discuss this.
>
> How would Mr Horvath or the department justify one network over an area that captures the Kimberley region in the north, with very high levels of Indigenous population; Albany in the far south, with a large non-Indigenous but ageing community; then young families spread across the Western Australian wheat belt and mining towns like Kalgoorlie? How do we envisage an organisation like that working with such variant health needs, big differences in population characteristics and the sheer distance? For those who are not familiar, the Kimberley of Western Australia is at the tip of the Australian continent and Albany fronts the Great Australian Bight. So how do we justify that?[94]

4.86 In answer to Senator Smith, the Department argued that despite the reduction in the number of PHNs, the state would still have adequate representation because one PHN could draw on multiple clinical councils:

> The key role there is where the clinical councils come in, in terms of operating at a more local level. Those clinical councils are based on existing WA Country Health Service boundaries. So they all link in with the boundaries that already exist. I take on board what you are saying. It is a

---

93 Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division, Department of Health, *Senate Community Affairs Legislation Committee Supplementary Estimates*, 22 October 2014, p. 33.

94 Senator Dean Smith, *Senate Community Affairs Legislation Committee Supplementary Estimates*, 22 October 2014, p. 34.

> huge geographical area but we would see the organisation that runs that being very dependent on the more local intelligence—both clinical and consumer—that it gets from the clinical councils and the consumer advisory committees in those areas.[95]

4.87 Medicare Locals voiced concerns about the reduction in the number of PHNs, with the most common concern being that the PHNs would have to be much larger and would lose a local focus. Mr Kim Hosking, CEO Country North Medicare Local South Australia argued:

> I think the number of primary health networks is one that needs to be worked through. I would safely predict that over time that number will change. As government changes, the number will change. To achieve the goal of [30], which is reducing the numbers by half, we start to create very sizable primary health network regions. In context, you can achieve a considerable amount in an area of high population density. In other areas it starts to not make a lot of sense. A lot of the work that we look at in the health environment is from the UK and about activities that have been done in the UK. They, of course, have created similar sorts of organisations over there. Their ideal population base that they have used, as I understand it, is a population base which sits around 300,000 to 500,000 people. In a country of 67-odd million, that is a lot of organisations. Translated to Australia, that would mean that we, at 61, have fewer by proportion than the UK. Whether you use that as an argument defies my opening statement about not spending too much time looking elsewhere; but, in regions like Western Australia, South Australia, the far west of New South Wales and Queensland, we would be starting to look at very big regions.[96]

4.88 Mrs Nancy Piercy the CEO of the Murrumbidgee Medicare Local compared the size anticipated for the PHNs to that of the 'mega area health services' trialled in NSW:

> One of the things that I would say is: learn from the experience of the New South Wales government in establishing mega area health services—which failed, so they came back to local health districts. I managed local health districts. I was in there discussing the return to manageable-sized organisations. Local health districts' size was the way to go in New South Wales, which I know very well from having worked all over it. I think the primary health organisation, whatever we call it, aligned to a local health district would have the greatest potential to achieve… The move towards having one primary health network with maybe two or three local health

---

95 Mr Mark Booth, First Assistant Secretary, Primary and Mental Health Care Division, Department of Health, *Senate Community Affairs Legislation Committee Supplementary Estimates*, 22 October 2014, p. 34.

96 Mr Kim Hosking, CEO Country North Medicare Local South Australia, *Committee Hansard*, 2 October 2014, p. 21.

> districts in that primary health network would be—from experience, we know it is very difficult to handle that.[97]

4.89 The committee asked the Parliamentary Library to analyse the changed ML-PHN boundaries.[98] From this analysis several striking features of the PHN boundaries become apparent.

4.90 Firstly, the committee notes the massive expansion in population that PHNs will be required to cover. An average Medicare Local services 355 000 people, whereas an average PHN will be required to service more than double this number, 738 000.[99] Six PHNs will be required to service populations of more than a million people.[100]

4.91 Secondly, there are 12 PHNs which individually will be required to service the geographic area and population currently serviced predominantly by three or more Medicare Locals. Table 3 demonstrates the PHN locations that will be required to cover three or more Medicare Local boundaries.

4.92 Finally, in stark contrast to those 12 PHN areas where there has been a high degree of amalgamation, there are seven PHN boundaries which match identically the equivalent Medicare Local boundary. These PHN areas are:

- Western Sydney
- Nepean Blue Mountains
- South Western Sydney
- North Coast NSW
- Gippsland
- Brisbane North and
- Gold Coast

4.93 The committee notes that while some of these Medicare Local regions have quite large populations, the government has provided no explanation as to why 12 PHNs will experience a very high degree of amalgamation while 7 others will retain an existing Medicare Local boundary.

---

97 Mrs Nancy Piercy, CEO, Murrumbidgee Medicare Local, *Committee Hansard*, 2 October 2014, p. 21.

98 A table of the Parliamentary Library ,

99 All population figures are based on 2011 Census data.

100 These are the Central and Eastern Sydney PHN; the Hunter New England and Central Coast PHN; the North Western Melbourne PHN; the Eastern Melbourne PHN; the South Eastern Melbourne PHN; and the Adelaide PHN.

Table 3—Population comparison of PHNs with Medicare Locals—three to one amalgamations[101]

Primary Health Network	Medicare Local (percentage population coverage)
New South Wales	
Central and Eastern Sydney	Eastern Sydney (100)
	Inner West Sydney (100)
	South Eastern Sydney (100)
Western NSW	Western NSW (100)
	Murrumbidgee (100)
	Far West NSW (100)[102]
Hunter New England and Central Coast	Central Coast NSW (100)
	Hunter (100)
	New England (100)
Victoria	
North Western Melbourne	Inner North West Melbourne (100)
	South Western Melbourne (100)
	Macedon Ranges and North Western Melbourne (97)[103]
Eastern Melbourne	Eastern Melbourne (100)
	Inner East Melbourne (99)
	Northern Melbourne (55)[104]
South Eastern Melbourne	Frankston-Mornington Peninsula (100)
	South Eastern Melbourne (100)
	Bayside (99)
Murray	Loddon-Mallee-Murray (91)
	Goulburn Valley (89)

101 The table is based on an analysis of the Parliamentary Library. All population figures come from 2011 Census data. Medicare Local boundary information comes from www.medicarelocals.gov.au/internet/medicarelocals/publishing.nsf/Content/digital-boundaries#.VGQNKE0cScV and Primary Health Network boundary information comes from www.health.gov.au/internet/main/publishing.nsf/Content/primary_Health_Networks, (accessed 13 November 2014). A Medicare Local is included in the PHN boundary if more than half of its population would be covered by the new boundary.

102 Also encompasses significant proportions of the Hume (40 percent); Lower Murray (14 percent) and Loddon-Mallee-Murray (9 percent) Medicare Locals.

103 Also encompasses significant proportions of the Northern Melbourne Medicare Local (45 percent).

104 Also encompasses significant proportions of the Goulburn Valley Medicare Local (11 percent).

Primary Health Network	Medicare Local (percentage population coverage)
	Lower Murray (86)
	Hume (60)
Grampians and Barwon South West	Barwon (100)
	Grampians (100)
	Great South Coast (100)
Queensland	
Central Queensland and Sunshine Coast	Sunshine Coast (100)
	Wide Bay (100)
	Central Queensland (100)
South Australia	
Adelaide	Northern Adelaide (92)
	Southern Adelaide-Fleurieu-Kangaroo Island (88)
	Central Adelaide and Hills (86)
Western Australia	
Perth South	Fremantle (100)
	Bentley-Armadale (100)
	Perth South Coastal (100)
Country WA	South West WA (100)
	Kimberley-Pilbara (100)
	Goldfields-Midwest (98)

Definition of 'Market Failure'

4.94 The Review's terms of reference included 'assessing processes for determining market failure and service intervention, so existing clinical services are not disrupted or discouraged'.[105] The Review was critical of the Medicare Locals, arguing contrary to government claims that they had focused too much on service delivery. The Review asserted that the stakeholders he had spoken to did not support Medicare Locals providing services, except where there is 'demonstrable market failure, where services do not exist or where there is insufficient access to services (i.e. performing a gap filling role).'[106]

105 Professor John Horvath AO, *Review of Medicare Locals – Report to the Minister for Health and the Minister for Sport*, 4 March 2014, p. 3.

106 Professor John Horvath AO, *Review of Medicare Locals – Report to the Minister for Health and the Minister for Sport*, 4 March 2014, p. 7.

4.95 The Review recommended that '[PHNs] should only provide services where there is demonstrable market failure, significant economies of scale or absence of services'.[107]

4.96 Medical Local representatives who provided evidence to the committee felt that often they had no choice but to become service providers. Mrs Brenda Ryan, CEO of the Goldfields-Midwest Medicare Local, argued that in her Medicare Local's area market failure was a way of life with regular workforce shortages.[108]

4.97 The Goldfields-Midwest area effectively demonstrates the need for rural and remote Medicare Locals to make the most efficient choice between 'buying a service versus providing a service'.[109] Mrs Brenda Ryan, CEO Goldfields-Midwest Medicare Local highlighted the point that drawing on an existing workforce in a remote area is not possible as there are already staffing shortages. Flying in professionals from regional centres is likewise an inefficient option because the cost of contracting services increases substantially:

> When you cannot find the workforce, you have to bring a workforce in and that workforce, wherever you bring them in from, comes at a cost. The cost increases whenever you bring in services that are not already there. There are some towns where the reality is that those health care professionals are not going to be there. If you look at small towns such as Laverton, Leonora and Norseman, for example, in the Goldfields of Western Australia, you would not find a social worker there, you would not find a podiatrist there, you would not find a physiotherapist there. They are areas of market failure.
>
> Even employing somebody at the cost of $55 an hour, it is still costly to send them to Leonora, Laverton and Norseman, et cetera, but when you cannot find that physiotherapist and the other allied health services in the closest major regional town to those much smaller towns, then you have to look further afield. Then you have to start flying in allied health professionals from South Australia or from Perth. They are the people you are paying $140 an hour or more to sit in a plane, plus accommodation and travel costs. That is market failure—that is where market failure is. I do not believe that anybody really looked clearly at that or even asked the question 'What is the difference between providing a cost in-house versus purchasing a service?'[110]

---

107 Professor John Horvath AO, *Review of Medicare Locals – Report to the Minister for Health and the Minister for Sport*, 4 March 2014, p. v.

108 Mrs Brenda Ryan, CEO Goldfields-Midwest Medicare Local, *Committee Hansard*, 10 October 2014, pp 18–19.

109 Mrs Brenda Ryan, CEO Goldfields-Midwest Medicare Local, *Committee Hansard*, 10 October 2014, p. 18.

110 Mrs Brenda Ryan, CEO Goldfields-Midwest Medicare Local, *Committee Hansard*, 10 October 2014, pp 18–19.

4.98 Mr Kim Hosking, CEO, Country North Medicare Local South Australia, observed that his Medicare Local had from the start looked at service provision as a means of solving access problems, and had the support of the Department of Health:

> Our belief is that as a Medicare Local we solved market failure in our region in a number of aspects of service provision. There is very little in the way of genuine market out there for delivery of service, so our entity from day one as a Medicare Local and with the acquiescence of the department provided a wide-ranging number of services. We think that route is still there for an organisation to provide the necessary services, and so we would seek to tender for those services from the PHN or from whomever is doing the tendering.[111]

4.99 Professor Horvath did not define 'market failure', but he did argue that PHNs 'should be providers of last resort and their decision to directly provide services should require the approval of the Department of Health'.[112]

4.100 Mr Stankevicius, CEO, Consumer Health Forum Australia, who attended a PHN information session run by the Department of Health, advised the committee what information there was currently about 'market failure' and the role of the PHNs:

> The information we have available to us about the private health networks is that they will only be able to actually provide a service—actually directly provide it themselves—as opposed to purchasing a service in the areas where there is market failure. The government has previously said that market failure is where they can pick up the Yellow Pages—I am not sure who picks up the Yellow Pages anymore—and see if there are any private providers in the area that can provide the particular service. If there are, the PHN would be seen as being a competitor to that service, and the government does not think that a government funded service should compete with a private service. That is when it would say there isn't market failure, because there is an existing player in the market place. Therefore, the PHN cannot provide that service. That is our understanding of it at the moment, but, as I said, that is based on the briefing that we were involved with a few months ago. I have not seen any other details.[113]

4.101 This working definition gave Mr Stankevicius cause for concern, especially for rural and regional health consumers who have very limited access to services. He told the committee:

> I suppose that one of the specific concerns—we have heard it from our rural and regional consumers—is that market failure has existed for a long time in a lot of rural and remote areas of Australia in terms of even getting a health professional, let alone having a health service provided. That will

---

111 Mr Kim Hosking, CEO Country North Medicare Local South Australia, *Committee Hansard*, 2 October 2014, p. 26.

112 Professor John Horvath AO, *Review of Medicare Locals – Report to the Minister for Health and the Minister for Sport*, 4 March 2014, p. 14.

113 Mr Stankevicius, CEO, Consumer Health Forum Australia, *Committee Hansard*, 2 October 2014, p. 8.

> continue. Does that mean that from the first step we will see PHNs in those areas able to provide those services or will they have to test a market that does not exist before they are allowed to provide that service? Again, they are questions we have not had yet had an answer to.[114]

4.102 Mr Hosking, CEO, Country North Medicare Local South Australia advocated a definition of 'market failure' that includes both commercial considerations and quality of service and access:

> It would be dangerous to define market failure just in commercial terms. Market failure needs also to be considered in quality of service. So in our experience, we deliver quite a significant sized mental health support to our region. There are no other providers in our region who can currently do that. I guess, in fairness, if somebody came along and was able to put the same resource in that we have put in they could be competitive. But you want to ensure that the service that is supplied is a quality service.
>
> We have a number of small NGOs that deliver mental health support but they do not provide clinical counsel to patients in need. We provide that service because there is nobody else there that can do it. In our experience, in a small community there may be a local psychologist or a local social worker or a counsellor who we have tried to see whether they could perhaps do this service for us, funded by us, in that community but they are already busy. It is very difficult. People from the metropolitan area do not easily move into the country to do a lot of the work because you need a critical mass to make it a worthwhile proposition for you.
>
> Market failure is commercial but, in particular, it is quality as well. That is a very important consideration and it goes back to my comment about variation. People with similar needs across Australia do not necessarily receive the same support.[115]

4.103 The Department of Health provided the following definition of 'market failure':

> Market failure is where the services could not be reasonably purchased within the community. That is largely the common definition. The next step on from that, which I think is what people are probably interested in, is: what is the process going to be for that?[116]

4.104 However, it appears that this definition is not as straightforward as it first appears. Ms McDonald, Acting Deputy Secretary, advised that there is another term, 'service gap':

---

114 Mr Stankevicius, CEO, Consumer Health Forum Australia, *Committee Hansard*, 2 October 2014, pp 8–9.

115 Mr Kim Hosking, CEO Country North Medicare Local South Australia, *Committee Hansard*, 9 October 2014, p. 17.

116 Ms Mary McDonald, Acting Deputy Secretary, Department of Health, *Committee Hansard*, 2 October 2104, p. 39.

> Ms McDonald: First of all, in the example you gave of where you cannot get services within an area that is a service gap. A service gap is not market failure. If it is a priority for the community then the role of the PHN—and other players will do this as well—will be to look at how to fill that gap.
>
> Senator DI NATALE: Yes, okay. But if that is not market failure then what is?
>
> Ms McDonald: Market failure is where you could not find another provider able to come into that area or deliver in that area with funding that the PHN might have to purchase the services.[117]

4.105 The *Frequently Asked Questions on the Establishment of Medicare Locals* supplies the following advice on a definition of 'market failure':

> 3.6 What process will be used to determine ‘market failure’?
>
> A definition of ‘market failure’ is currently being considered as part of the policy development process. Further information will be provided in the Approach to Market documentation.
>
> 3.7 Will Primary Health Networks be service providers?
>
> PHNs will operate as regional purchasers and commissioners of health services. PHNs will only provide services under exceptional circumstances, including where there is demonstrable market failure.[118]

4.106 Prior to release of the PHN tender documentation, the Department had not provided a definition of 'market failure'. There has still been no public information provided on 'market failure', a critical element of determining a PHN's role.

Committee comment

4.107 After months of delays, the tender documents were released on 28 November 2014. The committee believes that the delay and confusion in the PHN implementation model will ultimately lead to a poor tender process and a significantly inferior model of primary care integration that is correctly emerging from Medicare Locals.

4.108 It is clear from the Review that primary health organisations of some sort are necessary:

> It is clear that many patients continue to experience fragmented health care that negatively impacts on individual health outcomes and increased health system costs. There is a genuine need for an organisation to be charged with improving patient outcomes through working collaboratively with health

---

117 Ms Mary McDonald, Acting Deputy Secretary, Department of Health, *Committee Hansard*, 2 October 2104, p. 39.

118 Frequently Asked Questions on the Establishment of Primary Health Networks, 15 October 2014, p. 4.

professionals and services to integrate and facilitate a seamless patient experience.[119]

4.109 A tender process constructed on an unreasonable timeline is likely to result in PHNs which do not fulfil the role which Professor Horvath outlined and which many Medicare Locals already fulfil. As well as being a substantial waste of public money and resources, a flawed tender process would erode public confidence in PHNs and result in serious problems for primary health care access in communities.

4.110 With respect to the Review's recommendations, the committee cannot see that they justify the wholesale abolition of the Medicare Locals and the establishment of a new system of PHNs. In fact, the committee believes that it would have been far more efficient and cost effective for the government to retain the overall Medicare Locals structure and implement a series of targeted changes, in proper consultation with communities, healthcare stakeholders and Medicare Locals themselves.

4.111 Despite all of this it is clear the government intends to proceed with PHNs.

Recommendation 4

4.112 The committee expresses its concern that the government's decision to abolish 61 Medicare Locals and establish 30 new PHNs is resulting in a loss of frontline services that will see significant cuts to services and programs at the local level. Evidence to the committee demonstrates that Medicare Locals have been improving health outcomes, promoting better integration of primary care services and reducing the need for individuals to seek hospital care.

4.113 If the goal of better integration of primary care is to be achieved, the committee recommends that the Primary Health Network tender must include:

- **a clear statement of the population health needs to be addressed, including clear outcome measures;**
- **a statement of the population health data expected to be collected or used;**
- **a statement on the outcomes PHNs will be expected to achieve to improve access to primary care and improve primary care integration for the whole population, in particular for disadvantaged groups; and**
- **a requirement that the integrity of the data collected by Medicare Locals will be preserved.**

4.114 In considering the applications for funding for PHNs the government should have a mind to the success of Medicare Locals in:

- **reducing hospitalisations**
- **improving access to after-hours primary care services**

119 Professor John Horvath AO, *Review of Medicare Locals – Report to the Minister for Health and the Minister for Sport*, 4 March 2014, p. ii.

- **reducing rates of chronic disease**
- **reducing smoking rates**
- **increasing immunisation rates**
- **improving access to mental health services**
- **improving access to allied health services**

Recommendation 5

4.115 The committee expresses its concern that the government's decision to abolish 61 Medicare Locals and establish 30 new PHNs is resulting in the loss of frontline services and will see significant cuts to services and programs at the local level that are aimed at improving population health, better integration of primary care services and keeping people out of hospital.

4.116 The committee notes the government's insistence on only 30 PHNs has created some PHN boundaries that are unworkable. For example, six PHNs will be required to service populations of more than a million people or cover large geographical areas of up to 2.5 million square kilometres. The committee also notes the estimated cost of this process is up to $112 million.

4.117 In making this recommendation, the committee is mindful that the sector told the committee of the significant disruption caused by the uncertainty created by the government's decision. Given the importance of this issue, the committee believes it is vital for the government to take the time to get the tender process right and then for Medicare Locals to be allowed sufficient time to submit properly considered applications.

Recommendation 6

4.118 The committee notes the government's ongoing failure to consult with community groups, peak bodies including GPs and allied health, and state and territory governments in relation to Primary Health Networks transition arrangements.

4.119 The committee recommends that the government, as a matter of urgency, ensures certainty in regards to the maintenance of the suite of services supplied by Medicare Locals, particularly in areas of rural and remote Australia where access to medical facilities and services is less comprehensive to the level of access in metropolitan areas.

4.120 The committee also notes the government's consistent failure to meet its own timelines and the anxiety and confusion this has caused across the sector.

Recommendation 7

4.121 The committee recommends that the government must take immediate steps to reinstate funding to Indigenous health organisations and ensure that the particular health challenges facing Aboriginal and Torres Strait Islander Australians are effectively analysed and responded to.

4.122 The committee has grave concerns about the lack of continuity of vital primary healthcare services that is likely to result from the shift from Medicare Locals to PHNs. The committee notes the erosion of the positive programs currently being delivered by Medicare Locals as a direct result of the uncertainty created by the government in its mishandled transition to PHNs. The government must provide

greater certainty for Medicare Locals and their communities regarding the continuity of primary healthcare services.