
POLICY BRIEF

Recommendations for the future reform of Australia's Primary Health Networks (PHNs)

The Southgate Institute has developed the following recommendations for the reform of PHNs based on our research on regional primary health care organisations.

1. The **mandate of the PHNs** should be progressively broadened so that their primary roles are to:
 - a) Provide the necessary coordination and promote partnerships to ensure that access to health care is more equitable, and that the health system is integrated and less fragmented, and better able to meet the changing needs and expectations of the Australian community in relation to curative, rehabilitative and palliative care, disease prevention and health promotion
 - b) Contribute to the reorientation of their region's primary health care (including primary medical care) so that the health system aligns with the principles and practice of comprehensive primary health care and is better able to address the epidemic of chronic disease facing the Australian population. The reoriented system should include a balance of multidisciplinary clinical and population health approaches
 - c) Hear and respond to community voices about ways to improve the functioning of the health care system and advocate for broader system change
 - d) Work with state/territory/local governments and the community to determine unmet needs and plan ways to fill gaps in services so as to ensure equitable and integrated care and regional health promotion in a manner which reflects local needs and priorities, including using pooled funding where appropriate
 - e) Participate in needs based planning in Aboriginal health through the state and territory Aboriginal health planning fora
 - f) Assess the manner in which the social and commercial determinants of health are affecting the health of populations, and provide evidence-based health and social policy responses and facilitate local intersectoral action to address the impact of these determinants, and advocate to all levels of government for relevant change.

In order to do this the Primary Health Networks will need to be supported by the following processes:

2. **Much clearer, integrated federal, state and local government policy, frameworks and priorities**, endorsed and supported by COAG, to better guide and focus PHNs' work and encourage collaboration in priority setting, policies, planning, programs and funding
3. **Funding** – additional funding will be required to meet the PHNs' broadened roles suggested above, including more flexible funds to meet locally derived care and health promotion priorities, with a specific stream of funding for intersectoral collaboration on social determinants of health, and also funding (and associated policies) to encourage general practice and other PHC services to move to more comprehensive integrated models
4. **Governance** – representation on PHN boards and clinical and community advisory councils needs to better reflect groups identified as high need (including Aboriginal and Torres Strait Islander people, low income households, representatives of migrant and refugee communities, and young people). Overly tight departmental planning requirements need to be loosened so that clinical and community advisory council input can be linked through transparent processes to PHN decision making using IAP2 principles
5. **Consultation with communities** – PHNs need to use a range of mechanisms for consultation and especially to engage with community members living in disadvantaged circumstances whose voices are often not included. This should include engagement with relevant peak bodies representing community and consumer views
6. **Work with communities** – PHNs need to build community capacity and specifically collaborate to leverage the capacity of NGOs to build interventions that address health literacy, community engagement and collective work on the social determinants of health
7. **National Coordination of PHNs** – in order to reduce fragmentation and overlap, PHNs require a funded, nationally supported peak body to facilitate coordination, collaboration and shared learnings, to provide well-informed policy advice to the Federal Health Department, and to research and develop innovative approaches applicable to all or many of the PHNs
8. **Workforce capacity** – Comprehensive PHC and the work of the PHNs requires the supply of an appropriately trained workforce (for example adequate numbers of bilingual workers and a planned mix and geographic distribution of medical and allied health staff). The PHNs should be required to demonstrate through their KPIs that they have staff with experience and qualifications in population health and data analytic capacity. The Federal Health Department should assist in the development of these capacities

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9. **Commissioning** – open tender commissioning risks losing expertise and reducing valuable existing collaboration. Prior to commissioning processes, clear evidence-based service and program models need to be developed. The three-level commissioning approach, already utilised in some PHNs, should be required of all:
- (1) Targeted – specialist services with expertise (e.g. ACCHOs, migrant health services)
 - (2) Selected – where there are several possible services with appropriate expertise
 - (3) Open – as a last resort (and never for Aboriginal and Torres Strait Islander health services), and still requiring services to demonstrate relevant expertise, and where relevant, community relationships
10. **Reporting and accountability** should be simplified but allow for the collection of nationally comparable data and locally derived priorities and KPIs.

For more detail about this [research project](#).

For further information about the work of the [Southgate Institute](#).



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