Lessons from Medicare Locals for Primary Health Networks

Learning from the past to ensure effectiveness, efficiency and equity in primary health care

In the past few years, Australian primary health care (PHC) has experienced a major system restructuring that has created tensions in relation to efficiency, effectiveness and equity, fundamental concepts used to evaluate health systems performance.[1] Efficiency refers to making the most of available resources to maximise output,[2] effectiveness is meeting the needs of target populations and achieving objectives,[1] and equity concerns fairness in the delivery of services and outcomes.[1] Our analysis of Medicare Locals (MLs) provides insights into the tensions faced by PHC policy makers and Primary Health Networks (PHNs) when planning for improved population health. Between 2014 and 2015, as part of a 3-year study funded by the National Health and Medical Research Council, we conducted an online survey and 50 individual interviews with ML senior staff, which provided in-depth understanding of the challenges and opportunities for the new PHNs. The link to the online survey was sent to the chief executive officers (CEOs) of 61 MLs for distribution among senior staff and board members. To calculate the response rate, we asked CEOs to report on the number of people the survey was sent to, but we did not receive an exact number from all CEOs to calculate the response rate. However, the spread of responses was high across MLs (120 responses from 52 MLs; 86%), which shows that representatives from different MLs participated in the survey.

Different models of PHC organisation have evolved internationally over the past decade, with an attempt to implement organisational structures to improve coordination and integration of primary health care services;[3] for example, the primary care trusts in England, PHC organisations in New Zealand and PHC arrangements in some Canadian provinces. In Australia, the establishment of PHC organisations, in response to the first national PHC strategy,[4] was intended to improve system performance through better integration of PHC services regionally. The federal Labor government established 61 MLs across Australia in 2011, replacing the former national network of Divisions of General Practice. In 2014, following the change of federal government in 2013, a review of MLs criticised their variability in scope, perceived poor engagement with general practitioners and lack of clarity in goals.[5] The Coalition government replaced MLs with 31 larger organisations, called PHNs, which commenced operations in July 2015. This article outlines the vital aspects of regional PHC planning and organisation, based on our study of MLs, which can contribute to improve population health through the lens of efficiency, effectiveness and equity.

Importance of organisational size and governance

The requirement for aligning boundaries with major local public health and hospital authorities has been a major driver for the size of PHC organisations in different countries.[3] The transition from MLs to PHNs in Australia was generally accompanied by the geographic expansion of the catchment areas to align with the boundaries of the state-funded Local Health Networks. Although the impact of size on organisation performance is varied, there is evidence from the United Kingdom showing that increased geographic size may be a barrier for greater collaboration with, and inputs from, local communities.[6] The experience of Australia's MLs indicates that the efficiency gains that PHNs achieve as a result of being larger — through reduced administration costs and service duplication — must be balanced against a possible loss of local knowledge and expertise on local needs. Enhanced power and autonomy, and thus stronger influence from PHNs in the region, however, may improve their effectiveness in planning and partnerships. From an equity perspective, the amalgamation of metropolitan and rural MLs raises concerns in relation to equitable distribution of resources, with the risk that resources may be skewed towards the more populated urban areas.

The new PHNs' clinical and community councils provide opportunities for better inputs, particularly from communities. The involvement of private health insurers in the PHNs' governance causes significant equity concerns regarding PHC access for members of disadvantaged population groups with no private health coverage, although it could be argued that there are potential benefits from public–private partnership developments. Potential overgovernance, as a result of the new governance structure, raises concerns over how effective the coordination and collaboration between the

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councils will be. In addition, managing the power relations between professional and community members of the councils may be problematic.

Impact of commissioning on equity and the effectiveness of partnerships

Commissioning PHC services has featured in the health systems of some countries for decades,[7] although the evidence of its effectiveness is varied.[8] It is argued that the role of commissioning in the UK Primary Health Trusts and New Zealand PHC organisations has enabled these countries to improve the availability and range of PHC services at the local level and to increase the focus on prevention and early intervention activities.[9] The change in the focus of Australia's PHNs from service deliverers to service commissioning may similarly improve partnerships and lead to efficiency and effectiveness gains by reducing duplication, sharing expertise and infrastructure, and aligning actions that focus on a common goal.[10]

The potential impact of commissioning processes and competitive tendering on equity, however, is a concern, and PHNs need to ensure that equity and access are not undermined. Commissioning processes, for example, would need to support the important role of Aboriginal Community Controlled Health Services in local PHC systems. PHNs require sufficient resources to improve their capacities in commissioning and to learn from the models in those MLs that gained some experience of commissioning.

Achieving long term efficiency, effectiveness and equity through a narrow vision of primary health care

PHC is a contested territory with differing ideas about how it should be organised, which professional groups should provide leadership, and what the balance should be between treatment, disease prevention and health promotion. The focus of PHC on creating integrated models that meet local population needs, with accountability for population health outcomes, creates an opportunity for primary care organisations to focus on a continuum of PHC services, from disease management for individuals, to prevention and health promotion for populations. Most MLs reported that the policy context was not supportive of population health and favoured illness management, with a focus on short term efficiency over prevention and health promotion, reducing long term efficiency, effectiveness and equity of access to PHC services.

It is concerning that the priorities and funding models of PHNs are moving further away from prevention and health promotion, and are thus ignoring the emphasis placed on them by the World Health Organization.[11] There is growing evidence about the efficiency gains of health promotion activities and actions dealing with the social determinants of health.[12] MLs had limited ability to incorporate these activities in their planning and programs,[13] and the continued tension between prevention and illness management is an area that needs to be negotiated by PHNs and health policy makers if long term efficiency, effectiveness and equity are to be achieved.

The effect of centralised control on innovation and responsiveness to local needs

Needs and priorities differ between geographic areas, as does the cost of assessing needs and delivering services. Greater flexibility in funding and local power is critical in tailoring plans and services around local needs, ensuring resources are efficiently allocated and supporting greater community engagement in decision making.[14] Moreover, the centralised control of plans and resources also reduces opportunities for local innovation.[14] Despite a focus on local planning, the contractual requirements and reporting system in both MLs and PHNs encourage central control of program and resource management. MLs experienced little funding flexibility and were constrained in their ability to respond to local health priorities, particularly on health promotion and social determinants of health. A review of PHC organisations in the UK, New Zealand, Canada and the United States also revealed that, in spite of an overall focus on a shift from centralised governance towards regional authority and governance, there has been a trend towards centralisation of rules and standards in monitoring performance and accountability.[9] Our view is that PHNs will have to become adept at juggling the tension between being accountable to the federal government and being innovative in their responsiveness to local community needs.

Granting primary health care organisations stability and time to plan, implement and evaluate

The managers of PHC systems are continually driven to improve effectiveness, efficiency and equity. However, constant change can also undermine these improvements. The short lifespan of the MLs affected efficiency and effectiveness and led to uncertainty and frustration. We support the view of the Public Health Association of Australia and the Australian Healthcare and Hospitals Association that "stability is required in the system".[15] Operating in an environment of constant policy change makes it difficult to focus on the most important function of PHC: to improve population health, and to do so equitably. PHNs need organisational stability to ensure effective and long term planning for population health. Any further restructuring of PHC organisations in Australia is likely to have only adverse impacts on the efficiency, effectiveness and equity of PHC services.

Australian PHNs have opportunities to provide efficient, effective and equitable PHC, but need to heed the lessons from MLs on ways to minimise tensions and strengthen performance.

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