



PRIMARY HEALTH NETWORKS OPPORTUNITIES, CHALLENGES AND RECOMMENDATIONS

**PUBLIC HEALTH ASSOCIATION OF AUSTRALIA
AND
AUSTRALIAN HEALTHCARE AND HOSPITALS ASSOCIATION**

Communique

17 October 2014

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EXECUTIVE SUMMARY

The primary health care sector in Australia is undergoing a transformation with the wind up of the Medicare Local (ML) system and the introduction of Primary Health Networks (PHNs). Much of the information around PHNs is yet to be released, however interest in the new organisations, their functions, roles and performance measurement is high. Against this background, the Public Health Association of Australia (PHAA) in collaboration with the Australian Healthcare and Hospitals Association (AHHA) convened a Primary Health Care Roadshow in five cities across Australia.

The Roadshow identified a broad range of opportunities, challenges and recommendations for the new PHNs. Opportunities and challenges for the new PHNs identified that while they offer a significant opportunity to be drivers of reform and value for money in health care, they need to meet the needs of all people in their region which may be challenging given their larger size.

Key themes raised by participants included:

- Australia has a fragmented health system characterised by service gaps and duplication
- It is not clear whether current activities are reform or just reorganisation of the primary health care sector
- There are significant lessons to be learned from both the Medicare Local and international experience
- Population health planning needs to be at the centre of PHN activity
- Evidence and research will be required to support effective PHNs
- Emerging technologies offer new opportunities for effective and efficient service delivery
- Communication and consultation are key to a successful primary health care system
- Collaboration will be critical for the success of PHNs
- Commissioning should be a goal but skills need to be developed;
- The primary health sector needs to keep pace with growing and changing demand;
- Workforce and scope of practice are key issues for the new PHNs.

Based on the discussion undertaken during the Roadshow events, the PHAA and AHHA have made the following recommendations:

- Recommendation 1: Mechanisms for sharing information and innovation must be part of the PHN model
- Recommendation 2: Bilateral Primary Health Care Agreements must be progressed
- Recommendation 3: Stakeholders must have the ability and sufficient influence to advise Boards
- Recommendation 4: PHNs must have a clear governance and accountability model
- Recommendation 5: PHNs must work with Local Hospital Networks and Health Departments to undertake joint needs assessments
- Recommendation 6: Regional planning forums should be developed
- Recommendation 7: Community needs assessment data should be utilised effectively
- Recommendation 8: Partnerships should be formalised
- Recommendation 9: Provision should be made for an establishment period
- Recommendation 10: Good work already commenced by MLs should continue
- Recommendation 11: Timely responses are required to address service gaps during the transition period
- Recommendation 12: Greater investment is required

PHAA and AHHA commend these recommendations to the Commonwealth Health Minister as worthy of consideration and further exploration as PHNs are established.

BACKGROUND

In the lead up to the Invitation to Apply (ITA) for rights to operate PHNs, the Public Health Association of Australia (PHAA) in collaboration with the Australian Healthcare and Hospitals Association (AHHA) convened a Primary Health Care Roadshow in five cities across Australia. Participants were drawn from a broad cross-section of primary health stakeholders, including state health ministers, representatives from Medicare Locals (MLs), Local Hospital Networks (LHNs), state health departments, clinical and professional groups, academics, health consumer groups, non-government organisations (NGOs), private health insurers (PHIs) and private health providers.

PURPOSE

This Communique summarises opportunities, challenges, recommendations and themes which emerged during the Roadshow discussions, and which the PHAA and AHHA commend to the Commonwealth Health Minister as worthy of consideration and further exploration as Primary Health Networks (PHNs) are established.

OPPORTUNITIES FOR PRIMARY HEALTH NETWORKS

There has been bipartisan agreement about the central role of primary health care in ensuring a robust and sustainable health system in Australia. This has been articulated through a succession of agreements including those articulated under the Council of Australian Governments and through the National Primary Care Strategic Framework. In an environment where structures and services are being reorganized, sight should not be lost of this commitment to primary care.

There has also been support the need for meso-level organisations such as MLs and PHNs, not as an additional layer of bureaucracy, but to play a critical interface between the various components of the health system and to reduce fragmentation of health services to the Australian community.

PHNs have significant opportunities to be drivers of reform and value for money in healthcare – but this will require both a policy and funding mandate. In particular, they will have a stewardship role for the health of Australians, rather than a focus on episodic care – this provides an opportunity to turn the tide on the growing burden of chronic disease.

Partnerships are an underpinning feature of the proposed PHNs - given the complexity of issues, funding arrangements and increasing demand in primary health, better communication is essential. Strategic partnerships which leverage core strengths and goodwill, and are driven by pragmatism rather than ideology, will provide positive opportunities for PHNs to support primary health care. Opportunities are available via the development of evidence-based care pathways. Population health planning expertise and broad stakeholder engagement including with consumers will be important for this work.

PHNs should be consumer focused, promoting and supporting reform to the models of primary health care delivery such as the ‘medical home’ concept that is characterised as patient-centred, comprehensive, coordinated, accessible and committed to safety and quality. They should also aspire to the Triple Aim described by the Institute for Health Innovation¹: improving patient experience, improving population health and reducing the per capita cost of health care.

¹ <http://www.ihl.org/Engage/Initiatives/TripleAim/pages/default.aspx>

Work commenced by MLs on connecting and coordinating care is the basis of opportunities for PHNs to focus on integration of health services across the continuum of primary, secondary, tertiary and quaternary care, in order to provide seamless, appropriate, affordable and accessible care. In particular, this offers support for diversity and 'close the gap' initiatives.

Much has been achieved under MLs to ensure engagement with health professionals such as practice nurses, community pharmacists and other allied health professionals. PHNs have the opportunity to build on this, by formalising a role for these professionals in their engagement structures and processes.

There are opportunities to learn from the work undertaken by ACCHOs and Aboriginal Medical Services who have built and operated models of primary care that are integrated with others parts of the health system, and are characterised by a more holistic approach to healthcare.

Significant opportunities, both for enhanced information and cost savings, can be realised through better sharing of electronic health data, including for clinical management purposes, and for measurement of, and response to community needs.

CHALLENGES FOR PRIMARY HEALTH NETWORKS

Regardless of the ownership of future PHNs, they need to work for all people in their region, not just for the particular constituency of the business owner; this is particularly necessary for Aboriginal and Torres Strait Islander people.

The reduced number of PHNs, compared with MLs, will be particularly challenging in meeting primary health needs effectively in rural and remote areas. This will need to be factored in governance arrangements for PHNs as well as in their programs of work and associated funding arrangements. The provision of primary and specialist care in rural and remote areas has long been the role of ACCHS. ACCHS are responsible for providing over 2.5 million episodes annually of care to both Indigenous and non-Indigenous Australians.

As the transition is made from MLs to PHNs, clarity and guidance will be needed as to the shape of public health teams. PHNs will be judged on their capacity to achieve collaborative advantage, working across stakeholder groups to deliver outcomes rather than outputs as KPIs.

Targets such as a reduction in avoidable hospitalisations will be difficult, but not impossible, to achieve given the disconnect between primary health and hospitals particularly as the Commonwealth role in hospitals funding is changing, and states and territories are not strongly engaged in primary health service delivery.

Care will need to be taken that the work of PHNs is not reduced to experimentation, but is based on robust evidence. Policy initiatives such as bundled care, increased role of private health insurers and expanded scope of practice should be researched against international evidence, simulated and evaluated prior to implementation.

Service gaps and 'market failure' will challenge the model of PHNs as purchasers, not providers. Commonwealth and state governments will need to work together to address these gaps effectively, and in a timely manner. The disparity of health outcomes between Indigenous and non-Indigenous Australians may be attributed in part to 'market failure' in the provision of primary care by mainstream health services.

Health literacy remains a challenge to effective use of the health system - a concerted approach across the health system to improving health literacy is critical. This is of particular importance to Indigenous Australian, many of whom struggle with health literacy.

There appears to be little appetite from the Commonwealth to drive an agenda of consistency in primary health across Australia. Although variation based on local needs is desirable, this should not mask inappropriate variation based on evidence. The sharing of best practice, knowledge and experience can drive system improvement, and there is a real risk that this will be diminished if PHNs are not encouraged to work together rather than in isolation or competition.

Resourcing of PHNs will be problematic if funding is provided on a population basis, without regard to need. While there may be advantages related to economies of scale given the expected larger size of PHNs, the challenge will be to ensure that the PHNs are locally responsive. In areas with significant numbers of Aboriginal and Torres Strait Islander people this becomes even more important due to the fact that Indigenous people suffer a burden of disease and chronic illness that is 2-3 times greater than that of the non-Indigenous community. It is also important for rural and remote areas since healthcare is harder to access and can be significantly more expensive to deliver.

The PHN model, like the ML model before it, appears to be vague in terms of objectives, performance measures and targets, but may be more rigorous in terms of process. Greater rigour in objectives and measurement, coupled with a less detailed approach to process, would assist in providing the clarity and flexibility required for a high-performing primary health system.

Care will need to be taken to ensure that PHNs are genuinely primary care networks, while incorporating a strong role for GPs. While some stakeholders contend that this must be at governance level, including on PHN Boards, there will be challenges to good governance if board member selection is not skills-based.

Silos of professional interests will challenge PHNs, as they did MLs, and a strategic approach to communications and engagement will be needed to address this.

Stability is required in the system - there is a real risk that political change will see another round of changes in the way primary health care is organised. This must be avoided.

THEMES

A FRAGMENTED HEALTH SYSTEM WITH SERVICE GAPS AND DUPLICATION

Australia's health system is fragmented, with both workforce and service gaps and duplication. High service delivery costs, particularly in remote and rural areas, and an uneven distribution of health professionals contribute to service gaps.

The division of responsibilities between the Commonwealth and state governments for primary health and hospitals respectively further compounds this fragmentation, although one speaker noted that this division helped preserve funding for primary care, which might otherwise risk being diverted to higher cost hospital care in a single funder environment.

In some states, eg WA, a primary health care strategy provides a policy framework for statewide primary health initiatives, underpinned by a state-sponsored primary health network aimed at promoting communication. Joint core planning and purchasing across health departments and PHNs might assist in achieving efficiencies and a more strategic approach to primary health.

Likewise in SA, the Transforming Health Initiative and local alliances drawing together MLs, LHNs, consumers and the SA Ambulance Service are driving work to improve health pathways.

Notwithstanding these initiatives, universal access to primary health care is not achieved for all, particularly in rural and remote areas, for Indigenous people, and lower socio-economic population groups.

There is also fragmentation between health and other related sectors such as aged care. For example, recent funding changes in aged care have resulted in a reduction in the employment of registered nurses in aged care, with flow on effects including increased admissions from aged care facilities to hospitals.

REFORM OR REORGANISATION?

While organised primary health care is a major reform in the Australian health system, it will remain as reorganisation rather than reform unless change is aimed at doing things differently and doing different things. It will be dependent on the ability of players to behave differently, and will require an active program of monitoring and evaluation.

LHNs gravitate slowly towards objectives such as reduction of readmissions and avoidable hospitalisations. They need strong and stable partnerships with primary care in order to achieve these objectives, and this will require a long-term strategic approach to partnership development.

Participants noted concerns that the replacement of MLs with PHNs was more about reorganisation than reform, and that it would be important for this new round of reorganisation to have a longer life than that of MLs and to build on the positive achievements of MLs so that the momentum for true reform was not completely undone.

A medium to long term strategic approach to establishment of PHNs, and clear and measurable KPIs, would assist in ensuring the effectiveness of the PHN model.

WHAT ROLE SHOULD PHNS PLAY?

PHNs should be:

- regional leaders – negotiating and advocating for primary care, and addressing health inequities through partnerships
- planners – jointly undertaking systematic population health planning; using information to provide evidence for commissioning, health promotion and service redesign; engaging at clinician and community level
- managers - ensuring equity of health services; driving change in the system including savings and efficiencies
- enablers - building capability and capacity within service providers including via incentives (financial and non-financial); funding system enablers including e-health and IT systems; funding gaps and service redesign as commissioners; stimulating markets including via incentives to do things differently
- integrators - within and beyond the health sector, and including via health pathways
- innovators – including advocating for disinvestment where required, and breaking down care silos
- evaluators - monitoring and measuring change at PHN levels including performance against KPIs; and at population level to monitor changes in health outcomes

These roles will be performed within a system wide context where some aspects are not likely to change in the short term, including:

- fundamental aspects of current health service business models and funding systems
- public sector financial constraints
- Department of Health and contract-driven accountability imperatives
- limited levers for change at the PHN level
- limited access to information and data
- measuring and attribution of performance to PHNs.

However there are likely to be some changes to the context in which PHNs will operate, including:

- more local delegation – PHNs will become regional leaders and system managers
- some development of blended payments models, particularly for those with long term conditions
- increased role of health insurers in primary health care and linking to acute care
- realisation of some of the benefits of the investment in e-health
- increasing out of pocket costs and limitations on access
- new KPIs and performance measures for primary health care
- increased role and willingness of the states, and state funded services, to work in partnership with primary care services
- stronger relationships with other organisations such as Local Hospital Networks and Aboriginal Medical Services.

WHAT WILL PHNS NEED?

PHNs will need:

- clinician buy-in, both personal and professional
- strong engagement with GPs, including at Board level, where appropriate governance skills exist
- state government and LHN buy-in
- core capabilities at start up, including commissioning, partnerships and measuring change
- sufficient and flexible funding
- to be seen as independent of government
- not to lose the body of knowledge gained from the ML experience
- to be willing to be accountable
- to fill workforce gaps
- stronger and more streamlined referral pathways
- to recognise the important role of ACCHS in Indigenous health initiatives and providing health care delivery
- to be culturally safe for Aboriginal and Torres Strait Islander people.

WHAT LESSONS CAN BE LEARNED FROM THE ML EXPERIENCE?

From the ML experience, clarity of objectives will be required for PHNs, and these objectives should be able to be measured in terms of outputs and outcomes not solely processes.

PHNs must learn from the ML experience that attention must be paid to robust management and governance. This includes a need to focus on understanding the commissioning role and reporting robust performance results.

More considered spending choices need to be made by PHNs, which will effectively be statutory monopolies – budgets and activities need to be targeted at population health outcomes, and more effective means of assessing performance will be required. This might include incentives and sanctions related to performance.

Finalisation of bilateral agreements on primary health will be important to ensure clarity on the respective roles and responsibilities of the Commonwealth and the states.

GP disengagement from MLs was a contributing factor to some dissatisfaction with MLs, and while engagement requires both parties to make best endeavours, it must be addressed in the establishment of PHNs to ensure optimal outcomes.

Successful work undertaken by MLs was built on strong partnerships with broad stakeholder groups – and stakeholders such as local government and LHNs were more likely to remain ‘at the table’ where strong patient outcomes could be identified. In particular, significant progress was made in identifying and building relationships with allied health partners – it is important that this not be lost, in the re-focusing on general practice.

THE INTERNATIONAL EXPERIENCE

The international experience of primary health organisations showed that the model of organisation is dependent on the context that they operate in and the objectives to be achieved. However a set of common functions can be identified and they are similar to those identified for PHNs. They include:

- population health planning and needs assessment as a core function
- primary or secondary commissioning of services
- service provision under some circumstances
- coordination or integration of care within the health sector and wider through partnerships
- development of the primary health care system including; workforce planning, quality improvement, practice support and application of information technology.

Recent significant achievements by the US Accountable Care Organisations provide some learnings for Australia, including:

- a focus on high users’ risk stratification
- case management and care coordination
- engagement of patients in self-management
- alignment of payments and providers
- strategic partnerships
- a movement from fee for service, beyond fee for performance, to fee for outcomes.

GOVERNANCE

Governance of PHNs should be differentiated from the input required for effective collaboration, with Board members possessing the appropriate fiduciary skills and expertise to provide direction to the PHN. Clinical and community councils will provide options for broad sector engagement in an advisory role, and mechanisms should be in place for advice to influence and shape programs and practices.

EVIDENCE AND RESEARCH

Robust partnerships are required to support a contracting and purchasing environment which is separate from service delivery, and these partnerships must be driven by evidence and information that identifies key priorities.

Evidence-based commissioning and clinical governance models will be important to the success of PHNs in building an improved primary health care system. A number of MLs have done important work at a local, regional (and in some cases, state) level in building sophisticated and relatively low-cost data collection, warehousing and reporting mechanisms that focus not only on outputs, but on outcomes and identifying service needs. This work should continue, and data governance frameworks should promote use, sharing and publication of data as an important base for evidence in primary health.

Concern was expressed by a number of participants about the lack of funding for primary health services research. This could be addressed by a continued funding commitment by the Commonwealth to a primary health care research program. It was noted that grey research and better use of ML data would also be important contributions to primary health research.

POPULATION HEALTH PLANNING

Population health planning requires engagement with strategic partnerships – supported by work plans with priorities, action plans, care pathways, baseline data and evaluation plans.

EMERGING TECHNOLOGY

Participants recognised the potential value of better connecting patients to primary health practitioners, and GPs to hospitals, using new technologies. The benefits of a central referral system were noted, as was telehealth which was seen as relevant in outer metropolitan areas, as well as in more remote communities.

There is a role for PHNs in developing and implementing technologies including data collection and reporting platforms to support an enhanced evidence base for primary care, as well as improved communication and patient care. These bottom-up initiatives may deliver more useful, relevant information than top-down national performance reporting agencies are able to achieve.

The dissemination of information on best practice may be supported by better use of technology, for example via quality assessed information reported on a clearinghouse platform.

COMMUNICATION AND CONSULTATION

Consumers have an important role in PHNs as champions of change in clinical care. Clinicians should be championing consumer engagement in the development of PHNs and integrated care. The demand from consumers for better communications and information has led to an expanded availability and use of web-based tools such as clinician rating tools and appointment booking apps.

PHNs must make efforts to effectively engage with Aboriginal and Torres Strait Islander communities in order to effectively assess and meet their health needs. Furthermore, efforts must be made to ensure the cultural safety of all PHNs.

COLLABORATION

Partnerships will be critical for the success of PHNs - and it is important that these extend across the broad primary care stakeholder group and are not limited to narrow professional interests. Some consideration might be given to the role of inter-sectoral collaboration, eg with community and social services.

PHN partnerships will need to be robust, innovative, and progressive; and their development will require optimism and thinking outside of the square. Suspicions regarding the motivations and interest of private health insurers and providers will not be useful in the emerging PHN environment.

Partnerships underpinning PHNs might not necessarily be exclusive, and different forms of relationships might be required for different partners, eg as owners, advisers, decision-makers, research support. PHNs might also want to identify relationships that they don't want to pursue, particularly where these diverge from the core business or values of the PHN, however some level of pragmatism will be necessary.

From the experience of successful health advocacy initiatives, it is clear that good relationships are critical, take time to build, and should leverage the issues which can be agreed upon, rather than focusing on points of disagreement, and build on the relationships already established by MLs.

COMMISSIONING

Commissioning priorities may be mandated at a national level and PHNs funded to take responsibility for service development, provider engagement and evaluation. It is also important to enable local delegation based on locally-conducted needs assessment and this will require some form of flexible funding.

Commissioning for outcomes rather than outputs should be a goal. It should also be based on an assessment of what is needed, and how it should best be funded; to ensure it is not reduced to a contracting role.

KEEPING PACE WITH GROWING DEMAND

Participants recognised the challenges in ensuring support for primary health care for an ageing population with an increasing burden of chronic disease, while ensuring the health system is economically sustainable.

Primary care was described as the solution for health funding issues, not the problem, and investment in this sector will assist with achieving savings in the hospitals sector. There are opportunities for finding savings in general practice, which could be re-invested back into primary care:

- Change bureaucratic and mandated requirements for medical certification: between 1 and 2 per cent of all general practice consultations are for medical certificates for workplace requirements. Approximately \$70 million per year could be saved by removing these requirements.
- Quality use of medicines - encourage GPs to change prescribing practices, for example by the initiatives led by the National Prescribing Service
- Reduce pharmaceutical costs - by smarter purchasing practices
- Reduce use of pathology testing and investigation - GPs should be doing more on this; a carrot and stick approach might be required to encourage further change
- By following the ACCHS model and combining primary and specialist care there is potential to relieve the burden on hospitals to a substantial degree
- Significant investment in preventative health has the potential to realise substantial savings in hospital funding.

INTEGRATED CARE

Integrated care must focus on patient-centred care, supporting patient flow between primary and secondary care, helping patients navigate the journey through the health system and across the public and private sectors, and supporting those with chronic illness. It requires commitment from both the primary and the acute care sectors, and also requires new ways of working across Commonwealth and state governments as funders, and with the private sector.

The WA experience with liaison GPs in hospitals and a central referral system has proven to be useful. The work of MLs in clinical pathway development has been an important contribution to the development of integrated care and should continue.

A key definition of general practice is that it provides coordinated care in the community. In particular, the care that can be provided to patients who have embraced the 'medical home' by their regular GP is coordinated across allied health and hospitals through care plans, but complexities still remain. The challenge for GPs is to coordinate the right care which is both readily accessed and affordable for patients. GPs must also take a lead role in working towards broader cultural change in the health sector. By engaging with the community and supporting cultural safety, cultural change has the potential to see significant new progress in closing the health gap between Indigenous and non-Indigenous Australians.

The role of practice nurses was seen as important in connecting healthcare teams and patients and ensuring sustainability in general practice.

PHNs must also work across sectors, eg aged care, disability, justice – and this requires a commitment to shared agendas, shared data and research.

WORKFORCE AND SCOPE OF PRACTICE

Some workforce issues are a result of the increasing specialisation in the medical workforce - there is a need to focus on development of the generalist workforce.

Allied health practitioners will need to reflect on how their professions fit into PHN partnerships and a cohesive primary health care system, particularly in remote areas where they may be the only healthcare provider available.

Practices can be supported to deliver better care to patients via an active role for practice nurses. In the roll out of PHNs, genuine consultation and inclusion in the governance models for practice nurses will assist in ensuring practice support is identified as a priority. Further, PHNs must act on input from clinical and community councils, not just receive information.

The Aboriginal Community Controlled Health Organisations' model of salaried medical officers and allied health professionals may be useful in addressing service gaps and workforce mal-distribution.

Work initiated by Health Workforce Australia on the development of competency-based models and assessment to support extended scope of practice initiatives should be continued. This should aim to build health care professionals' competencies and align with professional structures, which are view to less rigidity in these structures.

WHAT ROLE FOR HEALTH PROMOTION?

With the cessation of the National Preventive Health Agreement, both the Commonwealth and the states and territories appear to have pulled back from health promotion and illness prevention. This does not bode well for the ability of Australia's health system to improve health outcomes, particularly in relation to chronic illness, or to achieve long term sustainability of the health system and budgets. These considerations are important matters in Indigenous health and the 'closing the gap' initiative. Chronic disease management accounts for nearly 70% of the health gap and chronic disease is twice as prevalent in the Indigenous population. PHNs must play a role as a change agent for health promotion, working with enabling organisations.

RECOMMENDATIONS

RECOMMENDATION 1: Mechanisms for sharing information and innovation must be part of the PHN model

While NGOs such as the PHAA and the AHHA have stepped into the gap to provide a national network for organised primary health care, following the defunding of the Australian Medicare Local Alliance, the benefits of sharing learnings and information across the country will only be realised with a level of funding support available to facilitate initiatives such as data collaboration. Likewise, state networks will be critical in larger states to ensure strong productive relationships with state health departments.

The Commonwealth must ensure that PHNs are able to share best practice, knowledge, research and information. In the absence of a funded national alliance for PHNs, non-government peak bodies such as PHAA and AHHA are prepared to step in and support PHNs and a national organised primary care system. There is an opportunity to establish formal partnerships between industry and research through a renewed research program that is focused on implementation of evidence based improvements in service delivery.

However, effective support programs require funding and the Commonwealth must fund strategically relevant programs to support information exchange, for example via funding for national workshops, and establishing a national clearinghouse for quality assessed information on best practice in primary care.

RECOMMENDATION 2: Bilateral Primary Health Care Agreements must be progressed

Work already commenced on bilateral primary health care agreements between the Commonwealth and the states, the National Primary Health Care Strategic Framework and the National Aboriginal and Torres Strait Islander Health Plan should be progressed at the earliest opportunity, particularly in light of possible reforms likely as a result of the Federalism white paper.

RECOMMENDATION 3: Stakeholders must have the ability and sufficient influence to advise Boards

While PHN boards must be appropriately skills-based to address fiduciary requirements, clinical councils and community advisory committees must include representation by key stakeholders including allied health professionals, primary health nurses, Indigenous health, professionals and consumers. Genuine consultation with these stakeholders is required. Mechanisms must also be in place to ensure advice and views from stakeholders are available to the PHN board and management to support good decision-making.

RECOMMENDATION 4: PHNs must have a clear governance and accountability model

The governance models proposed for PHNs should clarify any unique governance, audit and accountability requirements associated with Commonwealth funding, such that these independent companies will have full understanding of any requirements beyond that normally associated with the Corporations Act.

RECOMMENDATION 5: PHNs must work with LHNs and Health Departments to undertake joint needs assessments

Consideration should be given to the development by Health Departments, LHNs and PHNs of joint needs assessment and core services/purchasing plans based on primary health priorities and service requirements.

RECOMMENDATION 6: Regional planning forums should be developed

Regional planning forums across primary care and hospitals, and between PHNs and service providers, may assist in supporting planning and investment. This work must draw on evidence about community health needs to ensure investment is targeted to need. Aboriginal health planning forums in WA may provide a useful model for regional health planning.

RECOMMENDATION 7: Community needs assessment data should be utilised effectively

Community needs assessment data should be used to inform national policy deliberations on primary health, as well as population health planning by PHNs.

RECOMMENDATION 8: Partnerships should be formalised

Partnerships should be formalised, and broadened beyond those already established under MLs, to improve service delivery, to better integrate care and to address service gaps. General practice as well as broader allied health professions must be engaged and supported.

RECOMMENDATION 9: Provision should be made for an establishment period

Problems identified with the start-up pace of MLs suggest that a period of establishment will be required for PHNs before they are able to fully deliver on the requirements of funding agreements. Further, clear identification of priorities (essential, important, desirable) and achievable KPIs will be critical to avoid PHNs being set up for failure.

RECOMMENDATION 10: Good work already commenced by MLs should continue

Work commenced by a number of MLs on building data collection, warehousing and reporting platforms which integrate highly granular primary care, hospitals and population data using statistical linkage methodologies should continue, with appropriate funding, supported by data sharing agreements, and with methodologies shared across the PHN network.

Work commenced under MLs on community needs assessment, and on clinical pathway development should continue to be funded and valued under the PHN model. The data collected under MLs must inform the work of PHNs and this data collection must continue to allow analysis of change over time.

RECOMMENDATION 11: Timely responses are required to address service gaps during the transition period

Timely and effective responses will be needed to address potential service gaps during the transition from MLs to PHNs, and where the PHN purchaser model is unable to effectively ensure service availability to meet population need.

RECOMMENDATION 12: Greater investment is required

A more efficient health system would see greater investment in primary care. This could be funded through savings from less efficient parts of the primary health system, for example by reducing workplace and mandated requirements for medical certification, promoting quality use of medicines and reducing use of pathology testing and investigations (a Choosing Wisely initiative would assist), and reducing pharmaceutical costs by improved purchasing methods.

ACKNOWLEDGEMENTS

PHAA and AHHA appreciate the contributions of speakers and delegates, whose experiences and insights from the basis of this Communique.

The support of Bupa, armchairmedical.com and the Lonsdale Group for the Primary Health Care Roadshow is gratefully acknowledged.