



Statewide Primary Care Partnership Position Paper

Associate Professor Rae Walker, Dr Sally Fawkes, Professor Vivian Lin,
School of Public Health,
La Trobe University
Bundoora, Vic 3086

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Executive Summary

This paper was prepared for the Statewide Primary Care Partnerships (PCPs). It includes: a brief discussion of what PCPs are and some of their achievements; a summary of elements in the major agenda setting documents in the reform process that are most relevant to PCPs; and an analysis of the proposals for Primary Health Care Organisations (PHCOs) to identify their capacity to create a connected and person centred system and their likely implications for PCPs.

Over the last decade in Victoria a great deal of effort has been invested in the development of a connected service system that has a strong focus on community and client needs and outcomes. Victorian initiatives include establishing Primary Care Partnerships (PCPS) which are:

- voluntary alliances of the primary care service providers in a geographic area; that,
- improve the health and wellbeing of a community; and,
- work in a social model of health (Department of Human Services, 2000:4).

Their role is to enable collaborative planning and facilitate coordinated action between agencies. Program evaluations have described major achievements of the PCP program.

Partnerships and connections. Approximately 800 agencies in Victoria participate in at least one of the 30 Primary Care Partnerships. The most frequently reported reasons for participation were to improve relationships between agencies and thence improve outcomes for the community, including improved access to services (Australian Institute of Primary Care 2005). When agencies were surveyed for the 2005 external evaluation 79% (up from 60% in 2002/03) of responding agencies said that the benefits of participating in PCPs exceeded the costs (Australian Institute of Primary Care 2005:32).

Service coordination. Service coordination work involved the development of agreed approaches to improving access, initial needs assessment and coordination and referral processes. In 2000, prior to implementation of the Primary Care Partnership Strategy, there were over 250 service coordination tools used in the Victorian system. Currently there is one agreed suite of tools used across the system. The KPMG evaluation of service coordination reported: high levels of consumer satisfaction with the appropriateness of services received, increasing efficiency and quality of service organization within agencies, and improvements in the flows of information and referral between agencies (KPMG 2004).

Integrated Chronic Disease Management. There have been a large number of initiatives in this area that include partnerships between hospitals and Primary Care Partnerships, and organizational change management amongst others. Evaluations of the Hospital Admissions Risk Program (HARP) produced evidence of reduced: attendance at emergency departments by one third, emergency admissions by over half, and hospital bed days by over 40%. These were accompanied by reports of improved consumer quality of life (Department of Human Services 2006).

Integrated Health Promotion. In the 2005 evaluation agencies reported increasing capacity to undertake health promotion, to coordinate it across the catchment and to link health promotion to service coordination (Australian Institute of Primary Care 2005:58).

Platform for cross-sectoral activity. Increasingly, Primary Care Partnerships are functioning as a platform for cross-sectoral coordination of community level health and wellbeing activity. For example, under a program, Sustaining Community Wellbeing During Drought, Primary Care Partnerships facilitated the systematic development of mental health programs, outreach programs for farming families, and coordinated work with other sectors such as financial planners.

The framework used to analyse the PHCO proposals included: a) a set of characteristics that would be visible in a connected and person centred system; b) the capacity for coordination of the

kind of structure established; and, c) the role of the PHCO in planning, purchasing, providing and coordinating services.

The three existing structures with roles in planning, coordination and service provision in the primary health care sector are PCPs, local government and Divisions of General Practice. They each have different capacities and do different things. The most comprehensive are the PCPs which include both local government and Divisions of General Practice. The least comprehensive are Divisions.

The most recent document from Victoria, *Putting patients first* (Victorian Government 2010), contains a clear state position in regard to PHCOs although it refers to them as Primary Care Organisations (PCOs). The shift in terminology possibly refers to the debate that links primary care to medical services and primary health care to comprehensive services. It is argued that:

Victoria supports PCOs focused on coordinating general practice, nurse practitioners and Aboriginal health workers, and their liaison with acute health and community based health sectors...

PCOs would need robust governance structures to ensure they are accountable to the communities they serve. To this end, they should be established as new organizations, rather than being tied to reform of existing structures...

A reorganization of primary care should not include broader social care and community services, which are fundamentally linked to other State Government responsibilities.

Victoria supports the Commonwealth's intentions to reorganize GP-type services... However, Victoria does not support suggestions for a wider range of services to be folded in to the Commonwealth's primary care responsibilities (Victorian Government 2010:21-22).

The role of the Victorian concept of PCO appears to be that of a coordinating unit (possibly with a planning component) that is likely to leave PCPs largely intact but enhance medical service coordination. The potential combination of coordination and planning mandates is likely to work well. Under this proposal the progress made towards creating the features of a connected Victorian health system, and the potential to take it further, is likely to remain.

The most recent Commonwealth formulation of the PHCO concept, in the *National health and hospital's network: Further investments in Australia's health* (Commonwealth of Australia 2010), clearly focuses on general practice, inclusion of allied health in the general practice orbit, developing preventive care in the service environment, and strengthening links between general practice, aged and acute care. PHCOs are to evolve out of existing Divisions of General Practice. Although the boundaries around primary health care are unclear in this proposal there is a strong implication that the system consists of general practice in the lead with allied health, nursing, and pharmacy in subordinate roles. It is suggested that in the future PHCOs may take on the role of delivering services currently funded by the states when these services are transferred to the Commonwealth. Furthermore, they may also work closely with the Australian National Preventative Health Agency to deliver programs to identify and manage risk factors in their local community.

If this proposal were to be implemented the PHCOs would take over support of chronic disease management and care coordination amongst the member agencies, and the provision of risk factor based prevention and health promotion work in the community. Presumably, PCPs would be left with a diminished set of functions with agencies that are not members of PHCOs. There would be a gap between agencies that were members of the PHCO and those that weren't making it more difficult to coordinate and plan across the entire system. The emphasis on implementation of GP care plans could make it more difficult for non-general practice agencies, and those not in the PHCO, to initiate links and contribute to meeting their client's needs. If additional state level

services are transferred to the Commonwealth, and became incorporated into this PHCO model, the role of PCPs would be very significantly diminished.

The Commonwealth approach to PHCOs suggests that they would manage structural relationships between GPs and other clinical services (this appears to be what the Commonwealth mean by coordination), would deliver services and would potentially plan service development to meet a limited range of community needs. They appear to be conceived as a lead agency with its own service provision role accompanied by a limited coordination function with a narrow range of agencies. The mechanism by which new services would be funded is unclear but potentially it could be through development of a PHCO purchasing role. The lack of clarity and potential conflicts of interest to be found in combinations of planning, coordination, provision and potentially purchasing, roles makes it difficult to see clearly how PHCOs could create a connected health system for the Australian population.

There are three potential ways of creating PHCOs: create a new structure, transform Divisions of General practice, and, transform PCPs. There is a widely held that the best option for Victoria is the development of a new structure that can meld the existing structures and capacities into a coherent primary health care system. There is also a widely held view that the least desirable option is the transformation of Divisions of General Practice into PHCOs. The third option, the transformation of PCPs, has not been widely considered.

Statewide Primary Care Partnership Position Paper

1. The task for this project

The aim of this project was to produce a Primary Care Partnership position paper for an audience of the relevant commonwealth and state government departments and peak bodies. As the paper has developed it has become clear that the situation is very complex, uncertain and developing rapidly. This observation was reinforced by feedback from the field on the final draft. It is not possible to write a detailed position paper that will remain accurate, relevant and useful when the environment is like this. The paper has been reorganised and the information on the views of key stakeholder organisations expanded to provide information that is available at the time of writing. A more extensive analysis of that information has been undertaken. This analysis should assist Primary Care Partnerships to advocate and to craft responses to new proposals put forward, and decisions made, as the situation unfolds.

Details of the project brief and approach are included in Appendix 1

2. Brief background: Primary Care Partnerships in Victoria

The documents that provide a definition of primary health care all refer to the World Health Organization (WHO) definition derived from the Declaration of Alma Ata (World Health Organization and United Nations Children's Fund 1978) or the World Health Report on primary health care (WHO 2008). The Department of Human Services (2009a) adapted the Declaration of Alma Ata definition of primary health care to the contemporary Victorian context to read:

Primary health care is integral to the Victorian health system. Community-based, it seeks to protect, promote and develop the health of defined communities; and by addressing and managing individual and population health problems at an early stage reduces the need for more complex care. At the other end of the health care continuum, primary health care services can support rehabilitation and care at home.

Primary health care in Victoria should be provided by a range of suitably trained health practitioners, working collaboratively and in partnership with other sectors, to provide timely, appropriate, integrated and person-centred services and population health actions.

Primary health care services give priority to those most in need and address health inequalities; maximise community and individual self-reliance, participation and control, and use appropriate technologies. Primary health care in Victoria is underpinned by an understanding of the social, economic, cultural and political determinants of health (Department of Human Services 2009a:16).

In Victoria, publicly funded primary health care services include types of services such as community health, district nursing, general practice and primary health care services delivered by local government and in some cases hospitals; community based services for particular populations such as older people, women, Indigenous people, immigrants; and, the provision of particular services in a community setting such as psychiatric support and community drug treatment services. Clinical and public health services are central to health outcomes but health system users' needs cannot be met without the health system

facilitating *'appropriate and equitable access to other health and broader human services as required'* (Department of Human Services (2009a:2).

Over the last decade in Victoria a great deal of effort has been invested in the development of a connected service system that has a strong focus on community and client needs and outcomes. The achievements from this effort go a substantial way towards achieving a number of goals that are at the core of the Commonwealth government's health reform agenda. Victorian initiatives include establishing Primary Care Partnerships (PCPS) with a mandate to build partnerships across the broad primary health care sector described in the WHO documents. A Primary Care Partnership (PCP):

- is a voluntary alliance of the primary care service providers in a geographic area; that,
- will improve the health and wellbeing of a community; and,
- will work in a social model of health (Department of Human Services, 2000:4).

Their role is to enable collaborative planning and facilitate coordinated action between agencies.

Evaluation reports that are in the public domain describe a successful initiative that has achieved significant change in the primary health care system and in its relationships to other systems in Victoria. Some key findings are described below. Additional evidence of achievement has been collected by the Department of Health but this has not yet been released to the public in a form that can be used here.

Partnerships and connections

Approximately 800 agencies in Victoria participate in at least one of the 30 Primary Care Partnerships. Small agencies are participating in increasing numbers. The most frequently reported reasons for participation were to improve relationships between agencies and thence improve outcomes for the community, including improved access to services (Australian Institute of Primary Care 2005). Improvements in relationships were founded on knowledge of each other, trust in each other and the capacity to act together to achieve shared goals. Skilled partnership management was necessary to achieve the valued outcomes. When agencies were surveyed for the 2005 external evaluation of the Primary Care Partnership Strategy 79% (up from 60% in 2002/03) of responding agencies said that the benefits of participating in PCPs exceeded the costs (Australian Institute of Primary Care 2005:32).

Service coordination

Service coordination work involved the development of agreed approaches to improving access, initial needs assessment and coordination and referral processes. In 2000, prior to implementation of the Primary Care Partnership Strategy, there were over 250 service coordination tools used in the Victorian system. Currently there is one agreed suite of tools used across the system. Consumers attending agencies using these tools were more likely to report improvements in the communication of consumer relevant information between agencies (Australian Institute of Primary Care 2005:55). The KPMG evaluation of service coordination reported: high levels of consumer satisfaction with the appropriateness of services received, increasing efficiency and quality of service organization within agencies, and improvements in the flows of information and referral between agencies (KPMG 2004). A key summary statement from this evaluation was: *'Even in its early stages it is clear that Service Coordination delivers a range of quantifiable benefits, that by all accounts are not only sustainable but will continue to be realised'* (KPMG 2004:3).

Integrated Chronic Disease Management

Integrated Chronic Disease Management is a *'comprehensive and multidisciplinary approach to the care of people with, or at risk of, a particular disease or condition, aiming to reduce the burden of disease through a holistic approach. It incorporates the continuum of*

care from prevention through to treatment, management and maintenance' (Department of Human Services 2005). There have been a large number of initiatives in this area that include partnerships between hospitals and Primary Care Partnerships, and organizational change management amongst others. Evaluations of the Hospital Admissions Risk Program (HARP) produce strong evidence of the effectiveness of this bundle of initiatives. Overall, HARP programs have reduced: attendance at emergency departments by one third, emergency admissions by over half, and hospital bed days by over 40%. These were accompanied by reports of improved consumer quality of life (Department of Human Services 2006).

Integrated Health Promotion.

In the 2005 evaluation agencies reported increasing capacity to undertake health promotion, to coordinate it across the catchment and to link health promotion to service coordination (Australian Institute of Primary Care 2005:58). By 2008 it was found that the Integrated Health Promotion strategy had also increased agency access to health promotion funding (HDG Consulting Group 2008). Both of these evaluation reports describe widespread coordination of resources directed towards health promotion priority issues such as physical activity and healthy eating but not to the exclusion of local community priorities such as health support in drought affected areas.

Platform for cross-sectoral activity

Increasingly, Primary Care Partnerships are functioning as a platform for cross-sectoral coordination of community level health and wellbeing activity. One example is the Department of Justice funding Primary Care Partnerships in the North of Melbourne to develop community level integrated problem gambling initiatives that engage local agencies, focus on local population needs and use the agencies' capacities for intervention. Under a program, Sustaining Community Wellbeing During Drought, Primary Care Partnerships facilitated the systematic development of mental health programs, outreach programs for farming families, and coordinated work with other sectors such as financial planners.

The achievements of Primary Care Partnerships make them a major resource to support the reform effort in this state. They are flexible structures able to build connections, and develop coordinated activity, across the primary care sector, in its relationships to the acute sector, and to other sectors as required in some primary health care responses to particular problems. They engage both large and small agencies and have established a culture of collaboration that is based on communication, shared values about communities and quality of care, and have facilitated effective collaborative practice.

3. Current health system reform agendas: Implications for primary health care

In 2009 a number of health system reviews were completed each with implications for primary health care. These reviews have an important role in setting the agenda for health reform negotiation and decision-making.

The Commonwealth government initiated the Health and Hospital Reform Commission, the National Preventative Health Task Force and the National Primary Health Care Strategy. The Department of Human Services in Victoria published a primary health care discussion paper. In early 2010 additional documents have been published that refine and elaborate the initial agenda. From these documents a number of high level health system goals can be identified. They include:

- Access to services that meet needs should be improved, especially for population groups that are currently underserved, for example Indigenous people, people with mental health needs and people living in rural and remote communities.

- The system should be person centred focusing on the needs and preferences of system users and utilizing models including self management and shared care.
- The system should be configured in ways that facilitate the meeting of complex health and social needs. The services that constitute the health system should be connected to each other in ways that facilitate flows of information and referral, and enable user access to the services they need singly or in combination.
- A well configured system should also include inter-sectoral connections between health services and, for example, welfare, employment and educational institutions.
- The system should adequately address the care continuum, prevention, health promotion, early intervention and clinical care, for the population.

Primary Care Partnerships provide a framework within which the primary health care system, and its member agencies, is able to progress towards these goals.

Despite the similarities in goals expressed in the documents, and their use of the World Health Organization concept of primary health care, there are differences in the operationalisation of these ideas. The major fault line is drawn between those discussing the reform of clinical services and those discussing the full range of primary health care services required to meet the needs of individual users of the system and of populations.

The **National Health and Hospitals Reform Commission** (NHHRC) (Commonwealth of Australia 2009a) assumed a comprehensive range of services in the primary health care sector reforms. It recommended drawing together all the publicly funded primary health care services currently funded by Commonwealth, State and local governments (Commonwealth of Australia 2009a:102). It also proposes the devolution of appropriate hospital outpatients services to the primary health care setting. Clinical services are clearly a priority for the Commonwealth.

The second report from the National Health and Hospitals Reform Commission (Commonwealth of Australia 2010) focuses on initiatives that keep people out of hospital and healthy in the community, especially those with chronic disease and requiring coordination of care. To this end it proposes strengthening primary health care planning and identification of service gaps and access barriers. This is close to the PCP mandate. The Commonwealth proposes establishing regional structures, Primary Health Care Organisations (PHCOs), to undertake local primary health care planning and coordination. They will be: *'independent legal entities .. with strong links to local communities, health professionals and services providers, including GPs, allied health professionals and Aboriginal Medical Services'* (Commonwealth of Australia 2010:44). It is argued that PHCOs should evolve from Divisions of General Practice. The proposed role of PHCOs will be discussed below in the next section.

The draft **National Primary Health Care Strategy** (Commonwealth of Australia 2009b) identified four priority directions for change:

- Improving access and reducing inequity
 - An integrated service system that delivers more consistent quality, fills service gaps and meets the needs of specific population groups
 - Outreach programs for underserved populations
 - Transition services for people leaving hospital or navigating the system
 - Team based interventions providing joined up and flexible services
 - Better access after hours access
 - Closing the Gap activities for Indigenous people
 - Regional governance structures (PHCOs)
- Better management of chronic conditions through improved continuity and coordination of care particularly for those with chronic disease
 - Realign chronic disease funding

- Develop a more collaborative and patient focused chronic disease management approach and more consistent identification and assessment of patients
- Improve evidence based assessment tools and protocols
- Support self management tools and monitoring systems
- Use effective multi disciplinary teams
- Increasing the focus on prevention - strengthen the existing framework for promotion, prevention and early intervention, encourage more systematic approaches and link with other activities such as promoting health literacy in communities.
 - Health organizations to focus more on prevention
 - Modify work practices to use nurses, allied health and pharmacists to meet local needs
 - Support supplementary prevention services for individuals and practitioners, focused on high risk populations and conditions or behaviors where prevention and early interventions can improve outcomes
 - Improve individual and community health literacy and self care.
- Improving quality, safety, performance and accountability

The National Primary Health Care Strategy (Commonwealth of Australia 2009b) adopted a narrow focus that emphasises provision of clinical services, and services to individuals, rather than the full range of services utilized by primary health care system users.

The **Preventative Health Taskforce** (Commonwealth of Australia 2009d & 2009e) describes in quite a lot of detail a program to prevent ill-health and promote wellbeing focused on three major issues, obesity, tobacco, and alcohol, and on closing the gap in life expectancy between Indigenous and non-Indigenous people. Primary health care is one setting for prevention work alongside workplaces, schools, municipalities, sporting codes, low income and Indigenous communities, for example. In the view of the Preventative Health Taskforce the minimum requirements of a primary health care system which works effectively for prevention are that it:

- Systematically identifies people at risk and assesses their level of risk and readiness to change
- Delivers appropriate services on site or refers to external services
- Has in place referral processes that allow ready access to appropriate quality-assured lifestyle modification providers and programs
- Monitors and assesses outcomes and sustains improvements over time.

To achieve these the primary care sector requires:

- A multidisciplinary workforce with relevant skills and expertise
- Appropriate tools and resources
- Information systems that provide risk data on the practice population
- Effective linkages to wider community services

Refocusing primary health care involves the main strategies in the National Primary Health Care Strategy: team based care, prevention of chronic disease, targeting disadvantaged communities. As in the National Primary Health Care Strategy the Taskforce recommends that primary care focus on risk factors and lifestyles: risk assessment, lifestyle change programs, appropriate referral, monitoring and evaluation. The role for primary health care in prevention is defined narrowly, unlike the role of Primary Care Partnerships which foster comprehensive integrated health promotion in Victoria (Department of Human Services 2005).

The **Victorian Primary Health Care discussion paper** (Department of Human Services 2009a) identified three goals for the primary health care system:

- Focus on wellness and be person centered
- Address inequalities in access
- Enable people with chronic conditions to receive integrated community based care that supports self management and keeps them out of hospital

The emphasis was on continuing to strengthen the integration and innovations in the PHC system that have already begun. This included strengthening existing partnership structures. A new element was the introduction of stronger and more joined up area based planning and purchasing through provider partnership structures that exist already in PCPs and Divisions.

The Victorian government noted that the needs of individual users of the system cannot be met without the health system '*facilitating appropriate and equitable access to other health and broader human services as required*' (Department of Human Services 2009a:2). It argued that primary health care reform must take into account the distinctive features of the different jurisdictions. In Victoria for example, the state government has stated that:

Victoria has developed a distinctive primary health care system built on the principles of partnerships and service integration that has resulted in some unique features and innovative programs. These include PCPs [Primary Care Partnerships], Hospital Admissions Risk Programs (HARP), Early Intervention in Chronic Disease (IECD) programs and extensive networks of government and non-government community health services servicing local government across the state (Department of Human Services 2009a:1).

In its most recent paper (Victorian Government 2010), *Putting patients first*, the Victorian government supports the direction of change proposed by the Health and Hospital Reform Commission. It supports the reorganization of GP, nurse practitioner, allied health and Aboriginal Medical Services, and the forging of closer links between acute care, aged care and community based services. It also supports further development of care coordination for people with chronic conditions, building upon the achievements of the HARP program. However, it does not support the inclusion of the broader social care and community services, such as maternal and child health services, drug and alcohol services, and community mental health services, under commonwealth control. Victoria wants to see a greater emphasis on prevention as '*well-planned, community-led prevention has been responsible for many of the most significant improvements in our health*' (Victorian Government 2010:19). It also argues that the PHCOs should be established as new organizations rather than be an evolution of an existing structure.

The **Victorian Healthcare Association** (2010) supports the broad goals of the health reforms proposed in the Health and Hospital Reform Commission report. However, it argues that the actual reforms be tailored to the Victorian institutional context to avoid damaging the current achievements in developing an integrated person centre primary health care system. It makes a strong argument in support of maintaining a comprehensive primary health care system and planning that incorporates the social determinants of health. The PHCOs should be new organizations based on '*regional communities of interest*' (Victorian Healthcare Association 2010:4) rather than an evolution of Divisions of General practice.

4. Primary Health Care Organisations (PHCOs)

If we take an overview of the Australian health system we can describe some features that would be prominent if the system was well connected. These features are discussed in more detail in Appendix 3. The features are:

- Variability in the size, complexity and mandate of the agencies that are linked to each other in order to facilitate access by system users.
- Some key shared values and knowledge across the system.
- Active communication between agencies supportive of information sharing and referral, and that can be initiated from any part of the health system.

- All agencies have appropriate internal arrangements that support coordination with other agencies.
- Structures that can facilitate the communication and negotiation required for joint planning and implementation of programs are in place.

If system goals are to be achieved the proposed PHCOs need to support the development of such a system.

In the theoretical literature there are three main kinds of structures for organizing inter-organisational activity and system connectedness (Alexander 1995) – coordinating units, lead organizations and single organizations. These are discussed in more detail in Appendix 4. The proposal for creating PHCOs will be assessed in relation to them.

A *coordinating unit* is an organization or organizational unit that exists to coordinate decisions and action in a connected system (Alexander 1995:153). It has its own identify, budget and staff and has substantial independence in relation to the organizations participating in the system. A coordinating unit does not offer services and does not compete with members of the connected system it coordinates. In the context of health reform the strength of coordinating units, that is their separation from service provision and service purchasing (both sources of risk and competition for agencies), may be eliminated by changes that combine purchasing, provision and system coordination in the same structure. A primary care partnership is a good example of a coordinating unit.

A *lead organization* is one that, ‘in addition to its line functions, is responsible for coordinating the activities of all the other organisations’ (Alexander 1995:177). Coordination of the other organisations may be marginal to the lead organization’s main functional tasks. Maintenance of commitment and thence effectiveness can be a problem as the lead organization changes internally or the external coordination task changes. If lead organizations are also purchasers of services conflicts between the goals of the lead organization and goals of the agencies it coordinates can fracture the system relationships.

A *single organization* coordination system occurs when most important functions are incorporated into one organisation. They are common outcomes of restructures of large organizations or of mergers. These types of coordination structures typically require a greater investment of political and material resources than the other coordination structures (Alexander 1995:194).

Policymakers often use a framework consisting of the following tasks: planning, coordination, purchasing, provision of services, and governance, to think about system structure and management.

Planning. The enhance connectedness PHCO would need to engage, in some way with the structures that currently have a role in regional primary health care planning, for example, with PCPs, Divisions of General Practice, local government, regional offices of state health departments. A key question is the scope of the planning process. Does it focus on the narrow range of issues and clinical services described in the Primary Health Care Strategy or does it include the range of health, prevention, rehabilitation and social services at the community level that are used by health system users? Planning and coordination functions can work well together.

Purchasing. Health purchasing is a specialized field of activity and requires particular knowledge and skills. If regional level purchasing is introduced it makes sense for planning and purchasing to be undertaken by the same structure. However, putting coordination and purchasing together creates many risks for organizations that reduce their trust and

willingness to cooperate and thence the capacity to create effective system connections. Purchasing needs to be separated from coordination.

Providing. Provision of services is frequently separated from purchasing of services. If an agency purchases services from itself and from other agencies a perceived conflict of interest in the purchasing process undermines trust and reduces cooperation between agencies. From the beginning of Primary Care Partnerships agency managers have argued that combining purchasing and providing poses many risks for them and reduces their willingness to share information and work together (Walker et al 2007).

Coordinating. PCPs, Divisions of General Practice, and local government currently have established coordination structures and processes in their respective arenas. There are some links between them. The most comprehensive structures in Victoria are the Primary Care Partnerships which include both local government and the Divisions. Planning and coordination can work well together. Purchasing and coordination don't. Coordination and service delivery functions can be located in the same organization but, unless service provision has a very specific focus, it gives rise to problems of competition and distortion based on political and economic interests of the agencies. Coordination is most effectively done by structures that do not purchase or provide services in their own right.

The reports informing the health reform agenda argue for different models for PHCOs.

The Victorian perspective

In the paper *Primary Health Care in Victoria: A discussion paper* (Department of Human Services 2009a) the Department of Health outlines a vision and pathway by which the Victorian primary health care system can build on its strengths to achieve a more efficient and effective system that provides universal access to services for the community and, in particular, is able to meet the needs of people with chronic and complex conditions.

Proposals include:

- Continuing to strengthen the integration and innovations in the PHC system that has already begun. This includes strengthening existing partnership structures such as PCPs.
- Introduction of stronger and more joined up area based planning through a new structure and purchasing through provider network structures that exist already in PCPs, Divisions of General Practice and local government.
- A stronger prevention network structure may be introduced and become the provider structure through which prevention services can be purchased.

The most recent document from Victoria, *Putting patients first* (Victorian Government 2010), contains a clear state position in regard to PHCOs although it refers to them as Primary Care Organisations (PCOs). The shift in terminology possibly refers to the debate that links primary care to medical services and primary health care to comprehensive services. It is argued that:

Victoria supports PCOs focused on coordinating general practice, nurse practitioners and Aboriginal health workers, and their liaison with acute health and community based health sectors...

PCOs would need robust governance structures to ensure they are accountable to the communities they serve. To this end, they should be established as new organizations, rather than being tied to reform of existing structures...

A reorganization of primary care should not include broader social care and community services, which are fundamentally linked to other State Government responsibilities.

Victoria supports the Commonwealth's intentions to reorganize GP-type services... However, Victoria does not support suggestions for a wider range of services to be folded in to the Commonwealth's primary care responsibilities (Victorian Government 2010:21-22).

The role of the Victorian concept of PCO appears to be that of a coordinating unit (possibly with a planning component) that is likely to leave PCPs largely intact but enhance medical service coordination. The potential combination of coordination and planning mandates is likely to work well. Under this proposal the progress made towards creating the features of a connected Victorian health system, and the potential to take it further, is likely to remain.

The Australian General Practice Network perspective on PHCOs.

An early document that outlines what a PHCO might look like is *Connecting Care* prepared by the Australian General Practice Network (AGPN) (2009), the peak body for Divisions of General Practice. In this document it is noted that Divisions of General Practice currently have two roles: support for development of general practices and the provision of some general practice related services. It is argued that in the transition to PHCOs these roles should be maintained and expanded and sit alongside regional planning, coordination and purchasing. In the AGPN model the role of PHCOs would be to:

- *'develop expertise in population health planning, and identification of gaps and priorities which target those most in need;*
- *take increasing responsibility for service configuration in their community aligned to need;*
- *manage all primary health care funding for a region (excluding benefit payments such as MBS and PBS);*
- *continue to develop their financial management capacity, accountabilities and focus on demonstrating high performance and cost effective business systems.'* (AGPN 2009:5).

The idea is that PHCOs be built on the existing *'infrastructure, assets and intellectual capital'* of existing Divisions of General Practice but expand their governance structures to include other *'clinical, business, legal and marketing expertise'* (AGPN 2009:11). With these capacities the PHCOs are to plan for and coordinate a comprehensive primary health care system that includes *'health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation'* (AGPN 2009:12). This model is clearly visible in the most recent Commonwealth PHCO proposal.

The Commonwealth perspective

The Commonwealth argues that Divisions of General Practice are appropriate to transform into a regional level planning and coordination structure. The recommendation is to establish regional level Primary Health Care Organisations that coordinate and plan primary care through evolution of Divisions of General Practice or replacing them (Commonwealth of Australia 2009a). The NHHRC recommends: *... that the Commonwealth fund Divisions for 3 years to expand their membership to include non-GP members and to redevelop their strategic and operational plans* (Commonwealth of Australia 2009a:205).

The most recent formulation of the PHCO concept, in the *National health and hospital's network: Further investments in Australia's health* (Commonwealth of Australia 2010), clearly focuses on general practice, inclusion of allied health in the general practice orbit, developing preventive care in the service environment, and strengthening links between general practice, aged and acute care. PHCOs are to evolve out of existing Divisions of General Practice. A core function will be to enhance the capacity of GPs to manage chronic condition care. The functions proposed for PHCOs are:

- *Facilitate allied health care and other support for people with chronic conditions, as identified in personalized care plans prepared by GPs.*

- *Work with local health care professionals to ensure services cooperate and collaborate with each other so that patients can easily and conveniently access the full range of services they need.*
- *Identify groups of people missing out on GP and primary health care, or services that a local area needs, and better target services to respond to these gaps.*
- *Work with Local Hospital Networks to assist patient's transition out of hospital, and where relevant into aged care.*
- *Deliver health promotion and preventive health programs targeted at risk factors in communities in cooperation with the Australian National Preventive Health Agency, once it is established (Commonwealth of Australia 2010:45).*

An example given of how the PHCO system would work is for the PHCO to, after consultation with GPs, organize a roster of allied health professional to support the management of diabetes (Commonwealth of Australia 2010:45). Although the boundaries around primary health care are unclear in this proposal there is a strong implication that the system consists of general practice in the lead with allied health, nursing, and pharmacy in subordinate roles. This is consistent with the boundaries of primary health care identified in the report accompanying the Primary Health Care Strategy:

The focus of this Report [document supporting the National Primary Health Care Strategy] is primarily on services delivered by GPs, nurses, allied health providers, Aboriginal health practitioners, and pharmacists. (Commonwealth of Australia 2009c:24)

It is suggested that in the future PHCOs may take on the role of delivering services currently funded by the states when these services are transferred to the Commonwealth. Furthermore, they may also work closely with the Australian National Preventative Health Agency to deliver programs to identify and manage risk factors in their local community.

PHCOs will also be required to prepare a Healthy Communities Report for their local area addressing:

- *Preventive health risk factors and other measures of community health and wellbeing;*
- *access to GP services and out-of-hours GP care; and,*
- *the extent to which the health system is working in a coordinated way, for example through the number of avoidable hospital admissions and trends in this information over time (Commonwealth of Australia 2010:47).*

The role defined for local agencies (for example, local government, states, academics and consumer groups) will be to 'develop the Report structure, and to identify what data is already available and what will need to be developed over time' (Commonwealth of Australia 2010:47). It is possible (even likely) that the Healthy Communities Report would transform into a locality plan.

If this proposal were to be implemented the PHCOs would take over support of chronic disease management and care coordination amongst the member agencies, and the provision of risk factor based prevention and health promotion work in the community. Presumably, PCPs would be left with a diminished set of functions with agencies that are not members of PHCOs. There would be a gap between agencies that were members of the PHCO and those that weren't making it more difficult to coordinate and plan across the entire system. The emphasis on implementation of GP care plans could make it more difficult for non-general practice agencies, and those not in the PHCO, to initiate links and contribute to meeting their client's needs. If additional state level services are transferred to the Commonwealth, and became incorporated into this PHCO model, the role of PCPs would be very significantly diminished.

The Commonwealth approach to PHCOs suggests that they would manage structural relationships between GPs and other clinical services (this appears to be what the

Commonwealth mean by coordination), would deliver services and would potentially plan service development to meet a limited range of community needs. They appear to be conceived as a lead agency with its own service provision role accompanied by a limited coordination function with a limited range of agencies. The mechanism by which new services would be funded is unclear but potentially it could be through development of a PHCO purchasing role. The lack of clarity and potential conflicts of interest to be found in combinations of planning, coordination, provision and potentially purchasing, roles makes it difficult to see clearly how PHCOs would create a connected health system for the Australian population.

The Victorian Health Care Association and General Practice Victoria perspective

In February 2010 the Victorian Healthcare Association (VHA) (2010) prepared a paper defining their view of what PHCOs might do and how they should be formed. The proposed role for PHCOs should be to '*improve population level health planning and service coordination*' but not service delivery. Their role should be:

- *Implementation of a population health planning approach to primary health care, including service planning, workforce planning and community development.*
- *Improving primary health care services' capacity for data collection, aggregation and use, including the development of appropriate infrastructure.*
- *Coordination of primary health care services to provide connected care for consumers.*
- *Strengthening and building the capacity of the existing health service delivery infrastructure, with the aim of improving access, effectiveness, efficiency and sustainability of primary health care services* (Victorian Healthcare Association 2010)

In the view of VHA, PHCOs should be formed by existing local agencies and networks coming together to form a new structure to undertake the role of a PHCO. Potential partners include divisions of general practice, existing networks and collaborations such as Primary Care Partnerships, local governments, local communities and primary health care service providers. The formation of new organizations would allow each state to build upon its existing capacity in primary health care. The VHA proposal for PHCOs would create a coordinating structure closely linked to existing capacity for planning, coordination and service delivery. The inclusion of existing networks would probably avoid the disconnections between agencies likely to eventuate from the Commonwealth proposals.

The Victorian Healthcare Association (VHA) and General Practice Victoria (GPV) (2010) issues a joint statement on PHCOs. In the joint statement it is argued the role of PHCOs should be the same as that described above by VHA. The services covered by PHCOs would be general practice, family services, drugs and alcohol, mental health, community nursing, allied health, dental, and community development (VHA and GPV 2010:1). In addition, the joint statement argues that PHCOs might be fund holders for service coordination, quality and population planning. In the future they might purchase services in their local area. Although initially the idea is for PHCOs to be a coordinating unit with the capacity to facilitate development of a connected service system, the addition of purchasing would be likely to create financial risk for local agencies and distrust of the PHCO. The services identified for inclusion would weaken the coordination roles of both local government and Primary Care Partnerships. A strength of Primary Care Partnerships is their inclusion of services large and small including general practice and local government. The joint VHA-GPV model would be likely to weaken the broad system connections, unless a system of core and non-core membership was instituted and is done in PCPs. If that eventuated the role of Primary Care Partnerships would be supplanted.

5. Victoria's existing capacity for creating a connected system

Currently in Victoria there are three major structures with a role in planning and coordination: local government, PCPs and Divisions of General Practice. Local government and PCPs have coordinated their planning mandates and activities. The extent to which Divisions of General Practice planning is coordinated with PCPs and local government is less clear.

Comparison of the three major planning and coordination structures in Victoria

| | <i>Planning</i> | <i>Coordination</i> | <i>Purchaser/provider arrangements</i> | <i>Governance</i> |
|--------------------------------------|---|--|--|--|
| <i>Local government</i> | Legislated 3-yearly MPHP plan; Smaller population catchment | Where relevant to MPHP | Service delivery and some service contracting | Elected councillors |
| <i>PCP</i> | Mandated 3-yearly plans; multiple LGAs | At interface of all community-based services, include LGAs & Divisions of General Practice | No purchasing; no service delivery | Formal governance committee of members of the unincorporated alliance with legally binding partnering agreement. |
| <i>Divisions of General Practice</i> | Annual work plan | Where relevant to multiple GP practices | No purchasing; Some programs delivered; support GP practices | Board of directors largely recruited from Division membership operating as part of the company structure |

- Local government* is mandated to prepare a Municipal Public Health and Wellbeing Plan (MPHP) every three years. The scope of these plans is broad. They are to create social, economic, natural and built environments that are supportive of health. They are to be based on evidence about the community and from the community. Local government prepares the MPHP in consultation with other relevant agencies (including Divisions of general Practice and Primary Care Partnerships) and, in partnerships with some of those agencies, implements the plan. In Victoria local government provides important community services, health promotion programs and in many cases is an important coordinator of services. However, they have to give priority to their statutory obligations which limits the scope of their activities in primary health care. Local government is overseen by elected Councilors who represent interests in their communities but the officers (or staff) of Councils are responsible for operationalising Council policies within the legal framework of local government. Local government functions as either a lead organization or single organization.
- Primary Care Partnerships*, produce a 3 year strategic plan (for a catchment of 2-3 local government areas) that is different from but coordinated with the relevant MPHP plans. The strategic plan focuses on 2-3 local health and wellbeing priorities

that require a strategic and shared response by partner agencies. The priorities may include:

- *'A critical issue in the Region and/or the PCP catchment, for example addressing the mental health impacts of drought; and*
- *Be population, settings and/or service based, for example, diabetes in refugee communities'* (Department of Human Services 2009b:1-2).

The priority setting approach needs to demonstrate an evidence based approach. The role of PCPs is to drive collaborative planning and create the relationships, agreed frameworks and tools that make collaborative action possible. The PCPs are the only structure in Victoria that engages a comprehensive range of agencies. They are governed by a management committee of key service provider agencies and have a small staff to implement the programs decided. PCPs are coordinating structures, do not have a legal standing but have legally binding partnership agreements. Appendix 2 describes PCPs in more detail. PCPs function as a coordinating unit that must work with a set of core agencies but is encouraged to include the full range of primary health care service providers.

- *Divisions of General Practice* provide services and support to general practice at the local level. Existing functions of Divisions are developmental support for general practice and direct service delivery (AGPN 2009). Within medicine models of Community Oriented Primary Care have been developed but are not well established in this country (Wagner 2008). Rural practices can be funded to improve the availability of a specified list of allied health services. Each Division prepares an annual work plan. The focus is on supporting GPs to link to other, largely, clinical services. Divisions are members of PCPs. Divisions are established as companies limited by guarantee and are governed by a board of directors, primarily drawn from the membership, with the mandate to serve the needs and interests of the Divisions membership. Divisions function as a coordinating unit and potentially a lead agency.

None of these structures currently has a significant purchasing role for primary health care services at the local level. However, local government may purchase services relevant to its mandate eg maternal and child health services, aged care services. Some rural Divisions may be involved in the purchase of some allied health services.

In summary the capacity of the existing structures is:

- None have significant capacity for purchasing
- Local government and PCPs have capacity for planning that is broad in scope and engages diverse stakeholders. The scope of Divisions is the narrowest.
- Service provider agencies are most likely to have a collaborative service provision relationship with local government and/or PCPs.
- PCPs have achieved significant system change, for example, in the use of common assessment tools and electronic referrals between member agencies.

6. Risks and benefits of three potential PHCO structures

A key structure in the reform process is likely to be the Primary Health Care Organization (PHCO). PHCOs are likely to evolve and there are a variety of functions they could have. The health reform documents say that PHCOs could be the regional locus of community level planning, possibly purchasing, and of coordination. PHCOs may also have a role in service delivery.

In the following table three options for the development of PHCOs are assessed and risks and benefits identified.

Options for the development of PHCOs.

| | | | |
|-----------------|--|--|--|
| <i>Benefits</i> | <p><i>Creating a new structure</i></p> <ul style="list-style-type: none"> ▪ People with the required capacities could be employed from the beginning ▪ The new structure would not bring the intellectual and cultural baggage intact from the old organization. ▪ PHCOs may develop in slightly different ways that are compatible with the existing service systems in each state and territory thus enhancing short term effectiveness. ▪ PHCOs could be designed specifically to make the new roles and functions most effective. There would be no need to renegotiate articles of association or other legal frameworks governing existing activities. ▪ They have the potential to include a comprehensive range of agencies and thence improve their capacity to create system wide connections for patients/clients. | <p><i>Transforming Divisions of General Practice</i></p> <ul style="list-style-type: none"> ▪ Divisions are an existing structure with infrastructure and assets ▪ They are present in all states and territories ▪ Have experience of business development including quality improvement at the general practice level. | <p><i>Development of PCPs as PHCOs</i></p> <ul style="list-style-type: none"> ▪ In Victoria PCPs are the only structures that engage the range of agencies that constitute a comprehensive primary health care system used by the community. ▪ They currently engage in system wide planning ▪ They engage Divisions and local government, large and small agencies. ▪ The participatory processes used by PCPs have enhanced shared knowledge, values and practices across the primary health care system. ▪ PCPs have experience and expertise in service system redesign and continuous quality improvement. |
| <i>Risks</i> | <ul style="list-style-type: none"> ▪ Would need infrastructure investment ▪ May take longer to establish ▪ Commonwealth may not wish to take this path. | <ul style="list-style-type: none"> ▪ The current role of Divisions is unlike that proposed for PHCOs ▪ Attempting to maintain the existing roles of Divisions and expand into system wide planning, purchasing, coordination and service provision roles will create conflicts of interests between general practice and other services. This will create distrust and threaten cooperation between the PHCO and the agencies it is trying to coordinate. ▪ Divisions currently do not have the capacities to function as a PHCO and, as noted by the AGPN. Capacity will have to be developed based on existing intellectual and cultural capital that may | <ul style="list-style-type: none"> ▪ Planning capacity may not be sufficiently sophisticated to support purchasing. ▪ Adding purchasing to PCPs roles would disrupt its coordination capacity. Coordination is the main strength of PCPs. |

Effectiveness in creating a connected health system

- Creates the possibility of appropriate location of planning and purchasing in the PHCO and the location of coordination and service delivery in other structures such as PCPs, Divisions and local government.
- This option is more likely to maintain confidence and cooperation in the service system during the transition phase as the PHCO is likely to be seen as a 'good faith' institution.
- not be compatible with the new role.
- Renegotiation of Division's articles of association may be fraught and unsuccessful in providing a solid foundation for the new roles and responsibilities.
- By defining a narrow range of services as participants in PHCOs a gap is created between those services and all the rest of the services that constitute the comprehensive service system used by the public.
- Pressure from general practices to maintain existing roles and functions alongside new ones – egg maintaining direct service provision and purchasing will create conflicts of interest – could diminish the capacity for effective coordination as discussed in section 4. above.
- PCPs have the capacity and track record of facilitating a connected system that makes them experienced and competent coordinators. However, adding the purchasing function would introduce risks for participating agencies that would weaken their capacity to coordinate.

The interviews with a small number of individuals in key stakeholder roles in the reform process revealed the following themes.

- *Creating a new structure for PHCOs.* The option of introducing a new regional Primary Health Care Organisation was the preferred one if it meant that there would be a 'rational' approach to regional planning.

Most informants thought PHCOs would need to collaborate in planning activities with organisations that deliver services across the spectrum, including acute and sub-acute service providers, aged care, housing, social services and local government. A regional PHCO could overcome some of the existing weaknesses eg linking 3 levels of government.

PHCOs should not act as service providers and they should not have combined purchasing and providing roles. However, there is a risk that if PHCOs do not hold funds for the delivery of all primary health care services in an area they may lack authority and accountability to realise their service co-ordination and population health planning goals.

The benefits of introducing a new institution into the system included reducing the risk that past problems related to inter-agency connections would be carried over into the new arrangement for primary health care.

- *Transforming Divisions of General Practice.* Modification of Divisions of General Practice to incorporate non-medical primary health care providers and re-develop their strategic plans to incorporate a focus on non-medical work including health promotion was viewed by some informants as tending to centralise doctors and medical practice and 'set us back'. Given their skills, expertise and role, doctors were recognised as being important but 'not the only player on the block'. To design a better primary health care system, it was important to start by looking at what the system needs to provide.

Informants shared a view that participation by Divisions of General Practice and doctors in enhancing cross-sector coordination has been lacking. Consequently, GPs are unlikely to be the best professional group to coordinate in multi-disciplinary, cross-organisation arrangements. Organizing primary health care around GPs (reflected in the GP super clinic model) would not produce better connectedness or a regional-level system that would enable service users to access the range of care and services. It would also not support more organized participation in population level health promotion and public health action.

Informants thought that the risks identified with this option tend to outweigh the benefits and include: the continuation of medical dominance, regardless of whether this is a perception or reality; the subordination of the voice of consumers; and tendency to narrow down how problems are defined and interventions are framed. On this latter point, for example, issues like health literacy may be sidelined.

- *Development of PCPs as PHCOs.* The option of PCPs expanding was not considered to be adequate to addressing some of the system issues. If anything, informants suggested that some PCPs that are too small in scale to achieve the objectives.

7. Conclusion

The reform environment is currently very uncertain. Policy decisions are still being finalized, political processes will take some time to reach a conclusion, and implementation will have to be navigated.

In this paper the reform environment is explored from the perspective of system connectedness and person centredness. Both of these are central to the mandate of PCPs

and are high level policy objectives at the national level. A key element in the primary health care discussion has been the development of regional level Primary Health Care Organisations with a role in planning and development of the primary health care service system. The position statements of key participants in the policy debate (up to the time of writing) are described and analysed. Three approaches to the establishment of PHCOs are discussed and the benefits and risks of each explored. The views of individuals who are key stakeholders in the reform process on each approach are summarized.

The analysis of the PHCO proposals has used three sets of ideas. One is the articulation of the features that should be found in a successfully connected service system. Second is the theoretical framework that describes three different kinds of structures that can be used for coordination and their strengths and weaknesses. Third is the purchasing, planning, providing and coordination functions of a system and the implications of putting these together in different combinations. Whatever additional proposals for PHCOs emerge, and whatever decisions are made about them, this framework can be used to analyse the implications for Primary Care Partnerships and suggest arguments that might be used by the Statewide Primary Care Partnerships.

8. Appendices

Appendix 1. Project brief and approach

The aim of this project is to produce a position paper for an audience of the relevant commonwealth and state government departments and peak bodies that presents:

- a. Who and what is PCP?
 - A brief history and context of the PCP structure in Victoria
 - A key stakeholder profile across the state of those involved in the ongoing development of the PCP platform
 - Broad achievements summary including agreed number of pertinent case studies (prepared through DH-PCP)

- b. What is the context and planning for PHCOs?
 - Outline of PHCO – rationale, principles and likely features, proposed models and Government expectations of structure
 - Perspectives of other key stakeholders

What model/s would ensure that the strengths of PCPs are preserved in the redevelopment of regional PHCO structure?

The paper will acknowledge some of the challenges and key issues important to the investment in PCPs in Victoria and also reflect a coordinated and united stance which is backed up by sound evidence.

Approach taken to the tasks

- a. Document review. The following reform process reports were reviewed and their goals and key strategies summarized. The implications of the goals and strategies for system connections and coordination were a focus.
 - National Health and Hospital Reform Commission, A healthier future for all Australians: Final report. 2009
 - National Primary Health Care Strategy, Building a 21st Century primary health care system: Draft report. 2009.
 - Preventative Health Taskforce - Australia: The healthiest country by 2020: Final report. 2009.
 - Primary health care in Victoria: A discussion paper. 2009

- b. Interviews. Nine telephone interviews with people from government, stakeholder groups and agencies were undertaken. A copy of the interview schedule is attached in Appendix 4.

- c. A set of options for PCP development in the reform process were developed from reading the health system reform reports and from interviews with key stakeholders. The risks and benefits associated with each option are discussed.

Appendix 2. Primary Care Partnerships in Victoria

For three decades governments in Australia have sought to reform publicly provided health service systems to address perceived failures such as inefficiency and service gaps. Under Kennett a business-oriented Victorian state government transformed the public service system into one with many features of a market. By the late 1990s, the market model was perceived, by policymakers, to have failed to provide improved health services to users (Smith, 1999:175). In 2000, a new Victorian state government sought to address these problems by making greater use of partnerships. The Primary Care Partnerships (PCP) Strategy was to enhance cooperation between agencies to improve health service delivery to users and reduce the burden of ill health in the community (Department of Human Services, 2000). A Primary Care Partnership (PCP):

- is a voluntary alliance of the primary care service providers in a geographic area; that,
- will improve the health and wellbeing of a community; and,
- will work in a social model of health (Department of Human Services, 2000:4).

PCPs were 'voluntary' in the sense that there was no formal compulsion to participate but there were many compelling incentives for participation. Membership of the PCP was area-based and most included 2-3 local government areas. Primary Care Partnerships (PCPs) are a core part of the Victorian primary care and broader human services sector and seek to improve integrated care and health promotion. PCPs have enabled coordination of planning and care pathways for many population groups at risk of poor health, such as refugee and Indigenous groups, people facing difficulty due to severe drought, and people with chronic and complex conditions.

The use of a partnership model to inform service system reform in Victoria reflected similar developments in the United States (Rainey & Busson, 2001:49) and in Britain (Powell & Glendinning, 2002; Attwood et al, 2003). The partnership model, it was argued, would help solve difficult problems that crossed organisational and professional boundaries by facilitating the use of '*integrated ("seamless") service planning, management and delivery*' of services to clients (Hudson & Hardy, 2002:51). Following a review of diverse public sector service partnerships in Britain, Rummery identified two defining characteristics: interdependence between agencies in their achievement of objectives, and trust between partners '*to deliver on jointly held objectives*' (Rummery, 2002:235).

Evaluations of the Primary Care Partnerships have demonstrated substantial progress towards the stated policy goals (Australian Institute of Primary Care 2003, 2005). They have been a successful innovation.

To achieve their outcomes PCPs have worked across the levels of social organization articulated in the social model of health – from the provision of services to individuals to the coordination of community wide coping and prevention programs. They have developed structures through which services can coordinate activity at multiple levels (Delaney 2009) and service recipients can readily move between agencies and service types. PCPs have the capacity and mandate to establish systems for patients flow across the services system entering at multiple points and traversing varied routes according to need. They also have the capacity and mandate to embed health promotion and prevention activity at multiple levels of social organization. For example, they can facilitate health promotion service development, embedding health promotion in care protocols and care pathways, coordinating community level prevention work across localities, and facilitating inter sectoral linkages in relation to emerging problems, for example, in relation to drought relief.

PCPs are not legal entities and function as unincorporated alliances. However, they are required to have a formal governance body with membership from each of the core service

provider agencies: Aged Care Assessment Service, Community Health, Hospital or Health Service, Division of General Practice, Local Government, and District Nursing Service. The governance body also should include as least two representative from specialist service providers in the catchment: Mental Health Services, Drug treatment Services, Ethno-specific Services, Women's Health Services, Sexual Assault Services (Department of Health 2010). Furthermore, they are required to have consumer representation on planning and decision making structures. In addition to formal governance structures PCPs are required to negotiate a legally binding partnering agreement under which the partners are accountable to each other (Department of Health 2010).

The Primary Care Partnership program has been evaluated regularly during its decade of operation. In the first 5 years the most important reasons for agencies to participate in PCPs were: improved outcomes for the community, improved relationships between agencies, more coordinated planning across a catchment and, greater sharing of '*practices, processes, protocols and systems*' between agencies (Australian Institute of Primary Care 2005:50). In other words agencies valued Primary Care Partnerships as a structure for connecting them into a service system. Some major achievements of the connected service system include the following.

Partnerships and connections

Approximately 800 agencies in Victoria participate in at least one of the 30 Primary Care Partnerships. Small agencies are participating in increasing numbers. The most frequently reported reasons for participation were to improve relationships between agencies and thence improve outcomes for the community (Australian Institute of Primary Care 2005). Improvements in relationships were founded on knowledge of each other, trust in each other and the capacity to act together to achieve shared goals. Skilled partnership management was necessary to achieve the valued outcomes. When agencies were surveyed for the 2005 external evaluation of the Primary Care Partnership Strategy 79% (up from 60% in 2002/03) of responding agencies said that the benefits of participating in PCPs exceeded the costs (Australian Institute of Primary Care 2005:32).

Service coordination

Service coordination work involved the development of agreed approaches to improving access, initial needs assessment and coordination and referral processes. In 2000, prior to implementation of the Primary Care Partnership Strategy, there were over 250 service coordination tools used in the Victorian system. Currently there is one agreed suite of tools used across the system. Consumers attending agencies using these tools were more likely to report improvements in the communication of consumer relevant information between agencies (Australian Institute of Primary Care 2005:55). The KPMG evaluation of service coordination reported: high levels of consumer satisfaction with the appropriateness of services received, increasing efficiency and quality of service organization within agencies, and improvements in the flows of information and referral between agencies (KPMG 2004). A key summary statement from this evaluation was: '*Even in its early stages it is clear that Service Coordination delivers a range of quantifiable benefits, that by all accounts are not only sustainable but will continue to be realised*' (KPMG 2004:3).

Integrated Chronic Disease Management

Integrated Chronic Disease Management is a '*comprehensive and multidisciplinary approach to the care of people with, or at risk of, a particular disease or condition, aiming to reduce the burden of disease through a holistic approach. It incorporates the continuum of care from prevention through to treatment, management and maintenance*' (Department of Human Services 2005). There have been a large number of initiatives in this area that include partnerships between hospitals and Primary Care Partnerships, and organizational change management amongst others. Evaluations of the Hospital Admissions Risk Program (HARP) produce strong evidence of the effectiveness of this bundle of initiatives. Overall, HARP

programs have reduced: attendance at emergency departments by one third, emergency admissions by over half, and hospital bed days by over 40%. These were accompanied by reports of improved consumer quality of life (Department of Human Services 2006).

Integrated Health Promotion.

In the 2005 evaluation agencies reported increasing capacity to undertake health promotion, to coordinate it across the catchment and to link health promotion to service coordination (Australian Institute of Primary Care 2005:58). By 2008 it was found that the Integrated Health Promotion strategy had also increased agency access to health promotion funding (HDG Consulting Group 2008). Both of these evaluation reports describe widespread coordination of resources directed towards health promotion priority issues such as physical activity and healthy eating but not to the exclusion of local community priorities such as health support in drought affected areas.

Platform for cross-sectoral activity

Increasingly, Primary Care Partnerships are functioning as a platform for cross-sectoral coordination of community level health and wellbeing activity. One example is the Department of Justice funding Primary Care Partnerships in the North of Melbourne to develop community level integrated problem gambling initiatives that engage local agencies, focus on local population needs and use the agencies' capacities for intervention. Under a program, Sustaining Community Wellbeing During Drought, Primary Care Partnerships facilitated the systematic development of mental health programs, outreach programs for farming families, and coordinated work with other sectors such as financial planners.

Appendix 3. Some characteristics of a connected primary health care system and their implications for Primary Care Partnerships in Victoria.

A well-connected primary health care system in Australia will have a number of broad characteristics.

- *Variability in the size, complexity and mandate of the agencies linked to each other to facilitate access by system users.* There will be enormous variability in the size of the organizations connected to each other, the power they exert in relation to each other, the strength and flexibility of their existing institutional perspectives on health, service delivery practices and values, and their social rules and functional control systems. They will vary from large hospital to small specialist community based organizations. All of them will be important for users of a person-centred health system.
- *Shared values and knowledge across the system.* Members of the organizations are likely to share a core value that places client/patient welfare as a high priority. However, in many cases members of some organizations will not know what other organizations exist, what they do, and whether what they do is of a high standard. Information will need to be shared and quality processes established and communicated. Information sharing entails interaction between, and within, organizations over a substantial period of time.
- *Active communication between agencies that can be initiated by any part of the health system.* The organizations making up a comprehensive primary health care system provide a wide range of services often to different populations of users. The connections between organizations need to be able to be activated by any organization in the system that has a client or patient needing assistance from another organization. For example, consumers will be able to choose a Health Care Home organization that assesses needs, provides services and activates connections with other services when appropriate. Health Care Home organizations could be located in different parts of the connected system but all will need to be able to activate connections. Flexibility and active participation of organisations large and small will be necessary.
- *All agencies have appropriate internal arrangements that support cooperation with other agencies.* The work undertaken jointly with other organizations will be only a small part of most organizations' workload. Some aspects of structure and process undertaken by organizations joining a connected system will need to change for connections to form and function. However, the bulk of what organizations do will not be affected in any major way. However, without the relevant internal changes organizations will not be able to effectively participate in a connected system. An example of these kinds of changes is the development and use of the common referral tools and protocols in Victoria.
- *Structures that can facilitate the communication and negotiation required for joint planning and implementation of programs are in place.* Creation and maintenance of functional relationships between organizations in a health system requires a specialized set of 'boundary spanning' skills that are constantly deployed to create, maintain and develop relationships that achieve the outcomes required of a connected service system. Furthermore, it takes a long time, measured in years, to establish complex and reliable structures and processes for connecting and coordinating work across a system. Delaney (2009) describes the complexity Primary Care Partnerships have developed to make coordination happen. Coordination activity happens at different levels and in contexts that range from informal relationships to formal processes. PCP systems are constantly evolving but anything that fractures them or tries to replace them with poorly developed structures and processes would fragment the system and take a long time to repair.

Partnership issues likely to arise for Primary Care Partnerships in Victoria include:

The reports informing the health reform process suggest that there will be significant structural changes in the primary health care system. These changes have a number of implications for coordinating structures such as PCPs which would need to be worked through at the appropriate times.

- a. New and changed organizations will become new players in the system. For example, GP super clinics and the elements of hospital outpatients that are transferred to the primary health care sector will influence the structure of the system. Greater access to allied health services, for example, and changes to the MBS that fund it, will enhance the role of private providers of primary health care services, for example psychology, podiatry and physiotherapy. What is the desirable relationship between PCPs and these new or modified structures?
- b. If the Preventative Health Strategy is implemented to a significant degree there will be new prevention focused structures, for example the proposed National Prevention Agency, and revitalised mandates within existing structures such as local government. There may be new partnerships, with NGOs in particular, that will become relevant. What will be the role of PCPs in this area?
- c. At present GPs are the major private provider members of PCPs through Divisions of General Practice. Most other members are public agencies. If other private providers become members of PCPs, or become a significant influence on member agencies, they may change the system dynamics in important ways. Trust between partnership members is fundamental to achieving the cooperation that creates the connected service system. Over 10 years of PCP operation the risks and uncertainties that block trust and cooperation have been reduced to manageable levels in large part because agencies focus on public good outcomes for the community and negotiate differences to achieve this goal(see for example, Walker, Smith & Adam 2009; Walker, Bisset & Adam 2007). An issue for PCPs will not be new membership (which they already manage) but significant new **private** membership. Private providers operate in a different institutional context and face a different set of risks and uncertainties that influence their readiness to trust and willingness to cooperate. It is possible that Divisions of General Practice will take the opportunity to recruit private allied health practices into their membership and in so doing strengthen the voice of the private sector in primary health care. NGOs also come from a different institutional context which is intensely competitive but nevertheless had a strong public good ethos.
- d. New roles for some current members of PCPs may emerge and require adaptation by PCPs. For example, if roles of Divisions of General Practice and Community Health Services evolve in major ways there are likely to be the structural and functional effects on PCPs and their capacity to coordinate a wide range of primary health care services.
- e. One of the disincentives for Divisions of General Practice to cooperate fully in PCPs has been their Commonwealth funding. It meant the Department of Human Services had little capacity to influence cooperation and there were few risks for Divisions in not cooperating with a state initiative. When all (or most) services are funded from a single source system level risk will be shared by all major players.
- f. The Commonwealth is committed to promoting competition between provider agencies. Where the boundaries are drawn around competitive units will be crucial for the maintenance of connectedness within the system. For example, if agencies within a PCP system are required to compete against each other for funding cooperative relationships will be compromised. However, if the boundaries are drawn between PCPs the disconnecting pressures would be less significant.

Appendix 4. Coordination structures

There are three main structures for organizing inter-organisational activity and system connectedness (Alexander 1995) – coordinating units, lead organizations and single organizations.

A *coordinating unit* is an organization or organizational unit that exists to coordinate decisions and action in a connected system (Alexander 1995:153). It has its own identify, budget and staff and has substantial independence in relation to the organizations participating in the system. Its purpose is to use its coordinating capacity to generate benefits for the system and its members (Walker 2002). These features are a foundation for trust and for flexibility. A coordinating unit does not offer services and does not compete with members of the connected system it coordinates. In the context of health reform the strength of coordinating units, that is their separation from service provision and service purchasing (both sources of risk and competition for agencies), may be eliminated by changes that combine purchasing, provision and system coordination in the same structure. Coordinating units are common and can be very effective if their '*structure, authority and resources [match] the coordination tasks and the network that [are] to be coordinated*' (Alexander 1995:175). Primary Care Partnerships are a good example of a coordinating unit that has developed complex and sophisticated ways of coordinating diverse organizations in the primary health care system. Divisions of General Practice also function largely as coordinating units but coordinate activity primarily within the field of General Practice.

A *lead organization* is one that, '*in addition to its line functions, is responsible for coordinating the activities of all the other organisations*' (Alexander 1995:177). Coordination of the other organisations may be marginal to the lead organization's main functional tasks. Lead organization arrangements are common but to be effective the lead organization must take its coordination function seriously and maintain that commitment over the long term. Maintenance of commitment and thence effectiveness can be a problem as the lead organization changes internally or the external coordination task changes. If lead organizations are also purchasers of services conflicts between the goals of the lead organization and goals of the agencies it coordinates can fracture the system relationships. The success of a lead organization arrangement is related to the strength of its mandate and its willingness to use its authority to gain cooperation. Lead organizations are a common way of maintaining a partnership for the duration of a time-limited project in the health sector. Some versions of the Primary Health Care Organisation proposal look like a lead organization arrangement.

A *single organization* coordination system occurs when most important functions are incorporated into one organisation. They are common outcomes of restructures of large organizations or of mergers. Co-location of services is a variant of the single organization structure. Co-location can be effective but it requires a specific management focus to achieve the communication and cooperation required to arrive at coordinated service outcomes. These types of coordination structures typically require a greater investment of political and material resources than the other coordination structures (Alexander 1995:194).

The structure offering greatest chance of creating a connected and durable service system in primary health care is a coordinating unit in some form.

Appendix 5. Interview Schedule

PCP Strategic Positioning Project

Interview schedule

Interviewer:

Sally Fawkes, Senior Research Fellow/ Senior Lecturer

School of Public Health, La Trobe University. Email - s.fawkes@latrobe.edu.au. Tel: 9479 1135

Interviews:

30 minute interviews conducted either by telephone or face to face

The health care reform process currently underway recognises the principles of primary health care [Alma Ata] and seeks to strengthen:

- *access to services that meet needs, especially for underserved population groups*
- *person-centredness of the system*
- *capability to meet complex health and social needs*
- *connectedness between services to facilitate flows of information and referral, and enable users to access the services they need*
- *capability to address prevention, health promotion, early intervention and clinical care for the population.*

In this project, we wish to explore options for primary health care reform in Victoria, in particular, how connectedness between services and sectors can be strengthened.

1. What is your role in relationship to the primary health care system?

The three major structures in Victoria that support connectedness are PCPs, DGP and Local Government.

2. With regard to promoting connectedness within the primary health care system, what do you value about:

- PCPs
- Divisions of General Practice
- Local government

3. In the past, could these organisations have supported better connectedness in the system? If so, how?

Primary Health Care Organisations have been proposed as an innovation to support primary health care in Australia. There are 3 potential roles for a PHCO: planning; coordination; purchasing/providing services.

4. What do you think is/are the appropriate role/s for PCPs within the reformed system?

5 . Please comment on the implications for the primary health care sector of the following ideas:

Option A

A new regional PHCO is established that has purchasing responsibilities and engages with existing organisations (PCPs, GPs, ambulatory services, local government) to deliver primary health care and public health services

Option B

The governance and membership of Divisions of General Practice are modified to incorporate non-medical primary health care providers and their strategic and operational plans are re-developed to incorporate a focus on non-medical work including public health/health promotion.

Option C

The membership of PCPs is expanded to include sub-acute and ambulatory care services and the role of PCPs is expanded to include planning, purchasing and system development roles required of the proposed regional PHCOs. (Divisions of General practice and major primary health care providers are already members of PCPs.)

Option D

The federal government decides to tender for regional PHCOs across all jurisdictions.

6. Do you have any further comments to make about the current proposals for health system reform and primary health care?

Appendix 6. Stakeholder interviews

Approach

Interviews with stakeholders were conducted using the schedule of interview questions developed by the consultants in association with the PCP Statewide Executive Committee representatives. Their responses were recorded using notes (no tape recorder was used). In this commentary, the views of a range of stakeholders are set out in terms of general themes. Direct quotes are not used and attributions of observations are not made.

Results

The PCP Statewide Executive was commended for undertaking the project and proactively investigating the place of PCPs in possible reforms. Stakeholder interviews revealed a number of areas where there is common thinking about reform although different emphases were given to the value of new structures, the role of existing structures and the challenges facing PCPs. Some key general themes were as follows:

- Victoria has a substantial infrastructure around primary health care and especially free-standing community health organisations. A different perspective on community health and primary health care is apparent in Victoria compared with other states.
- Health care system reform should be led by primary health care as a way to manage costs and deliver care at the local level. Reform of the primary health care system is needed. Incentives in the system do not currently gear the system to primary health care.
- Whole health needs of individuals and communities need to be better addressed by the health care system.
- How the provision of care for chronic conditions is organized is a critical aspect of primary health care and needs to be given adequate attention and definition in the reform agenda. The Commonwealth is particularly concerned about the cost of health services for people with chronic conditions (including multiple chronic conditions).
- The term 'primary health care system' may be problematic because it allows those in the mental health, acute care sector, disability sector and other service systems to say 'this is not about us'. At the Department of Health level, the term tends to inhibit collaboration.
- There is merit in distinguishing between 'primary health care', 'primary care' and 'primary medical care' to ensure discussions can proceed with clarity.

What is valued about PCPs, DGP and Local Government in relation to promoting connectedness at the local level

It was noted that DGP, PCPs and local government represent the three levels of government.

The issue of power relations between DGP, PCPs and local government (as well as other players including State Government) was described by one informant as the 'elephant in the room'; that is, it an issue that underpins the potential and limitations of forming meaningful and sustainable connections.

PCPs

The major strength of PCPs has been their work in bringing agencies together around issues of common concern, such as service innovation to support more coordinated care. They have been able to operate as an 'honest broker' that can take a broad view of health and adopt a platform that is different to institutional silos and agencies. Their skills in making connections has been helpful at the level of individual PCPs where local level agencies have been engaged in projects and at a cross-PCP level where a cluster of PCPs has worked together on issues that have wider significance. In rural areas, there are existing imperatives to work together anyway and recognition that more is achieved when parties work together effectively.

One informant stated that PCPs' biggest achievements have been in:

- building a culture around health promotion based on collaborating and working together
- innovating for better service coordination in the primary health care sector, especially in rural areas. This has not been an easy path - there have been problems like the existing IT system and jurisdictional boundaries.

However, the performance of PCPs was viewed by most informants as being 'patchy', inconsistent and not uniformly effective across the state, for a number of reasons. Where there has been good leadership that is committed to local health issues and innovation and deft management of funding, projects and the political aspects of inter-agency relationships, PCPs have been able to bring about important changes in systems and processes. The quality of leadership of PCPs has been key to their effectiveness and capacity to innovate. Differences in performance between PCPs has not been on the basis of their geographical location alone. PCPs in both regional/rural and metropolitan areas have been recognized as having undertaken important and useful work where there has been good leadership, skills, approaches and willingness to cooperate in place.

PCPs do not have a legislated mandate but provide funding for partnership-based work. The voluntary nature of participation by agencies in PCPs was identified as a real problem eg doctors were identified as often being absent from meetings. Creating inter-agency collaboration takes time and this poses a problem for PCPs. It has taken considerable time to get PCPs off the ground and many agencies, to their credit, have persisted as PCPs have evolved. PCPs can be burdened by the history of relationships in an area and the uneven distribution of resources. There may be entrenched views of roles and responsibilities that may get in the way of working together effectively.

Boundaries for LG and DGPs are different - PCPs are able to bring them together.

Primary health care has been and remains a poor cousin to the acute care sector. PCPs have been punching above their weight in terms of continually flagging the importance of primary health care.

The performance of PCPs in promoting connectedness is linked to their scope and who is 'at the table'. In rural areas, PCPs may have 15-20 members with every agency of significance present in deliberations. There may be a perception that rural PCPs work well because all the relevant players are known to each other and are easily convened. This is not necessarily the case given personal and organisational histories. There may not be the headspace or time for innovation and creativity. In the metropolitan area, there may be 50-60 members which makes it harder to achieve engagement. Some organisations are not good at being part of this type of organisational structure.

DGP

An informant explained that in DGP, specific programs are funded by the Commonwealth but core funding sustains the work of the DGP. The spirit of the Commonwealth comes through in what they will fund. There is not much money for DGP to respond to local needs through projects.

Most informants recognised the benefits that have come from the work of DGP for primary (medical) care. One informant described DGP as professional and focused organisations that have been able to work on projects and systems issues. A number of DGP were described as doing a 'great job' of responding to the needs of GPs for training and support. DGP have done a lot to get a population health focus within general practice and encouraged the idea that well-developed interfaces and linkages with parties outside GP are important for effective care. DGP have focused on professional development in GP and practice systems to practice evidence-based health care. One informant argued that this emphasis is entirely appropriate and there is a need to ensure the whole population has continued access to skilled GPs who use evidence-based approaches in providing care. They have also progressed the translation of research to practice. DGP have worked on cultivating a variety of relationships - nurses, pharmacists, allied health professionals.

One informant observed that there is local variation in working arrangements between agencies – some work well, others don't work so well. Barriers exist, for example, general practices are small businesses and not like other publicly-funded primary health care organisations. Connections that seem to work well are between practice managers and other organisations, rather than doctors and other organisations. There are a range of reasons for this including the time available to do 'non-patient' work. DGP are sometimes used as vehicles for connecting with GPs around projects. GPs have similar and varied priorities. Barriers also include the boundaries pertinent to PCPs versus DGP.

The issue of general practices being small businesses was noted by several informants as being particularly important as it introduces a culture of working and set of priorities that may clash with regional and local work in primary health care and health promotion. There is likely to be a tendency for GPs to refer to private practitioners rather than public services; this may suit some patients, but for other unable to meet the associated out of pocket expenses, this way of working may aggravate poor access and use of health services.

An 'elephant in the room' is that doctors have a lot of social, technical and economic power, partly derived from their role as gatekeepers in the system, controlling access to allied health and other services including preventive services.

Local government

In most PCPs, local government is an important player as they provide fundamental health services (personal care, meals on wheels etc) and promote health through MPHPs. Some informants observed that local government's role in health is a Victorian phenomenon (eg maternal and child health, home nursing, immunisation, allied health services). Local government's has always been involved in community services.

Some informants noted that the strengths of local government is that it does particular work which when done well, contributes significantly to population health eg management of parks, environmental health management. In rural areas in particular, local government is an active player in coordinating services and promoting connectedness between agencies. They are an important planning body and there is recognition that local government can improve the physical environment through this role. They have to prioritise their statutory obligations, which now include the preparation of MPHPs.

In rural areas, participating in activities that go beyond statutory obligations can be difficult. The local governments may be poorer and struggle to do the basics of what they are legislated to do including MPHP and fixing pot holes. In some areas, PCPs bring their resource base into play by assisting with the development of MPHPs.

Role for PCPs in a reformed system

Most informants believed that the role of PCPs in a reformed system derives from perceptions and evidence about their performance in the past. Consequently, informants had varying views because of their different place in the system and the vantage point from which they observed the work of PCPs. One informant argued that PCPs - and community health services/centres should be rolled out nationally. Another felt they had contributed significantly to changing the culture of health promotion and service development. On the other hand, some informants believed there has been a diminishing relevance of PCPs in the last couple of years. One informant stated they were not sure if there is a role for PCPs in their current shape. Current reform may want broader answers to the problems the reform is trying to address.

A key question is what role the Department of Health sees for PCPs. One informant commented that the Department of Health 'doesn't seem convinced' about PCPs and seems ambivalent, hence there has not been strategic work done to consolidate and develop them. Another informant suggested that rather than ambivalence about PCPs per se, the Department of Health does not know how to properly locate PCPs in its structure and let it 'breathe' and grow. The observed 'defensiveness' of the Public Health Branch in relation to its responsibilities means that PCPs do not have a strong ally there.

PCPs can do a lot of different work. The Mental Health Branch is rolling out positions to promote better service integration (one position for each region). They will be encouraged to work with PCPs – there may be a need for each position to work with 2-3 PCPs because of the jurisdictional boundaries.

Among those informants who directly addressed the question, there was agreement that PCPs should not do purchasing. In the reform process there will be institutional resistance to handing over purchasing to specific agencies.

It doesn't make sense to give all the power to PCPs. It is more important to look at what needs to be done with a discriminating eye and determine which party should take the lead or play particular roles. One of the valuable things PCPs do is to show agencies that they have things in common that are amenable to research and development - type activities eg development of manuals that support service coordination at a regional level. When issues are pertinent to the local/community level, PCPs can be a potentially very valuable convening body that adds value through its expertise in building cross-agency relationships and approaches.

It is unclear what the Commonwealth is going to roll out as a result of introducing PHCOs. While one informant felt that there is potential for the PCPs to pick up on Commonwealth agenda and make it work for them, another felt they may have been overtaken to some extent by the environment of change: Victoria is having to respond to a national agenda.

PCPs play a valuable role in prevention currently by gaining funding for health promotion projects and developing initiatives that enable agencies to work more effectively. However, framing the value of PCPs in terms of the prevention agenda may be considered a little naïve given that the Commonwealth's interest is in chronic disease and money. One informant stated that the Commonwealth is not on about the prevention agenda really, but managing overall cost and the politics of health. How PCPs frame what they do and why is critical; similar work can be framed in different ways to make it appealing for agencies to engage and also to respond to government agendas. There are a range of possibilities for PCPs to frame their work in terms of priority agendas for bodies that fund and support them.

Where planning at a regional level may be relevant when there needs to be consideration of eg acute services (whose catchments are larger), planning at the local level (eg at the scale of PCP catchments) may be relevant in other circumstances. Coherent planning will rely on finding the appropriate levels/ scale to do it and ensuring these is compatibility of objectives up and down the

system at different levels. Planning is essential for effective implementation of programs as well and PCPs have considerable experience in this area.

PCPs are well placed to work creatively with de-identified datasets to examine what health and social problems exist locally/sub-regionally, to highlight where clusters of inequity are located (and revealed in data from eg juvenile justice and child protection sectors) and to investigate the dynamics of local communities as a basis for research and initiatives.

Issues that need to be addressed in health system reforms

Views expressed included the following:

- The enhancement of primary care is needs to occur in concert with enhancement of primary health care.
- Equity must be given primacy in thinking about the nature of reforms.
- Loose local alliances based on voluntary participation are inadequate to support effective work that is capable of being sustained and, where relevant, scaled up.
- There is a crowded environment of change and reform at present. There is a degree of change fatigue - nationwide and statewide. Some may fear that a new structure will be challenging because of this fatigue. There is a need to consider what degree of change is wanted.
- Relationships between some players are not conducive to promoting productive, cooperative relationships. For example, GPs and DGP; DGP and Department of Health; and GPV and AGPN.

Options for reform

The options were generally viewed as being concerned with progressing different objectives. It was recognised that the detail of some proposals (eg the Commonwealth Government's PHCO model) is not known at this time.

One informant noted that whatever model is adopted, there needs to be a cascade of clear responsibilities designated - from the Minister of Health to local level primary health care alliances - underpinned at all levels by a set of defined commitments.

Option A

The option of introducing a new regional Primary Health Care Organisation was generally positively considered by informants - out of the four options proposed, there was a preference for this option if it meant that there would be a 'rational' approach to regional planning. PHCOs could implement planning at a regional level, undertake service gap analysis and research pursue business development activities. The size of the population was considered to be important for PHCOs to work well.

The VHA and GPV shared position on the roles of PHCOs is that they would:

- Implement a population health planning approach to primary healthcare, including service planning, workforce planning and community development
- Improve primary healthcare services' capacity for data collection, aggregation and use, including the development of appropriate infrastructure

- Coordinate primary healthcare services to provide connected care for consumers
- Strengthen and build the capacity of the existing health service delivery infrastructure, with the aim of improving access, effectiveness, efficiency and sustainability of primary healthcare services
- Support the health service providers to improve safety and quality of health services.

Most informants concurred with VHA and GPV's view that to ensure coordination of services across the care continuum, PHCOs would need to collaborate in planning activities with organisations that deliver services across the spectrum, including acute and sub-acute service providers, aged care, housing, social services and local government. A regional PHCO will be able to overcome some of the weaknesses eg linking with 3 levels of government.

There was also concurrence that PHCOs should not act as service providers and they should not have combined purchasing and providing roles. VHA and GPV believed that the only funds PHCOs should hold would be funds for service coordination, improving the quality of care and population health planning. They recognised that if there is a major reform of all the funding streams that are directed to primary healthcare, the PHCO might hold funds for services that are required in the catchment area.

A risk was recognised that if PHCOs do not hold funds for the delivery of all primary health care services in an area they may lack authority and accountability to realise their service co-ordination and population health planning goals.

One informant called PHCO model a "PCP+" model because PHCOs would involve participation by a variety of organizations. There was a general view that PHCOs should be governed by lead players in the regional system of primary health care. The consumer voice should be strengthened.

PCPs have a legitimate role to play in PHCOs in representing the strategic issues related to needs and implementation at the local level. PCPs could be the convening body for local area players who need to work together on service development and health promotion.

PHCOs should have demographers on their boards - people who can make sense of trends, population statistics. They should have decision making roles but not purchasing roles.

The benefits of introducing a new institution into the system included reducing the risk that past problems related to inter-agency connections would be carried over into the new arrangement for primary health care. One informant noted the tendency for health professionals to move around the system, assuming different roles and sometimes increasing their seniority. This contributes to a continuation of cultural problems that may inhibit connectedness and cooperation.

The VHA and GPV have proposed that "the Minister develop and support a process through which the needs identified through population health planning could be considered, so that the goals of PHCOs can be met. One possibility is an Accord between the Federal Health Minister and the PHCOs that provides a commitment to focus on agreed key performance indicators, which may reflect the Australian Institute of Health and Welfare's national indicators of safety and quality in healthcare and other population health indicators."

Option B

Modification of DGP to incorporate non-medical primary health care providers and re-develop their strategic plans to incorporate a focus on non-medical work inc health promotion was viewed by some informants as tending to centralise doctors and medical practice and 'set us back'. Given their skills, expertise and role, doctors were recognised as being important but 'not the only player on the block'. To design a better primary health care system, it was important to start by looking at

what the system needs to provide. AGPN and GPV have signed onto different positions in regard to the PHCOs, with GPV, as reflected in their position papers.

The benefits of this option were identified by one informant as including the potential for transferring experiences of professionalising health care workers, increasing resourcing and developing a stronger research culture and commitment to evidence-based practice. GPs can bring wide experience of coordinating primary care for individual patients.

An informant referred to a study by the Commonwealth Fund that showed that GPs were generally good at the management of health not health care services but not as good at ensuring patients have the resources they need to play a confident role in their own care. This has implications for the potential of DGP to bring about a reorientation to prevention. The view was put forward that the development of a stronger DGP and super clinics would

Informants generally shared a view that participation by DGP and doctors in enhancing cross-sector coordination has been lacking. Consequently, GPs are unlikely to be the best professional group to coordinate in multi-disciplinary, cross-organisation arrangements. Organizing primary health care around GPs (reflected in the GP super clinic model) would not produce better connectedness or a regional-level system that would enable service users to access the range of care and services. It would also not support more organized participation in population level health promotion and public health action.

The DGP board is keen to see reforms of the health system that benefit the effectiveness of their contribution to primary health care.

Informants generally felt that the risks identified with this option tend to outweigh the benefits and include: the continuation of medical dominance, regardless of whether this is a perception or reality; the subordination of the voice of consumers; and tendency to narrow down how problems are defined and interventions are framed. On this latter point, for example, issues like health literacy may be sidelined.

One informant commented that Option B is appealing because it is not talking about purchasing and wholesale change.

VHA noted that GP super clinics represent an approach at a national level that was similar in some ways to Victoria's community health services/centres.

Option C

The option of PCPs expanding was not considered to be adequate to addressing some of the system issues. If anything, informants suggested that those PCPs that are too small in scale to achieve objectives should amalgamate.

One informant suggested that PCPs should consider amalgamating in order to gain greater political strength, rationalise staffing so that they work in the interests of a broader geographical area and can develop interventions at meaningful levels. This may assist in PCPs continuing roles that they have been successful in such as planning, workforce development (eg health promotion capacity building), system development (eg production of care coordination protocols) and acting as an honest broker in the interests of better health care and healthier populations.

Option D

The option of the Commonwealth Government tendering for a PHCO was not commented to any great extent degree by informants. Experiences of the past were cited in which approaches such as CCP (compulsory competitive tendering) proved to be quite divisive, eroding trust built up

between agencies and foiling the type of cooperation that is needed to underpin coordinated health care. This option was not considered to be likely. Theoretically, this option may challenge service providers/ primary health care organizations to decide on which organizations have a track record of effective work.

One informant observed that when the aged care act was changed and aged care packages were tendered, it showed how politics can get in the way of decision making and implementation processes. Providing consumer choice in residential aged care by opening the market to providers who have to compete for residents (and thus enabling the money to 'follow' the client may be a compelling approach but won't work.

Risks identified with this option included that it may:

- be difficult to manage over time
- entrench a territorial culture/ stance.
- not be consistent with promoting equity in access or health outcomes
- be a brave circuit breaker - but with what benefits?
- diminish existing trust between organisations and professionals.

Other options

Two examples of partnership-based initiatives that have grown from locally-identified needs were identified by informants as being useful to consider when thinking about reform options.

One informant commented on the *Planning for a Healthier North* Regional Health Consortium initiative in which PCPs have participated actively. It looks at the interface between acute and primary health care across a population rather than a sector. It has been a slow process but one that is thought by some informants to have borne fruit. It has considered what is the most rational use of funds to optimise population health.

Planning for a Healthier North is an area based planning structure which is currently being established in the Northern Metropolitan Region of Melbourne (NMR). This regional integrated planning framework, which was initially developed as a joint initiative between the Northern Health Primary Care & Population Health Advisory Committee (PC & PHAC) and the City of Darebin, will provide a powerful governance and partnership structure to improve the delivery of health care services within the region. The initiative is auspiced by the Northern Division of General Practice-Melbourne and is governed by a Regional Health Consortium Steering Group.

Another informant described the Health and Wellbeing pillar of G21.

The G21 Health & Wellbeing Pillar is funded under the State Government Primary Care Partnership Strategy . The G21 Health & Wellbeing Pillar works collaboratively to position health and wellbeing as a central element to regional planning. The HWB Strategic Plan for 2010/12 has four strategic directions to guide its progress which are:

- Understand populations, planning and impacts of change
- Connect people, communities and services
- Build healthy, resilient and innovative communities
- Strengthen community infrastructure and service systems.

Strategic action

An informant noted that it is a highly political environment in which favours owed may come to the fore. PCPs are a low visibility player at the moment and need to be proactive, monitor and read the environment well, put forward constructive views and manage the politics of advocacy. PCPs could take a leaf out the book of the acute sector, that analyses issues from an evidence-base and builds

political alliances (including with universities) to sustain their role in the system. The need to consolidate a valued niche eg cross-agency health promotion work. PHCOs could be a threatening innovation to PCPs if the niche role of PCPs is not clearly defined and defended.

A number of informants said that it would be desirable if PCPs 'go on the front foot' and articulate a clear, strong position on their role in a reformed health system. This position needs to be based on an understanding of what requires quality and what requires development in the system.

One informant commented that it appears that 'Canberra' does not know what goes on in the states in relation to primary health care - it hasn't been involved in primary health care since the Community Health Program. There is an opportunity now for PCPs to argue the case for continued support.

There is a risk that what has been achieved in Victoria is lost in the reform process as issues more pertinent to other states dominate. The process is highly political and concerns the Premiers, not just the health ministers.

Some informants argued that PCPs would be well advised to meet and identify shared perspectives on primary health care structures with peak bodies such as VHA and General Practice Victoria. This proactive approach may be well received by the Minister for Health as it is constructive and seeks to sort through points of difference rather than present problems and unresolved issues to the Minister's office.

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