Review of the PHN Business Model and Mental Health Flexible Funding Stream

A Summary of Key Messages and Recommendations from Wentworth Healthcare

Background

In February 2024 the Australian National Audit Office (ANAO) issued a Report examining the Effectiveness of the Department of Health and Aged Care's Performance Management of Primary Health Networks (PHN). One of the recommendations of this Report was that a full **Review of the PHN Business Model** should be undertaken.

The Department of Health and Aged Care (DoHAC) committed to this Review and engaged Boston Consulting Group and ConceptSix to manage the evaluation. In addition, DoHAC took the opportunity to add an evaluation of the **Mental Health Flexible Funding Stream** (MHFFS) and the role of PHNs in commissioning mental health services through this stream.

From mid-December 2024 until 22 January 2025 a stakeholder consultation was conducted as part of these Reviews. This included an invitation for written submissions and a stakeholder survey. Wentworth Healthcare provided a 32 page written response. A summary of the **key messages and recommendations from our submission is below**.

The PHN Business Model

The Role of PHNs:

- PHNs are relatively new in the context of the health system and the role, breadth, complexity and responsibility of PHNs has evolved since first established in 2015. PHNs are now recognised as part of the health infrastructure, yet sometimes still lack the authorising environment and recognition that other peak health organisations enjoy.
- As regional organisations, with deep local knowledge, PHNs can help drive healthcare reform, integration and equitable access, while considering geographical equity. Through our work supporting general practices and as commissioners of national and local programs, PHNs can help reduce service fragmentation and address unmet needs by collaborating with stakeholders to create innovative, locally tailored models of care.

Recommendations:

- Ensure PHNs are appropriately resourced, have long-term funding and an authorising environment to contribute to national health reforms.

National Priorities VS Local Need:

- The strength of PHNs lies in our ability to leverage local knowledge and strong commissioning processes to apply place-based approaches to national initiatives.
- PHN's local expertise is valuable and can help inform state and national policy reform agendas, while ensuring local nuances are considered.
- National programs provide opportunities for consistency across Australia to address common issues but should not jeopardise the ability for PHNs to pursue local place-based initiatives or to tailor national programs and service models to the needs of local communities.
- PHNs have limited funding flexibility to address local needs. Allowing more flexibility in the delivery of national priorities could enhance opportunities for PHNs to address local needs.

- There are no formal mechanisms, at state or national level, for review of innovative local initiatives and opportunities to consider scale up if appropriate.

Recommendations:

- Utilise the local knowledge of PHNs to help inform state and national health policy reform.
- Provide funding for PHNs to address local needs as well as nationally identified priorities.
- Provide flexibility in the delivery of national priorities so initiatives can be tailored to address local needs.
- Establish state/national mechanisms and funding to scale up successful local initiatives which would support efficiencies across the PHN network.

PHN Boundaries:

- Boundary alignment between PHNs and Local Hospital Networks (LHNs) is recognised as a positive enabler for better integration.
- In NSW, aligning PHN and Local Health District (LHD) boundaries has fostered more effective collaboration, especially among boards and executives from both organisations, providing a strategic platform for addressing common regional priorities.
- Boundary alignment facilitates opportunities for co-commissioning of regional and state-based programs. PHNs and LHDs are demonstrating that when we work together at a regional level, siloed funding and programs can be integrated on the ground.
- PHN boundaries in NSW are appropriate given the complexity of the state, population levels and regional variability.

Recommendations:

- PHN boundaries should continue to align (or incorporate) LHD/LHN borders to facilitate collaboration and local integration.
- NSW PHN boundaries should remain as they are.

PHN Governance:

- The current system of governance of PHNs is appropriate and effective as it allows for the prioritisation of regional needs, helps strengthen local capacity and fosters the development of a strong primary healthcare system.
- PHNs have local skills-based boards, clinical councils and community advisory committees and other multi-stakeholder committees that guide the work of each PHN. This system of local governance promotes accountability at a local level and enables us to involve individuals who are knowledgeable and invested in the outcomes of a PHN’s designated area, giving the local community and primary healthcare workers a voice and the ability to influence decisions.
- This local expertise is used at state and national level through PHNs' close working relationships and mechanisms such as state PHN forums and the national PHN Cooperative, which allows PHNs to work together, share knowledge and resources without the cost of a formal state or national body. These collaborative groups enhance both individual and collective PHN contributions, serve as effective channels for sharing knowledge and building capacity, enabling responsiveness, managing risk, and when applicable, ensuring consistency in PHN and primary healthcare-related activities.
- Being independent non-partisan organisations is an advantage as it allows PHNs to seek alternative funding sources, such as state or local government funding, philanthropic, fundraising or donation opportunities. It is also an advantage when working with some groups or communities who may have a lack of trust in government services.

Recommendations:

- PHNs remain as independent not-for-profit organisations with local governance structures.

Engagement and Collaboration:

- Despite limited funding for engagement and regional planning, PHNs successfully engage with stakeholders across the community, primary and acute healthcare sectors, including GPs, allied health providers, LHDs, state departments, federal departments, community services, consumers and many others in both formal (through advisory committee governance and commissioning) and informal ways.
- Specific expectations of each stakeholder differ depending on how they work with or engage with PHNs. Health professionals (such as GPs), commissioned providers and consumers would all have different expectations given the different roles PHNs perform for these stakeholders.
- PHNs have a wealth of knowledge within the primary care sector informed by local clinicians, commissioned providers, community organisations and their communities that is valuable but not well recognised or utilised at a national policy agenda level.
- Most PHNs have close working relationships with general practices in their regions and can be a voice for these practices helping facilitate integration with secondary and tertiary care, especially within LHDs.
- The relationship between NSW PHNs and NSW Health is regarded as a gold standard example of how state/PHN collaboration can work effectively on a national level and was recognised in the Health Reform Agreement Mid-term Review Final Report[1].

Recommendations:

- Appropriate funding is needed for PHNs to advance collaborative relationships and integration given the time, work and resources required.
- PHNs should be provided opportunities to participate in and contribute to the policy environment at a national level.
- There needs to be an authorising environment for greater PHN involvement, particularly when PHNs are often key players in the implementation of national initiatives at a local level.

Future Role of PHNs:

- Given that the role of PHNs has been identified in numerous reviews as local change agents for primary care reforms, in the next five years PHNs will continue to evolve.
- Currently, PHNs need to advocate for inclusion in areas where they can add value and are often not included in planning or designing initiatives when they have a significant role to play.
- PHNs are not funded to address prevention and funding to address early intervention is limited. This falls within the remit of PHNs and should be expanded.
- PHNs play a significant role in supporting GP workforce issues. They have relationships on the ground with practices that state-based organisations don't have. This is a significant area of focus and effort yet, funding is limited.
- As PHNs are not compliance organisations, the aged care sector trust and look to PHNs to provide them with support and access to the local health system. The ability to address challenges experienced by older people in their regions through the PHN functions of capacity building, connecting and commissioning, has proven incredibly beneficial to the aged care system.

Recommendations:

- PHNs need appropriate resourcing, longer-term funding and an authorising environment to contribute to national health reforms.
- PHNs should be considered for national initiatives that need a regional lens beyond the traditional health sector, such as psychosocial and disability programs and there should be opportunities for PHNs to address social determinants of health.
- Greater funding flexibility to address needs identified in local PHN Health Needs Assessments including funding to address prevention and early intervention initiatives.

[1] NHRA Mid-term Review Final Report (section 5.2 on page 67)

- The role of PHNs in primary care workforce, particularly the GP workforce, should be expanded with funding to support this critical role.
- There is scope for PHNs to play a more significant role in supporting aged care and in early intervention and prevention initiatives.

Barriers for PHNs to Operate Effectively and Efficiently:

- Over the last 10 years, PHNs have taken on more responsibility for delivering national programs and our role and scope has broadened. While PHNs have been agile and adaptable, the current PHN Program funding and reporting arrangements have not kept pace with the maturing role and complexity of PHNs.
- Constraints placed on PHNs by DoHAC through short-term contracts, contract execution and payment delays, limited funding to address local needs and inflexible funding or service models, can damage PHNs local reputation particularly if services/programs need to be established without adequate lead-time.
- Contract timeframes that allow programs to be evaluated and demonstrate outcomes are essential to reduce the risk of local initiatives being short-term pilots, eroding community and provider confidence in the PHN program.
- Funding uncertainty and short-term contracts make it difficult to recruit, retain and replace quality staff both at a PHN level and most significantly for commissioned providers. This disrupts service delivery and can lead to cumulative underspends within programs.
- Significant time is spent on understanding and documenting gaps and needs in local PHN Needs Assessments, however very little funding is available to address these needs unless they coincide with national priorities.

Recommendations:

- Longer-term program contracts with at least five-year commitments so programs never have less than 12 months forward planning.
- Timely receipt of funding contracts and adequate contract timeframes and longer lead times for PHNs to implement programs and/or commission so benefits can be realised and evaluated.
- Flexibility for PHNs to spread funding more appropriately over the initial years of contracts to recognise the different costs associated with commissioning or establishing new activities.
- Funding to evaluate effectiveness of programs and initiatives factored into activity contracts.
- Appropriate funding indexation for PHNs (and by extension commissioned providers) at the outset of the activity.
- Timely payment of funds from DoHAC as per payment tables in contract funding schedules.

Mental Health Flexible Funding Stream (MHFFS)

Challenges in Meeting MHFFS Program Objectives:

- Evolving health policies and the increase in population mental health needs, coupled with a shortage of available services/clinicians.
- PHN funding is mostly tied to national initiatives, limiting flexibility to address local needs through locally tailored solutions. Compounding this are geographical equity issues and recurring natural disasters with short-term funding not adequately meeting longer-term needs.
- Increasing limitations on flexibility to be innovative. Funding is limited to specific models of care that have an existing evidenced base without ability to pilot other innovative services.
- The decrease of PHN MHFFS funding by 4.5% to support the National Low Intensity Digital Mental Health Service, will further impact PHN capacity to deliver locally tailored services.
- Increasingly thin markets of the mental health workforce to meet the needs (for example not enough psychiatrists and mental health nurses particularly in regional and rural areas).
- Limited investment to support the capacity of primary care to adopt significant changes, including new models of multidisciplinary mental healthcare.

- Consistency in digital systems is highly variable across jurisdictions. Limited integration of digital mental health systems and data linkages across health sectors impacting transfers of care and conjoint care.
- The increasing emergence of telehealth solutions to support enhanced access to mental healthcare with limited consideration of the digital health literacy of the population and how this will impact access.
- Mental health needs that PHNs are not funded to address but that impact primary care's capacity to manage patient's long-term, such as assessments and diagnosis for neurodivergent conditions.
- The increase of co-morbidities and mental health not supported or addressed by current PHN funding nor preventative approaches, such as integrating mental healthcare with physical healthcare to deliver holistic care.
- Limited flexibility of funding aligned to the measures of the Primary Mental Health Care Minimum Data Set (PMHC-MDS) that demonstrate longer-term benefits/outcomes and are not always appropriate to the service delivery.
- Current prioritisation of NDIS clients for mental health services, limiting access to other members of the community who may need the same services. Conversely, changes to NDIS Legislation[2] that will similarly impact the availability of mental health services outside of this system.

Recommendations:

- A 'one system' mindset between Commonwealth, PHNs and state health services in addressing the same needs but from different sectors to avoid gaps, fragmentation and duplication.
- Equal partnerships between PHNs and state health services, with the defined role of PHNs in commissioning services and supporting connected pathways of care into the community.
- Governance and leadership at a national and state level to facilitate greater commitment and accountability for PHNs and LHDs.
- Systems integration to address the different systems often used for the same mental health service delivery i.e. triage scales, intake lines (phone and web).
- Nationally cohesive health technology to improve health technology decisions that will deliver safer, effective and affordable care, including development of digital capacity across sectors and digital integration to support communication and conjoint care.
- Continuity of care to support the patient journey across health sectors, supported by functional transfers of care and by digital health enablers.
- Improved funding distribution across PHNs to match local needs and more approaches to value-based healthcare models that motivate providers using financial incentives to align their care around improving value, reducing costs and/or improving health outcomes.

MHFFS Opportunities to Better Support PHNs:

- Increased flexibility of funding and models of care is essential to address the evolving mental health needs of the population and will enable tailoring of service delivery to local needs.
- Longer-term, consistent and timely prediction of MHFFS funding allocations is necessary to support sustainability and potential scalability of service delivery.
- Better alignment and coordination of funding sources at national and state level to support consistency in addressing local mental health needs across sectors and prevent duplication.
- Funding for integration and coordination, as PHNs are increasingly seen as key players in integrating and coordinating care across the health system. The funding model should support resources for joint planning and commissioning with LHDs and other stakeholders.

[2] Changes to NDIS legislation | NDIS

- Greater geographical equity in accessing MHFFS to include local population needs and the variable costs in providing these services in a specific region, such as how workforce availability and thin markets impact cost and access[3].

MHFFS Challenges for Commissioned Service Providers:

- Activity data is collected from mental healthcare providers regularly in the PMHC-MDS and measured against PHN performance. This collection can be technologically challenging for some providers. This data is currently activity-based and not a measure of longer-term health outcomes.
- Data measurement tools are not always fit for purpose or client centred and can be burdensome for patients and clients to complete at required intervals. This makes it difficult for providers to collect and adhere to data collection requirements.
- Limited data is collected relating to the social determinants of mental health outcomes such as education, employment and social supports. The data currently collected does not contribute towards service planning or evaluation of mental health programs.
- Service activity is limited to short time frames and a capped number of services, which limits capacity to support long-term improvement in the individual's recovery journey and participate in their continuity of care.
- Cost of quality and safety compliance such as accreditation to deliver digital mental health services can be prohibitive for individual providers. Similarly, the cost of procuring licenses to support digital transfer of information between service providers can be prohibitive for smaller providers.
- Market rate of service costs is not met by the funding that PHNs receive and there is a disparity in funding rates compared to the NDIS program.

Recommendations:

- Review the use of current data collected from providers and consider how this can better contribute towards service planning and evaluation of mental health programs.
- Deidentified patient data collected for national programs should be patient centred and co-designed with lived experienced consumers/service users.
- Recognise the need for services that can support an individual's longer-term recovery journey and their continuity of care.
- Recognise the cost of quality and safety compliance to deliver digital mental health services and provider market rates to deliver services and build this into service costs.

[3] Macquarie University Centre for The Health Economy: Getting more value from mental healthcare funding and investment 2023 Consultation Paper3.