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## **Ensuring that new Primary Health Networks will work well in rural and remote areas**

### **Discussion Paper**

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*This Discussion Paper has been prepared to stimulate discussion on an issue of importance to rural and remote health. The views and opinions in the paper do not necessarily represent those of the National Rural Health Alliance or any of its Member Bodies.*

## Ensuring that new Primary Health Networks will work well in rural and remote areas

### Background

Soon after taking office in September 2013, the Australian Government commissioned a review of Medicare Locals (MLs) led by former Chief Medical Officer, Professor John Horvath. The aim of the review was to provide independent advice on all aspects of MLs' structure, operations and functions, as well as to identify options for future directions.

The Alliance submission to the review in December 2013 supported the view that it is good for local communities and clinicians to have a genuine say in the management of their health care so that services can be responsive to local needs.<sup>1</sup>

In that submission the Alliance reaffirmed its support for the principles that were embedded in the establishment and operation of MLs as regional primary care organisations that would:

- provide the basis for collaborative and cooperative work across all individuals and professions involved in the delivery of primary care in a specific locality;
- act as a central point or 'locus of primary care authority' to enable the primary care system to negotiate and manage an efficient and effective relationship with hospitals and other acute care services;
- offer the prospect of a valuable amount of direct local engagement of health consumers with health services;
- constitute a new (and useful) level at which analyses of health and health-related services may be tracked; and
- over time, engage more fully across the breadth of *primary health care* activity for the people of their region, through such things as health education, special programs for those who are experiencing long term unemployment or living in unstable or unsuitable housing, and targeted support for at-risk individuals in their homes.

The purpose of this Discussion Paper is to reiterate the importance of the new Primary Health Networks (PHNs) working in such a way as to maximise the application of those principles.

The Alliance believes that, if properly supported and resourced, the work of PHNs will have a number of benefits for people in rural and remote areas, including a simpler and safer patient journey. They will have a critical role to play in ensuring that health services are patient-focused and that health expenditure becomes more closely aligned with local health need.

The Horvath Review strongly supported these principles, asserting the value of having an organisation charged with improving patient outcomes through working collaboratively with health professionals and services to integrate and facilitate a seamless patient experience.

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<sup>1</sup> National Rural Health Alliance. Submission to the Review of Medicare Locals. December 2013.  
<http://www.ruralhealth.org.au/document/submission-medicare-locals-review>

Professor Horvath noted that GPs felt disempowered by the governance structure of MLs. He identified a lack of clarity about what MLs had sought to achieve, with considerable variation in both the scope and delivery of activities, which in turn increased the confusion about their relevance within service sectors, government and the community.

The Review found that some MLs had been performing well, but reported a range of shortcomings with others. A number of anomalies were identified across the MLs and there was variability in expenditure on administration, varying levels of funds allocated to 'frontline services', inconsistencies between planned and actual budgets, cross-funding between programs and variable accounting practices – all of which suggested some financial inefficiencies. Professor Horvath suggested that many of these issues could be overcome, and economies of scale gained, by having fewer, larger organisations with consolidated corporate functions.

The recommendations from the Horvath Report are in Appendix 1.

### **Government response**

In the 2014 Federal Budget, the Government announced its acceptance of many of the recommendations of the Horvath Review, including that a smaller number of Primary Health Networks (PHNs) would replace the 61 Medicare Locals (MLs) across Australia.

MLs will operate until 30 June 2015. When they are replaced by PHNs from 1 July 2015, close attention will be paid to the alignment between the PHNs and the Local Health Networks (LHNs). This reflects the critical nature of the relationship between the primary care and acute care systems which has always been an important consideration.

Commonwealth funding to the Australian Medicare Local Alliance will cease on 30 June 2014, with its key functions being taken on by the Department of Health.

The number of PHNs is still unknown but it will be less than 61. It is expected that most States will have at least one metropolitan and one rural PHN, with the possibility of only one in Tasmania, the ACT and Northern Territory.

Since their introduction in 2011, MLs have been responsible for “supporting and enabling better integrated and responsive local GP and primary health care services to meet the needs and priorities of patients and communities.” Similarly, the new PHNs will be responsible for “improving patient outcomes in their geographical area by ensuring that services across the primary, community and specialist sectors align and work together in patients’ interests.”

GPs will have an enhanced role in PHNs and, through Clinical Councils, a greater say in the governance and strategic direction of their local primary care system and development of integrated care pathways. Allied health professionals and the private health sector will also be encouraged to participate in PHNs through Clinical Councils. Consumers will be involved through Community Advisory Committees which will work with Clinical Councils to ensure that PHN decisions are patient-centred and address the needs of the community.

## **PHNs that serve rural and remote communities**

The Alliance's focus is on ensuring that the PHNs work well in rural and remote areas, including for the people and the clinicians in Australia's far-flung communities.

The work of a PHN in an urban or metropolitan area will be undertaken where distances are relatively small, liaison for integration and coordination of health services will involve services that are relatively close, and the organisation may well be able to operate from a single office. In such areas staff will be able to visit all parts of the region in less than a day, and rely on consistent access to computer and telecommunications systems.

In contrast, rural PHNs will cover vast and isolated areas, and will need to:

- liaise with numerous towns and communities each with its own distinct characteristics and issues, to undertake planning, identify gaps, understand the unique service delivery issues and develop solutions to suit each place;
- work with many small towns or settlements that have no private healthcare practices, no GPs and indeed no salaried practitioners;
- develop and rely on relationships outside their own region to plan and develop responsive local services and to coordinate and integrate the patient journey to and from tertiary services located in regional or capital cities (which may be in a different State);
- develop and implement new models of service delivery that are effective in rural and remote areas where fee-for-service and market-based models have patently failed to deliver equity; for rural and remote services, efficiency cannot be measured solely on the basis of unit costs of delivery;
- travel hundreds of kilometres to meet and collaborate with consumers and service providers and provide support to clinicians and other service providers, often necessitating overnight stays and allowances for travel and time away from home and work;
- establish branch offices and overcome challenges with fixed and mobile telecommunications and limited access to high speed broadband (including training and support for uptake of improved technology) across the region to enable regular liaison with distant stakeholders;
- ensure the sustainability of local health services, including small rural hospitals and multipurpose services which are an integral part of primary, aged and subacute care;
- develop and find the means to fund innovative solutions to longstanding workforce (both clinical and administrative) issues such as:
  - recruitment and retention;
  - professional development and education;
  - providing high-quality, well-supervised training posts and student placements;
  - availability and affordability of appropriate accommodation for students and visiting health professionals (eg for consulting rooms or overnight stays);
  - subsidising high transport costs for students to participate in rural placements; and
- where services are not available locally, set up arrangements for distant health professionals to provide either visiting or e-health services – or, alternatively, facilitate patient travel to access services elsewhere.

In rural and remote Australia, strong functional links among and between care providers in all sectors (primary, community, acute, aged, disability, step-down, rehabilitation), both public and private, mainstream and Aboriginal community controlled, contribute so much to the effectiveness of care and to health outcomes. Facilitating these communications will be part of the challenge for PHNs.

Effective collaboration with other parties requires a substantial commitment by rural health professionals, many of whom are already time-poor. In the past, the stretched capacity of rural health services and health professionals has limited their capacity to be involved in the program planning and governance of MLs, which in turn has hindered progress.

It will be essential for PHNs serving rural and remote communities to be resourced appropriately to support the unique challenges of integrating primary care services across large - sometimes vast - geographical areas.

### **PHN size and boundary alignment with Local Hospital Networks**

Closer alignment of PHN and Local Hospital Network boundaries will benefit rural areas where many of the same health professionals and health services are involved in delivering primary, acute, aged and disability care as well as community services. Common boundaries for PHNs and LHNs will assist with rational approaches to needs-based planning and service delivery. This will help providers across primary and acute care to identify shared opportunities or benefits of working together.

For people living in rural and remote communities, it is particularly important for the boundaries to align with patient flows for secondary and tertiary health services. However, LHNs are established and funded by the States, not the Commonwealth. This raises questions about what the relationship will be; for example, for the new PHNs where the previous MLs crossed the NSW/Victoria border and worked with LHNs in both states.

The different approaches taken by the States in the number of LHNs they have established will need to be considered in establishing PHNs. There are currently a total of 136 Local Hospital Networks across all States and Territories. Of these, 123 are geographically-based networks and 13 are State or Territory-wide networks that will deliver specialised hospital services, such as children's services, across some jurisdictions. Some States such as Western Australia, South Australia and the Northern Territory have small numbers of LHNs, with many more LHNs in the more populous states, as shown on the maps on the yourhealth website<sup>2</sup>. The numbers of existing MLs established by the Commonwealth also vary substantially between States.<sup>3</sup>

There are some particular concerns about the possibility that with fewer, larger PHNs there may be a loss in vital capacity, potentially relating to:

- the capability for service coordination and integration at a truly local level;
- performance accountability: the health services delivered in a regional centre such as Hobart or Darwin may mask the under-servicing of small towns in the rest of the State/Territory; or aggregation of the data for the Inner regional areas of many PHNs with Outer regional and Remote areas may mask under-servicing in the Outer regional and Remote areas;
- lesser capacity for co-operation across communities in the wider network to achieve shared objectives, or for local community engagement and representation; for example, it would be difficult for a community representative from Wagga Wagga, NSW, to inform themselves about and represent the interests of people in Wentworth, NSW, who are

<sup>2</sup> Visit [yourhealth.gov.au](http://yourhealth.gov.au) for information on [Local Hospital Networks](#) and [Local Hospital Network Maps](#).

<sup>3</sup> See the directory of Medicare Locals by State at <http://www.myhealthycommunities.gov.au/directory>

located near the NSW/SA/VIC borders and who may be more likely to look to Mildura in Victoria for primary care services and Adelaide in South Australia for complex hospital care;

- consultation with local communities about the design, implementation and review of programs in health, disability and aged care; and
- coordination of patient journeys at great distance, often across Local Hospital Network boundaries, to receive health care, particularly secondary and tertiary services.

### **PHN Program design, implementation and evaluation**

The functions of the PHNs will presumably include those of the Medicare Locals (MLs) that are within the scope of the new guidelines and regulations to be developed, plus others not previously envisaged for such local primary care bodies.

When MLs were established, they received core funding from the Australian Government Department of Health and Ageing to cover the costs associated with operating the ML and meeting its strategic objectives. They were also provided with funding to deliver individual programs (eg after hours primary care). Other targeted funding to MLs was for certain mental health programs (including Access To Allied Psychological Services - ATAPS) and for some programs that are of particular importance to people living in rural and remote areas, such as the introduction of the Personally Controlled Electronic Health Record.

One of the recommendations of the Horvath Review was that "Primary Health Organisations (PHOs) should only provide services where there is demonstrable market failure, significant economies of scale or absence of services". The first and third of these criteria are characteristic of much of rural and remote Australia and some MLs in rural and remote areas have been highly effective in providing services where there had previously been none for people who are highly vulnerable. It will be critical to ensure that such service capabilities are not lost during the transition to the new arrangements.

Another important means of improving patient pathways in rural and remote communities is to overcome health workforce shortages so that service gaps can be closed. PHNs will be able to work with existing networks such as the Rural Workforce Agencies that operate in each State and the Northern Territory, rather than taking on such work themselves.

### **After-hours GP services**

Some MLs have been successful in improving local access to after-hours GP services, particularly where there are adequate numbers of GPs. However, where there are small numbers of local GPs and other primary care clinicians, the notion of centralised after-hours services is problematic. The call centre may not have the local knowledge to put people in touch with the most appropriate source of local care. Sometimes this new model resulted in existing local after-hours services being discontinued.

If this function is to be taken up by PHNs, funding and service arrangements must be developed in close consultation with rural doctors, local hospitals and other stakeholders. The arrangements must include an evaluation mechanism to ensure that PHNs are accountable both to the local communities they serve and to the Commonwealth for the planning and funding decisions they make.

## **Mental health work**

Mental health poses particular challenges in rural and remote areas, and it is to be hoped that PHNs will be equipped to treat mental health as a high priority.

There is already a complex range of mental health programs available, including Access to Allied Psychological Services (ATAPS); Better Access; Mental Health Nurse Incentive Program (MHNIP); Partners in Recovery Initiative (PIR); Mental Health Services in Rural and Remote Areas (MHSRRA); and headspace. Nevertheless, access to mental health services is limited in many parts of rural and remote Australia. Some MLs had a role in improving service provision or better coordination of mental health services to rural people and this must remain a priority activity for PHNs and in the period of transition from MLs.

There is a strong need for safer, simpler, more effective patient pathways for people in rural and remote areas with mental health problems and ongoing mental illness.

The Alliance has written a detailed submission to the National Mental Health Commission on the Review of Mental Health Services and Programs. The submission provides new evidence, sourced from the Australian Institute of Health and Welfare (AIHW), showing clearly that people in rural and remote areas are disadvantaged in access to Medicare-funded mental health services. This is a gap the PHNs might fill or have filled.

The Alliance has called for a three-pronged approach to improved mental health, with an emphasis on further support and training for primary care professionals who are already working in rural areas. There is also an even greater role for appropriate use of online and telephone mental health services, MBS for telehealth, and better recognition and resourcing of community organisations for their contribution to community health and wellbeing.

Although the new PHNs appear to have less responsibility than was envisaged for MLs in direct service provision, it will be critical that they take action to combat mental health workforce and service shortages in rural and remote areas. The PHNs can be assisted in this work by close consultation with their clinical and community advisory groups and LHNs.

## **Measuring progress**

The Budget decision to consolidate six data and evidence organisations into a Health Productivity and Performance Commission will be of significance to the work of the PHNs. At the national and jurisdictional level, analysis and reporting that has been effectively undertaken by the COAG Reform Council will hopefully be taken on board - without any lessening of timeliness or quality - by the Department of Prime Minister and Cabinet.

The detailed arrangements for performance monitoring and measurement are as yet unclear. The Alliance looks forward to engaging in discussions around the Federation White Paper, due to be finalised by December 2014, to make sure that the extent to which PHNs meet the needs of their local communities is one of the performance measures.

The National Health Performance Authority (NHPA), the Independent Hospital Pricing Authority (IHPA), and the Australian Commission on Safety and Quality in Health Care (ACSQHC) have had carriage of vital work to report on the performance of primary care and hospital services against the Performance and Accountability Framework of the National Health Reform Agreement.

The data and information available from the new Commission will be one of the main measures of the effectiveness of the work of PHNs and LHNs. The PHNs themselves will need the capacity to assess local needs in their new - larger - areas, and there will need to be analysis and evaluation of health outcomes per PHN, in just the same way as the NHPA has been reporting per ML.

It is also likely that PHNs will be responsible for supporting and overseeing the adoption of eHealth within their regions. It is important that PHNs support the adoption of telehealth and the electronic health record across all primary care professions. If allied health professionals are not equipped in this area, the system will ultimately fail.

According to the Horvath Review, "the rollout of eHealth across primary health care and other sectors and the use of population data in cooperation with LHNs and state health authorities in the long term, should provide more meaningful tools to measure health improvements and performance more generally. This would further benefit from developing a national primary health care data strategy that includes indicators of integration." The new Commission will no doubt consider this.

PHNs in (or with) rural areas will be able to work with University Departments of Rural Health (UDRHs) and Rural Clinical Schools to increase their capacity to identify needs, plan and implement responses, and monitor their effectiveness and impact on outcomes. These partnerships will be particularly valuable where a single PHN is tasked with identifying the needs of a large number of diverse localities and coordinating services across an entire State or Territory ( for example, the Northern Territory is currently covered by a single ML). Time-series studies will be required to monitor progress.

Consideration will need to be given to the realignment of the baseline data that has been developed around MLs with the proposed new boundaries for PHNs. The AIHW, by whatever name, will remain one of the key bodies in this work.

### **Health promotion**

The Alliance believes that the PHNs will also have an important role in developing and implementing health promotion and illness prevention programs that are specifically targeted to rural and remote areas, where people have higher rates of obesity, smoking and risky alcohol consumption.

With the functions of the Australian National Preventive Health Agency (ANPHA) to be integrated into the Department of Health, there will be the need for the Department to commission quality research to support the design and delivery of effective health promotion measures that target hard to reach populations, including people in rural and remote areas. Otherwise, rates of potentially-preventable hospitalisations for chronic conditions are likely to remain high, especially in more remote areas.

It may be beneficial to conduct a cost-benefit analysis of the PHNs' involvement in the coordination of services and programs in other areas such as rural eye health (such as the Visiting Optometrists Scheme and the Medical Specialist Outreach Assistance Program ophthalmology). This is an example of where illness prevention pays large dividends. Early intervention through better coordination of primary eye care can prevent avoidable blindness meaning less expenditure on blindness pensions, less preventable lost workforce productivity,

less pressure on health services, and of course the personal benefit of the patient retaining their eyesight.

### **Ensuring efficiencies and fairness in tendering and funding of PHNs**

The Budget proposal is that PHN operators will be selected through a competitive, open tender process, expected to commence in late 2014.

This process will be highly specialised and resource intensive and could distract people on the ground from their ongoing healthcare work.

A key issue will be to ensure the continuity of existing services where these are delivered or commissioned by MLs. Close attention will have to be paid to continuity of care and transitional arrangements. Without these, patients in need will be hit hard, including in under-served rural and remote communities.

Of particular concern is that people in the areas of greatest need often have less capacity to develop competitive applications in a tendering process. In that sense, there is a risk that some rural and remote communities' interests will not be represented or given due consideration in tendering processes and therefore lead to an unfair allocation of resources.

Tender documentation and contracts must include criteria for applicants to show that they have the means for identifying needs, coordinating healthcare and evaluating effectiveness across all parts of their catchment, with a particular focus on special-needs groups.

There are significant medico-legal and other implications in transitioning services and patients to new providers. This must be recognised and funded up-front as part of the new tender processes so that MLs and other agencies involved can include appropriate transition arrangements in their bids to become PHNs.

Once established, the Commonwealth should provide PHNs serving large geographical areas with additional resources to employ or contract a range of experts such as epidemiologists, population health experts, business advisers, communicators and service planners to re-examine key health priorities, develop their business plans, seek and obtain funding, commission appropriate services, and monitor implementation and evaluation across their catchments. This initial and ongoing support function may need to be built into the Department of Health with the closure of the Australian Medicare Local Alliance.

PHNs should be resourced according to need. Need is determined by geographic size and resultant travel and accommodation costs; the unit cost of service provision; the socio-economic profile of the communities within the PHN and the proportion of the population who are Aboriginal and Torres Strait Islander. Also significant is distance from major population centres; the cost of services and supplies; the difficulties of setting up, servicing and maintaining computer and telecommunications systems; and the incentives that are essential to recruit, develop and retain management and administration staff as well as members of the health and clinical workforce. On most of these criteria, rural and remote areas are more challenged and have greater need than suburbs of the major cities.

## **Conclusion**

The new Primary Health Networks (PHNs) have major challenges before them. However they also have the advantage of being based on strong theoretical and empirical evidence that the coordination and extension of primary care is a key determinant of better health.

Because of the well-known characteristics of rural and remote areas, and some which may be less well-known, the challenges faced by PHNs in rural and remote areas are likely to be even greater than those in the major cities. Much will continue to be achieved through the innovation, resilience and determination of those clinicians, consumers and managers involved with rural and remote primary care. But public and policy recognition of the pervasive and insuperable difficulties caused by large areas, big distances and sparse populations will be needed to support the work of PHNs in such areas.

For the people of rural and remote Australia who, on average, are already less healthy than those who live in the major cities, failure in this great primary care endeavour cannot be contemplated.

Success, on the other hand, must not only be contemplated but must be achieved. PHNs have a key role to play in ensuring that the more than 6.7 million people who are pleased to call rural and remote Australia home have good health and access to good health services.

## Appendix 1

### The recommendations from the Horvath Report

**Recommendation 1:** The government should establish organisations tasked to integrate the care of patients across the entire health system in order to improve patient outcomes.

**Recommendation 2:** The government should consider calling these organisations Primary Health Organisations (PHOs).

**Recommendation 3:** The government should reinforce general practice as the cornerstone of integrated primary health care, to ensure patient care is optimal.

**Recommendation 4:** The principles for the establishment of PHOs should include:

- contestable processes for their establishment;
- strong skills based regional Boards, each advised by a number of Clinical Councils, responsible for developing and monitoring clinical care pathways, and Community Advisory Committees;
- flexibility of structure to reflect the differing characteristics of regions;
- engagement with jurisdictions to develop PHO structures most appropriate for each region;
- broad and meaningful engagement across the health system, including public, private, Indigenous, aged care and NGO sectors; and
- clear performance expectations.

**Recommendation 5:** PHOs must engage with established local and national clinical bodies.

**Recommendation 6:** Government should not fund a national alliance for PHOs.

**Recommendation 7:** The government should establish a limited number of high performing regional PHOs whose operational units, comprising pairs of Clinical Councils and Community Advisory Committees, are aligned to LHNs. These organisations would replace and enhance the role of Medicare Locals.

**Recommendation 8:** Government should review the current Medicare Locals' after hours programme to determine how it can be effectively administered. The government should also consider how PHOs, once they are fully established, would be best able to administer a range of additional Commonwealth funded programmes.

**Recommendation 9:** PHOs should only provide services where there is demonstrable market failure, significant economies of scale or absence of services.

**Recommendation 10:** PHO performance indicators should reflect outcomes that are aligned with national priorities and contribute to a broader primary health care data strategy.