

Medicare Local—Local Health Network partnerships in South Australia: lessons for Primary Health Networks

Medicare Locals (MLs) were one of the shortest-lived features of the Australian health care landscape, existing for just 4 years. In 2011, the federal government established 61 MLs. The major reasons for their establishment were to strengthen the multidisciplinary aspects of primary health care (PHC) and to improve population health planning — features identified as important in recent proposals for Australian health reform.¹ Contractual requirements for MLs included population health planning; needs assessments; and working with general practices, other health providers and state and territory health networks. A 2014 review of MLs criticised their performance, noting that they “failed to appropriately involve and engage GPs” and that there was “lack of clarity in what many Medicare Locals are trying to achieve” and “variability in both the scope and delivery of activities”.² The government responded by replacing MLs with a smaller number of Primary Health Networks (PHNs) that commenced operating in July 2015.

Inter-organisational networks are increasingly recognised in the literature as a useful approach for complex problems, and for sharing knowledge and resources.^{3,4} Such networks require leadership, careful planning, time and resources, and their value is more evident in the longer term than in the shorter term.^{3,5}

Local Health Networks (LHNs) are state-based entities partially funded by the federal government under the 2011 National Health Reform Agreement.⁶ One area emphasised in this agreement was the partnership between LHNs and MLs in delivering coordinated services.^{6–8} Despite the emphasis on collaboration, little is known about how MLs have negotiated with LHNs in population health planning. An evaluation of nine MLs across Australia revealed examples

Abstract

Objectives: To examine the partnerships in population health planning between Medicare Locals (MLs) and Local Health Networks (LHNs) in South Australia, and the factors that facilitated or constrained collaborations, to offer lessons for LHNs and Primary Health Networks.

Design, participants and setting: We conducted a qualitative study using individual interviews with key informants (executive or program leader staff) from the five South Australian MLs and the five South Australian LHNs. A total of 34 interviews were conducted between March and July 2014.

Results: Significant work was undertaken by MLs in the process of population health planning and needs assessment. Participants from both MLs and LHNs described examples of collaborative work, including data sharing and synthesis, program implementation and community consultation. The focus of LHNs on acute and intermediate care, the lack of system-level strategies to support collaboration, and constant policy and structural changes leading to uncertainty in the primary health care landscape were perceived as key barriers to collaboration.

Conclusions: The experience of MLs and their achievements in building relationships and trust with stakeholders in their regions, including LHNs, provide valuable lessons for the new Primary Health Networks in Australia.

of specific links, such as ML representatives being appointed to LHN governing councils. This evaluation identified a need for a framework that ensured that the funding and governance of LHNs did not undermine the goals of MLs.⁹ To enable high-quality and coordinated PHC, further efforts to make ML and LHN policies and protocols more consistent were recommended.¹⁰

This article examines whether MLs made any significant contributions to improving PHC services, with a specific focus on the effectiveness of their partnerships with state-funded LHNs in population health planning. Here, we report on partnerships between South Australian MLs and LHNs. We examined factors that facilitated or constrained collaborations, with the aim of providing lessons and recommendations for LHNs and the new PHNs.

Methods

We conducted interviews with between two and five key informants

from each of the five South Australian MLs and the five South Australian LHNs (a total of 34 people) between March and July 2014 (Box 1). Chief executive officers were asked to nominate key executive or program leader staff for interviewing. With the exception of the Women’s and Children’s Health Network, which is a statewide network, the other LHNs cover specific geographical areas.

The interviews explored population health planning processes, examples of successful collaboration, and participants’ perceptions of political and contextual factors that facilitated or constrained collaboration between MLs and LHNs. We specifically discussed needs assessment and population health planning processes in MLs, the scope and areas of collaboration between MLs and LHNs, features that made the collaborations work, and factors that would contribute to effective and sustainable working relationships between PHNs and LHNs in the future.

Interviews were audio-recorded and transcribed. We developed a coding

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1 Roles and locations of the 34 study participants, South Australia

Organisation	Participants interviewed (number)
Medicare Locals	
Central Adelaide and Hills	
Northern Adelaide	
Southern Adelaide—Fleurieu—Kangaroo Island	CEO/deputy CEO (3)
Country North SA	Senior executive (9)
Country South SA	Program manager (7)
Local Health Networks	
Central Adelaide	
Northern Adelaide	CEO (1)
Southern Adelaide	Director/manager (10)
Country Health SA	Former director (1)
Women's and Children's	Project officer (3)

CEO = chief executive officer. ♦

structure, and three interviews were double-coded by two researchers to establish the usefulness of the coding structure in terms of concept validity and coding consistency.

Ethics approval was granted by the Southern Adelaide Clinical Human Research Ethics Committee.

Results

Quotes in this section have been included to illustrate our findings; we have identified the participants by number (P1–P34) and health care role.

Considerable work in needs assessment and population health planning has been undertaken by MLs

We found that all MLs in this study had completed a comprehensive needs assessment and instituted population health planning processes (including collecting, collating and synthesising health and social data), engaged with local stakeholders (including community engagement to identify needs), set priorities according to the needs assessment data and, to a lesser extent, undertaken program and outcome evaluations.

We've taken a detailed look at the quantitative and qualitative data, and engaged with

communities, health providers and key stakeholders, [to] identify health needs, prioritise those and determine strategies to assist in addressing those in the future, a significant work (ML representative, P17).

The process was also reported as a capacity-building process for the ML workforce that brought together a variety of skills (eg, health informatics, statistics, population health planning) to synthesise data.

We first outsourced our population health planning and data analysis, but we have tried to build that capacity within the organisation around research and analysis, mapping and interpreting data (ML representative, P16).

Population health planning and program implementation facilitated positive collaborations between MLs and LHNs

The participants described a range of interactions between MLs and LHNs, including data sharing, joint community consultation sessions, program evaluation, and joint training activities. These were undertaken in different contexts, including steering committees, working groups and

informal relationships. Having to deal with five MLs was seen as more difficult for the statewide Women's and Children's LHN. [Box 2](#) lists areas and examples of collaboration between MLs and LHNs.

Participants noted the establishment of the Southern Adelaide Health Alliance (SAHA), drawing together the Southern Adelaide—Fleurieu—Kangaroo Island ML, the Southern Adelaide LHN, the Health Consumers Alliance of SA and the SA Ambulance Service in southern Adelaide, as an example of a strategic partnership that generated opportunities to enhance collaborative planning and fostered trust and reciprocity between the key stakeholders.

Through SAHA we have been able to develop resources and share ideas and plan jointly, that's [ie, the establishment of SAHA] been a very good thing to formalise partnership (ML representative, P11).

The focus of LHNs on hospital services constrains engagement in broader population health planning

Participants described the importance of the ML–LHN partnership in population health planning. Participants from both organisation types noted, however, that the focus of LHNs on hospital management and the associated pressures of dealing with acute care demands limited their opportunity for stronger engagement in the population health planning work of the MLs.

LHN is missing the mark in that it's still a sickness-focus rather than a wellness-focus ... the focus is on providing hospital services, not preventing the need for hospital services (LHN representative, P31).

The new funding model was reported as a factor moving LHNs away from population health activities. For example, the shift to activity-based funding (ie, funding allocated to specific, mainly clinical activities) within the LHNs raised concerns that LHNs were becoming

2 Areas and examples of collaboration between Medicare Locals (MLs) and Local Health Networks (LHNs) in South Australia

Area of collaboration	Examples
Data sharing and interpretation	LHN providing health data to corresponding ML; eg, data on after-hours care, emergency department admissions, and general population health data (in all five MLs) Discussions and meetings about data interpretation and use
Community consultation	Joint consultation sessions, or LHN or ML members attending consultation sessions as invitees, sharing information derived from consultation sessions (in four sites)
Collaboration in program planning and implementation	General support and referring clients to programs; eg, diabetes management, physical health fitness and men's health programs Collaboration between Aboriginal ML health staff and hospital Aboriginal liaison officers to identify and assist Aboriginal people leaving hospital to navigate primary health care services, and to provide broader social support (in four sites)
Monitoring and program evaluation	Development of an evaluation framework and key performance indicators to manage and monitor respiratory disease in the region (in one site)
Sharing the load of clinical care	Patient referrals from GP Plus centres (state-funded primary health care services) to ML, and vice versa, for mental health consultations (in two sites)
Training	Joint professional development sessions to train people in residential aged care facilities on emergency admissions; staff training in mental health (in two sites)
Funding support	ML provided funding to LHN to run an Aboriginal community event program or to implement outreach programs (in one site)

less involved in population and preventive care.

The withdrawal of funding for most health promotion programs and the reorientation of state-funded PHC services towards chronic disease management in South Australia in recent years¹¹ resulted in LHNs and state-funded PHC services moving further away from a population health approach.

What was PHC in the [region] has been devolved into hospitals within the past few years, so it is a very different agenda to the agenda that the MLs are working on (LHN representative, P34).

MLs were successful in engaging with a broad range of local PHC stakeholders

One of the major strengths of MLs mentioned by all study participants was their strong focus on engagement

with a wide range of stakeholders, including general practitioners, allied health professionals, pharmacies, local community members, non-government organisations, local governments and state-funded PHC services. This engagement assisted in identifying local health needs, and in prioritising and determining strategies that focused on those needs. The time and effort invested by MLs in establishing working relationships with local stakeholders was particularly appreciated by people working in LHNs. Most participants saw the broader community focus, multidisciplinary work and better integration of allied health services into the PHC system as a major accomplishment of MLs that further distinguished them from the previous Divisions of General Practice.

MLs have a broader focus on population health, are more inclusive of non-general practice services, have the ability to pull

in private and non-government organisations in a way that general practice divisions didn't have. It is a positive addition for the PHC landscape, it's important that more voices are heard than just those voices of the general practitioners (LHN representative, P20).

Health promotion and social determinants of health attracted little attention in action and collaborations between MLs and LHNs

We found no specific examples of collaboration between MLs and LHNs that were directed towards social determinants of health. Although some MLs had strategies that focused on such factors (eg, links with the transport and education sectors, employment of outreach workers), there was considerable variability in terms of funding, resources and capabilities that affected the capacity of MLs to attend to social determinants of health.

In the current policy environment, there is much confusion about who is responsible for health promotion in the PHC sector. Recent state policy changes have led to an emphasis on acute and intermediate care, with extensive cuts to funding of health promotion and community-based programs in LHNs. Most ML participants believed that they had neither the capacity nor the funding to fill the gaps in health promotion.

There had been a thought from LHNs that health promotion fell within MLs' mandate, but we're not funded to do that type of work, and that's still not clearly defined with the State Primary Health Care Plan (ML representative, P17).

Strong leadership and systematic support are required to initiate and sustain collaboration

There was general consensus among participants that, in most cases, opportunities for collaboration between MLs and LHNs relied on individual leadership rather than on systemic support and organisational structures.

Both ML and LHN staff felt the lack of formalised collaboration strategies was particularly challenging, given that state and federal governments had different strategy directions and priorities.

[opportunities for collaborative engagement] depended so much more on personality rather than systems. With a system support it's easy to integrate two different agencies, but, because the cultures of the two agencies are so different and more dependent on individual leadership, it's hard to progress at any pace faster than what it is now (ML representative, P3).

The meetings and relationship that I had with the ML have changed over time depending on personality and management style ... I don't believe the systems were there to set up the relationship (LHN representative, P30).

Continual policy changes and uncertainty in the PHC landscape constrained collaboration

Continual policy changes, restructuring, and uncertainty in both the state and federal PHC landscapes were frequently mentioned by ML and LHN participants as a barrier to collaboration.

Uncertainty around the structure of MLs means that some of the things that we might have progressed haven't been able to go forward as confidently as we wanted to, we don't want to be in a situation where we're compromising the ability to deliver health care, we're not certain about the funding or the structural future of MLs (LHN representative, P23).

One ML participant noted that workforce movement caused by the restructuring of PHC hindered retaining expertise and maintaining collaborations.

Losing or shuffling of key staff with historical knowledge has been a real barrier ... when you

lose the people, you lose the knowledge and you lose the relationship, and that is very much what's occurred in SA Health (ML representative, P1).

Discussion

During the short period of their existence, MLs in South Australia were successful in identifying local needs and building good relationships with a range of stakeholders and health providers, particularly GPs and allied health professionals. Our study reports examples of such collaborations, and provides some lessons that may assist PHNs during and after their establishment (Box 3).

The findings of this study in South Australia may not be generalisable to other Australian states and territories. We acknowledge that the extent of implementation and the sustainability of some of our examples are unknown. Moreover, our study is unable

to compare the relative achievements of MLs in developing partnerships and those of the previous Divisions of General Practice.

The Public Health Association of Australia and the Australian Health-care and Hospitals Association convened a series of PHC roadshows to identify opportunities, challenges and recommendations for the new PHNs. Some of our findings are consistent with the points raised in their report, including that "community needs assessment data should be utilised effectively", "partnerships should be formalised", and "PHNs must play a role as a change agent for health promotion, working with enabling organisations".¹²

It is essential that the good work of MLs in establishing trust and working relationships is not lost, especially given the possible cost to the Australian Government of dismantling the MLs has been

3 Lessons for Primary Health Networks (PHNs) drawn from our analysis

PHNs should:

- acknowledge, utilise and apply the comprehensive work undertaken by Medicare Locals (MLs) in local needs assessments and priority setting;
- seek to retain the population health workforce built during the brief existence of the MLs;
- view general practice as a key stakeholder but also build networks with other primary health care providers, and balance the views of general practitioners with those of other stakeholders who may have diverse or conflicting views regarding the role of primary health care organisations;
- devote resources to promoting engagement with Local Health Networks (LHNs) and other stakeholders, to develop strategic partnerships in planning and program implementation; and
- ensure that network activity achieves measurable short- and long-term benefits.

LHNs should:

- accept and welcome PHNs as essential community partners in an integrated health care system;
- develop joint understanding of the roles and responsibilities of PHNs and LHNs, including their roles in health promotion and addressing social determinants of health as key elements of comprehensive primary health care; and
- seek to form strategic partnerships with PHNs that aim to overcome differences in focus and culture and improve the coordination of primary health care.

State and federal governments should:

- recognise that PHNs and LHNs require long-term investment, funding, and organisational stability and support to ensure they have adequate time and certainty to build and maintain collaborations, and to evaluate the impact of collaborative work on population health equity and outcomes.

estimated by the Opposition as being more than \$200 million.¹³ Effective and sustainable collaboration is more likely when supported by strategic planning, strong leadership, stable organisational structures and effective networks that draw on strong personal relationships. Individual networking opportunities and the importance of personal working relationships must also be exploited to boost effective partnerships. Inter-organisational networks have shown early promise in facilitating collaboration (eg, the SAHA) but need evaluation and long-term commitment to ensure the sustainability that will increase their chances of contributing to improved health outcomes.^{3,14}

Health promotion and action on the social determinants of health are integral components of comprehensive PHC.^{15,16} Reviews of the health system in Australia have reinforced the importance of health promotion in reducing the impact of chronic diseases and mental illnesses, as well as demands on hospital services and the costs of the health system.¹⁷⁻²⁰ The World Health Organization Commission on Social Determinants of Health has also

emphasised the role of PHC in taking action on social determinants of health at a local level.²¹ Despite strategies in some South Australian MLs to support this area of activity, they were patchy and financially not well supported. The PHNs do not appear to regard health promotion and disease prevention as being within their area of responsibility, but our study suggests that it is important that they do.

Planning for population health, building trust and relationships, implementing programs and evaluating outcomes all require long-term investment, support and commitment that should be explicitly clarified in the objectives, contractual requirements and outcome measurement strategies of PHC organisations. As PHC operates in an unstable environment in which it is affected by constant policy changes, political influences and repeated restructuring of the health system, it is difficult to achieve its long-term objectives of improving health equity and population health.

The short lifespan of the MLs has prevented evaluation of their long-term impact and effectiveness.

As noted in the Public Health Association of Australia and Australian Healthcare and Hospitals Association report,¹² “stability is required in the system”. Fostering networks of the kind that MLs established in the past few years is a complex and time-consuming venture. A further round of reorganisation risks paralysing activity because of continuing uncertainty about the form and function of population health planning and the fear that the new structures may again be transitory. In this case, the gains and investments made will be lost to our health systems. This underlines the need for rigorous evaluation of any health care reforms, and for assessing the extent to which the reforms have helped to improve levels of equity, effectiveness, efficiency, quality and sustainability.

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Competing interests: Richard Reed has served on the board of the Southern Adelaide—Fleurieu—Kangaroo Island Medicare Local. He was not involved in the recruitment or interviewing of participants in this study. ■

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