PHNs—will they be good for our health?

representing consumers on national health issues
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PHNs can be game-changers if consumers are in the team

Leanne Wells

From a consumer’s perspective, the replacement of Medicare Locals with the Primary Health Networks has drawn little enthusiasm. Perhaps this is because the consumer movement and the community have not generally understood their role.

Ask consumers if they would like a regional organisation with deep knowledge of local health care needs and the responsibility for planning and purchasing tailored health care solutions, then the response might be different.

Ask consumers whether they would like to be co-designers of local health care sitting alongside clinicians — and to be supported to fulfill that function — then the promise that PHNs represent for consumer-led health system improvement and innovation might even be met with exuberance.

CHF is devoting this issue of Health Voices to PHNs because, like it or not, these entities are the next big thing in primary health care and, not least, because of the lack of knowledge, let alone debate, about the future of localised, coordinated health care.

The articles reveal a variety of perspectives dealing with one of the most potent and perplexing areas of modern health policy, whether it be consumer engagement, the GP’s role, patient-centred systems, patient safety or the private sector role, and how these function in primary health care.

Minister for Health Sussan Ley says that neither of the previous structures divisions of general practice and Medicare Locals provided the right mix of functions and the right balance of input from health professionals and patients, to achieve the desired results. She says the end game is for an organisation to be charged with improving patient outcomes through working collaboratively with health professionals and services to integrate and facilitate a smooth patient experience.

Shadow Health Minister Catherine King says Labor has significant reservations about the privatisation of the PHNs and their becoming merely commissioning services, not real drivers for reform. There are concerns, she says that the PHNs are “a sure fire way of introducing a two-tiered health system that costs more and breaks up Medicare”.

Greens health spokesman, Senator Richard Di Natale, says: “The losers from another botched health reform are consumers and patients who, yet again, will be forced to navigate through a large, complex and uneven ‘network’.”

Health Voices finds there is considerable support for strong consumer and community engagement despite indications by the Government of a more GP-focused structure to replace the Medicare Locals. While clinical leadership is important, equally, if not more so, are the insights and experiences of those who use the service system.

Long-time advocate of primary health care reform, Dr Diana O’Halloran, says the evidence is growing that patient-centred systems can achieve the quadruple aims of enhancing patient experiences, improving population health outcomes, reducing costs and increasing provider satisfaction.

The PHN transition, Dr O’Halloran says, highlights the need to return to questions about values, core drivers and principles that should apply in our health system. The principles espoused by her Western Sydney Medicare Local include: consumer and community engagement and consultation, individual and family capacity building and prevention and early intervention.

She calls for a resumption of federal, state and territory dialogues about how best to ensure an integrated, equitable and cost effective health system for all Australians.

Dr Frank Jones, president of the RACGP states that the college’s “first principle” for PHNs is recognition of the central role that GPs and their teams have in patient care.

PHNs will need to foster “true integration between primary health care providers and other sectors such as hospitals ...” There is real opportunity, he says, to reduce duplication and fragmentation, “working in true collaboration with general practice”. CHF agrees there is real opportunity. The challenges and opportunities are many, not least of which is how to achieve a fully integrated system that engages GPs in leadership roles for which the typical time-poor GP may not have the time, qualifications or desire for. PHNs must invest in supporting clinical leaders — both GPs and others. Equally, they must invest in ‘expert patients’ programs so that consumers can be an equal part of local teams designing new health care solutions.

Stephen Duckett says preparatory documents about the PHNs tend to give more emphasis to clinical engagement than community engagement. However now is the time for consumers to identify what engagement they would like with PHNs and how they would like to shape strategies with the new PHNs, he says.

Community health leader Lyn Morgain, says the twin advisory structures proposed for the PHNs would seem to embed the divide between providers and users of services. But to be locally relevant, accountable and responsive in partnership with consumers, she says PHNs will need to support communities and consumers to play effective roles in shaping interventions. And likewise GPs and other health professionals leading clinical councils would need resources to
understand the need for active consumer participation, Ms Morgain says.

Public health leader Helen Keleher, says there are promising practices in consumer engagement that will inform the PHNs, such as monitoring and accountability for benefits to consumers.

Primary health care researcher, Lesley Russell, writes that whether PHNs will meet community needs or whether they will be constrained by red tape, financing and turf wars will in part depend on the extent to which they are patient-focused, have informed input from stakeholders and can build on previous work of Medicare Locals.

The value of embedding effective consumer engagement in the commissioning of health services has been demonstrated in England, say Paresh Dawda and Angelene True. We need in Australia a system where consumers can plan their care with people who work together “to achieve the outcomes important to me”.

Bupa CEO, Dwayne Crombie, also espouses more integrated care in partnership with local communities and providers. Bupa does not see a need to fund primary care services Medicare already looks after, he says. However there are areas where Bupa could supplement what is already available, such as health promotion, disease prevention, and chronic disease management and other programs that would help reduce unnecessary hospital stays.

Associate Professor Meredith Makeham suggests we have a fresh opportunity to reflect how the new organisations will improve effectiveness and safety of medical services for patients, particularly those at risk of poor outcomes and improve coordination of right care in right place at right time.

Primary care in Australia however has a major gap in patient safety, where practitioners could report “near misses and incidents” and learn from each other about mistakes, she says. Is there a role for PHNs to facilitate this?

Medicare Local CEO Deb Dutton says it is important that the PHNs believe that patients are always at the centre of the health system while a major aim is for PHNs to support GPs as the cornerstone of primary health care.

CHF representative Alison Marcus says the PHN development poses many questions about the future response to everyday health needs, such as access to allied health services and patient costs. “Most of all, how will we know when it is working for us?”

Possibly one of the least understood aspects of PHNs is their commissioning role. As Stephen Duckett outlines, this is the core function. It involves distinct steps including identifying needs, deciding priorities, making decisions about what new services need to be purchased and/or what services or aspects of the local health system should be redesigned, procuring the service and monitoring the contract.

We should expect to see comprehensive involvement of consumers in all stages of the commissioning cycle.

In several examples of primary health care organisations from around the globe, patient focus and strong clinical leadership are key shared characteristics. Building on their forerunners, Australian PHNs carry great promise as integrators of care if they adopt these hallmarks along with other key capabilities.

It is critical that PHNs establish good practices early as to how they involve consumers and patients in governance and operations. A standards-driven approach should be adopted to assure sophisticated and comprehensive models. At the very least, PHNs should be held to National Safety and Quality Health Service Standard 2 : Partnering with Consumers.

CHF cautions that the PHN structural reform in primary health care alone is not sufficient. However, with the right conditions, right patient and clinical engagement and a permissive policy climate, PHNs have the potential to be game changers in our health system. For CHF’s part we will work with the Government and PHNs to ensure that sophisticated, evidence-based programs are in place to make sure that the consumer voice and experience of care is centrally involved in planning and decision making. Equally importantly, we’ll work to ensure that the right measures of performance are in place so that consumers and the community can be satisfied that PHNs are achieving on key fronts. Are they contributing to a better integrated system? Are they sufficiently supporting patient self-management? Are they following sound consumer engagement and participation practices?

Leanne Wells is the new CEO of the Consumers Health Forum of Australia. She was previously CEO of the ACT Medicare Local and served as CEO of the Australian General Practice Network and as Transitional CEO of the Australian Medicare Local Alliance. Ms Wells has been a senior public servant in health, family and aged care portfolios. She is a member of the Australian Institute of Company Directors and the Australian Institute of Management.
PHNs offer a vital foundation to a healthier future

Sussan Ley

Since my appointment as Minister for Health and Minister for Sport, I’ve been travelling the country talking to a wide variety of health professionals and patients to discuss their views and ideas about how best to ensure our health system remains world-class for generations to come.

Always at the centre of these discussions is the most important part of our health care system – the patient.

I am a strong believer in the essential role preventative health plays in keeping us happy and healthy in our daily lives, as well as the importance of being able to access high-quality care and treatment when we need it.

I also believe the fact we’re living longer as a result of these ongoing health advances should be celebrated, rather than seen as a negative burden on the health system.

However, as we all understand from running our own budgets - whether it’s a small practice, a large hospital or the nation’s finances - we also need to ensure we spend wisely to ensure we get maximum benefit for patients and health professionals from our investment.

This can be a difficult balancing act to get right, particularly in such an important public policy area like health that interacts with the daily lives of all Australians.

It is certainly something that I come across regularly as a regional MP representing a third of NSW, where health issues vary as widely as the size of the cities and small rural and remote communities throughout my electorate.

That’s why I’m determined to deliver on my promise to be a consultative Minister for both Health and Sport and get out there on the ground talking to people at the coalface.

I want to ensure the Government has a clear understanding of the challenges currently facing the health system and how we can improve on them for the benefit of health professionals and patients alike.

A key part of this from a Federal Government perspective includes the establishment of Primary Health Networks from 1 July.

What I know from speaking with patients and health professionals is that everyone is best served when people receive health care earlier.

This is the core work of a primary health care team. Early intervention to ensure patients receive the right care, in the right place at the right time to keep them happy, healthy and out of hospital.

Primary Health Networks will include a broad range of highly skilled health professionals including GPs, pharmacists, psychologists, physiotherapists, dieticians and many other trained health professionals to provide primary health care.

New and innovative models for funding and delivery of primary health and medical services can improve coordination of patient care across services to ensure money is focussed on keeping people well.

These are not new ideas. Steps have been taken in the right direction, with the previous development of Divisions of General Practice and then Medicare Locals to coordinate primary health care at a local level.

Neither of these structures, however, provided the right mix of functions and the right balance of input from health professionals and patients, to achieve the desired results.

At the end of 2013 Australia’s former Chief Medical Officer, Professor John Horvath, was commissioned to oversee an independent review of Medicare Locals.

The chief finding of the review was that “patient outcomes can be improved by an organisation that reduces fragmentation of care”. While some Medicare Locals were doing a good job, the review said many were not.

As a result, many patients were still experiencing fragmented health care that negatively affected their health and at the same time, increased costs to the health system.

The review said there was a genuine need for an organisation to be charged with improving patient outcomes through working collaboratively with health professionals and services to integrate and facilitate a smooth patient experience.

The Australian Government is taking up the review’s suggestion for a new network of local bodies to guide primary health care. Unlike Medicare Locals, the new Primary Health Networks (PHNs) will be aligned with existing Local Hospital Networks, with the flexibility to suit local needs.

I recently announced the successful applicants for 28 of the new Primary Health Networks.

Many of the successful 28 applicants are consortia of both Medicare Locals and private organisations including universities, private health insurers and health providers.

The involvement of the private sector will support the delivery of innovative approaches and further encourage collaboration within the sector.

The 61 Medicare Locals will cease on 30 June 2015, and PHNs will begin the next day.

PHNs will work directly with GPs, other primary health care providers, secondary care providers, hospitals and the broader community to ensure improved outcomes for patients.

Funding will be focussed on frontline services and on the people who provide those services.
They will increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes.

In addition to their work for all patients, the Government will give PHNs six priorities for targeted work. The priorities are:

- mental health
- Aboriginal and Torres Strait Islander health
- population health
- health workforce
- eHealth
- aged care.

PHNs will be advised by GP-led Clinical Councils and Community Advisory Committees. This structure will give each PHN board a direct link to both health professionals and community representatives, ensuring that they are informed and focussed on the health needs of local communities.

As well as GPs, the Clinical Councils will include other health professionals such as allied health and community health practitioners, pharmacists, specialists and hospital representatives.

Patients will also have the opportunity to have their say, with Community Advisory Committees to advise PHN Boards from the patient perspective. This different perspective will ensure decisions, investments, and innovations are cost-effective, relevant and likely to be beneficial to local patients.

PHNs will also collaborate with other key health groups, such as Local Hospital Networks, to ensure that health services are working together with maximum benefits for their clients.

The introduction of the PHNs will be a solid step forward in the reform of the Australian health system. It will result in better primary care for all Australians — a vital foundation to a healthier future for us all.

Sussan Ley was appointed Minister for Health in December 2014. Before entering Parliament in 2001 as MP for Farrer, Ms Ley held a variety of occupations, including as an air traffic controller and commercial pilot and as an Australian Taxation Office employee.

She has been a Parliamentary Secretary for Children and Youth Affairs and for Agriculture, Fisheries and Forestry. In Opposition, she held a variety of shadow portfolios including Women, Customs and Justice, Assistant Treasurer, Employment Participation and Childcare and Early Childhood Learning.

On returning to Government in 2013, Ms Ley was appointed Assistant Minister for Education with responsibility for childcare, a position she held until her appointment as Health Minister.

After Medicare Locals, PHNs face twice the challenge

**Catherine King**

In a Budget that will stand for years to come as the benchmark for terrible health policy, one decision that has not attracted as much attention was the axing of all 61 Medicare Locals.

Medicare Locals form a key part of the architecture of the significant health reforms introduced under the former Labor government. Achieving better integration, closing service gaps and reducing avoidable hospital admissions.

It’s a decision that on our estimates will cost around $200 million in wind-up and transition costs for no appreciable gains.

As is common with just about every change the Abbott Government sought to make in Health in the 2014 Budget, Medicare Locals were scrapped in spite of evidence they were working.

As Professor John Horvath’s review found, Medicare Locals were substantially doing precisely what Labor established them to do — provide for the first time a mechanism for the Commonwealth to directly support the integration between primary care and hospitals, close gaps in service delivery and address population health issues at the local level.

Medicare Locals were identifying specific needs in local communities and planning for services to address the gaps that do exist, such as through the engagement of additional nurses and other allied health professionals at GP clinics, and better provision of after-hours GP services.

Then, despite the Prime Minister standing there staring down the camera in the Rooty Hill debate and promising, hand on heart, none of them would be scrapped, he scrapped the lot.

The government’s new Primary Health Networks are an unknown entity, with tenders set to be awarded shortly.

What is known is there’s only half as many of them, and in some places the area they cover is so massive their capacity for localised responses and services is restricted.

There will only be one PHN for all of North Queensland and only two for the whole of South Australia. One Medicare Local in Western Australia will cover over 99 per cent of the state — attempting to provide the same standard of care for remote settlements in the Kimberley as it does for Kalgoorlie, Broome and the Margaret River.

With many existing Medicare Locals bidding for the new contracts, it should still have been possible for at least some of the good work they had done to be carried over into the new PHNs.
Except, once more, the handing of this transition has been so botched, even this now looks like being lost.

With boundaries not even unveiled until October, and the successful tenders not announced until April, it’s no surprise experienced staff faced with the prospect of being out of a job come July, have left in search of more secure employment, taking with them years of expertise and ensuring the worst possible start for the PHNs. Especially in regional areas, Medicare Locals are struggling to retain the qualified health workforce they have brought to areas that up until that point had limited access to speech pathologists, psychologists and dieticians because there is uncertainty about what positions will be available and what funding will be left once this tender is complete.

Funding for vital Mental Health and Indigenous health services remains in doubt.

Given the turmoil already caused by the government’s breaking of its promise to retain Medicare Locals, and the chaotic handling of the PHN tenders, Labor believes a period of stability is needed. But we will be closely examining the results of these tenders in coming months. Labor does have significant reservations regarding the privatisation of the new Primary Healthcare Networks and their becoming merely commissioning services, not real drivers of reform.

And there are real concerns about just who will benefit most from these PHNs with the government openly encouraging private health funds to bid for the contracts, prompting suggestions they could be used as a back door way to allow private health insurers to start entering primary care—a sure-fire way of introducing a two-tiered health system that costs more and breaks up Medicare.

That is not what Medicare Locals were established to do.

Medicare Locals were established to respond to the specific health needs of local communities, to work as a go-between.

With fewer than half the number of their predecessor, PHNs already have twice the challenge ahead of them to achieve this and with $200 million already spent to downszie them and change their identity it’s hard to see how they can fill the health gaps created by this ill-considered decision to abolish Medicare Locals.

Catherine King, Shadow Health Minister and MHR for Ballarat, was elected to Federal Parliament in 2001. In the previous Labor governments she held a variety of positions including as Parliamentary Secretary in the portfolios of Health and Ageing, Infrastructure and Transport, and Regional Services, Local Communities and Territories. She was promoted to Cabinet in July 2013, as Minister for Regional Australia, Local Government and Territories. She holds a Degree in Social Work and a Masters in Public Policy from the Australian National University and is currently completing a law degree from Deakin University.

We now enter ‘very uncertain terrain’

Richard Di Natale

Primary Health Networks are a creation of the Abbott government. Their Policy to Support Australia’s Health System established a review of Medicare Locals, which had been created under the previous Labor government. Medicare Locals had initially struggled to prove themselves as the hub of local health care, in part because of the confusing health policies of the Rudd-Gillard administration and in part because they were never properly funded and supported to provide the services needed in the community.

Following the review by Professor John Horvath, completed in March 2014, the Abbott government decided to abolish the recently created Medicare Locals and replace them with a smaller number of Primary Health Organisations (PHNs). According to the Government, PHNs would “provide more efficient corporate structures that reduce administrative cost to ensure funding goes to provide frontline services to benefit patients.” PHNs would also “offer savings through economies of scale and greater purchasing power, have better planning capacity and increased authority to engage with Local Hospital Networks (LHNs) and jurisdictional governments.”

This all sounded workable in theory, however as I have brought to light through the Senate Select Committee on Health and through Senate Estimates, the Government’s grand plan for health reform is mired in confusion, poor planning and unknown outcomes, and health care consumers may be worse off as a consequence. There remains a high level of concern among health professionals, practitioners and consumer representatives that the PHN will actually deliver a reduced and inferior service than Medicare Locals.

With PHNs due to begin operating midyear, the Department of Health is still unable to provide satisfactory answers as to how the transition from Medicare Locals will occur. At a recent Senate Estimates hearing (March 2015), the Department of Health gave one of those classic Yes Minister answers on the transition process: “it really depends on what happens, because some of the Medicare Locals will be bidding to become PHNs. Some of the Medicare Locals are not going to...
do that but establish themselves as service providers. Some of the Medicare Locals are going into consulting. There is a whole range of different things happening at the moment so it is quite difficult to say what is happening ...”

We do know that some Medicare Locals will not be successful in their bid to become a PHN. The cost of winding up Medicare Locals means millions of precious health dollars may be expended on paying out leases and salaries. This would be a terrible waste of resources at a time when the Government is running around claiming that the health system is unsustainable. It also creates insecurity among clients and patients who also don’t know how PHN will deliver the services they currently access.

Indeed, abolishing 61 Medicare Locals and replacing them with a smaller number of PHNs is, as one doctor said, “creating nervousness within the sector”. The concerns of those currently working in Medicare Locals involve the paucity of detail about transitional arrangements, and in regional and rural Australia there is a heightened environment of insecurity. No one is absolutely clear about the roles and responsibilities of these new PHNs and how key services—such as mental health, disability, drug and alcohol services, preventative health initiatives and basic primary health care—will be maintained with continuity of care.

Short term contracts and the Government’s decision to provide funding for only a 12-month period to many health NGOs has further undermined the confidence of primary health care providers that they can seamlessly transition to the new PHNs without loss of service. Many of these Medicare Locals cover regional and outer-metropolitan areas where personal relationships and networks have been established. The impact of patients and clients reliant on a range of services seems to be ignored in the Government’s haste to undo Medicare Locals and implement their own brand of health care.

The evidence brought to the Senate Committee on Health consistently argued for a slow roll-out of these ‘reforms’ so that practitioners and their clients can adapt to the new PHNs. The common concern is that continuity of care may be lost and people in need will lose their health services. In rural and remote communities, the coordination between services and agencies is vital in providing proper health care. As one country doctor told the Health Committee “knowing who provides what and for whom” is essential. While this has been managed through Medicare Locals, many doctors and allied health professionals have no clear understanding of how these giant PHNs will manage this.

The sheer size of PHNs, some covering whole swathes of a state, means “knowing who provides what for whom” may become unwieldy, unmanageable and possibly unaccountable. There are giant PHN catchment areas, such as Far North Queensland or Western Victoria, and within these vast regions there are strengths in some areas of health care and weaknesses in others. No one yet knows how the PHNs will overcome the disparity in service provision over such enormous distances. The potential exists for the type of problem Medicare Locals were designed to overcome: duplication in some areas, service gaps in others.

As a former GP who has worked in regional and remote areas, as well as in outer metropolitan areas, I know how vital it is for consumers to know where and how to access services. Health literacy in Australia is already a problem and the creation of large PHNs is likely to further exacerbate the difficulties in establishing linked-up networks of care and coordinated services that manage chronic and other health conditions.

Medicare Locals were by no means the best solution. Some operated very efficiently while others struggled to meet the needs of their community. However, the evidence was that they were certainly improving in coordinating the sectors and services that produced better health care. More importantly, the evidence from health professionals in regional Australia is that Medicare Locals were working well with consumers.

We are now entering very uncertain terrain. The pace of the Abbott government’s so-called ‘reforms’ is not being matched with the detailed planning, funding and coordination needed to meet the needs of consumers. The Department of Health struggles to answer basic questions and the fate of millions of dollars tied up in Medicare Locals remains unclear. The losers from another botched health reform are consumers and patients who, yet again, will be forced to navigate through a large, complex and uneven ‘network’.

Dr Richard Di Natale is a Greens Senator for Victoria and spokesman on health. Before entering Parliament in 2011, he was a general practitioner and public health specialist. He has worked in Aboriginal health in the Northern Territory, on HIV prevention in India and in the drug and alcohol sector.
Shaping our regional primary health networks: what comes next?

Diana O’Halloran

What will our future Primary Health Networks look like? By the time you read this edition of Health Voices, the outcomes of the PHN tender process will be in the public domain, signalling the beginning of what may well be a significant change in the nature of regional primary health organisations: a role currently filled by Medicare Locals (MLs).

We know this because unlike the process by which divisions of general practice transitioned to become Medicare Locals (MLs), the PHN tender process was open to a range of organisations including MLs, Private Health Insurers (PHIs), other commercial entities and state health services.

In consequence, it seems likely that PHNs will be formed by organisations spanning the public, not for profit and commercial sectors, either alone or in partnership arrangements, and while all will be working to the same core Commonwealth objectives, underlying organisational motivations, structures, priorities and strategies may vary significantly.

This substantial shift in national policy directions deserves wide public discussion. Given this, it seems desirable for major stakeholder groups, most importantly consumers and community groups, to re-visit earlier conversations about what they most value in their health system, and specifically what they want to see delivered in primary health care, and through PHNs with their local networks.

The Commonwealth has identified its key PHN objectives to be:

• “increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and

• improving coordination of care to ensure patients receive the right care in the right place at the right time.”

Both levels of government will want to see which PHN models, and which PHN-Local Health Network (LHN) partnerships, can most successfully deliver against these essential objectives, particularly in relation to people with high risk (and high cost), chronic complex conditions. However, this focus comes with an associated risk of continuing under-investment in areas such as prevention, early intervention (especially for the very young) and whole-of-system redesign.

This risk would be significantly reduced by an agreed national framework of health values, goals, policy and principles. Health systems are recognised to function as complex adaptive systems, and the absence of these elements inevitably disturbs stable, efficient system function, especially in the presence of complex commonwealth-state jurisdictional and financing responsibilities.

In late 2012, wide consultation was taking place around our first ever National Primary Health Care Strategic Framework and its associated Commonwealth-state bilateral implementation plans, but from the latter half of 2013, progress appears to have stalled. In these circumstances, the health system’s framework including its core drivers remains uncertain. Does our health system have one, or a number of potentially conflicting...
drivers? If the latter, which predominates: patient-centred care, system efficiency or cost containment? Can they ever be synergistic?

The evidence is growing that when patient centredness is truly central, systems can be re-designed to align to the triple, or more recently, quadruple aims of enhancing patient experiences, improving population health outcomes, reducing costs and increasing provider satisfaction1-4.

Wherever the answers lie, the PHN transition period provides a reason - and a need, to return to questions about the values, core drivers and principles that should apply in our future health system. Meanwhile, despite progress apparently stalling on the national framework, most state governments and many health organisations have developed their own frameworks, with varying degrees of provider, community and stakeholder consultation.

The Western Sydney Medicare Local (WSML) found the process of developing guiding principles to be particularly valuable, as unlike the immutable principles of science, identifying local health system principles involved actively merging individual perspectives on values, evidence and context to form statements which have since proved valuable in guiding board, management and staff decisions, and communicating organisational values and key directions to partners and stakeholders.

WSML’s purpose (and core driver) can be paraphrased as achieving person-centred, wrap around care that is effective, equitable and accessible. Principles link this purpose with organisational values and key directions, and staff decisions, and communicating organisational values and key directions to partners and stakeholders.

An emphasis on prevention and early intervention — especially in the first years of life

Despite the strength of the evidence base, it has been, and likely will continue to be, a challenge to quarantine resources for these critical areas. Achieving gains in early intervention for children at risk for example, takes sustained work with parents and communities, and across services and sectors to strengthen families and influence socio-economic determinants of health. We can and should expect that future PHN-LHN-cross-sector alliances will create the climate required to precipitate sustained government commitment to these foundations of societal good health.

Partnerships and collaborations for comprehensive solutions

The creation of LHNs and MLs has multiplied collaboration at all system levels, and future PHN-LHN relationships provide particularly exciting opportunities to think and behave as if we are one integrated health system, rather than struggling with endless ‘work-arounds’ in our current siloed, fragmented and top heavy edifice. The possibilities are endless, from relocation of hospital based specialist services into new and supportive community based models of care, through to work on duplication, waste and unwarranted clinical variations. A hospital-to-community resource shift and capacity building investment in primary care will inevitably be required for success.

Individual, family and community empowerment and capacity building

MLs have long recognised the need to go beyond medical care for specific conditions, seeking to support GPs and other providers in caring for the whole person according to individual need, while also working to build health literacy, self/family management, and home/ community support systems. At a broader level, collaborative, cross sector strategies engage with communities or community groups: a western Sydney example would be Thrive at Five, but there are many such programs, and while there is a very long way to go, the future is in our collective hands.

Continuing, meaningful consumer and community engagement and consultation

This principle reflects a commitment expected of all MLs, to engage with consumers and community groups in establishing local needs, designing, refining and evaluating programs, and increasingly, in community development and research initiatives. The evidence demonstrating gains from deep community involvement across this spectrum of activities is growing, and PHNs will have great scope to collaboratively advance such processes in the years to come.

Just to complete the set, the remaining WSML principles are:

- Building ‘bottom up’ on what already exists;
- Working across systems and sectors to influence the socio-economic determinants of health;
- Strengthened general practice and primary care quality, capability and connectedness; and
- Teaching and research integrated into health service planning and delivery.

Ultimately, the most significant system limitations, and the power to remove those limitations, lie outside regional systems with governments at both levels, so here’s to restarting those earlier Commonwealth-state/territory dialogues around how best to rationalise jurisdictional responsibilities and minimise cost shifting pressures in the service of an integrated, equitable and cost effective health system for all Australians.

Diana O’Halloran is a general practitioner and Conjoint Professor, University Of Western Sydney. She has longstanding involvements in the evolution of a strong, integrated and equitable primary health care system with quality general practice at its centre. She is the Chair of WentWest, which is both the Regional General Practice Training Provider for Greater Western Sydney and the Western Sydney Medicare Local. This role is complemented by membership of the Western Sydney Local Health District Board which facilitates partnership between the two organisations. She also co-chairs the GP Clinical Advisory Group for the NSW Agency for Clinical Innovation, and is deeply involved in the evolution of initiatives such as HealthOne and NSW’s Integrated Care Program, both of which aim to improve person and family-centred continuing, coordinated care. She has chaired the RACGP’s Presidential Task Force on Health Reform and the NSW General Practice Advisory Council.

1 Primary Health Networks: Grant Programme Guidelines — Department of Health, Dec 2014
3 Bodenheimer, T, Sinsky, C. From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider: Annals of Family Medicine, March/April 13(2), 2015
Primary Health Networks need GPs at core to improve patient outcomes

**Dr Frank R Jones**

A change of government inevitably results in significant reforms to key health policies and as GPs we need to help our patients benefit from new frameworks, while also ensuring governments are held to account to deliver what was promised.

Primary Health Networks (PHNs) are just one of the Federal Government’s new health policies that GPs and other health care professionals are preparing to adapt to. PHNs have the potential to provide communities with improved health care that better meets local needs.

PHNs are the latest iteration following on from the Divisions concept and more recently Medicare Locals. The Federal Government has publically stated that PHNs will put general practice at the centre and align closely with local hospital networks (LHNs) to reduce duplication.

Announcing the PHNs in the May 2014 budget, former Health minister Peter Dutton said they would be “more locally relevant, accountable and responsive” and that in choosing PHN operators there would be a “strong emphasis on minimising bureaucracy and red tape to ensure activities are focused on improving outcomes for patients”.

Improving patient outcomes should be central to any health care reform and the Royal Australian College of General Practitioners (RACGP) is keen to see PHNs meet this aim. To enable this process, it is vital PHNs are appropriately resourced so they can effect and support change reflecting local needs and local demographics.

After evaluating the successes and failures of Medicare Locals and Divisions of General Practice, the RACGP has established a number of principles that should be adopted to ensure the success of PHNs.

The first principle is recognition of the central role that GPs and their teams have in patient care.

At the core of any successful health program is enabling patients to be part of the solution; the GP patient relationship is therefore pivotal to the success of any model in and around community-based care. PHNs will need to acknowledge that GPs and their practices are a patient’s medical home and that GPs are uniquely placed as the coordinators of their care. Any proposed governance structure for PHNs must recognise the lead role of GPs.

 Appropriately skilled GPs with leadership and governance skills must be part of PHN boards. In addition, the clinical advisory councils must have a strong GP presence. GPs live and work within their communities and can reflect local issues.

PHNs must be held accountable to their local communities, working in collaboration with other regional stakeholders to improve patient and community health outcomes. This will be critical in all geographical regions but in particular for those with regional and rural specific needs. Responsiveness and flexibility are critical.

PHNs will need to focus on a region-specific gaps needs analysis, in addition to directing the coordination of services. The RACGP supports the establishment of Community Advisory Committees reporting directly to the board.

Funding for PHNs needs to be in addition to that provided for patient services through Medicare. The RACGP maintains that PHNs should not be responsible for allocating funding to support the direct delivery of services, except as required due to service gaps. These funds are best managed by relevant government departments and providers themselves, including incentive payments for after hours and aged care services delivered by general practices.

PHNs will also need to foster true integration between primary health care providers and other sectors such as hospitals, aged care, palliative care and mental health care. There is a real opportunity to reduce duplication and fragmentation, working in true collaboration with general practice.

The inequalities and health issues faced by Aboriginal and Torres Strait Islander people also need to be directly addressed by PHNs. The RACGP recommends PHNs develop Reconciliation Action Plans in collaboration with Reconciliation Australia. PHNs should also allocate funding annually to initiatives that enhance access to services and promote care coordination for Aboriginal and Torres Strait Islander people.

PHNs will evolve and mature. The RACGP is looking forward to working in a collaborative manner with all PHNs, to improve the health care and health outcomes for all our patients.

**Dr Frank R Jones** was elected President of the Royal Australian College of General Practitioners in October last year. He has more than 30 years’ experience as a GP and is a senior partner at the Murray Medical Centre in Mandurah, south of Perth. He has served as a GP supervisor liaison officer for West Australian General Practice Education and Training (WAGPET), chaired the Medical Advisory Committee (MAC) for Murray District Hospital and assumed the MAC chair at Peel Health Campus during transition to the new health facility. In 2008 he was appointed Adjunct Associate Professor of General Practice at the University of Notre Dame Medical School, Fremantle. He is also a clinical lecturer at University of Western Australia Medical School and has an appointment as a visiting medical officer at Peel Health Campus.

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Dr Frank R Jones

A change of government inevitably results in significant reforms to key health policies and as GPs we need to help our patients benefit from new frameworks, while also ensuring governments are held to account to deliver what was promised.

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Consumer and community engagement in Primary Health Networks

Stephen Duckett

There are two key documents which have shaped the design and implementation of the new Primary Health Networks (PHNs) — the Horvath report and the documents associated with the Invitation to Apply (ITA) for funding as a PHN.

The documents are quite strong on clinician engagement:

I consider it essential that GPs have a significant presence within the corporate structures of any future primary health care entity. My preference is for locally relevant Clinical Councils to be established that have a significant GP presence and broad clinical membership, including from LHNs. These Councils would interact directly with the ...Board. ...The voice and opinions of the Council will directly inform the deliberations of the ... Board on matters such as, local and regional priorities, investment strategies, and primary health care professional and business support needs. (Horvath).

PHNs will establish and maintain GP-led Clinical Councils that will report on clinical issues to influence PHN Board decisions on the unique needs of their respective communities, including in rural and remote areas... Clinical Councils will assist PHNs to develop local strategies to improve the operation of the health care system for patients in the PHN, facilitating effective primary health care provision to reduce avoidable hospital presentations and admissions. Clinical Councils will be expected to work in partnership with LHNs in this regard.

Clinical Councils will also be expected to report to and influence their PHN Boards on opportunities to improve medical and health care services through strategic, cost-effective investment and innovation.

The language is not so strong on community engagement:

Community Advisory Committees, based on the same catchments as Clinical Councils, will provide a community voice into the Board decision-making and activities, particularly in regard to service gaps (Horvath)

Community Advisory Committees will provide the community perspective to PHN Boards to ensure that decisions, investments, and innovations are patient centred, cost-effective locally relevant and aligned to local care experiences and expectations (Funding Guidelines)

The Invitation to Apply implies that both bodies will be influential:

In addition, applicants should outline the framework, reporting obligations and degree of influence of the Clinical Council and Community Advisory Committee on the PHN Board, specifically, how the PHN Board will act on recommendations as appropriate. (Invitation to Apply)

Another important issue is how the new PHNs will operate. The emphasis is that PHNs will principally be commissioning rather than service providing organisations.

The implications for consumers

Although the interests of clinicians and consumers are not necessarily in conflict, the Horvath report and the ITA used much stronger language about clinical compared to community involved. Neither discussed consumer engagement.

What is important for consumers (and communities) is that they seek to have the same level of engagement as clinicians. It could be very easy for PHNs to slip into ‘provider capture’, assuming that providers, such as GPs, speak for and in the interests of consumers and communities.

The IAP2 spectrum

Best practice in public engagement is now influenced by the ‘Spectrum of Public participation’ developed by the International Association of Public Participation (http://www.iap2.org.au/resources/iap2s-public-participation-spectrum). This spectrum provides for five levels of engagement: Inform, Consult, Involve, Collaborate, Empower. The higher levels of the spectrum represent greater levels of public participation and greater levels of engagement. The different levels are associated with different goals and techniques. Consumers (and PHNs) should clarify the goals of consumer engagement for each engagement opportunity.

The commissioning cycle

PHNs are to be principally commissioners — purchasing services from existing (or newly created) providers rather than directly providing services themselves. Commissioning involves a number of distinct steps including identifying what needs to be purchased, procuring the service and monitoring the contract. The commissioning cycle used at Northern Melbourne Medicare Local is shown in the figure.

The commissioning cycle provides a framework for identifying consumer and community engagement opportunities.

The cycle starts with Assessing Needs. At the broadest this is about the PHN identifying what are the critical issues in the area. These might be information flows (hospital to GP in discharge planning), priority populations (people with chronic conditions, early years, domestic violence) or functions (prevention). Consumer and community engagement should be at the higher end of the spectrum at this stage of the cycle.

At other stages of the cycle (e.g. Managing...
(performance) consumer engagement might be at the opposite end of the spectrum. Setting key performance indicators might also be at the higher end, selecting tenders in the middle.

Community Advisory Committees

PHNs are required to have Community Advisory Committees envisaged as being in parallel with Clinical Councils. It is important that PHNs don’t operate as if their Advisory Committees are the community engagement strategy. They should not be. It is better to describe the role of Community Advisory Committees as one of developing and overseeing a consumer and community engagement strategy. The strategy should identify what are the goals of community and consumer engagement at each point of the commissioning cycle. The Community Advisory Committee (and PHN Boards) should receive reports on the nature of consumer engagement.

Next steps

The new PHNs will be developing their strategies in the next few months. Consumer and community groups should be working out what their goals for engagement with the PHNs are. Now is an opportune time for existing consumer organisations (including hospital network consumer advisory committees) to identify what engagement they would like with PHNs and how they would like to shape the consumer and community engagement structures and strategies of the new PHNs.

Stephen Duckett is health program director at the Grattan Institute, an Emeritus Professor of Health Policy at La Trobe University, Deputy Chair of the Board of Northern Melbourne Medicare Local, a former Secretary of the Federal Health Department and former senior executive in health agencies in Queensland and Canada.

Consumers integral to health system planning

Lyn Morgain

Australian health care consumers might be expected to gain considerable benefit from an effective population health planning entity, one that is capable of developing and strengthening the availability, integration and coordination of primary care.

The establishment of the new Primary Health Networks (PHNs) which will replace the Medicare Locals provide an important opportunity to consider the role of consumers in shaping the scope and approach of these new entities.

It is the contention of community health organisations such as mine that this is a task that by its nature requires the comprehensive involvement of those at whom the system is targeted - consumers. The views of policy makers, funders and clinicians are important but they are no substitute for the experience and insight of those who use and rely upon the service system.

Ultimately how efficiently and effectively integration and coordination are able to be realised will depend largely upon the intelligence brought to bear in the task of system analysis, design and reform.

The expectation of the PHN, stated in the PHN Grant Program Guidelines (November 2014) is that they are to be locally relevant, accountable and responsive to regional and local context. Key enablers for this are to be the two structures: a clinician-led Clinical Council and a Community Advisory Committee. From the outset it is clear that there will be considerable variability across the county, since each PHN is free to determine the role these structures have in governance.

The proposed new PHN with twin advisory structures means that clinician’s views will be explored in one forum and the needs and requirements of ‘others’ in another. At best this would seem to have embedded the divide between providers of services and users of them. At worst this avoids the necessity to balance differing perspectives. This also risks missing the opportunity facilitate each learning from...
the full and central involvement of those at whom these approaches are targeted. Evidence from the consumer health movement is clear: that active consumer participation at all levels in the development, implementation and evaluation of health strategies and programs is integral to their success.

Whilst clinicians are vital to the quality of care and have much to contribute to enhancing the efficiency and effectiveness of the system, this knowledge cannot be a substitute for the insight brought to the design process by those with lived experience. Some of the reasons that consumers need to be at the centre of policy are to represent the experience of consumers who are using the systems, to protect the interest of consumers and to ensure systems are accountable to consumers.

To take a strict regulatory approach, Standard Two of the National Safety & Quality Health Service (NSQHS) Standards require that there are ‘Governance structures … in place to form partnerships with consumers and/or carers’. It seems odd that PHNs would be held to a lesser standard.

Fundamentally the key tasks of the PHNs, such as is clear to date, are system-related. They are predicated upon a population level analysis of the nature of the burden of disease, a focus on communities of greatest need and the nature of the need. The related tasks are to plan system reform such as to improve care pathways, coordination, integration, system navigation and model design. By necessity this requires interrogation, reflection and reform. It is vital that consumers are at the centre of this task.

My own organisation has been actively involved in a number of Medicare Locals and are partners in PHN bids. Our strong view is that to realise the stated objectives - locally relevant, accountable and responsive care in partnership with consumers - PHNs will need to:

• Resource and support diverse communities and consumers to play active and meaningful roles in shaping the design, development and delivery of interventions; including consideration of training modules in consumer advocacy and leadership, and consumer advisory committee training workshops as an example;

• Resource and support general practitioners and other health professionals who lead Clinical Councils to understand the need for active consumer participation. This may include the use of good practice examples on how to implement and embed good consumer engagement and community participation within the networks;

• Embed the use of evidence-based models of care or clinical pathways that consider the social determinants of health, particularly through demonstrated engagement with communities;

• Identify high-risk groups and develop appropriate models of care to address and improve system integration in conjunction with local health services and hospital networks;

This is no small task and will require sophisticated and elaborate approaches to consumer participation and community engagement. Nothing less will provide the required experience, insight and initiative for system reform.

Lyn Morgain is Chief Executive of cohealth, one of Australia’s largest community health organisations, servicing Melbourne’s inner northern and western metropolitan suburbs.

In the past 25 years, her interests have included the impact of discrimination and marginalisation on health and the role of advocacy in the development of equitable public policy and consumer led practice. She chairs the National Complex Needs Alliance of the Public Health Association of Australia.
The value of partnership and collaboration in primary health

Helen Keleher

Interest in partnerships and collaboration in primary health is growing, and primary care reforms have embraced ideas about partnerships, collaboration and alliances. Partnerships between health professionals, across sectors and including consumers strengthen the capacity of health service providers to improve health status and reduce health risks.

Partnerships allow health services to create stronger impact and produce results that they could not have produced alone, which strengthen their core purpose. And there is growing evidence of the benefits of consumer involvement.

Examples of Australian best practice

Effective partnerships include collaborative planning, an agreed common agenda and the pursuit of common goals, organisational capacity, partnership competencies, leadership commitment, and sound communication practices to keep people engaged. These key elements are needed to create an environment that has the capacity to manage a partnership relationship over the time it takes to produce results.

Partnerships require backbone support by an organisation dedicated to coordinating the work processes of the partnerships and the collaborators involved in the initiatives. The Peninsula Model for Primary Health Planning (www.peninsulamodel.org.au), driven by the Frankston-Mornington Peninsula Medicare Local, is an exemplar, demonstrating the value that a backbone can provide to achieving outcomes.

The Peninsula Model is a practical example of partnership between health, hospitals and local government that demonstrates how collaborative advantage arises when actions are structured and coordinated across levels of influence and between a wide range of sectors, in a local catchment.

An evaluation conducted in late 2014 of the Peninsula Model showed that critical success factors include:

- robust core structures, processes and common agenda;
- backbone resourcing particularly for the necessary breadth and depth of engagement;
- commitment from partners despite impact of external reforms;
- continuous communication of the vision and ‘wins’ more broadly;
- investment in resources and skills (direct and in-kind).

Another strong partnership has been developed by Inner North West Melbourne Medicare Local, two Community Health Services and Melbourne Health, a major Local Hospital Network in Victoria. Their partnership aims to improve patient care, outcomes and pathways for their shared community.

Both the Peninsula Model and the Inner-North West Melbourne collaboration use a structured partnership as a basis for assessing, prioritising and planning for services to best meet local health care needs. Both partnerships are closely connected to their Local Hospital Network through Primary Care and Population Health Committees. Both partnerships have collaborated effectively on health care pathways, advance care planning, chronic disease management, integrated mental health services, after-hours access, and information technology developments. Through partnerships, they strive to find the best solutions to strengthen access to primary health care services, reduce avoidable hospitalisations, and keep people well, in ways that they could not achieve as single services working alone.

Consumer engagement

In relation to primary care systems and primary care reforms, benefits to consumers from primary care reform are yet to be shown. Yet there are promising practices in consumer engagement that will inform Australia’s Primary Health Networks. Structured approaches should include monitoring and accountability for benefits to consumers, and over time, of outcomes from consumer input to the reforms, particularly those that affect safety and quality.

Policymakers, researchers and practitioners need only look to Australian best practices, such as The Peninsula Model and the Inner-North Collaborative Framework among others, for models on how to develop effective partnerships and collaborative advantage to accelerate primary care reform. These models are showing improvements in many aspects of professional and organisational functioning from their partnership work. The work they are doing in the development of strategies for streamlined care, embedding of efficiencies, and reductions in avoidable hospitalisations, is just being realised.

Continuing financial and policy support for them is likely to bring tangible economic, consumer, and health system quality benefits to primary care reforms.

Professor Helen Keleher is an Adjunct Professor at Monash University’s School of Public Health & Preventive Medicine. Her expertise is in population health, primary health care, the social determinants of health and disadvantage, with a particular interest in women’s health. Professor Keleher wrote the Evidence Brief ‘Partnerships and collaborative advantage in primary care reform’ for the Australian Healthcare and Hospitals Association’s Deeble Institute for Health Policy Research.
Primary Health Networks: will they bring reform?

Lesley M Russell

Lots of questions, the answers are yet to come.

Governments across the world face the same array of problems in health care: disease prevention, an increasing number of people with long-term conditions and multi-morbidity, ageing populations, fragmented services, health inequalities, getting patients involved in their care, and financial constraints.

There are concerns that Australia is headed in a different direction, abandoning the centrality of general practice within Medicare that is a key contributing factor to Australia’s high life expectancy. Will the new Primary Health Networks (PHNs) that replace Medicare Locals (MLs) on 1 July 2015 counter this current trend and help strengthen primary care?

At first glance, the roles and functions of PHNs remain essentially the same as those for MLs, but there are significant variations in emphasis. The advent of MLs, linked to the development and promulgation of the National Primary Health Care Strategy and the National Primary Health Care Strategic Framework, set in train the transformation of general practice into the more expansive primary care, with hopes of primary health care to come.

The role of PHNs has contracted to a greater focus on general practitioners, hospitals and the commissioning of services. There is also the potential for the private sector to enter what has been a publicly-funded service area.

Will PHNs deliver the efficiencies, innovation and improved health outcomes that are needed while simultaneously tackling the health inequalities that are masked by the national averages proudly touted by politicians? Will these new organisations become medical fiefdoms or are there opportunities to drive new ways of delivering health care services, for health care professionals to work collaboratively to assure patients a seamless journey through the health care system, to involve patients and carers more, and to work with communities to improve public health and wellbeing?

Some recent initiatives from the United Kingdom and the United States point to what might be undertaken by PHNs to extend their activities beyond general practice and deliver the primary care capability envisioned for the health care needs of the 21st century.

Such a vision is provided by the Royal College of General Practitioners’ (RCGP’s) publication The 2022 GP: a vision for general practice in the future NHS. At the heart of the vision is a call for more GPs, with longer training, spending more time with their patients. At the same time, it sets out how GPs will need to lead redesign of the delivery of health care, to improve continuity and integration of care and enable as much care as possible to be provided out of hospital.

The companion Compendium of Evidence recognises that the National Health Service (like Australia’s Medicare) does not deal well with multi-morbidity and the associated problem of polypharmacy. Overall 35% of adult Australians have three or more chronic illnesses, and 50% of people aged 65 and over have more than five. The problem of multi-morbidity is not just confined to older people and with deprivation comes a greater mix of mental and physical health problems. Multi-morbidity is challenging for both health professionals and patients and creates a significant demand on GPs’ time and resources. The RCGP argues for:

- Continuity of primary care, with patients and GPs at the centre of care rather than the periphery of a fragmented range of specialist services.
- Integration of care across different conditions (treating the whole person, not just focusing on a specific disease) and between different professional groups and services.
- Sufficient resources to address the inverse care law and to encourage longer consultations.

The RCGP also addresses the challenge of engaging patients in their own care. The benefits of shared decision-making include better consultations and use of care plans, clearer risk communication for safer care, improved health literacy, fewer unwanted treatments, healthier lifestyles, improved confidence and self-efficacy, greater compliance with ethical standards, reduced costs and better health outcomes. Effective shared decision-making is not yet the norm and is difficult to achieve; it requires more time with health care professionals, the use of patient decision aids and increased patient support.

Australian GPs share these visions for a new way of working together in a team approach that is focused on patients’ needs and rewards improved outcomes. Importantly, a recent study of innovative practices found that much of the joy of practice is sapped when primary care doctors are doing tasks that keep them from what they are best trained to do and their work is most effective and enjoyable when they are working collaboratively within a good practice model.

As part of the Obamacare reforms, policy-makers in the United States are now emphasising the primary care team and the concept of a ‘medical
home’, especially in the provision of coordinated care for patients with multi-morbidities. There is considerable support for the concept of the patient-centred medical home in Australia and for encouraging patients with long-term health care needs to register with (effectively to partner with) a specific practice for their primary care. Will PHNs be provided with the authority and flexibility to develop such innovative approaches to meet the needs of the communities they serve, or will they be constrained by red tape, financing, and turf wars? In part the answers will depend on the extent to which PHNs are patient-focused, have informed input from the stakeholders they serve, and can build on the work previously undertaken by the MLs. Health care reform in Australia is hindered by federal / state, public / private and acute care / community care divides and reluctance to move from fee-for-service. These obstacles can be overcome if PHNs see name as reflecting their remit and their remit as reflecting their communities’ needs.

Dr Lesley Russell is a Visiting Fellow at the Australian Primary Health Care Research Institute at the Australian National University. Her research interests include health care reform in Australia and the US, mental health, Indigenous health, addressing health disparities and health budget issues. She has worked in Washington DC on health care reform and as a senior advisor to the US Surgeon General and has been a health policy advisor to the Australian Labor Party. Dr Russell holds a PhD in biochemistry from the John Curtin School of Medical Research at the ANU.
Paresh Dawda and Angelene True

“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.”

This narrative was produced in the UK by a grouping of 130 health and social care charities and was commissioned by NHS England. It represents an overarching patient centred perspective of what is expected of the health service.

The Commonwealth Fund ranked UK’s National Health Service (NHS) highest in eight of eleven measures of care including providing effective care, safe care, coordinated care and patient-centred care. Recognising the system is not perfect, the Health Foundation, responded by stating “that the UK’s health system has strong foundations to work with. However, more could be done to prevent and treat ill health, both within and outside of the remit of the NHS.”

Regional Clinical Commissioning Groups (CCGs) in England are charged with achieving the aims of the health system. Their core function is commissioning — a process of assessing the needs of people in their area, designing and then securing appropriate services and working with service providers to achieve desired outcomes. In Australia, Primary Health Networks (PHNs) will have commissioning as its core function from July 2015. PHN objectives will be to improve coordination of care to ensure patients receive the right care in the right place at the right time and increasing the efficiency and effectiveness of medical services for consumers.

Effective public and patient involvement is one critical enabler to successfully achieve those objectives and is the focus of this article. PHNs will have to engage successfully with consumers and citizens at two levels:

1. The collective level - the involvement of citizens, communities and healthcare consumers in commissioning processes and decisions.
2. The individual level — by commissioning services that promotes involvement of consumers as equal partners across the full spectrum of prevention or diagnosis, care planning, treatment and care management.

Both are statutory requirements for CCGs and directly related to Australian Commission for Safety and Quality in Health Care (ACSQHC) Standards for partnering with consumers. There are clearly opportunities for PHNs to learn from CCG’s successes and failures (and those of their predecessor organisations).

At the collective level Community Advisory Committees (CAC) have been prescribed as the structure to provide the community perspective to PHN Boards to ensure that decisions, investments, and innovations are patient-centred, cost-effective, locally relevant and aligned to local care experiences and expectations. Whilst the structure may be an appropriate start, PHNs will clearly need to go much further and deeper. The engagement cycle is used by more than 50 CCGs as a strategic tool (Figure 1) that maps opportunities for consumers, community and citizen engagement at different points of the commissioning cycle. At its hub is culture and systems; both of which should support proactive engagement, as a central function of the commissioning cycle and not an add-on activity. PHNs will need to ensure they move beyond a tell and sell approach to a collaborative co-design one that values consumers, community and citizens as key partners.

Healthcare commissioning organisations work in a collaborative environment with multiple stakeholders and have the ability to influence behaviours and approaches adopted by others. PHNs should constantly strive towards making meaningful consumer engagement a shared purpose in their local health economy and look for opportunities to collaborate for mutual benefit. PHNs must embed engagement into their governance arrangements, develop trusting relationships and capture the right data as well as building capacity and capability at all levels.

At an individual level what matters to patients are functional and relational issues (Figure 2). Those most commonly reported are:

- Feeling informed and being given options
- Staff who listen and spend time
- Being treated as a person, not a number
- Patient involvement in care and being able to ask questions
- The value of support services
- Efficient processes that provide the patient with a sense of continuity of care

The labels on the arrows reflect approaches to capture, understand and measure those experiences, a necessary process to inform system improvement. They need to be used at the provider level and results fed back to the PHN as commissioner, this requiring a supportive and collaborative relationship between the two. The capacity and capability to appropriately use the full range of methods to achieve feedback and support consumers and their representatives to influence care delivery may not exist in the early days. However, PHNs will need to evolve using a continuous quality improvement approach to rapidly build this capability within their local health economy.

The AIHW 2014 identified ‘two big-ticket’ items likely to dominate the

Consumer-focused commissioning
health landscape in the immediate future: increasing health costs, and "Australia’s biggest health challenge"—the rise of chronic diseases—\(^{14}\) The factors contributing to these are multiple and extend beyond health alone. PHNs working collaboratively with Local Hospital Networks, across human service system, with other key stakeholders and most importantly with the public have potential to be the change agents that address these issues.

Commissioning in the English NHS has evolved and matured over more than 20 years. As PHNs embark on their commissioning journey they too will need time to mature into effective commissioners. The learning from other healthcare systems may act as a catalyst but the context is clearly different. That said, PHNs will require a different paradigm of consumer engagement and a cultural transformation, which must be facilitated by strong and symbiotic clinical and non-clinical leadership.

Despite the experiences of UK and other countries there is a general lack of evidence in the area of consumer engagement in commissioning activity and particularly its impact. However, this is not an excuse to not engage actively in consumer participation. The English experience identified many important reasons for engaging including moral, business, social, political, health and legal. Moreover, it is to say that PHNs will need to build evaluation into their engagement strategies. It presents an opportunity for them to contribute to evidence gaps and shape future policy.

By embedding effective consumer engagement into the grain of it’s commissioning culture PHN’s will achieve one compelling enabler to take the Australian health system a step closer towards achieving better outcomes, better value and better experiences; so Australians are also able to say “I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.”

**Paresh Dawda**

Paresh is a GP, ACT Regional Medical Director for several integrated care clinics and GP Adviser in Implementation to the ACT Medicare Local. He has a visiting Fellow affiliation at the Australian Primary Health Care Research Institute (ANU), Keele University (UK) and an Adjunct Associate Professor appointment at University of Canberra. He is on the Editorial Board of three international journals and on the Advisory Board for BMJ Quality, RACGP Faculty Board and Quality Care Standing Committee member, a member of WONCA’s working party on quality and safety, and was previously an Associate with the Safer Care team at the NHS Institute for Innovation and Improvement, where he designed and delivered programs.

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**Figure 1: The Engagement Cycle**

This diagram is reproduced with permission. The Engagement Cycle was developed by David Gilbert of InHealth Associates.

**Figure 2: What happens to patients?**
Private sector has role in primary health but not to fund what Medicare does

Bupa is passionate about making a real difference to health because we know that good health is essential to thriving communities.

Australia’s current health system is highly fragmented. The government’s own review into Medicare Locals identified that many patients currently experience fragmented or disjointed health care and acknowledged the negative impact of that fragmentation on both health outcomes and overall system cost.

The ambition for Primary Health Networks (PHNs) is to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and to improve coordination across the primary care spectrum.

We all know that a health system that is effectively integrated across health care providers and coordinated across health events is essential for delivering outstanding health outcomes, at a sustainable price.

Across the entire health system, both private and public sectors, there is legitimate interest in understanding how resources are used and what outcomes are delivered. With increasing populations and people living longer, everyone wants to ensure healthcare remains accessible and affordable to all. The priority is to drive better health outcomes and value for investment across the system.

To be most effective, PHNs should draw upon the experience and expertise of both public and private sectors.

Bupa’s interest and engagement in PHNs stems from our desire to enhance connectivity across the system to improve health outcomes for all Australians. Our interest in PHNs is not driven by any short term commercial imperative. Given we don’t have any shareholders, we have the freedom to pursue areas that will improve the system as a whole and reinvest profits to provide more and better healthcare.

We want to work collaboratively with the primary health sector to develop and adopt shared goals that deliver clear, measurable outcomes for everyone, to support Australians throughout their entire health journey.

PHNs are a unique opportunity to address some of our health system’s biggest challenges by strengthening, better connecting and ultimately enhancing the quality of our primary health system.

They represent a real opportunity to better link people, processes and systems across different sectors to help consumers interact with the healthcare system and empower patients to more easily undertake primary and secondary prevention and self management activity.

PHNs offer the opportunity to develop new ways for people to interact with the health care system, to help them live well and ultimately, to reduce the burden on the health care system.

Although we are most often recognised in Australia as a health insurer, Bupa is, in fact, a diverse, broad based health and care organisation.

Around the world, we support 29 million customers through health insurance, residential aged care

including Commissioning for Quality and Safety. Above all he has a passion for practicing patient centred medicine.

Angelene True

Angelene currently leads on service development at ACT Medicare Local: leading on both the development of commissioning capability within the organisation and service system improvement within the ACT health economy.

Angelene had an extensive career in UK public sector management spanning Health, Local Government and Higher Education prior to moving to Australia in 2012. This included being Chief Executive of three consumer health organisations, Head of Service Improvement and Head of Community Engagement for a large London Borough.

Her passions are quality health care, improvement and innovation. She has extensive commissioning experience: working with Boards, Senior Executives, commissioning organisations and strategic partners under the ‘World Class Commissioning’ program to build healthcare commissioning capability; leading organisational and whole system developments, managing commissioning processes and teams, and leading service development and system transformation.

Dwayne Crombie

Bupa is passionate about making a real difference to health because we know that good health is essential to thriving communities.

Australia’s current health system is highly fragmented. The government’s own review into Medicare Locals identified that many patients currently experience fragmented or disjointed health care and acknowledged the negative impact of that fragmentation on both health outcomes and overall system cost.

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in genuine partnership with other, like-minded organisations and key stakeholders, to deliver better health outcomes.

General practice and community care is at the forefront of disease prevention and management for those with complex or chronic conditions. We support doctors as the medical home of prevention and their role in developing strong relationships with their patients. Regardless of whether or how Bupa as a health and care company participates in the PHNs, we believe that the private sector has a key role to play in the health system and needs to be engaged with the PHNs. Bupa does not see a need, as a health insurer, to fund primary care for items that Medicare already looks after. However there are areas where we could supplement what is already available, notably in the areas of health promotion, disease prevention, support for significant health life events, chronic disease management and advocacy for other programmes that ultimately will help to reduce unnecessary hospital admissions. Ultimately, we want to work in partnership with local communities, health providers and health professionals to create a system that is organised around what a patient needs, to get the best health outcomes.

By putting patient experience and health outcomes at the centre of decision-making, our vision is to help deliver a more integrated model of care across the primary, secondary, acute, aged care, public and private health sectors.

Dwayne Crombie is Managing Director of Bupa Health Insurance and has worked across both the private and public health sectors. Before joining Bupa’s Private Health Insurance arm in 2013, he led the Bupa Care Services business in New Zealand. He has held public health sector positions in NZ as Chief Executive Officer of the Waitemata District Health Board. He graduated in medicine, holds a diploma in community health from the University of Otago and maintains a current practicing certificate. He also qualified as an Executive Master of Business Administration at the University of Auckland.

Primary Health Networks — a new home for patient safety in Primary Care?

Meredith Makeham

As the time approaches for the establishment of Primary Health Networks, we have a new opportunity to reflect on how they might best achieve their key objectives: increasing the efficiency and effectiveness of medical services for patients, in particular those at risk of poor health outcomes; and improving coordination of care to ensure patients receive the right care in the right place at the right time. Should those be difficult objectives to achieve? We have many examples of health care service improvements to build upon if we look at the programs and innovations developed by GP Divisions and Medicare Locals as the predecessor organisations of PHNs. We can add the innovations that have occurred in information and communication technologies (ICT) in recent years in Australia.

We have an evolving Personally Controlled Electronic Health Record (PCEHR), providing another link between the traditionally siloed worlds of primary and tertiary health care, and allowing consumers and their health care providers immediate access to key medical information including medications and test results. We have the capacity to securely move electronic prescriptions, requests for investigations, and discharge summaries around the health sector. We are moving towards ICT models that place the patient at the centre of their care, able to easily see their own health information and better control its use. But what about those people at most risk of poor health outcomes? Who are they, and how do we know if the potential harms that they are exposed to are being minimised as they encounter health care provision in primary care?

One of the difficulties we face when attempting to answer this question (and therefore to help measure our progress in harm minimisation) is our absence of a structured and connected reporting and learning system for threats to patient safety in primary care.

In 2015 Australia, we have no standard
way of gathering information about patient harms or safety incidents in primary care. We do not have established regional, state or national reporting systems - that exist in many similarly high socioeconomic ‘first world’ primary care health systems around the world — to turn to for guidance about areas that may be causing harm to patients. Unlike the hospital sector, we do not collect national data about errors that occur in primary care.

We know that mistakes happen in health care, and there are many ways to learn from these. Incident reporting is only one such way — it’s not the answer to all of our questions about patient safety in health care, and has many recognised weaknesses. However it does provide an opportunity to share information about an event that seriously threatened or caused harm to a patient.

We know that by analysing patient safety incidents we can learn about ways to improve health care. Many very important lessons about factors that contributed to harm in the health sector have arisen from the analysis of incident reports.

Our hospital sector has been improving its patient safety culture and reporting and learning systems for the past 30 years in Australia. It has nurtured and developed a safety culture that includes incident reporting systems. There isn’t a hospital in Australia that doesn’t attempt to collect information about threats to patient safety that occur to its patients.

So why don’t we have something like that in Australian primary care?

It’s not because primary care clinicians don’t care about the subject or aren’t interested in reducing harm for their patients. There are many examples of individual general practices with excellent internal safety monitoring systems. In fact, a clinical risk management system that can monitor, identify and report near misses and mistakes in clinical care, and can identify deviations in practice that may result in patient harm, is a requirement of general practice accreditation. Therefore we presume this must exist in approximately 80 per cent of Australian general practices. The recent development of a patient safety collaborative manual intended for use in general practice to identify and prevent harm is a good example of a recent cultural shift in patient safety in primary care.

We also know that Australian primary care clinicians are willing and able to report near misses and incidents in general practice settings. With the provision of a secure online electronic reporting system, GPs in NSW reported around one patient safety event for every 1,000 patients seen per year, and approximately 70 per cent of these were attributed to system errors in the delivery of health care services.

Perhaps the absence of a collective incident reporting and learning system in Australia has some connection to our private practice traditions and the lack of medico-legal protection for primary care clinicians who would wish to talk openly about, and learn from, errors and threats to patient safety that they observe. This presents a barrier, but not an insurmountable one.

Whatever the contributing factors may be, we are faced with a major gap in primary care patient safety — we have nowhere to share our stories and lessons that we learn at an individual or practice level when we recognise that a threat to patient safety has occurred.

A focus on patient safety in the new Primary Health Networks may provide the answer to this dilemma, and become a place where we can collectively report near misses and incidents, and learn from and support each other to talk about mistakes in clinical care.

In order to achieve the objective of making health care safer for those at risk of poor health outcomes, it is time to think about creating a new home for patient safety in primary care.

Associate Professor Meredith Makeham is a member of the team at the Centre for Health Systems and Safety Research, Australian Institute of Health Innovation, Macquarie University. She is a general practitioner in Lindfield, Sydney and has major research interests in reporting and learning from patient safety incidents and ICT in primary care. She is also a member of the Clinical Governance Advisory Group for the Personally Controlled Electronic Health Record (PCEHR).

References
Primary Health Networks (PHNs) will be established to lead the change as part of the Australian Coalition Government’s commitment to rebuilding the primary health care system through efficient and innovative models of funding and delivery of health and medical services to improve the coordination of patient care. Across Australia, 30 PHNs are proposed to operate, as of 1 July 2015, with two key objectives:
- increase efficiency and effectiveness of services for those at risk of poor health outcomes;
- improve coordination of care so that people receive the right care in the place at the right time.

Primary health care in Australia recognises that effective consumer and community engagement is essential for the design and delivery of high quality care. In the development of the new national PHN programme it is vital that they are able to identify and utilise best practice approaches to engagement which are effective in the local, regional and metropolitan contexts. The PHN governance arrangements will include the establishment of GP-led Clinical Councils and Community Advisory Committees (CAC) to report to the PHN Board on locally relevant clinical and consumer issues. It is intended that CACs will:

“provide the community perspective to PHN Boards to ensure that decisions, investments, and innovations are patient centred, cost effective, locally relevant and aligned to local care experiences and expectations.”

Whilst this is a structural requirement, it is also critical consumer and community engagement models for PHNs are validated by consumers, carers and community representatives and are at the core of the development of the model’s principals and aims.

A key guide to support community engagement and consumer participation is the Australian Commission on Safety and Quality in Health Care’s Standard 2, “Partnering with Consumers - Embedding partnerships in health care”.

The strategies that this Standard details is that to embed partnerships, health care organisations need to focus on:

- the purpose of the partnership;
- having strong leaders who communicate a strategic vision of partnering with consumers;
- identifying and developing strategies for partnering with consumers that are appropriate for the organisation;
- working towards the establishment of an organisational culture that values partnering with consumers as part of core business.

An organisation that promotes consumer involvement in the design and delivery of services must embed participation, meaningfully, at all levels. PHN’s have the opportunity to truly embrace consumer partnerships in the development, design, implementation and evaluation of health services.

We at SAFKI Medicare Local underpinned our consumer engagement methods with a community development approach to create close relationships with community by:

- Harnessing local knowledge: By knowing the local area well and striving to understand our people. The building of comprehensive, up-to-date data on the issues facing our community and focusing on responding effectively to the key health needs of our local community;
- Driving community-led best solutions: We put local clinicians and communities in the driving seat — and work with them to identify local service gaps and develop the best and most cost-effective solutions;
- Joining the dots: We have strong relationships with primary health care services in our region and work with them to improve and strengthen the connectedness of primary health care. This results in better patient experiences and outcomes.

In reality we implemented this by promoting “Your Health, Your Voice, Your Choice”. This program was the public brand for all community engagement activities around our comprehensive needs assessment process, our stakeholder relationship management and our highly successful Community Connections forums.

Whilst it is important for new PHN organisations to promote consumer involvement at all levels in its policies, procedures and ethos, it is also important that it supports its other stakeholders (i.e. clinicians, service providers, the wider health system) to understand meaningful and culturally appropriate community engagement.

“If you want to go faster, go alone. If you want to go further, go together” (African Proverb)

The new PHNs enable a fresh approach with consumer engagement and renewed opportunities to implement models of care that are patient centred. One such model is where the patients are at the centre of their care and that individual patients have the best access to a range of health care providers including general practitioners, community health services and hospitals. The model of care is known as the Patient Centred Medical Home (PCMH).

The PCMH model was adopted by the American Academy of Family Physicians in 2002. The principles of the model are:

- an ongoing patient relationship with a GP who takes overall responsibility for patient care and leads a team of individuals also caring for the patient;
The PCMH model has been shown to decrease the use of inappropriate medications, significantly reduce avoidable hospital admissions and readmissions, emergency department use and overall health care costs. It is important that the new PHN organisations believe that patients are always at the centre of the health system to ensure that regardless of their location patients have the best access to health care providers.

The major aims of the PHN model is that they must support GPs as the cornerstone of primary health care; engage with Local Health Networks; and implement specific strategies to ensure patients are at the centre of the local health system. The PCMH model could certainly be considered as a framework in which those PHN components be delivered effectively across a region.

“What most people need is a good listening to” (Mary Lou Casey)

SAFKI Medicare Local has demonstrated the concept of patient-centred care through its Partners in Recovery program of which is illustrated in this YouTube video (https://www.youtube.com/watch?v=kjWPembGCA).

I am excited by what PHNs will have the ability to create, to truly change the course of health care and effectively improve the quality of life in our communities. If we are prepared to have courage to do things differently and enhance our community’s voice to improve its people’s health I believe we will see real change.

Deb Dutton is CEO of Southern Adelaide-Flinders-Kangaroo Island (SAFKI) Medicare Local and has extensive experience in business and operations management across commercial and not-for-profit sectors. Over the past decade she has worked in Divisions of General Practice and held an executive role in the State-based organisation in South Australia.
Alison Marcus

I have been a consumer of health care services for all of my almost 64 years, have been very involved in caring for a family, and have worked in the health care sector in various acute clinical and community areas since 1974, in metropolitan, regional and remote settings.

I read reasonably widely, and try to keep my ear to the ground.

But when I see the key objectives of the PHNs are to increase effectiveness of medical services for patients, particularly those at risk of poor health, and to ensure “right care at right place and right time” I do wonder what magic the PHN architects have in store. There is little help to be found for consumers searching the current material on the Department’s website.

I appreciate and understand the need for professional collaboration (and how difficult it can be), realise how critical consumer engagement and involvement is: nothing about us without us. there has been a shift in how we are involved in caring for others.

There are some clues that have me a little worried though. The Horvath Review of Medicare Locals 2014 on page 6 in a section titled “Selective engagement across sectors”, describes the avoidance of engagement by Medicare Locals with private hospitals and the private providers that dominate the primary health sector. Increasingly we are seeing health insurers seeking to provide selected interventions and support frameworks for patients in the community.

Government is already wanting to give ‘price signals’ for general practice consultations — what about other allied health services? How will that principle impact on the adherence or uptake of clinical guidelines if one assumes that not all care and education be delivered by already pressed general practice? Is this the thin end of the wedge?

Private health insurance for my partner and me currently costs $225 per fortnight, and covers little in primary care. When neither of us earns a salary, and we are living on our meagre superannuation and the increasingly threatened Aged Pension it is entirely possible that we will no longer be able to afford private insurance, and the increasing burden of ever-rising out of pocket expenses.

Will these changes inevitably mean that the universality of Medicare is threatened?

I am all for the examples of the National Key Performance Indicators described in the PHN Guidelines:

- potentially preventable hospitalisations (per 1000 population)
- selected preventable hospitalisations
- prevalence of smoking; and/or
- percentage of target population screening for breast, cervical and/or bowel cancer

But there is no mention of immunisation rates. This is particularly important as the immunisation schedule becomes more complex including implications with shared care with obstetricians for influenza and pertussis immunisation in pregnancy, herpes zoster for older Australians. How will adherence to diabetes, heart failure and respiratory failure clinical guidelines, and antibiotic stewardship be measured and potentially improved?

So far there is no coherent explanation about how such KPIs might be met, and what any corrective improvement measures might look like.

How are the ‘Clinical Pathways’ going to work? How much consultation will there be with consumers and disease specific support groups?

How good are the data linkages going to be? It is already clear that a ‘whole of life’ immunisation register is needed, and has been for some time.

How many resources will be necessary to collect clinical data? What do we know already about current adherence to existing clinical guidelines — antibiotic stewardship and diabetes for example? Or will those matters be
seen only after hospital admission — assuming anyone has the time to make that judgement?

How will this data be collected and managed? What are the plans for data linkage with other sources? And the much vaunted PCeCHR seems to be missing in action.

Will the new system support the idea of the ‘medical home’ that might improve clinical outcomes? Recent data suggests that many consumers use more than one general practice — so what do we know about why that occurs?

Most of all, how will we know when it is working for us? Will it be easier to get an appointment with a GP in poorly serviced areas?

Will my neighbour manage to get an appointment with a diabetes educator?

Will my niece be able to get help to manage her stoma?

Can my friend see a dietician without having to pay nearly $200.00, or waiting many months for an outpatient appointment?

What about nursing care when I come home from hospital? If I keep that increasingly expensive private health insurance, how much will that home care cost, particularly when my needs will not be met by district nursing services for several days or weeks after discharge in many cases, should I be an inpatient using that private insurance.

These are the everyday questions that confront so many Australians with chronic illness. The PHNs must be able to show that they can respond to those cases and hopefully improve the status quo if they are to meet the reasonable expectations of a 21st century health system.

Alison Marcus has been a member of CHF since 2003, and has represented consumer interests on a range of medicines related committees. She is currently the consumer representative on ACSOM - the Advisory Committee on the Safety of Medicines and the National Immunisation Committee.
Health Voices

Health Voices is published twice each year. Each issue has a theme that promotes debate on issues of interest to health consumers, government and industry.

Readers are encouraged to write letters to CHF in response to journal articles or other issues in Australian healthcare.

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The Consumers Health Forum of Australia

The Consumers Health Forum of Australia (CHF) is the national peak body representing the interests of Australian healthcare consumers.

CHF works to achieve safe, quality, timely healthcare for all Australians, supported by accessible health information and systems.

CHF does this by:
1. advocating for appropriate and equitable healthcare
2. undertaking consumer-based research and developing a strong consumer knowledge base
3. identifying key issues in safety and quality of health services for consumers
4. raising the health literacy of consumers, health professionals and stakeholders
5. providing a strong national voice for health consumers and supporting consumer participation in health policy and program decision making

CHF values:
• our members’ knowledge, experience and involvement
• development of an integrated healthcare system that values the consumer experience
• early intervention, prevention and early diagnosis
• collaborative integrated healthcare
• working in partnership

CHF member organisations reach Australian health consumers across a wide range of health interests and health system experiences. CHF policy is developed through consultation with members, ensuring that CHF maintains a broad, representative, health consumer perspective.

CHF is committed to being an active advocate in the ongoing development of Australian health policy and practice.

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