

Chapter 7

Medicare Locals

7.1 In August 2011 the Commonwealth, state and territory governments around Australia finalised the National Health Reform Agreement (the Agreement). One of the initiatives in the Agreement is the establishment of Medicare Locals to operate from 1 July 2012.¹ The Agreement explains the role and functions of Medicare Locals:

Medicare Locals will be the GP and primary health care partners of Local Hospital Networks, responsible for supporting and enabling better integrated and responsive local GP and primary health care service to meet the needs and priorities of patients and communities.

...

The strategic objectives of Medicare Locals are:

- Improving the patient journey through developing integrated and coordinated services;
- Providing support to clinicians and service providers to improve patient care;
- 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.²

7.2 The Department of Health and Ageing elaborated on the role of Medicare Locals for the committee:

The Medicare Locals have been tasked to do a number of things, one of which is to look at the health needs and requirements of the population within their area, also, to look at the professional services that are available. That includes general practice, allied health, community health, [and] specialists working in the community.

...

What Medicare Locals are particularly looking at is patient flow, and how we look at the barriers between primary care and secondary care and ensure that there are pathways that link primary and secondary care together.³

1 Council of Australian Governments, *National Health Reform Agreement*, 2011, p. 50.

2 Council of Australian Governments, *National Health Reform Agreement*, 2011, p. 50.

3 Mr Mark Booth, First Assistant Secretary, Department of Health and Ageing, *Committee Hansard*, 11 May 2012, p. 74.

7.3 Medicare Locals will have to provide a 'Needs Assessment Report' that will inform the planning and priority setting activities.⁴ The Department of Health and Ageing has developed a range of tools and materials to support Medicare Locals in this task with the intention of disseminating 'a comprehensive health needs assessment framework for Medicare Locals to implement in a consistent and systematic way'⁵ by July 2012.

7.4 Due to the relative novelty of Medicare Locals, the majority of the evidence received by the committee was tentative in reaching any conclusions on their effectiveness. For instance, the National Rural Health Alliance (NRHA) stated 'little is currently certain about the impact of the introduction of Medicare Locals on the provision of health services.'⁶ The committee was informed by CRANaplus that 'it is really too early to tell'⁷; and the NSW Rural Doctors Network stated that '[i]t is too early to tell what the effect of the introduction of Medicare Locals on the provision of medical services in rural areas will be.'⁸

7.5 There was broad, if conditional, support for the new arrangements. The Royal Australasian College of Physicians 'cautiously [welcomed] the introduction of Medicare Locals'.⁹ Likewise, the QAMH expressed hope that Medicare Locals would be able to develop networks between different types of service providers to create better health outcomes for communities.¹⁰ The NRHA also reported that regional communities have high hopes for the Medicare Locals scheme:

There are, as we said, major expectations of [Medicare Locals], but we believe that they are real, they are with us, they are happening, and we should be taking every opportunity to make it work in rural areas...There are lots of issues but we, the Alliance, take the view that this is, if you like, the focal point now of all the effort that has been put into health reform over the last three to five years and we want to make every effort to make it work best for people in rural and remote areas.¹¹

4 Department of Health and Ageing, *Background Paper: Medicare Locals Health Needs Assessment and Planning*, http://www.agpn.com.au/_data/assets/pdf_file/0011/40331/20120106_BRF_Background-Paper-Medicare-Locals-Health-Needs-Assessment-and-Planning.pdf, (accessed 30 July 2012).

5 Department of Health and Ageing, *Background Paper: Medicare Locals Health Needs Assessment and Planning*, http://www.agpn.com.au/_data/assets/pdf_file/0011/40331/20120106_BRF_Background-Paper-Medicare-Locals-Health-Needs-Assessment-and-Planning.pdf, (accessed 30 July 2012).

6 Mr Gordon Gregory, NRHA, *Committee Hansard*, 11 May 2012, p. 24.

7 CRANaplus, *Submission 26*, p. 6.

8 NSW Rural Doctors Network, *Submission 18*, p. 3.

9 Dr Leslie Bolitho, Royal Australasian College of Physicians, *Committee Hansard*, 11 May 2012, p. 54.

10 Ms Catherine O'Toole, QAMH, *Committee Hansard*, 23 April 2012, p. 28.

11 Mr Gordon Gregory, NRHA, *Committee Hansard*, 11 May 2012, p. 25.

7.6 The RCNA, while noting that it is too early to assess the efficacy of the program, expressed hope that positive outcomes could be achieved:

In relation to Medicare Locals, it is acknowledged that their introduction is at various levels of implementation. At this point it is too early to determine the effect they will have on the provision of health service in rural areas. RCNA continues to endorse Medicare Local partnerships, inclusive membership and skills based corporate governance arrangements and engagement with health service users. Achieving the goals of improving Australia's primary healthcare infrastructure and better integrating service delivery requires broad engagement with health professionals working in the sector.¹²

7.7 The Council of Ambulance Authorities Inc. informed the committee that Medicare Locals have the potential to improve patient outcomes, saying:

Medicare locals are an opportunity to support coordinated, client-focused health service delivery in all parts of Australia. The extent to which this opportunity will be realized remains to be demonstrated but it is there to be grasped.¹³

Key issues raised during the inquiry

7.8 Although there is as yet no concrete evidence regarding the efficacy of Medicare Locals, the committee did hear a number of specific concerns regarding the program. Central issues raised include:

- (a) Medicare Locals' management of after-hours services;
- (b) communication and consultation;
- (c) information management;
- (d) the administration of Medicare Local areas;
- (e) monitoring and evaluation.

After-hours service provision

7.9 The provision for after-hours care will be transferred wholly to Medicare Locals from 1 July 2013 with the cessation of existing after hours and Practice Incentive Program (PIP) payments.¹⁴ It is intended that the service will be added and integrated with the current *healthdirect Australia* service which provides telephone based nurse triage information and advice. According to the Department of Health and Ageing's website people who may need medical attention at night or at the weekend should follow these steps:

12 Professor Karen Francis, Royal College of Nursing, Australia, *Committee Hansard*, 11 May 2012, p. 39.

13 The Council of Ambulance Authorities Inc., *Submission 6*, p. 7.

14 Department of Health and Ageing, *Establishment of Medicare Locals and better access to after hours care*, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/factsheet-gp-01#2>, (accessed on 30 July 2012).

- (a) contact their local general practice and have their call referred as necessary to *healthdirect Australia*
- (b) have their condition assessed by a nurse, who will determine whether the patient should have their call transferred to an online GP
- (c) be provided with appropriate advice and options by the nurse if the patient is not referred on to a GP
- (d) where patients are referred on to the GP, the GP will provide further medical advice and treatment options.
- (e) To ensure appropriate continuity of care, a record of all GP consultations will be sent electronically to the patient's usual GP the following morning.¹⁵

7.10 Medicare Locals will be funded to ensure the availability of face-to-face after hours service in their area and the after-hours MBS items will remain unchanged.¹⁶ Doctors will not be directly financially affected if they provide after-hours care.

7.11 The RDAA is strongly opposed to Medicare Locals taking over this role. They made the point in their submission that they oppose Medicare Locals as fund holders in general, and as administrators of after-hours care in particular.¹⁷

7.12 In their submission they highlighted a potential conflict of interest as one of their concerns:

Under the new process, PIP will be replaced by locally-based arrangements for allocating funding that will be determined by the Boards of Medicare Locals. The potential for conflicts of interest is substantial. Many health professionals sitting on such Boards will have a private practice, or be affiliated with a private practice, that may wish to seek funding from Medicare Locals. Requiring the CEO or Board of a Medicare Local to make decisions about allocating funding to a Board member is less than ideal.

...

There is a real potential for a conflict of interest where the Medicare Local is a fund holder and also becomes a service provider. What happens where a Medicare Local establishes a new after-hours service in a community because the local medical practice did not provide this service, and some time later the practice is purchased by a doctor who wants to compete with the Medicare Local in terms of providing afterhours services?¹⁸

15 Department of Health and Ageing, *Establishment of Medicare Locals and better access to after hours care*, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/factsheet-gp-01#2>, (accessed on 30 July 2012).

16 Department of Health and Ageing, *Establishment of Medicare Locals and better access to after hours care*, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/factsheet-gp-01#2>, (accessed on 30 July 2012).

17 RDAA, *Submission 67*, p. 26.

18 RDAA, *Submission 67*, p. 27.

7.13 The submission continues to discuss the effects that a Medicare Local deciding to discontinue an after-hours service will have on the long-term viability of rural general practices. The RDAA also expressed fears that federal/state relations and responsibilities will be impacted:

RDAA has concerns that the new arrangements will create an environment that allows for cost-shifting to occur from State Governments to the Federal Government. With Medicare Locals now funded for the planning and funding of local face-to-face after hours services, State Health Departments may step away from afterhours industrial agreements. If this occurs, afterhours services in some rural and remote communities may collapse.¹⁹

7.14 The view of the RDAA was echoed by Dr Meagher from the Young District Medical Centre who expressed disappointment that support proposed to be provided by Medicare Locals would not match actual need:

Primarily their first interest was in after hours and we believed it. The health minister said that should be one of their first goals. Their interest in what they call after hours is supplying services. They said they would pay for staff between five o'clock in the evening and eight o'clock in the evening and that is where the money will go so that we can offer an after hours service. To us that is more a convenience service. There are also hospital staff working at that time. Really, the after hours that we need help with is the 24-hours a day, particularly those antisocial hours.²⁰

7.15 Orbost Regional Health provided an example of this uncertainty caused by the introduction of Medicare Locals:

[W]e currently receive Medicare Out of Hours funding and use this to ensure 24 hour cover 365 days of the year in a very large geographical area. No one in living memory can recall a time when we have not delivered on this. However we are about to lose the direct allocation of this money to the Medicare Local. We will have to apply for this money and we assume will be successful as we are the best mechanism for 24 hour cover in the subregion. We are now dependent on a new and unproven entity to make the correct decision and this makes us feel vulnerable.²¹

7.16 In response to the concerns raised during the inquiry the Department of Health and Ageing accepted that many of the concerns were caused by a lack of certainty about the role and ultimate service provision of the Medicare Locals:

I think the issue of concern comes down to the lack of certainty about what will happen come 1 July next year, which is why we are trying to make sure the planning and decision making on funding will be done sooner rather than later. GPs who are currently providing a good service will continue to

19 RDAA, *Submission 67*, p. 28.

20 Dr William Meagher, Young District Medical Centre, *Committee Hansard*, 11 May 2012, p. 31.

21 Orbost Regional Health, *Submission 16*, p. [3].

be funded to provide a service. We are trying to reassure them that that will happen but they obviously want greater clarity on that.²²

7.17 In light of the comments from the Young District Medical Centre's experience in applying for funding for after-hours service provision the department reiterated their definition of after-hours:

Mr Booth: We normally define after hours as after six and going through the weekend.

Senator MOORE: So not five to eight.

Mr Booth: No.²³

7.18 However, the Department did defend the potential of the Medicare Locals to both address the gaps in after-hours service provision, and to alleviate some of the pressure on rural GPs:

...there are a lot of places in Australia where we are not getting those services provided and the direct provision of GP after hours services by GPs currently is below 30 per cent. A lot of locum services and so forth are used to provide after-hours services...²⁴

What you tend to find, and I think this is where some of the concerns have been raised, is that in a lot of rural areas you actually tend to have quite good after hours services because the local GPs are the only people available and they tend to be available 24 hours a day. That is obviously an issue for them.²⁵

7.19 The Department also expressed their hopes that services currently working well in a community would retain their funding because one of the roles of the Medicare Locals in this respect is to work with the local GPs to improve access to after-hours services:

Because we are requiring the Medicare locals to work with the GPs in their communities to come up with plans about how they are going to ensure better access to after-hours services. If, for example, a GP after hours service is working well in a particular community, we would expect that service to continue to be funded. Those plans will come back to us for approval and it will be quite transparent and public about what services are going to be funded going forward.²⁶

Communication and consultation

7.20 The most common concern that the committee heard regarding the Medicare Locals scheme was that there had been a lack of communication regarding how the

22 Department of Health and Ageing, *Committee Hansard*, 10 July 2012, p. 22.

23 Department of Health and Ageing, *Committee Hansard*, 11 May 2012, p. 74.

24 Department of Health and Ageing, *Committee Hansard*, 10 July 2012, p. 22.

25 Department of Health and Ageing, *Committee Hansard*, 10 July 2012, p. 21.

26 Department of Health and Ageing, *Committee Hansard*, 10 July 2012, p. 22.

program would operate and what implications it would have for the existing regional medical workforce.²⁷ The Victorian Healthcare Association expressed this frustration, stating '[t]he Federal Government urgently needs to provide more details on the role Medicare Locals will play in identifying and resolving workforce shortages.'²⁸

7.21 Evidence received from the Australian Association of Social Workers suggests that to date there has been insufficient communication with key stakeholders leaving them unsure of what Medicare Locals will mean for their members:

It is essential that allied health professionals are involved in the governance and organisational structure of Medicare Locals to ensure that Medicare Locals represent a range of primary health care interventions and that communities benefit from full access to allied health as well as to medical services. It will be important for Medicare locals to offer allied health services as core to their operations, in parallel with medical services. This recognises the fact that primary health care covers a range of services to consumers, of which, medical care constitutes one component. This requires allied health professional bodies to have input at a high level.²⁹

7.22 Similarly, the NRHA reported:

I have had a lot of GPs ask me what I know about the Medicare Locals. For instance, at the moment they might have a diabetes nurse in their clinic who is the only one in the town. Will they lose that person and have that resource taken away from them because this is a more attractive thing that is going on than in the GP clinic? If we have only a given number of physiotherapists, allied health people, psychologists et cetera, are they all now going to be torn between too many places?³⁰

7.23 The Australian College of Rural and Remote Medicine reported some concern among its constituents that Medicare Locals may threaten the place of GPs as the principal health provider:

[T]here is still a feeling of uncertainty about Medicare Locals. In rural and remote Australia your local GP is pivotal to the whole of the healthcare system within that community. They are key people within that sector. There is certainly some feeling around that that may be challenged within those systems. I still do not think there is a clear understanding of what Medicare Locals are going to be doing and what their fund-holder role is. There still seems to be some mixed concerns around that and the message is still coming from our members that this is an area of concern losing that pivotal role within the community.³¹

27 Mr Gordon Gregory, NRHA, *Committee Hansard*, 11 May 2012, p. 27.

28 Victorian Healthcare Association, *Submission 2*, p. 3.

29 Australian Association of Social Workers, *Submission 96*, p. 4.

30 Ms Anne Handley, NRHA, *Committee Hansard*, 11 May 2012, p. 26.

31 Ms Dianne Wyatt, Australian College of Rural and Remote Medicine, *Committee Hansard*, 5 June 2012, p. 13.

7.24 The AMA also emphasised the importance of GPs to the overall success of the Medicare Local program:

With delivery of primary health care services being the central plank of the operations of Medicare Locals, the AMA supports a governance structure that ensures a significant presence of local GPs on Medicare Local Boards and all key committees established by the Boards...The current Medicare Local model being implemented by the Commonwealth does not encourage/prioritise strong GP involvement and to that extent the AMA believes that they will result in poorly targeted services and the diversion of resources away from patient care.³²

7.25 In contrast, the North Queensland Combined Women's Services expressed some concerns regarding the makeup of the Medicare Locals board for Townsville–Mackay, noting that it was heavily weighted towards GPs to the exclusion of other health professionals:

[I]t is quite GP-driven. So everything revolves from the GP out, rather than, perhaps, from another place to the GP...The board is made up of five GPs and two non GPs, and one of those positions is not filled, it would appear. So that strength is very much a clinical practice. I notice that of all the mental health professions that employ, there are no social workers there.³³

Information management

7.26 Concern was expressed by CRANaplus that the introduction of Medicare Locals may result in the development of information silos:

With each [Medicare Local] focussing on Population Health Planning it is quite likely that each region will once again have differing quality data with no real effort to look at the whole picture especially in the remote sector.³⁴

7.27 In contrast, the General Practice Network Northern Territory indicated that the introduction of Medicare Locals may increase the sharing of information within their Medicare Local area:

[F]rom a workforce agency perspective, that is certainly going to help us build the whole multidisciplinary approach...It will also open the door for a lot more information and data sharing. Whilst we have tried, I think you still get those pockets of people who want to keep information to themselves and not necessarily be open about sharing.³⁵

32 AMA, *Submission 42*, pp 9–10.

33 Ms Catherine Crawford, The North Queensland Combined Women's Services, *Committee Hansard*, 23 April 2012, p. 41.

34 CRANaplus, *Submission 26*, p. 6.

35 Miss Angela Tridente, General Practice Network Northern Territory, *Committee Hansard*, 24 February 2012, p. 14.

Administration of Medicare Local areas

7.28 The committee heard concern that the vast geographical spread of some Medicare Local areas, as well as their boundaries, may impact on the ability of some Medicare Locals to effectively deliver appropriate health outcomes. Representatives from Tropical Medical Training observed:

I think the Commonwealth really does not have a good understanding of really how large this region is...To put a Medicare Local, for example, in Cairns and expect it to deal with Cape York, the Torres Strait, Innisfail and the west up into the highlands, where there are communities of interest, diversity, cultural land and the various players – the sensitivities of the Apunipima Cape York Health Council and other significant players like Wuchopperen, who have significant services in the lower end.

...

Why would you put a Medicare Local in Townsville and expect it to administer Mackay, when Mackay as a health district itself is significant going from Bowen way down past Sarina and out west to Moranbah? That could have easily been a Medicare Local on its own.³⁶

7.29 Concern was also raised by the CRERRPHC in relation to the boundaries of Medicare Local areas:

[I]n some rural and remote areas, Medicare Locals have been established that bear no relationship to the functional operation of health services or natural; geographic and demographic catchments. Simply imposing catchments on the basis of administrative boundaries (such as ABS units) is likely to render them dysfunctional in operation.³⁷

7.30 A related view was put forward by representatives from RHWA who argued that rural health may not receive the necessary attention in areas where a Medicare Local areas cover both metropolitan and non-metropolitan areas:

We are hearing concerns about continuity of services and the fact that Medicare Locals have such a broad charter that their overall focus on rural and remote may be diluted. In a number of states the Medicare Locals spread from city to bush.³⁸

7.31 The large size of the Medicare Local areas also raised concerns about whether or not service planning could truly be considered 'local', with the Tasmanian Government Department of Health and Human Services noting that:

Remoteness measure insisted upon by centralised government may be anathema to the idea of local planning, especially in Tasmania where the

36 Mr Ian Hook, Tropical Medical Training, *Committee Hansard*, 23 April 2012, p. 9.

37 CRERRPHC, *Submission 32*, p. 6.

38 Ms Margie Mahon, RHWA, *Committee Hansard*, 5 June 2012, p. 25.

entire state will be served by one Medicare Local (albeit with regional branches).³⁹

7.32 A number of concerns were raised about the administration of the Medicare Local program as a whole. It was noted by Dental Health Services Victoria that 'each one of them seems to be reinventing the wheel'.⁴⁰ On a related matter, the Australian Physiotherapy Association reported that 'the governance structure for Medicare Locals are multiple and varied'.⁴¹

7.33 Similarly, RHWA observed that:

[T]here appear to be different approaches being taken by different Medicare Locals and that there is some general confusion as to what their roles will be in supporting a local rural and remote health workforce. While a 'local' approach to cater to 'local' needs is to be supported, it would be unfortunate if there were great inconsistencies between areas in terms of the basic workforce support functions of Medicare Locals. The health workforce drawing pool is truly an international one and Australia needs to maintain a concerted and cohesive approach.⁴²

Monitoring and Evaluation

7.34 The CRERRPHC argued that it will only be possible to assess the impact of Medicare Locals through a national evaluation framework:

[T]he essential issue here is that we require a comprehensive and nationally consistent evaluation framework that is based on the stated policy objectives of the Medicare Local program in order to be able to make an assessment of effectiveness in years to come.⁴³

7.35 The need for regular and timely evaluation was also emphasized by SARRAH and General Practice Queensland.⁴⁴

7.36 The Department of Health and Ageing said that the monitoring and evaluation of the Medicare Locals applies in a variety of ways. They pointed out that all applications, establishment and strategic plans were approved by the department, and then performance agreements were put in place. They then discussed the role of the National Health Performance Authority and the planned comparative assessment program:

...of course we also have the National Health Performance Authority, which is going to be doing healthy communities reports on Medicare locals, which is not just looking at the performance of Medicare locals but, rather, the health of the population within those regions. It looks more at efficiency,

39 Tasmanian Government Department of Health and Human Services, *Submission 69*, p. 21.

40 Dr Deborah Cole, Dental Health Services Victoria, *Committee Hansard*, 5 June 2012, p. 46.

41 Mr Jonathan Kruger, APA, *Committee Hansard*, 5 June 2012, p. 55.

42 RHWA, *Submission 107*, p. 17.

43 Centre of Research Excellence in Rural and Remote Primary Health Care, *Submission 32*, p. 6.

44 General Practice Queensland, *Submission 60*, p. 4; SARRAH, *Submission 62*, p. 9.

effectiveness, quality, patient experience and population health indicators as well. We will be able to look at the overall performance of Medicare locals within a geographic area and be able to do comparative analysis between different Medicare locals in terms of what is working and what is not and how we achieve good practice.⁴⁵

Committee view

7.37 Like the majority of submitters to this inquiry, the committee is of the view that the newness of the Medicare Local program makes it impossible to adequately assess its effectiveness at this time.

7.38 To be successful the program will require careful and intensive management to ensure that all the key stakeholders are adequately considered and consulted. According to many of the witnesses and submitters there has been a lack of communication between Medicare Locals and affected stakeholders regarding how the Medicare Locals program will operate, and what it will mean for their businesses. Greater effort needs to be expended to ensure that the necessary information is available for interested stakeholders.

7.39 However the committee shares the cautious optimism of the potential for Medicare Locals to fill the gaps between local hospital networks, and GP community care provision. The inclusion of all health stakeholders needs to be ensured and an open approach to innovative delivery models should be embraced. Evidence from bodies such as the Council of Ambulance Authorities in providing community paramedicine⁴⁶ illustrates that having a broader fund holder like a Medicare Local that can look beyond siloed budgets can benefit health care provision and improve health outcomes in rural areas.

7.40 In the committee's view the needs assessment element of the Medicare Local program is the singularly most important aspect of their work as it will provide the strategic overview that has been missing to date. The timely dissemination of the results of the needs assessments can ensure the constructive input of many of the key stakeholders. The uncertainty over the provision of after hours service provision is an area that requires evidence based decision making as quickly as possible to dispel the fear and anxiety that has been expressed over the status of existing services. In the medium to long term the regular dissemination of the monitoring and evaluation of the programs nationwide will also ensure that best practice is shared and replicated across the country.

Recommendation 16

7.41 The committee recommends that where existing after hours services are operating effectively there should be no disruption to their administration or funding.

45 Department of Health and Ageing, *Committee Hansard*, 10 July 2012, p. 23.

46 Council of Ambulance Authorities, *Committee Hansard*, 5 June 2012, p. 43.

7.42 In the medium to long term the regular dissemination of the results of monitoring and evaluation of the programs nationwide will ensure that best practice is shared and replicated across the country.

Recommendation 17

7.43 The committee recommends that Medicare Locals Needs Assessment Reports are made public and a process of engagement and consultation is undertaken.

7.44 A range of evidence has been mentioned in preceding chapters that identified potential gaps or overlaps between current policies and programs. The committee is also aware that Medicare Locals are expected to conduct needs assessments that include:

- [the] analysis of service gaps and identification of evidence-based strategies to improve health outcomes and the quality of service delivery in local area populations;
- joint service planning with Local Hospital Networks and other organisations; and
- [a focus on] early achievements and tangible outcomes in facilitating a reduction in inappropriate or inefficient service utilisation and avoidable hospitalisations.⁴⁷

7.45 According to evidence from Department of Health and Ageing, Medicare Locals are being tasked with firstly identifying gaps in service delivery between primary and secondary care through their Local Needs Assessment, and then breaking down the barriers to ensure there are pathways that link primary and secondary care together.⁴⁸ One of these barriers is the mismatch that sometimes occurs between Commonwealth and state or territory health policy and resourcing. The committee is of the view that this particular barrier should be addressed at a national level rather than locally. However the Needs Assessment Reports prepared by Medicare Locals will be a valuable resource from which to identify potential inter-jurisdictional issues.

Recommendation 18

7.46 The committee recommends that the Department of Health and Ageing prepare a brief for COAG's Standing Council on Health on existing or emerging gaps affecting the delivery of health services to rural and remote communities caused by mis-alignment between Commonwealth and state policy, including options for measures to remediate such gaps. The brief is to be based on engagement with relevant stakeholders, including state and territory governments, Medicare Locals, representatives of peak bodies such as RDAA,

47 Department of Health and Ageing, *Guide and Template for Medicare Locals Needs Assessment Report*, version 1.0, p. 1.

48 Mr Mark Booth, First Assistant Secretary, Department of Health and Ageing, *Committee Hansard*, 11 May 2012, p. 74.

SARRAH and NRHA at both national and state level, and to be provided on at least a bi-annual basis.

**Senator Rachel Siewert
Chair**

