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Change management in an environment of ongoing primary health care system reform:

A case study of Australian primary health care services

Abstract

Introduction/Background: Globally, health reforms continue to be high on the health policy agenda to respond to the increasing healthcare costs, and managing the emerging complex health conditions. Many countries have emphasised PHC to prevent high cost of hospital care, and improve population health and equity. The existing tension in PHC philosophies and complexity of PHC setting make the implementation and management of these changes more difficult. This paper presents an Australian case study of PHC restructuring and how these changes have been managed from the viewpoint of practitioners and middle managers.

Methods: As part of a 5 year project, we interviewed PHC practitioners and managers of services in seven Australian PHC services.

Findings: Our findings revealed a policy shift away from the principles of comprehensive PHC including health promotion and action on social determinants of health to one-to-one disease management during the course of study. Analysis of the process of change shows that overall, rapid and top-down radical reforms of policies and directions were the main characteristic of changes with minimal communication with practitioners and service managers. The study showed that services with community controlled model of governance had more autonomy to employ an emergent model of change and to maintain their comprehensive PHC services.

Conclusions: Change is an inevitable feature of PHC systems continually trying to respond to healthcare demand and cost pressures. The implementation of change in complex settings such as PHC requires appropriate change management strategies to ensure the proposed reforms are understood, accepted and implemented successfully.

Key words: Health reform, primary health care, change management

Introduction

In Australia, in common with other Organisation for Economic Cooperation and Development (OECD) countries, reforms continue to be high on the health policy agenda. Reform attempts have largely targeted the increasing health service demand variously attributed to the population demographic trends and an ageing population, a shift in disease burden towards chronic and complex health conditions, shortage of health workforce, and rising healthcare costs.[1-3] Globally, many countries are grappling with how best the health systems can respond to these increasing pressures in health costs and the burden of chronic health conditions. Evidence suggests that health systems with a strong primary health care (PHC) system contribute more effectively to improved population health outcomes, reduced costs and improved health equity.[4,5] The prevention of high cost of care in acute settings and trends towards reducing episodes of care and length of stay in hospitals, have also underpinned the emphasis placed on stronger PHC in governments' reform processes.[6,7] The World Health Organization report, *Primary Health Care: now more than ever,* provides examples of cross-country comparisons where well-functioning PHC systems contribute to higher levels of population health and calls for stronger PHC for improved health system efficiency, effectiveness and equity.[8]

Despite the intention to strengthen PHC in most major health reform and strategic planning documents the contested policy and practice space, and different ideas about PHC and its principles make the reform processes, implementation and management more difficult. The debates and contradictions on the role of PHC systems trace back to the Alma Ata conference on PHC in 1978 with its 'comprehensive' vision and emphasis on prevention, health promotion, social determinants of health and equity.[9] One year after the conference Walsh and Warren presented 'selective' PHC as an 'interim' strategy to begin the process of PHC implementation.[10] The selective PHC focused on disease specific and vertical interventions with less attention to social equity and broader socio-environmental contexts. After almost 40 years since the Alma Ata conference, the tensions between selective and comprehensive PHC are still visible in health and development policies and reforms. While the recent universal health coverage target in the United Nations Sustainable Development Goals seeks to promote population health through prevention and health promotion activities and acknowledges the role of social determinants of health to achieve equitable health outcomes[11,12], the broader policy initiatives and health reforms in many countries take a selective approach and focus mainly on individual and behavioural interventions.[13] Examples

of health system changes in both developed and developing countries demonstrates continued controversy around PHC. In some countries, PHC has moved towards individual care, risk factor management for selected chronic diseases and lifestyle-related determinants[14], although there are some examples of positive changes facilitating comprehensive PHC with strong attention paid to community participation and social determinants of health.[8,15]

Beyond these tensions around the role and mandate of the PHC system, there is a general tendency globally towards continued re-organisation of health systems around administration, funding models, and priorities as a means to address the challenges of health system costs, and managing complex health conditions. This results in difficulties for PHC managers and practitioners attempting to reconcile the historic tensions within PHC, between the social and medical mandates of PHC, while experiencing frequent shifts in system and organisational structures. The success and acceptance of these changes depend not only on how well the reform ideas address existing tension in PHC philosophies, they also depend on the extent to which appropriate change management strategies are adopted and implemented.[16-18] The literature contains little account of how successive PHC reorganisations are managed to minimise the negative impacts on system performance and front line staff.

Change management in health systems

The scale of organisational change in health systems varies considerably from incremental (as in some internally generated work process improvements) through to rapid and large-scale reforms driven by broader political, economic or social factors.[19] Despite extensive literature on organisational change management in general and in health systems in particular, there is little agreement on how system change is best managed[20] and a lack of empirical evidence to guide decisions on what works, where and why.[21] This makes management of change difficult at best and it remains the victim of a 'strife of interests' between the different players in health systems including health professionals and patients as noted by Sax in 1984.[22] Change management concerning comprehensive PHC is particularly difficult as it involves diverse players expressing varying values and ideas on comprehensiveness, empowerment and engagement and holding different amounts of power. Complex health systems, such as the one in Australia, with divided responsibilities between Federal and State governments and different jurisdictions further complicate the change processes.

The literature on change management reflects two core models: planned and emergent. The origin of the *planned approach* is attributed to Kurt Lewin[23,24] and his three-step model of unfreezing, moving and refreezing. Planned change places an emphasis on the role of top managers and policy makers in developing objectives and strategies. This approach can obscure the contribution of employees in the change process.[25] *Emergent approach* is a less centrally-directed, more employee-engaged and driven continuous process where managers become facilitators rather than controllers of the process.[26] The importance of middle managers in managing strategic change including interpretation and communication of change has also been highlighted by Balogun[19] and Huy[27] and specifically in health by Briggs, Cruickshank & Paliadelis[28], Buchanan et al[29] and Birken et al.[30] However, middle managers in many reform processes have been recipients of change with little influence on the decisions taken and minimal information about the reasons and processes of change and the means to achieve it.[19,31]

Based on a review of literature on change management in the health context, Antwi and Kale (2014) concluded that there are key components that health policy makers as leaders of change processes need to take into consideration.[32] These include: the external political forces and influences pushing the imperative for change; understanding the values of healthcare professionals and their alignment with organisational goals; the power dynamics; and the resources and skills required for the initiative. Antwi and Kale argued that successful change processes require strong leadership capabilities including communication of the vision and purpose of change, understanding staff perspectives and values and engaging them in a collaborative process which implements, evaluates and sustains change.

This paper presents an Australian case study of PHC organisational restructuring during a 5-year course of the study and how these changes have been managed from the viewpoint of health practitioners and middle managers in PHC services. It will contribute to a better understanding of the change management processes within the complex, dynamic and changing environment of PHC systems and thus inform those entrusted with the planning and implementation of future PHC reforms. The paper addresses the following questions:

1) What were the nature and key directions of changes in the study PHC services?
2) How were these changes managed, and to what extent were PHC staff informed about, and actively engaged in, the change process?

3) What role did middle health managers play in the implementation of changes?

Methods

The data presented in this paper are part of a five-year study (2009-2014) evaluating the effectiveness of comprehensive PHC. We interviewed PHC practitioners and managers of services in seven Australian PHC services including five South Australian state government-funded PHC services (including one Aboriginal Health Service), anonymised as Services A, B, C, D, and E, an Aboriginal Community Controlled Organisation in the Northern Territory - Central Australian Aboriginal Congress Aboriginal Corporation ("Congress"), and a non-governmental sexual health service (SHine SA), in South Australia which both requested to be identified. We also interviewed 6 regional and central health executives. The services all had pre-existing relationships with the research team, and were selected to maximise diversity and reflect different governance models (Table 1).

Table 1 Characteristics of the case study PHC services

We conducted two rounds of interviews with practitioners and managers from the case study sites. The first round of interviews (2009-2010) sought participants' views on the range and quality of PHC services including multidisciplinary care, community and advocacy work and issues of access to PHC services.[33-36] The follow up interviews, conducted in 2013-2014, in particular focused on changes that occurred in policy, structure, funding and human resources within the participating services since the time of the first interview. This paper presents the findings from the second round of interviews on the content of changes over the 5-year period, and how these changes have been implemented and managed within their services. Service B withdrew in 2012, due to high staff workloads, organisational change, and change of manager. Such turnover was not unexpected for a 5-year project occurring in a time of substantial change. However, Service B consented for the 3 original interviewees still employed at the service to participate in the 2013 interviews. Service E, another state-managed PHC service, participated as a replacement case study service. We interviewed a total of 57 practitioners and managers from the seven study sites in the 2013 round, and 6 regional and central health executives (N = 63). Participants in the follow-up interviews were recruited from those who were interviewed in the first round. Of the 60 original interviewees, 33 (55%) were still employed at the same PHC service, with only minor variations in roles. For the remaining, the practitioner in the same role or in the role closest to that of the original

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interviewee (when that role no longer existed) was requested. For Service E, which did not participate in the first round of interviews, a mix of disciplines was sought that included representation from the different work teams in the service. Table 2 shows the number of interview participants by role.

Table 2 Number of managers and practitioners interviewed by role

Interview questions were developed by the research team and were piloted on two practitioners and one manager from non-participating PHC services. Interviews were conducted face-to-face at the participant's workplace. All interviews were audio-recorded, transcribed and de-identified for further analysis. Qualitative thematic analysis was undertaken using NVivo software. A coding framework was developed and discussed during team meetings. The initial coding structure was developed based on key concepts from the research questions. Further codes were generated inductively to capture new themes that emerged from the interviews. Once the team reached a consensus on the coding framework, four interviews were double-coded to ensure rigour of data analysis and interpretation. Ethics approval was granted by the Flinders University Social and Behavioural Research Ethics Committee.

Findings

Context of case studies

The interviews provided information on the nature of changes staff experienced, the extent to which staff were communicated with and involved in the change process, and the role of middle level managers in the implementation of change. These findings are discussed in relation to the three questions we pose in this paper. We first describe the shape of the Australian PHC system and detail the key health reforms in the past few years that led to significant reorganisation and restructuring of PHC system.

The funding and control of the Australian PHC system is divided between federal and state governments, with service provision through (a) private general practice (supported by patients' access to federally-provided rebates from the national health insurance scheme Medicare), and (b) public services funded mainly through states and territories but with services identified in national priorities, such as maternal and child health services and chronic disease management receiving additional assistance from the federal government.

The PHC landscape also includes private allied health providers, Aboriginal community controlled health services, and services provided by non-government organisations.[1]

In the past few years, PHC structure, governance and funding has undergone numerous far-reaching reforms at national level. The key impetus for these changes was regional integration within PHC and between PHC and other sectors[37] and the changes were driven by major policy developments.[37,38] The policy developments have been accompanied by series of re-organisations and re-structuring of the PHC system. The more recent policies and their impact of organisational structures and priorities are shown in Figure 1.

Figure 1 Major Australian PHC policies and re-organisations since 2008

Each state and territory has also experienced a number of health system reforms, and public PHC system restructuring in recent years. In our case study state, South Australia, a review of the health system in 2002 produced the Generational Health Review report, which placed great orientation to PHC and emphasis on population health in planning and funding services including health promotion activities.[39] Considerable changes also occurred in the structure, boundaries, and location of PHC services in South Australia. These included changes in the regional organisation of health services from three metropolitan regions (Northern, Central, and Southern area health services) to one (Adelaide Health Service) and then back to three (Northern, Central and Southern Local Health Networks). Moreover, as part of the State health reform agenda, the South Australian government established GP Plus Health Care Centres, a strategy to integrate various PHC services including allied health, mental health and dental services and improve access to multidisciplinary health care. As a result, some of the PHC services were renamed and moved to new locations with specific focus on chronic disease management and individual care.[40] In 2012, the Review of Non-Hospital Based Services "McCann review" in South Australia recommended major cuts to PHC services with an assumption that the federally funded Medicare Locals would take up the preventive and health promotion activities.[41]

The nature and directions of changes in PHC setting

The national and state level policy and organisational changes mentioned above and the way these changes affected service directions, funding and priorities were reported by our participants. Our findings show that the state government-managed services in our study

were mostly affected by these policy changes. A shift of focus was evident from health promotion and community-based activities to chronic disease management, and clinical and individually-based treatment. The interview findings align with the results of the PHC policy review conducted by our research team that showed a policy shift to individual lifestyle and behavioural programs to address chronic disease.[14] Table 3 shows the major changes experienced by the participants in their services.

Table 3   Major policy and structural changes that occurred in the study PHC services

PHC practitioners in the government-managed South Australian services frequently referred to the McCann Review[41] that concluded that there was a lack of sufficient evidence for the contribution of health promotion activities to the key policy objectives of chronic disease management, hospital avoidance and population health. This review resulted in the defunding of most state government health promotion programs and was seen as a major policy shift limiting the PHC services' ability to work on broader health promotion and community-based activities.

'Well, I think the push has been –they want us to not do the community promotion work that we were doing and focus more on the people that are further up the chain to being in hospital. Hospital avoidance is our goal now, rather than prevention and health promotion.'
(Practitioner – state funded service)

Another PHC practitioner expressed a major change in the focus of their work from '*supporting community initiatives and really being responsive to the local community need'* to '*now just offering one on one work'* and '*managing chronic disease, essentially'*.
(Practitioner – state funded service)

The establishment of GP Plus Health centres and the change in the structure and location of some of the state-managed South Australian PHC services had a mixed effect on the perception of quality and performance of services and clients' access to and acceptability of the service. While for some participants from South Australian services the move to the new clinics was positive, e.g. *'feeling part of a network a bit more'*, facilitating *'easier access to dental services'*, and being part of a *'one stop shop'*, the majority associated the change with a shift from *'being a community-based health service operating on PHC principles of health*

promotion, illness prevention, to a much more clinically-focused, illness-based, not primary health'.

A service manager from one of the South Australian services felt that ongoing changes in the regional organisations of services, although not directly impacting on daily practice, took a lot of management time to explain and discuss with staff, producing a largely negative effect *'oh, my God, that's happening again'*. As well, there was all the *'time and cost associated with changing headers, templates and signature blocks'* as each new change was superseded by the next one. The establishment of federally funded Medicare Locals in 2011 also created new expectations and changes in state PHC services in terms of client referrals, communication with Medicare Locals, and confusion on how the PHC programs, particularly disease prevention and health promotion activities, were shared between state and federally funded services:

'I got the feeling that Medicare Locals were meant to be the answer to the prevention issue, but I don't know. That was an assumption that the State government made because they've just dropped the ball on any prevention.' (Practitioner – state funded service)

SHineSA, the non-governmental sexual health service in our study, also experienced a reduction in funding and a new service agreement with the state department of health, its main funder that deprioritised community work and preventive activities such as pap smears, and was reoriented towards treatment of sexually transmitted infections. Nevertheless, being relatively independent of government enabled SHineSA to provide services outside the scope of the service agreement and maintain some of its comprehensive services as opposed to state-managed PHC services.

The policy changes had less effect on Congress in the Northern Territory where participating practitioners and managers felt that the Federal and territory policy environment still provided them the opportunity and support to do community and health promotion work with minimal change over the past few years. A practitioner stated that the Federal 'Closing the Gap' program actually provided *'more services available for me and for the patients, and that's benefitted the patients'*. An increase in mental health, and rural and remote funding as well as outreach programs was reported by participants at Congress as an opportunity to engage more with the community and look at new models of service delivery in remote Aboriginal communities as opposed to the increasing 'stay in the centre' approach of the state

government-managed services: '*A lot more outreach programs we have now compared to what we did five years ago…So they're actually getting out and seeing people at their homes so it's been I think much more effective than what it used to be, to have all been based in the clinic'.* Being a community controlled service, Congress was able to maintain autonomy and control over development and implementation of PHC services: '*Aboriginal health is a bit of a protected space for primary health care compared to mainstream. So we've been able to build and develop programs and services, and innovate, and better use IT in a range of things, which has been useful.'*

Change management and staff involvement in the change process
Respondents provided comments on the internal processes of translating and integrating change within the organisation. As with the content of the changes, the change management process was evaluated overwhelmingly as negative, with none of the South Australian PHC staff interviewees evaluating it positively, and 13 making strongly-worded negative comments on how decisions were made. Poor communication with staff concerning the changes and description of roles and expectations was one of the key study findings. Some felt '*kept in the dark*', or that the service was '*in limbo*' with no one explaining anything or confirming what would happen in the future: '*we're all kind of speculating a bit… no one's actually giving any information much*'

Many staff members, mainly from the South Australian government-funded services, reported having no input into the decisions around the changes, which meant they experienced '*not knowing and then being told, being directed'*. Poor communication was also an issue of concern for service managers at the state-managed services, making it difficult for them to share the information with their staff and contribute to a smooth process of change implementation.
'*I feel like there's been no real sharing of the vision by the CEO or leadership around what made all these changes, what are they seeing and what it will look like in the future, why are they doing those changes and I think that's been really difficult for managers at my level and for staff because when change is implemented, if you can see the purpose and you hear the reasons, you can be brought along with it'* (manager, state funded PHC service)

The lack of proper communication strategies throughout the system was also confirmed by higher level managers: '*I think at times we probably haven't delivered our messages well'*

(SA Health funder) and *'from a management perspective, we haven't communicated that well because we haven't been clear' (regional executive).*

There was also a concern among some staff in the South Australian services about the lack of clarity in roles and expectations as a result of continuing change. A practitioner reported how this confusion is transferred to the frontline health volunteers and has an impact on client outcomes. "*We've got a whole heap of volunteer Foodies [a community based volunteer nutrition peer education program] that are in the same boat as we are ... We don't know what's happening and we're going through some turmoil and we're having to say to them, 'look, what you know as Foodies has been changed because you won't get the same support as you did from primary health care' (Practitioner – state funded service)*

The SHineSA staff reported having little ability to influence the '*very prescriptive*' and '*far more directed than it had been previously*' service agreement with the health department that happened during the course of this study. One of the SHineSA participants stated:
'So instead of just being given a block amount, our major funder now requires us to direct our funding towards certain goals which weren't really negotiable and so our scope of activity has potentially narrowed, and that's really forced us to pay attention to how we're going to meet our current objectives in a world where we have less discretion over how we apply our funding.'

In contrast to the more disheartened responses and disempowered experiences of state-managed service staff, the interviews with the Congress staff were marked by a sense of agency, pride in the organisation, and a desire to keep improving and doing better in the future. The issue of staff communication was described in less negative terms at the Aboriginal Community Controlled study site, for example:
'I think Congress engages in fairly rigorous discussion where possible. I think that actually perhaps needs to extend downwards a lot better. The discussion can get locked up into Congress having to manage upwards their funding bodies and with other commitments that they have, they probably need to start working a little bit more and their staff underneath having a sense of ownership and involvement in it over time." (Practitioner, Congress)

The role of middle health managers in change management

Middle managers have a central role in the implementation of changes. They are often tasked with the responsibility to communicate the necessity of change with staff and getting buy-in on the changes they need their teams to implement. They are in a position to see why a change may or may not work as they are closest to actual service provision.[30] The study findings indicate the challenges that health managers face in a system of ongoing change. There was a shared experience among state-managed service managers of the changes being centrally-controlled, without consultation and often without much explanation. A manager from one of the state-managed services reported a major shift from a locally controlled and managed service to a centralised model of management over time: '*Over the years, obviously the biggest change is going from having our own board and our own strategic plan to then having a more regional focus, then everyone's boards got dissolved in about 2004-5 and I think even more so these days is the directive down from SA Health. Everyone's been homogenised, so there's very limited local response.*'

The change in middle management's role from communicators and key agents of change to being only intermediaries in the implementation of centrally-determined policies and processes was frequently expressed by service managers, particularly in state-managed PHC services. For example, one manager reported: '*There's probably not a week that – a day that something else doesn't come through that says 'this is a directive' and it always says 'compliance is mandatory! This must be applied from four o'clock today' and it's 10 past three*'.

Another manager in the state-funded service described a significant change in her responsibilities from human resource management to managing buildings as a result of restructuring and increasing centralised control '*I'm now a buildings facilities manager, so I don't manage staff any more. There's been a whole load of changes to the structure of people reporting and so all allied health staff now report through their clinical leads to the director of allied health. Admin staff report through the admin stream, I report through corporate services*' (manager- state funded service)

Having a community board structure in Congress provided more opportunity for the service managers to play a role in identifying and responding to local needs, with one manager describing the importance of this as: '*We've got more of an opportunity to actually achieve things if we can get good direction, good advice from our clientele*'. In SHineSA, despite

some service restructuring, managers did not report any changes in their roles or responsibilities and the board were able to hold strategic discussions on how to best retain their comprehensive activities:

It's [the new agreement] starting to force the Board to examine how the current service provision is meeting, not only the needs in the agreement, but how are we going to retain our discretion to do what we want to do and that's been the strategic ... The work is harder, but the challenge for the Board is to enable SHineSA to remain relevant and to continue to deliver what it wants to deliver and retain its self-determination. (Board member -SHineSA)

Discussion

This study had the opportunity to follow the PHC services for a period of five years and capture the key policy and organisational changes that happened during this time, and to examine how these changes were communicated and managed at a service level. Below we reflect on our understanding of change processes from the wider literature and how the pre-planned and emergent models of change management theories have been employed within the broader health reform context and at the different types of PHC services (governmental, non-governmental and community controlled). The findings from this case study also highlight the conflicting ideas between comprehensive and selective PHC and the internal and external policy and governance contexts that facilitated or prevented the services' abilities to implement a more collaborative change management process.

The findings from the Australian case study have implications for PHC systems in other countries that are seeking to reform their health care systems. The study also provides insights for local and international health policy makers into the ways in which health reforms can impact on PHC and the importance of ensuring that change processes are informed by change management theories. Finally, our study shows how different models of service governance and culture impact on a health system's ability to implement a more collaborative and emergent approach to change management.

We used Gilber's (2015) *what, how, why* analytical framework to understand our findings.[18] We analysed *"what"* was changed, through an examination of PHC policy direction and practice changes over the 5 years. An analysis of the health policy changes in South Australia, undertaken by the research team, details the policy directions towards vertical chronic disease programs and centralised control.[14] The findings from this case study confirm

major shifts in core activities[42] and a shift of focus away from the values and principles of an integrated and comprehensive PHC including community engagement, health promotion and action on social determinants of health to individual based, one-to-one disease management. These changes were particularly noticeable in the state-managed services in our study that had less control over priority setting, decisions and funding.

The study also looked at the change context that deals with *"why"* change occurs. Gilber et al place an emphasis on the impact of both 'internal organisational context' including structure, governance and culture and 'external political, social and economic context' on why changes happen within the organisation.[18] The external policy and political contexts focusing on hospital avoidance, reducing hospital costs and individual based chronic disease management and clinical care were key driving forces for changes at service level. The state-managed health services in our study had less managerial autonomy and control, and were more affected by these external policy changes. The historical and contextual backgrounds and the governance structure (community board) of the Aboriginal community controlled service and the non-governmental sexual health service in our study as well as the influence of a national imperative through the 'Closing the Gap' program for Aboriginal and Torres Strait Islander health and the broader funding base of SHineSA provided these services with more authority to reduce external pressures and freedom to retain comprehensive PHC values and the ability to identify and respond to the local community's needs.

Analysis of the process of change, the *"how"* of change, suggests that overall, rapid and top-down radical reforms of PHC policies, directions and structures were the main characteristic of PHC changes over the period of this study. Our findings are consistent with a study undertaken by Dwyer in 2004, analysing health reforms in Australia that highlighted the dominance of 'centralised control' at the cost of using the experience of local providers.[43] Despite limited literature focusing on the change process in primary health care settings, they suggest emergent implementation of the change[44] and the importance of professional involvement in change processes.[45] State-managed services in our study experienced a prescriptive and constant cycle of change with minimal communication, dialogue and engagement. The study also provided an insight into some challenges that middle level health managers face in the context of health reform. The role of health managers in making sense of and negotiating meaning in the implementation of health reform are well documented.[19,28] Our interviews highlighted these challenges as middle managers perceived that they were

recipients of change with little influence on the decisions taken centrally, and little time allowed for them to implement adequate communication and engagement with service staff. This may be a reflection of a lack of clarity in the language of health reform generally, or perhaps a function of the nature of pre-planned change processes. Despite the political and funding pressures, the governance and management structure of Aboriginal community controlled and non-government services and the sexual health NGO enabled them to adopt a more emergent model of change management, or at a minimum, to employ emergent processes at various levels in the implementation of planned changes.[46] As noted by Franco et al (2002) 'radical reforms of organisational structures, processes and culture' without clear communication of the objectives and rationale for reform can lead to staff uncertainty, de-motivation and unwillingness to change.[47] This is particularly important in PHC setting which is characterised by the existence of multiple and highly professional staff with different ideas around PHC and thus their engagement in 'what', 'why', and 'how' changes happen is crucial for a successful implementation of change. These lessons are likely to be important for settings which are seeking to strengthen PHC as the centre of the system.

This study has some strengths and limitations. It investigated the change management in a low number of PHC services that may limit the generalisability of the findings. The inclusion of different types of services enabled us to compare organisational factors affecting services' ability and control over change processes and their impact of service practice. Given the international interest in primary health care reform to address contemporary health system issues, the results from our study offer some lessons for other settings in terms of dilemmas of comprehensive PHC in times of health system re-organisations.

Conclusion

There are two concluding remarks from this study. First, as the WHO Commission on social determinants of health reported, revitalising comprehensive PHC and policy actions towards universal health coverage are the main features that enable health systems to address health inequity.[48] The growing evidence on the effectiveness of strong PHC systems in reducing health system costs and improving population health urge health policy makers to support comprehensive PHC including health promotion, community engagement and action on social determinants of health.[49] Australia as well as many other OECD countries, as signatory countries to the UN Sustainable Development Goals, need to commit to 'universal health

care' through a more comprehensive PHC policies and interventions to achieve equity in healthcare access and outcomes.

Second, change is an inevitable feature of PHC systems to grapple with increasing health service demand and cost, and thus change managers need to attend to the change content, context and processes to ensure change policies are well planned, implemented and evaluated and address its main goals. This study provides key insights for health policy makers to allow better understanding of the underlying aspects of large scale organisational changes. The implementation of change in the complex and multi-dimensional PHC settings with its high level of professional staff requires communication strategies to ensure the proposed changes are understood and implemented successfully. At the very least, emergent and collaborative mechanisms should be adopted at various levels of implementing planned changes.[46]

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