

# The role of Primary Health Networks in the delivery of primary care reforms

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**February 2019**

## Introduction

A strong primary care system is essential to the equity, efficiency and effectiveness of the health system and improvements in health outcomes. However, the structure and funding of primary care has not kept pace with changes to disease patterns, the economic pressures on the health care system, workforce needs and evidence about the impact of social factors on health.

It does not encourage the integration of physical and mental health services and the seamless, comprehensive care needed by patients with complex and chronic conditions and does not allow a holistic person-centred focus that delivers health and wellbeing as outcomes rather than medical and pharmaceutical treatments.

There is a general consensus from all stakeholders that new models for the delivery and funding of health and healthcare services are needed, but mechanisms for fostering innovation and leadership to inspire it are lacking. To quote a recent [Grattan Institute report](#), “primary care policy in Australia is under-done.”

The Health Care Homes initiative was a tentative first step in innovation, but one that seemed almost deliberately designed to fail. Once touted as the government’s signature health policy reform, [enrolments and interest have lagged](#) and a [recent commitment to extend the trial](#) comes with no attempt to revamp or expand the current model. Those who work at the coalface recognise the value and success (even in the face of poor resourcing) of the [Aboriginal Community Controlled Health Organisations](#), but there is little interest in extending this model beyond Indigenous communities.

The [recent draft report](#) from the General Practice and Primary Care Clinical Committee (GPPCCC) of the Medicare Benefits Schedule (MBS) Review makes a number of recommendations for reforming the primary care system which are deserving of consideration and implementation. But the process for translating these recommendations into action is tortuous and the necessary leadership is currently lacking.

In the absence of government commitments, the Primary Health Networks (PHNs) remain the singular possibility for meaningful reform, and it is a relief to see examples where local innovative efforts responding to local needs, led by local expertise with a willingness to circumvent the many obstacles, are making a difference.

In this paper, a follow-up to a [previous look at the activities and outcomes of PHNs](#), and building on the work done in [2015 by Duckett et al](#) that explored how PHN Boards could help improve the Australian healthcare system, we investigate whether PHNs are fit-for-purpose to drive and foster primary care reforms.

## How does the government see the role of PHNs?

The Department of Health (DoH) website states that “Primary Health Networks have been established with the key objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time.”

This definition, and the objectives provided in the [Grant Programme Guidelines](#) and the [Designing and Contracting Services Guide](#) indicate that the key work of the PHNs involves strategic planning for

the commissioning of needed services and the monitoring and evaluation of these. They are also required to address services gaps and deliver value for money. PHNs are to reach these objectives by:

- Understanding the health care needs of their communities through analysis and planning.
- Providing practice support to GPs.
- Collecting, reporting and disseminating data to drive best practice and quality and safety.
- Assisting GP practices to make meaningful use of e-health systems.
- Purchasing and commissioning health and medical / clinical services for local groups most in need (eg. patients with chronic and complex conditions).

The focus is clearly on healthcare, clinical services and general practice serving people who are unwell rather than a more expansive view of primary health care that includes the social determinants of health and preventive activities to deliver health and wellbeing. There is some implicit recognition about the importance of prevention and population health data, but the outcomes to be measured are much more narrowly focussed on the provision of medical services, with those who have chronic and complex illnesses as the key target population.

In the [presentation](#) from the Minister for Health, Greg Hunt, to the 2017-18 Budget lock-up, there was no mention of PHNs and “Strengthening Primary Care” was mentioned only as part of a “third wave of reform” (no time frame provided). The [media release](#) that accompanied the 2018-19 Budget does not mention primary care or PHNs at all and to date the Government has ignored the limited achievements [of the Health Care Homes initiative](#) (identified by COAG as a [central component of needed national health reforms](#)).

There exists the possibility that funds from the \$1.25 billion [Community Health and Hospitals Program](#) announced at the time of the 2018-19 Mid-Year Economic Fiscal Outlook could be used to implement the primary care reforms recommended by the MBS Review, but with election announcements looming and no final agreement on these proposals, this does not seem likely. Overall, the current approach does not augur well for future reforms and investments in primary care.

Under such circumstances it is tempting to see PHNs primarily as a tool for the implementation of this Government’s political ideology about contestability and competition in the delivery of healthcare services. There is no specific mandate or incentive for innovation. To date, the innovation and incentive funding that is available to PHNs has been provided equally across the board, indicating that these are not based on merit. Moreover, there is [evidence](#) that some funding for PHNs has been politically driven.

That said, there is clearly an ability for appropriately resourced PHNs to be catalysts for reform and innovation in the delivery of primary care and there is evidence that some PHNs are doing this very effectively. The case that we make here is that the leadership, learnings and insights provided by these PHNs should be better utilised to drive healthcare reform at the local, regional and national level, and that changes in policy, funding and culture are needed for this to happen.

## Are PHNs ‘fit-for-purpose’ to drive primary care reforms?

It is early days for the establishment and full operation of PHNs – they are still relative newcomers to the healthcare system. Some PHNs appear to be doing well, others less so.

As identified in the [recent evaluation study](#), building PHN capability and capacity, as well as undertaking the associated change management, will require significant time and effort. A key risk is that new and competing priorities added in by Government could take the focus away from core business. The evaluation highlights that a key strength of the PHN Program has been the very collaborative way in which PHNs support each other and work together for the benefit of the network. But the [lack of formal communication and collaborative mechanisms](#) and constraints that the business model imposes on information sharing could undermine this.

### The Yes case

1. PHNs have a government mandate  
[PHNs have been established](#) with the key objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time.
2. PHNs must respond to community needs and local population data  
The [PHN Guidelines](#) state that: PHNs will work towards achieving these objectives [outlined above] on the basis of an understanding of the health care needs of their communities through analysis and planning. They will do this through knowing what services are available and help to identify and address service gaps where needed, including in rural and remote areas, while getting value for money. The collection of local data means that (at least theoretically) PHNs have the ability to monitor progress in addressing these needs.
3. PHNs have links into all parts of the healthcare system  
PHNs are [required to have established relationships](#) with Local Hospital Networks / Districts, residential aged care facilities, Aboriginal Community Controlled Health Organisations, pharmacy, and mental health and substance abuse providers. PHNs are one of the few parts of the healthcare system that has the ability to work across the federal / state and territory divide (although to date there is little evidence that this is occurring).
4. There are already pockets of innovation in some PHNs  
There are a number of examples of initiatives that PHNs has instigated in response to local needs. For the most part these are not publicly promoted and perhaps it is too early to expect publications in peer-reviewed journals and evaluations; descriptions and reports of such initiatives must be sought on the websites of individual PHNs. For example, WentWest, the Western Sydney PHN, which is well established, has a number of [reports on its website](#), including an evaluation report for a pilot program using clinical pharmacists in general practice.

Recent [preliminary evaluation findings](#) are that PHNs are able to take an agile and community inclusive approach to fulfilling their role in: (1) addressing health needs and service gaps; (2) integrating services; and (3) supporting general practice. In fulfilling these roles, it appears that the organisational design of PHNs is appropriate for achieving their regional objectives. Is this sufficient to drive reform?

## The No case

### 1. PHNs are too dominated by GPs

Although consumers and communities have required engagement in PHNs, it is not clear that this is the same level of engagement as clinicians. Consumers Health Forum has argued that PHNs must gear their governance, operations and the clinical practice they promote around the cornerstone principle of patients as partners in care. While stewardship is in the hands of GPs, in order to move from general practice to primary care, the team must be expanded to include pharmacists, dentists, allied health professionals, community services and carers.

### 2. PHNs have too many responsibilities and too few resources

The [recent evaluation](#) found that a potential limitation to ongoing development of PHNs is the very “lean” nature of most PHNs’ operating models, particularly for PHNs in rural and remote areas. Without sufficiently resourced operating models and sufficient secure resources for long-term planning, PHNs are hindered in their ability to build capability and scale-up to meet future expectations, let alone having capacity for innovation. Strategies to mitigate this risk include identifying potential economies of scale, as well as leveraging and formalising the collaborative approach and specific assistance and guidance for those PHNs found to be struggling.

### 3. Primary care services remain reliant on Medicare fee-for-service funding

The [recent report from the MBS review on general practice and primary care](#) recognises that GPs have “adapted provision of care to be viable in the framework of MBS fees and rebates presently available” – meaning that too often GPs are using items like those for chronic disease management based on decisions about their income rather than patients’ needs. It is well accepted that the [fee-for-service system works against effective and cost-effective models of care](#). Primary care financing must be structured [using evidence based policy](#) so that optimal outcomes for improved patient and population health can be achieved.

### 4. Concerns that PHNs have had a negative impact on ACCHOs

A [recent paper](#) has highlighted that PHNs, which control a significant amount of Indigenous-specific funding which ACCHOs have historically relied upon, have been resistant to meaningful engagement with Indigenous organisations. Moreover, the contestable funding and competitive services market in which PHNs operate has served to destabilise the Indigenous funding environment. These new mechanisms do not account for self-determination and cultural safety, factors which are integral to the operation of ACCHOs.

### 5. Specific problems with mental health have been identified.

The [recent report from the National Mental Health Commission](#) highlighted a number of specific problems, including:

- Funding and resources were commonly reported barriers across priority mental health areas for PHNs, with many reporting that they lack the funding necessary to implement the Fifth National Mental Health Plan actions. This includes the funding and resources required to achieve integrated planning and delivery.
- As a result of the short-term focus on the commissioning of services, with some contracts for only 12 months, many established providers of local services have been disenfranchised.
- Currently the ability of PHNs to ensure a continuum of mental health services with seamless transitions of care appears to be an issue: lack of service integration has been [identified as a common problem](#) for providers, consumers and carers.
- Almost a quarter of PHNs surveyed reported the availability of guidance from the DoH was a barrier across a number of priority areas, including for Indigenous mental health and suicide prevention.

6. Little is known about quality, safety and outcomes in primary care  
High quality and reliable data for primary care is limited, making it difficult to assess system performance with the same rigour as applied to hospital care and identify and monitor areas where improvements are better targeting are needed. Little is known about [patient safety in primary care](#). Limited data also restricts the ability to examine return on investments.

7. E-health support systems remain under-developed and under-utilised  
A [report from the Australian Commission on Safety and Quality in Health Care on digital health](#) looked at five digital health interventions: electronic patient portals; electronic patient reminders (mobile technologies); information-sharing at discharge (electronic discharge summaries); computerised provider order entry including electronic prescribing; and clinical decision-support systems. It concluded that the successes of these interventions are dependent on ensuring a rigorous implementation process and wide acceptance by potential users. The fact is that the e-health revolution in Australia is [easier said than done](#), as highlighted by continuing problems and concerns over [MyHealthRecord](#).

8. Engagement by both clinicians and consumers with PHNs is not optimal  
The [evaluation report](#) highlighted the need for PHNs to work with their Clinical Councils and other stakeholders to increase their engagement and reach with general practice. It also found that more needs to be done around effective consumer engagement. Many of the stakeholder relationships that PHNs have (for example, those with LHNs / LHDs) depend on the goodwill of individuals rather than being systematically embedded throughout the PHN Program.

## What needs to change?

1. Engagement needs to move beyond prescribed structures of clinical councils and community advisory groups

There needs to be large scale buy-in to the PHN programs and reforms from all primary care professionals and mechanisms to encourage this. We note that there is a difference between buy-in and active engagement: the former is more necessary than the latter, although ideally there should be both. As noted by the [evaluation report](#), the power of PHNs to influence the efficiency and effectiveness of medical services provided within general practice is currently more indirect than direct, for example via the provision of practice support. Mechanisms to strengthen the ability to drive change, including the better utilisation of data feedback, benchmarking and peer support should be investigated.

Consumer engagement strategies need to be broader and more meaningful. This must include a patient-centred approach and may also include efforts in co-design and co-production and greater stakeholder involvement in commissioning processes. [Experienced-based codesign](#) can improve quality and safety but is underutilised and [used variably](#) with the power imbalance between patients and health services remaining a challenge.

The [Collaborative Pairs Program](#) currently being rolled out by the Consumers' Health Forum will help in this regard. This is a leadership training program that supports the development of the mindset and practices that underpin the culture of shared leadership, partnership and, specifically, joint clinician-patient approaches to program and service development in health.

Feedback from patients, carers and community groups should be an essential part of all data collection and analyses. Patients are the [biggest resource](#) healthcare organisations have for improving the quality of care.

## 2. Changes to what Medicare pays for and how

As previously noted, current Medicare fee-for-service models hinder the adoption of the sort of collaborative and integrated care that is now recognised as best practice. New funding models are needed that are innovative, flexible, support healthcare professionals to consider and address their patients' needs, encourage preventive care and reward improvements in health outcomes and tackling health disparities.

A pragmatic beginning point that offers a stepping stone for future efforts is found in the [recent recommendations from the MBS Review](#).

## 3. Mechanisms to enable PHNs to share information

To take full advantage of the effort, funding (using public monies) and learnings from innovative initiatives undertaken by PHNs, it should be a requirement for PHNs to make their reports and evaluations publicly available. Currently many PHNs are not doing this, citing intellectual property and commercial-in-confidence issues. This is restricting learning and limiting the return on investment from use of public funds.

A central repository for such reports and evaluations and the ability to consolidate their findings will be essential. This could be done by building on the current [Primary Health Care Research and Information Service](#).

## 4. Increased guidance and resources

The governance and work of PHNs has been constrained by lack of formal guidance from the Department of Health, with the Department often seen as reactive rather than proactive to PHNs needs. There have also been constraints imposed by 'lean' budgets and limited resources. Funding levels in the future must be proportional to the work required, and there is a very clear need for a greater investment in primary care.

A [2018 report from the Grattan Institute](#) found that the funding, organisation and management of primary care has not kept pace with changes to disease patterns, the economic pressure on health services, and technological advances.

## 5. Capability building and learning systems

If the health system is to function optimally it needs to embed learning and improvement as normalised practice. This requires a paradigm change and whole of system transformation with population health data used by the whole system e.g. a chronic disease registry that goes beyond practice level data to one that is used by the whole system. There needs to be agreed minimum linked data sets (see below) that go beyond simple indicators supporting single loop learning to a comprehensive suite of indicators that support triple loop learning including the utilisation of PROMs and PREMS as routine practice. This will support the whole system to assume responsibility and enable a shift towards integrated care.

## 6. Scale up and translational efforts

The evidence about effective strategies for scaling up evidence-based practices in primary care is in [short supply](#). That said, there are opportunities to borrow (and then adapt) approaches from elsewhere, such as ["Scaling Up: a principled approach for primary care transformation in Alberta"](#). Here the basis is the [Diffusion of Innovations theory](#): this posits that the best way to bridge the "valley of death" - the point where innovations commonly fail to spread wider - is the engagement of early adopters with the majority and then the laggards. Other important principles include the identification and removal of barriers and disincentives.

## 7. Investment in leadership

The wicked problems facing health care may not have simple, obvious solutions but the evidence shows they all demand a leadership response that is adaptive in nature. This requires investment in meaningful leadership (clinical) development programs [that deliver competencies in a set of composite and contemporary capabilities and leadership behaviours](#). These leadership programs need to be ambitious and across whole systems and even across health, social and aged care sectors.

## 8. Data collection, analyses, utilisation and feedback

The May 2018 Federal Budget funded the Australian Institute of Health and Welfare to establish a [Primary Health Care Data Unit](#) and to develop a National Primary Health Care Data Asset. This Data Asset will support the reporting of key primary health care indicators, resulting in a better understanding of patient outcomes, from diagnosis, treatment and experiences within the healthcare system.

This Data Asset will support the reporting of key primary health care indicators, resulting in a better understanding of the patient's journey and experiences within the healthcare system, including their reason for an encounter with a clinician, diagnosis, treatment and outcomes.

The [Deeble Institute](#) has recently issued a call for the Government to capitalise on this initiative and back the AIHW in the development of a Primary Health Care National Minimum Data Set to assist PHNs in their business.

## 9. More primary health services research

The failure to continue to fund the work of the [Australian Primary Health Care Research Institute](#) and the cessation of the [Primary Health Care Research Evaluation and Development Fund Strategy](#) at the end of 2015 left a yawning gap in primary health care research and translation efforts. APHCRI worked with the DoH, researchers and clinicians to identify and conduct needed research and develop evidence-based policy responses based on that research.

It is likely that [funding provided via the Medical Research Future Fund](#) for the Advanced Health and Research Translation Centres and the Centres for Innovation in Regional Health will help fill this space.

Too often research funds small, time-limited projects with no mechanisms in place to explore how they might be scaled up or modified. Australia would benefit from the establishment of a centre along the lines of the [Center for Medicare and Medicaid Innovation](#) in the United States which supports the development and testing of innovative health care payment and service delivery models.

## Conclusion

There are plenty of words about the value of primary care, but only small efforts to turn the vision into reality. To quote a [recent report from the Grattan Institute](#): "Primary care policy is a renovator's opportunity". At the moment, absent change which might be driven by the forthcoming federal election, the only workmen available for this renovation are the PHNs.

Although publicly available information about their functioning, effectiveness and efficiency is limited, it appears that some PHNs are already well-placed to play a leadership role in primary care reforms at both the local and national level. Other PHNs will need assistance to develop this

capability and to ensure that the people they serve are not disadvantaged compared to those in areas with high-functioning PHNs.

This report outlines some of the barriers that currently exist for PHNs, some of the enablers that could help them drive changes in clinical practice and culture and provides suggestions about what would boost their capacity and capability to do this. The keys factors are leadership, sustainability, stability and funding commensurate with the tasks to be undertaken.

## Appendix 1: What do PHNs currently do?

There is a wide range of activities and consultations that all PHNs are required to undertake. Some PHNs have additional responsibilities as a consequence of their geographical location or funding grants.

### Operational activities

A long list of operational activities is detailed in the [PHN Grant Programme Guidelines](#). Significant personnel and resources are required for the optimal implementation of these requirements.

### Boards

Boards have accountability for the performance of the PHN in relation to outcomes, as well as clinical, financial, risk, planning, legal and business management systems. They also define the organisational culture and work with the CEO to develop and execute strategy.

### Clinical Councils

Clinical Councils which are GP-led, are a prescribed structure for each PHN. Other health professionals must also be involved, including but are not limited to, nurses, allied and community health, Aboriginal health workers, specialists and hospital representatives. Clinical Councils advise PHN Boards on clinical issues to assist PHNs to develop local strategies to improve the operation of the healthcare system to ensure effective primary care provision to reduce avoidable hospital presentations and admissions. Clinical Councils are expected to work in partnership with LHNs in this regard. Clinical Council are the regional champions of locally-relevant clinical care pathways, including pathways between hospital and general practice.

### Community Advisory Groups

Community Advisory Committees, also a prescribed structure, provide the community perspective to PHN Boards to ensure that decisions, investments, and innovations are patient centred, cost-effective locally relevant and aligned to local care experiences and expectations.

### Local engagement

PHNs must engage with LHNs, public and private hospitals, Aboriginal Medical Services, allied health providers, health training coordinators, nurses, state and territory government health services, aged care providers and private health insurers. (The purpose of this latter requirement is not clear as private health insurance cannot cover GP services).

PHNs are expected to develop cross-border cooperative relationships and shared Clinical Council and Community Advisory Groups where appropriate.

### Purchasing and commissioning of needed services

There are seven priority areas for targeted action by PHNs: these are mental health, Aboriginal and Torres Strait Islander health, population health, health workforce, digital health, aged care, alcohol and other drugs. It appears that [these priorities were determined by the government](#) rather than the individual PHNs, so addressing local needs must be added to this list.

By now all PHNs were expected to have moved from purchasing to commissioning. However there is no public statement that this has been done and no public listing of those situations where PHNs are unable to commission services and must therefore make other arrangements for their provision.

Achieving value for money is described as the “core requirement” of commissioning. There is no publicly available information on any instances where the DoH has over-ridden or rejected PHN commissioning decisions.

### Integration of services

Integration of health services is [described as a core function](#) of PHNs. This is to be done by:

- Reducing service gaps and duplication
- Engaging clinicians as agents of change
- Encouraging a multidisciplinary approach to patient care
- Improving health literacy

Digital health is seen as critical to integration.

However aside from several indicators relating to digital health, there are currently no indicators provided in the [PHN Program Performance and Quality Framework](#) to measure progress in this area. There is also no mention of the need to better integrate physical and mental health care and substance abuse treatment services.

### Data collection and reporting

PHNs are required to report on national, local and organisational indicators as outlined in the recently released [PHN Program Performance and Quality Framework](#). PHNs do not have direct access to data around some of these indicators such as preventable hospitalisations and rates of childhood vaccination, cancer screening rates and mental health treatment. This is assessed from a range of existing data collections by the AIHW and others.

There are 54 indicators (39 performance indicators and 15 organisational indicators). At this stage, the performance indicators largely reflect measures which already exist within the health care system (eg from MBS, PBS, AIHW, ABS). Some of the indicators are quite perfunctory: Is improving access effectively measured by the rate of GPs receiving payment for after hours services? Is the rate of discharge summaries uploaded to My Health Record a good measure of coordinated care? In some of the most important areas – health literacy, cultural safety, patient-reported experiences – there are no indicators.

### Practice support

The [DoH fact sheet on practice support](#) states that this involves a range of activities including (but not limited to):

- quality improvement and adoption of best practice methods.
- promoting and improving practice accreditation.
- professional and workforce education and development.
- supporting the uptake and meaningful use of digital health systems including the use of My Health Record.
- designing and supporting quality care initiatives (e.g. chronic disease management, mental health, diabetes, immunisation, Closing the Gap, and sexual health).
- supporting patient data management through software, guidelines, or training and meaningful use of data.
- cultural awareness and competency.

It is suggested that this could involve on-site practice visits, newsletters and bulletin updates, training, networking and educational events. There is no direct measure for this, apart from the rate of practice accreditation and uploads to My Health Record.

## Services that PHNs are required to commission

### Mental health

PHNs have several sources of mental health funding and it is assumed that separate reporting is required on each of these. These services are to be provided in accordance with a [‘stepped care’ approach](#).

*Services funded via the Mental Health Care Flexible Funding Pool:*

[Implementation guidance](#) is provided for:

- Low intensity mental health services for early intervention (with the Digital Mental Health Gateway as a core element).
- Psychological therapies to under-served groups (what used to be Access to Allied Psychological Services).
- Primary mental health services for people with severe mental illness.
- Aboriginal and Torres Strait Islander mental health services.
- Child and youth mental health services. The management and funding of *headspace* and the associated early psychosis intervention program has been transferred to PHNs).

### *Other mental health funding*

Some PHNs may also play a role in the delivery of programs such as Partners in Recovery (although is being phased out as the National Disability Insurance Scheme (NDIS) is implemented).

In June this year it was [announced](#) that the Commonwealth Government would provide additional funding to PHNs for the provision of psychosocial support services to people with severe mental illness who are not eligible for support under the NDIS (an announcement previously made in the 2017-18 Budget). This funding comes with matching funds from the states and territories, although it is assumed this will go to community health services and not to PHNs.

### *Lead PHNs*

Ten PHNs have been designated as [lead sites](#) and are described as having a central role in developing and modelling innovative approaches to regional planning, integration and stepped care. Some of the lead PHNs are trialling clinical care packages for individuals with severe and complex mental illness. Longer term, it is expected that this will [evolve](#) into a medical homes approach and engagement with the private mental health care sector.

### Suicide prevention

The [National Suicide Prevention Strategy](#) involves a “systems-based regional approach to suicide prevention led by PHNs in partnerships with LHNs and other local organisations including Aboriginal and Torres Strait Islander service providers.” This is a key priority for all PHNs which are required to undertake planning implementation and commissioning of regionally orientated community-based suicide prevention activities.

Eleven PHNs are also involved in the [National Suicide Prevention Trial](#) which is being conducted at 12 sites around Australia. It commenced in April 2017 and was initially funded through June 2019; it was recently announced that this funding would be extended through to June 2020.

Some PHNs are also involved in the [National Suicide Prevention Leadership and Support Program](#). It’s not clear if these are the same PHNs that are involved in the trial.

A [Primary Health Network Advisory Panel on Mental Health](#) was established in March 2017. This was announced as time limited Advisory Panel on Mental Health will be time-limited, to hold four meetings and conduct two PHN Forums to:

- develop a Framework for Primary Health Network mental health commissioning informed by the analysis of the guidelines for mental health commissioning

- undertake an analysis of needs assessments and mental health plans
- compile reports for individual PHNs based on the Framework
- compile an interim aggregate report in relation to PHN mental health commissioning and a final report for the Minister for Health.

The Panel held at least one meeting in [June 2017](#) but there is no information about further meetings or reports on the website, which has not been updated since July 2017. A specific document on a framework for commissioning mental health services does not appear in the list of [PHN Mental Health Tools and Resources](#).

#### After-Hours services

Following a review in 2014, [new funding arrangements](#) for the provision of after-hours services were implemented from 1 July 2015 with a new [PIP After Hours Incentive](#) funding to [Primary Health Networks](#) and a new after-hours GP advice and support line. PHNs are [required to plan, coordinate, and support](#) population-based after-hours health services, focusing on addressing gaps in service provision, 'at risk' populations, and improved service integration. This work is undertaken by all PHNs.

#### Palliative care

The 2017-18 Budget provided [\\$8.3 million](#) to enable PHNs to trial palliative care services in the home. The [ten successful PHNs](#) were announced in February 2018. This trial, which will run until June 2020, will involve GPs, palliative, hospital and specialist care support, and community and social services and will require the coordination with local and state services and aged care providers.

#### Drug and alcohol treatment services

Responsibility for the commissioning of drug and alcohol treatment services was nominally [transferred to PHNs](#) in late 2015 to "support improved access to services, within the primary health sector, for people that need help, but do not qualify for specialist treatment". The [aim](#) is to reduce the harms associated with drugs and alcohol, with a focus on methamphetamine use in the community, including Indigenous-specific services. However, there was a 12 month extension to existing direct funding arrangements for drug and alcohol treatment services to enable a review of these.

In March 2017 the Minister for Health announced the outcome of this review and funding was provided to PHNs to "commission and administer an additional two years funding to existing services until 30 June 2019" (from [Primary Health Network Grant Programme Guidelines Annexure A2](#)). Thus, it appears that contestability is not yet part of the provision of these services, although funding uncertainties likely meant some previous service providers have walked away.

#### Indigenous services

##### Integrated Team Care

The [Integrated Team Care activity](#) combines the former Care Coordination and Supplementary Services (CCSS) and Improving Indigenous Access to Mainstream Primary Care (IIAMPC) programs. ITC is provided by teams made up of Indigenous Health Project Officers, Aboriginal and Torres Strait Islander Outreach Workers and Care Coordinators to provide care coordination services to those with chronic conditions and improve access to culturally appropriate mainstream primary care.

##### Other PHN services

##### Health Care Homes

The [Health Care Homes initiative](#) has been rolled out in practices located in ten PHNs. There is no public information about specific funding to PHNs to support the practices taking part.

#### Activities carried over from Medicare Locals

2016 was supposedly the transition year for activities that carried over from Medicare Locals, but it appears that some of these remained in 2017-18. It is possible that even now there are some remnant programs.

Note: This is not a complete list of PHN activities. The extent to which PHNs deliver activities funded by states and territories, or other funding bodies is not known. Some PHNs may also have funds from the Commonwealth Government for specific initiatives such as counselling associated with testing for blood levels of per- and poly-fluoroalkyl substances.

## Appendix 2: Funding for PHNs and their activities

### Operational and flexible funding

The total amount of operational and flexible funding allocated to PHNs was [\\$852 million over the three years from 2015-16](#). It is not clear what funding has been provided since June 2018; it is not mentioned in the 2018-19 Budget Papers. The DoH Portfolio Budget Statement 2018-19 shows that funding for Outcome 2.5 (Primary Health Care Quality and Coordination – this includes PHNs) drops from \$435.4 million in 2018-19 to \$331.9 million in 2019-20, and even less in the out years. There is no explanation provided for this and it may indicate that funding for PHNs is set to decrease.

Operational funding provides for premises, staff, administration and IT expenses. Some of the flexible funding goes to mental health services, but there are also other sources for this. It is assumed that practice support initiatives are also supported by this funding source.

Other funding sources available to PHNs include:

### Additional funding for commissioned services

PHNs also receive program funding for after-hours services and alcohol and drug treatment services.

### Innovation and incentive funding

PHNs may receive funding to enable them to trial new models of primary care delivery and incentive funding is available to high-performing PHNs that reach specific performance targets.

These funds are allocated to PHNs on the basis of a number of factors, including population, rurality and socio-economic factors. The amounts each PHN receives and how this is allocated across each activity is not publicly available.

### Funding levels for required activities

#### Mental health

- \$1.030 billion over three years commencing in 2016-17 is provided for activities under the Mental Health Care Flexible Funding Pool. Funding is allocated to PHNs based on population size, rurality, socio-economic factors and relative access to Medicare-funded psychological services. An additional \$28 million / year is provided for Aboriginal and Torres Strait Islander services. ([Annexure A1](#)). (Note that this funding pool has subsumed funding previously provided for a number of programs including ATAPS, the Mental Health Nurse Incentive Program, *headspace*, and early psychosis programs.)
- [\\$80 million / 4 years](#) from July 2018 for services for people with severe mental illness who are not eligible for support through the National Disability Insurance Scheme.
- [\\$1 million](#) was provided to the Country SA PHN for mental illness during the July by-election campaign.
- [\\$26 million](#) for 10 PHN lead sites announced in October 2016.

In January the Health Minister announced that mental health funding for PHNs, due to expire in June 2019, would be continued through to June 2022, at a level of [\\$1.45 billion](#). This is \$170 million more than the previous three-year funding level. This is good news in that it provides some funding certainty into the future; it's disappointing in that the amount provided will be insufficient to meet the growing needs.

#### Suicide prevention

- [\\$46 million / 4 years](#) from 2016-17 to 2019-20 for 12 suicide prevention trial sites.

#### After Hours services

The 2017-18 Budget provided [\\$145 million / 4 years](#) but took savings of \$41.9 million from funding previously included in the forward estimates.

## Drug and Alcohol services

[\\$241.5 million / 4 years](#) from July 2016 was provided in 2015 (of this, \$78.6 million was specifically for Indigenous services). In 2017 a further [\\$42.6 million / year](#) was added to June 2019.

## Palliative care

In March 2018 the Minister announced [\\$9.0 million / 3 years](#) (from 2017-18 to 2019-20) to boost funding for PHNs to improve palliative care coordination to support people who have a known life-limiting condition.

## Contracts managed by PHNs

A [recent report](#) from the DoH that lists its major contracts for the 2017-18 financial year reveals that the total value of active contracts managed by PHNs, including multi-year arrangements, was \$4.46 billion.

According to an [independent analysis](#) this was made up of:

- \$1.7 billion in start-up capital, granted to the networks in June 2015 and intended to last until 2021.
- \$280 million for after-hours GP services, until June 2019.
- \$95 million for alcohol and drug treatment programs.
- \$8 million for palliative care programs.
- \$16 million for innovation and incentive programs.

These funding levels do not align with those sourced separately for this paper.

This analysis provides a measure of the active contracts for each of the 31 PHNs. This varied significantly across the country, with those PHNs covering rural areas with large Indigenous populations managing the most contract funding.

The DoH report indicates that all the PHNs received funding (of variable amounts) under the following headings:

- Operational and flexible funding
- After-Hours funding
- NGO treatment grants program
- Mental health and suicide prevention operational and flexible funding
- Integrated Team Care
- Transition Funding

Additionally, all PHNs received a sum of \$521,620 in Innovations and Incentive funding.

Some PHNs received funding for:

- Indigenous mental health
- Palliative care
- Health Care Homes
- Partners in Recovery
- Multicultural Australia community services
- Practice support
- PHNs may also receive funds from other sources that may include NGOs, PHI, philanthropy and state government.

## Appendix 3: Assessment of PHN performance against key indicators

Boards will have accountability for the performance of the PHN in relation to outcomes, as well as clinical, financial, risk, planning, legal and business management systems. This is then assessed by the DoH.

The [PHN Performance and Quality Framework](#) was only recently introduced, in September 2018. There are some earlier reports and plans for the period 2016-2018 available online.

The Framework document states that performance information on all PHNs will be made publicly available. Performance reporting is required every six months and individual PHN performances will inform contract negotiations. Over time, PHN performance peer groups will be established “in order to share results across different indicators to drive improvements.” High performing PHNs will be rewarded with incentive funding (note that to date all PHNs have received this), increased contract length, the opportunity to take over contracts for those regions with poor performance, and public recognition of their success.

An [evaluation report of PHNs](#) for the period for the period July 2015 to December 2017 was released late in 2018. There is also information available online about a [multi-part evaluation of the Mental Health Lead Site Project](#). Information about the progress or otherwise of a number of named PHNs in commissioning for mental health and suicide prevention services is included in the recent [NMHC report](#) on the implementation of the Fifth National Mental Health and Suicide Prevention Plan.