Acknowledgements

I would like to acknowledge the traditional custodians of the land, and pay my respects to their elders, both past and present.

AGPN Chair: Dr Emil Djakic
AGPN CEO: Mr David Butt, and
AGPN Former Chair: Dr Tony Hobbs – who was also the Chair of the National Primary Health Care Strategy External Reference Group.

Ladies and gentlemen.

I am very honoured to again provide the keynote address to the AGPN Forum. I think that this Forum is an important date on the calendar.

It’s a time when we can refocus on GPs and the broader Primary Care sector – the part of the system that means so much to the health and well-being of our community, and the part of the system which Australians most frequently visit.

The dedicated doctors, practice nurses and health professionals in general practice are at the frontline of Australia’s health care.

And the Divisions network which you comprise has been both a driver and a vehicle for reform and improvement in primary health care.

The network as a whole, and key visionaries – like Tony Hobbs and Emil Djakic – have been instrumental in helping to develop the health reform agenda. And assisted ably by your unstoppable CEO David Butt.
It doesn’t seem like 3 years since I first started working as Health Minister with the AGPN. The past year has gone particularly quickly – with the release of the final National Primary Health Care Strategy, the Government’s health reform agenda, and, of course the little matter of a federal election.

I was delighted and honoured to retain the health portfolio in the re-elected Gillard Government.

For a Labor Government, standing still in Health is not an option.

We achieved much in our first term.

We undertook a major methodical process of reform.

We first gained the evidence from the experts – through the Primary Care Reference Group chaired by Dr Tony Hobbs, and the National Health and Hospitals Reform Commission.

We then took their recommendations on the road – consulting over 100 communities on their reactions to the proposed reforms.

We then released a response and negotiated a landmark agreement with seven states and territories. (Here in WA I do need to note that there was one absent signature on that agreement - we are still working on that.)

We followed this with a Budget this year replete with health investments in primary care, e-health and aged care.

In short, what we did was go through a proper policy development process – it was open, evidence based and focused on addressing the problems. It enabled us to achieve an agreement and resources that would have been tricky without the years of hard work behind it.

There’s no doubt that we have faced challenges and we will still continue to face challenges.

But we are determined to tackle these challenges, because the alternative is a dangerous outcome for Australian patients. If we don’t act, reform and invest:

- We won’t be able to combat the increasing rate of chronic disease that could cripple our health services
- We will still have differing public health systems and providers shunting patients around the system for financial, bureaucratic and uncoordinated reasons.
- We won’t be able to combat the number of medication and other errors in our hospitals and health systems
- And the states will be under mounting pressure over time as health costs gobble up an ever increasing share of their budgets.

As I have said, we achieved a lot in developing our vision for the health system, but there is much more to be done.
The great opportunity and challenge for the Government’s second term will be to implement and deliver on our health reforms.

The government is fresh and ready to deliver our health reforms, with a better primary health care system at the heart of this.

Why is primary health care so central?

Firstly, because primary health care is the sector that is most appropriate to manage the challenges of the future: in particular, an increasing burden of a population that is ageing and a dramatic increase in chronic diseases.

Secondly, because effective GP and primary health care works. It is good for patients and is also the key for the long term sustainability of the health system.

As the adage goes, it is better – and more cost effective – to be preventing and managing disease with a fence at the top of the cliff rather than ambulances at the bottom. Preventing disease and reducing its severity is a key way to get better health outcomes and reduce future pressure on our hospitals.

Once the Commonwealth has funding responsibility for 60% of public hospital costs and 100% of primary health care, we will have an ever stronger and clearer incentive to stop the buckpassing and provide care in the most effective way possible.

So what are the key things that we need an improved primary health care system to deliver?

- It needs to provide well coordinated and integrated care, especially for patients with chronic disease – so patients aren’t being shunted around
- It needs to provide accessible care – people being able to get the care they need when and where they need it
- It needs a skilled workforce, working together collaboratively in multi-disciplinary teams – so patients get the range of services from the range of health professionals they need, and professionals’ valuable skills are used as effectively as possible
- It needs to focus on prevention and early intervention – actively preventing disease and its progression, rather than responding reactively to it.

In order to achieve these aims, the Gillard Government is investing in a number of building blocks.

- Centrally, we are supporting the training of more GPs and we’re funding more practice nurses so we have the key primary health care staff in numbers that are needed.
- We are also supporting team-based multi-disciplinary care through reforms such as enabling eligible nurse practitioners and midwives to provide Medicare and PBS-subsidised services.
While there have been some misinformed claims and counterclaims in the media, I have been clear all along that these measures will not make nurse practitioners substitutes for doctors. It is our clear intent that eligible nurse practitioners and midwives will need to work in collaboration with medical practitioners when providing MBS services and PBS prescriptions. This initiative will be monitored and evaluated over time, with stakeholder input, to ensure that our policy intent is being delivered.

It will support coordinated, continuous, and comprehensive care that is delivered by appropriately-trained health professionals. I would encourage doctors to look more for opportunities, not just problems, from these reforms.

- Medicare Locals: these organisations will have a critical role to play in coordinating and integrating services, addressing gaps in services, bringing health professionals together to work in teams, and over time bringing more focus to prevention and early intervention.
- Electronic health records will help improve coordination of patients’ information and the ease with which they can navigate the system – especially chronic disease patients who need to see multiple health professionals
- General Practice infrastructure: our investments in GP Super Clinics and smaller primary health care infrastructure grants will help bring together GPs and other health professionals together in the one setting, and provide more convenient access for patients.

Just last week, I announced the next steps in implementing 28 more GP SuperClinics, as part of a $355.2 million investment in primary care infrastructure that the Government funded in the 2010-11 Budget. And I am looking forward to announcing the results of the first round of primary health care infrastructure grants later this month (November).

- After hours services: our investments in an afterhours helpline and better coordinated services by Medicare Locals will make GP and primary health care services more accessible 24 hours a day, taking pressure off emergency departments.

Australia’s network of Divisions of General Practice will be one of the key players in delivering these health reforms.

In particular, Divisions will be transformed through the establishment of the network of Medicare Locals across Australia. The groundwork Divisions have laid over the last two decades will become much broader and much deeper – involving a wider range of health professionals and identifying community issues and working to fill gaps in care or service.

Medicare Locals

Medicare Locals are the key to regional integration and better coordination of local services. They will play a pivotal role as the platform for primary health care reform in Australia.

They will build on the strengths of the Divisions network, retaining and expanding activities currently performed by the Divisions and expanding into new areas.
They will support providers – GPs, practice nurses and allied health – to provide more integrated, coordinated care, while maintaining the important role that general practice plays in the primary health care sector.

They will improve access to services for patients, especially after hours care; and encourage integration across primary health care, with Local Hospital Networks and with the aged care sector.

They will also identify and target service gaps and people most in need, such as gaps in primary mental health care and psychological services.

They will deliver local health promotion and preventive health programs, informed by Healthy Communities Reports, which will measure community health and wellbeing. They will facilitate allied health care and other support for people with chronic conditions. They will promote better quality and safety of health services.

Medicare Locals will also work closely with other government services, and with education and training providers to support the education of primary health care professionals.

Finally, they will provide a platform for further reforms. This will include coordinating after-hours primary health care services. It could expand to supporting better integrated primary mental health care in the future.

And it will include helping facilitate the adoption of key infrastructure for the future, such as e-health.

We are now getting ready to make the transition from the Divisions network to the Medicare Locals Network, to allow that vision to become reality.

Late last week, I released a discussion paper on the future governance and functions of Medicare Locals.

I hope that many of you here today have or will read this discussion paper. As the discussion paper outlines, we expect that Medicare Locals will be independent legal entities.

They will need to have strong local governance, including broad community and health professional involvement, as well as business and management expertise.

Medicare Locals will need to have formal structures in place which bring together the range of primary care providers – not only GPs but also allied health professionals and practice nurses, mental health workers and others, working in true partnership.

They will also need to have close working relationships and formal linkages with Local Hospital Networks.

I invite you to view the discussion paper online at www.yourhealth.gov.au and encourage you to provide your views through the consultation process which runs until 15 November.
Next steps for Medicare Locals

I know that many of you here today are as excited and enthused by the potential for primary health care reform as I am, and so are interested in the next steps in our reform journey – so I will focus the remainder of my speech on these important next steps. I am pleased to announce as this next step that the Government is writing to all Divisions of General Practice seeking expressions of interests from Divisions interested in becoming one of the initial Medicare Locals.

As many of you are aware, our plans are to have the first group of Medicare Locals – potentially around 15 Medicare Locals in total – established in the middle of next year. We will be looking for lead organisations to become these Medicare Locals. These will be high performing Divisions of General Practice that have the demonstrated capacity to take on the expanded roles and functions expected.

The expressions of interest process will help the Government gauge the breadth, strength and quality of interest in becoming one of these initial Medicare Locals. This will help inform a selection process for these initial Medicare Locals that will occur within the next few months. We are not expecting Divisions to meet any particular criteria in this initial expression of interest – only to confirm whether or not they are planning to put in proposals in the first round.

A further step we will soon be taking will be to outline preferred boundaries for Medicare Locals.

I want to acknowledge and thank AGPN for the detailed work it commissioned, to develop draft boundaries.

This was important work that we were able to use as the basis for a public consultation which closed on 30 September 2010.

Around 120 submissions were received from key stakeholders – and I sincerely thank AGPN and individual Divisions for your extensive work with us on this issue.

We will be announcing the Government’s preferred boundaries in the very near future, which will form the basis of final consultations with AGPN and the States.

These boundaries will take into account the feedback received on the AGPN report, data analysis on populations and patient flows, and the likely shape of Local Hospital Networks and other health planning regions.

Consistent with the commitments of all Governments through COAG, we intend to finalise the boundaries of Medicare Locals and Local Hospital Networks by the end of this year. Following the expression of interest we will have a selection process for organisations seeking to be one of the initial Medicare Locals.

In selecting this first group of Medicare Locals, the Commonwealth will take into consideration key factors such as:

- the capacity of organisations to support local primary health care providers and the community through strong local governance;
the ability to link with other primary health care organisations including Indigenous and community health services and Local Hospital Networks;
the ability to put in place effective systems for the planning and integration of services across sectors;
the capacity to collect and manage data;
a track record in managing finances, resources and meeting accountability requirements;
performance in managing and implementing primary health care initiatives; and
a commitment to reform such as better chronic disease care and e-health.

We will also take into consideration the respective locations of the first Medicare Locals. Ideally, we would like to have a mix of organisations across metropolitan and rural areas. The selection process for the first cohort of Medicare Locals will be likely to draw on the kinds of factors and considerations I have just identified.

Funding

Alongside the work on boundaries and the selection process for Medicare Locals, my Department is also working on how the funding for Medicare Locals can be fairly and robustly distributed.

Different parts of Australia have different populations, health needs and health services, and it will be important for the funding to individual Medicare Locals to take this into account.

My Department is engaging professional economic consultants to develop a funding formula that will enable funding for Medicare Locals to be fairly distributed, taking into account the needs of different parts of Australia.

The consultants will consider whether and how factors such as population, socio-economic status, rurality and indigenous-status should be taken into account in distributing funding fairly.

Once the consultants have completed their analysis, the Government will consult with the AGPN before finalising the funding formula.

Performance

Many elements of the Government’s health reform agenda focus on improving the transparency and performance of the health system through better performance information.

Consumers benefit from greater information, so that they can make informed decisions about their care, while clinicians and healthcare providers benefit from greater feedback on how they are performing.
Consistent with these reform directions, the Government will develop a performance framework for Medicare Locals. We will work closely with AGPN on this, drawing on AGPN’s work at developing a national performance framework for the Divisions network. Development of this performance framework will need to take into account what kinds of information would be appropriate and useful to measure how Medicare Locals are performing, without creating an excessive burden of reporting. It will also be important to ensure both national consistency while enabling local flexibility and responsiveness.

Transition

While the vision for Medicare Locals is exciting, we should also be conscious that realising that vision will be challenging, and requires significant institutional and cultural change.

It will require leadership.

It will require negotiation, consultation and compromise.

This will need to bring together a diverse range of stakeholders – not only GPs, but also practice nurses, allied health, community health, indigenous health and consumers, training providers, along with strong links to aged care and hospitals.

And separate organisations, such as existing individual Divisions, will need to work together, across old boundaries and more cooperatively with other providers like, for example, community controlled indigenous services.

To help manage these challenges, the Government will be working closely with AGPN at a national level to support its role in assisting local Divisions build the capacity to become Medicare Locals. We will also be supporting Divisions which transition to become Medicare Locals.

Conclusion

As I have said earlier in this speech, we are now in the midst of an exciting period of reform.

We are taking major steps forward in the implementation of our health reform agenda, and my key focus as Health Minister will be on continuing this delivery through the course of the Government’s second term.

The Divisions of General Practice will be central to these health reforms.

While change can sometimes be challenging, there are also great opportunities to strengthen and expand on the work that Divisions have been doing – and to transform yourselves into an even more relevant lynchpin of the health system for the future. The next year will encompass big changes for health, for primary health care and of course for AGPN and the Network.

I have greatly appreciated the vision and enthusiasm of AGPN and the Divisions of General Practice network in working with us on our health reform journey so far. And I look forward to working closely with you through the exciting time ahead.

Ends