
Strategic Management of Australia’s Primary Health Networks: Learning from Horvath’s Review

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Abstract

Australia’s on-going restructuring of primary healthcare is a critical strategic management exercise. In that restructuring; Horvath’s review introduced a shift from Medicare Locals (MLs) to Primary Health Networks (PHNs), with promises of more efficient approach towards an integrated healthcare. There are concerns regarding transparency of Horvath’s review and the inconsistencies between his opinion and that of previous Australian Medicare Local Alliance. Given that inconsistencies between stakeholders’ understandings could lead to faulty strategic management of Primary health networks, there is a need to study Horvath’s review in greater detail. This paper has analysed Horvath’s review, with an independent view, particularly, assessing the commonalities and differences between Horvath’s recommendations and the opinion of other ML reviews submitted by different stakeholders. A systematic approach was taken to select ML reviews from organisations that operate at a national level and lesser likely to be biased due to association with previous ML operations. Qualitative constant comparison technique was applied to code data from Horvath’s and other stakeholder’s ML reviews. Authors have identified points where Horvath’s recommendation could be embellished further and accordingly, proposed five themes as focus areas for planning of implementation of PHNs. These themes are: increased funding, reducing waste, multidisciplinary stakeholder management, performance measures and metrics and effective communication. This research has contributed to conceptualise the strategic management mapping of Ginter, Duncan and Swayne (2013), in the context of Australian primary health care. With the lens of such mapping, authors have also articulated each of the five themes, as described in the findings, for pragmatic learning regarding service delivery and support strategies for Primary health networks. The method and scope of this paper had to be curtailed because restructuring of Australian Primary Health Networks is an empirical issue and there was scarcity of peer-reviewed literature on this topic.

Keywords: Australian primary healthcare (I1), strategic management (M1), service delivery strategy (M1), support strategy (M1), Primary Health Networks (PHNs) (I1), Horvath’s review (I1)

1. Introduction

Primary healthcare can be the key to value for money and desirable health outcomes in a

health system (Gillam, 2008; Macinko, Starfield, & Shi, 2003). Hence, Australia's on-going restructuring of primary health care is a critical strategic management exercise of the country's health system. The Australian Primary Healthcare aims to provide customer focused and integrated care, working towards improved access, reduced inequity, prevention and early intervention mechanisms and quality care with accountability (Standing Council on Health, 2013). The stated aim of the sector are consistent with WHO's (2008) general goal of primary health care (World Health Organisation, 2008). However, Australia's journey towards an integrated primary health care seems too complex. A particular complexity has been the strategic decision to move from Medicare Locals (MLs) to Primary Health Networks (PHNs), corresponding to the change of federal government from Labour to Liberal in the 2013 Australian federal election.

The previous Labour government (The year 2007 to 2012) established MLs as non-profit organisations and funded it through a five-year federal budget of \$1.8 billion from the year 2011. MLs were expected to work with local communities and hospital networks, especially in areas of management of chronic diseases and avoidable hospital admissions and contributed to an integrated primary health care (Gable & Foster, 2013). By 2013; Australian Medicare Local Alliance (AMLA) declared MLs as a success story (Sprogis, 2013), while others were more cautious and perceived MLs in need of more time and fine tuning to meet relevant expectations (Gable & Foster, 2013). In midst of such opinions, in December 2013, the current Liberal federal government invited Professor John Horvath, the former Chief Medical Officer, to conduct a review of established 61 Medicare Locals(Dutton, 2013).

Professor Horvath's review on MLs was publicly published on March 04, 2014. The review provided significantly valuable information but at the same time, it signaled inconsistency between stakeholders' opinions regarding the restructuring of primary health care. As, in contrast to AMLA, he found that despite few successful MLs, the reform through MLs was "faulty and unsustainable" (Horvath, 2014, p. 16).In accordance to Horvath's review, the current federal Liberal government has announced to replace the MLs with 30 Primary Health Networks (PHNs) by July 2015(Dutton, 2014b). Horvath's review made ten recommendations to explain how PHNs should be configured and be more effective than previous MLs.

The purpose of this paper is to undertake an independent analysis of Horvath's review, particularly, assessing the commonalities and differences between Horvath's recommendations and the opinion of other ML reviews submitted by different stakeholders. Such exercise can scrutinise the strategic decision towards PHNs and harness learnings for strategic management of PHNs. It might be worth to justify that movement to PHNs is a strategic decision because it involves a deep commitment from various stakeholders and significantly influences the scope of primary health care in Australia (Shivakumar, 2014). Therefore, this paper's approach to discuss Horvath's review against the opinion of other stakeholders is a worthy step. Moreover, this is a timely exercise given that Horvath's review is being criticised for lack of transparency(Senate Select Committee on Health, 2014) and furthermore, inconsistencies between stakeholders' understandings could lead to faulty strategic management of Primary Health Networks(Ginter, Duncan, & Swayne, 2013)

Please note that in this paper for the sake of consistency, authors have replaced the term

“Primary Health Organisation (PHO)”, which was used in Horvath’s review, with “Primary Health Network (PHN)”. The term PHN was used for the same concept of PHO by the previous Minister of Health and Sports, in his media release dated October 15, 2014 (Dutton, 2014b).

2. Method

Research method for this paper can be explained in three main phases; one, selection of Medicare Local Review submissions from different stakeholders; two, studying Horvath’s review and understanding his recommendations, and three, analysing the selected Medicare Local Review submissions against Horvath’s recommendations. The selection criteria for the Medicare Local Review submissions were that the documents are: available online, of English language, of Australian context, generated within the date range of December’2013 to March’2014 and lastly, from stakeholders who operate at national level and do not belong to either individual Medicare Locals or the AMLA. The criterion for date range was defined according to previous Minister of Health and Sports’ call for Medicare Local review and publication of that review i.e. Horvath’s review; which effectively screened documents specifically submitted for Medicare Locals review. The criterion regarding stakeholders was necessary to screen information that are not confined to state-specific situations and furthermore, lesser likely to be biased due to association with previous Medicare Locals operations.

Given that ML Review submissions are not peer reviewed documents, the authors found only two suitable databases i.e. Trove and Google. In the absence of any archived database for documents submitted for ML reviews (Senate Select Committee on Health, 2014), the chosen process was deemed credible. Terms for the search were Medicare, Locals, Review and Submissions with the first two words in a quotation. Document search in the Google database with the search terms initially resulted in 20,300 hits. Once the selection criteria for the date range and a country parameter of Australia was applied, through the search tool, it resulted in 164 hits. Another level of screening with the criterion regarding stakeholders, which authors had to apply manually, arrived at the final selection of twenty review documents. The same process of the search was repeated with Trove database, which led to two reviews that were already found through Google. The Table 1 has listed all the reviews of MLs included in the research analysis. It should be mentioned that the no. of reviews covered in this study is not sufficient to present a generalised picture of the opinion of MLs in the Australian primary health care. In any case, the proposition of generalizability is not suitable to the qualitative research design of this paper. Rather the intention is to capture a snapshot of the opinion of MLs by investigating insights of the specific stakeholders. Authors find that the twenty reviews covered in this paper have provided rich insights, touching on the perspectives of various health practitioners, including key registered professions, (e.g. AMA, APNA); chronic disease specific bodies (e.g. Kidney, Diabetes); academic health bodies (e.g. Universities Australia, ACHI), health advocacy bodies (e.g. AHHA, CHF) and health bodies with rural focus (e.g. SARRAH, RDAA).

The second phase, studying Horvath’s review, was conducted by each author at individual level first. Upon few readings of the Horvath’s review, each author proceeded to extract data according to ten recommendations made by Horvath. Author’s understanding of the extracted data was summarised following manual deductive coding process (Onwuegbuzie & Combs,

2010, p. 409); with each code representing one of Horvath's ten recommendations and covering data from the review and author's notes. A joint discussion took place, between two authors, once each author was comfortable with their own understanding of Horvath's recommendations. In these joint sessions, authors amended their notes for each code by comparing individual's understanding of Horvath's recommendations and sorting out ambiguities in the reviews. The tasks described in this phase till now reflect the initial step of coding in the technique of constant comparison analysis (Onwuegbuzie & Combs, 2010). In accordance to the constant comparison, researchers can systematically organise qualitative data into codes and then draw themes to reflect meaning of a phenomenon (Boyatzis, 1998; Onwuegbuzie & Combs, 2010).

Table 1: Medicare Local Reviews covered in the research analysis

| Sl. | Code | Name of the stakeholders conducting the review | Date of Review Publication |
|-----|------|---|----------------------------|
| 1 | A | Professor John Horvath | March, 2014 |
| 2 | B | Australian association of social workers(AASW) | December, 2013 |
| 3 | C | Australasian College of Health Informatics (ACHI) | December, 2013 |
| 4 | D | Australian Healthcare & Hospital Association (AHHA) | December, 2013 |
| 5 | E | Australian Healthcare Reform Alliance (AHCRA) | December, 2013 |
| 6 | F | Australian Medical Association (AMA) | December, 2013 |
| 7 | G | Australian Primary Healthcare Nurse Association (APNA) | December, 2013 |
| 8 | H | Consumer Health Forum of Australia (CHF) | December, 2013 |
| 9 | I | Councils on the Aging (COTA) | January, 2014 |
| 10 | J | Diabetes Australia | December, 2013 |
| 11 | K | Kidney Health Australia | December, 2013 |
| 12 | L | Medical Deans Australia & New Zealand | January, 2014 |
| 13 | M | National Rural Health Alliance Inc. (NRHA) | December, 2013 |
| 14 | N | Palliative Care Australia (PCA) | December, 2013 |
| 15 | O | Public Health Association Australia (PHAA) | December, 2013 |
| 16 | P | Royal Australian College of GPS | December, 2013 |
| 17 | Q | Royal Flying Doctor Service | January, 2014 |
| 18 | R | Services for Australian Rural and Remote Allied Health (SARRAH) | December, 2013 |
| 19 | S | Universities Australia | December, 2013 |
| 20 | T | Australian osteopathic association (AOA) | December, 2013 |
| 21 | U | Rural Doctors Association of Australia (RDAA) | December, 2013 |

The third phase, analysing selected ML reviews against Horvath's recommendations, was conducted jointly between two authors. The initial task was to continue with the deductive coding process, as described in phase two. Once all the twenty ML reviews (as shown in Table 1) were coded according to Horvath's recommendations, the agreed results were summarised in table format. At this stage authors decided to focus only on eight of ten recommendations of Horvath; leaving out the recommendations for renaming Medicare Local and the need to review the after hours' program. Analysis of these two recommendations could not offer much value addition, as the name change in the recommended direction has been well established by now and the after-hours program is already under a formal independent review.

The Table 2 in the result section is an accumulation of the results from the joint sessions. The next task was to develop themes, which involved interpreting the coded information according to authors' perspectives and need of the context. In this paper, authors felt that the most important need of the context was to articulate learning for strategic management of restructuring of primary health care. Accordingly, authors of this paper generated themes of strategic management for PHNs (i.e. Increased funding, waste reduction, multidisciplinary stakeholder management, measures and metrics and effective communication) in points where Horvath's recommendations could be embellished further to tackle the criticalities indicated in the other ML reviews. It is understandable that the drawn themes are subjective to authors' perspectives of the context. However, authors feel that the sessions of joint analyses between the two authors mitigated possible researcher biases in this paper (Creswell & Plano Clark, 2007).

This research was exempted from human research ethics approval, as advised by the office of research services at the University of Tasmania. The exemption is due to authors' reliance on archival data that are publicly available.

3. Results

In this section, analysis of the twenty national reviews of MLs from different stakeholders, as listed and coded in Table 1, are compared with the recommendations made by Horvath's review. The following Table 2 is a summary of this comparison, where the rows are describing Horvath's relevant, eight out of ten, recommendations. The heading of the columns is displaying codes for specific stakeholders. The symbols in the columns indicate whether opinions of each of the twenty reviews are either similar or offered important clarifications regarding Horvath's recommendations. A blank space in Table 2 reflects that the point was not addressed in that specific stakeholder's review of ML.

All the reviews from the twenty stakeholders were in line with Horvath's first recommendation, as placed in row 1 of Table 2, that is, PHNs should integrate patient care across the entire health system. Such support towards this recommendation implies that PHNs are facing a huge scope of work. In Table 2, eleven of the stakeholders are recorded with the symbol "✓", since they clarified certain important points. One such clarification is that PHNs would need to provide greater attention to quite a number of areas. Examples of such areas are: palliative care needs according to PCA; chronic disease care coordination at grass roots level according to APNA; targeted health promotion and illness program in rural and remote

according to NRHA; planning for aged care according to COTA; ongoing education for health workforce for better clinical outcomes and referral pathways, according to both Kidney Australia and Medical Deans of Australia & New Zealand and clinical placements and supervision for community-based health professionals according to Universities Australia. Some reviews e.g. APNA, NRHA & PCA made cases that PHNs should be assured with continued and increased funding in order to cater to medium to long-term time strategies. Accordingly, authors would like to highlight, “availability of funding” as a critical strategic factor for supporting PHN’s wide scope of work.

Table 2: Summary of twenty ML reviews against Horvath’s recommendations

| According to Horvath, PHNs need to | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U |
|--|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 integrate care of patients across entire health system | • | ¥ | • | ¥ | ¥ | ¥ | • | ¥ | ¥ | ¥ | ¥ | ¥ | ¥ | • | • | • | • | ¥ | • | • |
| reinforce GPs as cornerstone of integrated | ¥ | ¥ | ¥ | ¥ | • | ¥ | ¥ | ¥ | ¥ | ¥ | ¥ | ¥ | ¥ | ¥ | X | ¥ | ¥ | | ¥ | ¥ |
| 2 primary care | | | | | | | | | | | | | | | | | | | | |
| 3 have no government funded national alliance i.e. AMLA | | | | | • | ¥ | | | • | | | | | ¥ | • | | | | | |
| 4 have contestable establishment process; skill based regional boards with regions’ characteristics; meaningful engagement across health; clear performance expectations | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • |
| 5 engage with established local & national clinical bodies | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • |
| 6 be merged into high performing regional bodies, aligned to LHNs with operational units comprising of Clinical Councils & Community Advisory Committees | | | ¥ | | | | | | | | | ¥ | | | | | ¥ | | | |
| 7 have performance indicators for outcomes that are aligned with national priorities & primary healthcare data strategy | • | ¥ | • | ¥ | • | • | • | • | ¥ | ¥ | • | • | • | • | • | • | • | • | • | • |
| 8 provide services for demonstrable market failure, absence of services or with significant economies of scale | • | • | • | • | • | • | • | ¥ | • | • | • | • | • | • | • | • | • | • | • | • |

Note: “•” indicates similar opinion to Horvath’s review; “¥” indicates important clarifications in the review; blank space indicates that the review did not directly address the point

Horvath was positive regarding increased funding through PHNs, as he stated:

To maximise the return on investment in PHOs, it may be possible for the Commonwealth to provide PHOs with increased flexible and programme funding. Opportunities exist to devolve further responsibilities from the Department of Health or other agencies to PHOs. The advantage of this approach is two-fold, first additional funding through PHOs will increase their authority and leverage to effectively engage with the primary health care sector, LHNs and jurisdictional governments; and second, local decision-making is likely to deliver greater benefits to patients and a higher return on Commonwealth investment(Horvath, 2014, p. 13).

The above statement confirms that increased flows of funding through PHNs are likely to consolidate PHN’s strength to generate greater return for Local Health Networks (LHNs), Commonwealth and patients. However, it should be ascertained whether addressing the wide scope of work of PHNs requires not just an increase in the flow of funding, but, more importantly, efficient use of funds with reduced healthcare wastes? Some of the ML reviews did

indicate exhibits of waste e.g. Diabetes Australia informed that MLs did not connect to National Diabetes Services Scheme database which could have avoided repeated work to identify diabetes patients; ACHI expressed that ML's tele-health directories should have been coordinated with the National Health Service Directories by AHRA and AMA found ML's to be burdened with non-productive administrative practices. *Based on these results, authors find that the themes of increased funding and waste reduction should be priority agendas for strategic management of PHNs.*

Horvath's second recommendation for PHNs to refocus on GPs as cornerstone came across to be a necessity in the ML reviews from stakeholders. Along with this recommendation, Horvath had expressed frustration that GPs were not adequately empowered in the governance of previous MLs. Only AMA had similar frustration as Horvath, regarding empowerment of GPs, as shown in Table 2 with the symbol of "●" in row 2 and column F. Notwithstanding, other stakeholders voiced the crucial point that GP-led movement has to go hand in hand with the multidisciplinary team approach. AOA explained that the analogy of the term "cornerstone" (p.5) should mean that GPs are the first point that get constructed in a building, but in the functioning of building that point is as important as the other ones. Most of the reviews e.g. AASW, AHHA, AHCRA, AOA, APNA, COTA, Diabetes Australia, NRHA, PHAA, PCA, Royal Flying Doctor Service and SARRAH endorsed the need for a multi-disciplinary integrated approach around patient and family needs, alongside GP's engagement. The review of Royal Flying Doctor clarified that multi-disciplinary approach can be crucial, particularly for rural and remote areas where GPs are in shortage.

ACHI in their discussion of healthy advised of another insight, that is, PHNs should be accommodative of business perspective of private practice GPs, as the following quote explains:

The College is aware that many GPs and others healthcare practitioners are willing – in some cases desperate - to become involved with Medical Locals. However, they need tangible and intuitive systems that provide immediate benefits to their practices. The majority of GPs are private businesses and need to clearly see the immediate benefits of any service offered by Medial Locals, else they may well be shown the door(Australasian College of Health Informatics, 2013, p. 7)

The above quote is interesting as it amplifies the need for "immediate benefits" to GPs in the relationship between GPs and PHNs. However, other ML reviews from medical practitioners e.g. AMA and Royal Australian College of GPs do not mention such immediate benefits but asserts that there should be lesser administrative processes to facilitate meaningful and regular engagement between GPs and PHNs. The review from RDAA clarified that the relationship between previous MLs and GPs have become problematic as previous MLs were given too challenging responsibilities e.g. after hour services, too early with minimal consultation with GPs. Furthermore, RDAA claimed that previous MLs involvement with after hour services generated uncertainty of continued funding, particularly for rural GPs. Therefore, the authors' analysis is that the key to the collaborative relationship between GPs and PHNs is beyond the matter of immediate benefits. The matter possibly trades into PHNs operating with regular consultation with GPs on a platform that is less administrative but more viable, financially as

well as clinically, for a GP-led multidisciplinary health team. Authors find that the future of PHNs would have to tackle the issue of GP leadership and multidisciplinary health team carefully. It should be mentioned that Horvath's suggestion for PHNs to operate with guidance from community advisory committees and GP-led clinical councils is a good step to managing multidisciplinary stakeholders towards the common purpose of integrated health services. Such step has the potential to facilitate regular engagement between stakeholders from different disciplines e.g. the key registered professions through the clinical Council and the academic and advocacy bodies through the community advisory committee. *On the basis of results presented for Horvath's second recommendation; authors conclude that the theme of multi-disciplinary stakeholder management is another crucial strategic management issue for PHNs.*

Regarding the third recommendation, the withdrawal of Commonwealth funding for Australian Medicare Local Alliance (AMLA) (row3 in Table 2); there were three reviews i.e. AMA, Diabetes Australia and Royal Australian College of GPs (RACGP) that specifically identified AMLA's inability to integrate primary care at national level. Since these stakeholders opinion is similar to Horvath's, they are recorded with the symbol of "●" in Table 2. The following statement from RACGP provided useful information of AMLA's situation:

Each Medicare Local has a unique governance structure and negotiated contracts with Government. Medicare Locals have operational autonomy, and as such, AMLA's role is merely advisory. Therefore, AMLA has limited authority to direct Medicare Locals to any course of action and cannot serve as an effective point of national coordination for the unified provision of primary care (Royal Australian College of GPs, 2013, p. 2).

On the other hand, PHAA and APNA were still hopeful of how AMLA could play a critical role in upholding quality and efficiency in the PHNs. Horvath's review proposed that such guidance to PHOs can come from existing national bodies such as National Health and Medical Research Council (NHMRC) and the Australian Commission on Safety and Quality in Health Care. Accordingly, he did not see a rationale for the Commonwealth to fund AMLA for national coordination or propagation of best practices. Considering the Commonwealth expense for AMLA, about \$4 million per annum (Horvath, 2014), the authors find Horvath's propositions can lead to cost-effective approach for national coordination in primary care. Furthermore, Horvath's guideline to align PHN's performance with national priorities, in accordance to recommendation 7 in Table 2, can make PHNs more supportive towards necessary national coordination even without the existence of AMLA. *Therefore, authors find that Horvath's third recommendation is a fitting step for the implementation of the theme of wastage reduction in the strategic management of PHNs.*

Most of the national reviews had support for Horvath's remaining recommendations, as placed in rows 4 to 8 of Table 2. Horvath's recommendation to merge previous MLs into high-performing regional PHNs, recommendation 6 in Table 2, showed a path for smaller no. of PHNs in Australian primary healthcare. His rationale was that smaller no. of PHNs can release resources for frontline services, reduce the administrative tasks, and allow PHNs to enjoy economies of scale in working with the local health districts. It should be mentioned that while there were support for Horvath's idea of high performing PHNs, the matter of reduced no. of

PHNs was not an agenda in any of the submitted reviews, as depicted with blank space in Table 2. Moreover, the point of resource dedication to front line services needed further precision as identified in the reviews of AHHA, NRHA and SARRAH. These reviews discussed how certain cases, e.g. the primary healthcare organisations in remote areas, can involve clinical tasks which are dependent on funding of the associated administrative ones. Furthermore, SARRAH proposed to track the funding for the administrative and clinical tasks by a ration that is sensitive to the location of PHNs. Authors find that SARRAH's proposition reflects learning from the functioning of previous MLs and could be reinforced in Horvath's review.

Authors' analyses reveal few more matters that required better clarity than what was attempted in Horvath's review. One such matter is "clear performance expectation"; which is embedded in the recommendations 4, 6 and 7 in Table 2. Clarity in performance expectations seems critical as most of the reviews expressed concern regarding the variation in previous ML's performances. Horvath made a general suggestion for PHO's performance expectations, that is, performances should be streamlined with national priorities and the relevant reporting to be aligned with the outcomes of the local health networks. Notwithstanding, the review from ACHI indicated that more concrete performance evaluation framework would be beneficial in future; especially as previous MLs had worked on evaluation frameworks for its operations, administration, and outcomes. The reviews from Diabetes Australia, Kidney Australia and AHCRA discussed utility for performance indicators along the line for prevention of care and engagement with NGOs and the local community. *Therefore, authors find that the theme of performance measures and metrics is necessary for strategic management of Primary Health Networks.*

Similarly, the recommendation of PHNs to provide service only for situations such as demonstrable market failures, recommendation 8 in Table 2, could earn better clarity by engaging with suggestions made in the submitted reviews. It is not to say that this recommendation was not supported, since most of the stakeholders stated that PHNs should not be duplicating services or disrupting any existing service providers. However, the reality is that incidents of duplicate services is not uncommon as identified in different reviews, including that of AMA, AHHA, ACHI, Diabetes Australia and Horvath. The review of CHF further explained that PHOs are justified to disrupt existing service providers if it results in better value for consumers. Such wide reporting of duplication/disruption of services reflected a need for clear communication regarding what is a market failure and how the concept should be applied to assess whether any of the existing duplications of services are justifiable. Horvath failed to address this need as he continued to use the term "market failure" vaguely, leaving the task to draw parameters around it for later. *Hence, another strategic management theme for Australian primary health care networks is the effective communication of the processes to avoid duplication/disruptions of services.*

In summary, the above description of Horvath's recommendations, in light of the reviews of other stakeholders, reveal five critical themes for the strategic management of PHNs. These five themes are: increased funding, reducing waste, multidisciplinary stakeholder management, performance measures and metrics and effective communication.

4. Discussion

Harnessing learning from stakeholders' insights can facilitate understanding of shared purposes and guide restructuring journeys in a positive direction (Finney, 2013). Accordingly, this paper has analysed reviews of MLs between that of Horvath and other stakeholders to generate learning for a strategic move in the Australian Primary Health Care i.e. the shift from Medicare Locals to Primary Health Networks.



Figure 1: Five themes for strategic management of PHNs

Ginter et al., (2013; pg. 12) mapped the context of strategic management with three elements: one, Strategic thinking, the fit between an entity's vision and the external environment; two, Strategic planning, that is, the decision making regarding situational analysis, strategy formulation and planning the implementation of vision; and three, Managing strategic momentum, that is, the day to day activities of managing the strategy for achievement of goals. Before proceeding to discuss learning for strategic management of PHNs, it would be beneficial to place the five themes identified in the result section according to Ginter et al.'s (2013) mapping of strategic management. On the basis of evidence placed in the result section, authors perceive certain degree of harmony in the strategic thinking and planning of the PHNs. For instance, the comparison of ML reviews revealed shared understanding between Horvath and other stakeholders that PHN's vision is about an integrated primary care that should operate on a GP-led multidisciplinary health services network and achieved effective care across the entire health system. However, the strategic planning of PHNs was only partially in harmony, since the implementation of PHN's faced unresolved criticalities. Hence, the authors would like to present the five themes as focus areas for latter part of strategic planning, specifically the planning of implementation of PHN. According to Ginter et al., (2013), such planning should comprise of service delivery strategies, support strategies and associated action plan to enhance the value chain of PHN. The value chain of each PHN needs to be streamlined with customer-driven service delivery strategies such as lesser administrative hassle for patient's access to primary care. Then again, the service delivery strategies will require relevant support strategies and

actions e.g. increased financial and human resources to ensure each PHN's chain of activities are creating the value of integrated and effective care. While strategic management of PHNs from the value chain perspective is a magnanimous concept and beyond the scope of this paper, it is still beneficial for readers to be oriented with such concept. That way, readers are not kept ignorant of the big picture of the planning of implementation of PHNs.

As has been depicted in Figure 1, the proposed five themes for PHN implementation plan can influence not only the element of strategic planning but also the other two elements of strategic management of PHNs (i.e. strategic thinking and managing strategic momentum). Since the three elements of strategic management are interdependent, and movement in one element can generate rework in the other elements (Ginter et al., 2013). The remaining task for authors is to elaborate the five themes and articulate learning for strategic management of PHNs.

4.1 Increased funding through Primary Health Networks

This theme is about the support strategy to collect increased funding for the wide scope of work of PHN. In 2011-12, the primary care funding was split as 59.7 % Government, inclusive of Federal, State and Territories, and 40.3% non-government (Australian Institute of Health and Welfare, 2014a). As the Federal government has been increasing its share of funding for primary care (Australian Institute of Health and Welfare, 2014b), it makes sense to approach this theme from other options, that is, funding from the non-government or private sector.

This paper would like to concentrate on one such funding technique, that this, private insurance fund in the primary care since the topic is attracting great attention (Dutton, 2014a). Weiner, Famadas, Waters and Gikic (2008, p. 1116) explained that private insurances usually operate in three different ways: i) as substitute to the public program, releasing the government from major financial responsibilities of the public program ii) as complement to the public program so that partial fund of the associated public programs are released and iii) as supplement to the public program, providing alternative to public funding to finance areas of need beyond the current public programs. Authors perceive private insurance in primary care can be a value adding support strategy, only if PHNs can strike a favourable combination from the three options of Weiner et al., (2008). A favourable combination of private insurance should reflect cost effective service delivery and quality care for the wide spectrum of primary healthcare needs. PHNs will need to plan actions of integration between health service providers (e.g. General Practitioners and hospitals) and private insurances, achieving shared administrative work and reasonable financial incentives between these stakeholders. Therefore, in the implementation plan for PHNs, authors foresee PHNs as regional representatives, carrying the gate keeper's role and guiding the private insurance organisations. The other issue to highlight is the prospect of private insurance bodies (e.g. Medibank Private and Bupa) joining the sector as PHNs (Rollins, 2014). Authors would advocate such prospect should demand rework on strategy formulation of PHNs i.e. a specific policy framework from government to ensure private insurance bodies are adhering to intended objectives of PHNs. Without such specific policy framework, the gatekeeper's role in the primary healthcare sector can be distorted if private insurance bodies operate as PHNs. Therefore, the learning is, private insurances can be a value adding support strategy for funding the primary health if policies endorse each player (e.g.

PHNs, the health service providers and private insurance bodies) with responsibilities that are in line with PHN's vision.

4.2 Reducing waste

This theme is about reducing wastes through efficient processes of service delivery strategies in each of the 30 PHNs. While Australian health system's record on efficiency seems better than average, a 10th position in a group of 21 OECD countries (Afonso & Aubyn, 2006), definitely more can be achieved through careful restructuring of the primary health networks. There is literature that provide frameworks to identify different types of healthcare wastes such as administrative, operational and clinical (Bentley, Effros, Palar, & Keeler, 2008). It should be kept in mind that element of administrative and operational wastes e.g. non-productive administrative work for GPs, as revealed in the result section, can jeopardise the pre-service points and ultimately block service delivery for customers in primary health. Hence, an important learning comes across to be the mapping of the service processes according to customer and service provider's perspectives, along the framework of wastage identification and reduction framework. Again, the proposed value adding service delivery strategy might require rework on strategic thinking. That is, going back to the previous efforts of primary healthcare restructuring and availing the huge information of: regional need assessments, utilisation of resources by regional programs and national databases of pooled funds; to arrive at chain of value-adding processes that are free from waste. While the government has been vocal about reducing waste through PHNs (Dutton, 2013), the proposed mapping of processes can be a concrete action in this regard.

4.3 Multidisciplinary stakeholder management

The multidisciplinary stakeholder management is an inherent strategic management issue for PHNs, given the wide scope of work of the entity. On the strategic management mapping of Ginter et al. (2013), the matter of multidisciplinary stakeholder management would sit across the service delivery and support strategies of PHNs. For instance, the service delivery strategy of PHNs should have established processes to facilitate regular consultation and required contribution to patient and community care from necessary stakeholders e.g. GPs, nurses, allied health practitioners and other representatives from disease specific and rural-focused bodies. Similarly, the organisational structure of PHNs, which is a component of support strategy, should allow participation of required stakeholders in the operations of PHNs. As mentioned in the result section, authors believe that Horvath's suggestion for PHNs to operate with guidance from community advisory committees and GP-led clinical councils provide the necessary organisational structure for effective stakeholder management. However, greater initiatives of service delivery strategies are required, in order for PHNs to take benefit of the proposed organisational structure.

Horvath's recommendation has been in favour of the doctors, which is justified given that this stakeholder commands high level of power and urgency (Mitchell, Agle, & Wood, 1997) over the functioning of PHNs. However, as the result section has identified, the functioning of PHNs is dependent on other stakeholders as well. Hence, specific initiatives are needed to motivate the GPs towards a multidisciplinary team dependent service delivery strategy in primary care. These

initiatives should meet the financial and clinical focus of the GPs and moreover, be hassle free in involving other stakeholders in the service delivery. Therefore, the learning to conclude on this theme is that PHNs can be GP-led as long as the GPs facilitate multidisciplinary service delivery strategies.

4.4 Performance measure and metrics for PHNs

In line with the findings in the results section, another imperative theme for strategic management of PHNs is the clarity of performance expectations. Certain elements that are essential for the functioning of specific performance criteria in PHNs are “measure” and “metric”; which refer to the combination of objective and subjective assessments of what is important at the levels of service delivery and support strategies in a specific context (Stange et al., 2014; Stange & Ferrer, 2009).

The service delivery strategies of PHN need to be guided by specific criteria of customer satisfaction. For example, the National Health Performance Authority (2013) had reported performances of MLs in seven peer groups with criteria such as health status of adults and patient’s use and experiences with the GPs. Authors propose to expand such performance criteria to other service areas e.g. accessibility and quality of service of allied health workforce and apply the criteria to assess service delivery strategies for PHNs. In order for the proposed service delivery strategies to work, the support strategies of PHNs will require the associated strategic resources (e.g. human resources, information technology) and a constructive rather than punitive culture for performance management (Stange et al., 2014). The other point of learning is that measure and metrics also have a role for the third element of strategic management i.e. managing momentum for change. Once measure and metrics are set for the service delivery and support strategies of PHNs, then it can provide direction for day to day activities of PHNs as well.

4.5 Effective communication

This theme involves maintaining communication with the relevant health service providers, managers and customers during the implementation of PHNs. The aspect of this theme can be quite broad, but in this paper, in line with the research result, the authors have discussed the theme narrowly i.e. only about the communication of the concept of market failure as a way to sort out duplications of services through PHNs. Till now, the process to identify market failure and associated management of duplications through PHNs has not been well communicated by the government (Senate Select committee on health, 2014). The literatures (Arndt, 1988; Bator, 1958) and the current government’s communication are not clear whether market failure is an absence of service provider in a market that is too costly to serve or existence of an inefficient service provider that failed to take benefit of economies of scale.

Similar to above-proposed learnings, authors advocate approaching effective communication for the given situation both at the ends of service delivery and support strategies of PHN. As part of communicating the service delivery strategy of PHNs, there is a need to move away from the term “market failure”. Instead, PHN’s service delivery strategy should communicate two specific points for the health service providers and managers. One, in what

situations PHNs can seek approval for direct service delivery and two, what criteria are suitable to assess whether an existing service is unjustifiable. Additionally, the customers of primary care should be informed what measures are in place to tackle unavoidable service disruptions due to the closure of duplicated services. In regards to support strategies for PHNs, resources such as interim financial fund and human resources should be kept to manage the closure of duplicated services and transfer the clients to the preferred source of service. The proposed actions seem quite urgent for the sake of avoiding waste of well-spent resources in the on-going restructuring of primary health care (Senate Select committee on health, 2014). Therefore, the simple learning in this theme is to prepare for specific and targeted communication of the ways PHNs will deal with the existing duplication of services.

The above discussion of the five themes for strategic management of PHNs is an independent view of the authors and draws on insights of different stakeholders and literature. Interestingly, discussion of most of the themes showed opportunities to take benefit of some of the works of previous MLs. Therefore, this paper reiterates that strategic management is activated through learning from past experiences. Additionally, the discussion of learnings in the five themes reflected interdependency between support and service delivery strategies, as well as the three elements of strategic management. All of which should help the readers appreciate the nature of complexities in the strategic management of PHNs. Notwithstanding, authors are hopeful that genuine effort to work on the proposed learnings will provide a sense of progression in the evolving journey of Australian PHNs.

5. Limitations

The method and scope of this paper had to be curtailed because restructuring of Australian Primary Health Networks is an empirical issue and there was scarcity of peer-reviewed literature on this topic. However, authors have applied a systematic research approach, as mentioned in the method section, and presented specific evidence from stakeholders to mitigate possible limitations. However, authors would like to highlight that the five themes of strategic management presented in this paper is never expected to be an exhaustive solution for PHNs.

6. Conclusion

The 2014 Horvath's review of MLs is the guide book of the current government for the restructuring of Australian primary health care. The healthcare sector can face more fragmentation than before if Horvath's recommendations for PHNs are not implemented with a well-thought process of strategic management. This paper has presented an unbiased view of the alignment between Horvath's recommendations and that of other national reviews of MLs and articulated specific learnings for strategic management for PHNs. More discussions of this nature can make positive contribution to Australia's journey for an integrated primary health care.

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9. References:

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