

health

Enhancing the Victorian
Community Based
Pharmacotherapy System

Directions Paper

January 2013

Part One: The current system

1.1 Introduction

The use of pharmacotherapy treatment, also known as Opioid Replacement Therapy (ORT), has become established in Australia and many other parts of the world as an effective treatment for opioid dependence. Pharmacotherapy represents an important part of Victoria's community response to the treatment of drug and alcohol problems.

Pharmacotherapy is valuable in assisting people to successfully manage physical dependence, drug craving and compulsive drug use. Effective doses of methadone or buprenorphine have been shown to reduce the quantity and frequency of heroin use, criminal activity and the risk of blood-borne virus transmission whilst providing opportunities for clients to gain stability in their lives. If managed well, and in combination with other treatments, reduction on pharmacotherapy is also a viable option for clients wanting to achieve abstinence.

In Victoria the number of pharmacotherapy clients has increased by over thirty per cent over the last six years. With over fourteen thousand clients currently on pharmacotherapy, it is making a substantial contribution to reducing the harms associated with drug use and the demand for heroin.

Individual and community harms associated with heroin dependence

- Blood-borne infections, local infections, malnutrition, dental health, mental health, risk of overdose and death
- Financial cost of drugs and unemployment
- Social discrimination, isolation, stress on relationships, loss of self-esteem
- Cost of heroin related crime in Australia has been estimated at between \$550m to \$1.6bn a year
- Burden of social costs of unemployment, increased medical costs, loss of productivity
- Impact on family members including children

1.2 Community Based Pharmacotherapy System

The Victorian pharmacotherapy system is described as a 'community-based' model and was implemented in the 1990s. This model was chosen in order to normalise and de-stigmatise the treatment of drug addiction whilst making ORT readily available in the community. Access to ORT treatment is via a community based general practitioners (GP) and pharmacist allowing the integration of pharmacotherapy with primary health care. This results in greater client choice of practitioner and also maintains the client's privacy. The community-based model is primarily funded through the Medicare Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme (PBS) and clients paying dispensing fees directly to pharmacies.¹

The Victorian model differs from all other states and territories which to varying degrees rely on public clinic service provision. For example, the NSW pharmacotherapy program relies heavily on the public system to deliver pharmacotherapy and associated services to opioid dependent patients. In NSW patients need to be stabilised in the public system (clinics with a central intake service that are area based) before they can be transferred to the private sector (private clinics, general practitioners, psychiatrists and pharmacies). Under the NSW legislation medical practitioners who manage up to five clients do not require an approval to prescribe drugs of addiction and are not required to complete pharmacotherapy training, but may only prescribe up to five patients who are 'stable'. They can not induct a person on to treatment.

Despite some advantages associated with the NSW system, it is vastly more expensive than the Victorian system, access remains constrained (resulting in long waiting lists) and prospective patients are missing out on treatment. In contrast, the Victorian system is based on the premise that ORT should be readily available

¹ The Victorian Government acknowledges issues regarding program affordability for clients due to dispensing fees however these will not be addressed in this paper as the topic is outside the purview of this initiative.

in a setting where primary care needs can be addressed. The Victorian community-based approach considers prescribing of opiates as another health care service being provided by the GPs, redressing issues around stigma and marginalisation of the client group.

1.3 Clients on ORT in Victoria

The number of clients on ORT in Victoria is measured through a census of dispensing points conducted every 3 months. The census provides an accurate overview of the number of clients receiving pharmacotherapy at all dosing points in Victoria.

In October 2012, the Victorian census data indicated that there were 14,085 clients receiving ORT. Client participation in ORT has increased by 28.6% since 2007. There have also been significant increases in client numbers in rural areas over the past five years. For example the number of clients has increased by 86.9% in Gippsland, by 78.1% in Grampians and by 75.9% in Hume since 2006 (DH unpublished data, July 2011).

1.4 ORT dispensing outlets in Victoria

In 2010, there were approximately 1,146 pharmacies in Victoria, of which only 442 were active dispensing points for pharmacotherapy. This indicates that only about 40% of pharmacies were involved in the ORT system at this time. By July 2011 the number of participating pharmacies had increased to 462 (Anex, DH).

In Victoria, approximately 92% of pharmacotherapy clients are treated in pharmacies; 6% in correctional facilities; 1% in specialist services; and 1% are treated in hospitals. The actual numbers of clients treated at various dispensing points is detailed in **Table 1**.

Table 1: Number of clients within dispensing outlets

Dispensing Point	2006 Jul Clients	2007 Jul Clients	2008 Jul Clients	2009 Jul Clients	2010 Jul Clients	2011 Jul Clients	% increase past five years
Correctional	440	577	624	728	825	854	94.1%
Hospital	72	78	75	91	91	67	-6.9%
Pharmacy	10,031	10,249	11,041	11,654	12,163	12,738	27.0%
SPS	153	147	91	103	106	96	-37.3%
Grand Total	10,696	11,051	11,831	12,576	13,185	13,755	28.6%

Source: DH unpublished data, July 2011

1.5 Community based prescribing

It is estimated that in 2009 there were 6,334 General Practitioners (GPs) practicing in Victoria. Approximately 400 GPs participate in the Victorian ORT system which equates to only 6.3% of GPs prescribing pharmacotherapies (GPV Annual Survey, DH).

Table 2 illustrates that 65% of prescribers have between 1 to 20 clients; however this only represents 8% of total ORT clients. Twelve percent of prescribers prescribe to more than 100 clients, representing 73% of all the ORT clients.² Ten prescribers treat 30% or one third of all clients in Victoria.

² King, T., Ritter, A., & Berends, L. (2011). Victorian Pharmacotherapy Review. Sydney: National Drug and Alcohol Research Centre
pg 13

Table 2: Caseload of clients per prescriber

Numbers of clients per prescriber	% of prescribers	% of total ORT client numbers
20 or less	65 %	8 %
21 to 50	15 %	9 %
51 to 100	8 %	10 %
More than 100	12 %	73 %

Source: DH unpublished data, January 2010

1.6 Specialist Pharmacotherapy Services

To enhance and complement the community based system the Victorian Government provides funding for specialist services to assist the client and/or community based providers. Specialist Pharmacotherapy Services (SPS) are points of referral and support for complex clients with co-morbid psychosocial, mental health and medical needs that cannot be met by their local GP. Approximately 5-10 per cent of clients in the ORT system may require specialist support during their time in therapy. The five SPSs provide quality clinical services but cater for only 1% of the total ORT client group. An original key service requirement for SPSs was to engage with community ORT providers in shared-care arrangements and provide secondary consultation and training. These requirements have mostly been unrealised. These specialist services are currently being reviewed with a view to better inform the area based model into the future.

In addition to SPSs, some specialist treatment for the ORT client group is provided within the Victoria's alcohol and drug treatment system, including community health services. The review of the SPSs will also consider the role that the broader AOD treatment sector plays in the provision of pharmacotherapy services.

Part Two: The case for change

2.1 Alcohol and Drug Reform

There is significant work occurring within the Victorian Government, to address risks and harms associated with alcohol and other drug use. These initiatives will inform and enhance the whole of system response to pharmacotherapy and include:

- New Directions for AOD treatment services: a roadmap - June 2012 arising from the Victorian Auditor-General's 'Managing Drug and Alcohol Prevention & Treatment Services' report (March 2011)
- Whole of Government Victorian AOD Strategy
- AOD Workforce Strategy; and
- Revision of the Department of Health Policy for Maintenance Pharmacotherapy for Opioid Dependence.

Within the AOD Treatment Reform, pharmacotherapy is seen as a distinct treatment type. The reform of the AOD treatment system will address client pathways and support access across the service system. It is therefore important that whilst enhancing the pharmacotherapy system, pathways to other treatment types are also improved. Area based pharmacotherapy networks will be established and evolve alongside this reform process.

2.2 Victorian Pharmacotherapy Review 2010

The Victorian Pharmacotherapy Review (2010) was commissioned by the Victorian Government in response to reports of escalating service demand and decreasing access to community pharmacotherapy. These reports came from a range of key stakeholders including community based ORT providers, consumer groups, alcohol and other drug (AOD) agencies as well as other health and welfare agencies. Departmental data increasingly supported these concerns also.

In 2010 the National Drug and Alcohol Research Centre, University of New South Wales (NDARC) reviewed pharmacotherapy services in Victoria. The review involved comprehensive consultation with stakeholders across the pharmacotherapy and addiction medicine sectors. The review identified the need to strengthen the specialist pharmacotherapy component within the system; to further develop partnerships between specialist and community-based providers; to build workforce capacity; and to provide options for responding to treatment needs in the context of escalating demand.

The Pharmacotherapy Review found broad support for the community based model but noted the Victorian ORT system was fragmented and fragile. Rapid growth had resulted in a lack of service integration therefore the recommendations called for greater cohesion and coordination of services. The full review report can be found at:

[http://docs.health.vic.gov.au/docs/doc/C888C124C72245AACA2578B1007BFF94/\\$FILE/Pharmacotherapy%20Review.docx](http://docs.health.vic.gov.au/docs/doc/C888C124C72245AACA2578B1007BFF94/$FILE/Pharmacotherapy%20Review.docx)

As part of the 2011-12 State Budget the Victorian Government announced funding of \$11 million over four years for additional support to service providers in order to improve access for clients to ORT treatment. This effectively doubles the Victorian Government's existing budget for pharmacotherapy in Victoria.

2.3 Reasons for reform

Over recent decades any changes to the Victorian ORT system have been a pragmatic response to the need for rapid service expansion. The community-based model has been maintained and complemented by a range of specialist support services. The uptake of ORT by the community and private sectors was rapid from 1985-2000 and during this time the Victorian ORT service model was able to meet the needs of ORT clients and providers.

However during this period there were fewer clients in total and an even smaller number requiring specialist services. There were also fewer ORT medications available and GPs and community pharmacists had greater capacity to absorb the increasing demand.

The limitations of the current system are primarily due to the rapid growth experienced over the past 6-7 years. In addition, the emerging issue of pharmaceutical opioid dependence has placed additional pressure on the system and introduced a new cohort of clients.

Of further concern is the number of opioid users who are not yet engaged in pharmacotherapy or those who have previously attempted ORT. These client groups may benefit from participation in ORT and would likely engage if the system was more accessible. There is also a need for better consumer involvement to develop an enhanced 'client-centred' service system.

Limitations of the current system

- Insufficient treatment places due to limited number of GP prescribers and pharmacy dispensers
- Poor referral and support pathways between specialist and primary care
- Limited workforce development opportunities and support
- Varied quality of care provided, depending on provider
- Limited access to specialist system
- Limited options to consider reduction regimes
- Limited mentoring and support available for community based ORT providers
- The administrative systems for managing data and permits viewed as cumbersome
- The large increase in the use of S8 prescription and OTC opioids due to ill-informed prescribing practices potentially increasing the number of people who are medically dependent on opioids.

Part Three: Future Directions

3.1 Taking a whole system approach

The pharmacotherapy budget initiatives announced as part of the 2011-12 budget will enhance the existing community based approach by addressing identified limitations and building an integrated, robust and sustainable system that is complemented by quality specialist care.

To ensure a continued and consistent state-wide response including support for local areas, it is proposed to develop area-based pharmacotherapy networks that build a community of practice providing 'wrap-around' support for local prescribers, pharmacists and treatment.

3.2 Area- based pharmacotherapy networks

The development of area-based pharmacotherapy networks has been informed by the principles underpinning the formalised state-wide clinical networks to ensure a more consistent approach in connecting care, driving best practice and improving client outcomes. The networks will contribute to an enhanced role for general practitioners, particularly in rural areas and access to specialist support at the local level will be improved through an integrated service system and effective communications.

The pharmacotherapy networks will constitute a platform for formalised partnership arrangements between pharmacotherapy providers. They will aim to enhance access to pharmacotherapy, improve service coordination including referral pathways to specialist services and build capacity of the associated workforce. It will be important that each network operates within a harm minimisation framework, is committed to the community based pharmacotherapy model and is focussed on improving client outcomes. The networks will be underpinned by common aims and objectives as follows:

Aims	Objectives
<p>Clients</p> <p>Improve the overall health and wellbeing of pharmacotherapy clients by reducing drug use, reducing drug related harms and enhancing community participation, social connectedness, lifestyle stability and productivity.</p>	<ul style="list-style-type: none"> ▪ Improve access to pharmacotherapy by increasing the number of community based and specialist pharmacotherapy providers. ▪ Provide high quality localised clinical and specialist care by improving ORT provider and client access to specialist advice and secondary consult through an integrated service system.
<p>Services</p> <p>Enhance service integration, coordination, referral pathways and collaboration between community based and specialist ORT providers, and the broader AOD treatment sector.</p>	<ul style="list-style-type: none"> ▪ Improve client care pathways and enhance relationships, particularly between community based and specialist ORT providers, AOD services and other allied health services. ▪ Establish and enhance more effective and continuous working relationships between local AOD service providers, health services and community based ORT providers ▪ Actively work with relevant stakeholders to reduce inappropriate variation from evidence-based practice i.e. issues associated with long term prescribing of S8 prescription opioids
<p>System</p> <p>Reduce the vulnerability of the community based pharmacotherapy system by adopting and maintaining a robust and sustainable whole of system approach linked to the AOD treatment sector reform.</p>	<ul style="list-style-type: none"> ▪ Liaise with contracted GP and Pharmacy training providers and promote access to regular and accredited education and training for Opioid Replacement Therapy providers ▪ Provide clinical leadership, advice, influence, peer support and mentoring to GP's, pharmacists and other health providers to improve clinical care and service delivery of ORT. ▪ Provide and distribute advice regarding clinically based practice of ORT and other prescription opioids. ▪ Provide a forum for forecasting and planning future need and mitigating risk across the local service system

3.3 Network areas

Victorian ORT client demographics in each DH region have been analysed to inform the proposed boundaries of each network area. The proposed pharmacotherapy network areas are based on the percentage of ORT clients within the area, are aligned with Medicare Locals boundaries and the Department of Health regions. Emerging needs and gaps in service provision will be further analysed once networks are established, to ensure a 'local solution to local needs' approach. It is proposed that the following DH regions will form the pharmacotherapy network areas. A map of these proposed areas is available in **Figure 2** and **Figure 3**. A further breakdown of these areas to illustrate alignment with Medicare Locals, Primary Care Partnerships and Department of Health regions is at **Figure 4** and **Figure 5**.

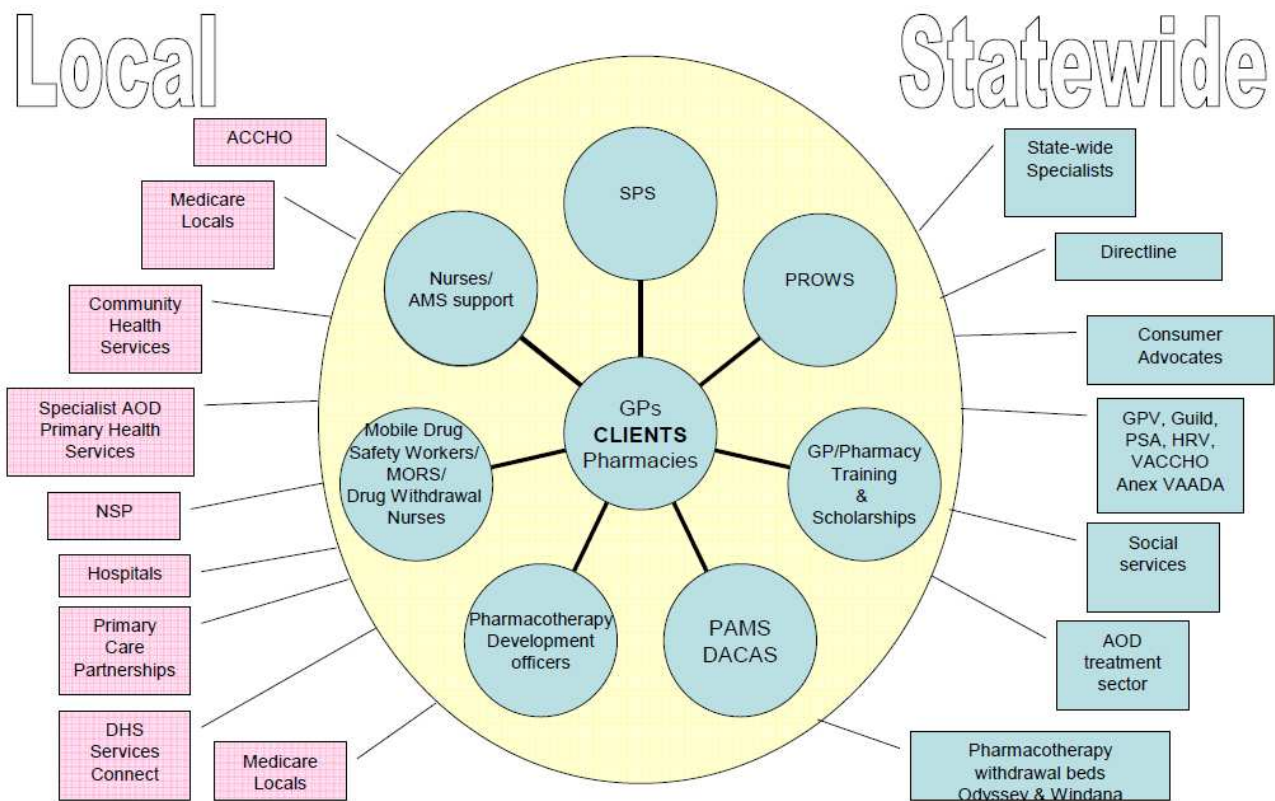
- Area 1 – Barwon South West
- Area 2 – Grampians and Loddon Mallee
- Area 3 – Hume and Gippsland
- Area 4 – South and East Metropolitan areas
- Area 5 – North West Metropolitan area

3.4 Conceptual model

The reformed approach for the pharmacotherapy area based model will further support and enhance the community based system, with pharmacies and general practitioners continuing to play the central role in providing treatment. The model will recognise and facilitate more effective use of the existing resources supporting the pharmacotherapy system. This includes exploring how existing resources can be better utilised to support pharmacotherapy clients and includes: Pharmacotherapy Advocacy Mediation and Support Service, Pharmacotherapy Regional Outreach Workers, pharmacy and GP training, Mobile Drug Safety Workers and Mobile Overdose Response Services.

In addition, there are services at statewide and local level, that may not necessarily provide direct support to the pharmacotherapy system, but are closely aligned and respond to the various needs of pharmacotherapy clients. This includes the broader AOD treatment sector, hospitals, specialist AOD primary health services (SAPHS) and more broadly social services (such as housing). Where possible, these services will be identified and better integrated as part of the area based model to ensure better linkages with the broader supports that are already available to pharmacotherapy clients.

This conceptual model for pharmacotherapy services in Victoria is diagrammatically represented below:



3.5 Governance

Governance structures

A governance structure that provides consistent state-wide direction, area-based service delivery and coordination is required to support the pharmacotherapy networks. Effective governance will require the networks to have strong leadership and sound strategy; clear understanding of respective roles and responsibilities; effective management and monitoring of the network's performance; and clear systems of accountability and supporting structures.

It is proposed that the governance structure for the networks incorporates a systems integration approach enabling stakeholders from different areas of the ORT service system to work in partnership. This will establish best practices for client engagement and provide integrated assessment, treatment, referral pathways and intervention, ongoing support and wrap around support and mentoring structures for community based ORT providers.

Pharmacotherapy networks will be delivered by organisations that demonstrate local knowledge and an ability to facilitate strategic partnerships to affect change. Selection of pharmacotherapy network providers will be undertaken through a Request for Tender (RfT) process. Organisations submitting a proposal responding to the RfT may choose to partner together to best utilise the existing infrastructure within the given area and to ensure that all the services required of pharmacotherapy networks can be offered across the entire area,

Network area teams

The core of pharmacotherapy services will be organised through a team structure in each of the five network areas. These pharmacotherapy network teams will be configured to include existing resources (which may need to be realigned to better fit the model) and new resources funded through the 2011-12 budget allocation to pharmacotherapy services. Exact team composition may vary depending on the specific needs and requirements within each network area and will be further informed by the submissions received as part of the RfT process.

<p>Area 1: Regional</p> <ul style="list-style-type: none"> •Barwon South West <p>Host agency</p> <ul style="list-style-type: none"> •TBA (subject to RfT) <p>New resources</p> <ul style="list-style-type: none"> •Team Leader •Nurse <p>Realignment of existing resources</p> <ul style="list-style-type: none"> •PROW •MDSW <p>Budget responsibility</p> <ul style="list-style-type: none"> •Addiction Medicine Specialisation budget •Scholarship budget •Operational costs/ annual FTE budget 	<p>Area 2: Regional</p> <ul style="list-style-type: none"> •Grampians/ Loddon Mallee <p>Host agency</p> <ul style="list-style-type: none"> •TBA (subject to RfT) <p>New resources</p> <ul style="list-style-type: none"> •Team Leader •Nurse <p>Realignment of existing resources</p> <ul style="list-style-type: none"> •PROW •MDSW <p>Budget responsibility</p> <ul style="list-style-type: none"> •Addiction Medicine Specialisation budget •Scholarship budget •Operational costs/ annual FTE budget 	<p>Area 3: Regional</p> <ul style="list-style-type: none"> •Hume/ Gippsland <p>Host agency</p> <ul style="list-style-type: none"> •TBA (subject to RfT) <p>New resources</p> <ul style="list-style-type: none"> •Team Leader •Nurse <p>Realignment of existing resources</p> <ul style="list-style-type: none"> •PROW •MDSW <p>Budget responsibility</p> <ul style="list-style-type: none"> •Addiction Medicine Specialisation budget •Scholarship budget •Operational costs/ annual FTE budget 	<p>Area 4: Metro</p> <ul style="list-style-type: none"> •South-East Metro <p>Host agency</p> <ul style="list-style-type: none"> •TBA (subject to RfT) <p>New resources</p> <ul style="list-style-type: none"> •Team Leader •Nurse <p>Realignment of existing resources</p> <ul style="list-style-type: none"> •PROW •MDSW •MORS <p>Budget responsibility</p> <ul style="list-style-type: none"> •Addiction Medicine Specialisation budget •Scholarship budget •Operational costs/ annual FTE budget 	<p>Area 5: Metro</p> <ul style="list-style-type: none"> •North-West Metro <p>Host agency</p> <ul style="list-style-type: none"> •TBA (subject to RfT) <p>New resources</p> <ul style="list-style-type: none"> •Team Leader •Nurse <p>Realignment of existing resources</p> <ul style="list-style-type: none"> •PROW •MDSW •MORS <p>Budget responsibility</p> <ul style="list-style-type: none"> •Addiction Medicine Specialisation budget •Scholarship budget •Operational costs/ annual FTE budget
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A new team leader role will be created for each of the network areas, to manage the team and budget, and lead a strategic response to the specific needs identified in the network area. Initially these positions will need to configure and implement the team structures according to local need and available resources. In discussion with the Department of Health, they will also have the ability to broker state-wide training resources based on local demand.

Resources will be made available to enhance clinical support in the network area teams and facilitate close working relationship with the specialist pharmacotherapy services (options available will be informed by the outcome of the SPS review).

In addition, existing positions will form part of the teams (and may potentially be realigned). These include:

- Pharmacotherapy Regional Outreach Workers
- Mobile Drug Safety Workers
- Mobile Overdose Response Service Workers
- Possibly Home Based Drug Withdrawal Nurses
- Possibly Hepatology Nurses
- Possibly Commonwealth-funded nursing support

The network teams may be virtual teams, which may involve some or all of the positions within the team being physically spread across the network area. Equally, the teams may be physically located together within a specific host agency. Team locations and configuration will be determined based on specific network area needs and identified gaps in service provision, and will be informed by the submissions received in response to the RfT.

Time to fully consolidate the existing resources may vary for different network areas. It is expected that there may be different phasing periods for different area networks. With support from the Department of Health, it will be the responsibility of the team leader to consolidate and manage the teams and to ensure that the teams are well interconnected with relevant local and state-wide services. Brief descriptions of the current positions proposed to be included in the network team structure are below.

Pharmacotherapy Regional Outreach Worker (PROW) Program

The PROW program was implemented in 2001-02 (originally called the Methadone Regional Outreach Worker Program) in response to an identified need to support rural GPs and pharmacists. The role of PROWs is to promote the use of ORT, to develop local and regional partnerships between GPs, Divisions of General Practice pharmacists and drug treatment services which in turn should increase client access to treatment. PROW's are located in the following agencies in Victoria:

- Barwon Health
- Bass Coast
- Bendigo Community Health Service
- Gippsland Lakes Community Health
- Latrobe Community Health Service
- Ovens and King Community Health Service
- South West Healthcare
- Sunraysia Community Health Service

Mobile Drug Safety Workers

Mobile Drug Safety Workers (MDSW) provide education and advice on drug safety; distribute sterile injecting equipment; respond to overdose events by providing resuscitation and first aid; and refer users for treatment and rehabilitation. MDSW target adult injecting drug users and clients of the Needle Syringe Program (NSP) in areas of high levels of street drug use, who have recently experienced an overdose. Referrals to MDSW services are generally self referred or received from other users, NSP and health services, support and user groups, or friends and families. MDSW are funded by the Victorian Government and are based at a NSP service in each region or at a drug treatment service with outreach and NSP distribution functions in those rural regions where no NSP service exists. MDSW are located in each Department of Health metropolitan and rural region across the State and in drug 'hot spots'. The MDSW services are provided by nine agencies as either full time or part time positions.

Mobile Overdose Response Services

The Mobile Overdose Response Services (MORS) provide an immediate, street based, mobile response to heroin overdoses. The MORS are funded by the Victorian Government to offer non-fatal overdose survivors support, information and assistance with access to treatment services. The MORS target individuals in areas of high levels of street drug use, who have recently experienced a non-fatal overdose. The MORS were established in identified 'hot spot' areas in metropolitan Melbourne that were experiencing high levels of street drug use, including the Melbourne Central Business District (CBD), Box Hill, Dandenong/Springvale, Footscray, Collingwood/Richmond, and St Kilda. Five groups of agencies operate MORS workers as either full time or part time positions.

3.6 Anticipated short, medium and long term outcomes

Short term outcomes (2012-2013)	Medium term outcomes (2014–2017)	Long term outcomes (2018-2022)
2012-model development, including KPIs and governance arrangements 2013-model commissioning and roll-out 2013–evaluation framework developed/ commissioned	2013/14-consolidation of teams 2013/14-alignment with recommissioned AOD treatment system 2014-each network team to develop and implement a local strategy/action plan 2014–commencement of evaluation 2015-monitoring progress against KPIs and model adjustment to meet emerging needs	Ongoing monitoring of system responsiveness to client needs Responding to emerging needs Adopting latest best practice clinical approach
Monitor real impact on practice, partnerships in regions, engagement of GPs and Pharmacies, linkages to broader AOD treatment sector and alignment with the Victorian AOD Strategy.		

3.5 Evaluation of networks

The Department of Health intends to evaluate and monitor the pharmacotherapy networks, to ensure they effectively deliver the aims and objectives of the initiative in the context of the broader AOD treatment reform.

3.6. Next Steps

There will be a request for tender process to establish pharmacotherapy networks based on the model parameters outlined in this paper, with the overarching objective to support GPs, link in to specialist provision including addiction medicine specialists, and work with treatment providers to co-ordinate care and recovery pathways for clients. Potential consortia and network partners within the new Pharmacotherapy Area Based Model are:

- GPs, Pharmacists, Medicare Locals
- Community Health Services
- Hospitals
- Medicare Locals
- Consumer advocates
- AOD Services

All model proposals will be invited. This may be a submission or consortium per network area, a submission or consortium for a number of network areas or a submission or consortium for all five areas. Assessments will be based on the strengths and weaknesses of the proposals received in achieving the desired outcomes.

Figure 2: Map of boundaries for Rural Pharmacotherapy Networks

Proposed Rural Pharmacotherapy Network Areas

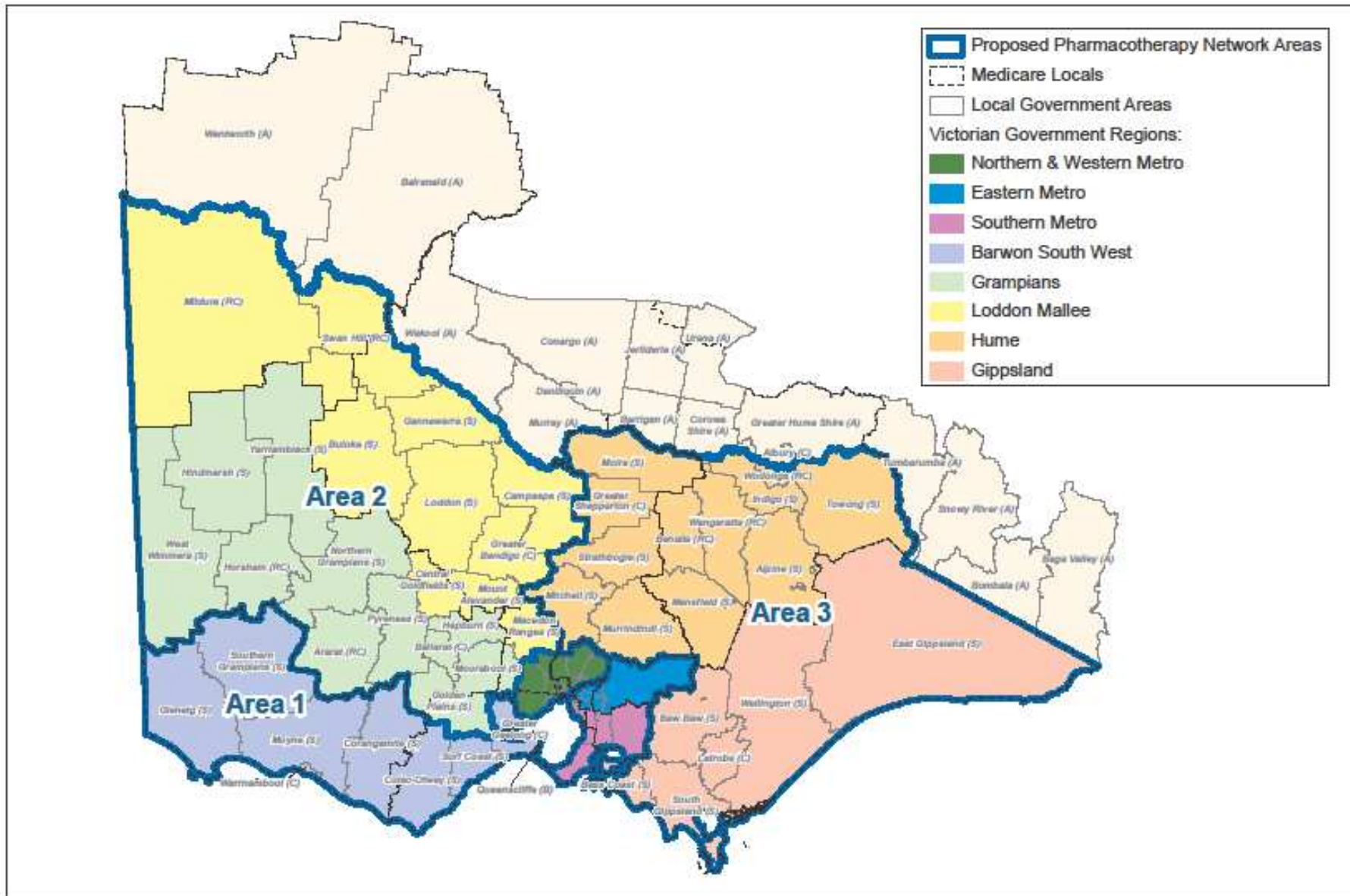


Figure 3: Map of Metropolitan Pharmacotherapy Network

Proposed Metro Pharmacotherapy Areas



Figure 4: Medicare Locals, Primary Care Partnerships and Department of Health Regions - Regional Victoria

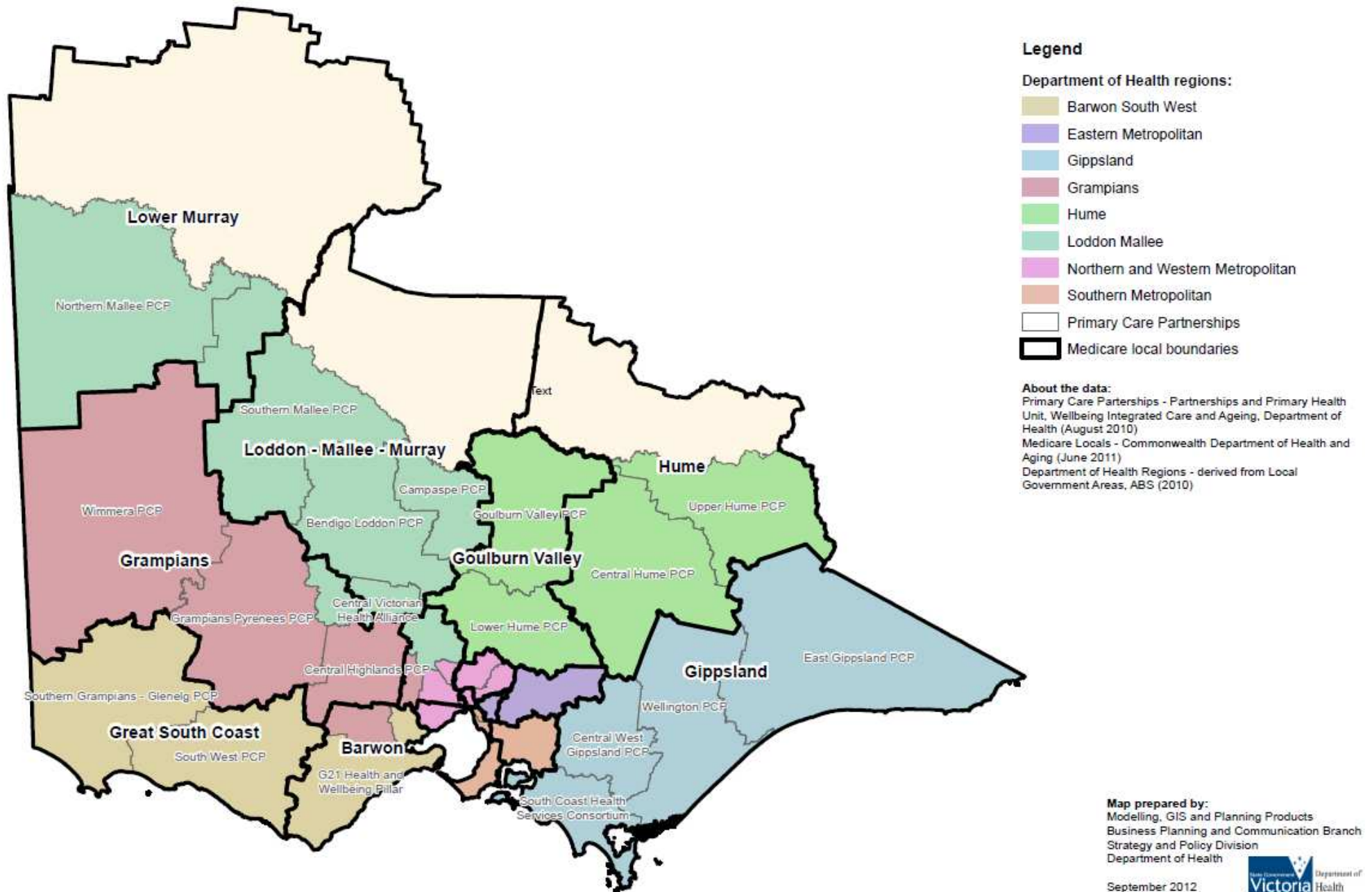


Figure 5: Medicare Locals, Primary Care Partnerships and Department of Health Regions – Metropolitan Melbourne

