Primary Health Networks - 2015

Introduction

The AMA acknowledges the need for an overarching structure of Primary Health Care Organisations (PHCOs) to improve the integration of health services within primary health care, as well as the interface between primary care and hospital settings. PHCOs can also play a key role in ensuring that services are tailored to meet the needs of local communities. In Australia PHCOs are known as Primary Health Networks (PHNs).

PHCOs have been defined as organisations that seek to increase the influence of primary care professionals, and in particular general practitioners, in health planning and resource allocation. Although the objectives of PHCOs vary, they fundamentally aim to forge links between activities at the micro level of care delivery (clinical care delivered by individual practitioners) and the macro level of care delivery (systems responsible for policy, funding, and infrastructure). PHCOs are primarily funded by governments and are regionally organised and are responsible for the needs of both the community and primary care clinicians. They also have some responsibility for access, quality of care, and coordination of primary care activities within a geographic region.[1]

The AMA believes that for PHNs to be successful they must:

- have a clear purpose, with clearly defined objectives and performance expectations;
- be GP-led and locally responsive;
- focus on supporting GPs in caring for patients and working collaboratively with other health care professionals;
- have strong skills based Boards;
- be appropriately funded to support their operations, particularly those that support the provision of clinical services;
- focus on addressing service gaps, not replicating existing services;
- not be overburdened with excessive paperwork and policy prescription; and
- be aligned with Local Hospital Networks (LHNs), with a strong emphasis on improving the primary care/hospital interface.

AMA Position

1. General

1.1 The AMA acknowledges the potential reach of PHNs, noting they have the potential to impact on aged care services, mental health outcomes, chronic disease management, Indigenous health services and services to the disadvantaged.

[1] Russell G. M. Integrated primary care organisation: The next step for primary care reform Can. Fam. Physician. 2010 Mar; 56(3): 216–218 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2837678/

1.2 Given the potential for PHNs to consume precious health resources, they need to be organised in an efficient and effective manner with transparency a key consideration.

1.3 PHNs must not compete with general practice service provision and should only be allowed to provide clinical services where there is a demonstrable market failure. The principle for determining market failure should be when the supply of a health service or health service providers is insufficient to meet the health needs of the local PHN community. Where there is market failure and before seeking to provide clinical services, the PHN would be expected to ameliorate the situation with local providers and commissioning of services where possible.

1.4 Understanding the processes and challenges of general practice will be vital for PHNs in meeting their objectives and they must have strong processes in place for effectively engaging and consulting with grass roots GPs on issues affecting patient care.

1.5 PHNs must be adequately funded to fulfil their role and deliver on their KPIs.

2. PHN role

2.1 The AMA believes that PHNs should work to identify and address gaps in local and regional health care services (including population health, mental health, aged care, Indigenous health, refugee health and so on). They should play a critical role in better integrating primary and hospital health services to improve patients' access to health services and patient health outcomes.

2.1 Consistent with the above, the AMA believes that PHNs should focus on the following areas:

Population Health - Identifying community health needs and gaps in service delivery; identifying at-risk groups; supporting existing services to address preventive health needs; and coordinating end of life care.

Building General Practice Capacity - Supporting general practice infrastructure to deliver quality primary care through IT support; education and training of practices and staff; supporting quality prescribing; training to support the use of e-Health technology and systems; enhancing practices capacity and capabilities to embrace the principles in being a medical home to their patients, and facilitating the provision of evidence-based multidisciplinary team care.

Engaging with Local Hospital Networks (LHNs)/Districts - Identifying high risk groups and developing appropriate models of care to address their specific health issues (e.g. those at high risk of readmissions, including non-insulin-dependent diabetes mellitus, congestive cardiac failure, chronic obstructive pulmonary disease, and other chronic diseases); and improving system integration in conjunction with local health networks.

3. Governance arrangements

GP leadership and input is vital to the success of any PHN in targeting service gaps, supporting continuity of patient care and facilitating access to appropriate services. GPs must be included at all levels of governance including PHN Boards. In this context:

3.1 Board

3.1.1 Local doctors must be represented on the Boards of PHNs and on all the key committees established by the Board.

3.1.2 GPs should not be precluded from being members of the Board, and should in fact be encouraged to do so.

3.1.3 Boards should be skills based with a preponderance of medical members with appropriate Board training and possessing the appropriate skills and attributes for Board membership. Other members of the Board could include local community members, persons with financial expertise, and others possessing the appropriate skills for Board membership.

3.1.4 The process of selecting the Boards of PHNs must be transparent and free of political interference or patronage.

3.1.6 Government must not mandate common Board memberships between PHNs and LHNs.

3.1.7 The Boards of the PHNs must have the power to select and dismiss the Chief Executive Officer of the PHN, possess all the usual powers and responsibilities of a Board, and follow the principles of good corporate governance.

3.2 Clinical Advisory Bodies

3.2.1 Clinical Advisory Bodies must be GP-led and have strong GP representation.

3.2.2 Only health practitioners who are registered with the Australian Health Practitioners Registration Authority and who work within the boundaries of the PHN should be eligible for membership.

3.2.3 The Board must have proper regard for the advice of Clinical Advisory Bodies, and as a general rule should follow its advice other than in exceptional and justifiable circumstances.

3.2.3 Clinical Advisory Bodies should focus on clinical issues and advise the Board on appropriate and effective actions and/or solutions.

3.3 Community Advisory Bodies

3.3.1 Members of Community Advisory Bodies must have the prerequisite skills and experience for committee participation.

3.3.2 Members must be representative of a PHN's demographic.

3.3.3 Membership should include medical representation to enhance understanding of the issues at hand.

4. Accountability

4.1 The primary accountability of PHNs is to their key stakeholders. Secondary accountability is to the local community and the Federal Government.

4.2 The Board structure of PHNs must ensure accountability to the key stakeholders. There must be transparent processes for selecting Board and Advisory Body members and for reporting on the operations, activities, and recommendations of each.

4.3 PHNs must develop key service deliverables with regard to their commissioning activities and key performance indicators against which their agreed performance and outcome objectives can be measured. Performance indicators should reflect the ability of the PHN to engage with GPs and to garner and utilise GP advice, identify and remedy gaps in primary care for the community, establish the clinical needs of the community, and through these actions, improve the health of their community.

4.4 Boards must be careful that the information requirements imposed on GPs and other health practitioners are not excessive. The Board should put limits around the cost and time taken for collecting data and reporting by GPs.

4.5 Boards must have clear and transparent mechanisms for managing conflicts of interest.

5. Performance Framework

5.1 The effective and efficient operations of PHNs must be regularly assessed against agreed performance criteria and publicly reported.

5.2 Agreed performance criteria should be tied to national health objectives.

5.3 Base data on the health and health care experiences of the community will need to be established as the basis for ongoing assessment of the performance of PHNs.

5.4 The performance framework for PHNs must enable benchmarking between the networks as part of a process for ensuring their effectiveness and efficiency.

6. Coordination mechanisms

6.1 Better coordination between general practice and other community primary care services, including state based primary care services, acute care and aged care, is a key task and must be led by the Board with follow through by senior management and ultimately at all levels of the organisation.

6.2 PHNs and LHNs should be regarded as organisations of equal status and should receive funding sufficient to enable them to function as equals. Just as GPs recognise the importance of the acute sector, the acute sector should recognise the key complementary role of General Practice.

6.3 Key coordination mechanisms should include the development of strong communication links, development of systems and protocols to facilitate e-health and IT connectivity between all sectors and the minimisation of red tape.

7. Fundholding

7.1 A key foundation of Medicare, supported by both sides of politics, is universal access to patient rebates for the provision of medical services initiated by patients as needed.

7.2 The AMA supports the continuation of these arrangements and rejects any move to divert rebate entitlements as bundled payments to General Practitioners or to PHNs to fund the provision of GP or Specialist medical services. The same applies to PBS entitlements.

7.3 The AMA has specific policies in relation to fundholding which continue to be relevant to this initiative.

8. Boundaries

8.1 The boundaries established for PHNs should be for the purpose of funding and administration only and must not be used to restrict access to clinical services or used as fence against historical or natural referral patterns.

8.2 The boundaries should be flexible and adaptable to reflect local considerations and patient flows and must follow and improve patient flows that already exist.

9. Vigilance

9.1 There is potential for PHNs to develop in ways which are inimical to good health provision and it is essential that the profession be vigilant against this and draw such developments, if they occur, to the attention of Government.

9.2 Examples of such developments would include PHNs evolving into powerful fundholding bodies purchasing GP services directly for a population group, interfering in the GP clinical care role as opposed to supporting it, interfering in the fee for service aspect of General Practice, rationing access to health services, proliferating bureaucracy and so on.

9.3 The Government should review the operations of PHNs at regular intervals to ensure they are performing in a manner which is consistent with their broad objectives. These reviews should have strong representation from the medical profession.