publichealth research&practice

January 2016; Vol. 26(1):e2611603
doi: http://dx.doi.org/10.17061/phrp2611603
www.phrp.com.au

Perspective – In discussion

The new Australian Primary Health Networks: how will they integrate public health and primary care?

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Article history

Publication date: January 2016.

Citation: Booth M, Hill G, Moore MJ, Dalla D, Moore MG, Messenger A. The new Australian Primary Health Networks: how will they integrate public health and primary care? Public Health Res Pract. 2016;26(1):e2611603. doi: http://dx.doi.org/10.17061/phrp2611603

Key points

- The Australian Government's new Primary Health Networks (PHNs) began operations on 1 July 2015
- The two overarching objectives of the PHNs are to increase the efficiency and effectiveness of medical services, and improve coordination of care
- Globally, there is a degree of separation between how primary health and public health services are organised, funded and provided, contributing to a lack of integration
- Evidence shows great benefits of collaboration between primary care and public health, and PHNs present an opportunity to develop this collaboration

Abstract

On 1 July 2015, the Australian Government established 31 new Primary Health Networks (PHNs), following a review by its former Chief Medical Officer, John Horvath, of 61 Medicare Locals created under the previous Labor administration. The Horvath review recommended, among other things, that new, larger primary health organisations be established to reduce fragmentation of care by integrating and coordinating health services, supporting the role of general practice, and leveraging and administering health program funding.

The two main objectives of the new PHNs, as stated on the Department of Health's website, are "increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time".

Below are three viewpoints, commissioned for this primary health care themed issue of *Public Health Research & Practice*, from the Australian Government Department of Health, the Public Health Association of Australia and a Sydney-based PHN. We asked the authors to focus particularly on how the newly established networks might help to integrate public health within the primary health care landscape.

Our authors have pointed out the huge overlap between public health and primary care and looked at evidence showing the great benefits for health systems of collaboration between the two. Challenges ahead include a possible government focus on delivery of 'frontline' medical services, which may come at the expense of population health, and the complexity of dealing with all primary health care stakeholders, including health professionals, Local Health Districts, nongovernment organisations, research institutions and local communities.

View from the Australian Government Department of Health

By Mark Booth and Graham Hill

The epidemiologist Geoffrey Rose, writing in the 1980s, noted that it was necessary to distinguish between individuals and populations.[1] This distinction has proved both helpful and unhelpful. Populations are made up of people, and people make up populations. Those in primary health care are routinely active in fulfilling public health roles through screening, early diagnosis, immunisation, interventions to support healthy lifestyles and, in particular, providing continuity of care. Equally, many public health activities – health improvement, service improvement and health protection – take place in general practice and in other parts of the primary health domain.[2]

Many countries have a degree of separation – sometimes even a schism – between how primary health and public health services are organised, funded and provided, which contributes to a lack of integration between the two.[3] At the same time, there is strong evidence of the benefits of collaboration between primary care and public health in many areas, such as communicable disease prevention and control, health promotion and protection, chronic disease prevention and management, maternal and child health, youth health, women's health, and working with vulnerable populations.[4]

A strong Australian health system needs both strong primary care infrastructure and a strong public health sector, and, crucially, a higher level of integration between the two than currently exists.[5] Are the new PHNs capable of playing a meaningful role in this space?

What are PHNs?

Thirty-one Primary Health Networks (PHNs) became operational on 1 July 2015. They are independent organisations with regions closely aligned with those of state and territory Local Hospital Networks (LHNs) or equivalent. They have skills-based boards, which are informed by clinical councils and community advisory committees.

PHNs have two overarching objectives: the first focuses on the efficiency and effectiveness of medical services, particularly for those at risk of poor health outcomes; the second on coordination of care. PHNs have a small amount of core funding for their corporate activities, plus a wider amount of flexible funding to put in place activities to help meet these two objectives.

What do PHNs offer in terms of integrating primary care and public health?

PHNs will focus on how an *individual* experiences health care – access to care, its efficiency, effectiveness and quality – as well as the degree of connectedness experienced by patients when navigating the health system, whether it is fragmented or seamless.

In this, PHNs will support general practice in a number of more traditional areas of public health, such as systematic and opportunistic screening, health checks, smoking cessation, exercise, weight reduction and diet, and interventions focused on specific chronic conditions such as diabetes and cardiovascular disease.[6] PHNs will also work with other parts of the primary health care system, including community nurses and pharmacists, and with LHNs in relation to both secondary and tertiary healthcare services and their extensive community and public health services.

PHNs will also focus on the health of the *populations* within their regions, and whether some groups, when viewed as a whole, are more at risk of poor health outcomes than others, and what can be done at the regional level to address this. Regional needs assessments and commissioning roles of PHNs will be critical to this role.

This dual focus has the capacity to ensure that health services are more accessible and tailored to community need, produce cost savings through reducing potentially preventable hospitalisations and improve care coordination, particularly for those at risk of poor health outcomes.[7]

Beyond this, however, much of the thinking on improving collaboration between primary care and public health is about issues broader than the nature or location of specific services and concerns – systemic factors like the fit between policy and local need, and organisational, behavioural and cultural factors.[8] The set of principles developed by the US Institute of Medicine as essential for successful integration of primary care and public health proposes a need for shared goals, community engagement, aligned leadership and shared infrastructure.[9] Through their clinical councils, community advisory committees and commissioning approach, PHNs provide, among other things, an important location in which these issues can be examined at the regional level.

Conclusion

The potential strengths of PHNs lie in their ability to focus on both the individual and the population, and in having regional scope within a nationally consistent framework. The strategies to improve and integrate public health within the primary care landscape are not unique: many of the hallmarks of successful collaboration with public health will be the same as successful collaboration more broadly.

View from the Public Health Association of Australia

By Michael J Moore and Danielle Dalla

Political focus and the bulk of health funding in Australia tends to funnel into our hospital systems. Australians spent more than $44 billion on the public hospital system in 2013–14 and another $11 billion on the private hospital system.[10] The health needs of our population would be much better catered for with much more work in prevention and early intervention: for the 2011–12 financial year, $2.23 billion, or only 1.7% of total health expenditure, went to public health activities, which include prevention, protection and promotion[11] – tasks more suited to the primary health care sector than to the hospital sector.

Coordinating population health

After just a few weeks of operation, PHNs, as the replacements of Medicare Locals, were asked by the government to efficiently and effectively coordinate population health – a fundamental part of our health system.[12] Serious challenges and interesting opportunities face leaders in the primary health sector. The transition from Divisions of General Practice through to Medicare Locals and now PHNs has come with benefits and disadvantages. Medicare Locals were still in their infancy when they were merged to create PHNs, but had developed a much broader understanding of primary health delivery than their predecessors, the divisions.

In realigning PHNs, the former Minister for Health, Peter Dutton, emphasised returning increased control to general practitioners (GPs)[13] and "recognising general practice as the cornerstone of primary care".[14] Fortunately for Australia, and for our primary health sector, many GPs have developed well beyond seeing their role as sole providers of primary health care and have become involved in complex team arrangements and organisations, liaising closely with allied health professionals to deliver much more holistic care.

"A state of complete physical, mental and social wellbeing"

However, primary health care goes beyond our valued GPs, or even holistic medical services involving allied health professionals. As far back as 1978, the World Health Organization conference on primary health care identified a comprehensive role for primary health in the Declaration of Alma-Ata.[15] Rather than clinical care, once the prime focus of GPs, the declaration describes health as "a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity".[15]

Population health planning has been identified as one of six key priorities for PHNs. However, an announcement by the new Minister for Health, Sussan Ley, in April 2015, did raise some concerns: "The key difference between PHNs and Medicare Locals is that PHNs will focus on improving access to frontline services, not backroom bureaucracy".[16] In Queensland, under the government of Campbell Newman, this same argument pre-empted slashing of health promotion and prevention.[17] The statement above by the Minister might be great politics; however, she is emphasising the medical treatment of patients rather than the fundamental causes of poor health. Even at Alma-Ata, "the existing gross inequality in the health status of the people"[18] was recognised and emphasised with the goal of "providing promotive, preventive, curative and rehabilitative services".[19] Primary health care must be comprehensive and incorporate an understanding of social determinants of health.

Conclusion

Nearly $900 million was committed by the former Abbott coalition government for PHNs to deliver primary health care. At the same time, nearly $800 million was cut from the federal Health Flexible Funds over four years. These funds are largely used for prevention and treatment. If the focus becomes too narrow and the positive lessons from Medicare Locals are not transferred to the new organisations, the clinical care merry-go-round will simply keep turning. There has been a great deal of pain for many dedicated health professionals in the constant reinvention of primary health care organisations over the past decade. It is now time to settle into delivering genuine primary health for the whole community.

View from a Primary Health Network

By Michael G Moore

The future for health is person-centred care: right care, right place, right time. To achieve this, the health needs of communities must be tackled at a local level, and primary health care professionals and the community must be supported locally as they build the skills and knowledge required to address local health needs.

The 2014 Horvath Review of Medicare Locals recommended the establishment of organisations that "integrate the care of patients across the entire health system in order to improve patient outcomes".[20] In a surprisingly swift response, the Australian Government Department of Health went on to establish 31 PHNs nationwide by 1 July 2015, to address this specific task.[12]

PHNs have been asked to address six priority areas: Aboriginal health, aged care, e-health, mental health, population health and health workforce.[12]

Determining health priorities

PHNs will be the coordinators of this local assessment of need and response. Conducting comprehensive needs assessments and area profiles of the local regions, and determining health priorities, is a consultative process, and will ensure that the perspectives of public, private and nongovernment providers, universities and our local communities are accurately captured. All PHNs are establishing clinical and community councils to guide their activities, with internal organisational structures being further tailored to ensure all voices are heard.

PHNs will also address nine national health priority areas: arthritis and musculoskeletal conditions, asthma, cancer control, cardiovascular health, diabetes, dementia, injury prevention and control, mental health, and obesity. A key first activity will be determining how best to address these, appropriate to each PHN region.

Addressing identified needs and gaps

To address identified need, in many cases the most cost-effective course of action will be to work with existing providers, adopting a person-centred ethos, and improving accessibility, equity of access, quality, efficacy and efficiency, and integrating existing service provision.

Quality and integration will be addressed by PHNs as they support local practitioners to acquire new skills and knowledge through comprehensive continuing professional development programs. PHNs are also working with universities to support training of the emerging primary health care workforce.

PHNs will provide advocacy at both local and regional levels and, where needed, advocate for system change. They will also facilitate better health promotion and improved health literacy through programs for provider and consumer target groups.

PHNs will facilitate better integrated care through joint initiatives with other providers – for example, the rollout of locally developed online and best-practice guidelines systems, such as the HealthPathways web portal.[21]

The alignment of New South Wales PHN boundaries with those of the state's local health districts and family and community services districts represents a new impetus for cross-sectoral collaboration.

Commissioning

PHNs are tasked with resolving service provision gaps in a cost-efficient manner. In many cases, these gaps, once revealed, can be filled by negotiation with existing providers. In some cases, PHNs may choose to step into the gap, funding new services through their small, discretionary, Commonwealth-provided, flexible funding budget.

Frontline services funded by PHNs will be commissioned through external providers. In contrast to Medicare Locals, PHNs have greater economies of scale. They already commission a wide range of mental health–related services, with further commissioning roles being developed to address identified gaps in local service provision.

Measure of success

Performance will be measured at a national level against the PHN performance framework (www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Performance_Framework), expected to be released shortly. There will be a series of national indicators, as well as local indicators relevant to individual PHNs. Success in creating real change, however, will be determined by ongoing consultation with providers and recipients of healthcare within the local community. Clinical and community councils will be an integral part of the process.

Conclusion

PHNs are a major step forward, moving Australia towards a world-class, person-centred healthcare system. If PHNs manage this process well, the potential for improved experience of care, better health outcomes, greater service efficiency and enhanced provider satisfaction in the Australian health system will be substantial.

Competing interests

None declared

Author contributions

MB and GH worked together to produce the section from the Department of Health. MJM and DD jointly prepared the section from the Public Health Association of Australia, with each making a drafting and proofing contribution after joint planning and discussion. MGM is sole author of the section from the Central and Eastern Sydney Primary Health Network. AM wrote the abstract and key points, and collated and edited the final manuscript.

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