

# What can the Experiences of Primary Care Organisations in England, Scotland and New Zealand Suggest About the Potential Role of Divisions of General Practice and Primary Care Networks/Partnerships in Addressing Australian Challenges?

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*This paper focuses on what can be learnt from the experiences of Primary Care Organisations (PCOs) in England, Scotland and New Zealand about the potential role of Divisions of General Practice (DGPs) and Primary Health Care Networks/Partnerships (PCN/Ps) in Australia, in addressing the challenges of ensuring access to a comprehensive range of primary health care services that are well coordinated and address population health needs. Responsibility for contracting and commissioning gives PCOs considerable leverage to influence the availability and range of primary health care services. A capitation-based funding system and associated patient enrolment enables a population focus and care over time, while aligned regional and local planning boundaries between PCOs and other health service planning boundaries also help with more coordinated approaches to planning, service development and service delivery. These elements are largely absent in the Australian health care system and set significant limitations on the role of DGPs and PCN/Ps. While DGPs can contribute to improving general practice quality and access to multidisciplinary care, and PCN/Ps can improve coordination, their scope of responsibilities and authority will need to be significantly strengthened to enable them to take a comprehensive approach to ensuring access to primary health care, service coordination and addressing population health needs.*

**Key words:** Primary health care, Systematic review, Organisational models, Primary care networks

Cross-country comparisons suggest that a well functioning and effective primary health care system makes an important contribution to improving the health of a country's population and reducing health inequalities (Bunker, Frazier, & Mosteller, 1994; Macinko, Starfield, & Shi, 2003; Shi, Starfield, Kennedy, & Kawachi, 1999; Starfield, 1994). However, even countries with advanced health care systems face considerable challenges in ensuring access to a comprehensive range of primary health care services that are well coordinated and address population health needs. Recent international surveys have found that both primary health care providers and consumers tend to experience poorly coordinated and duplicated care (Schoen, Osborn, Huynh, Doty, Davis et al., 2004; Schoen, Osborn, Huynh, Doty, Peugh et al., 2006).

In a number of countries, a major strategy to address these challenges has been the development of various forms of primary care organisations (PCOs) as intermediate level structures that sit

between government and local primary health care providers. PCOs are intended to support the development of appropriate primary health care services for the populations they serve and have roles that include planning, coordinating, supporting, and, in some cases, managing primary health care services. These organisations have different structures, mandates and powers in different countries, and their scope for action is determined in part by the structure, funding and organisation of that country's health system. While differences in these system characteristics mean that primary care structures cannot be directly copied from one country to another, they do allow countries to learn from the experiences in other health systems.

This paper will focus on what can be learnt from the experiences of PCOs in Great Britain (England and Scotland) and New Zealand about the potential role of PCOs in Australia in addressing the challenges of ensuring access to a comprehensive range of primary health care services that are well

**Table 1: Summary of Key Characteristics of Health Systems and PCOs**

Country characteristics					
	Australia		Great Britain		New Zealand
Level of government responsibility for PHC	National: General Practice State: Community Health		National		National
Funding model	Fee-for-service (GPs, private allied health practitioners) Incentives Salaried (community health services)		Capitation Fixed allowances Quality Salaried (as an alternative to capitation)		Capitation Salaried (not-for-profit PCOs)
Patient enrolment	No		Yes		Yes
PCO characteristics					
	<i>DGP</i>	<i>PHCNP</i>	<i>PCTs</i>	<i>LHCCs/CHPs</i>	<i>PHOs</i>
Type	Membership (predominantly GPs).	Alliance or Network.	Hierarchical.	Hierarchical (NHS C'ttee).	Commonly incorporated society.
Governance	Elected from membership.	MOUs Steering groups.	Appointed Board.	Appointed Board.	Local board Mandatory community representation.
Accountability	Dual: To members & Commonwealth Government against performance indicators.	Single: To state government.	Single: To the Health Department for achieving performance targets.	Single: To local NHS LHCCs: for negotiated functions. CHPs: for mandated functions.	Single: To government via District Health Boards.
Boundaries	Not aligned with State health boundaries.	Not aligned with DGP.	Aligned with NHS.	LHCCs: non aligned. CHPs: aligned with Local Authorities.	Not aligned with DHBs.
Authority	Hold limited funds to contract allied health for GP referrals. Some funds to support service development. Rely on negotiations with members.	Very limited funds to influence service delivery. Rely on cooperation of member agencies.	Hold funds to provide, contract & commission services.	Hold funds to provide, contract & some commissioning.	Hold funds to contract with general practices.

coordinated and address population health needs. It begins with a summary of the characteristics of the health system and PCOs in each country, and then reviews the implications for the role of PCOs in Australia.

### **Health system context: Great Britain**

Both England and Scotland have a single level of government with responsibility for primary health care policy and funding. Funding for general practice is largely through capitation-based payments for patients enrolled at the practice, with additional provider incentives in the form of fixed allowances and for achieving quality targets. Other primary health care services are commissioned or directly provided by the health service. Some general practitioners (GPs) and practice staff (e.g., on Personal Medical Service contracts) are paid on a salaried basis, as are most National

Health Service (NHS) staff employed in community health services.

Primary health care has been subject to considerable reform in recent years. The change of government in 1997 heralded a significant re-investment in and overhaul of the NHS to address a number of challenges, including variable quality of care and difficulties with accessing timely primary health care services. The changes have placed primary health care at the centre of the NHS.

### **Primary care organisations**

In England, Primary Care Groups were established in 1997 and evolved into Primary Care Trusts (PCTs) in 1999 (Department of Health, 1997). They are governed by appointed boards. They number approximately 300 and typically serve a population of about 250,000. Their aims include improving population health and reducing health

inequalities, improving access, integrating primary and community health services, and supporting general practice. This is achieved through a mixture of providing community health services (e.g., community nursing and health visiting), developing new primary health care services, contracting with GPs, and commissioning secondary health services (Smith & Mays, 2005). Commissioning involves the specification and obtaining of health care services to meet population health needs, usually through a mix of service development, contracting or purchasing (Opit, 1993; Smith et al., 2005). PCTs hold NHS budgets for these purposes.

The commissioning role has given PCTs considerable authority to influence service delivery, in order to improve access (especially targeting poorly serviced areas or groups), extend the primary care team, and expand the range of primary health care services (Audit Commission, 2004; Charles-Jones, Latimer, & May, 2003; Dowswell, Wilkin, Kirk, & Banks-Smith, 2002; Wilkin, Coleman, Dowling, & Smith, 2002; Wilkin, Dowswell, & Leese, 2001). The devolution of funding and planning initially to PCTs and more recently to the practice level has been accompanied by an emphasis on accountability and performance management for the extent and range of services provided (outputs) as well as for governance (process) (National Health Service, 2005, 2006) in a way not seen in Australia. Particularly important has been the transfer of responsibility for general practice contracts from the NHS to the PCT, where they could be coordinated with other elements of commissioning. From the start, PCTs have had an emphasis on improving the quality and clinical governance of practices (Regen, Smith, Goodwin, McLeod, & Shapiro, 2001; Wilkin et al., 2002; Wilkin et al., 2001; Wilkin, Gillam, & Leese, 1999; Willcocks, 2003), which was consistent with a strong national focus on quality and development of the National Service Frameworks for a number of conditions and population groups (Davies, 2001).

With political devolution, Local Health Care Co-operatives (LHCCs) were initially established in Scotland as the operational arm of PCTs to develop and coordinate population-wide approaches to health improvement and disease prevention, improve the quality of general practice, and to support the development of extended primary care teams (Simoens & Scott, 2005). There was

considerable variability in the extent and nature of the functions delegated to LHCCs as well as in their size and scale, and this impacted on their competency and capacity (Primary Care Modernisation Group, n.d.). As a consequence LHCCs were abolished between 2005 and 2006. They were replaced by Community Health Partnerships (CHPs), the boundaries of which, are aligned with local authority boundaries. Governance is through a NHS board committee and includes frontline primary health care staff and a wide range of other stakeholders (Scottish Executive Health Department, 2004). Unlike LHCCs, CHPs have mandated rather than discretionary functions, which include coordinating planning, developing and providing a comprehensive range of primary and community health services (Scottish Executive Health Department, 2004) through devolved funding for direct provision and contracting. However, CHPs have more limited commissioning functions than in England, and commission primarily but not exclusively from the non-profit sector. Two of the Partnerships follow a different model, which combines local authority social care services with primary and community health services in an integrated management model and which have an expanded range of delegated functions (T. Findlay, personal communication<sup>1</sup>). These are known as Community Health and Social Care Partnerships.

### **Health system context: New Zealand**

New Zealand has a single level of government responsible for primary health care policy and funding. A lack of clear direction for primary health care and concerns over poor access arising from high user charges led to the release of a Primary Health Care Strategy in 2001. The Strategy aims to develop a strong primary health care system in order to improve health and reduce inequalities in health (King, 2001). The release of the strategy saw the establishment of Primary Health Organisations (PHOs), the introduction of patient enrolment (at practice level), capitation funding for PHOs, and increased investment in primary health care to reduce user charges, through increased subsidies for particular population groups (Cumming et al., 2005; King, 2001).

Prior to the strategy, there were two major forms of PCOs. Capitation-funded not-for-profit community-governed organisations, which

provided comprehensive primary health care services targeting disadvantaged populations through a multidisciplinary mix of salaried providers including GPs (Crampton, Dowell, & Bowers, 2000). Independent Practitioners Associations (IPAs) were GP-led initiatives, the major aims of which were to enhance the influence of GPs in a new competitive and contracting environment, strengthen the capability of general practice fund-holding (albeit in a limited form), and work with practices to improve the quality of care (Barnett, 2003; Malcolm & Powell, 1996).

### *Primary care organisations*

PHOs were established between 2002 and 2005. There are 81 of varying size, legal arrangements and distribution, with just under half having fewer than 20,000 enrolees (Hefford, Crampton, & Foxley, 2005). General Practices can join the PHO of their choice. PHOs are governed by local boards and are required to involve a range of stakeholder groups, including community representatives, in governance and decision-making (King, 2001). They are funded on a weighted capitation basis by District Health Boards (DHBs) and are responsible for planning, contracting, and, to a lesser extent, providing primary health care services for their enrolled populations. Their accountability to government has been strengthened with the introduction in 2006 of a performance management framework. Unlike PCTs in England, PHOs do not fully integrate primary health care policy, funding and service delivery at the local level as a range of community health services are still provided or contracted directly by DHBs and more than one PHO can operate in the same geographic area, although with a different enrolled population.

Most of the early focus of PHOs has been on establishing governance and management arrangements, systems and other infrastructure to support their capacity and relationships with practices (Cumming et al., 2005). Their influence on local service delivery is beginning to be seen in a broader range of population-based prevention and early intervention services, and reported improved access for particular groups such as Maori, Pacific Islanders and those on low incomes (Hefford et al., 2005; Perera, McDonald, Cumming, & Goodhead, 2003; Wyllie, 2004). IPAs are now playing a number of new roles in the health system. Some have become PHOs in their own right; others

are partnering with other organisations as part of PHOs; and some are also providing PHOs with management support services (Gauld & Mays, 2006). The other PCOs that existed prior to the strategy have either formed into PHOs in their own right or are partnering with PHOs.

### ***Health system context: Australia***

The Australian health system is characterised by two levels of government responsibility for policy, funding and organisation of health services, which adds a layer of complexity not seen in either the British or New Zealand health systems. The Commonwealth Government has major responsibility for general practice and the state/territory governments have responsibility for hospitals and the network of publicly-funded community health services. These differing responsibilities create an ongoing tension and lack of fit between Commonwealth and state initiatives (Powell Davies et al., 2006), which is not helped by the lack of a national primary health care policy or strategic framework.

These characteristics, coupled with a predominantly fee-for-service payment system for general practice and commitment to ensuring consumer choice, have a significant influence on the reform process and development of system-wide responses.

The thrust of Commonwealth Government reforms has been to enhance the capacity of general practice and to strengthen their collaboration with other health service providers, predominantly in the private sector, especially in relation to improving the management of chronic disease. While state/territory governments share similar aims to strengthen collaboration, this has focused more on the vertical coordination between primary and community health services and the hospital sector, aimed at reducing or avoiding hospitalisation. Only more recently has there been an emphasis on horizontal collaboration between general practice and community health services.

### ***Primary care organisations***

Commonwealth and state/territory governments have set up their own arrangements for managing and supporting primary health care. State/territory systems vary between jurisdictions. The only national set of primary care organisations is Divisions of General Practice (DGPs), which were established in the

early 1990s as voluntary, GP member based and led organisations. There are now 120 operating across Australia. There is a strong and largely effective focus on engaging with GPs (Review Panel, 2003); however, there has been considerably less involvement of other health professional groups, consumers or community groups in governance (Kalucy, Hann, & Guy, 2005; Review Panel). As with LHCCs in Scotland and PHOs in New Zealand, variations in size and a lack of alignment with health and other related planning boundaries have limited their collaboration with other health services (Review Panel).

The aim of DGPs is to support the development of general practice in their catchment area by: enhancing quality of care; improving access; encouraging integration and multidisciplinary care; focusing on prevention, early intervention and better management of chronic disease; and ensuring a growing consumer focus (Commonwealth of Australia, 2004). They are funded according to a weighted population formula and hold budgets for some national initiatives. A quality and performance system, which strengthens their accountability to government, was introduced in 2005. However, in the absence of significant financial leverage or a commissioning role to affect service delivery changes, the support from member GPs has been an important influence on the nature and range of their activities (Rogers & Veale, 2000). This has led to a somewhat uneven performance across DGPs, both in the issues addressed (reflecting member interests) and to the extent and reach of DGPs' activities that members will support.

While DGPs have generally been effective in their core aim of supporting general practice, this has mostly related to specific Commonwealth Government initiatives for which there have been funding programs directed at either practices (as incentives for GPs to participate) or to DGPs as a vehicle for implementation (Kalucy et al., 2005). Approximately half of all DGPs provide direct patient services in mental health and/or diabetes and many are increasing their focus on prevention. Many provide practices and patients with access to allied health professionals through contracts or employment arrangements and have supported practices to develop chronic disease management programs. However, while many DGPs are involved in improving after-hours primary medical care access, few have addressed financial and locational access barriers (Kalucy et al.).

In some state jurisdictions, primary health care networks or partnerships (PCN/Ps) have been established as voluntary alliances of predominantly state government funded primary and community health care agencies. South Australia is the exception, where the core partnership is between the regional health service and local DGPs (The University of Adelaide and the South Australia Department of Health, 2006). They are most widespread in Victoria, with 31 operating across the state and most extending to two to three local government areas. However, they are not always aligned with other health service boundaries and there is variable engagement with general practice. In NSW, eight were funded for two years, and in South Australia, four have been recently established

These networks or partnerships are governed by some type of memorandum of agreement and representative committee, and they receive limited funding to support improved coordination among their member agencies. In Victoria, where they have been established the longest, they have been effective in improving service coordination and increasing the use of care plans for intensive service users (Australian Institute for Primary Care, 2003, 2005). The NSW Networks, despite some important achievements in improved service coordination, were isolated and fragmented from other area health service developments (Jan Smith & Associates P/L, 2005) and their funding was not continued past the pilot phase.

### ***The evidence***

A recent systematic review of the empirical evidence for PCOs in these three countries found that much of the research on the development and impact of PCOs uses descriptive designs, with few designs employing a control group (McDonald, Cumming, Harris, Powell Davies, & Burns, 2006). Thus, in the context of rapidly changing health systems it is difficult to attribute the achievements to PCOs themselves, rather than to other contributing factors such as funding, workforce and quality initiatives that have accompanied primary health care reforms.

Moreover, most of the empirical evidence has focused on the implementation of PCOs and changes to service development and delivery, including integration and coordination with

other services. Only the ongoing evaluation of PHOs in New Zealand is providing emerging evidence of their impact on access and utilisation of primary health care services. There has been little research effort that examines the impact of these organisations on patient outcomes or health outcomes for local populations in the PCO catchment area. This was a somewhat surprising finding given the policy focus and investment in PCOs that has occurred over the last decade.

**Lessons from Great Britain and New Zealand**

PCOs are interposed between government and local primary health care service providers. They work to implement government policy to improve access to high quality primary health care. Typical aims include improving access to a comprehensive range of primary health care services that address population health needs, and to improve service coordination and integration with other health services.

Table 2 summarises the way in which characteristics of each health care system and the structure of PCOs support or undermine major primary health care policy goals.

In England, Scotland and New Zealand, primary health care policy, funding and service delivery are the responsibility of a single level of government. This facilitates the development of shared priorities and goals across the system. This is stronger in Great Britain, where PCOs are essentially the local implementation arm of the NHS, than it is in New Zealand, where, while the role of PHOs is prescribed by government, they are governed by local boards and they work with local DHBs, and there may, at times, be differing priorities associated with this set of multiple accountabilities.

However, in all three cases, PCOs are required to ensure a broad range of stakeholder input into decision-making, including local community representation in governance arrangements, thus enhancing a community orientation. One of the strengths of a community-oriented model includes a greater focus on equitable access to services for populations (Lamarche et al., 2003). By contrast, an important feature of the Australian health system is its reliance on the professional-oriented model of general practice, whose strengths include access and responsiveness, but whose drawbacks appear

**Table 2: Summary of the Major Enablers and Limitations to the Role of PCOs in Achieving Primary Health Care Policy Goals**

Policy goals	Australia	Great Britain	New Zealand
Access to comprehensive PHC	<p>Enabled by:</p> <ul style="list-style-type: none"> <li>Incentives.</li> <li>New Medicare items for allied health.</li> <li>Performance-related indicators.</li> </ul> <p>Limited by:</p> <ul style="list-style-type: none"> <li>Split responsibility.</li> <li>No commissioning.</li> <li>Limited contracting/provision.</li> </ul>	<p>Enabled by:</p> <ul style="list-style-type: none"> <li>Single responsibility.</li> <li>Commissioning.</li> <li>Contracting.</li> <li>Provision.</li> </ul> <p>Limited by:</p> <ul style="list-style-type: none"> <li>Performance-related targets, indicators.</li> </ul>	<p>Enabled by:</p> <ul style="list-style-type: none"> <li>Single responsibility.</li> <li>Contracting.</li> <li>Performance-related targets, indicators.</li> </ul> <p>Limited by:</p> <ul style="list-style-type: none"> <li>The limited range of services they provide.</li> </ul>
Coordination	<p>Enabled by:</p> <ul style="list-style-type: none"> <li>Incentives.</li> <li>Membership priorities.</li> </ul> <p>Limited by:</p> <ul style="list-style-type: none"> <li>Split responsibility.</li> <li>Different boundaries.</li> </ul>	<p>Enabled by:</p> <ul style="list-style-type: none"> <li>Commissioning.</li> <li>Performance-related targets, indicators.</li> </ul>	<p>Enabled by:</p> <ul style="list-style-type: none"> <li>Contracting.</li> <li>Performance-related targets, indicators.</li> </ul> <p>Limited by:</p> <ul style="list-style-type: none"> <li>Lack of a clear geographical area to service.</li> </ul>
Population focus	<p>Limited by:</p> <ul style="list-style-type: none"> <li>No patient registration.</li> <li>No capitation-based funding.</li> </ul>	<p>Enabled by:</p> <ul style="list-style-type: none"> <li>Registration.</li> <li>Capitation-based funding.</li> <li>Aligned boundaries.</li> <li>Single responsibility.</li> </ul>	<p>Enabled by:</p> <ul style="list-style-type: none"> <li>Registration.</li> <li>Capitation-based funding.</li> <li>Single responsibility.</li> </ul> <p>Limited by:</p> <ul style="list-style-type: none"> <li>Lack of a clear geographical area to service.</li> </ul>

to be in relation to equity of access (Lamarche et al.). This professional orientation is also seen in the governance of DGPs, where there is little community or broader stakeholder representation and which in part has been attributed to their low engagement in broader primary health care reform (Review Panel, 2003).

Responsibility for contracting and commissioning gives PCOs in Great Britain and New Zealand considerable leverage to influence the availability and range of primary health care services at the local level. This is most evident in Great Britain, in particular in an expansion of the typical primary health care team, but there is emerging evidence in New Zealand of improvements in access to a core and enhanced range of primary health care services at a local level, including a stronger focus on prevention and early intervention. However, little research has been done that has examined the attributable impact of PCTs on quality or health outcomes associated with these service delivery changes.

In both Great Britain and New Zealand, patients are enrolled (with a practice in Great Britain and with a PCO in New Zealand), and funding is predominantly through a capitation system. This has some advantages for a population focus and care over time (Macinko et al., 2003). Patient enrolment defines the population for whom the service provider has ongoing responsibility, and where (as in Great Britain) the whole population is enrolled, this ensures universal coverage. Capitation funding makes it easy to fund service providers for the full range of tasks involved in comprehensive primary health care, where fee-for-service is generally used for more narrowly defined tasks. Regional and local planning boundaries that are aligned also help with more coordinated approaches to planning, service development and service delivery for defined populations. This is more a feature of PCTs and CHPs than of LHCCs and PHOs.

In Australia, DGPs do not have the authority or responsibility to commission a comprehensive range of primary health care services for local populations in the same way as PCTs can in England. Their role in direct service delivery and contracting is limited to specific government-funded initiatives which have restrictions, for example, confined to areas identified as high needs, for specific conditions, or numbers of

consultations per patient over a specified period of time. In the absence of a significant role for contracting, their influence is more indirect, through their engagement with their members and their (voluntary) relationship with other parts of the primary health care sector; for example, state/territory government community health services.

This sets a significant limit on the extent to which they can enhance access to a comprehensive range of primary health care services. This limited influence on behaviour applies even more to PCN/Ps. Without funding levers, the most that can be expected of these structures is that they improve service coordination across the range of state government funded services. With these limitations, there is a very real question about the extent to which they can engage general practice and extend service coordination across the primary health care sector as a whole. The absence of capitation-based funding and patient enrolment in Australia also limits the contribution that PCOs can make in ensuring a population health focus and their ability to equitably hold funding for services other than general practice; the current fee-for-service regime supports only a limited range of preventive and population-focused activities.

The division of responsibility for primary health care between Commonwealth and state/territory governments and the differing geographical boundaries impede planning, service development and coordination at the local level across the range of primary health care services and providers. Commonwealth and state/territory systems may have different priorities, and the introduction of health insurance rebates for private allied health services on referral from a general practitioner tend to encourage referral to private providers rather than to community health services. Moreover, no additional funding has been allocated to community health services to take on referrals from GPs and contribute to Commonwealth Government policies.

Thus the structure of the Australian health care system and the structure and mandate of Divisions and PCN/Ps means they have neither the scope of responsibility nor the authority to take a comprehensive approach to ensuring access to primary health care, service coordination and addressing population health needs. Simply strengthening the mandate of, for example, DGPs,

through introducing some form of commissioning or substantially enhancing their role in contracting, would not solve the problem. The problems of the divided responsibility for primary health care and the system of payments for primary health care services would also have to be addressed. Not having the responsibility or authority, they cannot devolve these to the local provider level (as in Great Britain and New Zealand). Furthermore, any significant change in the role and authority of DGPs would risk altering the relationship between them and their members, and so compromise their influence as member organisations.

Finally, the devolution of commissioning and contracting responsibilities to PCTs and PHOs has been accompanied by an emphasis on accountability and performance management, including for service provision. There has been less attention to performance monitoring and accountability of the primary health care sector as a whole in Australia, with the focus mainly on processes and uptake of general practice-related incentives. While the recent development of the quality and performance system strengthens accountability for DGPs, this is still a far cry from accountability for general practice and other primary health care service providers.

### ***Possible ways ahead***

Despite the entrenched structural barriers in Australia, incremental reforms are possible which could strengthen the role of DGPs in supporting improved access to a broader range of primary health care services, and partnerships with state/territory government-funded community health services could go some way to extending this to a more coordinated approach to planning and primary health care service provision for local communities. The payments introduced in 2005 to subsidise care provided by private allied health practitioners (for patients referred by a GP), and in 2006 the changes to the Medicare Benefits Scheme to improve access to psychiatrists, psychologists and GPs for people with mental health conditions,

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will undoubtedly strengthen the role of DGPs in planning and coordinating primary health care services. These initiatives would be strengthened if DGPs were required to plan and coordinate services in conjunction with state/territory government-funded community health services, although this would need Commonwealth and state/territory support. This could also help address concerns that unilateral approaches may have unintended consequences on equity. Planning and coordination between these two arms of primary health care would also be assisted if there was a better alignment of geographical boundaries.

Finally, there is also scope for trialling new forms and mixes of payment type. It might be possible to retain fee-for-service payments for episodic care (retaining the virtue of responsiveness), and introduce capitated payments for aspects of primary health care that are not easily funded in this way, particularly chronic disease care and preventive care. Any such developments would need to be designed to accommodate consumer preferences for retaining choice of doctor and practice.

### **Conclusion**

Divisions of General Practice contribute to improving the quality of general practice and enhance the access of GPs to multidisciplinary primary health care providers, and Primary Care Networks/Partnerships can improve service coordination among their member agencies. However, in the current context, both types of PCOs have limited ability to enhance population access to a well coordinated and comprehensive range of primary health care services. This reflects both the structure of the Australian health care system and the nature of the PCOs. It will require greater coordination between Commonwealth and state/territory governments, a clearer delineation of populations served and further devolution of responsibility and authority if they are to take on a significantly greater role in integrated primary health care service planning and provision for populations.

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