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## Victorian Rural and Regional Health Plan

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The Department of Health released its Rural and Regional Health Plan on 16<sup>th</sup> December. This is part of the Victorian Health Priorities Framework 2012-2022, and complements the Metropolitan Health Plan which was released in May. The Rural and Regional Health Plan and its accompanying technical paper can be downloaded at [www.health.vic.gov.au/healthplan2022/rural.htm](http://www.health.vic.gov.au/healthplan2022/rural.htm).

The Department will be consulting over the coming months, and is seeking comments on the Plan. At this stage it has given no date by which submissions need to be received.

This paper for Victorian Divisions and Medicare Locals (MLs) identifies some of the sections and suggestions in the plan that are most relevant to Divisions and MLs. GPV will be making a submission to the Department early in 2011 and would welcome your comments to inform our submission. Should your Division or Medicare Local choose to make its own submission, please send a copy to GPV, so we can remain informed of your views. Contact Louise Willis, policy analyst ([l.willis@gpv.org.au](mailto:l.willis@gpv.org.au)) or Christine Macdonald, general practice workforce consultant ([c.macdonald@gpv.org.au](mailto:c.macdonald@gpv.org.au)).

GPV's June 2011 submission to the earlier Metropolitan Health Plan can be viewed at: [www.gpv.org.au/files/downloadable\\_files/Policy/Submissions/20110531\\_sub\\_GPV\\_submission\\_re\\_Vic\\_Metro\\_Health\\_Plan.pdf](http://www.gpv.org.au/files/downloadable_files/Policy/Submissions/20110531_sub_GPV_submission_re_Vic_Metro_Health_Plan.pdf) or go to [www.gpv.org.au](http://www.gpv.org.au) > Resources > Policy.

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### Summary of components relevant to divisions and MLs

The Rural and Regional Health Plan addresses the same priorities as the earlier Metropolitan Plan:

- Developing a system that is responsive to people's needs
- Improving every Victorian's health status and health experiences
- Expanding service, workforce and system capacity
- Increasing the system's financial sustainability and productivity
- Implementing continuous improvements and innovation
- Increasing accountability and transparency
- Utilising e-health and communications technology

Like the Metropolitan Health Plan, it reflects the same broad policy direction of taking a system-wide approach that recognises the public, private and not-for-profit sectors, and emphasises evidence-based patient pathways; delivering care in the most clinically appropriate, cost-effective settings; and developing and training the workforce.

The Plan lists a number of "immediate actions" which the government has already committed to, including the establishment of a General Practitioner Rural Generalists Program, the establishment of the Rural Relocation Fund, various workforce recruitment and infrastructure commitments, establishing the Health Innovation and Reform Council, to advise on improvements to the system, developing a reform action plan for alcohol and other drug treatment system and mental health initiatives (pp.42-44).

DH proposes in the plan to establish area-based integrated care networks (p.49), which are intended to complement the statewide clinical networks (which each focus on a clinical condition or service type, including renal, cardiac, stroke, maternity and newborn, paediatric, emergency, cancer and palliative care). DH will take action “in the short to medium term” to

- *“Develop and apply service capability frameworks in rural and regional setting that articulate specific roles and responsibilities for health service providers and link these to appropriate performance mechanisms, to reduce duplication and maximise the use of available resources across a specified area”*
- *“identify leading regional providers who will have responsibility for
  - *Facilitating the establishment of integrated care networks... to develop and agree the most clinically appropriate and cost-effective pathways...*
  - *Facilitating uptake of routine monitoring and reporting that supports greater compliance with the agreed patient pathways, clinical guidelines and the associated patient outcomes by all network partners*
  - *Facilitating and supporting teaching and training and development of innovative workforce models that align to agreed patient pathways...*
  - *Developing and implementing standardised approaches to service planning, such as coordinated sub-regional service plans, and align local resource allocation models to ensure they are sensitive enough to reflect the needs of local populations...*” (p.53-4)*

The Technical Paper accompanying the Plan includes some data on GP services (using the Health Services Directory as a data source, and using GP services per 1,000 population, rather than GP to population ratios), and includes some analysis of the possible effect of GP service availability on rural hospital demand. GPV has prepared an analysis of the DH catchments compared to the Medicare Local catchments, for the information of MLs and Divisions. (See attachment.)

## **GPV initial comments**

### ***System-wide approach***

GPV welcomes the continuation of the system-wide approach that “recognises and includes the public, private and not-for-profit sectors” (Foreword). GPV also welcomes greater inclusion of GP services in the plan, analysis of the potential relationship between hospital use (including ED presentation) and availability of general practice, and the acknowledgement that “GPs are fundamental to ensuring early diagnosis and ongoing management of care for many rural people” (p.62). GPV agrees that all aspects of the service system, irrespective of funding source, need to be included if we are to understand the real availability of health services and plan for the best system for Victorians.

### ***Medicare Locals’ roles to help achieve Victorian Health Priorities***

Medicare Locals’ roles have been agreed by the Commonwealth and the states.<sup>1</sup> Both population health planning and coordination to help improve the patient journey will be central roles for Medicare Locals. One of the five stated strategic objectives is:

#### **Identification of the health needs of local areas and development of locally focused and responsive services**

To achieve this objective, Medicare Locals are expected to have the appropriate expertise in data collection and analysis, strategies and referral pathways to:

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<sup>1</sup> Council of Australian Governments, National Health Reform Agreement, August 2001, Schedule D.

1. maintain a population health database including community health and wellbeing measures, provide input to population health profiles, and undertake population health needs assessment and planning;
2. actively participate in the performance and accountability framework of the Government's health reforms;
3. undertake detailed analyses of primary health care service gaps and identify evidence based strategies to improve health outcomes and the quality of service delivery in local area populations, including for disadvantaged or under-served population groups;
4. conduct joint service planning with Local Hospital Networks and other appropriate organisations; and
5. facilitate a reduction in inappropriate or inefficient service utilisation and avoidable hospitalisations<sup>2</sup>

Another ML objective (improving the patient journey through developing integrated and coordinated services) includes:

3. Work with patients and the local clinical community to *develop, monitor and maintain high patient care standards and integrated and coordinated clinical pathways* to improve access to services, including after-hours services and telehealth services, provided in the most appropriate setting, and connectedness between services in the local area<sup>2</sup>

The suggestions in the Rural and Regional Health Plan about area-based planning and about establishing area-based integrated care networks need to happen in conjunction with Medicare Locals. It is important to connect the statewide clinical networks with the area-based implementation work. But the state needs to use the existing network of Medicare Locals because they will offer a vehicle for engagement with health service providers (including general practice and allied health providers in private practice, who are otherwise very difficult to reach), and to ensure that extra networks are not established which would duplicate functions. There is already a suggestion that Lead Clinician Groups should be established (with Commonwealth funding) to provide a mechanism for engaging local clinicians from both Local Hospital Networks (LHNs) and Medicare Locals, and to work on patient pathways. In Victoria, where the number of LHNs have not been reduced, so there is no match between LHNs and MLs, this may be more difficult than in other states. Establishing another set of area-based networks would lead to inefficiency, and would be likely to lead to reinforcing a division between public and private sectors, which would be counter to the explicit approach of the Victorian Health Priorities Framework.

Medicare Locals are crucial for addressing coordination, for reaching agreement on patient pathways (including taking into account local availability of services), for getting clinicians to use such pathways, and for reporting on results. Although the indicators have not been finalised, Medicare Locals will be providing data for *Healthy Community Reports* and providing data to the National Health Performance Authority.

### ***The need for common planning catchments***

The data in the technical plan is very useful, but given that population health planning and needs assessment is an important role of Medicare Locals, its use would be greatly enhanced if common catchments for analysis were used. Boundaries for Divisions of General Practice were idiosyncratic, as they were not originally designed in a systematic way (being the result, in part, of pilot projects in the early 1990s) and Division leaders in Victorian recognised the need to change to catchments based on LGAs. Victorian Medicare Locals boundaries do use LGAs (although they are split in a handful of cases) and in most parts of the state they reflect PCP

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<sup>2</sup> See Department of Health & Ageing, December 2011, Discussion paper for the development of the *Regionally Tailored Primary Health Care Initiatives through Medicare Locals Fund*.  
[http://www.health.gov.au/internet/main/publishing.nsf/Content/6E4A70B64310FEB6CA25795200108100/\\$File/MLF\\_discussion%20paper\\_8Dec11%20FINAL.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/6E4A70B64310FEB6CA25795200108100/$File/MLF_discussion%20paper_8Dec11%20FINAL.pdf)

catchments. In our response to the DH Metro Health Plan, GPV expressed concern that the catchments DH used for the metro area in it did not appear consistent with the Department's stated preference to use PCP catchments. The catchments in the Rural Plan are more consistent with the PCPs, which is helpful, but they still do not match the Medicare Local boundaries that the Victorian state government negotiated with the Commonwealth. The practice of continually changing the unit of analysis does not provide a good basis for planning and monitoring of either service provision or health status. GPV recommends that the Department use the same catchments as it negotiated for Medicare Locals, to improve the basis for planning, coordination and reporting.

We also suggest that it would be useful to use "Bass Coast" (or similar), not "South Coast", as the name for the ML catchment extending from Barwon to the SA border is "Great South Coast."

### *General practice data*

We note that the Human Services Directory (HSD) 2010 is used as the data source for GP services. GPV's understanding is that the data for 2011 is more accurate than it was in 2010, as more general practice details have been included over time. This may result in some differences to the GP: population estimates. It would be worthwhile to examine the current data. It may also be informative to compare it to other general practice data sources, e.g. AIHW Medical Labour Force data, the RWAV Annual Survey and PHCRIS data. (Comparison with PHCRIS data may be difficult because the catchments do not match.)

### *Primary health care – definition*

The definition in the appendix indicates, correctly, that primary care can be accessed through a range of providers (e.g. GP, physiotherapist etc.), but primary health care can also mean the approach to care (based on the Declaration of Alma Ata in 1978) which includes equity, accessibility, community self-determination and intersectoral collaboration. The 2<sup>nd</sup> meaning is omitted in DH's document, and instead there is an oversimplified statement that suggests primary healthcare is delivered by allied health providers while primary medical care is delivered by GPs. This could give rise to misunderstanding the terms, reinforcing a division between medical and social care, rather than recognition that both are crucial contributions to a good primary health system. Such misunderstandings sometimes act as a barrier to joint work between professions and organisations. Helen Keleher has described primary care as the first point of entry when assistance is sought by a client, involving management of a specific illness or disease. She writes "Drawn from the biomedical model, primary care is practised widely in nursing and allied health, but general practice is the heart of the primary care sector."<sup>3</sup>

It would be clearer and more accurate to say something along these lines: "Primary health care can be seen as the first level of care or entry point for consumers (including care delivered by GPs, allied health providers etc.), and can be delivered by community health services or private providers. Primary health care can also be taken to mean a particular approach to care which is concerned with continuing care, accessibility, community involvement and collaboration between sectors."<sup>4</sup> The second sentence is from the Commonwealth's Primary Health Care Strategy. The terms from the Alma Ata definition have been somewhat softened (e.g. community self-determination becomes community involvement.) An alternative would be to describe the approach by using terms that more closely reflect the Alma Ata Declaration.<sup>5</sup>

<sup>3</sup> H Keleher, "Why Primary Health Care offers a more comprehensive approach to tackling health inequalities than primary care" Australian Journal of Primary Health 7 (2) 57-61, p.57

<sup>4</sup> Commonwealth of Australia, 2009, Primary Health Care Reform in Australia - Report to Support Australia's First National Primary Health Care Strategy, Chapter 3. <http://www.health.gov.au/internet/yourhealth/publishing.nsf/Content/nphc-draftreportsupp-toc~nphc-draftreportsupp-ch3~nphc-draftreportsupp-ch3-def>

<sup>5</sup> Definitions of Primary Health Care, including links, are available at Primary Health Care Research and Information Service, Infobyte: Primary Health Care [www.phcris.org.au/infobytes/about\\_phc.php](http://www.phcris.org.au/infobytes/about_phc.php)

Attachment: comparison of Medicare Local catchments and DH Rural Profile Areas

**Catchments that use the same boundaries:**

Medicare Local	DH rural profile area
Goulburn Valley	Goulburn Valley and Lower Hume
Hume	Central and Upper Hume
Great South Coast	South West
Barwon [ML additionally includes part of Golden Plains]	Geelong and Coast

**Catchments using similar boundaries, but with 1 ML relating to more than one DH rural profile area:**

Medicare Local	DH rural profile area
Gippsland	East Gippsland (includes Wellington & Gippsland PCPs)
Gippsland	Central and West Gippsland
Gippsland	South Coast [not to be confused with Great South Coast ML, to the west of the state]
Grampians [includes additionally most of Central Highlands PCP area; Golden Plains LGA is split between Grampians and Barwon]	Pyrenees and Wimmera 2 PCPs: Wimmera, Southern Grampians-Glenelg
Grampians	Central Highlands (Central Highlands PCP– ie Hepburn, Ballarat, Moorabool and Golden Plains)

**Catchments with substantially different boundaries:**

Medicare Local	DH rural profile area
Loddon Mallee Murray [this ML extends further north, splits LGAs of Buloke and Swan Hill, and does not include Macedon Ranges]	Central Vic LGAs: Loddon, Campaspe, Greater Bendigo, Central Goldfields, Mt Alexander, Macedon Ranges ie 3 PCPs: Bendigo-Loddon, , Campaspe, Central Vic Health Alliance
Lower Murray [The ML catchment includes Mildura, part of Swan Hill, part of Buloke and part of Yarriambiack]	Mallee. LGAs: Mildura, Swan Hill, Buloke, Gannawarra 2 PCPs: Northern and Southern Mallee



**General Practice Victoria**

ABN 80 081 371 968 ACN 081 371 968

458 Swanston Street  
Carlton Victoria 3053

Tel: (03) 9341 5200 Fax: (03) 9341 5299  
Email: gpv@gpv.org.au Website: www.gpv.org.au