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PHN Business Model Review and Mental Health Flexible Funding Stream Review

Submitted via Online Survey:

Australian Government

Department of Health and Aged Care

Consultation Hub

https://consultations.health.gov.au/primary-health-networks-strategy-branch/copy-of-review-of-primary-health-network-business/consultation/intro/

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Introduction

Lived Experience Australia Ltd (LEA) is a national representative organisation for Australian mental health consumers and carers, families and kin, formed in 2002. Our 'friends' include more than 10,000 people with lived experience of mental health concerns across Australia. This includes lived experiences with all parts of the mental health care system, NDIS, psychosocial disability support outside the NDIS, PHN commissioned services, public and private service options, and service provision across urban, regional, rural and remote Australia. All members of our Board and staff have mental health lived experience as either a consumer, family/carer/kin/supporter, or both.

Lived Experience is core to our advocacy, recognising that the impacts of policy and practice are felt not only by individuals, but also by families and whole communities. Our core business is to advocate for effective policies and systemic change to improve mental health care and psychosocial disability support services and support across the lifespan, across the whole Australian health and social care system, including within State and Territory jurisdictions.

We welcome the opportunity to provide our feedback to this PHN Business Model Review, particularly how the 5 areas of focus for this review impact individuals with mental ill-health and distress, and their families, carers and kin in the Australian community.

Background

As stated in the consultation briefing, the Primary Health Network (PHN) Strategy, released by the Australian Government Department of Health Aged Care in 2023, sets out a PHNs' purpose, objective and key functions.

The primary objectives of PHNs are to keep people healthy and well, particularly people with chronic health conditions and mental illness, and reduce avoidable hospital presentations in their regions. To accomplish this, PHNs deliver programs using a 'place-based' approach by tailoring initiatives to meet their local population's health needs. Under the PHN Strategy, PHNs are expected to achieve their objectives through three core functions:

- Coordinate and integrate local health care services in collaboration with state Local Hospital Networks (LHNs) or equivalent, to improve quality of care, people's experience and efficient use of resources.
- Commission primary care and mental health services to address population health needs and gaps in service delivery and improve access and equity.
- Capacity-build and provide practice support to primary care and mental health providers to support quality care delivery.

Purpose of this Consultation

PHN policy settings have not changed significantly since they were established. The Department of Health and Aged Care is initiating a review to examine the PHN Program business model in the context of the changing operating environment, and to ensure the Program is structured to meet Government objectives:

- Improving the efficiency and effectiveness of health services for people, particularly those at risk of poor health outcomes.
- Improving the coordination of health services and increasing access and quality support for people.

The Department is seeking written responses across five key topics:

- Program Objectives and Activities
- Program Governance
- Regional Planning, Communication, and Engagement
- Program Funding Arrangements
- Mental Health Flexible Funding Stream

Our Response to the Consultation

Overall, we wish to make the comment about the review being poorly timed over the Christmas/New Year period which has then potentially limited the ability for a more diverse range of the stakeholders to respond.

Also, the consultation questions seem to be geared towards providers of services, not the lived experience communities they serve which are best placed to respond because they are at the receiving end of all the activities of the PHNs.

It is our understanding that, to date, the national PHN executive has not contacted the national mental health Lived Experience peaks. LEA, which has a disproportionately higher number of friends network members located in regional and rural Australia (as evidenced by their response to our nation advocacy projects on a range of topics), has sought to engage in dialogue with PHNs but, to date, has not been proactively contacted by them during the past decade.

Finally, the broader community has very low literacy of PHNs - their role, purpose and functions – despite their decade of operations. This is concerning given that, from mid-2016, a significant increasing in commissioning responsibility and funding passed to them. A lower-than-expected response to this consultation from the mental health Lived Experience sector is also concerning.

Across the 5 consultation question areas below, we have listed the questions but not responded to each question individually. Instead, we have chosen to provide a combined set of comments to each area of review.

1. Program Objectives and Activities

Consultation Questions:

1. Are the roles of PHNs clear and understood by stakeholders, including your own organisation? How will the relative importance of the different roles need to evolve to meet broader changes in health policy and delivery?

1.1. What are the key roles played by PHNs, and how should the balance between local insight and national consistency be managed for each role?

1.2. How have the roles of PHNs evolved over the past 9 years to align with changing objectives, and how are they expected to adapt in the next 5 years?

1.3. What key examples can you share of the key benefits delivered by PHNs?

1.4. What activities or programs does your PHN excel at delivering, or should be recognised as a national leader?

1.5. What additional roles, if any, should PHNs take on-either broadly or in specific circumstances-to better address community needs?

1.6. Are there roles currently performed by PHNs that might be more effectively managed by other organisations? If so, why and how?

Overall, we believe PHNs need to focus much more on 'walking the talk' and demonstrating transparency and accountability for authentic co-design with people with lived experience (personal and family/carer/ community). This includes demonstrating greater inclusion and valuing of Lived Experience workforce and researchers in program development and evaluation of programs to set KPIs that are meaningful to communities, and to determine if and to what degree those programs have met their objectives or not.

Currently, there seems to be no transparency or accountability in the achievement of program objectives; outcomes are not public facing, PHNs are not consistently walking the talk, and there is too much rhetoric about engagement with Lived Experience communities. Engagement varies, and engagement is held by set roles which can mean that its focus as a core responsibility for all layers of the PHNs is overlooked, which then stifles the integrity of the overall values and community facing ideals and objectives.

There are positive examples of programs driven by more authentic community engagement and consequent improved impact and outcomes. Examples include the Sydney North Health Network's GPs in Schools program, programs delivered by the SEMPHN on the Mornington Peninsula in Victoria, and the TRISP suicide prevention program in NQPHN in northern Queensland.

PHN engagement seems to work only if people are involved in PHN committees. Broader and more indirect influence is poorly understood so if you're not connected with the PHN, you're sitting outside and don't really have a sense of what's happening with PHNs. The programs are well positioned but there's a lack of awareness by many people who don't realise that some programs are PHN funded. Their visibility has arguably been shielded by non-government organisations which have been commissioned by PHNs to provide services. The challenge is for PHNs to be more transparent and relevant to the communities they serve.

2. Program Governance

The PHN Program is a national network of 31 PHNs, administered by 29 individual not-for- profit, non-government organisations (NGO). PHNs are governed by skills-based Boards and supported by GP-led Clinical Councils and Community Advisory Committees.

Consultation Questions:

2. Is the governance of PHNs and the broader PHN Program appropriate, efficient and effective?

PHN organisational governance

2.1. What challenges, if any, arise from PHNs operating as non-governmental organisations (NGOs)? Please provide examples and suggestions for addressing these challenges.

2.2. Are there specific issues or areas of concern related to PHN governance? What measures or improvements could be implemented to address these?

PHN Program governance

2.3. Are the processes currently used to measure and manage PHN performance sufficiently clear? Are there any challenges with these processes, and what potential improvements could be made?

Support for improvement

2.4. How could the Department support PHNs in enhancing capability and performance? What alternative bodies (whether current or conceptual) could further contribute to achieving these objectives?

Our overall response to this question is to not 'reinvent the wheel'. There has been significant time, energy, expertise and money already invested in producing jurisdictional and national Lived Experience governance frameworks. To continue doing this is wasting valuable resources and is likely to be met with frustration by the community. The PHNs' own developed governance documents are relevant here, as are the National Mental Health Commission materials, and the MHLEEN (PHN Lived Experience) and the National Mental Health Consumer Carer Forum collaborative projects, are examples of existing comprehensive tools and resources. We have listed key resources here:

PHN Consumer and Carer Engagement and Participation:
https://www.health.gov.au/sites/default/files/documents/2021/04/primary-health-networks-phn-mental-health-care-guidance-consumer-and-carer-engagement-and-participation.pdf

PHN – Mental Health and Suicide Prevention Peer Workforce Guidance:
https://www.health.gov.au/sites/default/files/documents/2021/04/primary-health-networks-phn-mental-health-care-guidance-peer-workforce-role-in-mental-health-and-suicide-prevention.pdf

National Mental Health Commission resources:
https://www.mentalhealthcommission.gov.au/publications/lived-experience-workforce-development-mental-health

The 2023 Lived Experience Leadership Digital Library:
https://livedexperiencedigitallibrary.org.au/

The MHLEEN/NMHCCF national projects:
https://nmhccf.org.au/news/projects-launched-nmhccf-mhleen-lived-experience-leadership-projects

What we believe is needed is genuine effort by PHNs to implement these foundational tools, and genuine investment in and engagement of Lived Experience groups and communities to achieve that implementation. This includes at national, regional and local levels of PHN governance (from the national co-operative coordinating committee through to community advisory committees). This should improve strategic planning within the governance process by addressing siloes in funding and priority setting too.

Further to these issues, we believe current challenges and barriers to more effective Lived Experience engagement begin with addressing commitment and culture at the PHN executive level. This includes recruiting effective Lived Experience representatives – they need more then their lived experience alone at this level; they need established experience in governance and systemic advocacy, otherwise, their role and input risks being token. Support and training are also important to build capability.

Governance of PHNs has, arguably, been driven by management which has meant that community advisory committees have been 'tickbox' agenda driven. The 'place and space' model needs to shift even more; it's happening in some PHN programs and has been a game changer. Examples include CESPHN, SESPHN and SWSPHN across the Sydney regions in NSW, SEMPHN on the Mornington Peninsula in Victoria, and NQPHN in northern Queensland.

3. Regional Planning, Communication and Engagement

PHNs have responsibility for undertaking data analysis and working with local communities, clinicians, service providers and state and local governments to identify and prioritise the health care needs of the population in their region. They commission health services to meet the prioritised health care needs of their communities.

PHNs participate in delivering complex programs across population health, general practice support, digital health, mental health, alcohol and other drugs, health services in aged care, Aboriginal and

Torres Strait Islander Health, workforce and emergency preparedness and response. PHNs also support delivery of the Government's Strengthening Medicare reforms; partnering with local communities, including health and other care providers and government entities on regional planning; brokering solutions in thin markets (for example, in rural areas); and assisting with transition to Aboriginal community control.

Consultation Questions:

3. Does the PHN Program support regional planning, effective communication and engagement between relevant stakeholders?

Local collaboration partners

3.1. How do PHNs engage with stakeholders across primary and acute care sectors, including GPs, allied health providers, Local Hospital Networks (LHNs), state departments, and community services? What aspects of these engagement processes work well, and where could improvements be made?

3.2. What are the expectations of different stakeholder groups of PHN regional planning, engagement, and communication? Are these expectations currently met, and should there be minimum requirements to guide these activities?

3.3. Are current PHN boundaries appropriately aligned with service delivery boundaries? Are there opportunities to adjust these boundaries to better support stakeholder consultation and engagement?

Your PHN Clinical Council and Community Advisory Committee

3.4. How do PHNs establish and use Clinical Committees and Community Advisory Councils? What factors contribute to their effectiveness, and are there areas for improvement?

Measuring effective collaboration

3.5. How should PHNs assess whether their collaborations with stakeholders are effective and result in measurable improvements in health outcomes and other key performance indicators? What tools, metrics, or approaches could support this evaluation?

We believe more should be done to measure effective collaboration with stakeholders / communities. This would require greater transparency and accountability for person-centred, recovery-focused KPI's for the Department and PHNs. A clear section on consumer and carer engagement and Lived Experience workforce is suggested.

There is also a need for coordination and independent advice at a national Level for some areas to keep consistency and utility of feedback on what works and what doesn't work. This should also involve advice from national and state/territory Lived Experience peaks, particularly with regard to bi-lateral arrangements, integration of psychosocial services, and state jurisdictional areas of responsibility, and regional local level support, particularly for hard-to-reach groups and local services beyond those 'commissioned' by PHNs.

We are concerned that, within current regional planning communication and engagement, there are a lot of motherhood statements in the regional plans. We believe there needs to be a specific section on Lived Experience leading change in the plans. Again, this includes greater transparency and accountability in how regional plans are developed, including KPI's about these plans. This will become even more important as State governments and PHNs grapple with bilateral agreements. Currently, plans are very layered down to local regional level which means the potential for duplication is ever present. How do they include advocacy bodies in the regional planning? As stated earlier, LEA has never been contacted by PHN's to contribute to any of this process.

Again, effective communication and engagement between relevant stakeholders occurs for people who are 'on the list' but not for others. PHNs need to be more visible to community and broader organisations.

4. PHN Program Funding Arrangements

PHN's are managed by the Australian Government through grant funding arrangements. Funding includes a combination of core and individual program schedules, totalling $1.6 billion across the network in 2023-24. In addition, PHNs also receive funding from other sources such as state governments and philanthropic organisations. PHNs are regulated under the Australian Charities and Not-for-profit Commission (ACNC) and must follow the Commonwealth Grant Rules and Guidelines under the Public Governance, Performance and Accountability Act 2013.

Consultation Questions:

4. Do the current PHN Program funding arrangements support effective delivery of the objectives?

Funding model

4.1. Does the current level of flexibility in PHN funding effectively support the delivery of locally relevant solutions? What changes, if any, could enhance this flexibility while ensuring alignment with nationally consistent health priorities?

4.2. Are there opportunities to streamline core activities or deliver them more efficiently, such as through shared service arrangements or similar models?

Operational experience of the funding approach

4.3. Do current funding arrangements create challenges for service delivery? If so, what changes could be made to address these issues and improve outcomes?

The current PHN Program funding arrangements have been mixed in their ability to support effective delivery of the PHN objectives, with pockets of excellence and other programs and regions that continue to struggle to deliver on the objectives.

We believe it is crucial to undertake more critical analysis of the evidence base for commissioning to include dedicated funding for Lived Experience (consumer, carer workforce), not just topping up existing Lived Experience with PHN underspend. Internationally, there is clear evidence for the Lived Experience involvement at this level for increased quality of outcomes, improved translation of practice, and sustainability within communities.

There also needs to be consideration of evaluation data beyond just K5-10 and the Your Experience of Service (YES) Survey as they are done differently across regions and states. This should include more Lived Experience-lead evaluations (for examples, as was the case with the Partners in Recovery evaluation for BNPHN).

Current funding arrangements mean that PHN's in regional areas struggle to consult and engage with their communities in the same way as metropolitan PHNs. They don't have the allocation of consumer and care engagement in their funding. Our recommendation is that PHNs make sure there is a budget allocation for Lived Experience workers and engagement; that Lived Experience contributions and expertise are not exploited. This will likely require co-contribution at the local level and agreement at the PHN CEO level for co-investment at the national level too.

One issue that has potential to undermine progress is that existing PHN-commissioned requests for tender applications can favour organisations with more administrative resources but do not necessarily have strong local expertise and experience. Our recommendation is that there needs to be diverse funding

allocation the recommendation is for diverse funding allocation to enable inclusion of those with more 'grassroots' ability and expertise in bring a community development perspective. This would mean that tenders will need to incorporate space and dedicated funds for developing capacity of the local groups. We are aware that this approach is favoured by other commissioning bodies, especially when they related to programs that aim to build capacity and capability for Aboriginal community-controlled initiatives. Other philanthropic organisations like the Fay Fuller Foundation also take a developmental / capacity building approach. Current processes may lead to situations where the best applications 'on paper' are not necessarily the best choice for the communities where the programs will be implemented because they don't have the local connection to those communities.

5. Mental Health Flexible Funding Stream

The PHN Mental Health Flexible Funding Stream (MHFFS) was introduced in 2016 and subsequently expanded as part of the Australian Government's broader reforms to mental health care.

It aims to enable PHNs to commission tailored, regionally appropriate mental health services that address the unique needs of their local communities. The funding stream supports a stepped-care approach, emphasising flexibility in delivering services across a continuum of mental health needs, from early intervention to acute care.

Consultation Questions:

5. What is the role of PHNs in commissioning services through the mental health flexible funding stream within the mental health and suicide prevention system, and how effective has it been? How could that role evolve to be more efficient and effective?

Role within the mental health system

5.1. How has the landscape of mental health and suicide prevention system changed since the introduction of the Mental Health Flexible Funding Stream (MHFFS) in 2016? Please provide the key changes based on evidence or policy changes relevant to your organisation.

5.2. What further changes in mental health and suicide prevention system do you predict, and how could the role of the MHFFS adapt to support these changes effectively?

5.3. What challenges do PHNs face in delivering their role within the mental health and suicide prevention system? How can these challenges be addressed to improve outcomes?

5.4. How does your PHN currently coordinate services and referral pathways across the stepped care continuum? How could this evolve in the future?

Operational experience of the Mental Health Flexible Funding Stream (MHFFS)

5.5. Does the current funding allocation under the MHFFS support PHNs in meeting the objectives of the program? Have any challenges appeared over time as community needs and priorities have evolved?

5.6. What changes to the funding allocation under the MHFFS could better support PHNs in addressing evolving needs and achieving program objectives effectively?

5.7. Do service providers experience challenges in delivering mental health services under the MHFFS? If so. what are these challenges. and how could they be resolved?

With the national sector focus of concerns now on the significant psychosocial unmet needs, the PHNs will play a vital role in Commonwealth and state/territory agreements and collaboration to address the gaps in service and support access to programs. But significant negotiation is still to occur regarding who pays for what, within a fiscal climate in which various governments see priorities for mental health differently.

People with lived experience want seamless services and want a right to 'have a say' at all levels. However, significant amounts of mental health funding is not flexible because pre-determined goal posts exist regarding what the Department of Health will allow, particularly for the larger programs that have been and will be rolled out in future. For example, Headspace is a very defined model which doesn't then enable flexibility.

The growing evidence base for the benefits of lived experience (peer) support must be considered. Mental Health funding processes should not be about just topping up the status quo; expecting a different result by continuing to do the same thing over and over doesn't make sense. Local planning should be centred on a community development ethos to ensure local buy-in, to meet and match to actual local needs, and ensure sustainability locally.

Significant amounts of funding go primarily to existing commissioned providers first; and our experience is that these same set of providers often perpetually shift and change as part of competing for funds to deliver programs. In regional and rural areas with thin markets and greater workforce pressures (attracting and retaining them), this can be really disruptive to the continuity of mental health programs. It can create confusion, duplication, information and service gaps in the local communities, and lack of consistency and sustainability as new providers come and go. Valuable contract time and resources are then spent trying to recruit and establish a new workforce to deliver services, build knowledge of local needs and build trusting relationships with other providers and communities, then pulling out later when funding contracts change to new providers. The Partners in Recovery program was seen as effective by many because it was premised on a model that worked to decrease competitive siloes and brought service providers together rather than a competition model.

Another issue for PHN-funded mental health programs is the missed opportunity to learn and share data. For example, there are 100+ suicide prevention networks but no-one is capturing the benefits of local connection of these. Likewise, Lifeline has significant data being collected but not used or shared to undertaken deeper learning about need or what works for the people who use these services.

It is also unclear how further planned mental health reforms will impact PHNs. One clear example is the planned investment in a National Early Intervention Service (NEIS) low-intensity time-limited coaching service for people with mild mental distress that will be delivered digitally and is therefore likely to have particular relevance to regional and rural communities due to thin markets, service access and workforce issues.

Contact

We thank you for the opportunity to put our views forward. We wish you well with the next steps and would be pleased to contribute our Lived Experience perspectives to any future discussions about this important topic.

Your sincerely

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