



# Connecting Care

*A Blueprint for improving the health and wellbeing  
of the Australian population - the role and function  
of Primary Health Care Organisations*

26 November 2009



THE AUSTRALIAN  
GENERAL PRACTICE  
NETWORK

Delivering local health solutions through general practice



AGPN represents a network of 110 general practice networks as well as eight state based entities. More than 90 percent of general practitioners (GPs) and an increasing number of practice nurses and allied health professionals are members of their local general practice network. The Network is involved in a wide range of activities focused on improving the health of the Australian community including health promotion, early intervention and prevention strategies, health service development, chronic disease management, medical education and workforce support.

AGPN aims to ensure Australians have access to an accessible, high quality health system by delivering local health solutions through general practice.

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## Executive Summary

The introduction of Australian primary health care organisations (PHCOs) will enable higher quality, better connected care and improve the health and wellbeing of the Australian community.

Recent health reviews conducted on behalf of the Australian Government about health care reform have recognised that health systems with strong and vibrant primary health care services have much better health outcomes for lower cost than those with an acute care focus.

If these reports have a common theme, it is 'connecting care': better connecting care through high performing multidisciplinary health care teams, by breaking down the service silos between Commonwealth and state/territory funded services and through more regionally organised and responsive primary health care.

This *Blueprint* for Connecting Care sets out a vision for PHCOs and provides the detail to enable their implementation in the Australian health system. It contains recommendations about PHCO scope and purpose, roles and responsibilities, guiding principles and key capabilities. It provides advice on corporate structure and governance, criteria for boundaries, number and size, thoughts on a performance, improvement and business excellence framework and plans for transition arrangements.

The *Blueprint* has been developed by AGPN – the body best placed to advise on these matters as the national peak body for Australia's unique system of existing 'meso' level organisations generically known as general practice networks (or local divisions of general practice). It has the support of the entire Network leadership – Chairs and CEOs of all SBOs and general practice networks – and has emerged from more than six months of comprehensive consultation within the Network.

A key premise is that PHCOs should evolve from existing general practice networks. They have the existing national footprint, general practice engagement and other characteristics on which to build.

A further key requirement is for partnerships – with others involved in the primary health care sector such as State and Territory health services, non-government organisations and private practitioners, as well as with the interface with the acute sector. The dawn of PHCOs across Australia requires a collaborative approach which is inclusive of those key parties which are already contributing to the health and wellbeing of Australians

Initial consultations on the principles contained in this *Blueprint* have been held with others operating in the primary health care space – for example, the National Primary Health Care Partnership, a coalition of 19 national peak organisations with an interest in primary health care service provision. The Partnership has expressed its support for more organised primary health care integrated with general practice and building on existing infrastructure, with the flexibility to respond to local health needs. Pending Government decisions, further consultations will be held with key bodies in finalising design issues and developing a transition plan for PHCOs.

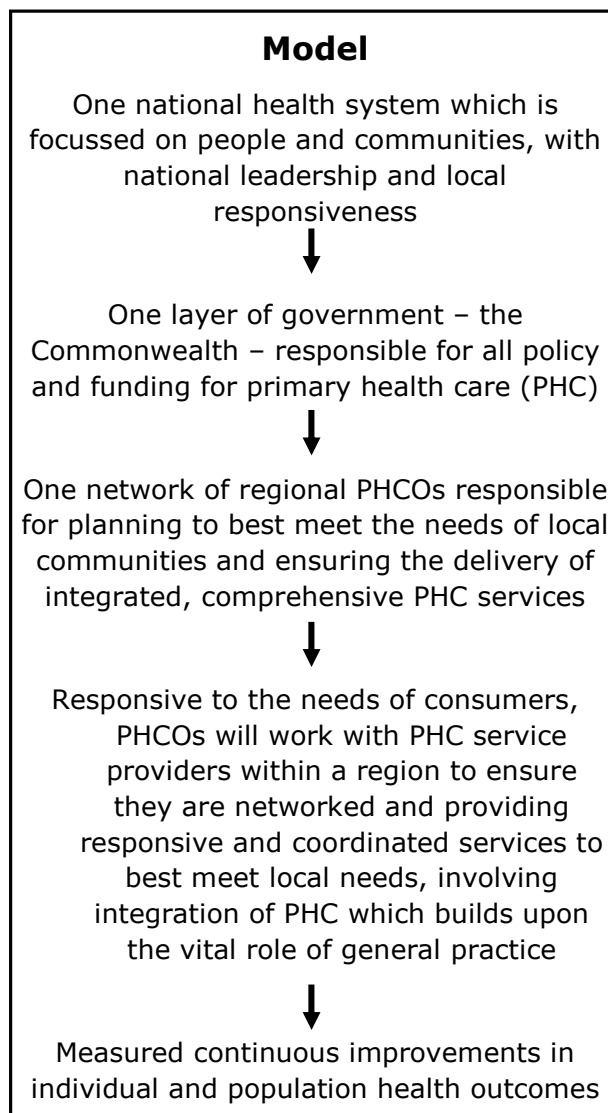
In transitioning to these new organisations it is essential that the gains made by the Network are not lost but are nurtured and built upon. Most importantly, this includes general practice support and the capacity to drive change management in this setting, local clinical leadership as an integral part of local health partnerships, as well as direct service delivery to community, particularly to address gaps in service. The primary health care reform agenda provides the opportunity to build on what has worked well across the Network and apply it consistently across the country.

If implemented, this *Blueprint* will support the Network to evolve and transform over time, to build capacity and competencies to take on the varied roles proposed for PHCOs; to develop expertise in population health planning, and identification of gaps and priorities which target those most in need; to take increasing responsibility for service configuration in their community aligned to need; to manage all primary health care funding for a region (excluding benefit payments such as MBS and PBS) and to continue to develop their financial management capacity, accountabilities and focus on demonstrating high performance and cost effective business systems.

The Network's ability to deliver on this ambitious reform agenda is subject to a number of factors such as the extent and timeliness of Government decisions, adequate transition and ongoing funding to enable PHCOs to operate as a viable force for change, and agreement to policy that ensures the ongoing engagement of GPs and general practice.

An immediate option open to Government is to test the Network's agility and the types of models that could be developed through support for early testing of proof of concept with a range of general practice networks that are already well advanced in developing PHCOs. Such an approach would enable the trialling of different models of PHCOs which are specifically designed and flexibly implemented to best meet local needs and circumstances. This flexibility in design and implementation will be essential to reflect the differences which already exist between health systems in different States and Territories, as well as between metropolitan, regional, rural and remote Australia, and with potentially different local partners.

The following simple model illustrates our vision for PHCOs and their role in a reformed system:



## Recommendations

1. Australian PHCOs should build on a strong general practice base. Integration with general practice, general practice engagement and strong clinical-managerial partnerships are essential to lead more organised primary health care in Australia.
2. Australian PHCOs should be independent, not-for-profit regional entities. Independent organisations with clear accountability to communities, members and funders are the best option for driving locally responsive health care.
3. Australian PHCOs should build on what exists and what works. The existing general practice network is the logical platform to establish PHCOs. They already have the national footprint, strong engagement with general practice and increasingly strong engagement with other providers and communities.
4. It is essential that existing services and programs be maintained and extended: there should be no retraction in primary health care services as a result of PHCO introduction.
5. To ensure this occurs, Government support is sought for proposed hub and spoke or branch arrangements which maintain existing GPN services and infrastructure.
6. Where existing GPNs do not or cannot become PHCOs, additional models must be examined to assist in maintaining their essential services. These models must involve transition of these GPNs into service providers where they can demonstrate their value adding contribution to the local health system, with a direct funding relationship to their regional PHCO.
7. PHCOs should be introduced in stages with a view to full establishment by June 2012. Early adopter PHCOs should be funded and supported to pilot the various pathways to establishment and to evaluate flexible models which are responsive to local circumstances. A process to identify potential participants should commence as early as possible in 2010.
8. An expression of interest process internal to the existing Network should be conducted to form all PHCOs.
9. A transition support fund should be made available from July 2010 to support the development of appropriate legal, strategic and operational frameworks for PHCOs.
10. There must be adequate recurrent funding for ongoing operations in order for PHCOs to fully and comprehensively fulfil their roles.

## About this *Blueprint*: a vision for health

This document presents the Australian Government with AGPN's blueprint for the development of a network of Primary Health Care Organisations (PHCOs) across the country leading to strengthened, integrated, organised and coordinated primary health care and the improved health and wellbeing of Australians.

Our vision is for a network of high performing PHCOs, evolved from the general practice network, which drives improved health outcomes for the communities and individuals we serve.

This vision will not be achieved overnight: it will need to evolve progressively as changes occur between Commonwealth and State/Territory roles and responsibilities, and divisions of general practice – generically known as General Practice Networks (GPNs) – evolve into PHCOs, and over time build the capacity and competence to take on increasing responsibility for population health planning and ensuring the delivery of quality, integrated services.

While the first is outside of AGPN's control, AGPN has begun work on a transition plan to achieve the second. This plan will see the Network:

- Evolving and transforming over time
- Building increased capacity and competence to take on the varied roles proposed for PHCOs
- Developing expertise in population health planning, and identification of gaps and priorities which target those most in need
- Managing all primary health care funds within a region (other than benefit payments such as MBS and PBS)
- Taking increasing responsibility for reconfiguration of the health service delivery system to better align services with the needs of the community
- Continuing to develop their governance competencies, financial management capacity, accountabilities, focus on demonstrated high performance, and cost effective business systems
- Managing costs and ensuring value for money.

In transitioning to these new organisations, it is essential that the gains made by the Network are not lost but rather are nurtured and built upon. In their relatively brief history, GPNs have consistently developed two key functions:

1. General practice support, which is focussed on change management, broadening the scope and capacity of general practice to work in a more integrated multidisciplinary way, with increasing connections with other PHC providers and the acute sector.
2. Direct service delivery, as GPNs have taken on responsibility for holding increasing levels of funds for specific programs, and have either delivered those programs directly through employed or contracted staff, or have paid others to deliver those services.

These two functions are essential to the future development of PHCOs and they are examined further in the section, 'Building on General Practice Networks' on page 15.

The Network's ability to deliver on this ambitious reform agenda is subject to a number of factors, including:

- Extent and timeliness of government decisions
- Adequate transition funding to plan and implement the proposed changes
- Adequate ongoing recurrent funding to ensure the delivery of comprehensive primary health care services. To fund PHCOs on the same basis as GPNs will not achieve any real change and will result in an inability to meet expectations. If change is to result, PHCOs need to be funded and empowered to engage with providers more broadly and to ensure the delivery of necessary services, with a particular focus on improving access and equity
- Agreement to policy positions which ensure the ongoing engagement of GPs and general practice, as well as the maintenance of existing essential services to members and the community

## Background

The National Health and Hospitals Reform Commission (the Commission) has presented the Australian Government with a long-term health plan for Australia and the External Reference Group has provided a draft National Primary Health Care Strategy.

A key principle of these reviews is that health systems with strong and vibrant primary health care services have much better health outcomes for a lower cost than those with an acute care focus.

Among its 123 recommendations, the Commission suggested the Australian Government take responsibility for all policy and funding for primary health care. It called for service coordination and population health planning priorities to be enhanced through the establishment of PHCOs. The Commission said PHCOs should build on or replace existing divisions of general practice – generically known as general practice networks (GPNs).

The draft Strategy suggests PHCOs are needed to ensure services respond to the needs of regions, that local communities are actively involved in health planning, to better integrate and coordinate the range of organisations and service providers operating within primary health care and to better link with other sectors. This will include a much stronger focus on health promotion and illness prevention, as well as building on the many successes of the Network in areas such as mental health, chronic disease management, nursing in general practice, quality improvement, primary health care collaboratives, eHealth, data management, workforce recruitment and retention, rapid responses to issues such as the swine flu epidemic, immunisation, palliative care, and programs specifically targeted at rural and remote communities.

The Commission's Final Report, *A Healthier Future For All Australians*, provided little further detail about PHCOs other than to say they should have governance that reflects the diversity of clinicians and services forming comprehensive primary health care, be an appropriate size to provide efficient and effective coordination, and meet required criteria and goals to receive ongoing Australian Government support.

This *Blueprint* provides a vision for PHCOs and provides the detail to enable their implementation in the Australian health system within the next three years (subject to government decision-making). It has been developed by AGPN – the body best placed to advise on these matters as the national peak body for Australia's unique system of existing 'meso' level primary health care organisations: general practice networks.

The *Blueprint* contains recommendations concerning the scope and purpose, roles and responsibilities, guiding principles and key capabilities of PHCOs. It also makes recommendations about corporate structure and governance; the criteria that should determine boundaries, size and number; the need for an appropriate performance improvement framework; the role of a national agency; and transition arrangements. The *Blueprint* assumes the Commonwealth will be taking a greater policy and funding role in primary health care over time, ultimately leading to full responsibility. This assumption is reflected in the role and functions described for PHCOs:

*'Regional structures are unlikely to be effective unless the divided responsibility for primary health care and the system of payments for primary health care services is addressed.'*<sup>1</sup>

<sup>1</sup> Mc Donald et al 2007

Based on an initial assessment of roles and need, it is estimated that up to 60 PHCOs will be needed across Australia (there are currently 111 GPNs). AGPN has commissioned a consultant to develop a model of boundaries based on a systematic review of data.

The *Blueprint* represents a whole-of-Network view and has been developed in close consultation with the general practice network leadership. AGPN plans to consult other stakeholders such as the allied health, nursing and the Aboriginal community controlled health sector on the detail of this model and the implementation strategy with a view to providing advice on how transition could be best supported and managed.

One early option open to Government is to pilot the proposed PHCOs in a number of areas in Australia. In many parts of Australia, general practice networks are well advanced in developing PHCO models which fit this Blueprint. With agreement to a piloting approach, AGPN could quickly identify potential participants from across the Network where models for PHCOs can be developed to proof of concept stage. AGPN welcomes further discussion with Government on this option.

## Summary of PHCO Blueprint

<b>Corporate structure and legal framework</b>	<p>PHCOs will be evolved or newly constituted, not-for-profit regional independent companies limited by guarantee under Corporations Act 2001, and any other enabling health legislation where relevant.</p>
<b>Objects</b>	<p>PHCOs should aspire to improve the health and wellbeing of their populations through planning, coordinating, funding and developing and delivering primary health care services. A consistent suite of objects should apply across all PHCOs, reflecting the following core functions:</p> <ul style="list-style-type: none"> <li>Undertake population health and service planning</li> <li>Strengthen the effectiveness, efficiency and vitality of regional primary health care services</li> <li>Ensure access to PHC services that meet community need</li> <li>Contribute to regional leadership and innovation in health</li> <li>Promote cooperation, collaboration and communication with other regional organisations with an interest in health and social care</li> <li>Deliver a primary health care system that is integrated with and through general practice</li> </ul>
<b>Formation and transition</b>	<p>PHCOs will be governed under new constitutions but should not necessarily involve new infrastructure or organisations. They should build on the existing national footprint, expertise, capacity, clinician and community engagement of GPNs.</p> <p>GPNs should be given the opportunity to submit a proposal to establish PHCOs (an 'internal tender'). Flexible approaches to transition should be considered ranging from amalgamations and mergers, through to partnerships, the establishment of new umbrella structures and branch-based models.</p> <p>Funding for the general practice network (AGPN, SBOs and GPNs) runs to June 2012 under the current Multi Purpose Agreement. A phase-in of PHCOs is recommended with the support of initial adopters from as early as June 2010.</p> <p>A transition support fund should assist evolution by providing resources to support the development of new constitutions, strategic plans, performance frameworks, marketing and branding strategies, and organisational standards and to establish the relationship between PHCO Network entities.</p>
<b>Membership</b>	<p>PHCOs should be member-based entities. Membership options range from whole-of-community, primary health care providers or provider organisations, or some sub set of these.</p>

<b>Governance and structures</b>	<p>PHCOs should be governed by a skills-based Board with Directors possessing the mix of competencies desirable to set and drive strategic direction eg. general practice, other clinical, business, legal, marketing.</p> <p>There should be a proportion of appointed and elected Directors to ensure optimum skill mix and appropriate clinical governance arrangements.</p> <p>Effective advisory and consultative structures and engagement strategies will be established to garner clinical, community and other stakeholder input into direction setting and decision making.</p> <p>A number of organisational structures are possible for PHCOs. Where they have purchaser and provider functions, these should be developed over time as distinct and separately accountable functional arms of the organisation to avoid conflicts of interest.</p>
<b>Accountability</b>	<p>PHCOs will have dual accountability: to the community/members and to funders. The primary funder would be the Australian Government. PHCOs should operate under a set of organisational standards and a nationally agreed performance improvement framework.</p>
<b>Boundaries, size and number</b>	<p>Population will be a starting point but cannot be the only criteria for determining size and boundaries. These need to be determined by a number of criteria that balance scale and resources for efficient service delivery with capacity for local community and stakeholder engagement. These criteria include geography, predicted future growth corridors, communities of interest and relationship to other service infrastructure.</p> <p>Based on these factors and the population criteria identified in the Final Report of the NHHRC, this would result in no more than 60 PHCOs across Australia.</p>
<b>Relationships and overall Network structure</b>	<p>PHCOs would be part of a national network. To ensure effective community engagement, coverage and efficient provision of services, PHCOs in some regions could have local branches.</p> <p>They would be supported by a national agency whose functions would include promotion of innovation, accreditation, performance improvement and policy.</p>
<b>GPN scenarios</b>	<p>PHCOs will build on the infrastructure, assets and intellectual capital of existing GPNs. This could occur in a number of ways:</p> <ul style="list-style-type: none"> <li>Individual GPNs (with existing sufficient size and capacity) evolving into a PHCO by setting up the new legal entity</li> <li>Partnering between GPNs (and potentially other organisations) to establish a new legal entity</li> <li>Fulfilling a role as service provider engaged by their regional PHCO (or other funders) on a contestable basis – this could include the provision of professional and practice supports services to general practice</li> <li>GPNs transitioning to be branch offices of the PHCO</li> </ul>
<b>Authority</b>	<p>PHCOs will hold funds to provide, contract and/or commission services – particularly to respond to service gaps and to improve access and equity. They will have more responsibility for commissioning and service provision as their capacity improves and competence builds. This could include greater horizontal integration with other services impacting on the social determinants of health. MBS and PBS arrangements will remain outside the PHCO system.</p>
<b>Partners</b>	<p>PHCOs would have a number of formal/informal partnership arrangements to assist advancing PHCO objects eg. Regional Training Providers, Aboriginal Community Controlled Health Services, the acute care sector and community service agencies.</p>

## Organised primary health care: setting the context

Our health system is in need of transformational change: otherwise it simply will not be able to bear the pressures it will experience in the future, AGPN, in its Primary Health Care Position Statement<sup>2</sup>, has long argued that a paradigm shift towards an enhanced primary health care system is required to improve the way health care is delivered, funded, organised and governed, and to best meet the current and future needs of Australians.

In conjunction with reforms in other domains of health care such as financing and coordinated, comprehensive models of care, organised primary health care has international support as well as the backing of Australia's recent health reviews. Organised primary health care is associated with improved health outcomes and greater cost effectiveness. Structurally, this has taken a number of forms including primary health organisations (PHOs) in New Zealand, Primary Care Trusts (PCTs) in the United Kingdom and local GPNs in Australia.

Reflecting the fragmentation in the current Australian system, a key theme of the Commission's Final Report was 'connected care'. A single policy prescription will not achieve this result: there are many policy and funding levers that need to be applied in tandem in order to drive this goal for the Australian health system. Chief among them is the role regional PHCOs can play. PHCOs represent a vital means by which primary health care can be better organised, coordinated and integrated on a regional basis in order to meet local community needs.

## PHCO scope: comprehensive primary health care

Australian PHCOs should focus on regional leadership, innovation, flexibility, responsiveness, and ensuring the delivery of comprehensive primary health care.

Comprehensive primary health care is socially appropriate, universally accessible, scientifically sound first-level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health. Comprehensive primary health care includes health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation<sup>3</sup>.

The key role for PHCOs should be to facilitate improvements in the health and wellbeing of local populations through planning, coordinating, funding, developing, commissioning and/or delivering comprehensive primary health care services integrated with general practice.

<sup>2</sup>see: [http://www.agpn.com.au/\\_\\_data/assets/pdf\\_file/0020/16274/20090402\\_pos\\_AGPN-PHC-Position-Statement-2009-FINAL---Graphic-Designed.pdf](http://www.agpn.com.au/__data/assets/pdf_file/0020/16274/20090402_pos_AGPN-PHC-Position-Statement-2009-FINAL---Graphic-Designed.pdf)

<sup>3</sup>Definition developed by the Australian Primary Health Care Research Institute (APHCRI) and cited in [Primary Health Care Reform in Australia: Report to Support Australia's First National Primary Health Care Strategy](#) (September 2009) This definition was developed for an ADGP Primary Health Care Position Statement in 2005, and was also included in the Australian Medical Association Primary Health Care Position Paper, 2006.

PHCOs should drive the following six key directions:

1. Undertake population health and service planning
2. Offer access to comprehensive services to improve, maintain and restore people's health by strengthening the effectiveness, efficiency and vitality of regional primary health care services, including an increased emphasis on health promotion and illness prevention
3. Identify and tackle health inequalities by ensuring access to primary health care services that meet community need, particularly where there are service gaps
4. Coordinate care across primary health care providers and between primary and secondary/tertiary care by promoting cooperation, collaboration and communication with other regional organisations with an interest in health. Relationships with the acute care sector could include improved vertical integration ranging through to the delivery of specific services designed to reduce demand and cost pressures such as hospital avoidance programs, to models of care designed to promote coordination such as shared care arrangements
5. Develop and support the primary health care workforce, particularly in areas of acute workforce shortage (eg. rural and remote areas)
6. Continuously improve the quality of services and programs by effective use of good data and eHealth systems

## **What will be different for patients and the community?**

It is widely reported that consumers experience a health care system that is disjointed and fragmented. Additionally 71 percent of GP providers in the Australian system say that fundamental changes are needed to the system<sup>4</sup>. It is time for transformational change in health, and a renewed focus on primary health care.

In a PHCO environment, patients will experience a health system where:

- Arrangements will be simpler and the system easier to navigate
- Connected providers and services will deliver the right care, in the right place at the right time: integrated care that overcomes fragmentation in the system
- Local issues and service gaps will be identified and addressed
- Better access to front line health care will be possible through reinvigorated general practice networked with allied health, nursing and community services that are affordable and accessible

In a PHCO environment, providers will experience a health system where:

- There is improved acknowledgement and respect for the contribution made by GPs and other primary health care providers, boosting the attractiveness of general practice and primary health care as a career option for doctors, nurses, allied health professionals and other members of the PHC team
- Better professional and practice services support GPs and other primary health care providers to deliver quality, multidisciplinary care
- Better team work and communication systems for the collection and sharing of patient information across the continuum of care result in truly linked up services
- Better patient satisfaction and health outcomes result

<sup>4</sup>Schoen C et al A Survey of Primary Care Physicians in 11 Countries, 2009. Perspectives on Care, Costs and Experiences. Health Affairs Web Exclusive, 5 November 2009

## What will be different for GPs?

The establishment of PHCOs is not expected to lead to significant initial change for GPs and general practice. Over time, it should lead to new opportunities for patients including increased availability of services, greater flexibility in planning and delivering services according to patient need, simplified coordination and increasingly seamless, horizontal continuity of care, and an increased emphasis on ensuring maximisation of the skills of GPs, as well as practice nurses and allied health professionals, working together within their scopes of practice to ensure effective, efficient, integrated care of patients.

Effective reforms involving PHCOs will need to:

- Build on the infrastructure, resources, skills and relationships that currently exist in general practice, rather than trying to replace or compete with them
- Ensure general practice is fundamental to integrated primary care, and resist systems that fragment care
- Make general practice a more satisfying and rewarding place for the GPs and staff that work in it
- Demonstrably lead to better health outcomes for patients and communities
- Be an integral part of the system that trains the health workforce of the future

## Principles

The Prime Minister has described seven guiding principles for reform<sup>5</sup>:

1. Building a health system focused on people not systems – which delivers genuinely 'joined up' services that are easier to navigate
2. Maximising a focus on prevention because prevention is better than cure
3. Delivering comprehensive primary or front line care that properly connects GPs and community care, and acute and sub-acute care

4. Minimising waiting times for acute care
5. Improving care provided after hospital discharge by doing a better job in delivering sub-acute and community-based care
6. Providing better access to care and improving the quality and safety of our system
7. Delivering health care more efficiently with a clear-cut delineation of the roles and responsibilities of the Commonwealth and the States.

The introduction of Australian PHCOs will be a vehicle through which this vision can be realised. PHCOs will deliver on these imperatives by integrating primary health care with general practice to create the 'health care home'; undertaking service planning and monitoring; knowing their population's health profile and enhancing the capacity and responsiveness of services in accordance with need; supporting collaboration and integration between providers and service sectors; and delivering supplementary programs and services to meet service gaps.

The following principles should underpin Australian PHCOs:

- Access
- Equity
- Participation
- Sustainability
- Accountability
- Partnerships
- Integration
- Multidisciplinary
- Empowerment
- Intersectoral
- Cultural appropriateness

<sup>5</sup>Prime Minister the Hon Kevin Rudd, Reforming Health Care, Address at the Launch of NHHRC Final Report, John Curtin Medical School ANU, 27 July 2009

In addition, the following are fundamental to the establishment of PHCOs:

- PHCOs must help achieve health reform objectives: maximising a focus on prevention; addressing health inequity; building a safer more effective health system by improving integration and optimising patient safety; providing 'joined up' services and assisting to ensure the most effective and efficient use of resources
- General practice is the front line setting where most people go for their health care, with more than 100 million consultations each year: integration with general practice is critical to reform of comprehensive, continuing primary health care
- General practice engagement and strong clinical-managerial partnerships are critical to leading more organised primary health care in Australia. The general practice network is the only mechanism that universally engages and leads change management for general practice in Australia
- PHCOs should be built on what exists and what works. The Network is the logical platform to establish regional PHCOs. They already have strong engagement with GPs and general practice. They also have the agility, coverage, credibility, capability and increasing consistency of performance on which to base PHCOs
- An urgent and significant commitment by federal, state and territory governments to develop eHealth solutions, including electronic patient records able to be used consistently in general practice and other primary health care settings, is essential to ensure the most effective joined up system

## Building on general practice networks

Strong primary health care systems feature devolved health care planning and delivery. In many OECD countries, this devolution occurs through 'meso' level primary health care organisations. General practice networks are Australia's only established equivalent of overseas models of meso-level organisations.

Since their inception, general practice networks have successfully bridged the primary health care agenda of government and the needs and interests of local primary health care providers and communities, ushering in a new era of primary health care organisation and practice. The Network has matured and evolved and today is involved in a wide range of activities including practice support and quality improvement, health promotion, early intervention and prevention strategies, chronic disease management, medical education, information management, health service development, health service delivery and workforce support. It is also frequently involved in the development and implementation of broader PHC models with an emphasis on social justice and intersectoral collaboration.

These GPN activities can be clustered into two key functions that will be essential to the future development of PHCOs. They are examined further below:

1. General practice support, which is focussed on change management, broadening the scope and capacity of general practice to work in a more integrated multidisciplinary way, with increasing connections with other PHC providers and the acute sector
2. Direct service delivery, as GPNs have taken on responsibility for holding increasing levels of funds for specific programs, and have either delivered those programs directly through employed or contracted staff, or have paid others to deliver those services

### **General Practice Support**

The most fundamental strength of the Network is its engagement with general practice, and this engagement will be critical to the success of PHCOs. The National Health and Hospitals Reform Commission identified the Network as the ideal platform for establishing PHCOs because it is the only mechanism that universally engages general practice in Australia. Any transition to new organisations cannot afford to lose what has already been gained since the inception of the Network's development.

If that engagement is lost, involvement of GPs and the broader general practice workforce in primary health care reform and new models of integrated care will be at risk, and Australia will continue to have a disintegrated, divided and disorganised system. Little progress will be made and the result will be similar to the community health movement of the 1970s, when GPs were left outside and disenfranchised, resulting in community health being operated as a separate, almost adversarial system, with the PHC sector never realising its full potential – much to the detriment of the Australian community.

To ensure maintenance of this vital role, options in this area are:

- a. GPNs which evolve into PHCOs could either continue to provide these services or could engage another organisation (or subsidiary) to provide these services (eg. see (b) below)
- b. GPNs which do not or cannot evolve into PHCOs could continue to provide these services: they would no longer be called Divisions but would be among the many service providers engaged within a region by PHCOs to provide essential services (like general practices, community health etc)

### **Direct service delivery**

GPNs now provide (or commission) an increasingly broad range of direct services, with funding coming from a range of sources, including increasing amounts of State/Territory funding, as well as funding from non-health government departments. These include:

- what might be regarded as “mainstream” PHC through new services in identified areas of need such as refugee health, mental health, homelessness and youth eg. More Allied Health Services (MAHS) or Access to Additional Psychological Services (ATAPS)
- broader models of PHC eg. Market gardens in areas with poor access to fresh vegetables, toilet blocks to improve sanitation, access to fresh water, support for homeless people and refugees, and increasing involvement in support for the broad health determinants which impact on indigenous health

Once again, these are vital services to the community and cannot be lost in the transition to the new PHCOs. Options for the future include:

- a. GPNs which evolve into PHCOs will continue to develop and extend their direct service delivery role, albeit that this may be run as a distinct separate service arm within the organisation. This is similar to what has occurred in other countries (eg. UK, New Zealand) where organisations have held both purchasing/commissioning roles and provider roles
- b. PHCOs can have both purchasing and providing roles: GPNs have already demonstrated this is possible. Over time, as PHCOs develop to their full potential, they may choose to split off their service provider role/s into a separate organisation/s
- c. GPNs which do not or cannot evolve into PHCOs once again could continue to provide these services: they would no longer be called Divisions but would be among the many service providers engaged within a region by PHCOs to provide services, on the basis that they could demonstrate cost effectiveness/value to the community.

GPNs are now a well recognised and valued part of the Australian health system and represent the only major structural reform in the provision of health care since Medicare began in 1984. They are irrefutably the logical building block around which to frame PHCOs, building on existing local relationships and vital GP engagement. GPNs:

- Are established organisations with defined catchment areas
- Have extensive local population health knowledge
- Have a national footprint but local flexibility
- Have capacity to integrate primary health care with general practice
- Relate to GPs, other primary health care professionals and services, state-run services (including the acute sector), Aboriginal community controlled health sector and communities
- Are experienced in working in networks
- Have established partnerships that can be extended, and have the capacity to lead and drive new partnerships
- Have planning, commissioning and purchasing skills
- Have capacity to organise and deliver broad primary health care services in very large rural and remote areas<sup>6</sup>
- Have a will to evolve into regional primary health care focused enterprises<sup>7</sup>

## Roles and responsibilities

The overall role of PHCOs in Australia should be to improve health outcomes by enhancing service coordination, population health planning at the local level and planning, developing and, at times, funding and/or delivering primary health care services.

Consistent with the international evidence about roles and experience<sup>8</sup>, Australian PHCOs should focus on:

- Population health and service planning
- Engaging and supporting primary health care providers, including maintaining engagement with, and support for, general practice
- Contributing regional service solutions that help manage and control overall health care costs
- Developing and delivering more accessible services with a focus on filling service gaps, complementary to fee-for-service.
- Enabling greater horizontal integration of primary health care, aged care and social support services, and vertical integration between primary health care and acute care
- Enabling greater scrutiny, accountability and assurance of quality primary health care services

Functions of PHCOs should fall into four categories, underpinned by patient/service user experience and community engagement:

- Strategic planning and development
- Workforce planning, development and support
- Health service development and delivery, including purchasing or contracting
- Population health and community development

There should be appropriate arrangements in place to ensure transparency and appropriate management and controls where the PHCO has both a purchaser and provider role.

<sup>6</sup>Kalucy L. Partnership approaches, regional structures and primary health care reform. *Australian Journal of Primary Health* 15(3) 188 – 192, September 2009

<sup>7</sup>Refer to Adelaide and Sydney communiques: [www.agpn.com.au](http://www.agpn.com.au)

<sup>8</sup>Smith J & Goodwin N. *Towards managed primary care: the role and experience of primary care organizations*. Ashgate Publishing; Aldershot: 2006.

## PHCO functions

Strategic planning and development	Workforce planning, development and support
<p>Regional and local population health analysis and planning</p> <p>Health service development and innovation to focus on need, inequity and service gaps</p> <p>Development of health and social care programs and partnerships</p> <p>Brokerage and fund-holding</p> <p>Advocacy, strategy and policy</p> <p>Support for primary health care research</p> <p>Infrastructure development and delivery (eHealth)</p> <p>Data and knowledge management</p>	<p>Staff development (learning organisation)</p> <p>Clinical and managerial leadership development</p> <p>Health workforce recruitment, development and support</p> <p>Professional and practice support services to GPs, allied health and other primary health care services such as Aboriginal Medical Services</p> <p>Interdisciplinary education and training</p> <p>Change management services</p>
Health service development, delivery and integration	Population health and community development
<p>Service standards and benchmarking</p> <p>Purchasing and brokering services</p> <p>Commissioning, changing or developing new services</p> <p>Providing services to fill gaps (eg. outreach, after hours)</p> <p>Quality, safety and accreditation (coaching and support role)</p> <p>Clinical leadership and governance</p> <p>Direct service delivery or brokerage of a full range of locally relevant primary health care services</p> <p>Service integration and coordination within primary care and across primary/secondary care</p>	<p>Regional health promotion campaigns and programs</p> <p>Linkages with other sectors (eg. housing) to address social determinants of health</p> <p>Intersectoral community partnerships</p> <p>Community surveys and profiles</p> <p>Social marketing</p> <p>Social care services</p>
<p><b>Patient focus and community engagement</b></p>	

## Key characteristics and capabilities

To carry out the roles suggested in this *Blueprint*, PHCOs will need clear responsibilities, the authority for planning and funding/commissioning services to meet gaps in service provision and the skills and resources to carry this out. In addition PHCOs will:

- Have strong local leadership and community engagement and support
- Operate under clear performance expectations
- Build upon the vital work already done by GPNs in supporting and engaging with general practice
- Network and engage with others involved in the local service delivery environment: primary health care providers and support services to primary health care professionals
- Feature appropriate corporate governance including a skills based board
- Have effective mechanisms to garner clinical, consumer, community and health stakeholder input into PHCO strategic direction and decisions about planning and provision of services
- Be accountable to Government and the community for measurable outcomes, using a consistent national performance improvement framework
- Promote research and evaluation, and the enhancement of an evidence-based culture in primary health care
- Play a major role in education, training and distribution of Australia's future primary health care workforce
- Provide leadership in ensuring quality patient care by focussing on data and information and on eHealth solutions, including the introduction of electronic patient health records
- Drive and establish effective partnerships

## Legal structure and corporate governance

PHCOs should be regionally based, independent, not-for-profit companies limited by guarantee: independent organisations with clear accountability to both communities and funders are the best option for driving locally responsive health care delivery.

A credible governance structure is critical to the PHCO success for a number of reasons:

- They will be operating on behalf of the public to fulfil the social goals of improving health and wellbeing of a population. This will be expressed through delegation from the Commonwealth either through legislation/regulation or contractually
- They will be delivering and/or contracting significant services and therefore must be effectively governed to ensure probity, value for money, quality and performance against national and local standards
- Their planning and integration roles require effective partnerships and engagement with key stakeholders
- Community and service user participation in the planning, prioritising and evaluation of its activities is a central principle of primary health care

The PHCO board should be accountable for the efficient delivery of the organisation's objectives within applicable business, legislative and regulatory frameworks and contractual agreements with the Commonwealth (and other) funders. It should take a strategic overview of the PHCO's activities, priorities and objectives and hold management to account for the delivery of its strategic and business plans.

The board should:

- Determine policy and strategy
- Approve resource allocation and monitor financial performance
- Monitor and review performance against national and local indicators
- Monitor the CEO's performance to ensure that human and physical resources are managed appropriately
- Ensure that effective processes are in place to measure and improve the quality of activities/clinical governance

PHCO Boards should be skills-based comprising a mix of expertise desirable to fulfil the above roles and direct and steer the organisation. This is best achieved through a mix of elected and appointed Directors.

PCHO boards also need to be small in order to be nimble and responsive. Best practice governance suggests that this is best achieved through Boards that generally do not exceed nine Directors. The skill range envisaged for PHCO boards would include Directors with expertise in the following categories:

- Governance and strategy
- General practice and other primary health care service provision
- Health service development and innovation
- Business, financial and legal acumen
- Communications and marketing
- Family and community services
- Not-for-profit governance
- Community and consumer sectors

It will be essential to have clinical governance as an integrated element of the overall governance and management of the PHCO particularly as they are envisaged to have a service commissioning role and, in many cases, are likely to have a service delivery arm. Clinical governance, with its components of risk management, quality and safety, is inextricably linked to safety and improved patient outcomes.

Issues identified as risks should lead to improvement activities or enhanced consumer outcomes through the risk treatment process.

At the primary health care service or health service management level, clinical governance includes elements such as the following, complementing the standard setting roles of professional bodies and medical boards:

- Clinical policies & procedures
- Evidence based practice
- Episodic management
- Clinical pathways
- Case management
- Care planning
- Risk management including adverse clinical events
- Clinical competencies and quality assurance
- Professional development
- Clinical documentation
- Clinical products evaluation
- Clinical indicators, review and audit
- Research & ethics

Any company – whether for profit or not for profit – needs members. Options for PHCOs range from whole-of-community, primary health care providers or provider organisations, or some subset of these. Membership should build on the strengths of GPNs' GP membership, extending and broadening to reflect the local service delivery environment, namely comprehensive primary health care providers. As well as GPs, key PHCO members will include practice nurses, allied health providers, Aboriginal Community Controlled Health Services and individuals/agencies who provide support services to primary health care professionals (such as Regional Training Providers).

## Boundaries, size and numbers

Australia is a diverse country with unique characteristics: a large geographic spread, remote areas and population dispersion. The Commission has recommended PHCOs have a population size of 250,000 to 500,000. There must be a balance in PHCO size between being large enough to perform the required roles and manage funds efficiently and effectively, with being able to engage locally with communities and providers. To make a strategic assessment of the location, number and size of PHCOs, further research and modelling is needed that takes into account additional criteria such as:

- Relationships with other agencies
- Existing service infrastructure
- Existing patient flows
- Natural topography
- Alignment with the acute sector
- Growth corridors
- Alignment with other planning boundaries eg. state/territory health, LGAs, etc
- Transportation systems
- Communities of interest

Based on initial consultation with SBOs and GPNs, no more than 60 PHCOs are envisaged with the following dispersal by state and territory:

State	Potential number of PHCOs
New South Wales	12 – 16
Victoria	12 – 15
Queensland	8 – 9
South Australia	5 – 7
Western Australia	6 – 7
Tasmania	1
Northern Territory	1
Australian Capital Territory	1
Australia-wide	46 – 57

States and territories have suggested a range due to the need for further work on factors such as geography, projected population growth and other synergies. AGPN has commissioned a consultant to develop a model of boundaries based on a systematic review of appropriate data.

## Funding

If PHCOs are to be effective vehicles for change, they must be adequately funded to carry out the roles and responsibilities that are assigned to them. It is not realistic to expect them to build the capacities and competencies required, and to take on additional roles, responsibilities and accountabilities without funding to support this. Existing levels of GPN funding will not be sufficient: these funds are already stretched carrying out existing essential functions. Additional funds are needed if PHCOs are to take on broader population health perspectives and ensure the delivery of more comprehensive, equitable, integrated primary health care services. Flexible funding arrangements create the power and authority to influence and leverage quality, effective service delivery. This will be essential if real and lasting improvements in the population's health are to be achieved.

The MBS and PBS will sit outside the PHCO model. Funds which should come under control of the PHCO could include:

- Existing GPN funds: to sustain and improve existing GPN services such as practice support, eHealth capacity and critical services such as MAHS and ATAPS
- Other Commonwealth PHC funds which are currently paid to other non-government organisations within the community: these should be channelled through PHCOs in future to enable more flexible utilisation and integration with other funding streams in response to local needs
- Funding which currently comes via the States and Territories to existing community health services
- Additional Commonwealth funding allocated to PHCOs on a weighted population basis to address health inequities and issues of access

In the initial establishment of PHCOs, much of the funds redirected through these new entities will be passed on in accordance with existing provider patterns. Over time, PHCOs will develop additional expertise to use those funds to reshape and integrate services to best meet identified community need.

To be able to do this effectively, funders will need to move away from a siloed approach to program funding and enable PHCOs to use funds effectively to achieve improved outcomes for the community. This will require a significant shift from the manner in which Commonwealth programs are currently operated, and will essentially involve a move to flexible outcomes-based funding in the context of a nationally negotiated and agreed performance and improvement framework. PHCOs will need to receive budget certainty and timely cash flow, with flexibility in how to use funds to enable the best response to local priorities.

In addition, Commonwealth funding will need to take a weighted population approach to enable new services to be developed and delivered to those most in need and to effectively address inequities. The allocation of equivalence payments to PHCOs, as identified and recommended in the Commission's report, is one such important way of enabling PHCOs to undertake this vital role.

## **A performance, improvement and business excellence framework**

A robust and meaningful performance improvement framework should be developed for PHCOs at the outset as a basis for establishing benchmarks, monitoring and improving performance. The framework could build on the principles and elements of the Network Performance Development Framework that has been evolving throughout 2009. The major principles underpinning the framework are:

- A continuous quality improvement cycle
- Supporting implementation of strategic directions: performance indicators should be structured around the four key functional areas proposed for PHCOs:
  - \* population health and community development
  - \* strategic planning and development
  - \* workforce planning, development and support
  - \* health service development, delivery and integration
- Performance measurement across a balanced range of internal and external perspectives over time. A globally recognised methodology such as the balanced scorecard perspectives of customer; process; financial and learning and growth could be considered to drive performance improvement
- Common performance indicators and targets to enable benchmarking and shared learning
- The framework becomes the basis of accountability reporting to funders

As new entities with responsibility for the health of their regions and a wide range of programs and services, PHCOs will operate in a complex environment with a scale of operation that requires strong organisational capacity in governance, management and operations. It will be essential for the funder and the community's confidence that PHCOs demonstrate a level of business excellence, accountability and quality in management.

Accreditation is designed to assist organisations to improve their management and service delivery processes and should be part of a PHCO performance, improvement and business excellence framework. There are existing mechanisms in the Australian health system for standards setting, review and accreditation, and recognised accreditation models such as the International Organisation for Standardisation's ISO9001:2008 standards and the Australian Council of Healthcare Standards' (ACHS) EQuIP Corporate standards. As a condition of funding, all PHCOs should be required to complete accreditation with a recognised accreditation provider (all GPNs are currently accredited).

In addition, a system for PHCO accreditation is proposed in order to establish an industry or sector-specific standard. This will specify a set of minimum characteristics required of PHCOs and ensure consistency in issues such as PHCO branding, systems and approaches and should also be a condition of funding.

## Critical PHCO partnership arrangements

PHCOs must demonstrate that they have other effective ways of engaging stakeholders and/or members other than via their board. PHCO-led partnerships will be essential to integrated care and better 'joined up' systems. General practice networks bridge the primary health care agenda of government and the needs and interests of local primary health care providers and communities. By extending these partnerships, PHCOs will usher in a new era of primary health care organisations and practice.

Essential PHCO partners will include:

- Private primary health care providers and services, and specialist clinicians
- Public primary health care providers eg. child and maternal health services, community health
- Other key services such as mental health, drug and alcohol, youth health and sexual health
- Community pharmacy
- Aged care services and Home and Community Services (HACC)
- Education and training partnerships eg. Regional Training Providers, and regional arrangements for clinical placements proposed under Health Workforce Australia
- Community partnerships
- Aboriginal Community Controlled Health Services

A critical relationship for PHCOs will involve the interface with the acute sector. Given the separation of primary health care and acute care policy and funding which is likely to occur under this model, this increases the need to ensure there is good communication, liaison and referral pathways between the sectors.

The extent and nature of community based health services varies considerably between States and Territories, and between metropolitan, regional, rural and remote areas. These differences must be recognised and taken into account under these new arrangements. Likewise a key component of this relationship will be to work together on opportunities to reduce avoidable hospital admissions as well as to provide non-hospital step-down services to support patients post hospitalisation and to avoid readmission. This includes further development of community based rehabilitation and palliative care services. Many States and Territories have invested significantly and made considerable progress in these areas. Given their importance to the State-run hospital systems to improve access and patient care, those gains must be recognised, preserved and built upon.

It also will be important to put in place mechanisms to ensure the current cost-shifting which occurs between the Commonwealth and States/Territories is not simply transferred to the interface between the PHCOs and the acute sector.

## Community partnerships

Community engagement, in particular, is vital in comprehensive primary health care: there is evidence that links better health care with effective community engagement. While representation is one approach, PHCOs should be required to demonstrate they have in place effective methods of connecting with and engaging local consumers and the community. PHCO consumer and community engagement practices should be guided by best practice approaches such as those advocated by the International Association for Public Participation (IAP2).

## National functions to support PHCOs

A range of nationally performed functions is proposed to assist with the formation of PHCOs, help build their capacity, enhance efficiency and support their ongoing operations. While further development work is required on this aspect of the PHCO model, roles and functions performed at a national level could include:

- Promotion of innovation and best practice – to drive evidence based models of care and primary health care programs
- Development of PHCO-specific standards
- Developing and administering a new system of PHCO accreditation and ensuring that PHCOs meet these pre-determined standards – to ensure consistent and high quality industry performance
- Working with PHCOs to continually improve their performance – to promote a culture of continuous improvement
- Providing education, support and networks directed at improving practice – to promote innovation and service and program excellence
- Providing information about industry (PHCO) performance – to ensure accountability and transparency of PHCO sector activity
- Policy, representation and advocacy – to ensure PHCOs have a policy voice, are represented in appropriate national and State/Territory government negotiations, and to provide a focal point for other national stakeholders to engage with the Network.

These functions could be provided through the one national organisation – a national primary health care agency – or through two separate agencies:

- for example, if the agency were to have delegated authority from the Department of Health and Ageing for policy implementation and PHCO system performance, it may be preferable if this were either in a separate arm of the one agency, or performed by a separate agency, discrete from other functions which are about support, policy, representation and advocacy
- likewise funding for these functions could be either direct from government or via member contributions (or a mix of both) depending on what specific services are being provided

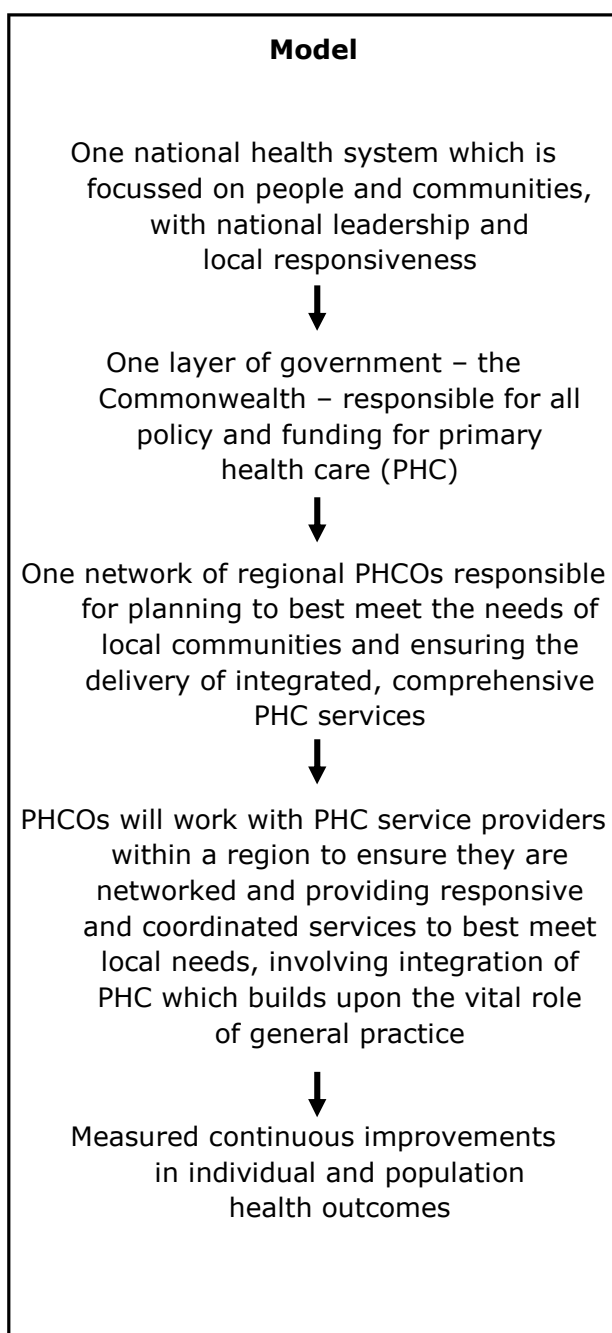
The national primary health care agency could be an evolved AGPN and SBOs, replacing these entities in their current form. In the event that the Australian Government does assume responsibility for primary health care policy and funding, an essential ongoing role will be liaison and communication with State and Territory Governments.

It is not proposed that the national agency should hold and disperse funds to PHCOs for program or service development and delivery (as is currently the case). This will ensure there is no conflict between its leadership, advocacy, standard setting, capacity building and monitoring role. For economies of scale PHCOs could elect to purchase shared services (such as 'back of house' services like HR systems) or member services (deals which bring benefits for all members responsive to the buying power of the Network) from the national agency.

As part of the transition plan, further work will be done on the roles, funding and structure of the national agency and the implications for AGPN and SBOs.

## Network configuration, structure and relationships

The Divisions of General Practice Program will be the forerunner to an Australian system of PHCOs. One of the critical success factors of organised general practice in Australia is its network. Networks operate on shared objectives, offer innovation, the opportunity to exchange knowledge and skills, the flexibility to respond to changes in the environment and more efficient operation.



Key features of the proposed configuration, structure and interrelationships include:

- The Australian Government as principal policy setter and funder
- A system of no more than 60 regional PHCOs governed by skills-based Boards and with strategies for ensuring clinical engagement and leadership, and community participation in the strategic direction and decisions of the PHCO. In some regions with a wide geographic spread, branch offices should exist to ensure efficient and effective service delivery, engagement with and support for general practice and other primary health care professionals, community participation and partnerships with local agencies
- PHCOs will progressively assume more responsibility as they develop over time and build up their competencies and capacities, and will ultimately hold all primary health care funds for their community (other than MBS/PBS)
- A national agency or agencies will be established to network PHCOs, provide national policy, set and monitor standards and build capacity
- The PHCOs will be directly funded by the Australian Government, with funding for the national agency/agencies potentially coming from government and/or PHCO members. PHCOs also could purchase member or shared services from the agency if there were economies of scale in doing so. The MBS and PBS payment system will sit outside the PHCO structure
- A member agreement should govern the relationship between the agency and PHCOs. The agreement would set out common aspirations, agreed PHCO criteria and accreditation arrangements, performance and improvement frameworks and the obligations of each organisation consistent with overarching policy

## Transition

Establishment of PHCOs will require systematic, planned and staged implementation, change management, leadership and support. Establishment of an Australian PHCO Network by the cessation of the current Multipurpose Agreement under the Divisions of General Practice Program (June 2012) is possible and recommended.

A transition support fund to June 2012 is essential to develop appropriate legal, strategic and operational frameworks for PHCOs and the implementation of a strategy to build and develop PHCO leaders – both managerial and clinical. In particular, this fund would support:

- Initial piloting of the transition of a number of GPNs to PHCOs in order to demonstrate the various pathways that can be taken to establish PHCOs and evaluate early gains. Final proposed pilots would include a formal process of Network development and assessment of proposals
- The development and implementation of a transition plan for the Network
- Development of the national agency
- The development of a business case for an Australian system of PHCOs, and modelling of boundaries, size and numbers
- Production of resources and tools to support transition such as legal structures and model constitutions, board skills matrix, delegation of authority models, sample strategic and operational plans, member agreements, stakeholder engagement strategies, risk management frameworks and communication strategies
- Development of a PHCO leadership development program for both managers and clinical leaders

Final policy decisions with respect to Australian PHCOs are subject to upcoming COAG negotiations and Federal Budget processes. Assuming a decision is taken to establish PHCOs and the enabling policy and funding environment exists, a two and a half year transition period is envisaged with the following stages:

<b>Six months</b>	<p>Communication plan with/for members</p> <p>Consultation with allied health community and other stakeholders on detailed blueprint</p> <p>Develop and finalise transition plan</p> <p>Model PHCO size, boundaries and location</p> <p>Submit transition plan and business case for transition and ongoing operations for PHCOs to</p>
<b>Year 1</b>	<p>Commission the development of resources and tools eg. due diligence check lists, model constitutions etc.</p> <p>Pilot early adopter PHCOs</p> <p>Distribute an internal Network tender to form PHCOs</p>
<b>Year 2</b>	<p>PHCOs announced and introduced (in phases)</p> <p>National agency established</p>
<b>Year 3</b>	<p>PHCO member agreements executed between national agency and PHCOs</p>

## Recommendations

1. Australian PHCOs should build on a strong general practice base. Integration with general practice, general practice engagement and strong clinical-managerial partnerships are essential to lead more organised primary health care in Australia
2. Australian PHCOs should be independent, not-for-profit regional entities. Independent organisations with clear accountability to communities, members and funders are the best option for driving locally responsive health care
3. Australian PHCOs should build on what exists and what works. The existing general practice network is the logical platform to establish PHCOs. They already have the national footprint, strong engagement with general practice and increasingly strong engagement with other providers and communities
4. It is essential that existing services and programs be maintained and extended: there should be no retraction in primary health care services as a result of PHCO introduction
5. To ensure this occurs, Government support is sought for proposed hub and spoke or branch arrangements which maintain existing GPN services and infrastructure
6. Where existing GPNs do not or cannot become PHCOs, to assist in maintaining their essential services additional models must be examined, involving transition of these GPNs into service providers where they can demonstrate their value adding contribution to the local health system, with a direct funding relationship to their regional PHCO
7. PHCOs should be introduced in stages with a view to full establishment by June 2012. Early adopter PHCOs should be funded and supported to pilot the various pathways to establishment and to evaluate flexible models which are responsive to local circumstances. A process to identify potential participants should commence as early as possible in 2010
8. An expression of interest process internal to the existing Network should be conducted to form all PHCOs
9. A transition support fund should be made available from July 2010 to support the development of appropriate legal, strategic and operational frameworks for PHCOs
10. There must be adequate recurrent funding for ongoing operations in order for PHCOs to fully and comprehensively fulfill their roles