Commissioning and equity in primary care in Australia: views from Primary Health Networks

Abstract

This paper reports findings from 55 stakeholder interviews undertaken in 6 Primary Health Networks (PHNs) in Australia as part of a study of the impact of population health planning in regional primary health organisations on service access and equity. Primary health care planning is currently undertaken by PHNs which were established in 2015 as commissioning organisations. This was a departure from the role of Medicare Locals, the previous regional primary health organisations which frequently provided services. This paper addresses perceptions of 23 senior staff; 11 board members and 21 members of clinical and community advisory councils or health priority groups from 6 case study PHNs on the impact of commissioning on equity. Participants view the collection of population health data as facilitating service access through redistributing services on the basis of need and through bringing objectivity to decision making about services. Conversely, participants question the impact of the political and geographical context and population profile on capacity to improve service access and equity through service commissioning. Service delivery was seen as fragmented, the model is at odds with the manner in which Aboriginal Community Controlled Health Organisations (ACCHOs) operate and rural regions lack services to commission. As a consequence, reliance upon commissioning of services may not be appropriate for the Australian primary health care context.

Keywords: Primary Care Networks, commissioning, equity, health services, Australia.

What is known about the topic.

- Commissioning is used as a means of creating efficiencies and cost saving through competition between service providers
- Commissioning is viewed as increasing service equity through strategic planning
- Commissioning has had little impact on health outcomes

What this paper adds

- Commissioning may inhibit service equity in Australia as responsibility for service delivery is fragmented, appears particularly inappropriate when Aboriginal community controlled services are available and in rural regions which lack services to commission.

Introduction

This paper explores the relationship between commissioning and equity through data from 55 key informant interviews with participants from six Primary Health Networks. Equity for the purposes of this paper relates to equity of access. Equity of access has been associated by Thiede et al. (2007) with the availability, affordability and acceptability of services (Freeman et al. 2011). Availability relates to geographical accessibility but also to social and physical barriers to service access; affordability to service costs including transport costs and acceptability to the perceived appropriateness of a service to meet care needs (Freeman et al. 2011; Nelson & Park 2006). Recent policy changes have been associated with a reduced commitment to equity of access to primary health care services in Australia (Freeman et al 2016). One contributing factor has been the election of a Federal Coalition government with a policy agenda of increasing market competition for health service delivery (Henderson et al. 2016). A strategy for opening the primary health care system to market forces is the introduction of service commissioning through competitive tendering for service delivery. Booth and Boxall (2016: 3) define commissioning as "strategic purchasing decisions based on local health needs, priorities and service availability, and service quality". Commissioning is based on a separation of the purchaser from the provider of the services (Checkland et al.2012). It is underpinned by an understanding that efficiencies and cost saving can be achieved through competition between service providers (Booth & Boxall 2016; Gardner et al, 2016) and that priority setting will result in improved service integration and service delivery to at-risk populations (Robinson et al 2016).

Commissioning relies on three activities: strategic planning, contracting services and service evaluation (Gardner et al. 2016). Strategic planning involves making decisions about the health needs of a population, the services to be provided and capacity of providers to deliver

that service (Checkland et al. 2012). The planning process is viewed as a means of increasing equity of access to services through locating services in underserved areas and ensuring the affordability of those services. Strategic planning depends upon the collection of population health data to identify gaps in service delivery. There are limitations to these data. Wenzl et al (2015) argue service utilisation is viewed as proof of service access and health status as a measure for service need ignoring unmet need but also other factors, including social determinants of health.

Service commissioning in primary health care has been used in other contexts. Both the United Kingdom (UK) and New Zealand have a history of commissioning primary health care services. Commissioning in the UK has its roots in attempts to reduce health spending in the 1980s through creation of an internal market in the National Health Service (NHS) (O'Flynn & Potter 2012). This involved channelling funding through a local health authority with responsibility for purchasing care for their population. The most recent of these, the Primary Care Trusts (PCTs), involved service commissioning for populations of approximately 300,000 people (O'Flynn & Potter 2012). The election of a conservative government in 2010 resulted in the replacement of PCTs with Clinical Commissioning Groups (CCGs) led by GPs. This change was promoted by the view that clinicians would have a better understanding of health needs. These changes are seen as a means of increasing the professional autonomy of clinicians through constituting CCGs as statutory bodies at the same time ensuring greater accountability to patients (Checkland et al. 2013).

Similar changes have occurred in New Zealand. New Zealand has a mixed health care system with both public and private service provision. In 1993 the national government established four Regional Health Authorities (RHA) to commission services on a competitive basis from publically owned Crown Health Enterprises (hospitals, public health units) and private service providers. In 1997, the focus shifted from competitive tendering to

collaboration and the RHAs were incorporated into a single Health Funding Authority (HFA). In 2001 the HFA was replaced by 21 District Health Boards (DBH) which manage health service delivery at a local level and Primary Health Organisations (PHOs) were established as planners and commissioners of primary health care services. The establishment of PHOs was accompanied by the enrolment of New Zealanders with a general practice (GP) and channelling of all public funding for primary health care including GP services, through the PHOs enabling the development of a wider range of services (Cumming 2016; Finlayson et al 2012).

Commissioning in the UK has generally been viewed as making little difference to both healthcare outcomes and service delivery. Failures have been identified in the planning, procurement and evaluation phases of the commissioning cycle and largely focus upon shortfalls in implementation rather than shortfalls in the approach to care delivery (Hudson 2011; Checkland et al. 2012; OFlynn & Potter 2011). A number of reasons have been offered for failure including the tension between competition for funding between service providers and the development of integrated care; the quality of data upon which decisions are made; poor preparation for the commissioning role; loss of relationships through restructuring of services; power imbalances between service providers and commissioners; and the prevailing culture of the NHS which inhibits market forces (Checkland et al. 2012; Hudson et al 2011; Wenzl et al 2015). The end result observed by Hudson (2011) has been increased fragmentation and service rivalries. New Zealand has faced similar issues with additional difficulties arising from the small and geographically dispersed population and insufficient funds to meet the needs of lower income PHOs (Cumming 2016).

Primary health care in Australia

Australia currently has Primary Health Networks (PHNs) which were established by the Federal Coalition government in 2015 to replace Medicare Locals in planning and coordinating primary health care. The expressed purpose of PHNs is to provide "an efficient and effective primary health care system" through integrating care particularly for "those at risk of poor health outcomes" (Department of Health 2015). The primary means of improving health outcomes is through population health planning and service commissioning (Booth & Boxall 2016; Robinson et al 2016). PHNs do not have a direct role in service provision but rather work with existing services in both the public and private sectors to improve service continuity (see Figure 1).[1] PHNs receive funding from the Federal government to commission services for their local region. The majority of this funding is tied to specific programs with a limited pool of flexible funding. All PHNs are required to undertake a comprehensive needs assessment to identify at-risk and underserved populations. The needs assessment and service planning documents developed on the basis of the needs assessment are then reviewed by the Federal government. Once approved, services are commissioned to meet identified gaps in service delivery. This is a departure from Medicare Locals which often provided services although some MLs already fully or partially commissioned services.

There are features of an Australian system which impact capacity to commission services and to use commissioning to improve equity of access. Australia has a Federal system of government with both public and private health service providers. The constitution enforces a division of labor in which the public provision of secondary and tertiary health services is a

[1] Services outlined in blue are funded and provided by government while services outlined in orange are privately provided services which receive some government funding for service provision. The arrows indicate the nature of the relationships. PHN are answerable to the Federal government and work collaboratively with other services.

State government responsibility, funded by both State and Federal governments. The Federal government primarily shapes health services through targeting funding through existing services in the public and private sector. The provision of primary care is the province of private fee-for-service general practices that are primarily funded by the Federal government through Medicare rebates with an increasing out-of-pocket contribution and Primary Health Networks which plan but do not provide services (Department of Health & Ageing 2010). Local governments are a third level of government and provide very limited health services concerning vaccination and home care but may play an important role in addressing heath inequity through addressing social determinants of health (Fisher et al 2016).

Figure 1 about here

Petrich et al. (2013) argues that the Federal system leads to systemic fragmentation and contributes to fragmentation and perceived duplication of service delivery. The Federal system means that PHNs have to work with State and Territory governments as service providers in commissioning services. This is a barrier to equity of access as there may be more or fewer services to draw upon dependent upon the State or Territory government. Further, the Federal system results in PHNs only managing a small percentage of the total health care budget (see Table 1) which limits their capacity to effect change in the secondary care system (Robinson et al 2016).

Secondly, Australia has a dual primary health care system with mainstream services largely provided by general practices. The Aboriginal Community Controlled Health Organisations (ACCHOs) provide an alternate system. The average life expectancy of an Aboriginal and Torres Strait Island Australian is approximately 10 years less than a non-Indigenous Australian with Aboriginal and Torres Strait Islander people experiencing higher rates of chronic illness (AIHW 2014). ACCHOs were first established in the 1970s in response to

discrimination within mainstream, the poorer health status of Aboriginal and Torres Strait Islander peoples and to address service access (see Griew et al. (2004) or Scrimgeour (1997)). The ACCHOs provide a major source of primary health care for Aboriginal and Torres Strait Islander people with Medicare data suggesting a 50-50 split with general practice, with higher ACCHO usage in rural and remote regions (Panaretto et al 2014). These services provide comprehensive primary health care in a culturally appropriate setting (Gajjar et al 2014). Jowsey et al. (2012) in a study of a metropolitan ACCHO noted for example, that the waiting room often acted as a meeting place for informal exchange of health information and that time was used more flexibly than mainstream services. The community is involved in governance of the services and care is team based rather than GP focused (Panaretto et al 2014).

A third key difference is the geographical dispersion of the population. Australia has one of the lowest population densities in the world. The Australian Bureau of Statistics determines remoteness on the basis of distance by road to 5 types of service centres (Hugo Centre for Migration and Population Research *nd*). In 2015 71% of the population resided in Major Cities. Of the remaining population 2.2% live in remote or very remote areas and 26.8% in inner or outer regional areas. (ABS 2016). Rural residents generally experience poorer health outcomes associated with the ageing of the rural population (Farmer et al 2012), extended waiting times for General Practitioner appointments and limited access to specialist health services and support services (Allen et al 2012; Vaganes et al. 2009). Aboriginal and Torres Strait Islander people are disproportionately concentrated in rural and remote regions areas where they are widely dispersed (65% of Aboriginal and Torres Strait Islander people vs 29% of non-Indigenous people live in rural or remote regions), with 44% living in regional areas, and over 20% living in remote or very remote areas of Australia (ABS 2011).

This paper addresses the advantages and disadvantages of commissioning as a means of increasing equity of access in primary health care service delivery in Australia. Using data from key informant interviews, we argue that the Australian political, population and geographical context inhibits the capacity to use commissioning to achieve equity of access.

Methods

This paper draws on key informant interviews conducted approximately 12 months after the establishment of PHNs (May to August 2016). Data for this study were collected across 6 Primary Health Network case study sites with varying histories with commissioning of services (see Table 1). The case study sites covered rural and metropolitan populations and were situated in different states. Semi-structured key informant interviews were conducted with 55 representatives of the six PHNs comprised of: 23 senior staff of the PHNs; 11 board members and 21 members of clinical and community advisory councils or health priority groups which are community groups with an interest in a specific aspect of health that advise the PHN on that issue. Participants were recruited via email with support from the management of the PHNs. The interviews were of 30-60 minutes duration and were conducted by phone by three members of the research team. Ethics approval for the case studies was obtained from the [university] ethics committee. Information sheets and consent forms were sent to all participants prior to the interviews and verbal consent sought from participants prior to recording. The interviews addressed the transition process from Medicare Locals to Primary Health Networks; issues of governance and power; population health planning; equity; and work undertaken with three equity groups: Aboriginal and Torres Strait Islanders; people with mental health problems and new migrants and refugees. The interviews were transcribed verbatim.

Table 1 about here

Data were analysed inductively using thematic analysis with data managed by NVivo10 (Fereday & Muir Cochrane 2006). The coding frame was developed by review of four transcripts by two team members working independently and collating of the codes and is loosely based on the interview guide. Where conflicting views were evident a third coder was asked to review the transcript. The remaining transcripts were coded by the first author with feedback from the research team. Data for this paper were drawn from a theme related to commissioning. This theme was recoded for incidents where commissioning was discussed in relation to equity. The data is presented using a letter to identify the PHN and number to identify the individual (eg: C4 is the fourth person interviewed at case study site C) to protect the anonymity of the interviewee and the PHN.

Results

Analysis of the data identified three ways in which commissioning was viewed as facilitating equity and five barriers to equity arising from the commissioning process (results summarised in Table 2 below).

Table 2 about here

Facilitating equity in PHNs

In identifying the advantages of commissioning respondents drew upon the perceived benefits of a market model of service delivery for improving service equity. The primary advantage of commissioning was viewed as reduction of conflict of interest through the separation of the purchasing and service provision role. Direct service provision by PHNs was seen by respondents as leading to competition with other service providers detracting from a capacity for collaborative planning. For one respondent "*as soon as they [Medicare*

Locals] started offering services for themselves, they actually became a competitor with those very agencies that they were meant to be fostering collaboration among."(C4). For another respondent competition undermined trust through distorting market relations.

> *I think it's impossible to actually be a service delivery provider as well as a commissioner without there being some level of conflict of interest. And, probably the most significant impeding factor is the trust, that if you are actually seeking to do the services yourself, then you're very quickly going to lose the trust of other organisations that feel you're manipulating the market so to speak*. (D1).

Service provision was also viewed as detracting from service planning. A third respondent stated "*when you're the doer and the contractor of different services, it's difficult to focus on …aspects of service delivery*" (E12).

Respondents also saw the commissioning process as having the potential to lead to greater objectivity around decision making concerning the services to commission. Objectivity was associated with the strategic planning process and identification of populations in needs of services but also with effective service evaluation. One respondent identified the role of strategic planning in promoting service access. "*I think commissioning is going to allow us to bring a lot more objectivity into it and allow us to really focus [upon] those key underpinnings such as access"* (E12). Another respondent associated commissioning with the power to effect change through evaluation of services improving health outcomes.

> *I've never seen any change to the way things are done, unless it's purchased in a different way. So if you're purchasing with much more power, with much more data, with much more opportunity to actually evaluate what the effectiveness of your purchasing is, then the chances are that you will start to build up a database that says, "This works, this doesn't."* (C2).

A third and final advantage of commissioning was the capacity to specify, through the tendering process, the types of services and service approach that were required. This capacity was being used in some instances, to ensure that the services had the relationships in

place to deliver collaborative care (F3) and that service providers represented the broader community.

> *There's a requirement that diversity is thought of and different groups are represented by people that are tendering or being contracted to do the services, and that if that's not demonstrated then those services are not going to get up and are not going to become commissioned* (E14).

Barriers to equity

Five barriers were identified by respondents which highlight the impact of policy, population and geographical factors upon the capacity of commissioning to improve health equity.

Many respondents identified concerns with lack of funding (see table 1) but also with the extent to which funding is tied to specific programs resulting in limited flexibility to respond to local needs in innovative ways. A respondent in discussing moves to channel all primary mental health funding through PHNs stated that:

> *My concern is that the PHNs are provided with particular streams of funding that are the same old types of services, and they're not resourced to be able to be innovative and reform in ways that doesn't just leave us with just a few pieces shifted around the chess board* (D17).

Another respondent noted that while PHNs received additional funds to provide mental health services they only "*end up with a couple of million dollars to actually then commission that is actual[ly] flexible*"(A1).

A second concern identified by respondents was the impact of commissioning on delivery of Aboriginal and Torres Strait Islander Health Services. The advent of the commissioning process was viewed by some, as formalising and bureaucratising relationships (D18). This was viewed as being at odds with the ways in which Aboriginal and Torres Strait Islander communities work. PHNs were also required to collate data and complete a comprehensive needs assessment by March 2016. This deadline was viewed as inhibiting planning through

lack of sufficient time for community consultation. A respondent with a long history in working in Aboriginal health services noted that the short timeframes for development of the needs assessment undermined the manner in which services usually work:

> *…time is always the key to doing things properly[in the Aboriginal health sector], and so it kind of goes against the grain for organisations that have been working so hard to engage communities, to now say 'but just for the moment, we're just going to do it really quickly and then we'll come back and do it properly'. It's like 'oh no we've just worked out a process with communities to engage them and not be in a hurry, now we have to be in a hurry again'* (B10).

The short term funding cycles associated with commissioning were also viewed as having a detrimental effect on relationship building insofar as it contributed to clinician turnover undermining community trust in services (B16). Concern was also expressed about the impact of competition on Aboriginal Community Controlled Health Organisations (ACCHO). While some PHNs were situated in States where government policy ensured ACCHOs were the provider of choice for Aboriginal health services it was noted that "*that is their grave fear, that they [ACCHOs] will have to compete with other non-government organisation*s" (B15). This is the case in some instances. A respondent from one PHN indicated that "*funding that's for access engagement of Aboriginal communities, not necessarily that will go to an AMS [Aboriginal Medical Service that may or may not be community controlled]. The AMS may not be best positioned to provide that service"* (F3). Where this occurred however, it was expected that the successful service have strong links to an ACCHO. This approach is in line with the principles developed by the Federal government to guide relationships between PHNs and ACCHOs. In these principles the use of a range of publically and privately owned organisations is recommended with services largely (but not exclusively) provided by an ACCHO (Department of Health 2016). A final issue related to loss of or relocation of employment for Aboriginal Health Workers that had previously been employed to deliver services by Medicare Locals. This issue was identified by respondents in two PHNs.

> *I'm aware of a number of other PHNs as well who had employed an indigenous workforce under that program and now the suggestion is obviously they won't be able to employ people to deliver that work. So yeah, that's definitely a challenge* (A5).

A third issue which was identified by respondents in PHNs with smaller, geographically dispersed and rural and remote populations was access to services to commission. A respondent from a PHN with a rural population stated that:

> *We already have had and will continue to have real problems with getting both providers that are suitable as well as providers who are prepared to go to the regions we need them to go to provide the services* (E2).

Another respondent from a PHN servicing remote and very remote populations noted that commissioning is "*predicated on there being things to commission. So in a lot of the areas that we're covering, there's not anything to commission*" (F11). Capacity to provide services to rural and remote regions was further disrupted by job insecurity for employees who were previously employed on fixed term contracts moving to commissioned services. In one site delays in establishing new contracts and competition for service delivery led to a loss of clinical expertise as clinicians sought other, more secure job opportunities (F4). Furthermore, two of the PHNs in this study with large rural and remote populations were built on partnerships between the major service providers. This creates potential for conflict of interest as both experience limited access to other services to commission.

> *I probably would say that one of the challenges, one of the things that I don't believe our organisation has got its head wrapped around is where we sit in the stakeholder engagement conversation. So as this, this commissioning organisation really our partners are the services providers* (B15)

To counter lack of service availability one PHN was offering tenders which combined rural and urban service delivery while anticipating a need for continued service provision through the PHN to meet local needs in communities in which services could not be commissioned (E2).

Related to service availability is concern with the commissioning of services with limited

understanding of the local context. This issue was raised by respondents from both rural and metropolitan PHNs. A respondent from a metropolitan PHN states that "*we don't want the large multi-nationals competing because they won't understand the contex*t" (C4) while a respondent from a rural and remote PHN raised issues about the capacity of rural organisations to compete with larger service providers leading to loss of local expertise and employment opportunities (F7). Loss of local understanding was viewed as particularly problematic when working with Aboriginal and Torres Strait Islander populations. A third respondent working in a PHN with a large remote Aboriginal and Torres Strait Islander population stated that:

> *It's going to be a challenging piece going forward because from both ways, our providers, so some of the AMSs we work...would absolutely and probably quite appropriately tell you that they know their region and their people and their population better than anyone and so they should be doing the engagement with community and developing the service planning and doing the elements around needs assessment* (B15).

A final barrier to effective commissioning relates to the impact of commissioning upon relationships with other organisations and clinicians, focussing upon the impact of competition, service evaluation and decommissioning on capacity to work collaboratively with other organisations to effect improvements in health. Respondents identify "*a tension between competition and collaboration*" (F4) that is also recognised by service providers.

> *They [the PHN] are commissioning so therefore our engagement with them is when we need to ask for funding, that's how we deal with them. You know what I mean? So it becomes I think another arm of a Commonwealth department.* (D18)

Respondents identify tensions arising from services which are not funded as they cannot meet tendering requirements but also due to a responsibility to evaluate service provision.

> *….everyone had the opportunity to work and be commissioned to do work, but we were very clear that we wanted particular outcomes, particular KPIs and a particular culture and approach, so that not everyone was going to fit in with that* (A3).

> *And that, that expectation needs to shift as well, both from a PHN but also from a provider's perspective is that, you know, it is reasonable to expect programmatic*

> *evaluations, services evaluations to demonstrate the evidence of, you know, outputs let alone outcomes* (B15).

Respondents also highlighted the impact of service decommissioning on relationships. Concerns were raised about managing the process of decommissioning particularly when health providers had a commitment to an organisation.

> *The difficulty is actually what we're not going to do, rather than what we're going to do. For example, let's say in mental health we say, "Look, this particular service doesn't work. The outcomes are no better…We need an organisation that's prepared to operate in the following way. And guess what? We don't need that organisation," then the difficulty that we've got is decommissioning. Because as you know, what will happen is that health providers will start to lobby that their particular service, which has done so many wonderful things for many years and for so many people is now no longer getting any money* (C2).

Commissioning was also viewed as impacting negatively upon clinicians. The respondents from the clinical and community advisory councils were often service providers. One noted that in moving from being an employee of the Medicare Local to a commissioning role they were incurring costs that were previously covered by the organisation (B16). Professional competition was also a factor. GPs in particular, were concerned with the impact of commissioning which might mean they lose the delivery of certain services to other health professionals. One respondent who worked as a GP stated that "*I'm a little bit worried whether some of those jobs may be handed out to non-medical people, when it's clearly previously been a GP's role to manage a lot of those things*" (B9). He viewed the employment of other professions to provide primary health care as having:

> *…a danger of fragmenting general practice…and giving it to non-medical people to do that job and fragmenting primary health care and GPs losing more of their continuity of care, which is their strength* (B9).

Discussion

This paper has explored the way in which commissioning is viewed as a barrier and facilitator of equity in PHNs in Australia. Equity for PHNs primarily relates to equity of

access. Wenzl & Mossialos (2016) argue that a focus upon equity of access has become the norm as equity of outcomes is viewed as depending upon social determinants of health which are outside of the remit of health services. Equity of access for the purposes of this paper is associated with the availability, affordability and acceptability of services. While limited information is publicly available about the purpose of PHNs, the Department of Health (2015) identify a need to improve the health outcomes of sick populations through "ensuring patients receive the right care in the right place at the right time". Despite this, the interviews provide evidence that the commissioning process may impact negatively upon the availability and accessibility of primary health care services. Our respondents identified issues arising from the Australian political context, population profile and geography as inhibiting equity of access. These will be addressed in turn.

Gardner et al. (2016) in a review of literature note that effective commissioning relies on a clear policy framework, engagement by service providers and consumers, and flexibility in responding to changing conditions. The political context in Australia is complicated by an additional layer of government which requires PHNs to negotiate different policy contexts. The goal of improving health outcomes through co-ordinated care requires PHNs to work with state run hospitals and health care providers whose priorities and interests may be at odds with the Federal government and with local government. Fisher et al (2016) in a review of policy found that intersectoral policies primarily addressed health service access issues with little evidence of interdepartmental co-operation and attempt to address structural inequities. Improving health service access is also a primary goal of the PHNs. However, different levels of engagement by State and Territory governments in primary health care have the potential to lead to different outcomes between PHNs, contributing to unequal access to primary health care services.

Secondly, these interviews suggest that commissioning has potential to undermine existing service relationships. Respondents identify a tension between competition and collaboration with service evaluation and decommissioning of services highlighted as creating concerns for PHN employees. This has been evident in other contexts. Hudson (2012) argues that service competition and continual restructuring of services have contributed to fragmentation of services and loss of networks in the UK. Service commissioning is also viewed with distrust by clinicians and particularly by GPs who fear competition for service delivery. McDonald et al (2011) argue that private service providers such as GPs have a different approach to health than government services in that they seek results for specific patients while government services have a population approach. Working with GPs may not be the most cost effective solution, and a focus upon individual rather than population outcomes may be an impediment to the commissioning of GP services.

Thirdly, capacity to address equitable service availability is impacted by funding. Our respondents identified a lack of flexibility in funding arrangements, particularly in relation to mental health, due to ongoing financial commitments to existing programs such as HeadSpace (Ley, 2015; McGorry et al. 2016). Lack of funding flexibility leave PHNs with limited scope to address local needs identified in the needs assessment. Responsibility for funding for community mental health support services for example, was previously administered centrally but was devolved to PHNs with respondents identifying limited funding to commission new and innovative mental health programs (Ley, 2015).

Other barriers relate to spatial and population issues. Gardner et al. (2016) note that commissioning in Australian primary health care has traditionally been used to provide services to populations that have been underserved (eg: rural and Aboriginal and Torres Strait Islander populations). In this study these populations were identified as being penalised by

the commissioning of services. Respondents identified concerns about competition with ACCHOs for service delivery to Aboriginal and Torres Strait Islander communities. This is a reality in some contexts. Gajjar et al (2014) state that the Queensland government has explored the option of using services that are not community controlled to deliver care to Aboriginal and Torres Strait Islander people. Our respondents identify a formalisation and bureaucratisation of management and funding processes which is at odds with the manner in which ACCHOs operate. ACCHOs are governed by local communities and are responsive to community needs. Current funding models require ACCHOs to adopt a proactive approach to managing at-risk populations with continued funding dependent upon meeting externally established health outcomes (Gajjar et al 2014).

Issues were also raised about service continuity due to commissioning and potential for loss of work for Aboriginal Health Workers. ACCHO provide comprehensive primary health care using multi-disciplinary teams including Aboriginal Health Workers (Panaretto et al 2014). Aboriginal Health workers are also employed to work with general practice to support chronic disease management (Britt et al 2013). Data from this study suggest that Aboriginal Health Workers were employed by Medicare Locals to liaise with general practice about cultural safety and provide services where ACCHOs were not available. Employment of Aboriginal Health Workers has been associated with greater clinic attendance and greater compliance with self-management of health for Aboriginal and Torres Strait Islander people (Si et al 2006). Loss of staff and in particular, Aboriginal Health Workers is likely therefore, to contribute to poorer health outcomes and may compromise the acceptability of services for Aboriginal and Torres Strait Islander people.

A final issue relates to the availability of services to commission. Rural communities were identified as lacking services to commission and issues were raised about the commissioning of external service providers who lack local knowledge at the expense of local service

providers who are unable to compete for tenders. Crotty et al (2012) found that health services in rural communities often rely upon informal networks based upon existing personal relationships and shared knowledge to improve service delivery and collaboration. This may be a barrier for external service providers who are not part of these networks potentially reducing service access for health consumers.

Limitations

This study draws upon interview data from six PHNs which were chosen to represent a range of contexts and service types. Nevertheless the data may not be generalisable to all PHNs. In addition, data collection occurred within a year of establishment of the PHNs, prior to a full commissioning cycle and access to data assessing the success of the commissioning model in addressing inequities is not currently available. As such, the paper reports the barriers and enablers of equity identified by PHN personnel and Board members.

Conclusion

This paper has reviewed the views of key stakeholders in PHNs of the impact of commissioning on achievement of equity of access. Respondent's identified a number of political, population and geographical features of the Australian context which make achievement of equity through commissioning more difficult. Among these are the impact of a Federal system in which secondary and tertiary health services are provided by State and Territory government; funding and service models that work against the interests of ACCHOs; and regions with limited access to services to be commissioned. All suggest that a market model may not be the best option for primary health care in Australia.

References

Allen, J., Inder, K., Lewin, T, Attia, J & Kelly, B (2011) Social support and age influences distress outcomes differentially across urban, regional and remote Australia: An exploratory study. *BMC Public Health.* 12: 928.

Australian Bureau of Statistics [ABS] (2016) 3218.0 - Regional Population Growth, Australia, 2014-15, Canberra: ABS.

Australian Bureau of Statistics [ABS] (2011) 3238.0.55.001 - Estimates of Aboriginal and Torres Strait Islander Australians, Canberra: ABS.

Australian Institute of Health and Welfare [AIHW] (2014) Mortality and life expectancy of Indigenous Australians 2008 to 2012. Cat. no. IHW 140. Canberra: AIHW Available at: http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129548468. Accessed 22/2/2016.

Booth, M. & Boxall, A. (2016) Commissioning services and primary health networks, *Australian Journal of Primary Health,* 22(1): 3-4.

Britt, H., Miller, G. C., Henderson, J., Bayram, C., Valenti, L., Harrison, C., ... & O'Halloran, J. (2013). *General Practice Activity in Australia 2012-13: BEACH: Bettering the Evaluation and Care of Health* (No. 33). Sydney University Press.

Checkland, K., Harrison, S., Snow, S., McDermott, I & Coleman, A. (2012) Commissioning in the English National health Service: What's the problem?, *Journal of Social Policy*,41(3): 533-550.

Checkland, K., Allen, P., Coleman, A., Segar, J., McDermott, I., Harrison, S., Petsoulas, C. and Peckham, S., (2013) Accountable to whom, for what? An exploration of the early development of Clinical Commissioning Groups in the English NHS. *BMJ open*, *3*(12), p.e003769.

Crotty, M.M., Henderson, J., & Fuller, J. (2012) Helping and hindering: Perceptions of enablers and barriers to collaboration within a rural South Australian mental health network, *The Australian Journal of Rural Health*, 20(4): 213-218.

Cumming, J. (2016) Commissioning in New Zealand: learning from the past and present, *Australian Journal of Primary Health* 22(1): 34-39.

Department of Health (2016) Primary Health Networks (PHNs) and Aboriginal Community Controlled Health Organisations (ACCHOS) –Guiding principles

Department of Health (2015) PHN background, http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Background (accessed 22 Sept 2016)

Department of Health and Ageing (2010) Building a 21st Century Primary Health Care System: Australia's First National Primary Health Care Strategy, Commonwealth of Australia: Canberra.

Farmer, J., Prior, M. & Taylor, J. (2012) A theory of how rural health services contribute to community sustainability, *Social Science & Medicine,* 75: 1903-1911.

Fereday, J. and Muir-Cochrane, E. (2006) Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International journal of qualitative methods*, *5*(1): 80-92.

Finlayson, M.P., Sheridan, N.F., Cumming, J.M. and Fowler, S.(2012) The impact of funding changes on the implementation of primary health care policy, *Primary health care research & development*, *13*(2):120-129.

Fisher, M., Baum F., McDougall, C., Newman, L., McDermott, D. & Phillips, C. (2016). Intersectoral action on SDH and equity in Australian health policy, *Health Promotion International*, DOI: https://doi.org/10.1093/heapro/daw035

Freeman, T., Baum, F., Lawless, A., et al. (2016) Revisiting the ability of primary healthcare services to respond to health inequity, *Australian Journal of Primary Health,* 22: 332-338.

Freeman, T., Baum, F., Lawless, A., Jolley, G., Labonte, R., Bentley, M & Boffa, J. (2011) Reaching those with the greatest need: how Australian primary health care service managers, practitioners and funders understand and respond to health inequity?, *Australian Journal of Primary Health,* 17: 355-361.

Gardner, K., Powell Davies, G.et al. (2016) A rapid review of the impact of commissioning on service use, quality, outcomes and value for money: implications for Australian policy, *Australian Journal of Primary Health*, 22(1): 40-49.

Gajjar, D., Zwi, A., Hill, P.& Shannon, C. (2014) A case study in the use of evidence in a changing political context: an Aboriginal and Torres Strait Islander health service re-examines practice models, governance and financing, *Australian Health Review*, 38, 383-386.

Griew, R. W., B. Sibthorpe, et al. (2004). On Our Terms: The politics of Aboriginal health in Australia. Accessing Health Care: Responding to Diversity. J. H. H. J.McKee. Oxford, Oxford University Press: 257–280

Harris, M. (2016) Strengthening prevention in primary care, *Public Health Research & Practice*, 26(1): e2611600.

Henderson, J., Willis, E.M., Xiao, D., Toffoli, L. and Verrall, C.C. (2016) Nurses' perceptions of the impact of the Aged Care Reform on care services for residents in multi-purpose services and residential aged care facilities in Rural Australia, *Australasian Journal on Ageing*, DOI: 10.1111/ajag.12343

Hudson, B. (2011) Ten years of jointly commissioning health and social care in England, *Journal of Integrated Care,* 11, 1-9.

Hugo Centre for Migration and Population Research (nd). ARIA (Accessibility/Remoteness Index of Australia), https://www.adelaide.edu.au/apmrc/research/projects/category/about_aria.html (Accessed 1 March 2017).

Jowsey, T., Yen, L., Ward, N., McNabb, J., Aspin, C.,Usherwood, T. & SCIPPS team (2012) It hinges on the door: Time, spaces and identity in Australian Aboriginal health services, Health Sociology Review, 21(2), 196-207.

Ley, S. (2105) A new blueprint for mental health services www.health.gov.au/internet/ministers/...nsf/.../health-mediarel-yr2015-ley151126.htm, Accessed Oct 2016.

McDonald, J., Davies, G., Jayasuriya, R. & Harris, M (2011) Collaboration across private and public sector primary health care services: benefits, costs and policy implications. *Journal of Interprofessional Care*, 25: 258-264.

McGorry, P.D., Goldstone, S., Pennell, K. and Hamilton, M., 2016. Response to Allison et al.,'The National Mental Health Commission Report: Evidence based or ideologically driven?'. *Australian and New Zealand Journal of Psychiatry*, *50*(1): 11-12.

Nelson, C. & Park, J. (2006) The nature and correlates of unmet health care needs in Ontario, Canada, *Social Science & Medicine,* 62:

O'Flynn, N & Potter, J. (2011) Commissioning health care in England: an evolving story, *Annals of Internal Medicine*, 155: 465-469.

Panaretto, K., Wenitong, M., Button, S & Ring, I. (2014) Aboriginal community cotrolled health Services: leading the way in primary care, *MJA,* 200(11): 649-652.

Petrich, M., Ramamurthy, V.L., Hendrie, D., & Robinson, S: Challenges and opportunities for integration in health systems: an Australian perspective. *Journal of Integrated Care*. 2013; 21(6): 347-359.

Robinson, S., Dickinson, H. & Durrington, L. (2016) Something old, something new, something borrow, something blue? Reviewing the evidence on commissioning and health services, *Australian Journal of Primary Health,* 22(1): 9-14.

Scrimgeour, D. (1997).Community control of Aboriginal health services in the Northern Territory, Menzies Occasional Papers. Alice Springs, Menzies School of Health Research. 2

Si, D., Bailie, R. S., Togni, S. J., d Abbs, P. H., & Robinson, G. W. (2006). Aboriginal health workers and diabetes care in remote community health centres: a mixed method analysis. *Medical Journal of Australia*, 185(1), 40.

Vagenas, D., McLaughlin, D & Dobson, A: (2009) Regional variation in the survival and health of older Australian women: A prospective cohort study. *Australian and New Zealand Journal of Public Health*. 3(2), 119-125.

Wenzl, M., McCuskee, S. & Mossialos, E. (2015) Commissioning for Equity in the NHS: Rhetoric and practice, *British Medical Bulletin,* 115, 5-17.

Wenzl, M. & Mossialos, E. (2016) Achieving equity in health service commissioning in M. Exworthy, R. Mannion & M. Powell (eds.) *Dismantling the NHS?: Evaluating the impact of health reforms,* Policy press: Bristol (pp.233-250).

Table 1: Description of study sites and history of commissioning of services

Identifier	Description of site	History of service commissioning	Budget
A	Metropolitan, based on Medicare Local (ML)	ML commissioned services	Not available
B	Metropolitan and rural, large remote population, based on ML	ML commissioned most services but provided others	$12.9 million (2016)
C	Metropolitan , incorporates 3 MLs	Two ML with history of commissioning	$8.8 million (July2015-June 2016)
D	Metropolitan, incorporates 3 MLs	One ML with history of commissioning	Not available
E	Metropolitan and rural, based on ML	Limited history of commissioning	$19.9 million (2016)
F	Regional and remote, initially based on 2 MLs	No history of commissioning	Not available

Table 2: Summary of findings

Facilitators of equity	
Reduction of conflict of interest	Tensions between role as commissioner of services and service provider
Control of service specifications	Is being used to ensure that tenders have inclusive teams and specific relationships
Bringing objectivity to decision making	Commissioning services on the basis of performance and need
Barriers to equity	
Lack of flexibility of funding	Contributes to incapacity to respond to identified needs Diminishes innovative service provision
Impact of commissioning on Aboriginal and Torres Strait Islander health	Relationships are more bureaucratised Potential for competition with ACCHO for tenders Loss of employment through move to commissioning
Availability of services to tender	Difficulty in finding services willing to provide services to rural and some outer urban communities Conflict of interest through commissioning service providers who are partners in the PHN
Lack of understanding of local context	Potential for larger companies to receive contracts over local service providers
Changing relationship with PHN	Tension between competition and collaboration Reporting to PHN and service evaluation Decommissioning services Impact of commissioning (and competition) on service providers

Figure 1: Relationship of PHNs to other health care providers