

# LEADING **CHANGE** IN PRIMARY CARE:

## **BOARDS OF PRIMARY HEALTH NETWORKS CAN HELP IMPROVE THE AUSTRALIAN HEALTH CARE SYSTEM**

Stephen Duckett, Marilyn Beaumont, Gabrielle Bell, Jane Gunn, Amanda Murphy, Rod Wilson & Tom Crowley.

Leading Change in Primary Care: Boards of Primary Health Networks can help improve the Australian health care system

(c) 2015 Stephen Duckett, Marilyn Beaumont, Gabrielle Bell, Jane Gunn, Amanda Murphy, Rod Wilson and Tom Crowley

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### **Key Messages:**

PHNs have the ability to bring about meaningful reform to Australia's primary care system. To do so, they must:

- Recruit the right team, appointing board members and executive staff with diverse experiences and shared vision;
- Create a functional working environment with robust governance structures;
- Resolve to be innovative and active in pursuing reform rather than being content to act as managers of a stable state;
- Carefully target their funding to fix problems of funds pooling, promote integration and encourage the delivery of important services;
- Gather evidence and advocate for change in practice behaviour and in system coordination, locally and nationally;
- Facilitate change by building positive and constructive relationships with and between health professionals, working within existing structures as an enabler rather than pursuing change in isolation;
- Commission carefully and deliberately, using the specification process to shape the health landscape by commissioning for activities and outcomes that reflect the PHN's vision for change;
- Work with clinicians and the community, engaging them meaningfully in the decision-making process to ensure shared ownership of the task of improving the health system.

## The purpose of this book

In July 2015, Australia's 61 Medicare Locals were replaced by 31 Primary Health Networks (PHNs). The PHNs will do broadly similar work to the Medicare Locals, with the goals of improving the primary health care system, promoting coordination and pursuing integrated health care.

This book has been written for the PHN boards. It draws on the experience of the authors, who were on or associated with the board of the Northern Melbourne Medicare Local (NMML). Their experience is presented alongside existing knowledge and research on the primary health system with the intention of providing a context to inform the strategic decisions the PHN boards will make.

The book explores the need for change in the primary health system, with a focus on how this can be achieved within the limited parameters faced by PHNs. The book examines how PHNs can structure their organisations and manage their resources to circumvent these limitations and pursue meaningful system reform.

*The book explores the need for change in the primary health system, with a focus on how this can be achieved within the limited parameters faced by PHNs.*

Every effort has been made to ensure that the context provided in this book is comprehensive. Accordingly, some of the discussion will be familiar to board members. The standard principles of corporate governance, in particular, will be familiar territory. This has been included for the sake of completeness.

## Chapter Outline

### Chapter 1: Background to the Primary Health System

Historically, coordination of Australia's primary health system has been weak. The PHN is the latest attempt by the Commonwealth Government to rectify this. Chapter 1 provides a brief overview of the primary health system and its importance, outlining the main problems it faces and providing context for the establishment of the PHN program.

### Chapter 2: Corporate Governance

The book's main purpose is to examine the strategic decisions boards will have to make. This chapter contextualises this by summarising standard principles of corporate governance and presenting them as they relate to PHNs. This material will be familiar to many board members, but has been included for the sake of framing and clarifying the discussion that will follow. This chapter deals with the roles, selection and evaluation of both the board and the CEO.

### Chapter 3: Strategies for Change

PHNs are to act as agents for change and reform in the primary health system. This ambitious undertaking entails diverse challenges and trade-offs. Chapter 3 examines the strategies that will allow PHNs to achieve this aim. Central to this discussion is an acknowledgement of PHNs' limitations. They cannot legislate, nor can they compel providers to act in a particular way. But although this limits PHNs, it does not incapacitate them. The capacities and resources available to PHNs offer many levers for reform. This chapter will explore some of these levers, drawing upon numerous case studies.

### Chapter 4: The Commissioning Model

An important function of the PHN is its role in service provision. Rather than directly providing services themselves, PHNs will primarily be commissioning organisations, purchasing services in response to gaps and shortages. This is an important task in itself but it is also one of the most important levers for change that PHNs have at their disposal. Chapter 4 discusses the commissioning process in depth, exploring its challenges and its opportunities, with particular emphasis on how selective commissioning can contribute to integration or other improvements in the primary health system.

### Chapter 5: Engagement with Clinicians and Communities

PHNs do not work in isolation. Change of the sort PHNs will pursue cannot occur without the joint effort and support of health providers. Moreover, the right sort of change cannot be achieved unless PHNs have a strong and meaningful relationship

with the communities they serve. Chapter 5 examines the process of consultation with these two stakeholder groups. The development of positive working relationships with these groups is essential in determining a PHN's success.

### **NMML Regional Profile**

In its four years of operation, NMML catered to a diverse community in Melbourne's northern suburbs. It served around 712,941 residents, including the local government jurisdictions of Banyule, Darebin, Hume, Nillumbik and Whittlesea. The catchment was diverse in several ways:

- **Geographic diversity:** the catchment included higher-density inner suburbs, lower-density outer suburbs and a rural interface. Outer suburbs, in so-called 'growth corridors', tended to lack infrastructure and amenities, while rural areas tended to be under-resourced.
- **Socioeconomic diversity:** although the median weekly household income was higher than the national average, there were significant pockets of disadvantage. According to the SEIFA index of disadvantage, the catchment contained above average disadvantage compared with Melbourne, Victoria and Australia as a whole.
- **Demographic diversity:** A significant proportion of residents were from non-English speaking backgrounds. The catchment also included Aboriginal and Torres Strait Islanders, refugees and asylum seekers.

As well as posing administrative challenges, the diversity of the NMML catchment gave its board and executive a broad understanding of the challenges facing primary health providers Australia-wide. From the start, NMML functioned as a 'community-oriented' organisation, and had little direct service delivery. In that sense, it functioned in a way similar to the way PHNs are expected to function. Accordingly, the insights gleaned are broadly applicable.

Like any organisation, NMML had its ups and downs, successes and failures. Overall, however, the board was proud of its achievements and what it did to improve health and health care in the northern suburbs of Melbourne. It learned a lot in its short existence. It felt that it could help the new PHNs begin their own learning experience by documenting some of the lessons it learned and the approaches it took. Hence this book as a 'legacy project'.

- Australia's primary health care system is poorly coordinated.
- PHNs are the third attempt by the Commonwealth Government to remedy this.

### Background: primary health care in the Australian context

Primary health care is essential to a well-functioning health system. As the first point of contact for management of health problems, primary health care providers are pivotal in improving patient experiences and outcomes, especially for people with chronic illness. Good primary health care can play an important role in implementing public health initiatives. It can coordinate access to and from secondary and acute care. It can also reduce costs elsewhere in the health system by minimising unnecessary hospitalisations and increasing screening and prevention.

Most primary care services are delivered by autonomous providers. These providers are sometimes single professionals, but increasingly they are groups owned by, or part of, private businesses. The past decade has seen an increase in the number of general practices owned by corporate providers.

Primary health providers include:

- General practitioners
- Dental practitioners
- Pharmacists
- Nurses (maternal and child health nurses, general practice nurses, home-visiting nurses, school nurses)
- Allied health professionals (such as physiotherapists, occupational therapists, podiatrists, orthotists and prosthetists, optometrists, dietitians, osteopaths, chiropractors, social workers, psychologists)
- Paramedics
- Aboriginal health workers
- Complementary medicine practitioners

Australia's health system has a history of weak coordination between these diverse primary health professionals, and between primary health and secondary and acute health. This is partly due to the lack of financial incentives to reward and enable systematic, integrated service delivery or coordination between providers. Some funding mechanisms perversely incentivise a lack of coordination. Poor coordination is also attributable to the lack of clear referral pathways and patient registration.

***Australia's health system has a history of weak coordination between these primary health professionals, and between primary health and secondary and acute health.***

This has significant adverse effects. The most apparent are the adverse outcomes for patients that can result from uncoordinated health care. This is particularly true for people with chronic conditions. Chronically ill patients require regular health care, and are amongst the most frequent true users of primary health care services. They often need to visit multiple providers, including allied health professionals and specialists. When there is little or no coordination, a patient's continuity of care is compromised. Information obtained by one professional that might be useful to another is not shared, and processes for referral do not function properly. Patients have to repeat their story to many professionals, leading to duplication of investigations, procedures, treatments and referrals. The result is difficult and often expensive for patients, especially given that most allied health professionals are private providers with limited coverage under the Medicare Benefits Schedule. Chronic illnesses are becoming increasingly prevalent among Australians, exacerbating these problems.

More broadly, a poorly coordinated primary health system is less capable of fulfilling important functions such as minimising hospitalisations, increasing screening and prevention, caring for those with mental illness and promoting community health.

Weaknesses in coordination mean that Australians are not benefiting from what the systematic and well-coordinated expertise of health professionals could achieve.

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Successive Australian governments have taken steps to rectify this. The first step was the introduction of Vocational Registration, in recognition of the need for specialty training for general practice. In the 1990s, Divisions of General Practice were introduced as so-called 'meso-level' organisations, designed to act as intermediaries for the promotion of better coordination amongst general practitioners (GPs).

In 2011, the Government saw a need for coordination across the broader primary health care spectrum, especially in response to the increased prevalence of chronic illness. The 110 Divisions of General Practice were replaced with 61 Medicare Locals, which were to focus on the full range of primary providers.

The Medicare Locals were short-lived. In the 2014 Budget, the Government announced that they would be replaced by 31 Primary Health Networks (PHNs) from July 2015. PHNs will do broadly similar work to their Medicare Local predecessors but serve larger populations<sup>1</sup>. There will be some adjustments, in line with the recommendations of the Horvath review into primary care structure, which reported its findings in 2014. In particular, GPs are expected to play a more central role in PHNs than they did in Medicare Locals. PHNs are also expected to focus more on improving the linkages between primary and hospital care. But the fundamental purpose of the PHNs is similar to that of their predecessors: to facilitate improvements in the primary health system, promote coordination and pursue integrated health care.

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1 Australian Government Department of Health, 'Primary Health Networks: Grant Programme Guidelines', December 2014.

- Good corporate governance structures are essential for an organisation's success. Roles must be clearly defined and personnel carefully selected.
- Boards must focus on past, present and future. They are responsible for 'big-picture' strategic thinking.
- Boards must represent diverse skills and experience. Regular evaluation is important.
- The CEO is responsible for enacting the board's big-picture goals, making the relationship an important one.
- The CEO should be selected carefully and in line with organisational priorities.
- The CEO and the board must work together in strategic planning.

One of the themes of this book is the importance of clarity on behalf of PHNs. To successfully change the primary health system, the board must clearly define a meaningful strategic plan. Without firmly settling upon this purpose and strategic direction, a PHN will risk failure.

But while a clear purpose is necessary for success, it is not sufficient. It must be accompanied by useful and functional structures of governance. Measurable improvements in primary health can only be achieved if proper structures are put in place to allow the PHN to go about achieving them.

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This chapter summarises the requisite structures. It draws largely upon standard principles of corporate governance, as these are broadly applicable. Most, if not all, of the material will be familiar to board members. It is included not for the sake of introduction, but to provide a complete picture of the task that boards face. Efforts have been made to link these standard principles to the PHN setting.

The chapter focuses on the PHN board and executive, their appointment, evaluation and roles. The relationship between the two will determine the cohesiveness and effectiveness of the PHN as a whole. This makes clear definition of their roles and responsibilities vital.

The chapter begins with the selection, role and evaluation of the board. The process for the board's appointment of a CEO will then be discussed, including the relevant selection criteria and method for evaluation. Finally, a blueprint is provided for effective strategic planning.

### **The role of the board**

Whereas the executive of an organisation concerns itself with day-to-day process, strategy and management, the board is responsible for broader thinking. The board oversees and evaluates the work of the executive, but is also responsible for giving the organisation its 'flavour'; that is, the purposes and values that define its actions.

The board must take a broad view of the organisation, establishing long-term priorities about what the organisation should be and what it should do. The executive will translate this big picture thinking into concrete strategy and planning, and will be responsible for executing this plan. As Tricker<sup>2</sup> summarises, "***management runs the business; the board ensures that it is being well run and run in the right direction***".

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2 Tricker, B, Corporate Governance: Principles, Policies, and Practices, 2009, New York, Oxford University Press, 36-8.

In his textbook on Corporate Governance, Tricker includes a matrix summarising the board's role (Figure 1):

**Figure 1: Tricker's model of board function**

	Short term	Long Term
External	<p><b>Accountability</b></p> <ul style="list-style-type: none"> <li>• Reporting</li> <li>• Ensuring statutory compliance</li> <li>• Reviewing audit reports</li> </ul>	<p><b>Strategic thinking</b></p> <ul style="list-style-type: none"> <li>• Reviewing and initiating strategic analysis</li> <li>• Formulating strategy</li> <li>• Setting corporate direction</li> </ul>
	<b>Appointment and rewarding CEO</b>	
Internal	<p><b>Supervision</b></p> <ul style="list-style-type: none"> <li>• Reviewing key executive performance</li> <li>• Reviewing business results</li> <li>• Monitoring budgetary control and corrective actions</li> </ul>	<p><b>Corporate policy</b></p> <ul style="list-style-type: none"> <li>• Approving budgets</li> <li>• Determining compensation policy</li> <li>• Creating corporate culture</li> </ul>

Source: Tricker, B 2009, Corporate Governance: Principles, Policies, and Practices, New York, Oxford University Press, 38.

Important for PHN boards, as for the board of any organisation, will be deciding how much time should be devoted to each one of the boxes in this matrix. How much time will the board spend dealing with the present and the past? How much time will be spent looking to the future?

These are difficult questions to answer, and will depend on the preferences of board members at the stage of PHN development. Both retrospective and prospective functions are important, but if strategic, long-term thinking of the sort advocated in this book is to be achieved, significant amounts of the board's time will have to be devoted to the future.

It is easy to overlook this sort of future-focused thinking. Organisations often spend much of their time dealing with the present and evaluating the past, with discussion of future strategy scantily discussed or perhaps confined to a biannual retreat.

Unless it looks to the future, it will be difficult for a PHN to achieve its objectives. Although both executive and board will consider the present, only the board is tasked with determining future plans and strategies.

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Strategy formulation and policy-making should be taken seriously by the board. One way to ensure this might be to devote half of each board meeting to discussing the future, debating and evaluating strategic change initiatives. Board members might reflect on what proportion of their time has been spent on transformational proposals compared with marginal change. The board might also consider to what extent it is ensuring that tenders are forward-looking and tailored to facilitate a service system that is better equipped for the future.

Some strategies used by NMML to increase the effectiveness of strategic focus include:

- Two off-site meetings each year including dinner, external facilitations and a broad agenda.
- Presentations from staff on major change initiatives (approximately every second board meeting).
- Dedicated time in each board meeting for strategic issues (and management of board agenda with time allocated to routine reports and compliance).
- Establishment of working groups on key strategic priorities (generally chaired by a board member but with external membership).
- Reports on key developments from these working groups (which informed budget priorities) as a regular part of the board agenda.
- CEO report including a specific section on strategic issues.

### Principles of good governance for boards

Another description of the board's role, directly applicable to the PHN context, is the Good Governance Principles and Guidance for Not-for-Profit Organisations released by the Australian Institute of Company Directors (AICD)<sup>3</sup>.

The 10 principles the AICD lists are as follows:

**Roles and responsibilities:** there should be clarity regarding individual director responsibilities, organisational expectations of directors and the role of the board.

**Board composition:** a board needs to have the right group of people, having particular regard to each individual's background, skills and experience, and how the addition of an individual builds the collective capability and effective functioning of the board. In the PHN context, this means balancing health sector-specific knowledge with generic skills across the various board functions.

**Purpose and strategy:** the board plays an important role in setting the vision, purpose and strategies of the organisation, helping the organisation understand these and adapting the direction or plans as appropriate.

**Risk-recognition and management:** by putting in place an appropriate system of risk oversight and internal controls, boards can help increase the likelihood that their organisation will deliver on its purpose.

**Organisational performance:** the degree to which an organisation is delivering on its purpose can be difficult to assess, but this can be aided by the board determining and assessing appropriate performance categories and indicators.

**Board effectiveness:** may be greatly enhanced through careful forward planning of board-related activities, efficiently-run board meetings, regular assessments of board performance, having a board succession plan and, where appropriate, effective use of sub-committees.

**Integrity and accountability:** it is important that the board have in place a system whereby: there is a flow of information to the board that aids decision-making; there is transparency and accountability to external stakeholders, such as through clinical councils and consumer engagement strategies (see later chapter); and the integrity of financial statements and other key information is safeguarded.

**Organisation building:** the board has a role to play in enhancing the capacity and capabilities of the organisation it serves.

**Culture and ethics:** the board sets the tone for ethical and responsible decision-making throughout the organisation.

**Engagement:** the board helps an organisation to engage effectively with stakeholders.

For the most part, these speak for themselves, and each is relevant to the case of PHNs. They provide an alternative way of thinking about the board's role to Tricker's matrix.

### Choosing the board

Given its central role in the organisation, the makeup of the board is important. The PHN boards must be made up of the right mix of people to achieve the objectives of the program.

The first important component to getting this right is the board selection process. Generally, an independent nomination process is preferable. NMML used an independent consultant to help recruit board members (including reference checking), along with a nominations committee comprising board members not seeking reappointment and external members (for example, the chair of CEO of local hospital networks) to shortlist or recommend appointments.

Board composition can be thought of as a three-dimensional matrix.

3 Australian Institute of Company Directors, Good Governance Principles and Guidance for Not-for-Profit Organisations, 2013, <<http://www.companydirectors.com.au/Director-Resource-Centre/Not-for-profit/Good-Governance-Principles-and-Guidance-for-NFP-Organisations>>

Firstly, the board must include appropriate professional skills. These will be diverse, matching the functions of the board and the multidisciplinary work of PHNs. The board should include members skilled in accounting, law, management and other relevant disciplines. Importantly, there should also be professionals skilled in health-specific areas, such as medicine, health service management, health policy, health financing and population health planning. Those able to articulate a consumer perspective on the health system should also be considered. A diversity of backgrounds will ensure a diversity of views and approaches, which is important when making difficult, big-picture decisions about the direction of their PHN.

Secondly, PHN boards must also have 'domain' skills; that is, knowledge pertaining to a specific part of the health system. These build upon professional skills, but are different. The first and most obvious of these is experience in the primary health care system. The board must include members who have worked in or had extensive dealings with the primary health care system in the past to understand properly its challenges in their historical context. The board might also seek health system experience more broadly, whether in the hospital system or in public or private health management. Other, non-health-related experiences are also relevant. Some board members should have experience in dealing with governments (Commonwealth, state and local), businesses, schools, universities, community groups and consumers.

Thirdly, board members must have skills in areas such as strategic planning and risk management. Once again, strategy, as the future-focused aspect of the board's role, is vitally important to ensuring that the PHN's vision for reforming the primary health system is realised. It is fitting, then, that the board should be well-equipped to plan strategically, and that its members have experience in developing and carrying out long-term plans. An essential element of this, as explained at the end of chapter 2, is the ability to identify and mitigate risks, hence the importance of risk management experience.

Board composition can also reflect broad organisational priorities. For instance, if a PHN decides that eHealth improvement is a key priority, it might appoint a board member with a background in IT, or contract an IT consultant. This is a case where a board member selected for a specific purpose might in fact be useful.

Typically, the board matrix is described as a 'skills' matrix. That is, what boards are looking for is not simply someone who has had experience in an area, but someone who has gone beyond that to be truly skilled, showing leadership and with demonstrable achievement. If PHN boards are to achieve major change in the primary care system, the board as a collective needs to have credibility and be able to add value.

An important consideration for the board is diversity. The skill sets outlined in this three-dimensional matrix will ensure to some extent that board members have diverse backgrounds, experiences and skills. But the board should also consider other types of diversity. It should be representative of the population it serves. It should be gender diverse, culturally and linguistically diverse and geographically diverse, with members who are familiar with the challenges of different areas of the PHN's catchment.

Finally, boards are not collections of individuals but are to function as a cohesive whole. Board members have to work well together, with each member taking responsibility for board functioning. Accordingly, there needs to be an emphasis on relationship skills and the extent to which members share the PHN's values. This last attribute is particularly important. If a PHN is to enjoy success, its board must have aligned values, with each member committed to the same goals and how to achieve them.

A balance between 'left-hand' and 'right-hand' skills should be struck. Broadly speaking, left-hand skills refer more to the technical, professional or financial skills necessary for board work, whereas right-hand skills pertain to the bigger-picture questions and normative considerations with which a board will also be concerned.

These requisite qualifications are many and varied. It is not expected for the most part that boards will select one member who specifically fits each of the above descriptions. For instance, a board will not necessarily need to appoint someone to serve as an accountant, someone for a specific geographic region or somebody specifically to work on strategy. If board selection proceeded in such a way, boards would become unwieldy, individuals would become typecast and the board would fail to take joint responsibility for critical issues such as the financial health of the organization. The board would not function as a cohesive whole. Instead, preference should be given to finding board members with experience in multiple areas (with potential exceptions on areas like eHealth as suggested above). For instance, one board member might have a background in law and government and also have extensive experience in health management.

Finally, board members are not 'representatives'. Rather, they are to bring their diverse perspectives and experience to the collective decision-making process. A board that is diverse in experience, background and skills will be a board best placed to help the PHN reach its objectives.

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## Evaluating the board

Appointing the board is only one important aspect. Once appointed, the board must be regularly and rigorously evaluated on its performance.

To facilitate effective evaluation, boards must first decide upon performance indicators which go hand in hand with the organisation's strategic purpose. Once a PHN has decided what it wants to achieve and how, the board and the executive should be assessed by the extent to which they have succeeded in meeting these aims. The indicators will be both quantitative and qualitative, taking into account the PHN's financial position and organisational culture as well as health and integration outcomes.

Just as the specification of criteria will affect the type of feedback received from an evaluation process, so too will the style of evaluation. Different ways of assessing performance will provide information on different aspects of board performance. The way in which board evaluation is conducted should therefore vary from year to year. For instance, a board might establish an evaluation cycle of three years. The first year might involve an external review. The second year might involve a more qualitative standard questionnaire. A questionnaire like the one provided by the Australian Institute of Company Directors<sup>4</sup> would be a suitable starting point.

The third year might involve a board self-evaluation, in which members discuss how the board is functioning, how meetings are working, how members are contributing and so on. Part of this process could be to ask board members to rate themselves on the key elements of the skills matrix, as discussed earlier in this chapter, to ensure that the skill set remains relevant as the organisation's needs evolve. A more challenging evaluative approach is to ask all board members to rank other board members' skills anonymously for feedback to the chair of the board.

Since different types of information will be generated by each of these processes, an evaluation cycle provides boards with a broader understanding of how the organisation is working than would be gained by a single approach.

The board chair has a critical role in the evaluation process, including providing feedback to board members on their performance and contributing a part of the regular evaluation cycle. It is also critical that the board receives feedback from other relevant parts of the organisation and the health community. As well as conducting its own reviews, the board should seek to know what the executive thinks of its interactions with the board, or the department, or local health providers or consumers. This sort of feedback can again provide a broader understanding of board performance.

An effective board helps to ensure an effective organization. The board evaluation process should thus be a serious and rigorous one and feed into board reappointment processes.

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## The role of the CEO

One of the most important tasks to be carried out by any board will be hiring, evaluating and possibly firing a CEO. Although the board will decide in broad terms on the long-term purpose of the PHN, the CEO will be responsible for developing the strategic plan to carry this out. Accordingly, the CEO must be carefully chosen. Appointing the right person is vital for the success of the organisation.

PHNs are to be transformative agents in the primary health care system. The board must choose a CEO who can achieve this. The CEO must be comfortable with pursuing change, and would ideally have a track record for managing reform and facilitating innovation. Willingness for and experience with change will thus be important criteria, to be weighed against other considerations. Any CEO who has no history of successfully implementing innovation is unlikely to be an ideal candidate for leading a PHN which aims to transform and innovate.

Moreover, the CEO must be someone the board members believe they can work well with. The relationship between the board and the CEO is perhaps the most important in any organisation. The CEO serves as the driver of strategy, distilling the purposes identified by the board into an implementable plan for action. If the CEO and the board cannot work together in this important regard, the clarity of purpose which is so vital to success will not be achieved. A positive working relationship is essential.

One crucial element is that the CEO, like the members of the board, shares in the values of the organisation. One of the most important roles of the board and the CEO is to create and shape the values of the PHN. These values are the 'heart' of the PHN,

<sup>4</sup> Australian Institute of Company Directors, Governance Analysis Tool™, <http://www.companydirectors.com.au/Director-Resource-Centre/Governance-analysis-Tool>

acting as the basis for the organisation's purpose and strategy. The PHN will have its greatest chance of success if all crucial personnel are on the same page with regard to organisational values. The CEO is an important part of this.

***One of the most important roles of the board and the CEO is to create and shape the values of the PHN.***

It is vital that the board and CEO work together to carefully define the organisational culture. The CEO must know how innovative the board would like the PHN to be. Any other board decisions about the characteristics of the organisation must also be communicated clearly. For instance, a CEO should be aware of how confrontational the board wants the PHN to be in its external and internal environment, how bureaucratic its operations are to be, how transparent it will be and what its risk appetite will be. Given that the CEO has primary responsibility for enacting the board's strategy and vision, clear communication of these directions and values is also important. Ideally, boards will have worked out their position on the nature of this working relationship before appointing a CEO and this information can be used in CEO selection.

Having appointed a CEO, the board must be able to ensure that the CEO's performance is satisfactory. As suggested by Tricker's matrix, CEO evaluation is one of the board's most important functions. To do it well, the board must clearly determine the measures by which the CEO's performance will be assessed, and must communicate these to the CEO.

These measures are likely to take two forms: quantitative and qualitative. The quantitative aspects should encompass all key parts of the organisation. They might, for instance, include measures to track service delivery, service transformation, service financing and the performance indicators incorporate in contracts and deeds of funding. Qualitative measures of performance are equally important. They include, in a general sense, adherence to organisational values (as determined by the board).

Importantly, these guidelines given to the CEO ought not create a relationship that is adversarial. Relations between the CEO and the board should be extremely positive, with interactions characterised by creative tension rather than animosity. As well as giving direction to the CEO, the board must support her/his work, playing the role of a 'critical friend'. After all, the CEO and the board must work together to turn vision into action. A positive relationship between board and executive not only improves organisational culture but can also improve the chances of meeting the PHN's objectives.

As well as playing a supportive role, the board must take responsibility for firing the CEO if necessary. Ideally, this will never eventuate. If the processes for evaluation and feedback are functioning properly, the CEO will be told of his/her shortcomings and will modify their priorities or behaviour to match the board's expectations. However, if the CEO fails to meet these performance requirements, boards must make the difficult decision to terminate his/her contract. Dismissal with cause should not come as a surprise to the CEO. The contract should include clear provision for termination without reasons in exceptional circumstances.

### **Blueprint for strategic planning**

The board and the CEO must work together to effectively develop and execute strategy. This section provides a blueprint for joint strategic planning.

A critical part of the board's responsibility is big-picture thinking. As explained at the beginning of this chapter, boards are responsible for deciding upon the organisational 'flavour' and the broad, long-term aims of the PHN. This is an important process, and must be done thoroughly and clearly.

This long-term thinking, however, is useless without an effective plan for achieving desired outcomes. Ideals and visions must be shaped into a concrete strategic plan for action. It is vitally important that the executive leads this process, given that it will be responsible for carrying out the board's vision and will have its performance assessed by the extent to which the vision is realised. The CEO must then be the driving agent in the strategic planning process. The CEO should work with the board to craft the broader organisational purpose into a constructive, implementable plan.

Methodical planning is achieved through careful documentation. There are two key documents involved in strategic planning, which the executive will be responsible for formulating in consultation with the board.

The first important document is a broad strategic plan stretching over a period of around five years. This will discuss the PHN's broad purpose and the board's vision for its role in the primary health landscape, as discussed in the next chapter. Given that its time horizon is large, it will deal primarily with long-term strategic thinking, clearly articulating the vision for the organisation and setting out where the PHN is headed and what it eventually hopes to achieve. This long-term trajectory will be important for boards and executives to have documented in the early stages of the PHN's existence, so that the organisation can best direct its resources from the outset. Put differently, the executive must be aware of future plans to best tailor present actions.

As clarity of vision and purpose is important, the long-term plan might also be summarised into a short, one-page document that makes the PHN's priorities easy to describe to new staff and stakeholders.

The second document deals with more immediate concerns. It is a short-term business plan documenting objectives for the coming financial year. Once again, the formation of this one-year plan will be led by the CEO, given that the CEO will be primarily responsible for implementing it. The document will reflect and promote progress towards the long-term trajectory of the PHN, determining the optimal allocation of financial and other resources. This translation of the long-term vision into a short-term plan is a crucial step. Failure to develop a concrete plan for implementing the PHN's goals will almost guarantee failure to achieve those goals.

It is important to note that the clarity of purpose spoken of here and elsewhere in this book is twofold: clarity of vision and clarity of implementation. Vision is the domain of the boards, dealing with the big-picture aspirations of the organisation. Implementation is the domain of the executive. The two in conjunction amount to a clear purpose, and one that has a good chance of being achieved.

From this it is clear that a positive and productive relationship between the board and the executive is essential. Only in conjunction can they achieve the sort of clarity of purpose necessary for the PHN to enjoy success. The process of strategic planning involves both of them, dealing with both the short-term and the long-term. If the board and CEO are chosen well, this strategic planning can be effective, empowering the PHN to make meaningful change to the primary health care system.

***A positive and productive relationship between the board and the executive is essential.***

## CHAPTER 3: Strategies for change

- PHNs exist to improve the functioning of the primary health care system and in particular its coordination.
- To do this, PHN boards should actively pursue change, innovation and system reform.
- PHNs will face obstacles in pursuing change, chiefly their limited authority.
- Despite their limitations, several levers for change are available, including funding incentives, advocacy, relationship building, skill development and health promotion.
- Innovation entails risk, which must be managed well.
- PHNs must be clear about their purpose and should see themselves as enablers.

The information provided to successful applicants on 1 May 2015 outlined the role of the PHN as follows:

"The key objectives of Primary Health Networks are:

- increasing the efficiency and effectiveness of health 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.  
PHNs will undertake regional Needs Assessments and conduct service planning for their PHN Region, in collaboration with local health service providers including Local Hospital Networks (or equivalent). With support from Clinical Councils and Community Advisory Committees, PHNs will seek to develop local strategies to improve the operation of the health care system for patients and facilitate effective primary health care provision, to reduce avoidable hospital presentations and admissions within the PHN catchment area.  
PHNs will work directly with general practice, other primary health care providers, secondary care providers, hospitals, and private providers to ensure improved outcomes for patients."

This description leaves considerable scope for interpretation. It is clear that PHNs will play a significant role in leading change and reform in the primary health system. But PHNs have some choice as to how this change should be achieved, what it should look like and how fervently it should be pursued.

This makes the PHN board's role crucial. The board must decide on what changes it will pursue and how to pursue them. The

PHN's success will depend heavily on the board's decisions in this regard. If the board fails to articulate clearly how the PHN will undertake its roles, objectives are unlikely to be met. Choices about strategy are difficult but all-important. Broadly, it comes down to deciding on the balance between stability and innovation.

In pursuing stability, the PHN works within the primary health system as it exists. The PHN would fulfil the everyday functions of a primary health organisation: managing contracts, overseeing service provision, providing information and feedback and facilitating coordination. Emphasis is placed on continuity and stability. Any attempts to change the local primary health landscape are minor only. For instance, the PHN might focus on coordinating services to fill specific gaps in its catchment area.

Innovation, on the other hand, involves actively seeking to reform the system by promoting new ways to deliver services and improve health outcomes. Rather than working to patch up imperfections in the system, an innovative PHN will devote its resources to changing the way health is provided to the community. The board and executive will think and act creatively to improve outcomes for patients.

***Innovation, involves actively seeking to reform the system by promoting new ways to deliver services and improve health outcomes.***

A PHN should pursue both of these ends to some degree. Consequently, boards face a tradeoff between the two. Resources spent maintaining the status quo are not spent innovating. Conversely, any resources devoted to innovation and change entail risk. Moreover, staff with a track record of acting as managers of a stable state are unlikely to transform themselves overnight into innovators, such that a PHN which devotes itself to one will find it difficult to switch to the other. It is natural to favour the familiar; innovation requires concerted effort. Ultimately board members must decide upon the organisation's priorities. Specifically, PHNs must decide how much change they want to pursue and how quickly.

This is a difficult choice. There are strong arguments supporting either approach. A PHN that opted primarily for stability would do so with good reason. Australia has a very good health system. Health spending is below the international average per head and as a share of the economy. We have a strong primary care system, with well-trained professionals providing affordable care.

Nevertheless, the authors believe there is a pressing need for system reform. The primary health sector, although functional, faces numerous problems. As outlined in the first chapter, the duplication, wastage and under-utilised capacity that result from poor coordination adversely impact health outcomes for patients. The primary health system is not improving community health as much as it could. PHNs exist to improve health outcomes. They are best placed to do so if they seek to innovate rather than accept the status quo.

***PHNs exist to improve health outcomes. They are best placed to do so if they seek to innovate rather than accept the status quo.***

PHNs are well placed to evolve and expand. They could take on a new function from Commonwealth and state governments or, potentially, private health insurers. These increased functions will occur because of government, public and provider recognition that changes and improvement in health care are necessary. The health system will be expected to work differently in the future from how it works now. PHNs that develop a track record of leading change now will be better placed to lead change in the future.

***PHNs that develop a track record of leading change now will be better placed to lead change in the future.***

As suggested in the introduction, PHNs will face limitations in pursuing innovation and change. Their inability to mandate change

and their limited financial levers are hindrances. PHNs will often be powerless to address the root causes of adverse outcomes. Nonetheless, there is scope for PHNs to achieve meaningful change. The targeted use of funding levers and commissioning processes can encourage integration and innovation amongst health providers. Other pursuits, such as advocacy or relationship-building, can also help to gradually but significantly transform the primary health landscape.

Moreover, PHNs are well poised to achieve local change. If they operate like Medicare Locals, PHNs will develop a good working understanding of the region they serve. By performing a needs analysis of the local area, they will better understand regional issues and particularities. Armed with local knowledge, a PHN can do that which state and federal governments generally cannot; that is, to craft and implement locally-tailored solutions to the problems of primary health care. PHNs have a unique power to innovate and reform the system.

If, then, a PHN decides to be an agent for innovation and change, how should it proceed? What challenges will be faced, and what difficult decisions will need to be made? It is hoped that the discussion here will help the boards of PHNs develop strategic plans that will achieve real change and improve patient outcomes. The potential for PHN-driven system reform will be explored in depth.

The main ways in which PHNs can position themselves as agents for change are by

- using funding to encourage integration;
- funds pooling;
- using funding to encourage delivery of important services;
- influencing the system through evidence and advocacy;
- building relationships with and between health professionals;
- promoting skill development; and
- promoting public health.

None of these are straightforward. There are difficulties associated with each. This chapter will explore these areas in greater depth, in the hope of familiarising PHN boards with the primary health care landscape. Having highlighted the areas in which strategy is needed, the chapter will conclude by discussing strategic planning, and the important role it can play in helping a PHN reach its goals.

### Using funding to encourage integration

The need for better integration in primary health care services is well recognised. As quoted earlier, the Commonwealth Government identified “coordination of patient care” as an area for improvement. PHNs, according to the government, are to play a role in bringing this about. Indeed, as public primary health organisations, their main function is to facilitate coordination and integration between primary health services.

### What would greater integration look like?

Much discussion about the need for improvement in primary health care, including the discussion in this book, emphasises the need for greater coordination and integration. Often, however, there is little attempt to explain precisely what is meant by these terms, or what integration and coordination would look like in the primary health sector.

Broadly speaking, what is sought is a remedy to the existing situation, where autonomous providers do not communicate effectively on matters like sharing information and providing patient information and patient referral, or on programs and planning for population health. This present situation adversely impacts on continuity of care, particularly for people with chronic illnesses. Any attempt to build coordination or integration is an attempt to ameliorate this failure.

There are three levels of relationship that can be built between service providers. The first of these is a *referral* relationship. This involves a practitioner referring a patient to another professional for advice and/or treatment. The quality of the relationship depends on the extent of knowledge the referring practitioner has about the other practitioner, including skills and billing practices, and the level of feedback provided from the other practitioner to the referring practitioner, as well as the level of trust.

A coordinating relationship is a more developed relationship. It involves an initiating practitioner (typically a GP) assigning part of a treatment plan to others, making referrals to a number of practitioners, monitoring and keeping track of what each of them is doing and initiating changes to their work/role in light of feedback and reassessment of the patient's condition. The consequences for continuity of care are better for the patient in this case than in the case of a referral relationship.

An *integrated* relationship is more developed still. Integration exists where a number of practitioners work together as a team to treat a patient. This includes joint involvement in developing the treatment plan, joint monitoring of progress and joint agreement on changes to the treatment plan.

Although integration is arguably more desirable than coordination, both are highly desirable compared with the present situation, which generally is a lack of either. The successful pursuit of either integration or coordination would constitute a significant improvement to primary health in Australia. Rather than focusing on the relative merits of the two, this book seeks, amongst other things, to suggest ways in which PHNs can pursue *either* of these paths to achieve reform. Both coordination and integration fit under the broad objective of the PHN program outlined at the beginning of this chapter. Accordingly, they will be treated in tandem.

As mentioned at the beginning of this chapter, PHNs cannot compel primary health providers to coordinate their services; it is not within their brief. Nor do PHNs have financial levers to reward coordination: the Medicare Benefits Schedule (MBS) is a national one that shapes GP behaviour far more powerfully than PHNs can. MBS incentives currently do little to encourage autonomous and diverse health providers to work together. In some cases there are even disincentives. Another significant barrier is that Australian health care has a higher level of out-of-pocket costs relative to similar countries. This makes the PHN's job more difficult, as the level of out-of-pocket costs might drive patient pathway choices.

***Integration exists where a number of practitioners work together as a team to treat a patient.***

These factors severely inhibit the ability of PHNs to achieve the integration the government seeks. However, their levers for change are not non-existent. In particular, they can prioritise their use of funds to encourage or mandate integration of commissioned services, so as to bring about system change at the structural level.

Initially, PHNs will be funded for specific services only. Principally, their funding will be directed towards specific, government-mandated programs, such as the Access to Allied Psychological Services Program (ATAPS). However, the role of PHNs should increase as the Commonwealth Government and, potentially, state governments, devolve service program responsibilities to them. A second stream of more flexible funding will be available to PHNs to provide services not specified by the Commonwealth. From 2015-16, PHNs will be able to apply for innovation and incentive funding. Innovation funding will enable the Government to invest in new innovative models of primary health care delivery proposed by PHNs. Incentive funding will be available for PHNs that meet specific performance targets. PHNs can also apply for other services or programs put out to tender by the Commonwealth and state governments. With these channels available, PHNs will be able to play a significant role in the funding of service delivery within their catchment.

This role can be used to advantage. As mentioned in chapter 1, PHNs are to be primarily commissioning organisations. When commissioning services, PHNs must specify the services to be purchased. Proponents are then assessed according to the specifications, as well as other criteria. Specifying the services to be commissioned is not a trivial or routine task. In fact, it is one of the most important things the PHN will do. Careful selection and specification of performance criteria can be perhaps the most effective lever in changing the way services are delivered.

***Careful selection and specification of performance criteria can be perhaps the most effective lever in changing the way services are delivered.***

A PHN board's key role is identifying what sort of system change it wants to achieve and ensuring that management writes tender specifications which facilitate this. A PHN concerned with promoting integration could do so by making willingness to integrate, as well as demonstrated capacity to do so, part of the commissioning criteria. Preference can be given to funding applicants demonstrating a capacity to integrate their services with other primary health providers and local health networks. For example, a PHN seeking to commission a mental health service might require its applicants to coordinate their services with other general health providers in order to receive funding. A stronger specification might require that general health providers be placed at the centre of the service network, with specialist mental health providers to work as consultants to the generalists in a more integrative service model. Thus the funding and commissioning capacity of the PHN can be used as an incentive for integration.

### **Funds pooling**

One of the factors contributing to the lack of coordination in the primary health sector has been the 'siloed' approach to funding employed by Commonwealth and state governments.

Rather than coordinating on service purchasing and delivery, Commonwealth and state governments have historically kept their roles in service provision separate from one another, and have also made little effort to tender for the purpose of integration. Funding contacts specify deliverables that have no recognition of any other organisation, encouraging silos and a lack of integration and networking, and discouraging joint delivery responsibility. This approach has been one of the major obstacles to achieving better integrated primary health services. When services are tendered, or even retendered, there is often little emphasis on better integration. Services contracted separately by the Commonwealth and the states are rarely connected. This has obvious ramifications for coordination and continuity of care.

***When services are tendered, or even retendered, there is often little emphasis on better integration.***

A PHN has some capacity to remedy this by encouraging the pooling of funds. A PHN could consolidate the funds previously spent separately by Commonwealth and state governments and purchase services for a particular service area, such as mental health, as an integrated whole. When it tenders, the PHN can specify deliverables not only for the organisation receiving the tender but also for other organisations.

Some organisations do attempt to develop integrated service models by funds pooling at a micro service or agency level. But a PHN working to coordinate funds on a larger scale might be able to achieve wider integration than these individual attempts, thus building system change. By developing positive relationships with Commonwealth and state governments, as well as NGOs, consumers and other stakeholders, PHNs might be able to promote better integration in publicly-provided health services as well as private ones.

### **Using funding to encourage delivery of important services**

PHNs, if they function like Medicare Locals, will develop detailed knowledge of the regions they serve. In particular, they will be able to identify service shortages. These shortages can be prioritised and potentially addressed using funding incentives.

One example from the NMML experience was the employment of incentives to improve after hours health services (see box).

#### **Case study: NMML and after hours care**

In response to an observed lack of after hours services in its catchment, NMML crafted a targeted incentive grant program, supporting clinics to open after hours. NMML worked directly with local GPs on this. It recognised that one of the main reasons for a lack of after hours care was a funding model that rewarded practice size rather than hours of opening. NMML's innovative funding model rewarded hours of opening. The structure of incentives responded to the perceived need for after hours care based on analysis of hospital emergency department data and other sources. Because of the way the incentives were structured, a number of general practices which had not previously opened after hours did so and service access improved. At one stage in the commissioning process, NMML had expected it would have to establish its own after hours clinic in the northern, rapidly-growing part of its catchment. However, the new structure of incentives encouraged a number of existing providers in that part of the catchment to open, removing the need for direct provision by NMML. In total, 58 GP practices were funded by NMML in 2013/14, delivering over 450,000 after hours consultations to the NMML catchment.

In this instance, a creative solution to a broader problem brought real health benefits to local patients. This real-world example demonstrates the potential for the targeted use of incentives to achieve primary health objectives. PHNs could consider such programs in their pursuit of integration, or in response to particular service needs identified in their catchment areas.

#### **Influencing the system through evidence and advocacy**

There is a gap between the problems PHNs are designed to fix and their capacity to fix them. PHNs have limited authority to bring about substantive reform.

They can, however, influence change by taking advantage of their position as primary health leaders, to advocate. PHNs might not be able to force providers to integrate with one another, but they can pursue change by making the case for it in the right places. A PHN will be able to speak with some authority, given its local knowledge, and some credibility, given its status as part of a national network acting in line with government policy. Accordingly, such attempts at influencing are not a trivial task for PHNs. Concerted lobbying has the potential to bring about meaningful change to the primary health system.

***PHNs might not be able to force providers to integrate with one another, but they can pursue change by making the case for it in the right places.***

This sort of advocacy is best achieved in tandem with other groups. Working with other PHNs or other health organisations to advocate jointly on important causes will maximise the chance of success.

Advocacy is most useful when it is accompanied by evidence. It is the use of evidence, combined with local knowledge, that will give PHNs the greatest chance at influencing change.

A key role for PHNs will be in building evidence. This may include well-designed demonstration projects accompanied by sound evaluation. It might also involve collection of data from patients, the community or practices. Evidence can be used locally to demonstrate to other practices that a particular initiative works or is financially viable, or to advocate more broadly. Where no evidence exists, PHNs should build the evidence base themselves. They might partner with universities and other research institutions to commission research on innovative ways of improving primary health service delivery. The sort of evidence that such an approach can provide can then be used to make a case for change that is more likely to be successful.

Evidence-building can be used to ensure that innovation is built into the structure of the organisation. Innovation is one of the PHN's most important functions, but it is risky and difficult. If it is simply expected to be conducted by management in a routine way, it might easily be prioritised behind other duties and forgotten about. But this could be avoided by appointing someone whose specific role is to stimulate innovation. For instance, the PHN might establish an 'innovation unit' whose role could be to work with universities to build the evidence base for particular methods of primary care provision. This appointment could even be a joint appointment in partnership with a university, or it could be outsourced to the university with a primary health researcher contracted as a consultant on innovation. The board might engage regularly with the innovation unit to discuss developing ideas. This will ensure that innovation is a continuous process and will also feed back into the PHN's efforts at advocacy.

It is important to combine this evidence with local knowledge. PHNs will come to know the local area well, eventually developing a detailed knowledge base which can be used to craft tailored solutions to locally-identified problems. A PHN might seek to survey its population or obtain data on its demographic and health outcomes. This sort of information is important to lend concreteness and applicability to any prescriptions a PHN makes.

To summarise, a key role for the board in executing successful advocacy will be:

- Ensuring that PHNs develop a sound evidence base for change
- Guiding advocacy strategies both locally and more broadly
- Using this network to advocate for change local and more broadly

Having accumulated evidence and local knowledge, the PHNs will be able to target change in many areas. They can be condensed into three headings:

### Promotion of 'best practice'

- Local advocacy
- Broader system reform advocacy
- Promoting 'best practice'

PHNs are expected to oversee improvements and innovations in primary health care practice. It will be important for them to increase the number of primary health care services in their catchments employing 'best practice' processes. The specification process will allow them to do this, by promoting particular models of practice or service delivery when they commission services. This sort of promotion will be discussed in chapter 4. But PHNs also have the ability to influence the practice of the many autonomous providers that make up the primary health landscape through their evidence-based advocacy.

A PHN can keep abreast of innovative and best-practice models in primary health by drawing on examples from its catchment, or more broadly from around Australia or from comparable health systems overseas. It can also commission research into best-practice service delivery in order to build the evidence base for the promotion of new ways of providing health care. In this area in particular, success is only likely if the requisite evidence and local applicability are used to bolster a PHN's suggestion. The stakeholders it wishes to influence, health practitioners themselves, are often businesses, who will only make adjustments to the way they provide services if it is clear that the financial analysis stacks up or it is otherwise worthwhile. A PHN must therefore make a sensible 'business case' for change whenever it advocates. It can only do this with supporting evidence.

***Success is only likely if the requisite evidence and local applicability are used to bolster a PHN's suggestion.***

### Local Advocacy

The PHN's detailed local knowledge can also make it acutely aware of the shortcomings and failures of the local system as a whole. Although their ability to address this themselves will be limited, PHNs can work with relevant community groups and stakeholders to fill gaps or strengthen local systems.

A crucial component of successful local advocacy is the formation of positive relationships with relevant community groups and stakeholders. The development of these relationships should be a priority for any PHN. Establishing lines of communication with local primary and secondary health providers, as well as community groups, local governments and other local institutions, will be vitally important to improve the PHN's chance of success when it seeks to advocate. The Clinical Council to be established by PHNs could be used to this end. The councils could be tasked with identifying areas where change is needed locally, what evidence could be collected to support the case for change, and what a viable solution and robust evaluation strategy might look like.

*A crucial component of successful local advocacy is the formation of positive relationships with relevant community groups and stakeholders.*

A PHN might use its relationship with a local hospital network to promote better integration between primary and secondary health care. If the PHN became aware of a lack of coordination in its catchment area between primary providers and hospitals, it could seek to rectify this by encouraging hospitals to communicate more with general practice and allied health professionals. This might be done by building care paths to improve continuity of care, or improving patient flows to reduce unnecessary hospitalisations, the sorts of proposals a PHN might credibly make if supported by an evidence base that identified the problem and endorsed a solution. If a PHN had a strong relationship with the local hospital network, this could be leveraged to improve the chance of change.

Another problem a PHN might identify is the lack of resourcing in relatively new, outer-suburban areas, or under-provision in rural areas. The first of these problems was identified by NMML in its own region. The NMML catchment extended to the so-called 'growth corridors' on the outskirts of Melbourne, where rapid housing development was often not matched with the necessary health infrastructure. Any PHN with a catchment that includes newly developing suburbs is likely to encounter a similar problem.

One idea developed by NMML as part of a bid for PHN tenders in its area was to introduce a Service and Business Development Unit to encourage GPs to establish clinics in areas that suffered from undersupply due to market failure. The unit would provide sophisticated business development support covering service model development, strategic and financial planning. In particular, integrated service models could be promoted. Such a program can be seen as mutually beneficial: sophisticated business development planning can be well received by new or inexperienced health providers, and the community would benefit, not only by seeing a correction of the undersupply but also through the establishment of properly integrated services.

Lack of health infrastructure can be broadly viewed as a symptom of poor urban planning. Having identified this, a PHN might work with the relevant local governments or private developers to consider health needs more carefully when approving developments. This was seen by NMML as another area where the Service and Business Development Unit could play a role. It would do so by developing a robust business case for a new development and then acting as a conduit between potential providers and private funders.

There are many other examples of the potential for local advocacy to bring about change. For instance, encouraging primary schools to change tuckshop menus might bring about tangible improvements in public health, of the sort that will be discussed later in this chapter.

### **Broader system reform advocacy**

By advocating at a local level and leveraging positive local relationships, PHNs can bring about significant small-scale changes to the primary health landscape. However, not all of the issues PHNs will identify will be so contained. Many of the problems in primary health have their roots not in local shortcomings, but in broader failures of the system as a whole.

If PHNs are limited in their capacity to force local change, they have even less power to drive broader system reform. Once again, then, advocacy is important. As well as pursuing causes on a local level, a PHN can and should agitate more broadly for change. The PHN can seek to change the environment in which it is situated. As previously stated, such an approach is in line with the government's intentions for PHNs as agents for system reform.

For instance, PHNs might advocate for changes to the primary school curriculum to improve population health literacy. They might advocate for changes to MBS funding arrangements for GPs to improve quality of care. They might advocate for enrolment of particular patients, such as people with diabetes, to improve continuity of care. They might advocate for changes to their own funding arrangements, so as to better facilitate integrated service provision. These sorts of issues can be addressed at a Commonwealth or state level, but only if the public case for change is made. Once again, this should be supported by the relevant evidence.

Of course, the likelihood of advocacy from a single PHN bringing about national reform is slim. These sorts of causes might best be advocated through networks of PHNs, at a state or national level. By jointly advocating on a common cause, multiple PHNs might carry more weight. If large numbers of PHNs identified a problem and agreed on an evidence-based solution, their petition to government might be taken seriously and could lead to positive outcomes. Accordingly, a board which wants to see a particular change brought about at a national level might seek out other boards with similar views, building relationships with them and engaging in joint advocacy. It will also be important for PHNs to work with organisations that participate in health advocacy, such as the Australian Healthcare & Hospitals Association (AHHA) and the Australian Medical Association (AMA).

***By jointly advocating on a common cause, multiple PHNs might carry more weight.***

### **Building relationships**

As mentioned in chapter 1, the primary health landscape is diverse. Service providers are typically autonomous and there is little history of coordination, due in part to the lack of funding incentives.

Typically, the relationship between professionals in primary health and between primary and secondary care providers includes a referral, with inconsistent reporting back of the results of the referral. This is sometimes adequate, but when a patient's condition is complex and can benefit from the views of multiple professionals, much more coordination is required, especially if there needs to be discussion and debate about treatment.

Improving coordination is difficult. The very mention of 'improving' coordination implies that lines of communication already exist. In many cases, they will not. The diverse providers in the primary health system will not be accustomed to working together on a common goal, or even working together on individual patients. Information sharing between providers is limited, impacting on continuity of care and creating unnecessary duplication. Paths for referral are often weak.

If this situation is to change, relationships between primary health providers must be built, in many cases from the ground up. However, without adequate government funding incentives for cooperation, there is little chance of this occurring on its own.

Accordingly, PHNs must play an active role in the building of relationships between providers. To some extent, integration in individual cases can be promoted using funding incentives, as discussed earlier in this chapter. However, long-term, system-wide cooperation, as is the ultimate aim of the PHN program, can only be achieved if positive relationships exist between service providers.

To build these positive relationships between providers, PHNs must first establish their own positive relationships with each provider, of the sort discussed in the previous section. The PHN should seek to build a rapport with health providers of all types: primary and secondary, generalist and specialist, medical and allied health, public and private. Moreover, the PHN should build relationships with local government, schools, community organisations and the local community itself.

Having established its own relationships, a PHN can then seek to establish relationships between providers. It can serve to some extent as a middle person, providing lines of communication between providers, facilitating the sharing of information and assisting with referrals. This function as a central link is important. Coordination is lacking not because providers are unwilling to cooperate with each other, but because they have not been provided with incentive to do so, and because cooperation is unconnected with the providers' business models. If the benefits of cooperation are made apparent by a competent and active PHN, providers might be more willing to work together. To frame this in a different way, coordination is lacking because stakeholders have no platform on which to come together. This is something a PHN can provide.

***Coordination is lacking because stakeholders have no platform on which to come together. This is something a PHN can provide.***

One existing example of a relationship-building organisation that NMML dealt with is the national Mental Health Professionals Network (MHPN), outlined in the case below.

### **Case Study: The Mental Health Professionals Network (MHPN)**

The MHPN was established to strengthen community mental health by creating opportunities for relevant practitioners to network and build referral and communication pathways. It is a unique national program designed to champion interdisciplinary practice and collaborative care. MHPN supports local, self-directed professional development networks in more than 385 communities across Australia, including in NMML's catchment area.

MHPN's interdisciplinary model provides a foundation for collaborative care, establishing relationships between practitioners of mental and physical health, to better address co-morbidity. The networks, consisting of an interdisciplinary mix of practitioners from local community, hospital and private practice settings, meet quarterly for professional development and networking. The program has enjoyed the ongoing support of key professional bodies and has a history of strong relationships with Medicare Locals.

It is important that the PHN does not see itself as needing to build coordination entirely from scratch. While systematic coordination will likely be lacking, there may be existing mechanisms and initiatives for local coordination, like MHPN, and the PHN should seek to join and bolster these rather than seeking to duplicate them. Working within the existing channels for communication and coordination will assist the development of positive relationships with those in the local area who are working towards the same goal as the PHN.

Once again, the commissioning framework can help. Contract specifications, for instance, might include the requirement for clearer referral paths, or for information sharing with other providers. The provider of an allied health service might be assessed on its willingness to work with general practice. GP clinics might be rewarded with funding if they seek to establish referral paths. This careful deployment of financial incentives might build relationships within the local primary health system.

### **Promoting skill development**

One of the key objectives of the PHN program is to reduce costs in the health system as a whole. One way it can do this is by increasing the capacity of the primary health system to decrease reliance on hospitals and relieve pressure on the hospital system.

The hospital system is becoming increasingly specialised. Hospitals offer an increasing number of services, such that some chronically ill or seriously ill patients stay there almost constantly. These extended inpatient stays and multiple outpatient visits are expensive for the public health system. Moreover, primary health providers are becoming reliant on the hospital system, in many cases using it as a first port of call.

This cost burden could be reduced if GPs and other primary health providers 'upskilled', increasing their capacity to manage health problems, particularly for patients with chronic illnesses. This could reduce unnecessary hospitalisations, which in turn reduces the public cost of health.

One example is in the management of diabetes. Diabetes is one of the most common chronic diseases in Australia. Its management is complex and diabetic patients require a wide range of services. At present, many people with diabetes are referred to hospital outpatient clinics. One of the problems with this approach is that the patients are often captured and then remain in the hospital outpatient system.

An alternative is to skill up GPs to enable them to manage diabetes more effectively. If a GP was better able to manage a diabetic patient's needs, the specialists in hospitals, to which patients are at present referred, could act as a consultant to the GP rather than an alternative.

This is applicable not just to diabetes. There are many common chronic or other illnesses that GPs could be trained to manage more effectively, reducing costs on the hospital system. This should be done in tandem with the development of pathways that connect GPs and specialists.

This concept of developing the skills of GPs in areas that are not specific to their training was promoted by NMML, as explained in the case study below on the General Practice and Primary Care Support program.

### Case Study: General Practice & Primary Care Support (GP & PCS) program

As part of promoting skill development, NMML worked to consolidate the GP&PCS program resources to a core set of in-practice or webinar training modules, checklists and information packs. These were targeted towards allowing staff to be more confident in areas that were beyond their specific expertise. NMML was eager to respect the practices' time by presenting this training in a less ad hoc, more refined way than had been the case previously. Staff could train other staff using supplied information. Presentations and information packs were tailored from a master plan to address each practice's particularities.

NMML had plans to further develop this GP training program, cut short by the cessation of the Medicare Local program. The next stage in the process was to be in-practice professional development, or a planned series of roadshows. NMML wanted to work with an external peak body or institute (e.g. Baker IDI or Cancer Council) to develop in-practice training with professional development points that addressed its broader priorities. NMML staff themselves might ideally have presented to practices in training workshops, allowing particular organisational priorities to be promoted through the training process.

To a certain extent, this skills development already happens organically. GPs who encounter a large volume of patients with a particular illness will often seek to build their capacity for managing that illness. However, as agents for the pursuit of improvement in primary health, there is much that PHNs can do to facilitate this process more systematically. PHNs can use their local health knowledge to identify key areas where upskilling is needed. They can encourage this upskilling by promoting professional development and training for GPs and other health professionals. If this approach is successful, the primary health system will become better able to address unmet needs.

### Promoting public health

Many of the PHN's aims are specific in nature. These include the facilitating of coordination and the improvement of service provision. Binding these specific aims together is a commitment to improving the health of the local population.

The PHN's work in coordination and service delivery is designed to achieve this. A better coordinated and more capable primary health system results in better health for patients. But there are other ways in which a PHN can promote public health in a more general sense, which builds on the primary care system's critical role in personal preventative services.

One way in which PHNs can do this is by promoting preventive measures and disease screening. This is consistent with the national Key Performance Indicators for PHNs. They can attempt to increase immunisations, whether through funding incentives, advocacy or other means. They can also campaign in local communities to increase health literacy and educate at-risk populations about necessary precautions, such as disease screening.

NMML frequently devoted resources to achieving these general public health goals. In one instance, NMML was successful in reducing smoking rates amongst the Arabic-speaking community in its catchment, thanks to a targeted public health campaign (see case study).

### Case Study: Quit smoking initiative targeting the Arabic-speaking community

NMML identified that the Arabic-speaking community in the city of Hume, within its catchment, had high smoking rates. NMML and Pfizer Australia, in partnership with Dianella Community Health and Quit Victoria, implemented a coordinated campaign to reduce rates.

Mainstream Quit campaigns and messages had not achieved the same level of effectiveness across the Arabic-speaking community as with other cohorts. Accordingly, NMML and Pfizer undertook market research to develop a communications strategy that would have a stronger resonance for the campaign's target audience.

The local campaign was highly effective. An independent evaluation demonstrated that almost all who saw the campaign took positive action. One in three sought out their GP for advice, and even higher numbers talked to a pharmacist about quitting. The campaign won the best public health initiative at the 2014 PRIME Awards (that recognised excellence in the Australian Pharmaceutical and Life Sciences industry) and was awarded a silver medal at the Victorian Public Healthcare Awards.

As well as generally improving public health, these measures relieve cost pressures on the rest of the system. A PHN that succeeds in improving screening and immunisation rates will prevent unnecessary and costly hospitalisations and treatment programs down the track. There are other ways in which public health can be promoted by PHNs, including in health education and health promotion. An example of this was given in the previous section on advocacy with the case of promoting healthy tuckshop lunches at primary schools.

***A PHN that succeeds in improving screening and immunisation rates will prevent unnecessary and costly hospitalisations and treatment programs down the track.***

## Risk appetite

The various approaches outlined in this chapter provide very real opportunities for PHNs to achieve change in the primary health sector. However, each approach entails risk. This is true of any attempt to be innovative or to reform. Accordingly, PHN board members must decide on the appetite for risk their organisation will have.

Deciding on a risk appetite is one of the key tasks for the board of any organisation, especially in the business world. Its importance is amplified by the perceived existence of a tradeoff between risk and reward. Frequently, actions that promise the highest reward entail the greatest risk of failure. Lower-risk options are often less rewarding. In the case of for-profit businesses, these risks tend to refer to profit margins. Although PHNs are not-for-profit, this tradeoff will be applicable to their work.

From a financial perspective, taking too many risks runs the risk of high rates of project failure, resulting in the PHN having little to show for its spending. More broadly, the PHN must understand the risks involved in the approaches it chooses if it is to be successful in improving health outcomes.

The first step towards successful risk management is being able to identify the risk. Potential pitfalls should be carefully examined by boards and management before a decision is made. Early identification of risks is crucial in an organisation's capacity to mitigate them. The type of risk should also be determined, whether financial, reputational, staffing or other.

Projects can be separated into categories such as high-, medium- and low-risk, based on a combination of the likelihood of a particular outcome and the consequences of that outcome. Although difficult to determine precisely, the general riskiness of a proposal can be gleaned in a number of ways. For example, an innovative method of service delivery that has never before been trialled in Australia has a high chance of failure. Significant amounts of money might be invested for no reward. Conversely, a program that has been trialled several times in nearby areas, although not completely risk-free, might be less risky.

Some risk mitigation strategies pursued by NMML included:

- using staff networks to identify whether similar projects had been undertaken elsewhere;
- creating project advisory groups comprised of people with expertise in the project area, including staff from universities;
- researching (online and using journals) for prior examples;
- establishing a formal project approval process which required documentation of the desired achievement, plan for implementation and plan for evaluation; and
- establishing a process of internal review and discussion to update evaluate these methods.

But as well as the day-to-day identification and mitigation of risk, PHN boards must make a deeper decision about the amount of risk they are willing to take on. This question relates directly to the tradeoff posed at the beginning of the chapter between managing a stable state and stimulating change. The former approach is low-risk, but potentially low-reward, the latter higher-risk and potentially high-reward.

***PHN boards must make a deeper decision about the amount of risk they are willing to take on. This question relates directly to the tradeoff posed at the beginning of the chapter between managing a stable state and stimulating change.***

As was explained at the beginning of the chapter, a PHN will most likely function in both of these capacities to some degree. Deciding on the balance between the two, it was suggested, was a crucial decision for boards.

This chapter has put forward a case for the PHN as innovator, suggesting that boards preference the pursuit of change over the

management of a stable state. But if innovation entails risk, is this not a dangerous path for a PHN to take? How might the risks of such an approach be mitigated?

Having successfully identified and categorised risks, boards can decide on an optimal balance of high-, medium- and low-risk options in its 'risk portfolio'. A PHN that wants to innovate might balance out a small number of high-risk, high-reward projects with medium- or low-risk 'safe' options. Thinking about the PHN's projects as a portfolio in this way, rather than examining each individually, can help to clarify the board's decision.

Ultimately, however, the board must still make a decision on its appetite for risk. It must decide how earnestly it will seek to innovate and reform. Some boards might choose to be risk-averse, innovating cautiously and balancing out any innovations with low-risk projects. Others might choose to embrace risk in the hope of achieving greater reward. Thinking about risk portfolios is a way for boards to clarify this tradeoff, aiding their decision.

### Enabler/network approach

This chapter has been devoted to ways in which the PHN can circumvent a fundamental problem: the gap between the problems it seeks to fix and its power to fix them. Several solutions have been offered for how PHNs can address problems in the primary health system using the levers at their disposal.

Amongst the approaches outlined have been:

- using funding to encourage integration;
- funds pooling;
- using funding to encourage delivery of important services;
- influencing the system through evidence and advocacy;
- building relationships with and between health professionals;
- promoting skill development; and
- promoting public health.

These are not directive measures. They do not involve coercion, control or forcing autonomous providers to behave in a particular way. Their effectiveness lies in indirect power and persuasion. Each of these measures involves the PHN building its relationships with health providers and the wider community, and then using these relationships to bring about system reform.

In this respect, a PHN that pursues change in the ways suggested in this chapter can be seen as an enabler. Change is facilitated rather than forced. Reform relies on encouragement, persuasion, financial incentives and the use of evidence. Networks between previously uncoordinated service providers and community groups are formed and used as a vehicle for progress. Existing structures for coordination are used to maximum effect. The desired goals for the primary health system are gradually and carefully worked towards. Shared ownership of the goals is promoted, rather than a lead agency owning the process.

This enabler approach is only one way of conceiving the role of the PHN, or of defining its purpose. However, the authors believe that this approach, which involves facilitating rather than forcing change and using its funds and activities creatively and purposefully, is the best one to tackle the problems facing the primary health system. There are several reasons for this.

***Facilitating rather than forcing change and using its funds and activities creatively and purposefully is the best way to tackle the problems facing the primary health system.***

Firstly, it combines idealism with realism. Unlike the view of the PHN as the manager of a stable state, the view put forward in this chapter is ambitious. It strives to change the primary health environment and conceives of the PHN as actively pursuing reform. However, the restrictions faced by PHNs are recognised. In particular, the enabler approach is built around the understanding that PHNs are unable to directly bring change about. The focus of the approach is on indirect methods that lie within the scope of the PHN brief.

Secondly, the approach is practical. Frequently, boards that set out to craft a 'vision' for their organisation fall victim to vagueness and abstractness. Visions of this sort contain ideas for change, but little consideration of how this change might be pursued. In contrast, the approach explained in this chapter is specific, and grounded in the realities of the Australian primary health system. It draws upon multiple case studies from the NMML experience to demonstrate how ideals and values can be

translated into meaningful change.

Thirdly, the role of the PHN under this approach is clearly articulated. The challenges are frankly acknowledged, their solutions carefully considered. As explained at the beginning of this chapter, this clarity of purpose is essential for an organisation to achieve its aims. Only by clearly defining the problems an organisation seeks to overcome and the means by which it will overcome them can success be realised.

## CHAPTER 4: Commissioning

- PHNs will be commissioning organisations.
- The commissioning specification process allows PHNs to achieve reform. Done well, commissioning can improve coordination and health outcomes.
- Careful thinking about commission specification is essential, as is the determination of performance metrics for assessing outcomes.
- The board will not consider individual commissioning cases, but will determine an overall commissioning strategy.

As mentioned in chapter 1, PHNs, like Divisions and Medicare Locals before them, have been given responsibility for central aspects of service provision. A PHN essentially faces a choice between two options: to provide the service itself, or to commission someone else to provide the service. This is commonly referred to as the 'make-or-buy' decision.

In the case of PHNs, this decision has to a large extent already been made. As quoted in chapter 1, the government has indicated that PHNs will serve as commissioning organisations. There will be some exceptions, specifically where there is 'market failure', which is most likely to occur in rural areas where there are no existing services, or in urban growth corridors where there is a mismatch.

The government has provided PHNs with a definition of commissioning:

"Commissioning is a strategic approach to purchasing that seeks to ensure that services meet the health needs of the population and contribute towards service and system improvement and innovation.

Commissioning is a continuous process that requires your organisation to be responsible for:

- a. strategic planning – assessing the needs of the community and available health services, and determining priorities based on service analysis and professional and community input;
- b. service procurement- purchasing health services in line with the outcomes of strategic planning, the PHN objectives and the identified local and national priorities for the PHN; and
- c. monitoring and review – assessing the efficiency and effectiveness (including value for money) of health services, and implementing strategies to address gaps and underperformance."

This language indicates that, although PHNs won't provide the services themselves, they will be responsible for identifying health needs in their catchment area and using their funds to procure the provision of these services from external providers.

As indicated in section 'b' of the above quote, some of the services the PHN is required to commission will be dictated by national priorities. The Commonwealth government will specify in the PHN budget a range of services that are to be funded, including the Access to Allied Psychological Services (ATAPS) program.

However, there will be some freedom under the so-called 'flexible funding' arrangements. The government explains that flexible funding refers to:

"Funding provided under the Flexible Funding stream that may be used by Your Organisation to respond to:

- PHN specific priorities identified through health needs assessment and planning; and
- National priorities as determined by the Department."

As well as national priorities, then, PHNs will have the opportunity to themselves identify local health priorities and commission services accordingly.

This will become one of the most important functions of the PHN. As it builds a base of unique local knowledge, it will find itself well-placed to identify ways in which the health of the community can be improved. Its ability to fund programs that will realise

these improvements is significant. Successful commissioning is one of the best ways a PHN can achieve the program's overall aim of improving health outcomes.

However, commissioning is not an easy task. Successful execution of the commissioning of services requires careful planning and identification of priorities on behalf of the board.

The key to commissioning is specifying what is to be purchased. Defining 'the product' in a clear and measurable way is critical to any good purchasing. Contracts should, ideally, specify key attributes of the product including volume, quality and price.

***The key to commissioning is specifying what is to be purchased.***

Whilst the PHN executive will be primarily responsible for the writing and signing of individual commissioning contracts, the board must play a role in determining the general 'flavour' of the PHN's portfolio of projects. As was identified in chapter 3, the commissioning process provides PHNs with an opportunity to pursue their broader interests, as PHNs have the power to use their funding to alter the commissioning specifications with particular objectives in mind. It will be important, then, for the board to be clear about what these overall objectives are, and how the PHN's overall commissioning strategy might be best tailored towards achieving them.

This chapter will begin with a discussion of how the commissioning process can be carried out. Then it will discuss some of the ways in which commissioning can be used to achieve particular outcomes. This will be familiar territory, having been discussed in chapter 3. The second half of the chapter will shift focus to the discussion of commissioning metrics. Commissioning contracts will, of course, contain in them details on how the performance of the commissioned provider will be assessed. How should these performance metrics be defined? PHNs have several options in this regard, each of which will be discussed. The chapter will conclude by analysing the broad role of the board in the commissioning process.

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### **The commissioning process**

Commissioning is the core of what the PHN does. It is the vehicle by which the strategic intent of the PHN gets transformed into change on the ground. It must, therefore, be carried out in a planned, methodical way. NMML achieved this by using a 'commissioning cycle' (see Figure 2). The cycle included the three key stages of the commissioning process: strategic planning, procuring service and monitoring & evaluation, and included more details about what needed to be done at each of these stages.

***Commissioning is the core of what the PHN does. It is the vehicle by which the strategic intent of the PHN gets transformed into change on the ground.***

**Figure 2: The NMML Commissioning Cycle**



The first stage, strategic planning, begins by assessing population needs. The fundamental goal for PHNs, as was the case for NMML, is to improve the health status of people in their catchments. This should be the focus of needs assessment. PHNs should maintain a population health database including community health and wellbeing measures. They should also undertake detailed analyses of primary health care service gaps in their local catchments. This can be combined with a detailed review of existing services. In light of this information, commissioning priorities can be settled upon.

Thorough and continuous needs assessment will be an important task for PHNs. Several elements are required for a comprehensive assessment. The first and most obvious of these is the collection of population data. This might include data on avoidable mortality, the prevalence of certain conditions, emergency department visits, social determinants of health influences, the financial burden of disease or health literacy statistics. This quantitative data should then be compared against the

perceptions of need of agents within the system. This includes the perceptions of consumers and providers.

The next important step, once this information has been collected, is to clarify its consequences. But this synthesis of information alone does not constitute a complete needs analysis. The most important step in the process is to link this information to the required response. This process is twofold. Firstly, the PHN should clarify the current service response to a given problem, developing a picture of how existing organisations are dealing with the issue and, if relevant, what they plan to do. Secondly and finally, the PHN must then decide on an optimal service response, directing the information it has gathered into a concrete plan to rectify whatever service shortage or shortcoming has been identified. Different options should be evaluated according to risk and efficacy. Whilst it is easy to think of the needs assessment process as simply the collection of data, the process will be incomplete unless avenues for improvement have been considered and evaluated.

Having decided upon priorities, a PHN can begin to procure services. The first step towards this is clearly defining the scope and nature of the services that will be provided. This will involve using the evidence base and local data. It is also an important opportunity to specify service requirements that are in line with broader organisational priorities. For instance, an integrated service might be mandated. This sort of commissioning specification was discussed briefly in chapter 3, and will be discussed later in this chapter. Performance evaluation metrics should be decided upon. This is a critical step: the performance metrics must comprehensively describe how this service will be evaluated. They must go beyond simple metrics of volume of services to also include measures of key dimensions of quality (such as timeliness, cultural acceptability and, if possible, quality of service).

It will also be important to decide upon the service model for supply that is most appropriate, and to carefully plan capacity and manage demand. Once again, this will be aided by solid information about the local population needs and existing and lacking primary care services.

Once a service has been commissioned, it will be important for PHNs to monitor it and evaluate it. This involves working with consumers to get feedback about the services, and to promote consumer choices and effective information tools for consumers about the services. It also involves managing performance in line with the performance metrics specified in the procurement phase. Different performance metrics will be discussed later in this chapter. Once public views have been considered and evaluation has taken place in line with performance metrics, the PHN will have a better idea about what still needs improvement and can begin the commissioning cycle again.

This cycle is just one way of thinking about the commissioning process. Its value is that it is clear and methodical, detailing at every step the considerations that need to be made by the PHN.

### Commissioning for coordination

As explained in chapter 3, the funding that PHNs have at their disposal through the commissioning process can serve as a lever for change in the primary health system. Whenever commissioning takes place, a contract must be developed to specify exactly what is being commissioned. A PHN that wishes to improve coordination or integration in the primary health sector (one of the main objectives of the PHN program) can make steps towards this by specifying that funding recipients be involved in processes to develop coordination and integration.

There are a number of ways in which service integration and coordination can be improved through commissioning specification. When funding a new service, generalist organisations might be given weight over specialist organisations, so as to promote more interaction between a wide range of practitioners rather than exacerbating the disparate primary health landscape. Weight might also be given to organisations that can show evidence of working well with others to develop networks, including referral paths and information sharing. Choices of this sort can easily be written into the commissioning document. If successful, PHNs can in this way bring about incremental but significant change to the primary health system.

***Service integration and coordination can be improved through commissioning specification.***

For further detail on how this style of commissioning can work in practice, refer to the case studies provided in chapter 3.

### Commissioning for what works

The way in which a PHN can commission to achieve its coordination objective was outlined in depth in chapter 3. There are, however, other ways the commissioning specification process can be used to improve health outcomes. One of these is commissioning based on evidence of what works.

If functioning well, PHNs will have a wealth of knowledge. They will develop an in-depth, localised understanding of their catchment area, its strengths and its weaknesses. Their boards might include those with experience in health and health

management, and might also involve links with health research. With this wealth of expertise, PHNs will most likely have ideas about how to improve the actual provision of health services. This, too, can be written into a commissioning document.

***PHNs will most likely have ideas about how to improve the actual provision of health services. This, too, can be written into a commissioning document.***

For instance, the PHN might identify that it needs to tender for a physiotherapist to meet a local shortage. It has a choice in how it does this. On one hand, the tendered physiotherapist could be given full autonomy in determining how to provide service, based on the physiotherapist's own expertise and style of practice. Alternatively, the PHN might decide to tender specifically for an evidence-based physiotherapy procedure, as determined by the advice of researchers from universities or from experience in the health sector. This sort of evidence-based prescription could be written into a tender.

Whether or not a PHN will want to commission in this way will depend on the inclination of the board. If done well, however, this could be an effective way to improve the provision of primary health services and promote best practice care.

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### Community strengthening commissioning

One important consideration that PHNs will have to make is whether they want to commission for specialty services or with a view to community strengthening. Community strengthening commissioning involves strengthening the local generic primary care system to deal better with specific health problems such as mental illness. That is, it works to build better capacity and infrastructure in the system as a whole to deal with this sort of health problem. Such an approach recognises that the primary care system is the first point of contact for chronic disease, mental illness and other health problems, and that a lot of the work GPs and general community health organisations do involves dealing with these sorts of health problems. It also recognises that one of the important functions of the primary health system is in early intervention and prevention, which can be another specific focus of community strengthening commissioning.

***Community strengthening commissioning involves strengthening the local generic primary care system to deal better with specific health problems such as mental illness.***

All of this stands in contrast to specialty commissioning, which, rather than seeking to build the system as a whole, commissions specialist services for a health problem like mental illness. For instance, a PHN engaging in specialty commissioning might engage a professional from a specialist organisation with deep skills in treating a particular illness. The result of such commissioning is a 'siloes' approach to health service provision, which stands in contrast to the coordination and integration PHNs will seek to bring about. Accordingly, community strengthening commissioning is preferable. Strengthening the local network or service organisations to deal with these specialty needs, rather than relying on specialists, is in line with the objectives of the PHN program. This preference can be factored into the commissioning specification and evaluation processes. Community building is perhaps the more challenging option, at least insofar as it requires greater sophistication. In the long run, however, it is preferable to the commissioning of specialists.

### Performance metrics

In short, there are many objectives PHNs can work towards by selectively commissioning, some listed here and others in chapter 3. This makes the specification process neither trivial nor repetitive, but rather vitally important to the success of the PHN.

As well as making broad decisions about the sort of service that is to be tendered, PHNs must also decide how the performance of the successful applicants will be assessed. This second half of the commissioning specification process is just as important as the first. Whilst it is vitally important for PHNs to decide what they want to tender, in line with their broad organisational priorities and strategic purpose, it is equally important that they put in place the means to determine whether they have been successful in achieving their aims.

To a large extent, the ability of PHNs to assess performance will depend on the style of commissioning they choose. Broadly

speaking, there are three ways a PHN can commission. They are:

- Block contract commissioning
- Activity commissioning
- Outcome commissioning

Each of these approaches has different implications for evaluating the performance of commissioned service providers. Some provide greater scope for encouraging providers to meet particular objectives than others. The three approaches will now be discussed in more detail.

### Block contract commissioning

One way a PHN can commission is to give a tender recipient a block of funds to achieve a particular objective. For instance, a psychologist might be given a determined amount of funding with the simple objective of supplying psychological services to a given population.

Recipients of block funds can be assessed on general criteria, such as service quality or financial viability. Providers that perform well in these areas might be granted more funding to expand their capacity, while those who fail to meet basic criteria can have their funding discontinued.

However, there is little scope under such a funding model for tailored performance evaluation. For instance, it is difficult to reward providers who have a block contract for delivering particular qualities or quantities of service. There is also little capacity under such an arrangement for a PHN to reward those who deliver a service in a particular way, or are cooperative in achieving a particular end. It is difficult for the PHN to precisely pursue its broader objectives under such a funding arrangement.

### Activity commissioning

Alternatively, commissioning could be tied to a particular activity. Rather than providing a psychologist with a block of funds to provide psychological services, for instance, a PHN could tie funding to the number of patients the psychologist sees or the number of patients with specific conditions. This would create an incentive for the psychologist to make the service accessible to the widest possible number of patients. If a PHN wanted to promote a particular health procedure, for instance a screening procedure for a preventable disease, it could tie funding to the number of these procedures a provider carried out. This makes it easier for the PHN not only to assess the performance of those it commissions, but to tailor funding directly to the successful achievement of the PHN's commissioning goals.

As well as tying funding to specific health activities, PHNs could tie funding to their coordination objectives. For instance, if a PHN wanted to promote coordination between two distinct providers, it could tie funding to the number of referrals a recipient makes. As well as providing a financial incentive for coordination, assessing performance in this way allows PHNs to clearly determine the success or failure of a funding contract by tying it to a tangible, easily measurable, quantitative performance metric. Importantly, even when using activity commissioning, PHNs should incorporate measures of quality into the contract specification and contract evaluation.

### Outcome commissioning

Thirdly, a PHN could choose to commission for a particular outcome. For instance, it might tie funding to a GP clinic to achieve its aim of reducing the number of visits to hospital emergency departments for people in a particular district, perhaps a government housing estate that is home to an at-risk population. In such a case, the financial incentive is for the service provider to carry out the PHN's objectives. Notably, this approach does not involve the PHN telling the provider how to go about achieving their objective. Providers would have autonomy in this regard. What it does do, however, is allow the PHN to assess performance specifically against the program's broader aims.

There are merits to each of these approaches to commissioning. The last two methods allow the PHN more capacity to ensure that its broad objectives are achieved, but there may also be some circumstances in which block funding is deemed more appropriate. In any case, the style of commissioning must be clearly determined and articulated in the commissioning contract. Funding recipients must be aware of the criteria against which their performance will be assessed. This is crucial to ensuring that the PHN is successful in its commissioning objectives.

***Funding recipients must be aware of the criteria against which their performance will be assessed.***

## The role of the board

The PHN executive will be responsible for the day-to-day business of the commissioning process including developing commissioning documents, assessing applicants and evaluating performance. It will also be responsible for managing conflict in the process and ensuring a fair, consistent and transparent process.

The board, however, has a role in determining the overall purpose of the organisation's commissioning strategy. Whilst it will not necessarily consider each funding case in detail, the board will determine the executive's general approach to commissioning. This includes the extent to which the board will strategically commission to achieve particular outcomes. It also includes the sort of language the commissioning documents are to contain, the sort of metrics that are to be regarded as suitable for assessing performance, and the sort of recipients who are to be sought out. How much emphasis will be placed on quality methods as opposed to volume methods? How will quality be measured? The board must decide upon the 'flavour' of the PHN's commissioning operations, both at the beginning and as a form of evaluation at the end.

*The board must decide upon the 'flavour' of the PHN's commissioning operations*

This is no trivial task. The process is one of the most important opportunities for a PHN to achieve its goals in the primary health sector. The careful distribution of its funding is one of the most effective levers a PHN has at its disposal for bringing about system reform. Successful commissioning is crucial but it cannot be achieved unless the board makes clear decisions about overall strategic purpose. Unless the board defines clearly and unambiguously its vision for how the PHN will commission services, the commissioning process will not live up to its full potential for bringing about change.

## CHAPTER 5: Clinician and consumer engagement

- Engagement with clinicians and consumers is essential to improve the primary health system.
- PHNs must go beyond the bare minimum of Clinical Councils and Consumer Advisory Committees. In doing so, they should be clear about what is to be achieved by engaging.
- Successful clinician engagement can allow a PHN to change the way primary health is delivered, but only if positive relationships are built.
- Consumer engagement is important to ensure that the PHN best serves the needs of the community.

In pursuing greater coordination and integration in the primary health system, PHNs will need strong relationships with providers and stakeholders. Engaging with these diverse stakeholders is important.

The Commonwealth government has recognised this by mandating the establishment of a Clinical Council and a Community Advisory Committee to consult PHNs.

From the tender documents in May 2015:

“Your organisation is required to:

- b. establish and maintain Clinical Councils that report to your organisation's board. Clinical Councils must be GP led and comprise other health professionals appropriate for the PHN that may include but are not limited to nurses, allied and community health professionals, Aboriginal health workers, specialists and hospital representatives. Clinical Council members will have the appropriate knowledge and specific skill sets to address inter-sectoral care, service gaps and integrated care plan pathways; [and]
- c. establish and maintain Community Advisory Committees that ensure broad representation of the PHN, and provide a community perspective to your organisation's board to ensure that decisions, investments and innovations are patient-centred, locally relevant and aligned to local care experiences and expectations”

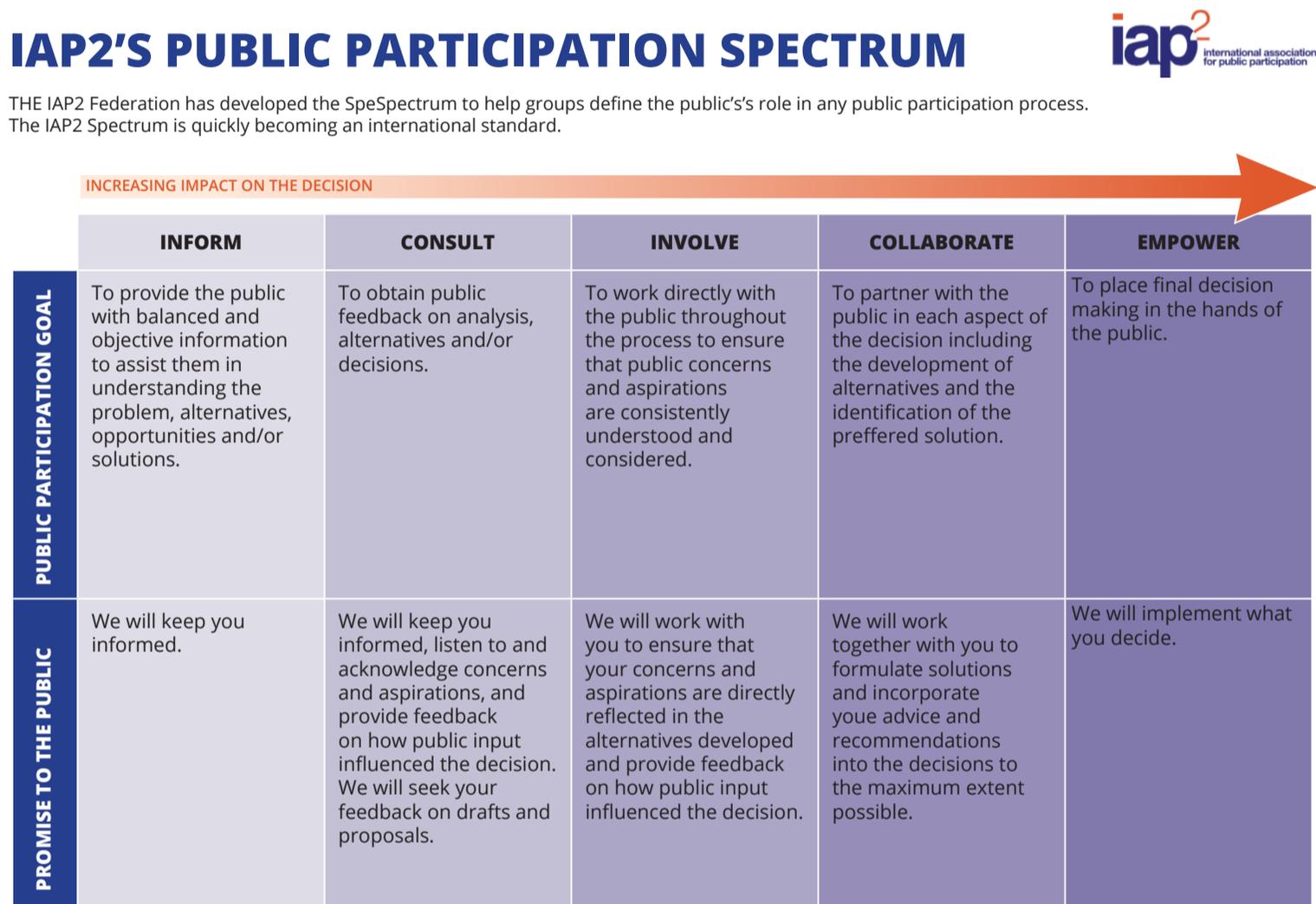
These two bodies will provide a starting point for PHNs to engage with clinicians and consumers. However, they do not in themselves constitute meaningful engagement. If a PHN is to build the sorts of positive relationships that are conducive to achieving meaningful reform, they must view these bodies as part of a broader engagement strategy. The purpose of this chapter is to explore what that strategy might look like, both in regards to clinician engagement and consumer engagement.

### The purpose of engagement

In order to engage effectively, a PHN must first understand why it is engaging, and what it wants to achieve from the process.

A useful way of framing this discussion is the Public Participation Spectrum released by the International Association for Public Participation (IAP2). It is regarded as an international standard for assessing public participation. Although designed with public participation in mind, it is generally applicable (see Figure 3)

**Figure 3: IAP2's Public Participation Spectrum**



Source: <http://www.iap2.org.au/resources/iap2s-public-participation-spectrum>

This spectrum suggests that stakeholder engagement can have five goals. At a minimum, it can seek simply to inform. The level up from this is consultation. The third level is involvement in the decision making process. The next step is collaborating with the stakeholder to make a joint decision. The highest level on the spectrum is empowerment, placing the final decision in the hands of the stakeholder.

These different levels are associated with different goals and techniques, and different participation levels will be suitable for different tasks. Most important is clarity. Whenever they engage with clinicians or consumers, PHNs should be clear about the level on which they seek to engage.

Thinking of things in terms of this IAP2 spectrum is relevant to the PHN context. If a PHN limits its engagement strategy simply to establishing and maintain the Clinical Councils and Community Advisory Committees, it might only engage with stakeholders on the first two levels, informing and consulting. Such an approach is not conducive to achieving the sort of change PHNs seek. PHNs do not act alone. They require the cooperation and active participation of health professionals and the local community to bring about change. This can only be achieved by more actively and meaningfully involving consumers and clinicians in the decision-making process.

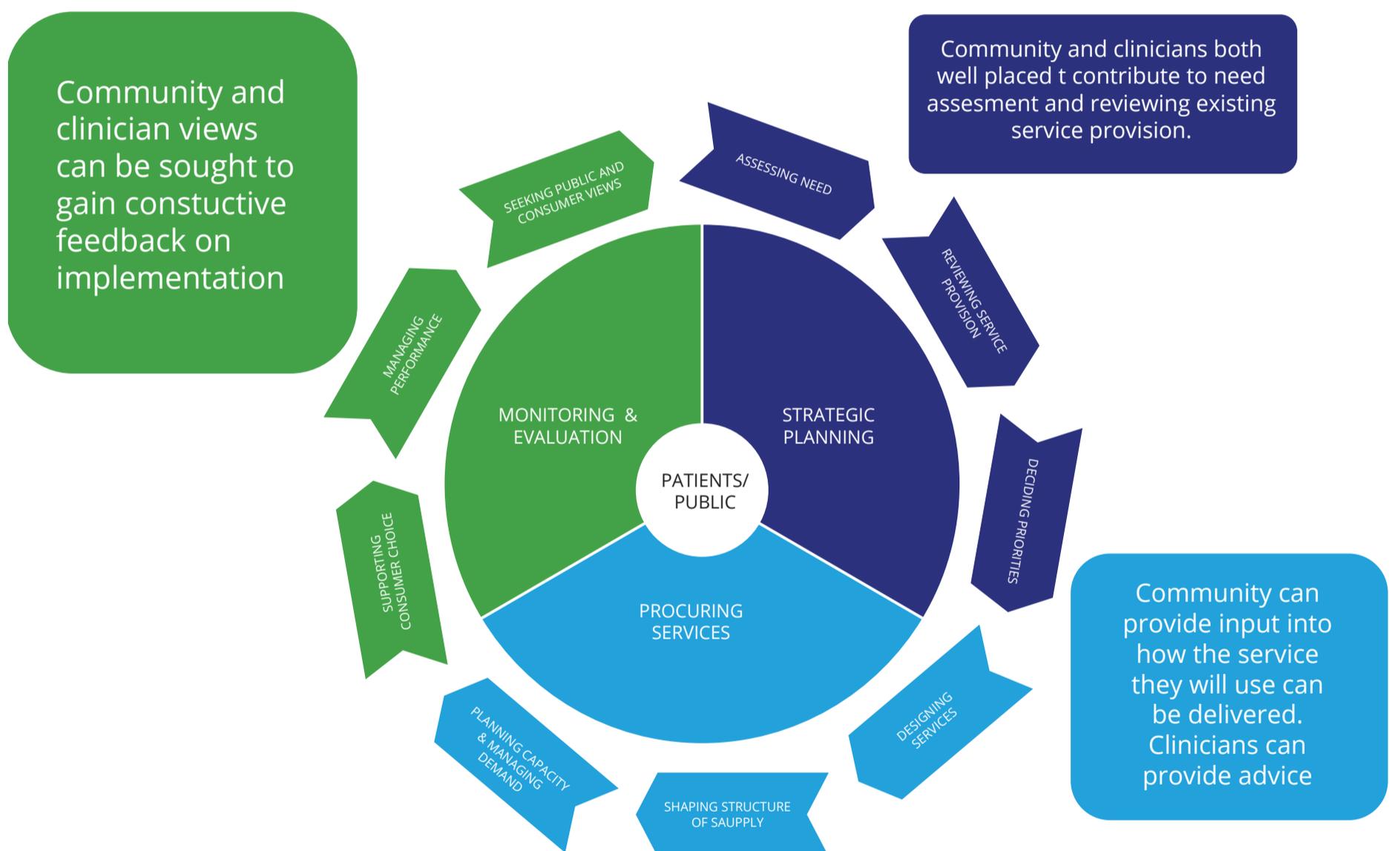
*PHNs do not act alone. They require the cooperation and active participation of health professionals and the local community to bring about change.*

## Engagement and the commissioning cycle

As explained in chapter 4, 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.

In chapter 4, the ‘commissioning cycle’ used by NMML was explained. It is included again in Figure 4:

**Figure 4: Engaging through the Commissioning Cycle**



The commissioning cycle provides a framework for identifying consumer and community engagement opportunities. This cycle will form the backbone of the discussion of engagement in this chapter. The places at which clinician and consumer and community engagement can be most effectively achieved will be identified and discussed.

## Consumer (community) engagement

The terms consumer and community are sometimes used interchangeably when discussing engagement. The terms, however, are not exactly the same. To speak of consumer engagement is to recognise the population as service users. Engaging with them in this way is important, but PHNs should not view the population solely as consumers. Community engagement refers more

broadly to community priorities that extend beyond simple service use. For instance, the community will be concerned that all people have proper access to health services, especially those that are disadvantaged. The priority for the community is to have a strong health system that benefits the many. This means that the PHN will seek not only to engage with the population in terms of their service use, but should pursue more broadly the ideals and aspirations of the community. This distinction is subtle but significant.

***The PHN will seek not only to engage with the population in terms of their service use, but should pursue more broadly the ideals and aspirations of the community.***

The Commonwealth government's language on clinician engagement was strong, but it is less so on consumer or 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.<sup>5</sup>

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.<sup>6</sup>

It is implied that both the Community Advisory Committees and the Clinical Councils 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.<sup>7</sup>

But little specific detail is provided.

Although the interests of clinicians and the community are not necessarily in conflict, the Horvath report and the tender documents used much stronger language about clinical compared with community involvement. Neither discussed consumer engagement. It is important that consumers and communities seek 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. However, it is the authors' view that they should not. Consumer and community engagement should be at the heart of the PHN model. This chapter will briefly explore how this engagement might be achieved.

### Consumer and community engagement and the commissioning model

There are several stages in the commissioning process at which consumers and the community could be involved. The first of these is Assessing Needs, the first step of the process. Broadly, this is about the PHN identifying the critical issues in its region. Examples of issues have been provided throughout this book. One might be poor information flows from hospitals to GPs in discharge planning. Others might pertain to priority populations, such as people with chronic conditions, children or victims of domestic violence. Other issues might pertain to disease prevention or screening. Importantly, when attempting to identify these issues, detailed community engagement must be a high priority. Consumers themselves will often be able to provide pertinent information to PHNs to help them develop the local knowledge with which they can best perform their tasks. Moreover, a PHN which seeks to remedy problems identified by community members, better serves its community than a PHN which does not engage in consultation.

Another point at which consumers can be involved is at the designing stage of the process. Once priority areas for improvement have been decided upon, service users can be engaged to discuss what works and what could be improved. Including users in the process of service design is an obvious way to incorporate the population in the decision-making process, and is an example of meaningful and constructive engagement and involvement. The community might also be involved to a high level in the setting of key performance indicators and other evaluation measures. Not only might their input on this front be valuable, community involvement in this process also improves transparency.

Having engaged consumers and the community in these planning phases of the commissioning cycle, it will also be important to

5 Horvath, J, Review of Medicare Locals: Report to the Minister for Health and Minister for Sport, March 2014,

<[https://www.health.gov.au/internet/main/publishing.nsf/Content/A69978FAABB1225ECA257CD3001810B7/\\$File/Review-of-Medicare-Locals-may2014.pdf](https://www.health.gov.au/internet/main/publishing.nsf/Content/A69978FAABB1225ECA257CD3001810B7/$File/Review-of-Medicare-Locals-may2014.pdf)>

6 Australian Government Department of Health, *Primary Health Networks: Grant Programme Guidelines*, May 2015

7 Australian Government Department of Health, *Primary Health Networks Programme: Invitation to Apply for Funding*, November 2014

include them in the evaluation phase. Not only can consumers and the community provide feedback about the success or otherwise of the new service, they can also have the opportunity to see that their engagement has led to meaningful change. Re-engaging the community once a project is completed is an important way to reassure them that work is being done to improve their health system, and that their role in influencing this work is a significant one.

### The role of the Community Advisory Committees

Community Advisory Committees (CACs) are a requirement for PHNs. They are envisaged as being in parallel with Clinical Councils. These CACs will be an important medium for consumer engagement. However, it is important that PHNs don't operate as if their CACs suffice for a community engagement strategy in themselves. They should not. Any PHN that does so will not engage as meaningfully as it might.

It is better to describe the role of CACs as one of developing and overseeing a broader consumer and community engagement strategy. This strategy should identify the community and consumer engagement required at each point of the commissioning cycle, and in the other functions of the PHN. The Community Advisory Committee (and PHN boards) should receive reports on this consumer engagement to ensure that it is sufficient and effective.

### How to proceed

In seeking to build this platform for community consultation, PHNs should, fittingly, consult with the community. Community groups and organisations will have ideas as to how they envisage their relationship with PHNs. Working with these groups to develop engagement strategies that satisfy their desires will set off consumer engagement on the right footing, engaging relevant groups from the beginning.

If done well, consumer engagement can cement the PHN as a well-regarded body in the community. This will give it greater chance of success when it seeks to achieve its broader aims, especially when it advocates for particular causes or seeks to build communication between community groups. Conversely, a lack of consumer engagement could lead to resentment and disengagement, which might in turn make achievement of the PHN's objectives difficult.

### Clinician engagement

Broadly, there are four sets of stakeholders PHNs will seek to engage with that fall under the heading of 'clinicians'. These are:

- GPs
- Allied health professionals
- Specialists not based in hospitals
- Specialists based in hospitals

Each of these groups will be targeted in different ways and for different reasons. Engagement with each is important, but GPs will be an area of particular focus. This is in line with the findings of the Horvath report. The report criticised the Medicare Local program for its lack of engagement with GPs, suggesting that GPs should play a more central role in any future primary health organisation:

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.<sup>8</sup>

The Invitation to Apply for funding as a PHN picked up on this recommendation in its discussion of Clinical Councils, which it suggested were to be GP-led:

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.<sup>9</sup>

The engagement process with clinicians will face in two directions. In one capacity, the PHN engages with clinicians to hear their concerns and attempt to act on the feedback they receive. However, PHNs will also seek to change the way clinicians do their jobs, so as to achieve broader objectives of primary health reform. This second aspect to the engagement process can only be

8 Horvath, J, Review of Medicare Locals: Report to the Minister for Health and Minister for Sport, March 2014,

9 Invitation to Apply for Funding, November 2014

achieved if a PHN has built up a positive and trusting relationship with clinicians.

***The PHN engages with clinicians to hear their concerns and attempt to act on the feedback they receive. However, PHNs will also seek to change the way clinicians do their jobs.***

It is vital that the PHN makes it clear to clinicians why they will benefit from engagement. Primary health clinicians are primarily private providers. Reasonably, they regard time spent on engagement activities as time not spent making their income. It must be demonstrated, then, that engagement is worthwhile.

The PHN must demonstrate that it is listening to the concerns of clinicians and acting on them, taking into account their feedback and seeking to improve their circumstances. If clinicians feel valued in the process, they are more likely to continue to engage. Conversely, clinicians will be far less likely to engage with a PHN that seems to be simply consulting with them for the sake of ticking a box.

Another way of making engagement appear worthwhile to clinicians is by including access to data that the PHN has collected. The PHN's needs assessment, as discussed in chapter 4, will provide it with valuable knowledge about the needs of the local population. Sharing this with clinicians is a way to have all the relevant stakeholders on the same page and can be a good way to promote engagement.

Moreover, it will be important that the engagement is convenient for clinicians. A meal or some other incentive might be provided to make it feasible to meet. Clinicians should be clear about exactly what is to be achieved from the process. Location should also be convenient. PHNs, dealing with a larger geographic area than Medicare Locals, might have to set up multiple locations for engagement. Existing structures should also be used where applicable, especially in the case of hospital-based specialists, who will tend to have existing mechanisms for consultation and engagement.

Working to make engagement convenient and valuable to clinicians in this way can assist the PHN in building positive relationships, which can then be leveraged to help achieve the sort of change discussed earlier.

### **Clinician engagement and the commissioning cycle**

Much as in the case of consumers, clinicians can be engaged at crucial stages of the commissioning cycle. It will be important to consult with clinicians during the early stages, when the PHN is assessing need and reviewing existing service provisions. Duplication is best avoided by working with clinicians to discuss the mechanisms that are already in place to deal with the issue at hand, as well as any past attempts to rectify the issue. Clinicians might also have a moderate level of input in the development and planning stage, providing input as to what is feasible and what is likely to be effective. Much like the community, clinicians should also be consulted at the end to gauge their feedback on the effectiveness of the commissioning process.

## CONCLUSION

PHNs are to be agents of change in the primary health system. The problems facing primary health care in Australia are numerous, entrenched and, in large part, beyond the capacity of PHNs to solve. But PHNs do have the ability to bring about meaningful reform. To do so, they must:

- Recruit the right team, appointing board members and executive staff with diverse experiences and shared vision;
- Create a functional working environment with robust governance structures;
- Resolve to be innovative and active in pursuing reform rather than being content to act as managers of a stable state;
- Carefully target their funding to fix problems of funds pooling, promote integration and encourage the delivery of important services;
- Gather evidence and advocate for change in practice behaviour and in system coordination, locally and nationally;
- Facilitate change by building positive and constructive relationships with and between health professionals, working within existing structures as an enabler rather than pursuing change in isolation;
- Commission carefully and deliberately, using the specification process to shape the health landscape by commissioning for activities and outcomes that reflect the PHN's vision for change;

- Work with clinicians and the community, engaging them meaningfully in the decision-making process to ensure shared ownership of the task of improving the health system.

The aim of this book has been to provide practical advice about how change can be achieved. This is not an easy undertaking, but the authors are optimistic about the potential for meaningful improvements in primary health care.

***The problems facing primary health care in Australia are numerous, entrenched and, in large part, beyond the capacity of PHNs to solve. But PHNs do have the ability to bring about meaningful reform.***

## About the authors

Stephen Duckett is Director of the Health Program at Grattan Institute in Melbourne and was Deputy Chair of the Board of Northern Melbourne Medicare Local (NMML). Jane Gunn, a General Practitioner, is Professor of Primary Care Research at the University of Melbourne and was Chair of the Board of NMML. Marilyn Beaumont, Gabrielle Bell, and Amanda Murphy are former board directors of NMML. Rod Wilson is a former CEO of NMML. Tom Crowley is a student at the University of Melbourne contracted to help write this book.