

Medicare Locals

Governance and Functions

NSW General Practice Network submission

Background

Primary Health Care is defined as: *"socially appropriate, universally accessible, scientifically sound first level care provided by a suitably trained workforce supported by integrated referral systems and in a way that gives priority to those most in need, maximises community and individual self-reliance and participation, and involves collaboration with other sectors. It includes health promotion, illness prevention, care of the sick, advocacy and community development"*¹ Access to comprehensive primary health care services, including comprehensive and coordinated care for people with multiple and complex conditions, is a key foundation of a well functioning and equitable health system.

The establishment of Medicare Locals, Australia's first organised primary health care structures, has been driven by the Australian Government, which identified regional health care integration, through the establishment of Medicare Local organisations, as the first building block in its *National Primary Health Care Strategy*.² These organisations, coupled with the introduction of Local Hospital Networks, are fundamental elements of the Government's National Health and Hospitals Network. The Council of Australian Governments (COAG) National Health and Hospitals Agreement³ (signed by all jurisdictions except Western Australia in April 2010) defined the key function of Medicare Locals as improving patient navigation and health system integration which included a range of functions aimed at ensuring services cooperate and collaborate with each other. Over time they will also bring more focus to prevention and early intervention.

The Australian Government has committed to establishing the national network of primary health care organisations from 1 July 2011. Over the past 18 years, Divisions of General Practice have laid the groundwork for the establishment of Medicare Locals. Around 15 division and division consortia across Australia will make up the first wave of Medicare Locals from the middle of 2011, with the remainder commencing in mid-2012 (approximately 60-70 in total nationwide, with around 15 in NSW).

To this end, the Commonwealth Department of Health and Ageing has released a discussion paper on the Governance and Functions of Medicare Locals. This paper provides the following advice:

¹ [Australian Primary Health Care Research Institute: What is Primary Health Care? Canberra: Australian National University; 2008]

² National Primary Health Care Strategy www.health.gov.au/internet/yourhealth/publishing.nsf/Content/report-primaryhealth

³The Council of Australian Governments (COAG) National Health and Hospitals Agreement www.coag.gov.au/coag_meeting_outcomes/2010-04-19/docs/NHHN_Agreement.pdf

“The establishment of Medicare Locals will need to take account of existing regional primary health care infrastructure, partnership arrangements, including those established and operated by states and territories, while considering opportunities to build on elements that are currently working well. The introduction of Medicare Locals will require careful consideration of a wide range of issues, including clearly defining roles and responsibilities, structural and clinical governance and determining boundaries and catchment areas. Above all, successful implementation of Medicare Locals will require communication with a broad range of stakeholders, focusing on elements critical to the success of this major reform. Input and comment on this Discussion Paper is sought from state and territory Governments, health and related professional and consumer groups, patients and other interested individuals and relevant organisations”.

The NSW General Practice Network welcomes the opportunity to respond to the discussion paper. The Networks submission addresses each of the specific questions asked in the discussion paper and provides an overview of the potential role of a state based support organisation in the Medicare Local reform process and ongoing development.

General comments

Overall, the Network supports the general aspects outlined in the paper. There are concerns around the future operation of Medicare Locals regarding a range of issues that will need to be considered if the new entities are to be successful in ensuring effective responsive primary health care in Australia.

Notwithstanding adequate overall resourcing and infrastructure, and a fully inclusive, open and transparent process of consultation with all relevant stakeholders, and particularly with community members on their expectations, needs and concerns about the new establishments, the Network provides recommendations against each question raised.

What will Medicare Locals do?

What features will Medicare Locals need to have in order to achieve their objectives?

Health care systems are designed to meet the health care needs of target populations. While core characteristics should set Medicare Locals (MLs) apart from other health care systems, there should be **no prescriptive model of operation** for MLs. To truly succeed in improving health outcomes they will need to be responsive to **local** community health service needs and priorities, including the needs of the disadvantaged and vulnerable, such as the local elderly and Aboriginal populations. Those MLs that include communities with the poorest health outcomes and that pose the greatest challenges will need the flexibility to work innovatively and collaboratively with a range of community stakeholders that may not be seen as ‘usual’ primary care partners, including welfare agencies, courts, commercial groups, licensed premises and other social establishments, detention centres and others.

1. Identification of the health needs of local areas and development of locally focused and responsive services

To accurately identify the health needs of local areas and develop locally focused and responsive services, MLs will ideally need:

- Unrestricted access to small area (suburb/SLA) health risk, service utilisation (MBS), disease morbidity/mortality/prevalence data (and sociodemographic data) so small area health differentials can be identified and targeted (some data is currently available at larger area levels via AIHW, Chief Health Officers, ABS, cancer registry).
- Full support from the Public Health Information Development Unit (PHIDU) including opportunities through this unit for tailored and targeted data requests.
- The availability of more accurate data on the prevalence and nature of chronic disease multimorbidity (and at small area levels).
- The opportunity to contribute to the design and content of established health surveys, such as NSW Health Survey.
- Access to real time data that is currently unavailable or difficult or costly to access such as Medicare and PBS data; electoral data; research data and linkage sets such as the 45 and up study; workforce data etc
- The funding to ensure local general practices have the systems and capabilities to automatically extract regionally collated primary care activity and outcome data from General Practitioner desk top records programs.
- A skilled workforce across community engagement and needs identification and assessment, epidemiology, health promotion, planning, community mapping and development, project/program implementation etc.
- Some research capacity to pilot and evaluate strategies that address resistance to research/best practice uptake in local professionals and community members. To this end adequate ongoing training opportunities, university partnerships/student placements, CPD and other upskilling opportunities will be needed. Trans-disciplinary health care models and research are emerging as potentially promising approaches to address workforce and real world complexity issues.
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2698591/>
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836480/>
- The capacity and opportunities to influence high level policy across disparate public sectors on a regular, formal basis to properly address health care access barriers and social determinants of health.
- Access to and sound relationships with a wide range of local community organisations to work collaboratively on the accurate identification of local health care needs, concerns and priorities.
- Adequate support for ongoing monitoring and public reporting of primary health care data. Existing infrastructure such as the newly established *NSW Bureau of Health Information* which is responsible for hospital performance reporting could undertake this work.

2. Improving the patient journey through developing integrated and coordinated services, including across the transitions between primary and acute and aged care

To appropriately support MLs to improve the patient journey via the development of integrated and coordinated services, **sufficient “strings and levers”** will need to be in place. Common policy directives and funding approaches that foster a political environment that is favourable to the incorporation of integration and coordination of services in the planning, delivery and performance reporting of primary care (general practice) and the public secondary health care sector will go a long way to progress this area. There will also need to be:

- Agreed common goal or set of goals across primary and secondary care for service integration and a willingness among leaders to put the common interest beyond the needs of their own organisation.
- A detailed assessment by MLs and the secondary care sector of changes required to services to provide for better coordination and integration such as agreed referral pathways, shared care protocols and tools and processes.
- Real time assessment capabilities of the current demands on local primary, acute and aged care services to inform necessary changes in agreed arrangements.
- General and competitive grants available to MLs to develop and trial innovative local service models to bring about improvements in care coordination. These could be collected and shared across the national primary health care organisation network.
- Full support for new skills and competences demanded by the complexity of integrated services. Staff will need to adapt to a new working culture and have the ability to overcome the entrenched interests of bureaucracy and professional groups that may otherwise hinder successful integration.
- Infrastructure to support secure patient data transfer and interoperable electronic communication between service providers to connect providers, particularly across large geographic areas.

3. Providing support to clinicians and service providers to improve patient care

To provide needed levels of support to clinicians and service providers to improve patient care, MLs and providers will need to have access to:

- Reliable information channels that provide best practice summaries / interpretations relevant to primary health care (full ongoing knowledge translation support).
- Clinical information that specifically addresses common chronic disease multi-morbidity to provide guidance for its effective management rather than the current widespread availability of single-disease clinical management guidelines in an environment of rising levels of co-occurring chronic illness.
- Evidence based clinical pathway templates that provide opportunities for collaborative practice and team approaches that can maximise the expertise of multiple disciplines.
- MLs will also need to understand and develop effective strategies to address GP and other provider support needs and expectations. Maintaining GP engagement during the change process will be crucial to the successful operation of the ML.

4. Facilitation of the implementation and successful performance of primary health care initiatives and programs

To facilitate of the implementation and successful performance of primary health care initiatives and programs, MLs will need to have access to:

- Supportive, sustainable funding mechanisms and policies that offer appropriate recurrent and other funding (rather than the short 'term of government' funding arrangement in place for the Divisions Program). A single recurrent source of funding, based on population needs, is important to maximise flexibility to respond to changing regional needs, such as those resulting from population changes.
- Funding policies that positively discriminate to properly address health inequities in particular population groups, communities and geographies. Currently, significant impediments inhibit equitable access to appropriate primary health care for many Australians.
- Flexible funding policies that factor-in the intersectoral nature of health care needs such as transport and social support needs.
- An opportunity to link researchers directly to service providers to ensure the generation of new knowledge on effective strategies for improving the quality of primary health care and fostering effective and efficient exchange and use of data and information among service providers and policy makers to achieve evidence-based resource allocation, service planning, system development, and improvements in service delivery and health outcomes.

5. Be efficient and accountable with strong governance and effective management

- MLs will need to establish robust corporate and clinical governance arrangements that adhere to relevant best practice activities.

Are there other roles and functions Medicare Locals could potentially adopt?

Medicare Locals could potentially:

- Coordinate action outside the health sector by working with other government and non-government groups that have an impact on the health of local community members.
- Identify opportunities where non-health organisations and groups may contribute to improved health care integration and care coordination in local communities.
- Have a strong focus on developing innovation in care models to inform best practice chronic disease care in Australia across population and age specific groups.
- Medicare locals will also need to have some role in workforce development, often in partnership with other agencies.

What challenges will there be for Medicare Locals in performing the proposed roles and functions?

The scale and scope of the operations of the Medicare Local will be a critical factor in its capacity to achieve its objectives particularly in work with other partners such as Local Hospital Networks. If Medicare Locals are largely confined to a coordinating and facilitating role then their power to realise change will be limited and they will not be an equal partner in discussions with LHNs. The following factors are likely to be the most significant challenges and have a detrimental effect on the functioning of MLs:

- Inadequate funding, influence and/or leadership
- Unsupportive, poorly supporting and/or inconsistent policy and funding drivers between LHNs and MLs in service integration and coordination
- Low level of self determination (prescriptive funding requirements)
- Ability of rural MLs to attract, retain and develop staff to a skill level necessary to support the organisation
- Poor community uptake of programs/initiatives offered/commissioned by the ML
- Poor or no electronic interoperability between providers

How should Medicare Locals and Local Hospital Networks work together?

Joint acknowledgement of the challenges ahead, adequate transition planning and inclusive stakeholder involvement will be important components of successful collaboration between LHNs and MLs on the proposed national health reforms.

Medicare Locals and Local Hospital Networks should also work together under the following arrangements:

- Agreed cross-governance elements including common plans and linked systems and structures that support communication and integration at the regional level.
- Full and early funding differentiation between LHN and ML services is needed to effectively work together and avoid the common situation of state funded community based health services historically suffering when hospitals over-run their budgets, and cut backs and cost savings are disproportionately made from these services.
- Jointly developed mechanisms to avoid future service duplication and inconsistencies.
- Share clinical governance expertise.
- Electronic interoperability and routine exchange of information to support integration and care coordination such as hospital admission and discharge information.
- Reorienting the dominant culture towards primary health care by ensuring the primary health care sector plays a leadership role. History shows that change emanating from acute care settings place acute care settings first.

What will Medicare Locals look like?

What other broad principles or characteristics are important in establishing governance arrangements for Medicare Locals?

Improved integration and coordination of health care can only happen if there is a significant level of general practice involvement. It is important that in the transition to Medicare Locals, general practice engagement and the services and benefits delivered by Divisions are not lost.

In performing their functions and exercising powers, ML board members will have regard to the policies and directions of the Australian Government. All new members of the board and senior committees will need to undergo an induction program and receive a comprehensive orientation pack detailing their role and responsibilities and agree to the adherence of a recognised code of conduct.

Organisational governance arrangements for MLs will need to provide for:

- Enabling conditions such as the ongoing application of recognised organisational standards and a focus on continuous improvement.
- A sense of independence from government sufficient to enable MLs to advocate on behalf of their communities.
- Strong relationships with their local communities and range of providers, including ongoing local community engagement and input.

What formal linkages are required between Local Hospital Networks and Medicare Locals to ensure good coordination of services to the community?

Formal linkages between Local Hospital Networks and Medicare Locals to ensure good coordination of services to the community will need to include:

- Cross governance structures that have balanced representation, promote productive dialogue and effective partnerships between LHNs and MLs and have mechanisms in place to reduce or mitigate conflict of interest. Professor Stephen Leeder advises that otherwise we *“run the risk that membership will be compromised by those who already have influence at the expense of those who do not”*. Establishing a cross sector advisory body to provide policy and strategy advice as part of the governance structures will support meaningful collaboration.
- Enabling arrangements including common systems that reinforce communication and integration at the regional level.
- Formal agreements to 'share' resources and capacity in delivering services as required.
- Some relevant common objects in each organisations constitution.
- Joint steering and management structures to provide oversight for specific initiatives and/or service interfaces
- Common agreed policies/procedures/pathways that define agreed processes for shared management, transfer of care and also define organisational roles in prevention, health promotion, and service delivery.

What is needed to ensure that the structures and governance arrangements for Medicare Locals are flexible enough to deal with future changes in the health care system, including potentially different roles and responsibilities in primary health care?

- It will be important that MLs resist a heavily prescriptive corporate path and adopt a flexible outcomes-based governance approach.
- Flexibility of membership arrangements may accommodate potentially different roles and responsibilities in primary health care.
- MLs will need to constantly test and adapt their governance models to meet changing circumstances.
- Avoid a representational board structure which has the potential to entrench particular organisations as having 'positions on the board' which could limit flexibility.

What other types of internal governance structures are needed to support the Board and the operations of the Medicare Local?

- A change management steering committee will be important to support transition and the ongoing development of the new ML organisation.
- Technical and implementation groups specific to the ML programs and that straddle ML and LHNs as appropriate, to provide expert advice and instruction.
- A community/consumer advisory committee to provide advice and propose solutions on local needs, concerns and changes in community contexts.

Who should the members of Medicare Locals be?

- MLs will need broad representation in membership that aligns with local need including representation from primary health care groups, relevant community organisations, health charities, education providers and consumer groups.

How should membership be structured to ensure Medicare Locals focus on the health needs of their local community?

- A simple membership structure, such as organisation and possibly individual level membership that best suits the purpose of MLs and encourages relevant membership, but also restricts inappropriate membership such as corporate groups that carry a high potential conflict of interest risk.

What rights should members have and should they be able to influence the governance or the activities of Medicare Locals?

- Members of MLs should have Board member voting rights only. Their most important engagement in local policy and planning would be through stakeholder groups below the level of the board.

What aspects of clinical governance should Medicare Locals be responsible for?

- Implementing comprehensive clinical governance for clinical services operated by the ML will be a core role of the organisation. Clinical governance arrangements / structures should include identifying and supporting the application of standards for patient-centred care including both quality and safety, guaranteeing equity in access to health care and where necessary reporting adverse consequences of health policies on community level health care. A strong focus on shared care protocols and supporting patient self management will also be required.
- It is important to note that clinical governance requirements may vary with the nature of the activities of the ML (i.e. provider vs purchaser may change these requirements)

What is required to ensure appropriate linkages between Medicare Locals' clinical governance and Local Lead Clinician Groups?

To ensure all relevant clinicians are involved in linked clinical governance process, including identifying and managing risk, as well as planning, implementing, delivering and evaluating clinical services, it will be necessary to:

- Establish cross-professional clinical governance committees to establish agreed arrangements including shared care protocols that are based on best practice guidelines and consensus mechanisms.
- Ensure that clinical governance leaders develop ongoing communication mechanisms and sound reciprocal relationships.
- Establish professional development networks to support shared review of current quality of care improvement work, discussion of problems, and identification of priorities for future focus.
- Secure funding to support the time of clinicians who are engaged in leading change for the benefit of the wider system and to support their learning.
- Identify and clarify the term 'local lead clinician group' where a common agreed definition does not currently exist.

How will Medicare Locals interact with patients and providers?

How can communities' best be supported to fully participate in the activities of Medicare Locals?

Communities can best be supported to fully participate in the activities of Medicare Locals via the provision of:

- Widespread social marketing that supports community members to make good choices, sustain healthy behaviours and have more realistic expectations of health care services, and counter misperceptions.
- Targeted funding of ML to support community-wide interventions to improve health care navigation skills including facilitating transport to and from health care providers and up-to-date list or map of general practices and MLs.

- Targeted funding of ML to provide/commission routine self-management support that improves health and physical function outcomes.
- Targeted funding of ML to support broad improvement in health literacy in the local community.

What can Medicare Locals do to facilitate stronger community participation in local primary health care service planning and delivery?

- Consumer memberships on ML decision-making/governance structures. Give community representatives real power to make decisions and hold MLs accountable for their performance.
- Establish dedicated consumer structures to inform/advise the ML on an ongoing independent basis.
- Learn from health charities, consumer groups and others with significant expertise in this area on establishing a community of interest and best practice approaches to ensure effective consumer and community partnerships. Dominant professional partners will lead to a lack of consumer commitment and involvement.
- Consult with communities on planning governance structures and funding models that will maximise responsiveness to local communities identified priorities.
- Research is needed to show more clearly which components of consumer and community involvement contribute most strongly to improved planning and service delivery. MLs could be supported to conduct this research and increase the available vital knowledge in this area.

What kinds of information would be appropriate to provide in Healthy Communities Reports?

Healthy Communities Reports can be used to provide ongoing accurate analysis of:

- Community level health care and service needs and gaps
- Service user satisfaction reports on primary care services
- Health data (risk factor, chronic disease prevalence, etc) and the characteristics of those most affected
- Sociodemographic data and health determinant interpretations
- Health workforce levels compared with identified need (and workforce turnover and action to improve recruitment and retention)
- Immunisation levels and associated infectious disease rates
- Breastfeeding rates

There will be a need to establish and communicate initial baseline measures against which improvements will be made and measured.

Role of General Practice NSW in Medicare Local Reforms

General Practice NSW (GP NSW) is the state based leadership, advocacy and support organisation for the thirty-three regional members of the NSW General Practice Network.

GPNSW has been operating for over 10 years to provide a range of functions and roles that are tailored to meet the needs of the NSW Network and the communities they serve:

- Is the principal means by which the Commonwealth Department of Health and Ageing delivers contracts and contract assistance to NSW General Practice Network members. The organisation is also a fund holder and contract manager for various NSW government contracted programs and initiatives.
- Provides ongoing assistance to Network members in the form of staff education and training, program specific workshops and resources, technical advice for contracted program areas, mechanisms for networking and shared communication, models of best practice in corporate and clinical governance and other administrative functions and areas.
- An active member on a wide range of state level health advisory, research and program specific groups (>32 state level and university committees and groups).
- Recognised as a leader among state level health and other government and non-government organisations and is regularly invited to inform high level policy on general practice and broader health issues that impact community members.
- An important forum for advocating for the particular needs of Network members and the community it serves
- Has a leadership role in increasing awareness of members and other stakeholders on the progress of reforms, research and policy changes that impact Australian primary care.
- Conducts regular research on the primary care sector to identify best practice, where policy might be changed to improve conditions, and provider preferences, needs and patterns to develop a more detailed picture of where improvements could be made in the sector and what triggers and motivates progress. The results inform resource development for the sector and for organisations, government and other agencies wishing to work with the sector to support their capacity to interact with, engage and understand primary care.
- Facilitates networking opportunities and partnerships between Network members, government, non-government, business and community/consumer groups.

GP NSW is responsive to its members and works in a timely, cooperative manner with the Australian Government Department of Health and Ageing and other portfolio agencies to effectively fulfill its requirements. The organisation is fully accredited against recognised best practice standards for quality administration, including maintaining the highest standards of corporate governance. The on-site skills and capacities of GPNSW includes high level research, planning, epidemiology, policy, strategy and development, contract management and a range of other skills including doctorate level community engagement expertise.

Over the past two years GP NSW has taken a significant role in stimulating and supporting change in the primary care sector in NSW that is aligned with the prevailing national health reform agenda, including providing transition support for its Network members. To guide successful change efforts, key change agents should have at least a broad understanding of the context of the change effort and the environment undergoing the change. This includes understanding the basic systems and structures including typical ways of working and roles. GP NSW is an obvious and well equipped vehicle through which the current health reform efforts can be supported well into the future.

The ability of MLs in each particular state and territory to work with their relevant public health services and structures, and share resources and practices to create efficiencies and cost savings will depend largely on state level support. If each were to work chiefly independently of each other it would result in significant duplication of effort, time, resource development etc. They would function more effectively and efficiently if they were provided the necessary support and have the benefit of aggregate jurisdiction appropriate models and practice examples, HR and other administrative policies and templates, program guides and other essential tools that fit with state jurisdiction practices, regulations and policies. The development of agreed marketing and communication tools and templates could also be supported and shared.

GP NSW looks forward to continue to build on its significant track record in working with the Network and state level agencies and groups, linking services and programs, and developing innovative resources and initiatives tailored to the needs of primary health care organisations and the communities they serve across NSW.

GP NSW contacts

Carla Saunders
Manager Policy, Development and Communication
carlasaunders@gpnsw.com.au

Jan Newland
CEO
jannewland@gpnsw.com.au

About the NSW Divisions of General Practice Network

The NSW Divisions of General Practice Network works to enhance communication and integration between GPs and the wider health system, and improve the health of the community by supporting General Practice collaboration with other health professionals in the delivery of quality health care. The Divisions Program has been successful in contributing to General Practice participation in health planning and policy development, identifying and targeting population health priorities at a local level, improving the coordination of health services in the community and improving the quality of general practice.

The operational and general practice professional support capacity of the NSW Divisions of General Practice Network is significantly contributing to:

- The coordination of effective multidisciplinary community care through a case management and coordination model, with flexible, effective health care delivery
- An integrated health system in which community-based health services including GPs, aged care, allied health providers and medical specialists are supported by communication systems (e-health)
- Models of care that focus on patient needs rather than reactive to demands on the system or purely profit driven.

- Increased numbers of people with chronic disease enrolled in self management courses/groups
- Community assessment and management of targeted population groups discharged from public hospitals that are designed to meet each patients assessed clinical and ongoing support needs

Members of the NSW Divisions of General Practice Network

- GP NSW www.gpnsw.com.au
- Bankstown GP Division Inc. www.bankstowngp.com.au
- Barwon Division of General Practice Ltd www.barwondgp.org.au
- Blue Mountains Division of General Practice Inc www.bmdgp.com.au
- Central Coast Division of General Practice Ltd www.ccdgp.com.au
- Central Sydney General Practice Network www.csqpn.com.au
- Dubbo/Plains Division of General Practice Ltd www.dubboplainsdgp.com.au
- Eastern Sydney Division of General Practice Ltd www.esdgp.org.au
- GP Access www.gpaccess.com.au
- GP Network Northside www.gpnn.org.au
- Hastings Macleay General Practice Network www.hmgpn.org.au
- Hawkesbury-Hills Division of General Practice Ltd www.hhdgp.com.au
- Hunter Rural Division of General Practice Ltd www.hrdgp.org.au
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- Macarthur Division of General Practice Ltd www.macdivgp.com.au/default.aspx
- Manly Warringah Division of General Practice Ltd www.mwdgp.com.au
- Mid North Coast (NSW) Division of General Practice Ltd www.mncdgp.org.au
- Murrumbidgee General Practice Network Ltd www.murrumbidgee.net.au
- The Nepean Division of General Practice Inc www.nepeandgp.org.au
- The New England Division of General Practice Ltd www.nedgp.org.au
- North West Slopes (NSW) Division of General Practice Ltd www.nwsdgp.org.au
- Northern Rivers General Practice Network www.nrgpn.org.au
- Northern Sydney General Practice Network Incorporated www.nsgpn.org.au
- NSW Central West Division of General Practice Limited www.cwdgp.org.au
- NSW Outback Division of General Practice Ltd www.outbackdivision.org.au
- Riverina Division of General Practice & Primary Health Ltd www.rdgp.com.au
- The Shoalhaven Division of General Practice Incorporated www.sdgp.org.au
- Southern General Practice Network www.sgpn.com.au
- South Eastern Sydney Division of General Practice Limited www.sesdgp.com.au
- Southern Highlands Division of General Practice Incorporated www.shdivgp.com.au
- St George Division of General Practice Inc www.stgeorgedgp.asn.au
- Sutherland Division of General Practice Inc www.shiregps.org.au
- Tweed Valley Division of General Practice www.tvdgp.org.au
- WentWest www.wentwest.com/public/default.asp

Electronic submissions should be emailed to: medicarelocal@health.gov.au