

VTPHNA Response

PHN Business Model Review

Paper 1

22 January 2025



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This submission (Paper 1) was prepared by the VTPHNA Office on behalf of the Victorian and Tasmania PHNs

22 January 2025



EXECUTIVE SUMMARY

Overview

- PHNs were established to strengthen the national capacity and coordination of primary care, improve patient-centred service integration and increase the efficiency and effectiveness of primary healthcare services for Australians, particularly those at risk of poor health outcomes. The PHN model allows localisation, agility and flexibility and ensures policy responses are rapidly deployed nationally but with local nuance.
- Formed in 2016, the Victorian and Tasmanian PHN Alliance (VTPHNA) comprises six Victorian PHNs and the Tasmania PHN and aims to optimise individual effectiveness and the collective capabilities of the PHNs to proactively align efforts with a jurisdictional purview, to advance primary care reform, and enhance their contribution to the health system.
- The total national PHN funding is approximately \$1.9 billion, equating to less than 1% of the total national health expenditure. However, within the Victorian and Tasmanian contexts, PHNs are critical meso-level health organisations that foster the connection and integration between health systems and activate and support policy reform at the local level.
- The Victorian State funded health system includes 76 independently governed health service (hospital) entities – this is more than all other states and territories combined. The complexity of the Victorian health system inherently impacts on the work of Victorian PHNs, resulting in a need to manage a multitude of stakeholder relationships to work effectively within the Victorian system.
- Tasmania, with a population of over 557,000, faces healthcare access challenges due to its distributed regional populations. With 61% of state population living outside Hobart, Tasmania has the greatest regional/rural population proportion of all jurisdictions. Primary Health Tasmania (PHT) operates statewide and partners with the Tasmanian Government on health reforms such as the Long-Term Plan for Healthcare in Tasmania 2040. PHT plays a significant role in bilateral mental health activity but remains a secondary partner in state collaborations for primary care activities.

Key Review Question 1: PHN Role

Opportunity: *PHNs are uniquely placed to identify and address the barriers to health care that consumers face across Australia. Working at the meso-level, PHNs coordinate healthcare services across multiple providers, manage regional resources, implement solutions, and translate national health policies locally to improve health outcomes for communities. The role of the PHN contribution is unique in Australia, as a primary care co-ordinating entity that has evolved from previous iterations and has been replicated internationally. PHNs develop place-based solutions, connect local services into systematised approaches according to local and regional contexts, and translate and implement national policy for local outcomes. With appropriate support, PHNs have the capability to effect meaningful change at the care interface with acute, aged care, and mental health, towards a one-health system.*



Key issues:

- **PHN Roles and Activities:** PHNs have three core functions: capacity building, commissioning, and coordination however, the diversity of the role and capability of PHNs are not always clear to stakeholders, who may only see one aspect based on their interactions. PHNs are recognised for their regional commissioning and workforce development, and offer significant expertise in health system integration, shaping of local health markets, and use of data to derive insights about local health needs.
- **Diversity of PHN Roles:** Since 2015, PHN Commonwealth funding has tripled, from almost \$900 million in 2016¹ to over \$2 billion in 2024, with the number and scope of funding schedules, programs, and activities increasing significantly. In parallel with this growth in scale and scope for Commonwealth programs, state governments have also significantly increased their investment in the health system via PHN structures. This growth demonstrates the evolving role of PHNs, but also brings administrative burdens that outpace Department of Health and Aged Care's (DoHAC) governance and reporting systems.
- **Stakeholder Perceptions of PHNs:** Stakeholder understanding of PHNs varies based on their engagement type. Whilst some see PHNs solely as commissioners, others recognise their roles in service design, education, and system reform. Effective communication strategies supported by the Commonwealth are needed to improve the visibility and understanding of PHNs' impact and capacity.

Opportunities for improvement:

- Clearly articulate the three core functions of PHNs—capacity building, commissioning, and coordination—to all stakeholders. This will ensure a comprehensive understanding of PHNs' multifaceted roles in health system integration, local health market shaping, and data utilisation for local health needs. Ensure role definitions correspond with a current PHN strategy that aligns with contemporary issues of the Australian health system.
- With Commonwealth funding for PHNs having tripled since 2015, alongside an increase in the number and scope of funding schedules, programs, and activities, PHNs face significant administrative burdens. Enhance governance and reporting systems through DoHAC to keep pace with the evolving scale and scope of PHN activities.
- Develop and implement effective communication strategies supported by the Commonwealth to highlight the impact and capacity of PHNs. This will enhance stakeholders' understanding of the diverse roles PHNs play beyond just commissioning, including service design, education, and system reform.
- Given the increasing statutory and regulatory responsibilities of PHNs as Australian Public Companies Limited by Guarantee, it is essential to regularly update PHN program guidelines. Ensure adequate resourcing to meet compliance requirements effectively.

¹ <https://www.phrp.com.au/issues/january-2016-volume-26-issue-1/the-new-australian-primary-health-networks-how-will-they-integrate-public-health-and-primary-care/>



Key Review Question 2: PHN Governance

Opportunity: *The CLG structure is the most appropriate governance model that balances local autonomy and flexibility with a robust set of protections that minimises risk for the Commonwealth and stakeholders. Devolved governance and independence of the PHN allows a focus on local outcomes, policy translation and strategy through integration with local services and systems. The CLG structure for PHNs would be strengthened through improved performance management and a clear outcomes framework. To achieve this, DoHAC should focus on building its own capacity to integrate principles of good contract management with PHNs to drive and monitor performance towards shared goals.*

Key issues:

- **Fit for Purpose or Strengthened Governance Arrangements:** The current Company Limited by Guarantee (CLG) structure provides a strong legal framework for PHNs, balancing autonomy with accountability, and ensuring stakeholder protection and governance flexibility.
- **Flexibility and Responsiveness:** The devolved governance model of the PHN program allows PHNs to drive local outcomes by adapting national policies to local contexts. This enables local implementation of national policies and development of place-based solutions associated with PHN capacity to enhance and integrate local enablers with flexibility and responsiveness. PHN boards comprise individuals with local and system knowledge, ensuring regional insights and community accountability. This local intelligence is considered alongside national objectives for improved patient outcomes.
- **Governance and Regulatory Obligations:** PHNs, as Australian Public Companies Limited by Guarantee, are regulated by various acts, including the Corporations Act and the ACNC Act. Over time, statutory and regulatory responsibilities have increased, necessitating regular updates to PHN program guidelines and adequate resourcing to meet compliance requirements.
- **DoHAC Oversight and Assurance:** The DoHAC PHN audit program provides independent analysis of the quality of governance, consumer, service delivery and business processes. However, inconsistent formal oversight creates a significant burden on PHNs. A consistent PHN Assurance cycle would reduce duplication and improve planning for assurance activities.
- **Common Infrastructure and Activities:** PHNs have demonstrated effective collaboration to produce common infrastructure and activities where it benefits the local community and minimises bureaucratic burden for service providers across multiple PHNs. Collaboration on workforce skills and competencies between PHNs has led to increased efficiency and consistency.
- **Health Outcomes and Funding Arrangements:** Realistic planning and commissioning timeframes are essential for effective service delivery. In addition, the PHN Deed, Program Guidelines, and program KPIs do not have a clear line of sight to measuring the effectiveness of the three C's, nor whether improved health outcomes have been achieved within the community. Funding for health outcomes, rather than service activity should be a focus of model reform.
- **Adequacy of Performance Monitoring:** PHNs face challenges with unclear performance benchmarks and performance reporting tools that have previously been judged as not fit for purpose in the recent ANAO audit. There is a need for outcome-focused performance management measures and a single source of truth for PHN performance data.



- **Comparable Meso Structures:** Health system commissioning models in the UK, New Zealand, and Canada offer insights into devolved governance. These models emphasise the utility of meso structures that offer local agency with central oversight and provide valuable lessons for the Australian context. This highlights the following two questions that appear are not being addressed within this review but which we think are critically important, namely:
 1. Is there a case for a meso level structure in the Australian Health Systems?
 2. If so, what are the factors that ought to inform the design of this structure?

Please refer to the supplementary paper '**The case for Primary Health Network Meso-level structures in Australia**' for exploration of these questions.

Opportunities for improvement:

- Reinforce the appropriateness of the current Company Limited by Guarantee (CLG) structure which balances autonomy with accountability and ensures stakeholder protection and governance flexibility. Evaluate the structure periodically to ensure it remains fit for purpose and implement best-practice contract monitoring activities.
- Implement a consistent PHN Assurance cycle to reduce duplication and improve planning for assurance activities. This will mitigate the significant burden created by inconsistent formal oversight and enhance the quality of governance, consumer service delivery, and business processes, whilst allowing for collaborative action to address issues.
- Support effective collaboration among PHNs to produce common infrastructure and activities that benefit the local community and minimise bureaucratic burden for service providers. Encourage collaboration on workforce skills and competencies to increase efficiency and consistency.
- Shift the focus of funding from service activity to health outcomes. Align PHN Deed, Program Guidelines, and program KPIs with health outcome measurements to ensure realistic planning and effective service delivery.
- Develop outcome-focused performance management measures and establish a single source of truth for PHN performance data. Address current challenges with unclear performance benchmarks and performance reporting tools to ensure they are fit for purpose and measure what matters to consumers.

Key Review Question 3: Regional planning and integration

Opportunity: *Integrated care and joint regional health planning can benefit consumers by improving the quality of care, reducing costs, and increasing access to services. PHNs have deep knowledge and understanding of the local health systems within their regions. There is PHN readiness, capability, and opportunity for a DoHAC commitment supporting integrated regional planning at the bi-lateral policy level, that is then translated into NHRA and PHN 5-year funding agreements. Expectations for regional planning could include a requirement for PHN's and LHN's to develop integrated 3–5-year Regional Health Plans and report implementation progress to the joint Health Ministers meeting on a triannual basis.*



Key issues:

- **Fragmented Authority and Resourcing:** PHNs have developed strong capabilities in needs assessments, providing valuable insights for decision-making to inform regional planning and program implementation. PHNs are not adequately supported or resourced for their role in joint regional planning or emergency response, especially with regional actors and state governments. They lack the authority to plan beyond the scope of primary health, despite high expectations from DoHAC and the evidence that service integration is a key opportunity for health systems sustainability and improved health outcomes. PHNs face several constraints, including limited influence in bilateral discussions, lack of commitment to integrated planning by all policy, funding and service delivery actors and lack authority. Short-term funding is also cited as a blocker to joint planning due to perceived program instability. These constraints hinder collaborative planning and sustainable model development.
- **Diluted Responsibility and Fragmentation:** Responsibility for population health is spread across multiple health agencies, leading to diluted accountability and fragmented efforts. In Victoria, numerous local governments, public health units, and health service partnerships (HSPs) undertake health needs assessments and planning, without standardisation. In addition, most health planning is conducted at individual health service or PHN levels, resulting in ad hoc and program-specific planning. Clear joint planning expectations and dedicated resources are necessary for more cohesive regional planning. A suggested way forward could include – commitment to integrated regional planning at the bi-lateral policy level, that is then translated into NHRA and PHN 5-year funding agreements, with a requirement that PHN's and LHN's develop integrated 3–5-year Regional Health Plans and report progress to the joint Health Ministers meeting on a triannual basis.
- **Meso Structures:** International models show that meso-level structures, like PHNs, are effective in delivering primary health care outcomes by implementing local, place-based solutions. PHNs play a crucial role in system planning, integration and coordination. In Victoria, LHN and PHN boundaries could not align due to the 76 independent LHNs as LHNs work with service catchments rather than geographic boundaries. Despite this, the six PHNs manage a balance between population size, addressing diverse health needs, and coordinating with existing health services. The newly announced 12 Local Health Service Networks (LHSNs) in Victoria will enable improved alignment however, in the short term the reduction from 76 to 12 LHSNs in the Victorian system is likely to include a high distraction factor, and likely to increase change management and engagement work for PHNs over the next 2 to 3 years. Optimistically, 12 LHSNs and 6 PHNs will provide a much-improved basis for strengthening regional population health and service planning and coordination of services-and systems.
- **Regional Coordination and Flexibility:** PHNs have developed strong capabilities in needs assessments, providing valuable insights for decision-making to inform regional planning and program implementation. However, the lack of a clear bilateral policy direction severely limits the impact of these assessments on regional planning and program implementation. The 'Shifting the Dial' report suggests that central governments should avoid prescriptive rules for integrated care, instead allowing regional institutions like PHNs and LHNs flexibility to experiment and respond to local variations.



- **Bilateral Activities:** The Commonwealth has bilateral agreements between jurisdictions for mental health and primary health. Engagement with state agencies varies, where PHNs are often driving joint work in the primary care space, the mental health is a different story with state agency driving the work. Greater involvement from DoHAC and aligned funding could improve collaboration. However, PHNs routinely and successfully collaborate with local health stakeholders on initiatives to facilitate integration and reduce fragmentation. These local innovations have not been widely adopted or embedded into the system due to the structure of the wider health system.

Opportunities for improvement:

- Recognise and provide adequate resources for PHNs to enhance their role in joint regional planning, especially with regional actors and state governments. Strengthen collaboration and ensure all policy, funding, and service delivery actors are aligned. Provide PHNs with more authority in bilateral discussions to support sustainable planning and system reform.
- Establish clear joint planning expectations and allocate resources to promote cohesive regional planning across health agencies. Support standardised health needs assessments and planning processes through PHNs and LHNs to develop integrated 3–5-year Regional Health Plans and report progress Tri annually to the joint Health Ministers meeting.
- Consider opportunities to align PHN and proposed LHSN boundaries to improve service coordination and reduce fragmentation. Support the transition to 12 LHSNs in Victoria to enhance regional population health and service planning opportunities.
- Allow PHNs and LHNs flexibility to experiment and respond to local variations, avoiding rigid rules for integrated care. Strengthen the impact of needs assessments on regional planning by establishing clear and accountable bilateral policies.

Key Review Question 4: PHN Funding Model

Opportunity: *To create system change within the primary health care system, to meet the needs of consumers, to support a stable health workforce, and to ensure access to sustainable services, PHNs require the following amendments to the PHN funding model:*

1. *Five-year funding cycles to align with other health system actors*
2. *Indexation of funding to reflect CPI and actual costs*
3. *Renewal of agreements on a rolling three-year basis to ensure service stability and sustainability*
4. *Core-flex funding increased to reflect actual operational costs.*

Key issues:

- **PHN Funding Model Adequacy:** The current PHN funding contracts are mostly renewed on a three-year cycle, creating financial risks and inefficiencies for PHNs. Despite massive growth in PHN expectation and role, the core operational funding component has not changed since program inception, therefore, the operational funding has not kept pace with inflation or the actual costs of running PHNs, leading to budget shortfalls. Misaligned upfront payments for new



programs and inadequate establishment funding further complicate financial management. There is a need for a more realistic and flexible funding approach to support long-term system reforms.

- **Grant-Based Funding Suitability and Efficiency:** The current grant program system is completely at odds with the long-term system reform and commissioning intentions of the PHN program and PHNs themselves. The grant program is not fit for purpose due to approval delays, misalignment of funding and policy timeframes, and a simplistic annual budget and reporting system. Delayed approvals for budgets and new activities impact PHN performance, staff morale and frequently results in commissioned providers reducing staff numbers in the absence of appropriate levels of funding commitment (which exacerbates workforce challenges in the health sector). It also impedes stakeholder engagement, with the broader health sector less able to trust in the program approach resulting from these funding arrangements. The competitive grant application process is unsuitable, and the annual budget system requires resource-intensive rollover requests. A shift to a more consistent and streamlined funding approach is necessary for better efficiency and local effectiveness.
- **Adequacy of Financial Reporting Systems:** The Department's requirement for PHNs to report operational costs in a siloed manner obscures the true operational cost. Financial reporting should be at a 'whole of business' level to enable better cost benchmarking and financial modelling. Core funding streams should be simplified to reduce accounting and reporting complexity, and outcomes focused KPIs should be established for effective performance accountability.
- **Funding Flexibility and Local Innovation:** The complex arrangement of funding schedules affects service planning and delivery. More stable and flexible funding would allow PHNs to better respond to local community needs. Potential improvements include establishing streamlined budget approval processes, combining funding streams, and periodically reviewing grant terms and conditions.
- **Funding Services Sustainably:** One year funding for services that need to be ongoing is highly frustrating for both patients, local communities, and service providers. No sooner is the service stood up before it must be stood down. It is highly frustrating for service providers, their staff, and of course highly confusing for patients and local communities. There are two elements to consider in sustainable services funding:
 - **The lack of funding indexation** is highly problematic for continuity of services. In primary health and mental health settings, 70-80% of funding is used to pay staff salaries and wages. Most NFP providers have salary rises of approximate 2.5-3.5% per annum, whilst tertiary health providers under professional awards may need to sustain higher increases.
 - **The fixed nature of the Commonwealth funding** combined with escalating costs in salaries effectively means service providers are taking a funding reduction every year they contract. Over multiple years this can add up to an effective 10-20% funding reduction.

Opportunities for improvement:

- Extend PHN funding contracts beyond the current three-year cycle to reduce financial risks and inefficiencies. Provide more stable and flexible funding to allow PHNs to better respond to local community needs. Extend funding durations for ongoing services to avoid constant service disruptions.



- Adjust the core operational funding to reflect inflation and actual costs, ensuring budget sufficiency. Simplify core funding streams to reduce accounting and reporting complexity. Index funding to account CPI and salary and wage increases in the primary health and mental health settings. Ensure funding adjustments reflect escalating costs in salaries to prevent effective funding reductions over time.
- Reform the grant program system to better align with long-term system reform and commissioning intentions. Replace the competitive grant application process with a more suitable funding approach. Align upfront payments and establishment funding to improve service planning and financial management.
- Streamline the approval process for budgets and new activities to enhance PHN performance and stakeholder engagement. Simplify the annual budget system to reduce resource-intensive rollover requests. Establish streamlined budget approval processes and combine funding streams for improved efficiency.
- Revise Financial Reporting Systems to report operational costs at a 'whole of business' level for better cost benchmarking and financial modelling.
- Establish outcomes-focused KPIs for effective performance accountability.

Key Review Question 5: PHN role in mental health system

Opportunity: *The role of the PHNs within the mental health and suicide prevention system mirrors the role described in Review Question 1, as a meso-level health organisation that aims to integrate the mental health system and improve health outcomes for communities. Proportionally, PHNs have a greater funding influence in the local mental health system and hold deep understanding of local health needs and system gaps. To strengthen the framework for PHNs to demonstrate accountability and effectiveness in their work, and thereby increase effectiveness, a clear, equity-focused purpose for the MHFFS, with outcome-based goals that align with regional needs is required. With a clearly defined systemic purpose and an aligned outcomes framework, PHNs offer capability in driving mental health system integration in the context of local needs, gaps, and capacity. In addition, PHNs are uniquely placed to lead enhanced integration with primary care, and system reform would benefit from increased accountability and delineation of roles for bilateral activities.*

Key issues:

- **Role within the Mental Health System:** As one of the few meso level mental health agencies, PHNs play a crucial role in commissioning, building capacity and co-ordination ('the 3 C's') that aligns with national and jurisdictional strategies. This includes and is not limited to commissioning services across the stepped care model, supporting marginalised groups, and co-ordinating and promoting integration across the care pathways and continuum, building the capacity of local providers to integrate services, and creating learning health systems at the local and regional level. PHNs play a key role in addressing gaps within the system whilst promoting and maintaining a clear equity focus.
- **Effectiveness:** PHNs serve as independent regional commissioners, capacity builders and coordinators and it is the interplay between the '3 Cs' that enabling them to work with key stakeholders to design locally integrated mental health and suicide prevention care, often pushing up against current funding structures and reporting requirements that inhibit integration with



related services (i.e. AoD). Challenges include unstandardised effectiveness measurements, lack of an outcomes framework, limited funding flexibility and a generalised lack of clarity by multiple stakeholders of the role of a meso level actor. Examples of effective and ineffective programs underscore the need for better coordination between state government and PHNs.

- **How the Role Could Evolve:** A clearly defined systemic purpose aligned with DoHAC's vision for equity of access, the role of meso level actor and the '3 Cs' is essential. Developing equity-based planning tools, innovative care pathways, data integration, and leadership in service reform will enhance PHNs' effectiveness.
- **Changes Since MHFFS Introduction in 2016:** Increased complexity of consumer presentations, unmet needs from NDIS changes, post-COVID mental health surge, workforce pressures, and state-level implementation gaps highlight the need for adaptation and flexibility.
- **Adapting to Future Changes:** Clarification of mental health terms, intentional outcome service commissioning, data linkage, primary care reforms, early intervention services, and facilitating self-determination approaches to Aboriginal and Torres Strait Islander wellbeing are key areas for future focus. Leveraging the lived experience workforce, responsive commissioning for crises, addressing workforce distribution, and expanding digital health interventions are also crucial.
- **Challenges and Solutions:** Challenges include limited flexibility in local planning, lack of a clearly defined systemic purpose, program complexity, siloed funding, and lack of national coordination. Solutions involve increasing flexibility in service planning, clarifying program purpose and accountability, simplifying service models and funding mechanisms, creating national platforms for collaboration, and strengthening governance and collaboration. The development of an authorising environment which mandates a PHN role in local regional planning governance structures is critical. Implementing these solutions will improve mental health outcomes and create a more effective mental health system.

Opportunities for improvement:

- Establish a clearly defined systemic purpose for PHNs that aligns with DoHAC's vision for equity of access, emphasising their role as meso-level actors and their '3 Cs' functions (commissioning, capacity building, and coordination). Allow PHNs greater flexibility in local planning to better respond to the unique needs of their communities.
- Encourage PHNs to take on leadership roles in service reform, focusing on developing and implementing equitable, integrated mental health and suicide prevention services. Focus on commissioning services with a clear intention towards achieving specific outcomes, supported by appropriate data linkage and primary care reforms.
- Create equity-based planning tools that support collaborative planning, enabling innovative care pathways and effective data integration to enhance the impact of PHNs. Implement standardised effectiveness measurements and an outcomes framework to better assess the impact of PHNs.
- Support PHNs to prioritise early intervention services and facilitate self-determination approaches to improve Aboriginal and Torres Strait Islander wellbeing. Utilise the insights and expertise of the lived experience workforce to inform responsive commissioning and address workforce distribution challenges.



- Enhance governance structures and foster collaboration among stakeholders to support the effective implementation of mental health initiatives. Establish national platforms for collaboration, allowing PHNs to share best practices and coordinate efforts more effectively.
- Clearly define the purpose and accountability mechanisms for mental health programs to ensure alignment and effectiveness between multiple actors. Create an authorising environment that mandates a PHN role in local regional planning governance structures, ensuring their active participation and influence.

Key Review Question 6: Adequacy of the PHN mental health funding stream

***Opportunity:** Person-centred mental health care is a way of providing care that is tailored to each person's needs, preferences, and goals. Service continuity, workforce stability, and supported navigation through the health system improve the experience of care and health outcomes. Updating the MHFFS funding model to support co-commissioning, implementing longer-term funding cycles, and integrating it with related policy areas such as Alcohol and Other Drugs (AOD) and family domestic violence would better meet the evolving needs of the community and promote a more holistic approach to care. The funding model should focus on commissioning for outcomes and be supported by meaningful performance indicators. The revised MHFF Program should be a lever that assists integration with other related programs, fosters collaboration and accountability, is long-term, supports workforce stability, and results in innovative and value-based care.*

Key issues:

- The current funding allocation under the Mental Health Flexible Funding Scheme (MHFFS) has a **misalignment with its program objectives**, which is creating administrative burdens and inefficiencies for service providers and stakeholders.
- Primary Health Networks (PHNs) require **greater flexibility in funding allocation**. This flexibility is essential to effectively address and meet the evolving and diverse needs of their respective communities, especially considering varying local conditions.
- **Reducing the number of activity streams and prescribed priority populations** within funding guidelines would enhance the efficiency and effectiveness of service delivery. Simplifying these aspects would allow for more streamlined operations and a focus on key priorities.
- **Funding should be outcome-focused** rather than prescriptive. Emphasising results and impacts would encourage innovation and ensure that interventions are tailored to achieve the best possible outcomes for the community.
- There is a need to **review and update the program's Key Performance Indicators (KPIs)**, data collection methods, and overall performance measures. This review aims to reduce barriers, make the process less cumbersome, and ultimately improve the level of care provided to consumers.
- **Service providers face significant challenges** in delivering mental health services due to complex funding models and high reporting burdens. Addressing these challenges is crucial to enable providers to focus more on service delivery and less on administrative tasks.
- **Updating the MHFFS funding model to support co-commissioning**, implementing longer-term funding cycles, and integrating it with related policy areas such as Alcohol and Other Drugs (AOD)



and family domestic violence would better meet the evolving needs of the community and promote a more holistic approach to care.

- **Incentivising innovation and value-based care** is essential for the future success of the program. Encouraging new and effective ways of working will drive system reform and improve overall service delivery and outcomes.

Opportunities for improvement:

- Establish a clear alignment between the MHFF Program's purpose, funding, and outcomes to better support the evolving role of PHNs and the Program.
- Simplify the MHFF stream to alleviate the significant administrative and reporting burdens faced by PHNs and providers.
- Reduce the number of activity streams and prioritise locally informed populations to enhance the efficiency and effectiveness of the MHFF Program, allowing PHNs to commission for outcomes.
- Acknowledge and fund the roles of PHNs in mental health system integration, planning, and reform within the MHFF funding model.
- Evaluate MHFF Program KPIs, data collection, and PHN performance measures to emphasise health outcomes, reduce perverse incentives, lower compliance costs for providers, and minimise negative impacts on consumer care.
- Ensure the revised MHFF Program supports integration with related programs, encourages collaboration and accountability, and promotes innovative and value-based care. Address the ongoing issue of lack of indexation for service providers.



1 OVERVIEW

1.1 Primary Health Networks

In 2015, the Australian Government established 31 Primary Health Networks (PHNs) to strengthen the national capacity and coordination of primary care, improve patient-centred service integration and increase the efficiency and effectiveness of primary healthcare services for Australians, particularly those at risk of poor health outcomes.

PHNs are independent organisations funded to plan, design, and commission primary care and mental health services in their designated region. PHNs assess the needs of their community and commission health services so that people can get coordinated health care where and when they need it.

PHNs' three primary roles are to:

- **commission** health services to meet the needs of people in their regions and address gaps in primary health care
- build the **capacity** of the health workforce by engaging with general practitioners (GPs) and other health professionals to deliver high-quality care, and
- **coordinate** health services at the local level to improve quality of care, encourage more effective use of health resources, and reduce service duplication.

PHNs are the 'arms and legs' of the Commonwealth government to allow the delivery of national policy and programs 'on the ground' within local contexts. That is, **the PHN model allows localisation, agility and flexibility and ensures policy responses are rapidly deployed nationally but with local nuance**. This was most obviously demonstrated during the COVID-19 pandemic and is currently visible in the implementation of the Strengthening Medicare reforms.

1.2 Victorian and Tasmanian PHN Alliance

Formed in 2016, the Victorian and Tasmanian PHN Alliance (VTPHNA) comprises six Victorian PHNs and one Tasmania PHN: Eastern Melbourne PHN, Gippsland PHN, Murray PHN, North Western Melbourne PHN, Tasmania PHN, South Eastern Melbourne PHN and Western Victoria PHN.

VTPHNA aims to optimise the collective capabilities of the Victorian and Tasmania PHNs to proactively align efforts with a jurisdictional purview and to advance primary care reform. Where possible, VTPHNA strives to support shared impact on current and emerging issues affecting the health outcomes of the community; to provide leadership and work in partnership with the wider primary care and health system; and to support operational excellence and alignment to maximise scale and collective talents.

VTPHNA members have established strong and productive working relationships, having collaborated on many initiatives to achieve efficiencies, learning, and excellence whilst the independence of individual PHNs supports the best possible outcomes for local communities via place-based responses tailored to local contexts, capacity, and priorities.



1.3 Australian health system

Internationally, primary health care is a vital component of health systems and makes a large contribution to population health and health equity. It is a frequent focus of reforms, driven by desires for cost efficiency and containment, reduction in emergency department presentations and improvements in efficacy, equity, integration, and coordination².

Australia's Federal, State, Territory and Local governments share responsibility for health, and they have many roles (funders, policy developers, regulators and service deliverers). Many federated countries, like Australia, experiences challenges because of the divided responsibilities for health between levels of government, in addition to the private health system including private hospitals, health insurers, and allied health providers.

In Australia in 2022–23, governments funded \$178.7 billion of the total health expenditure (70.8%) with non-government sources funding the remaining \$73.8 billion (29.2%)³. Of the total government health funding in 2022–23, the Australian Government contributed \$101.5 billion, and State and Territory governments contributed \$77.3 billion.

In 2022–23, total health spending was distributed across health services, with estimates of:

- 42.4% (\$107.1 billion) on hospitals
- 33.0% (\$83.3 billion) on primary health care
- 8.4% (\$21.3 billion) on referred medical services.

Of the \$83.3 billion spent on primary health care, the Australian Government contributes \$36.8 billion (44.2%), non-government entities \$33.0 billion (39.6%), and state and territory governments \$13.5 billion (16.2%)⁴. It is also important to recognise that in terms of total costs of health care, and additional to Government spending, consumers contribute a significant proportion to the costs of their own care through private insurance and ever increasing out of pocket costs.

Health care systems are multilevel in nature, from the micro (clinical) to the meso (population or organisational) and macro (political/policy) level. These levels are connected to each other and interact in various ways. Each level plays a unique role—policies at the macro level shape professional and organisational practices and activities at the meso level, which in turn influence patient care at the micro level⁵. For consumers with care and support needs, the different levels, can impact their experiences and care adversely.

In a Federated nation, such as Australia, system integration necessitates a customised blend of responses, structures, processes, and techniques designed to address the diverse needs of individuals and populations throughout the continuum of care in different jurisdictions, and across a range of organisational tiers within the health system.

² <https://www.sciencedirect.com/science/article/abs/pii/S0168851021000324>

³ <https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure>

⁴ <https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2022-23/contents/trends-by-area-of-spending/primary-health-care>

⁵ <https://bmcpalliatcare.biomedcentral.com/articles/10.1186/s12904-024-01585-2>



In Australia, at the meso-tier, primary care services are supported by PHNs, whilst hospital and community services are provided by over 135 Local Hospital Networks (LHNs) of varying size and capacity, which are governed by each state and territory.

The total national PHN funding is approximately \$1.9 billion, equating to less than 1% of the total national expenditure (i.e. >\$250 billion) on health. However, within Victorian and Tasmanian contexts, **PHNs are critical meso-level health organisations** leveraging this small proportional investment to foster the connection and integration between health systems and activate and support policy reform at the local level.

1.4 Victorian context

Australia's population was 27,204,809 people on 30 June 2024, and Victoria's population was 6,981,000⁶, representing 26% of Australia's population. Victoria's landmass covers 227,600 square kilometres representing approximately 3% of the total area of Australia.

The Victorian State funded health system includes 76 independently governed health service (hospital) entities – more than all other states and territories combined. These health services differ vastly in size, from small rural sites delivering fewer than 20 admitted episodes a year, to enormous multi-campus organisations, with the largest delivering over 280,000. Each of these health services has its own CEO and board⁷.

Victoria's acute health system is unique in Australia given there are no regional boundaries. This decentralised approach has resulted in a “many to many” approach to LHN interactions which is duplicative and thus resource intensive. As such, PHN regions are not the issue, rather the lack of Hospital / Health Services regions.

There have been attempts over the past 10 years to aggregate / cluster the Victorian system, but there has been little practical effect. The Victorian Department of Health has developed a [Health Services Plan](#) that flags potential clustering of health services. The report from this work recognised that Victorian state health services, not only vary significantly in size, but also in capability and are often not well connected with each other. Health services will be encouraged rather than forced to be amalgamated / clustered, and there are no resources available to assist in that process. For PHNs in Victoria this results in significant and substantial extra effort to work effectively with the State service system, to support a one-system approach and PHNs' work in coordination, integration and effective planning in primary health.

In its current fragmented state, Victoria's health system is not well placed to meet these ambitions, or to benefit from future reforms to integrate primary and acute care. This is because Victoria's six PHNs would need to interface and jointly plan and commission services with 76 independently governed health services. In contrast, PHNs in NSW and Queensland would only need to engage with between 16 and 18 Local Hospital Networks. (ibid)

Whilst the Victorian Government has recognised the need for a reduction in the number of health services, it is not forcing amalgamations of health services but is rather establishing a new set of 'Local Health Services Networks' (LHSNs). The intention is that these LHSNs will support greater

⁶ <https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release>

⁷ <https://www.health.vic.gov.au/research-and-reports/health-services-plan>



collaboration and connection between Victorian health services within a geographical region and will be responsible for delivering better care, as close to home as possible –this may include coordinating clinical services and attracting and retaining the right workforce⁸. The Victorian Government have released the 12 LHSN groupings (January 2025), to come into effect from 1 July 2025. Victorian PHNs have had some initial engagement with the Victorian Government on the development of LHSNs however, this work is still very much ‘internally’ focused on Victorian services, and it a long way from maturing to be an effective structure to support coordinated work with PHNs.

Given that for PHNs, collaboration happens at the community, clinical, service system and organisational levels, the complexity of the Victorian health system inherently impacts on the work of Victorian PHNs, resulting in a multitude of relationships needed to be able to work effectively within the Victorian system to support integration and coordination and to support equity and access for consumers. As such, despite the pending Victorian reforms, **Victorian PHNs expect the Victorian health system to continue to be very complex to work with for the medium to long-term future.**

1.5 Tasmanian context

Tasmania has a small but regionally dispersed population of just over 557,000 people. As an island the PHN geographical boundary and statewide remit aligns with the Tasmanian state funded health system which includes the Department of Health and the Tasmanian (LHN) Health Service which has responsibility for 4 hospitals and a range of community health facilities and services. There are 29 local government areas of which 21 are classified as outer regional or remote and therefore access to health care is problematic for many Tasmanians.

Primary Health Tasmania is a single-state Primary Health Network (PHN) operating across three office sites in the north, north west and south of the state. As an organisation, Primary Health Tasmania has evolved from General Practice Tasmania to Tasmania Medicare Local, launching as a PHN in 2015.

Like all PHNs, Primary Health Tasmania has positioned itself as a system partner with the Tasmanian Government, despite receiving very little direct funding. The Tasmanian Government is working to its Long-Term Plan for Healthcare in Tasmania in 2040 with a vision that all Tasmanians are supported by a world class, innovative and integrated health system. The first stage of this reform agenda commenced in 2015 with One State, One Health System, Better Outcomes, which was the first step of designing and implementing a single, statewide service. Our Healthcare Future is the second stage of the Tasmanian Government’s long-term health reform agenda.

PHT partners with the State Government in both the primary and Mental Health Bilateral agreements with the scale and scope of collaborative MH investment driving a much more positive and productive partnership. Development of the bilateral agreement for primary care has not progressed significantly with activity and resourced commitments, however, PHT remains an enthusiastic yet peripheral partner.

⁸ It is worth noting that the Victorian Government has previously established ‘Health Service Partnerships’ (HSPs) to support similar activities, but these have been greatly variable in operational effectiveness and in relation to PHN engagement.



1.6 Key points of this chapter

- PHNs were established to strengthen the national capacity and coordination of primary care, improve patient-centred service integration and increase the efficiency and effectiveness of primary healthcare services for Australians, particularly those at risk of poor health outcomes.
- The PHN model allows localisation, agility and flexibility and ensures policy responses are rapidly deployed nationally but with local nuance.
- Formed in 2016, the Victorian and Tasmanian PHN Alliance (VTPHNA) comprises six Victorian PHNs and one Tasmania PHN that aims to optimise the collective capabilities of their PHNs to proactively align efforts with a jurisdictional purview and to advance primary care reform.
- PHNs are critical meso-level health organisations that foster the connection and integration between health systems and activate and support policy reform at the local level.
- The Victorian State funded health system includes 76 independently governed health service (hospital) entities – more than all other states and territories combined. The complexity of the Victorian health system, and the pending reform to Local Health Service Networks, inherently impacts on the work of Victorian PHNs, resulting in a multitude of relationships needed to be able to work effectively within the Victorian system.
- Tasmania, with a population of over 557,000, faces healthcare access challenges due to its distributed regional populations. Primary Health Tasmania (PHT) operates statewide and partners with the Tasmanian Government on health reforms such as the Long-Term Plan for Healthcare in Tasmania 2040. PHT plays a significant role in bilateral mental health activity but remains a secondary partner in state collaborations for primary care activities.

1.7 Purpose and structure of this document

This document (Paper 1) was developed by VTPHNA to supplement the submission prepared by the national PHN Cooperative, and by individual Victorian and Tasmanian PHNs, to provide the shared perspective of PHNs within the Victorian and Tasmanian contexts, and to communicate the collective experiences of PHNs operating within the current PHN Business Model.

Paper 1 includes an executive summary, an overview chapter (this chapter) and is structured according to the six key review questions where key issues are presented, and solutions are proposed. In addition, summarised case studies of relevant PHN-led activities are included to evidence PHN capability, effectiveness, and agility. Detailed case studies are provided in Appendix B.

A supplementary paper (Paper 2) exploring the role of meso-level health agencies within the Australian health system is also provided to provide an important contextual overview, and a higher-level discussion of the role and structure of PHNs as meso-level organisations within Australia. This highlights the following two questions that are not explicitly addressed within this review, but which we think are critically important, namely:

1. *Is there a case for a meso level structure in the Australian Health Systems?*
2. *If so, what are the factors that ought to inform the design of this structure?*



2 KEY REVIEW QUESTION 1: PHN Role

Is the role of the PHN Program in the primary health care setting 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?

***OPPORTUNITY:** PHNs are uniquely placed to identify and address the barriers to health care that consumers face across Australia. Working at the meso-level, PHNs coordinate healthcare services across multiple providers, manage regional resources, implement solutions, and translate national health policies locally to improve health outcomes for communities. The role of the PHN contribution is unique in Australia, as a primary care co-ordinating entity that has evolved from previous iterations and has been replicated internationally. PHNs develop place-based solutions, connect local services into systematised approaches according to local and regional contexts, and translate and implement national policy for local outcomes. With appropriate support, PHNs have the capability to effect meaningful change at the care interface with acute, aged care, and mental health, towards a one-health system.*

2.1 Overview

Whilst the role of PHNs has been articulated in various policy documents and reviews, the breadth of PHN roles is not always well understood across relevant sectors, or even within DoHAC. This may be due to the rapid growth and expansion of PHN activities and scope since their inception, as well as many different organisations and sectors only interacting with certain parts of PHN operations at any given time. It is noteworthy that it was not until late 2023 that DoHAC released its first '[PHN Strategy](#)' to clarify "PHNs' purpose, objective and key functions". It outlines the crucial role PHNs play in supporting health reform by driving local innovation to meet specific local health needs, data management and support, and facilitation of local delivery of national and co-commissioned programs." However, **the 2023-24 PHN strategy included outdated funding information and has now lapsed.**

This chapter presents the VTPHNA response to key review question 1 focusing on the current role of PHNs, potential future roles, opportunities to maximise the effectiveness of PHNs through greater role clarity and scope, and the impact of current reforms on PHN roles and responsibilities.

2.2 Key issues

2.2.1 PHN roles and activities

- **Core functions:** PHNs' core functions and activities include capacity building, commissioning, and coordination. Although these three core functions are not always clear to stakeholders, who may only view PHNs as one of the three based on their relationship or interactions.



Generally, PHNs are recognised for their functions in regional commissioning, education and workforce development, including capacity-building in primary care. However, their role in health system integration and reform often lacks clarity and understanding among stakeholders.

- **PHNs as change agents:** PHNs have proven essential in driving primary health care reforms, including implementing the Strengthening Medicare initiatives and developing innovative models of multidisciplinary care. They act as regional change agents, facilitating the connection between health and social reforms to maximise governmental investment impact. However, due to the perception that PHNs mainly implement national programs, combined with the constraints of funding grants, there is poor acknowledgement of the support PHNs provide for place-based solutions, and that localisation of programs are negatively seen as variability in how the PHN program is rolled out.
- **Diversity of PHN roles:** The diversity of PHN roles is demonstrated by the changes in the Commonwealth funding for the PHN program. In parallel with this growth in scale and scope for Commonwealth programs, state governments have also significantly increased their investment in the health system via PHN structures, along with the emerging role for PHNs involvement in emergency management. PHN funding from the Commonwealth has risen incrementally each year, tripling since 2015 to exceed \$2 billion this financial year. Over this time:
 - the number of funding schedules has risen from seven to 13
 - the number of individual funding programs has risen from 29 to 71
 - the number of activity work plans across PHNs has risen to over 275, and
 - the number of individual activities, undertaken by providers and subject to the full governance and reporting requirements of the Program, has risen to over 2,700
 - **core funding to run the PHNs has remained the same quantum since commencement.**

The increases detailed above aptly demonstrate the **significant evolution of the role of PHNs over the last nine years**. As the number of programs and funding complexity has increased, PHNs have also experienced increased burdens in program administration. Whereas PHNs have matured their role, with an ever-increasing scope of work, the DoHAC governance and reporting mechanisms and internal systems have not kept pace. Please refer to Appendix A for a visual representation of the various areas within DoHAC that PHNs interact with.

Defining the role of a PHN

In 2020-21 NWMPHN developed a Vision for Primary Care, that was informed through consultation with consumers and primary care stakeholders, to clearly define the PHNs role. The vision outlines the role of a PHN across five domains (5Cs):

Capability builder: PHNs as a capability builder, ensuring primary care providers can access the best education, tools and resources, and promote primary care as a rewarding career path.



Communicator: PHNs as a communicator, delivering timely and relevant localised information to health care providers. PHNs provide evidence-based, accessible information to inform and empower diverse communities.

Champion: PHNs as a champion, advocating for primary care as the foundation for a high-performing and sustainable health system. This includes influencing state and federal investment in primary care and advocating for more flexible workforce models through work with expert Advisory groups and clinical and community councils.

Commissioner: PHNs as a commissioner, commissioning co-designed local and regional solutions to address service gaps, better integrate health care and ensure equitable access.

Coordinator: PHNs as a coordinator, fostering strong partnerships and collaborations across local, state and federal governments – between primary health, acute and specialist services.

These 5 roles are consistent across the PHNs' engagement across the broad primary care sector including mental health, alcohol and other drugs, aged care, allied health, and general practice.

ment Initiative

- **Duality of PHN roles:** Recent output from Strengthening Medicare reform activities have signalled a range of additional, new, roles for PHNs as the primary care reform agenda matures. Several of the reviews proposed the development and implementation, transition to, or mandating of new clinical governance, accreditation, or national frameworks to improve quality care. In most cases, PHNs were highlighted as a key agency in the implementation or monitoring of such activities. In addition, PHN administration of GP payment eligibility was proposed which could impact on the relationships with practices. Alongside a funding and monitoring role, PHNs are also expected to partner with healthcare providers to design services and address health priorities. Conflation of the funder and partner roles of PHNs may impact the effectiveness of partnership activities.
- **Consistent messaging:** The development and adoption of a national PHN program strategy and logic should be a continuous process, regularly reviewed as part of the Department's internal workplan in consultation with PHNs. Once established, a strategic communications plan would be beneficial, crafted in conjunction with PHNs to enhance clarity and understanding of the PHN program. This should target three key audiences: within DOHAC itself; between Commonwealth Departments; and to external stakeholders. Such a plan would establish a strong foundation for local promotion and ensure nationally consistent, yet locally tailored, messaging.

2.2.2 PHN role in primary care data

Digital health tools and data driven decision making is gaining increasing prominence, PHNs need to focus on enabling technology and use of data to identify and address local health needs.

- **GP data:** PHNs act as regional data custodians for primary health care data, which they manage, store, analyse, protect, and share. Overtime there has been an increase in primary care providers (general practices) willing to share their data with PHNs (approximately 80% of practices), some choose to share their full de-identified dataset, and others share only the Practice Incentive Program Quality Improvement (PIP QI) dataset. There is a significant obligation on PHNs to make the most of the data entrusted to them, to provide data and insights back to practices, and to maintain a high level of data governance. Part of this obligation involves developing expertise in GP data and continually improving how it works with that data.



Primary Care GP POLAR Data

This case study focuses on PHN support for general practices in adopting digital tools and systems like POLAR and Florence with the aims to improve patient management, proactive health interventions, and service delivery efficiency.

The digital interventions include:

- Increasing the adoption of the POLAR system from 30% in 2018 to 90% in 2024.
- Implementing digital solutions like RediCASE for mental health reporting and Florence for patient monitoring.
- Participating in the Data Linkage pilot to connect cardiovascular-related emergency patient data with general practice information.

Impacts and outcomes include improved data capture and decision-making for clinicians, leading to better patient management and healthcare coordination; insights from the Data Linkage pilot potentially reducing hospital admissions and improving chronic disease management; enhanced patient clinical engagement and clinician workflow through the implementation of RediCASE and Florence. Positive feedback from stakeholders and patients highlights improved access to care and timely interventions.

SEMPHN's experience demonstrates the effectiveness of devolved governance in driving digital transformation and supporting general practice capability and emphasises the need for structured governance around data privacy and security to ensure responsible use of health data. *(please refer to Page 74 for the detailed case study)*

- **Ongoing access to GP data:** Ongoing access to de-identified GP data has enabled Primary Health Networks (PHNs) to strengthen and mature their role in the primary care data value chain, spanning from data collection to generating measurable impact on health outcomes. PHNs are integral to driving health system improvements and achieving measurable change through their work in curating and analysing primary care data:
 - **Population Health Planning and Policy:** Aggregate primary health care data, particularly from general practices, can identify health trends, inform population health planning, policies, and programs, support evidence-based funding, facilitate research, and improve support for priority populations at national and regional levels.
 - **Service Planning and Commissioning:** Data provided to PHNs aids in better local or regional service and system planning, resource allocation, and coordination. PHNs use this data to identify gaps in primary health care services, address local population health needs, and minimise service duplication.
 - **Quality Improvement:** De-identified or aggregate data can be analysed and shared with general practices to support benchmarking and quality improvement. This helps practices understand and evaluate their performance, improve care provision and efficiency, maintain accreditation, understand consumer behaviour, and make effective operating decisions.
 - **Data quality:** PHNs also have a role in assessing and supporting improvements in data quality at GP level. Without local custodianship and analysis, there may be a risk that centralised data collections become weak and biased.
 - **Data Linkage and Insights:** Linking general practice data with other health service data at federal or state levels provides insights into patient journeys, opportunities to



improve patient outcomes, and supports value-based healthcare investment decisions. It also helps practices benchmark performance and manage chronic and complex health conditions, reducing premature morbidity and mortality.

- **External factors impacting PHNs role in primary care data:** the role of PHNs within the primary health care data chain is becoming unclear due to the following disruptors:
 - Department is moving to external parties for data collection (e.g. direct relationship with Pen for UCC, Carefinder)
 - Development of the National Primary Care Data Asset which may duplicate, fragment, or supersede the current PHN role. PHNs should be integral to any discussions around the development the National Primary Care Data Asset given their pivotal role in primary care data.
 - Bilateral agreements and linked data projects
 - Clinical software vendors moving to cloud and proposing direct data feed to Government (e.g. Best Practice GP software vendor who is 75% of the GP market). When alternative data-sharing models are put forward, such as direct data feeds from clinical software vendors to government bodies, it is essential to consider the substantial groundwork that has already been laid by PHNs in curating and standardising this data. The existing systems and infrastructure, built to enhance the utility of primary care data at the local level, must not be overlooked. These tools, processes, and relationships represent years of investment and knowledge, which, if bypassed, could lead to fragmented data systems and lost opportunities for improving local healthcare outcomes.
 - GPs are unclear about where the PHN's role in collection and use of practice data sits in the context of broader data collection processes. PHNs hold data sharing agreement with GPs and the responsibility lies with PHNs to provide clear guidance on data ownership, purpose, use, security, and data-sharing agreements. Given the evolving data landscape and the expanded role of PHNs in primary care data, it is crucial to establish a nationally recognised authorising environment to empower PHNs to consistently communicate how GPs' data is managed, the benefits of data sharing, and the safeguards in place.
 - Commercial vendors – whilst competition between different vendors and tools drives innovation, the reliance on commercial entities to assist with implementation of national reforms, and to develop standardised data is expensive and challenging. There is also potential that the vendors will bypass PHNs which could result in a loss of oversight and control over how primary care data is managed.
 - Policy developments such as the intergovernmental agreement on digital health, Digital Health Blueprint, development of the Health Information Exchange (HIE), etc.
- **PHN Data and Digital Health Strategy:** To maximise PHNs' trusted relationships with general practices and to support quality improvement and integrated care across the primary health sector, DoHAC should develop a strategy for a unified and consolidated approach to PHN



digital and data priorities across DoHAC Divisions and agencies, and more broadly alignment with the National Digital Health Strategy and Implementation Road Map, given there are a number of strategies that impact PHNs and primary health care that sit outside of DoHAC governance. The strategy should include the role PHNs play in shaping the future of primary care data, be developed in collaboration with PHNs and inform the development of jurisdictional data and digital strategies that recognise both the similarities and differences in data and digital capability. On completion of above, development and implementation of a PHN digital and data roadmap to ensure clear guidance, consistency of approach, and indicative timelines will support PHN planning and investment in data and digital tools.

2.2.3 Stakeholder perceptions of PHNs

As the PHN program matures, there are changing perspectives of stakeholders regarding the PHN role. Stakeholder perceptions of the PHN is influenced mainly by their type of engagement. For example, those who have been commissioned by the PHN will be familiar with the PHN role in commissioning but are likely not as familiar with the other core roles of the PHN (coordinate and capacity-build).

- **Primary healthcare:** The 'primary health care setting' is a series of often unconnected sectors, providers, craft groups, state and local governments, unions and is intertwined with acute, community and private settings. In larger catchments, this means there are thousands of actors in the space, all of whom have varying needs / wants / issues / aspirations. As such, the overall role of the PHN program is not universally clear and understood. There is some understanding by stakeholders of PHN roles in service commissioning, primary health care education, workforce development but their role in system reform, coordination, and capacity building is not widely acknowledged.
- **Promotion of PHNs:** Since inception of the PHN program, DOHAC has provided little or no resource at a central level to promote the role of PHNs externally. It is also clear that there is a lack of clarity within DOHAC divisions, and between DOHAC and other Commonwealth Departments. Ineffective communication strategies means that the impact of PHNs is less visible compared to other healthcare agencies leading to an underappreciation of PHN role, and difficulties in establishing meaningful collaborations.
- **Relationship with Jurisdictions:** PHN experiences in working with State Governments demonstrate that State colleagues often do not understand these roles. For example, in Victoria, discussions and shared work with the State in primary care and mental health have at times revealed limited understanding of the role and purpose of commissioning and the commissioning cycle. The State often conflate the concept of commissioning with procurement and will often want PHNs to procure a service in a specified location without leveraging the commissioning capability of PHNs, such as planning work, systems understanding or full suite of commissioning approaches that a PHN can provide (e.g. relational commissioning, commissioning for capability building, etc.).
- **Authorising environment for joint planning:** Despite their capability, the PHNs' role in regional planning and commissioning is not consistently recognised or respected by health system partners, impeding further health system integration and reform. PHNs can contribute to prevention and could serve as an instrument of the Australian Centre for Disease Control.



- **Funding Instability:** Short-term funding can affect community and sector perceptions of PHNs. Concerns about program sustainability and demonstrating outcomes with only short-term funding impact views on the PHN program and its long-term health benefits for the community. This is particularly relevant for programs focusing on vulnerable populations. Funding instability is a key issue in stakeholder perceptions – driven by DoHAC rather than PHNs. **A more stable funding model which is not grants based needs to be considered** for 5-10-year cycles to be able to demonstrate impact and build trust in the sector.
- **General practice perspective:** there is an increasing understanding of the role of PHNs across general practice. Practices that were not well engaged with PHNs following the transition from Divisions of General Practice to Medicare Locals has significantly decreased, this has been influenced by policy directions that have focused on PHN and general practice partnerships such as PIP QI, COVID -19 and Strengthening Medicare Grants.
- **Aged care:** The aging population is growing rapidly, with the number of Australians aged 65 years and over expected to more than double, and those aged 85 and over expected to triple. This demographic shift places increasing pressure on the healthcare system, especially for services tailored to seniors. As the PHN role expands to include targeted work with a range of primary care stakeholders, their understanding of PHNs increases. For example, since having a role in supporting RACHs through capability building in the after-hours period, telehealth grants, and through COVID, engagement with RACHs has increased providing a foundation upon which reform such as the General Practice Aged Care Incentive can be implemented.

Aged Care commissioning

The ageing population in Australia is rapidly increasing, putting pressure on the healthcare system to provide tailored services for seniors, especially those who are vulnerable or have complex health needs.

PHNs involvement in care improvement for the ageing population focuses on interventions such as coordinating local referral pathways, developing solutions to improve vaccination access, dementia support and local care pathways, after-hours care access, and telehealth options for older adults and their carers in both metropolitan and non-metropolitan areas.

The PHN programs have resulted in improved care planning, better patient outcomes, reduced hospital visits, and increased confidence and satisfaction among staff, patients, and carers. This case study demonstrates how a local PHN can scale services to meet the aging population's needs. It highlights the importance of local commissioning, coordination, and capacity building to support effective care models and prevent unnecessary hospital admissions. *(please refer to Page 87 for the detailed case study)*

- **Allied health:** The addition of allied health support as a core role for PHNs will see the perceptions of this group towards PHNs shift. However, the relatively small amount of funding provided to PHNs to support allied health engagement may mean that allied health provider expectations may not match what can be delivered within the current funding. It is recommended that DOHAC, in conjunction with PHNs, explore models that can **better support and integrate allied health providers into the care system**. Some work (PHN led) is underway, but it is inadequately resourced.
- **Crisis and Emergency Management and Preparedness:** PHNs playing critical roles in crisis management (COVID-19, bushfire recovery, flood recovery) and natural disaster response has strengthened trust and relationships with stakeholders through demonstration of the



effectiveness and capability of PHNs. However, in the absence of a crisis, it is difficult for PHNs to match this engagement due to limited funding and time barriers, especially with stakeholders that aren't already familiar with the PHN model. In the case of emergency response and preparedness, the success of the PHN COVID-19 response highlights the importance of agile governance and flexible service delivery models in managing health emergencies. This approach can serve as a blueprint for future crisis management, where the ability to quickly mobilise resources and adapt to rapidly changing circumstances is critical. Local PHN partnerships with other health entities, such as GPs, RACFs, Pharmacy and local public health units, underscores the need for continued collaboration and integration of services to improve population health outcomes at a local level and facilitate community and system preparedness. Stronger inter-agency collaboration, along with streamlined data sharing and joint service planning, will be essential for managing future health emergencies.

COVID emergency response + Ongoing vaccination program

SEMPHN's COVID-19 response demonstrates the agility, strategic partnerships, and effective communication approaches that PHNs used to significantly impact vaccination rates and public health. The success of SEMPHN's COVID-19 response highlights the importance of agile governance and flexible service delivery models in managing health emergencies. This approach can serve as a blueprint for future crisis management, where the ability to quickly mobilize resources and adapt to rapidly changing circumstances is critical.

The PHN roles during the pandemic included:

- **Vaccination Access:** SEMPHN increased COVID-19 vaccination access for vulnerable groups through GP Vaccination Hubs, pop-up clinics, and specialized sessions.
- **Support for Aged Care:** They coordinated vaccination efforts in Residential Aged Care Homes, ensuring timely delivery and adherence to guidelines.
- **Childhood Immunisation:** The Childhood Immunisation In-Reach Pilot Program provided at-home vaccinations in under-vaccinated areas, reducing socioeconomic barriers.
- **Communication and Partnerships:** SEMPHN's comprehensive communication strategy and partnerships with local health entities improved vaccine distribution and kept healthcare providers informed. *(please refer to Page 78 for the detailed case study)*

2.2.4 Contribution to broader primary care system

In addition to the PHN roles described in the above sections, PHNs contribute to the broader primary care system through participation in local partnerships and committees, sharing of key health data and information relating to community health needs and priorities, and assisting State and Commonwealth Governments to implement reforms. Few people outside of the PHN program branch understand the full scope of that which PHNs are involved.

- **Demand for Primary Care:** PHNs can support a broadening role in meeting the growing demand from the population for primary health care as well as emerging and emergency health sector challenges and opportunities. Whilst there is great capability and capacity to support a broadening role, PHNs nevertheless face the ongoing challenge of enhancing their systems, processes, and workforce to effectively manage expanded responsibilities within the stated priority areas, limited timeframes and resources, as population epidemiological needs, complexity, and challenges continue to change and grow. Therefore, realistic consideration of the resources required to deliver this work is needed.



- **Market failure:** A major area for concern is the increasing frequency of primary medical business failure. Whilst to an extent, all PHNs are faced with periodic medical business failures or closures, those operating substantially in regional, rural, and remote areas, where these impacts are much more visible and alternate access impossible, are increasingly being called upon to respond to support failing markets. Indeed, PHNs are already inherently seen as the bodies who should be responding and should be focussed on helping address service sustainability challenges. Whilst it's feasible for PHNs to support one or two closures within a year, increasingly PHN's are facing multiple simultaneous high profile market failures. In addition, PHNs are also being asked to intervene earlier to help save businesses in advanced decline and help prevent communities from suffering loss of access to primary care. PHNs are well-placed and trusted by providers to provide this type of support and to draw together agencies and other services to find sustainable solutions. However, this is a critical area for further government investment in support of equitable access to our health system as the PHN response requires considerable time and resources and calls upon skillsets that PHNs do not have at their immediate disposal. As such PHNs must draw skillsets and resources away from other programs and services to apply a prioritised response.

PHN role during medical market failure

Primary Health Tasmania (PHT) is currently working with four rural towns experiencing major high profile medical market failure. Two of these are in areas where PHT has successfully secured the support of the Thin Markets program. PHT has another two areas rapidly approaching crisis and requests from the practices in those areas for urgent support. PHT's current practice stability surveillance also indicates other practices with major or emerging stability challenges likely to fall into this category within the next 12 months.

Every time a practice identifies itself to the system as at risk of closure PHNs are implicated in political blame apportionment between Federal and State government, whilst increasingly seeing state invest in short term "Band-Aid" cash injection responses that delays the inevitable failure a few months without adequately addressing underlying sustainability challenges. The PHN can respond by drawing core staff away from other programs however, it is increasingly apparent that the complexity of response requires financial analysis and business redesign skillsets that PHN staff do not have readily accessible or available.

Ideally as a PHN, PHT would have an urgent response team of 2-3 staff to undertake this work Statewide as the frequency and scope of demand consistently exceeds capacity to respond without negatively impacting other important areas of our work.

- **Primary care reform:** Australian states and territories are working towards increased collaboration between primary care and hospital services. For example, the Mid Term Review of the National Health Reform Agreement recommended increased collaboration between Primary Health Networks (PHNs) and Local Hospital Networks, with an ambition of improving patient pathways and outcomes through joint planning and commissioning. Several new roles for PHNs have emerged from the Strengthening Medicare reforms indicating their importance in the stewardship of the primary care system. Acknowledgement of the resourcing requirements of change facilitation needs to be reflected in the funding arrangements for PHNs, and the impact of modified PHN responsibilities on the capacity and capability of the current PHN workforce.

Shared approach to GPACI implementation

The General Practice Aged Care Incentive (GPACI) program was introduced in 2023 to address workforce challenges and improve healthcare in Residential Aged Care Homes (RACH) through local GP



engagement. Implementation of the program required PHNs to develop or extend relationships with consumers and carers, GPs, and Residential Aged Care Homes (RACH).

PHNs collaborated with stakeholders and contributed to the National PHN MyMedicare project, using various engagement methods such as forums, webinars, and newsletters to address barriers and enhance communication.

PHNs are playing a crucial role in integrating national policy with local delivery, enhancing care coordination, and encouraging proactive care for aged care residents through shared learning and resource optimisation. Consistency and efficiency in key messages were achieved through national and state-level collaborations.

This case study demonstrates the capability of PHNs to deliver national initiatives locally by conducting needs assessments, service commissioning, and stakeholder engagement to improve health outcomes. *(please refer to Page 80 for the detailed case study)*

ment Initiative

- **Primary and acute care interface:** Future reforms are focused on the integration of primary and acute care, citing a key role for PHNs. Whilst PHNs have been actively working to integrate local services, a lack of authorising environment with state-funded health services, along with the complexity of the Victorian system has made this difficult. Victoria's six PHNs would need to interface and jointly plan and commission services with 76 independently governed health services, or the 12 new local health service networks *once established*. In contrast, PHNs in NSW and Queensland would only need to engage with between 16 and 18 Local Hospital Networks.
- **Integration:** PHNs monitor how health services interface with the broader system to ensure communities can access appropriate, connected care across the full spectrum of care needs, including integration with other sectors. Most PHNs have established relationships with local governments, schools, Departments of agriculture and environment, Ethnic and Multicultural Organisations, public health units, and Women's health organisations.

WVPHN Population Health ECHO network Women's Health Series (Q3)

The WVPHN Population Health ECHO network developed a Women's Health Series in 2023 to address reproductive health issues in women, focusing on cervical screening, persistent pelvic pain, and access to early medical abortion. Regional clinicians have limited opportunities to hear multidisciplinary perspectives in patient care, leading to demand for comprehensive clinical education that addresses treatment needs from a range of consumer and clinical views.

The Women's Health Series utilized the ECHO online learning platform to provide in-depth case studies and sessions on cervical screening, persistent pelvic pain, and early medical abortion, targeting primary care workers in western Victoria. The series resulted in improved knowledge and practices among clinicians, leading to the creation of quality improvement projects and a PHN-accredited cervical screening test activity, the first of its kind.

Project ECHO demonstrated the capability of the PHN to respond to local health needs, the importance of collaborative education among primary care clinicians, and the benefits PHNs can provide to embed learning into clinical systems and care pathways. *(please refer to Page 82 for the detailed case study)*

2.2.5 Regulatory obligations

As required by DOHAC, PHNs are Australian Public Companies Limited by Guarantee and are regulated by the Corporations Act and the Australian Charities and Not-for-profits Commission Act. These corporations are very common in the Australian not-for-profit sector.

- **Statutory and regulatory responsibilities:** Since the inception of the program, statutory and regulatory responsibilities have increased over time, with some requiring a high resource load



to implement (e.g. [Modern Slavery](#)). PHN program guidelines have not kept pace with these changes, resulting in some cases of PHNs being “caught” between external compliance and program guidelines. A recent example was the effect of changed industrial relations legislation and the treatment of redundancies and fixed term employment contracts. **PHN Program Guidance should be updated on a regular, periodic basis (12-24 months) as part of the PHN Branch work program.** This should occur in consultation with a small group of PHN representatives to provide input on changes, potential impacts and costs.

- **Resourcing compliance:** Whilst external compliance has increased, base funding has not – this applies not only to PHN operations, but also to commissioned service providers, and DOHAC staff do not necessarily have the skills / expertise relating to regulatory / statutory requirements outside of the Health and Ageing to adequately understand the PHN and provider compliance requirements. **Base funding model should be reviewed (scope and resources) and take account of increasing complexity, compliance, and therefore costs. Consideration should be given for DOHAC staff training and development to keep abreast of regulatory and compliance changes outside of the Health and Ageing portfolio.**
- **Obligations:** PHNs are required to comply with all statutory and regulatory requirements applicable at Commonwealth, State and Local Government levels. Statutory and regulatory obligations include, but are not limited to:
 - ACNC Act
 - Corporations Act
 - Workplace Gender Equality Act
 - Modern Slavery Act
 - Industrial relations legislation / National Employment Standards
 - Privacy Act
 - Accounting standards
 - Taxation legislation
 - Financial probity regulations and requirements
 - Occupational Health and Safety legislation
 - Anti-discrimination legislation
 - Environment legislation
 - Child safety legislation
 - Health practitioner regulation legislation
 - Office of the Australian Information Commissioner.

2.3 Opportunities for improvement

Significant opportunities exist for DoHAC to enhance the roles and functions of PHNs. These include:

- **Increasing Stakeholder Engagement:** There is a need for improved Commonwealth-led communication strategies to help stakeholders better understand PHN roles. This enhanced visibility will foster more effective collaboration.



- **Market failure:** PHNs are increasingly being called upon to support primary medical businesses in financial crisis, particularly in regional and remote areas. The demand for PHN support and intervention is growing due and there's increased need for early intervention to prevent closures. PHNs are trusted to provide support and sustainable solutions but require further government investment to manage these responsibilities effectively.
- **Enhancing Data Utilisation:** Clarifying PHNs' roles in data collection and access, especially regarding GP data, can improve health trend identification and care quality. Streamlining data processes will also mitigate any current challenges.
- **Strengthening Funding and Recognition:** Addressing the limitations of short-term funding, the inadequacy of the grant funding model, and enhancing the recognition of PHNs' contributions to local coordination can improve their engagement and collaboration with various stakeholders. An improved grant funding model with longer funding cycles would assist local engagement for improved coordination.
- **Updating Program Guidelines:** Regular updates to PHN program guidelines are necessary to stay aligned with evolving statutory and regulatory obligations. This will ensure PHNs are adequately resourced and compliant with laws related to charity, corporations, and workplace standards.
- **Promoting Leadership in Crisis Response:** Leveraging the leadership demonstrated during crises, such as the COVID-19 pandemic and natural disasters, can further solidify PHNs' roles in primary and acute care integration.



3 KEY REVIEW QUESTION 2: PHN Governance

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

***OPPORTUNITY:** The CLG structure is the most appropriate governance model that balances local autonomy and flexibility with a robust set of protections to minimises risk for the Commonwealth and stakeholders. Devolved governance and independence of the PHNs allows a focus on local outcomes, policy translation and strategy through integration with local services and systems. The CLG structure for PHNs would be strengthened through improved performance management and a clear outcomes framework. To achieve this, DoHAC should focus on building its own capacity to integrate principles of good contract management with PHNs to drive and monitor performance towards shared goals and collectively resolve key issues.*

3.1 Overview

PHNs are companies limited by guarantee and registered charities, ensuring sound governance and accountability. They have skills-based boards and advisory committees to ensure regional insights and community accountability. The DoHAC audit program provides independent analysis, ensuring PHNs are a cost-effective option for outsourcing risk associated with national programs. PHNs can also secure funding from other sources, amplifying Australian Government investments. PHN performance is monitored through a Performance and Outcomes Reporting Framework aligned with the Australian Health Performance Framework. However, there are challenges embedded within the current governance and operating model due to short-term funding arrangements, which negatively affects longer term (10+ year) planning and engagement with local stakeholders (GPs, hospitals, and other health services) and population (including people, local government, community and social services).

This chapter presents the VTPHNA response to key review question 2 focusing on the effectiveness of the governance arrangements, opportunities and examples of sharing best practice and common infrastructure, and the adequacy of the Deeds, agreements, guidelines, and performance measures that drive PHN activity.

3.2 Key issues

3.2.1 Devolved governance: oversights, supports and safeguards

- **Flexibility and responsiveness:** The devolved model enables PHNs to drive local outcomes by translating national policy into local context, integrating primary care and other services, elevating prevention and population health, and building capacity in general practices. Devolved governance allows PHNs to tailor programs to meet the unique needs of local communities and catchments with flexibility and responsiveness. Local stakeholder engagement, relationships, and community consultation allows PHNs to maintain relevance and effectiveness within their regions.



Supporting governance for place-based health planning

Primary Health Tasmania collaborated with the Tasman Peninsula community to address barriers to effective healthcare in rural areas. In 2019, Primary Health Tasmania initiated a collaboration with various stakeholders to improve local healthcare, resulting in a thorough community consultation and the creation of an action plan and governance structure. The initiative led to significant improvements, improved access to healthcare, increased referrals, telehealth facilities, and various training programs. The success of the project has sparked interest from other communities and health systems, leading to further collaboration and funding opportunities.

PHNs are ideally placed to lead and facilitate place-based work at a community level bringing together agencies, service providers and community. However, the level of resourcing for PHNs required to sustain engagement and continue working alongside a community is significant. Building capacity does not fit neatly in to project funding blocks, it needs to be flexible with PHNs able to scale up (intensive level of engagement) or scale down (supporting engagement). (please refer to Page 84 for the detailed case study)

- **Local knowledge:** PHN boards comprise individuals that bring appropriate local and system knowledge and diversity, which meets the requirements of local intelligence, connectivity with the health sector and civil society through the diversity of board members and first-class governance. This is consistent with the recommendation from the 2014 Horvath 'Review of Medicare Locals'⁹ that the Government should establish Primary Health Organisations tasked to integrate the care of patients across the entire health system to improve patient outcomes that have strong skills based regional Boards. PHNs offer agility and responsiveness to their population and health systems as a local interfacing agency that can ensure care is delivered in a way that best suits local circumstances whilst still aligning with national objectives. Each PHN can tailor their approach to coordinate, commission, and capacity build for the specific metro / regional / rural/ remote population health needs, market, and service gaps.

Clinical and community perspectives and advice

The case study explores the governance structure and impact of Primary Health Tasmania's (PHT) approach to clinical and community advisory councils. The 2015 Australian Government PHN operating guidelines required clinical and community advisory structures for each PHN to provide informed perspectives on improving health systems and addressing local needs.

In 2016, PHT integrated its clinical and community advisory councils, allowing them to work together whilst retaining their own memberships and independent chairs, which proved to enhance collaboration and advice to the Board. The integrated council model continues to be successful in supporting the Board's decision-making, contributing to policy submissions, monitoring performance, and advising on community engagement and health needs.

However, the decision as to the nature, scope and composition of specific governance advisory processes should be a matter for each individual PHN's Board. PHN Boards should have the flexibility to determine their advisory processes, as rigid requirements may not be optimal, and sourcing council advice is a significant investment in terms of staff support and sitting fees. The suitability of the Commonwealth guidance on council structures should be revised to reflect current capabilities and contexts. (please refer to Page 85 for the detailed case study)

- **DoHAC oversight:** The DoHAC PHN audit program provides independent analysis of PHN governance processes. In addition, DOHAC has initiated several reviews since inception of the program such as the Governance and Efficiency Review, and baseline maturity assessments.

⁹ <https://www.health.gov.au/resources/publications/review-of-medicare-locals?language=en>



These initiatives have not resulted in significant change due to a lack of response or implementation from DoHAC. Formal DoHAC oversight and PHN assurance measures are undertaken inconsistently and create significant burden on PHNs to complete. In addition, broad understanding of PHN governance is poorly understood within DoHAC branches. For example, in the Background section of DoHAC's Request for Quotation for the Review of the PHN Program Business model (page 2) it notes *"PHN's are managed by the Australian Government through grant funding arrangements"*. From a governance perspective this is incorrect. PHNs are managed by their Boards and are accountable under the Corporations Law and the ACNC Act. The Australian Government manages the PHN Program, and contractually, the funding is attached to that with individual contracts with each of the 31 PHNs. That is, PHNs are independent companies limited by guarantee – not government agencies.

- **Lack of consistency in assurance activities:** Development of a PHN Assurance cycle whereby measures are reported in a consistent and regular review pattern. The assurance cycle should utilise existing Governance and statutory reporting measures (such as ACNC) to reduce duplication for PHNs and enable planning and resource allocation for completion of assurance activities.

PHN Governance reviews at different levels

All seven PHNs have continually matured their governance systems and capability. The following case study is one example of this. It summarises three governance reviews conducted at various levels within the South Eastern Melbourne Primary Health Network (SEMPHN).

- **Internal Governance Review:** SEMPHN commissioned an external consultant to review its governance framework and board evaluation, which helped identify strengths and areas for improvement, ultimately enhancing accountability and transparency.
- **External Audit:** The Commonwealth engaged McGrath-Nicol to assess SEMPHN's compliance with performance and financial management obligations, leading to improved financial management and alignment with strategic objectives.
- **VTPHNA Alliance Review:** The VTPHNA Alliance conducted a review in 2023 to strengthen strategic alignment and engagement, emphasizing the value of regional and local focus in translating national policies and programs.

The impact and outcomes of these reviews included improved accountability, transparency, and governance structures, as well as enhanced relationships with stakeholders. The reviews also identified strengths and areas for improvement, leading to better decision-making and alignment with local needs. Additionally, the external audit process provided valuable insights into financial management and compliance.

The case study highlights the CLG structure offers a solid foundation for PHNs to achieve autonomy and accountability, with local flexibility. Opportunities include the importance of scheduled review cycles, clear implementation of action plans, and enhanced collaboration across PHNs to optimize resource allocation and improve governance effectiveness. *(please refer to Page 87 for the detailed case study)*

- **Safeguards:** PHNs are independent companies governed in line with ACNC and ASIC requirements and Commonwealth, State and Territory legislation. Maintaining compliance with these requirements **ensures sound governance and accountability** independently of DoHAC initiated assurance activities.
- **Governance arrangements and opportunities for improvement:**
 - **Preserve the Company Limited by Guarantee (CLG) structure and leverage its' benefits:** The Company Limited by Guarantee (CLG) structure presents a compelling



legal framework for PHNs, offering a strong foundation to fulfill their purpose and balance autonomy with accountability.

- *Alignment with Purpose:* The CLG structure allows PHNs to translate national policies into responsive local health systems, enabling flexibility to address local priorities within broader national objectives.
 - *Advocacy for Local Voices:* The CLG model enhances PHNs' ability to bring local insights into national policy and funding discussions, fostering trust and collaboration with stakeholders.
 - *A Robust and Enabling Legal Structure:* The CLG model offers several advantages that align with PHN objectives:
 - *Stakeholder Protection:* It safeguards the interests of funders, local communities, and healthcare providers by ensuring financial accountability and compliance with governance standards.
 - *Not-for-Profit Assurance:* It reinforces the commitment to public benefit, mandating that resources are directed toward health outcomes rather than profit.
 - *Governance Flexibility:* It allows PHNs to maintain independence in decision-making whilst adhering to transparent and rigorous corporate governance standards and contractual obligations with the funder.
 - *Strengthening Membership and Engagement:* The CLG structure can be further leveraged to strengthen stakeholder engagement and regional membership, fostering greater collaboration with healthcare providers, local governments, and community representatives. This inclusive approach ensures a more robust and representative voice in shaping health system priorities.
- **Accelerate Implementation of DOHAC Review Recommendations:** Expedite the governance and efficiency improvements outlined in DOHAC reviews to refine PHNs' practices and enhance their operational effectiveness.
 - **Introduce Quality Accreditation/Assurance measures for PHNs:** Establish a quality accreditation framework for PHNs with regular reviews to ensure consistent standards in governance, service delivery, and outcomes. The framework should include an expectation to work in partnership with DoHAC to develop shared expectations and requirements and provide an opportunity to work through issues collaboratively.
 - **Strengthen Mechanisms for Collaboration Across PHNs**
Strengthen and further clarify processes and systems to enable collaboration among PHNs and between the PHN's and health departments at jurisdictional and national levels. Facilitate shared learning, optimise resources, and promote collective problem-solving to maximise impact.



- **Implement a Multi-Year Funding Agreement:** Establish a sustainable multi-year agreement (e.g. 5- 10-year funding cycles) like arrangements between the Commonwealth and state governments. This would provide PHNs with long-term health planning, workforce stability, and capacity-building initiatives, ensuring ongoing improvement in health service delivery.
- **Promote Stakeholder Engagement and Clarify PHN Roles:** Enhance coordination and communication with stakeholders by defining PHNs' roles more clearly within broader health system reforms, ensuring effective partnerships across all sectors.

3.2.2 Sharing best-practice, economies of scale, and common infrastructure and activities

- **PHN activities:** The key steps in the commissioning cycle, capacity building and coordination and current/emerging best practice in clinical care is generally the same locally, nationally, and internationally. The PHN governance model supports local flexibility by acknowledging regional population differences whilst maintaining consistency in key commissioning steps and emerging best practices. What differs between regions are:
 - **population** socioeconomic status / opportunities, demography and epidemiology
 - **communities** of culture and identity
 - **health service market** make-up and maturity; market gaps / inefficiencies, and ability / incentive to mobilise
 - **workforce** capacity and capability
 - **environment**, geography, and regional characteristics (e.g., transport, education, green space, centres of trade and employment, distance to services, pollution).

2024 COVID-19 vaccination campaign for the 65+ community

The case study outlines the 2024 COVID-19 vaccination campaign for the 65+ community in Victoria, which aimed to address the decline in vaccination rates and provide continued support and information.

In 2023, there was a significant drop in COVID-19 vaccination rates for the 65+ population, with a 79% reduction from June to August, highlighting the need for continued information and resources despite fluctuating COVID-19 waves.

The Victorian PHNs pooled funding to engage a marketing company and develop a campaign to target priority population groups. The marketing campaign targeted Victorians aged 65+ and included culturally relevant content using real people, with a call to action to consult healthcare providers. It utilised various media channels and was run by individual PHNs across Victoria from mid-June to the end of August.

The campaign resulted in a smaller drop-off in vaccination rates compared to the previous year, with over 16,000 more people aged 65+ receiving vaccinations during July and August 2024. Additionally, the campaign generated nearly 40,000 click-throughs to the Health Direct site.

This case study demonstrates the effectiveness of PHNs working together to achieve greater impact, efficiency and value for money. *(please refer to Page 90 for the detailed case study)*

- **National and jurisdictional collaboration:** As described above, VTPHNA is one of a small group of PHN alliances that exist to reduce duplication and create efficiencies across a regionalised group of PHNs. Jurisdictional and national collaboratives help share resources, innovations, and clinical care models, promoting efficiency and knowledge transfer. However, local



differences in health needs, workforce distribution, State and Territory policy settings and infrastructure require tailored approaches. Whilst there are many examples of collective work producing quality outcomes, the limitations to the PHN alliances are due to regional health system and health priority variation. Unsuccessful attempts to streamline commissioning and standardise program implementation across multiple PHNs merely demonstrates the diversity in community needs, priority populations, and workforce distribution, and reinforces the need for tailored local approaches. Devolved governance has allowed diversity across PHN systems and structures to meet the needs of their regions and is entrenched by weak national performance and outcome measures that fail to drive standardised outcomes, as PHNs prioritise meeting local needs over national consistency. However, alliances such as VTPHNA provide demonstrated benefits in statewide coordination across program areas. This coordination function across the Victorian and Tasmanian PHNs has achieved:

- coordinated liaison between PHNs and funders, PHNs and jurisdictions, and PHNs and providers
- sharing of best practice initiatives
- generating a learning culture across the network
- efficiencies both in contracting and capacity building
- model/program fidelity
- centralised funding model development.

Care Finder Program

The VTPHNA PHNs collaborated in the implementation of the Care Finder Program to address inconsistencies in commissioning, contract management, and evaluation across different PHNs. A working group was established to ensure a consistent approach, resulting in uniform key performance indicators and messaging. This led to efficiency and shared learning opportunities for suppliers. Despite differences in PHN management processes, the program achieved consistency in its rollout across Victoria and Tasmania. *(please refer to Page 92 for the detailed case study)*

- **Common infrastructure and activities:** Recent examples of efforts to develop common infrastructure and activities across VTPHNA PHNs include the following:
 - **VTPHNA primary care executives** have worked together to redefine the PHN workforce skills and competencies required to support general practices through the current primary care reforms. Noting the shift in responsibilities of PHNs in practice support towards a more generalised business support and change management approach, the PHNs acknowledged that the current workforce and position descriptions required revision to ensure a capable workforce, consistency in role descriptions across PHNs, and opportunity for a shared approach to capacity building for existing staff.
 - **VTPHNA Corporate Managers** have undertaken a review of corporate functions across the VTPHNA PHNs to scope how a structured model of efficiency and effectiveness with potential for shared services on key functions. The review determined each PHN is using different IT platforms for each function and non-aligned structures within each PHN, finding, only two of the functions were consistent across PHNs. A significant change process, including harmonising IT Systems, would be required to address this and there is further work underway to determine the resourcing and appetite for a



shared function to be trialled across VTPHNA PHNs. In the interim, collaboration continues a range of emerging topics, including ESG, IR changes and shared legal advice. Select PHNs are also collaborating on shared Risk Frameworks and exploring the opportunity of a shared HR team structure.

- **Development of a shared digital health infrastructure** there are several examples of PHNs collaborating to address a need or gap in data management and reporting systems to support new services or health reforms.

Head to Health (H2H) Data Management System and National Analytics and Reporting Project

In late 2020, the mental health impact of the COVID-19 pandemic became increasingly evident in Australia, particularly in Victoria. Victoria's mental health system struggled to meet the overwhelming demand for support, resulting in growing waitlists and immense pressure on the hospital system. The Department of Health and Aged Care (DoHAC) and Primary Health Networks (PHNs) also lacked the data to fully understand or respond quickly to service demands.

In response, DoHAC and Victorian PHNs established the HeadtoHelp mental health intake, assessment, and referral service, yet there was no commercial data system that could support the program. A PHN-developed (NWMPHN) Data Management System was developed that enabled comprehensive data reporting to PHNs and DoHAC, and supported standardised referrals, intake and assessment, and experience data. Recognising the effectiveness of consistent data collection and reporting in Victoria, DoHAC expanded the service to New South Wales and the Australian Capital Territory in October 2021, followed by a national rollout in July 2022. This system enabled comprehensive data reporting to DoHAC and PHNs.

The H2H telephony and data management system has significantly benefited DoHAC and PHNs by offering a seamless care pathway for consumers, improving efficiency, collaboration, agility, and economies of scale. *(please refer to Page 93 for the detailed case study)*

- **Victorian approach to regional population health planning** is a project being undertaken by VTPHNA in partnership with Victorian Department of Health to develop a consistent approach to population health and service planning across state and PHN commissioned services. This project is building on initial work undertaken by SEMPHN which developed joint planning across three local health services and the PHN, along with existing work such as the NWMPHN single needs assessment across several health services and the PHN. This project will identify and seek to address the barriers preventing joint planning, data analysis, and prioritisation between health agencies across Victoria for longer-term planning. The project has identified the lack of an authorising environment for PHNs to compel state-run services to plan together as a key barrier in joint regional planning.

3.2.3 PHN capability and capacity to support a broadening role

- **Systemic barriers:** Despite all the benefits of the devolved governance model, PHNs face systemic barriers that impact their ability to efficiently and effectively deliver on national and regional priorities, and to support a broadening role:
 - **Uncertainty and Long-Term Planning:** PHNs have limited ability to engage in long-term planning (5+ years) and implement generationally impactful health initiatives, reducing the effectiveness of their programs, services, and offerings.



- **Resource Dependency:** A reliance on short-term funding cycles creates instability, affecting workforce retention and the delivery of regional health plans, which in turn creates inefficiencies.
- **Inconsistent Implementation of DOHAC Reviews:** Limited follow-through on governance and efficiency review recommendations delays necessary system improvements.
- **Fragmentation:** Limited understanding of skills, resources and effort required to address misalignment across sectors and challenges in building seamless care pathways, particularly when linking primary care with acute, aged, and social services. Additionally, limited coordination across different branches or areas within departments, and between departments, exacerbates these challenges.
- **Focus on meso-level approach:** Retaining the meso-level structure approach and strengthening the role and responsibilities of PHNs would improve PHN capability and capacity to sustainably coordinate, commission, and capacity build across broadening roles and demands. Authorised joint coordination activities with local and state governments, as well as primary, secondary and tertiary care providers, general practice, allied health, local populations, communities, and patients will drive national goals for holistic primary care.
- **Clear expectations of broadened role:** Clarity of the expected capability and capacity of PHNs is required to support the broadened role and responsibilities in commissioning, capacity building, and coordination. In this way, by supporting and strengthening the role of PHNs to meet the holistic needs of populations, the Australian primary health care landscape will be positioned to meet the growing demand pressures from complex chronic disease driven by an aging population, as well as generational whole-person, whole life, opportunities.

3.2.4 Adequacy of SLA to guide and enforce program service delivery

Whilst governance arrangements for PHNs are fully devolved, funding arrangements are not. At the system level, the PHN program is governed like a simple grants allocation, rather than a complex program of intersecting priorities and services, serving differing geographic and socio-economic environments.

- **Fragmentation of grants and agreements:** PHNs do not receive population-based budgets for which they are accountable however, receive separate operational and core program funding, as well as opportunities to apply for grant program funding. PHN funding arrangements are highly specified and cyclical, and this means that Service Level Agreements with providers are likewise highly specified and operate on even shorter cycles to account for administrative requirements for enforcing program service delivery.
- **Time-limited programs:** The lack of devolved budget generally results in circumscribed and time-limited programs (generally 2-3 operational years are approved at a time) that are constantly challenged to realise sustainable commissioning, capacity building, or coordination benefits over short timeframes and demonstrate efficacy. Currently, Commonwealth policy teams spend considerable time describing the broad scope of upcoming programs, which are then followed by the detailed funding requirements (Deed) becoming available. These Deeds come with a few weeks for PHNs to respond / apply, and short 2–4-year time frames to deliver



full-scale program solutions. The PHN programs are expected to deliver planning, design, procurement, implementation, monitoring, and evaluation for local health needs and market failure through Service Level Agreements; until the funding comes to an end or is announced to be continuing toward the planned decommissioning of the program with less than a year to turnaround recommissioning. From the provider perspective, this often leads to multiple agreements with their respective PHN of various durations leading to significant administration and duplicative reporting burden.

After hours commissioning

The PHN aims to guide and commission After Hours programs that meet local population needs and incentivise general practices to provide appropriate access, despite challenges such as short-term funding risks. The After-Hours model targets high-need localities and collaborates with primary care providers to offer extended hours and connecting services. The program has saved nearly \$5.5 million and reduced 10,000 potentially preventable hospitalisations but faces challenges with multiple funding sources. Sustainable long-term funding and improved commissioning timeframes are recommended.

The After-Hours programs demonstrate the local flexibility and agility required of the PHN to commission, adapt, and sustain delivery through multiple rounds and buckets of funding to improve access, availability and capacity of primary care. *(please refer to Page 96 for the detailed case study)*

- **Realistic planning and commissioning timeframes:** More realistic commissioning and service procurement timeframes would at a minimum require 3 months for a 'light touch' service planning and design approach (followed by procurement), and at least 9-12 months for full priority area stream population-wide regional planning and stakeholder consultation, plus time for procurement and implementation toward the agreed model over a 2-3 year service transition period as and when contracts end or are able to be recommissioned under the new approach.
- **Pace of change of PHN program:** The Deed, Program Guidelines, and program KPIs have not kept pace with change since the inception of the program. This is confounded by several factors:
 - Government policy, legislative and regulatory changes (both internal and external to DOHAC)
 - No apparent mechanism for regular review
 - Inconsistent requirements across DoHAC Divisions
 - Government procurement machinery changes – such as the establishment of the Grants Hub
 - Turnover of leadership and program staff within DOHAC
 - Impact of the COVID-19 response

3.2.5 Adequacy of performance monitoring

- **Lack of clarity:** PHNs have experienced a lack of clarity around performance benchmarks and metrics for success, resulting in overlap and at times ambiguity in accountability structures. A consolidated view of PHNs and the varied work they undertake may be impeded by a limited understanding across various DoHAC branches of PHN roles and functions, including capability and commissioning functions, often leading to unrealistic expectations or inappropriate / ill-thought-out initiatives.



- **Inadequate performance reporting tools:** Since the inception of the PHN program there have been challenges with the performance management and reporting tools used by DoHAC to assess the work of PHNs. Whilst the PHN branch continues to try to improve this, to date these tools and processes have not been fit for purpose and have not supported comprehensive reporting of PHN program outcomes. As such, PHNs spend considerable time responding to ad-hoc requests for data that could be provided by a fit-for-purpose data system. The PHN Branch does have a clear process for identifying and addressing performance through the 12-month performance and financial reporting and Individual Performance Assessment processes, complemented by an active cycle of independent auditing. PHNs submit their annual financial-year performance reports in September, but typically must wait 9 or 10 months for the reports to be assessed by the PHN Branch.

The PHN Cooperative has previously highlighted a range of opportunities for DoHAC to support PHNs in enhancing capability and performance. These include:

- **Improve performance management measures, processes and tools** to ensure that the Program targets the right outcomes and can track those outcomes efficiently and effectively.
- Continue to refine the PHN Performance Measurement and Reporting Framework to incorporate **trend analysis, and benchmarking of like PHNs** (e.g. large urban, remote, regional), in alignment with PHN Program objectives and outcomes.
- Use PHN reporting systems to help turn the almost limitless flow of health and care data into information, insights and stories that can improve performance and drive policy.
- Develop a Primary Health Outcomes Framework – a comprehensive set of public health and wellbeing outcomes, indicators and targets for health and wellbeing priorities and their determinants
- Establish a single ‘source of truth’ for PHN performance data.

3.2.6 Comparable commissioning models and meso structures

- **International meso-level approaches** have evolved informally and formally over decades, refining localised governance and delivery approaches. These public health systems tend to devolve responsibility for governance, decision-making, and budgets to local agencies, while central offices administer national policy and hold local agencies accountable.
- These international models **evolved from small primary care/general practice networks** to larger structures meeting changing national and local needs. In Australia, PHNs evolved from Medicare Locals and general practice divisions. There is a need to support and strengthen PHNs to meet changing national and local needs.
- **Examples from the UK, New Zealand, and Canada show health system commissioning models with centrally set regulatory standards and national goals.** Responsibility for implementation is delegated to regional arms-length agencies with independent boards, a devolved budget, and participation of locally based general practice/primary care organisations and community representatives. Australia can learn from international



experiences to develop its approach to manage an increasing population and complex health needs, learning from international experiences.

3.3 Opportunities for improvement

The following solutions and opportunities aim to enhance the effectiveness and efficiency of PHN governance in delivering primary health care services ensuring accountability and alignment with national objectives.

- **Expedited Governance and Efficiency Improvements:** Accelerate the adoption of governance and efficiency enhancements as outlined in DOHAC reviews, ensuring a more streamlined and effective operational framework.
- **Multi-Year Funding Agreements:** Establish a 5-10-year funding cycle to facilitate long-term health planning, workforce stability, and capacity-building, reducing the reliance on short-term funding and enhancing overall stability.
- **Realistic Planning and Commissioning Timeframes:** Implement more realistic timeframes for service planning, design, procurement, and implementation to improve project execution and deliverables.
- **Assurance and Performance Monitoring:** Develop a quality accreditation framework for regular reviews to ensure consistent governance, service delivery, and outcomes across the board. Create fit-for-purpose tools to efficiently track and report PHN program outcomes, providing clear metrics for success and areas needing improvement.
- **Comprehensive Primary Health Outcomes Framework:** Design a framework that outlines public health and well-being outcomes, indicators, and targets, to drive better health outcomes across the population.
- **Enhanced Collaboration and Shared Learning:** Strengthen collaboration mechanisms to improve partnerships among PHNs and with health departments, optimising resources and promoting collective problem-solving. Build common infrastructure for activities such as health needs assessment and regional population health planning to foster a more unified approach.
- **Development of a standard form contract** across all PHNs, or all PHNs in a state, to minimise bureaucratic overburden for services which are provided across multiple PHNs. This would be supported by a fit for purpose performance framework for PHNs so that consistent provider KPIs could be agreed upon in alignment with the performance framework.
- **Strengthening the Meso-Level Approach:** Enhance the role of PHNs in commissioning, capacity building, and coordination through an authorising environment for joint activities with local and state governments and care providers. PHNs are well placed to lead commissioning, regardless of state or national funding, and should be supported to achieve co-commissioning with state agencies.



- **Recognition and Resourcing for Regional Planning:** Acknowledge and adequately resource PHNs for their role in joint regional planning, particularly with state governments, to ensure effective engagement and planning beyond their own remit. Tackle structural issues such as misalignment of priorities and timeframes, and inflexible funding arrangements, to create a more supportive environment for regional planning and stakeholder engagement.
- **Providing Authorising Environment:** Establish an authorising environment for PHNs to drive joint regional planning, enabling them to meet the significant expectations placed upon them within various national agreements.



4 KEY REVIEW QUESTION 3: Regional Planning and Integration

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

OPPORTUNITY: *Integrated care and joint regional health planning can benefit consumers by improving the quality and experience of care, reducing costs, and increasing access to services. PHNs have deep knowledge and understanding of the local health systems within their regions. There is PHN readiness, capability, and opportunity for a DoHAC commitment supporting integrated regional planning at the bi-lateral policy level, that is then translated into NHRA and PHN 5-year funding agreements. Expectations for regional planning could include a requirement for PHN's and LHN's to develop integrated 3–5-year Regional Health Plans and report implementation progress to the joint Health Ministers meeting on a triannual basis.*

4.1 Overview

The PHN program, specifically the way grants and funding are administered, does not effectively support PHNs with regional planning and engagement. The role of PHNs in joint regional planning is poorly described and recognised, however significant expectations are placed upon PHNs in this regard, such as those within the National Health Reform Agreement and the National Mental Health and Suicide Prevention Agreement. There are a range of limiting structural issues such as misalignment of priorities and timeframes, and inflexible funding arrangements, however, the key factor is the lack of authorising environment for PHNs to drive joint regional planning.

This chapter presents the VTPHNA response to key review question 3 focusing on the effectiveness of the PHN Business Model to support regional planning opportunities, drive integrations of health services and systems, and whether PHNs are supported to engage and deliver services in partnership with other key health system stakeholders.

4.2 Key issues

4.2.1 Regional planning and engagement

- **Limited authority and resourcing:** Under the current governance and funding arrangements, the PHNs are not recognised or resourced for their role in joint regional planning, particularly with State and Territory governments. PHNs do not have authority for regional planning, despite DoHAC expectations of engagement in planning with jurisdictions as per various bilateral agreements.
- **Diluted responsibility and fragmentation of effort:** Responsibility for population health is diluted between multiple health agencies of varying capabilities who service overlapping geographies. Ultimately, this dilutes accountability for meeting the community's care needs



within any given geographic area. Within Victoria, health needs assessment and service prioritisation planning are undertaken by 79 local governments (a legislated activity), nine Local Public Health Units, and eight HSPs. There are no standardised planning frameworks, formal data or indicator lists, nor alignment in geography or when and how the findings are presented and disseminated.

Regional Planning - PHN role in the coordination of Local Health Services in regional planning

This case study discusses the role of the South Eastern Primary Health Network (SEMPHN) in its collaboration with local health services to improve regional healthcare planning and delivery.

- **Formation of SEMHSP:** The South East Metro Health Service Partnership (SEMHSP) was formed in July 2021 to align with statewide services and facilities, connecting primary, acute, and community health services within the region.
- **Collaborative Governance:** In 2021, SEMPHN teamed up with three acute health services to form the SEMHSP Governing Council, and later included Better Health Network and the South East Metro Mental Health Interim Regional Body.
- **Impact of COVID-19:** During the COVID-19 pandemic, the SEMHSP established governance to support the development and delivery of the COVID Positive Pathway Program, aiding over 11,000 vulnerable community members through integrated care.
- **Key Initiatives:** Key initiatives driven by SEMPHN include the establishment of the Joint Primary Care and Population Health Advisory Committee, a priority population mental health needs assessment, and Residential in Reach skills training.
- **Referral System Research:** SEMPHN is coordinating the research into the major inhibitors and enablers of an effective referral system between primary health and public specialist clinics, aiming to improve system efficiency.
- **Barriers to Collaboration:** Key barriers included lack of recognition for PHNs in regional planning, resource constraints, system complexity, workforce capacity issues, and policy alignment challenges.

Recommendations to enhance PHN capacity to collaboration with LHNs include embedding dedicated collaboration support, strengthening funding models for integration, enhancing governance flexibility, and leveraging technology for efficiency. *(please refer to Page 97 for the detailed case study)*

- **Ad hoc planning:** In some instances, health agencies within a geographic area will collaborate on a regional plan for a condition or program. However, region-wide service planning is the exception not the rule and most planning currently occurs at an individual health service/PHN level. In the absence of clear joint planning expectations, along with dedicated time and resourcing to undertake planning activities, ad hoc and program specific (i.e. narrow focus) planning will continue to be the norm. A potential solution, which is aligned with national policy goals, would involve a commitment to integrated regional planning at the bi-lateral policy level, that is then translated into NHRA and PHN 5-year funding agreements, with a requirement that PHN's and LHN's develop integrated 3–5-year Regional Health Plans and report progress to the joint Health Ministers meeting on a triannual basis.
- **Constraints on joint planning:** Some of the constraints on PHNs' ability to lead joint planning include:
 - Limited to no opportunity to meaningfully inform or influence bilateral discussions and agreement with jurisdictions
 - Limited authority to plan, prioritise and coordinate regionally due to requirements from DoHAC to administer 'programs' rather than commission to regional context



- Current funding and governance arrangements do not recognise PHNs role in joint regional planning and integration, especially with Local Hospital Networks where PHNs have no authority or direct influence (as an example, the regional planning guidance developed with representatives from PHNs, jurisdictions and Commonwealth have recently been recast as principles rather than guidance with defined roles and expectations)
- Budget and acquittal/ reporting requirements create significant constraints and do not recognise, especially for new initiatives, stages of implementation and operational maturity requiring investment, for example the Commonwealth PHN unspent funds policy. This inhibits collaboration with commissioned services to drive continuous improvement, service continuity, integration and developing sustainable workforces
- PHN stakeholders (ACCHOs, Commissioned services, sector stakeholders) assume alignment between the different divisions/ branches and policy intent in DoHAC, there is a lack of coherence which has the consequence of PHNs being directed to implement disparate and fragmented programs
- **Tight timeframes:** Current planning and service design timeframes impede co-designed, fit-for-purpose models of care. Budget announcements in May are expected to commence implementation in July, often before requirements and funding are available. DoHAC timeframes and lack of timely provision of schedules impedes engagement and co-design that would deliver more sustainable models and the required market capability building. This also inhibits co-commissioning opportunities and development of more integrated responses.
- **Needs assessments:** PHNs have developed significant capability in undertaking needs analyses which are strengthened by regional context and insights on population and health and social care. These analyses are well placed to enable better informed and objective decision making between stakeholders on priorities for investment. E.g. for new initiatives, continuous improvement focus and / or integration focus in programs or between parts of the system. Deriving value from these needs assessments is constrained by the lack of authority (at a system level) for PHNs with regional planning and expectations on jurisdictions and their LHNs. In relation to DOHAC, it is unclear that the data and insights derived from HNAs inform program planning at a national level. New initiatives (e.g. new headspace sites) appear not to be based in evidence or relative need. In addition, program structures mean that if need changes, PHNs have extremely limited levers to move resources to where that need is. As such, HNAs appear to be a compliance task for DOHAC rather than an insights and planning process.

West Metro Health Service Partnership's Population Health Needs Assessment

The West Metro Health Service Partnership's Population Health Needs Assessment (WM HSP) is a collaborative initiative involving several health services and organisations in Victoria. The project aimed to understand the health needs of the population in the West Metro catchment of Melbourne by delivering a comprehensive and system-wide view of these needs.

The project utilised an evidence-based approach to define need, considering four types of need (comparative, normative, felt, and expressed) through the examination of quantitative and qualitative data. This included a deep dive analysis into four priority cohorts (older people over 65, children aged 0 to 9, women and females aged 20 to 39, and people currently unwell with cancer) and two focus areas (potentially preventable hospitalisations and avoidable emergency department presentations). The



findings were communicated via a roadshow across all six health services, helping to inform priority setting and coordinated action in response to need.

The project has strengthened relationships across the WM HSP and system partners, informing strategic and service planning, including major infrastructure projects. It has demonstrated the value of a coordinated, system-wide approach to population health and provided a model for future collaboration. The methodology developed is now being used for health needs assessments and has sparked discussions about joint needs assessments with other health service partnerships. *(please refer to Page 97 for the detailed case study)*

ment Initiative

4.2.2 PHNs as meso-level health organisations for regional planning and system integration

- **Meso structures:** Internationally, comparable models in delivering primary health care outcomes apply a meso-level structure approach; where person-centred, locality population level, place-based solutions and structures are implemented to drive and respond to local need under the auspices of broader macro-level goals and outcomes set by a central authority.
- **Regional coordination:** A core role of PHNs, as meso-level organisations, is to support system integration and coordination to reduce any impacts of a fragmented health system. Consistent with the regional focus of PHNs, the Productivity Commission's 'Shifting the Dial' report ¹⁰, recommended that the integration of care is generally best managed regionally. Additionally, the 'Shifting the Dial' report noted that cultivating relationships between hospitals and GPs is critical, especially for new models for care or any system reforms, with this task of engagement is best undertaken by PHNs.
- **Regional flexibility:** The 'Shifting the Dial' report also noted that whilst resourcing for regional variations in care can be funded centrally, flexibility at the regional decision-making level uses local information better and is more adaptable. A prescriptive approach to the management of regional health institutions, such as PHNs, would undermine the capacity to respond to the needs of populations in different regions. Regional flexibility gives permission for experimentation. The international evidence shows there is no best single model of integrated care, and that therefore central governments should step away from prescriptive rules about how it is delivered.

Community Led Integrated Healthcare Program - demonstrating effective use of core flex funds

The case study discusses the Community Led Integrated Healthcare Program by Gippsland PHN, focusing on addressing chronic conditions, socio-economic disadvantages, and limited access to healthcare in rural Victoria. Gippsland has high rates of chronic conditions, socio-economic disadvantages, and limited access to healthcare workforce, prompting Gippsland PHN to explore an integrated, place-based primary care model.

The evaluation of existing services led to a shift towards a value-based approach to outcomes, aiming to deliver innovative, multi-disciplinary team-based care to meet local needs and address regional access barriers.

The project was implemented in four phases: Analysis, Discovery, Design, and Commissioning, engaging community members and healthcare professionals to co-design care models and draft tender specifications. The co-developed model is a flexible, patient-centred healthcare hub providing team-based care through locally based professionals and telehealth support, designed to meet community needs.

¹⁰ Productivity Commission 2017, Shifting the Dial: 5 Year Productivity Review, Report No. 84, Canberra



Two services were commissioned: one for vulnerable children in Latrobe LGA, and another for remote communities in Tabbut and Bendoc, each targeting specific cohorts with tailored care coordination and support. The program's impact is illustrated by a consumer story, showing significant improvements in a child's health and social wellbeing, and positive client feedback highlighting the program's effectiveness.

The Community Led Integrated Healthcare program demonstrates effective use of Core Flexible funding to meet local need, using a place-based solution that was codesigned by the community experiencing the health need. Supporting PHNs with flexible funding and clear outcome expectations can enhance the design and delivery of services to better meet community needs and improve health outcomes. *(please refer to Page 102 for the detailed case study)*

ment Initiative

4.2.3 PHNs, jurisdictions, and regions

- **Distribution of PHNs:** PHNs have a deep understanding of primary health needs in their regions and drive reform, integration and equitable access across the health and social care system. As regional commissioners, PHNs reduce service fragmentation and address unmet needs by working with Local Health Networks/Local Health Districts or equivalents, and other partners through developing fit for purpose models of care to address local needs. When considering the appropriate number of PHNs within different jurisdictions, the following variables should be assessed:
 - **Population size, distribution and demography:** PHN boundaries were designed to ensure each network manages a population size that allows for effective service delivery and resource allocation, given that population distribution and demography (e.g. age, SES, language, ethnicity, family structure etc).
 - **Geographical considerations:** The delineation of PHN regions considers geographical factors to ensure accessibility and coverage, and rurality versus metropolitan considerations, e.g. workforce.
 - **Wider health system:** The number of PHNs within a jurisdiction also needs to be tailored to the jurisdictional health system. E.g. in Tasmania one PHN is an appropriate response but in Victoria the sheer number of health services in the Victorian system means that multiple PHNs are required.
 - **Alignment with other geographic systems and structures:** Currently, the PHN boundaries within Victoria do not consistently align with other geographic structures or state catchments/regions. However, the six PHNs do reflect a balance between managing a feasible population size, addressing diverse health needs across different regions and geographies, and ensuring effective coordination with existing health services, given the complex nature of the Victorian health system. The recently released Local Health Service Networks (January 2025)¹¹ further highlights the complexity of the system whereby 12 networks were announced that do not align with PHN boundaries, nor other existing Victorian health structures (i.e. nine public health units). Note that the proposed new regions do not align with Ambulance Victoria, Victoria Police, Human Services regions, SES/CFA regions at a state level nor any other Commonwealth regions.

¹¹ [3952894.pdf](#)



- **Bilateral activities:** As discussed elsewhere, the VTPHNA PHNs have bilateral agreements and activities underway with their respective jurisdictions across mental health and primary care. Engagement with state agencies is varied and, in most cases, the burden of activity of joint work is carried by PHNs. There are formal agreements in place to support mental health activities however, they carry little weight to influence state-led buy-in and commitment to the agreed activities and outcomes. Greater involvement and oversight from DoHAC, aligned funding and outcome measures, as well as tri-lateral monitoring may act to improve joint work.
- **Local collaboration:** PHNs have worked collaboratively with hospitals both within and outside of catchments to facilitate integration and reduce fragmentation. This has led to several innovations at a local level that have led to broader impact across a jurisdiction's health system.

Using digital health technology to improve integration of care across the Tasmanian health system – PHN capability to lead innovation

This case study discusses the implementation and impact of eReferrals in the Tasmanian health system, led by Primary Health Tasmania (PHT). Before eReferrals, Tasmania's referral system was paper-based, inefficient, and insecure, causing distrust and administrative burdens among healthcare providers.

PHT funded and led a trial for eReferrals, which expanded to include all Tasmanian general practices and several hospital departments, resulting in positive feedback and a decision for statewide rollout. The eReferral system improved referral efficiency, security, and patient care coordination, and is now part of Tasmania's long-term digital health strategy.

With a focus on innovation, PHT was in a unique position to lead this fundamental digital health initiative for the state. The proof of concept enabled an injection of funding and engagement outside the scope of the Tasmanian Government. **This is a great example of a PHN funded, led and supported major project that has been successfully translated into permanent whole of system change.** PHNs should continue to be flexibly supported and resourced to drive system level innovation and change. *(please refer to Page 106 for the detailed case study)*

4.3 Opportunities for improvement

The following opportunities are proposed to address the key issues highlighted in this chapter in relationship to the limitations of the PHN model to support regional planning, stakeholder engagement, and local effectiveness of their commissioning, coordination and capacity building activities. Victorian and Tasmanian PHNs are committed to, and work hard to foster, engagement with key stakeholders in each jurisdiction to focus on 'one-health system' planning and better collaboration between PHNs and State health services/ LHNs. If the above issues were addressed, much greater progress could be made and at greater pace.

- **Align PHN Functions with International Best Practices:** Adapt PHN structures and functions to align with international best practices in meso-level regional health service structures and delivery, ensuring that PHNs are equipped to implement sustainable, people-centred, and place-based healthcare solutions. Consider empowering PHNs with greater authority to make decisions and manage budgets, enabling tailored responses to local health priorities whilst ensuring the departmental accountability for the contextualised implementation of strategies and the achievement of national health outcomes



- **Take a ‘tri-lateral’ approach** by bringing PHNs to the table in primary care and mental health bilateral discussions (i.e. the National Health Reform Agreement and the National Mental Health and Suicide Prevention Agreement) and informing decisions
- **Clearly define and monitor the expectations on jurisdictions** (and LHNs) to contribute and participate in joint regional planning to strengthen integration and ensure there are mechanisms for accountability.
- Strengthen **alignment between the different branches in DoHAC** on policy and authorise the role of PHNs with flexibility to localise initiatives and programs
- Allow **greater flexibility for PHNs to manage budgets** across the term of a funding schedule
- **Ensure funding schedules are provided in a timely manner** to enable the required planning, engagement and design- a longer lead time of minimum six months (exceptions for responses relating to natural disaster/ situational crises)
- Strongly recommend that **no PHN boundary changes occur in Victoria**:
 - Hospital boundaries are not yet established.
 - When / if they are established, there is very likely to be significant system disruption.
 - This disruption must not impact short / medium term commissioned services.
 - Suggest review in 2027 when / if the Victorian system is clustered.



5 KEY REVIEW QUESTION 4: PHN Funding Model

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

OPPORTUNITY: *To create system change within the primary health care system, to meet the needs of consumers, to support a stable health workforce, and to ensure access to sustainable services, PHNs require the following amendments to the PHN funding model:*

- 1. Five-year funding cycles to align with other health system actors*
- 2. Indexation of funding to reflect CPI and actual costs*
- 3. Renewal of agreements on a rolling three-year basis to ensure service stability and sustainability*
- 4. Core-flex funding increased to reflect actual PHN operational costs.*

5.1 Overview

PHN budgets are a small proportion of the healthcare spend in each jurisdiction. More than half of the PHN funding is directed to DoHAC programs, resulting in the PHNs having approximately 0.2% of total health system funding to improve and reform the health system. The PHN Program funding has expanded in complexity, leading to a significant administrative burden with much of the reporting being unhelpful for policy development. PHNs control a minor portion of the total health system funding, limiting their ability to drive substantial health system reforms. Streamlining budget approval processes and extending funding cycles to 5-10 years could enhance flexibility and responsiveness to regional needs. Furthermore, consolidating funding streams and reviewing PHN grant terms and conditions could facilitate more effective, regionalised, health system improvements. There is also a call for increased flexible funding to support long-term structural reforms across primary care, acute care, aged care, and disability support sectors.

This chapter presents the VTPHNA response to key review question 4 focusing on the effectiveness of the PHN Program funding arrangements, the suitability of the funding mechanisms to support program delivery at the local level, and potential improvements to the funding model.

5.2 Key issues

5.2.1 PHN funding model adequacy

- **PHN Funding Contracts:** PHN Funding contracts are generally renewed on a 3-year cycle, but typically only within one month prior to expiry and in some cases after expiry. This funding uncertainty creates extraordinary financial risks for PHNs and their Boards, and adversely impacts their ability to run their businesses efficiently. In addition, funding uncertainty significantly constrains PHNs to commission health services for long term ongoing improvement and allow service providers to recruit and develop highly skilled and experienced health professionals.



- **PHN Core Operational Cost Funding Shortfall:** Currently PHNs are having to plan and budget for core operational annual funding shortfalls ranging between \$2M to \$5M due to inadequate combined funding from their Core PHN Schedules and Capped operational cost contribution funding from Program Delivery Funding Schedules. To meet their program delivery obligations PHNs typically fund their core operational capability via the use of a range of financial management mechanisms. Such short-term variable shortfall funding mechanisms are an unsustainable and high-risk manner to financially manage \$80-\$100M businesses. PHN's Core Funding Schedules should be updated to reflect PHN's Core funding requirements as of 2025 rather than 2016 when the Core Funding Schedule was first issued, i.e. based on an \$80M p.a. business rather than \$25M businesses.
- **Funding indexations:** Recent funding indexations provided to PHNs have ranged from 0% to 2.5% which have been significantly lower than CPI index and wage increase in the labour market. This creates significant financial pressure for PHNs and service providers to recruit and retain employees, to manage risks such as social engineering and cyber risks; and to comply with even more complex compliance / legal requirements. Funding should include indexation adjustments that are at least on par with CPI. This principle applies to both program and core operational funding.
- **Short-term and siloed program funding:** Short-term and siloed program funding inhibits long-term, customer-centric reform. PHNs were established to support long-term health system change, but the short-term nature of funding means that PHNs cannot build the relationship and processes needed for those changes. The funding programs have either two-or-three-year funding cycles, which do not align with policy goals of four-to-five years.

Transitioning from Victorian Priority Primary Care Centres to Urgent Care Centres

The rollout of urgent care clinics (UCCs) in Victoria began in September 2022 with the opening of the first state-funded Priority Primary Care Centres (PPCCs). The Victorian PHNs were contracted by the Victorian Department of Health (Vic DH) to commission these services and were involved in establishing the model specifications. PHNs were funded to support the implementation including statewide coordination and data functions to ensure a consistent approach and integration with other healthcare services, and local support to establish working groups to support the development of local referral pathways.

In July 2023, Victoria entered into a Federation Funding Agreement with the Commonwealth as part of the Medicare UCC program, transitioning nine existing state-funded PPCCs to co-funded (state and Commonwealth) Urgent Care Centres (UCCs). However, the funding for these co-funded UCCs was for one year, unlike the two years offered in other jurisdictions, due to constraints in Vic DH funding.

In January 2024, all clinics received a reduction in funding due to reduced expectation regarding opening hours. By April 2024, Vic DH offered an extension for FY24-25 with further funding reductions, which was rejected by most clinics. The Victorian PHN CEOs coordinated efforts to bring together Vic DH, DoHAC, and PHNs to work through the funding methodology and support the continued delivery of urgent care. This coordination included statewide clinical and project governance, local project working groups, and a statewide community of practice to ensure a consistent approach and integration with other healthcare services.

The Victorian PHNs' coordination was successful, with all clinics agreeing to the new terms and receiving funding for the full two years. The transition of 17 clinics to co-funded Commonwealth clinics was managed without service interruption. The statewide coordination role provided by the PHNs created efficiencies and informed the Commonwealth UCC rollout. This case study recommends that for future programs, Victorian PHNs should be funded directly to support commissioning, reducing duplication and delays. *(please refer to Page 108 for the detailed case study)*



- **Single PHN jurisdictions receive every new national program, trial or government initiative –**
As government needs to be seen to be equitably distributing new opportunities across all states, Tasmania as a single-state PHN receives a vastly disproportionate new program load in comparison to larger state peers. This creates a very demanding and constantly changing work environment for moderately sized PHNs in single PHN jurisdictions.
- **New Program Funding - Mis-aligned Upfront Payments:** New funding programs are typically structured with the total 2–3-year funding amount evenly spread across the initial financial years, including the year of announcement. New funding programs require 6-12 months of establishment work, (including needs assessment, stakeholder engagement, design, procurement and new service contract development and embedding), until ongoing 'full-service delivery' costs begin to be incurred. This misalignment of funding receipt and funding spend results in substantial upfront underspend and subsequently gets carried forward as accumulated program surpluses, (sitting in PHN's balance sheets as deferred revenue going forward).
- **New program establishment costs:** New funding programs are typically funded with a 'nominal' amount of establishment cost funding which has little relationship to the likely actual establishment costs to be incurred by PHNs. New funding programs should include establishment funding amounts with greater consideration of the likely actual cost requirements of the program.
- **Company and Director Obligations:** As noted earlier, PHNs are structured as companies and are subject to standard corporate regulation. There are strong sanctions against a company and its directors if it trades whilst insolvent. All companies must be able to meet all their obligations when they fall due, and all Directors have a duty to prevent insolvent trading. This means that there are significant risks to PHNs if they authorise spending based on promises rather than signed Deeds. Delays in processing new Deeds, or extensions of existing Deeds, create problems in continuity of service provision.

5.2.2 Grant-based funding suitability and efficiency

The problems with the grant program system, as it currently operates, may be grouped into approval delays, misalignment of funding and policy goals, unnecessary competitive 'bidding', and the annual budget and reporting cycle.

- **PHN grant program system:** The current PHN grant program system, as it presently operates, is not fit for purpose, due to approval delays, a misalignment of funding and policy timeframes, and a simplistic annual budget and reporting system. The PHN program works on an annual grant management cycle to deliver on 13 funding schedules that address different policy areas and are administered by different areas of the Department. These 13 schedules drive 71 funding programs, 275 activity workplans and 2700 individual activities (as at the end of FY2023). Each funding program has a different funding framework, with different funding cycles. The activity workplans which each PHN must prepare for each of the 13 funding schedules, (each with hundreds of activities) then must be updated whenever new funding or activity is proposed.



- **Delayed approvals:** An additional significant issue is the delayed approvals of annual budgets and of new programs. After PHN funding requests are submitted by 30 September, approvals are typically not received until April the following year. This means that PHNs have been carrying the risk of funding shortfalls the 10 months from July until April of a financial year. This includes approval for use of carryover funding from the *previous* financial year. The funding cycle needs to commence earlier, to allow funding approvals made in April, to apply to the following financial year, rather than when the year is almost over.

Commissioning impact of deeds not arriving in a timely manner

This case study highlights the challenges faced by Eastern Melbourne PHN (EMPHN) due to the delayed receipt of funding deeds from DoHAC, particularly in delivering Psychosocial Support Services (PSS). PHNs consistently receive funding too late to undertake robust planning for services, leading to limitations in the efficiency and effectiveness of service provision, and potentially poorer health outcomes for vulnerable communities.

EMPHN's experience with psychosocial funding highlights the impact of late funding deeds on consumers and providers, with complexities including timing and one-year rolling deeds. These included:

- **Provider Challenges:** Providers planned to suspend services due to the clinical and financial risks of accepting new patients without confirmed funding, despite receiving letters of comfort. Providers also face workforce retention issues, increased training costs, data recording problems, and inability to improve services due to uncertain funding. Service volume analysis demonstrates a significant dip in services due to funding instability.
- **Commissioning Processes Affected:** The retrospective receipt of funding deeds hampers essential commissioning processes, such as decommissioning poor-performing services, market analysis, and service redesign. Delayed funding may also result in the inability to expend funds, and challenges in managing provider performance, leading to decreased trust from providers.
- **Community and Consumer Impact:** The community experiences service gaps, longer waitlists, and less experienced clinical staff due to the instability of funding. Consumer experience and trust of services is also impacted due to staff turnover.

Recommendations to address funding delays include providing larger, more flexible funding pools, extending deed periods to three or four years, simplifying outcome measurements, and ensuring deeds are received six to nine months prior to expected service commencement. *(please refer to Page 110 for the detailed case study)*

- **New activity approvals:** Delays are also the norm for the approval of new activities. In 2022 the PHN Cooperative formally raised that the majority of PHNs were waiting 1-6 months for approvals against new funding, and the majority of PHNs were waiting 3-12 months for approvals on activities against other core funding. The time lag in the approval process is significantly and adversely impacting the performance of PHNs. PHNs are aware of the staff shortages and turnover within the PHN Branch that leads to these delays. They are also aware that approvals for both budgets (via activity work plans) and the use of carry over funds (via the 12-month performance reports) must be sought for the 71 funding programs across multiple branches. Delays may also be due to funding approvals that must go through the grants hub administered by the Department of Social Security.
- **Impact of delays:** These delays affect staff morale and turnover at PHNs and are felt even more keenly by commissioned providers who lose staff, are reluctant to lease buildings, and may see patient continuity of care compromised due to disrupted service provision and staff shortages. Any options that can be developed to streamline that process should be explored.



- **Funding cycle misalignment:** The three-year PHN funding cycles for mental health, for example, do not align with the four-to-five-year Department programs in mental health. Likewise, significant funding is available for the Department priority of psycho-social support, but only for one to two years. PHNs are unable to commit to funding providers and providers cannot invest in setting up operations, if neither party is sure whether the funding will continue. This misalignment is exacerbated during any national program review. It is challenging to implement key reform and improvement initiatives for programs that are currently under review, when the program's future term or scope are uncertain, and PHN funding is constrained whilst the review is being completed.
- **Lack of support for system reform:** As all funding relates to a specific funding program, no funding is available to support the long-term system reform for which the PHNs were established. Nor does it support a holistic customer-centric range of services from either the same provider or through the same program. If different services were available under the same funding framework, PHNs could fund services where they are most needed across the funded programs.
- **Unnecessary 'competitive' applications:** When funding is available, PHNs are invited to apply. Each PHN then prepares an almost identical application, for the same funding, and are the only applicants to do so. A competitive grant application framework is unsuitable for the PHN program in these instances. Once the value of a service is shown, it may be more efficient, effective and equitable to make funds available to all PHNs based on their socio-demographic need (as described within PHN Needs Assessments). This would only apply where all PHNs would receive funding. PHNs are also required to routinely submit the same documentation such proof of entity. Remove the requirement for submission of information already held by the funder to reduce administrative burden.
- **Annual budgets and reporting leading to increased requests for carry-over approvals:** Whilst funding is typically on a three-year basis, budgets are planned and reported annually, often then requiring resource-intensive requests for funding to be "rolled over" into the next year. Approvals often take an additional nine months or more – by which time the relevant financial year has again passed, with the PHN carrying the funding risk and having to enter yet another cycle of rollover requests. The difficulty in matching annual 'assumed' budgets to actual expenditure makes the complex role of service management and delivery even more difficult. Instead, to support programs, PHNs and providers more effectively, there should be flexibility for the PHN to allocate its funding across the three years according to service rollout, with automatic carry over of funding within the three years unless there is clear cause not to.
- **Terms and conditions:** The terms and conditions (T&Cs) of the grant arrangements define the relationships between the Branch, PHNs and providers. A review of the T&Cs is overdue to ensure that they align with the desired nature and specifics of those relationships. The T&Cs have not been reviewed since they were prepared in 2015 – prior to the PHN program commencing and are not keeping pace with regulatory reforms in relevant non-health areas: for example, with the Fair Work Act provisions on the employment status and redundancy of staff, on child protection, and cyber governance. Ideally, the T&Cs would reflect a commissioning relationship and partnership through Branch-PHNs-providers. Instead, they present a distant or legalistic commercial transactional relationship. Whilst that is an



inevitable risk of legalistic T&Cs, it is possible to present conditions in a clear and reasonable way. The current provisions are long and complex. The administrative requirements are often onerous and must be passed through to providers.

5.2.3 Adequacy of financial reporting systems

- **Shift to 'Whole of Business' financial reporting:** Currently the Department requires PHNs to report operational costs in a siloed manner against each funding schedule (by Separate AWP's each with its operational costs approx. 5%-6% of total program funding), thus losing visibility of the true operational cost of a PHN. PHN's should ideally be required to report their financial performance regarding the utilisation of operational funding at a 'whole of organisation' level to the Department.
- **Cost benchmarking and financial modelling:** It is critical to the effective administration of the national PHN program that the Department's online PHN financial reporting templates are structured to provide the Department with visibility of the true core operational cost of the program's PHNs. This reporting structure needs to also facilitate PHN cost benchmarking and analysis insights of PHN financial management performance. Such reporting will provide assurance around PHN financial management performance but also allow PHN Core funding to be restructured and delivered to better match the requirements of high performing PHNs.
- **Core funding streams:** PHN Core Funding is allocated to arbitrary funding streams of Corporate Governance and Health System Improvement in PHN Contracts. This arbitrary division of core PHN funding tends to be meaningless, adds confusion and adds unnecessary accounting and reporting complexity. PHN Core funding and reporting of its effective use should be managed via 'whole of business' reporting, including KPI's such as a standard % of total costs - i.e. expected Core Operations vs Program Operations = 20%/80%, expected Corporate Operations as % of total PHN Costs, etc.

5.2.4 Funding flexibility and local innovation

PHNs receive funding through a complex arrangement of funding schedules that have different timeframes, and this impacts service planning.

- **Funding stability:** More stable funding would provide PHNs with greater certainty in being able to respond and meet their local community needs. Consideration should be given to shifting from the current complex grant system to a mechanism that provides longer term continuity of between five to 10 years. This could include:
 - Establishing a streamlined process for approving PHN budgets and carryovers so that these are confirmed within three months of receipt by the Department, with budgets approved before the financial years to which they relate.
 - Allowing greater flexibility for PHNs to adjust expenditure within the funding guidelines and periods, rather than forcing expenditure to be reconciled against annual budgets.
 - Potentially combining PHN funding streams to allow greater flexibility and ability to respond to local needs.



- Periodically reviewing the PHN Terms and Conditions of grant to ensure they remain fit for purpose and align with changes in legislation.
- **Workforce management:** Managing a workforce with rolling short-term funding streams presents several challenges, however, careful planning and strategic approaches can mitigate the risks. Current Fair Work legislation has resulted in PHNs carrying significant risk to maintain employee contracts where the roles are required to deliver the objectives of short-term funding streams.

5.3 Opportunities for improvement

The major driver of inefficiency in the PHN program in terms of cost, time and effort is the structure and operations of the grants program. A new approach is necessary as the “grants for grants” approach is overly cumbersome. In summary, addressing the below issues would improve the effectiveness of the PHN funding model, and in turn, the effectiveness of the PHN program.

- Develop a consistent approach between DOHAC Divisions and branches in terms of funding splits and outcomes.
- Implement a transparent funding model(s) and an outcomes framework across DOHAC Divisions and branches to inform funding and reporting expectations.
- Update PHN program guidance to keep pace with external change and broadened roles of PHNs.
- Ensure PHN funding is consistent with external change and cost drivers to prevent commissioned service providers receiving less and less and expected to deliver more.
- Address and revise processes to ensure significant delays in approvals and acquittals are prevented.
- Revise PHN-specific Grants Hub processes to ensure they are fit for purpose for the PHN program.
- Structure new program funding streams to reflect a more realistic timing of spend including a realistic program establishment period until 'full-service delivery' funding is allocated
- As primary care funding moves to a future bundled/block model PHNs could have a significant role in local co-design and monitoring performance of bundled payment outcomes. This could be particularly beneficial in regional locations where the care team mix may be quite different to a metro location.
- PHNs are the right organisations to deliver new initiatives but the demands and challenges of doing so need to be better reflected in the core funding formula.
- Provide early and clear communication on the intention to extend/cease funding sources that allow PHNs to undertake strategic workforce planning.



6 KEY REVIEW QUESTION 5: PHN role in the mental health system

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?

OPPORTUNITY: *The role of the PHNs within the mental health and suicide prevention system mirrors the PHN role described in Review Question 1, as a meso-level health organisation that aims to integrate the mental health system and improve health outcomes for communities. Proportionally, PHNs have a greater funding influence in the local mental health system and hold deep understanding of local health needs and system gaps. To strengthen the framework for PHNs to demonstrate accountability and effectiveness in their work and thereby increase effectiveness, a clear, equity-focused purpose for the MHFFS, with outcome-based goals that align with regional needs is required. With a clearly defined systemic purpose and an aligned outcomes framework, PHNs offer capability in driving mental health system integration in the context of local needs, gaps, and capacity. In addition, PHNs are uniquely placed to lead enhanced integration with primary care, and system reform would benefit from increased accountability and delineation of roles for bilateral activities.*

6.1 Overview

As the government's regional planner and commissioner of mental health services, PHNs leverage their independent regional capacities to design and manage an integrated mental health care system. This system addresses the full spectrum of mental health needs—from early intervention to acute care—following a stepped-care approach. The PHNs' roles ensure that mental health services are responsive, evidence-based, and coordinated across primary, secondary, and tertiary care pathways.

This chapter presents the response to Key Review Question 5 focusing on the role of PHNs within the mental health, AOD, and suicide prevention system highlighting key issues and opportunities for improvement for the PHN Mental Health Flexible Funding (MHFF) program.

6.2 Key issues

6.2.1 Role within the mental health system

The key roles of PHNs in commissioning services through the mental health flexible funding stream within the mental health and suicide prevention system include:

- Funding across the stepped care model
- Supporting gaps or enhancing services at the local system level, especially for marginalised groups or people at risk of missing out on care they need (e.g. ensuring equitable access for rural populations in regional PHNs)



- Aligning/ coordinating to Jurisdictional systems and strategies
- Aligning/ coordinating to national system and strategies
- Leveraging system thinking, funding mechanisms and local/Jurisdictional relationships to push markets towards greater integration, alignment, and non-siloed client centred care.

Establishment and delivery of Head to Health services

The case study on the establishment and delivery of Head to Health services highlights the role of PHNs within the mental health system, and their capability at delivering local solutions.

The case study demonstrates the capability of Primary Health Networks (PHNs) to rapidly mobilise effective health commissioning in response to environmental and situational events, leveraging regional knowledge, insights, and expertise. Victorian PHNs effectively led innovation in several areas which are now embedded in primary care and reform:

- Multi-disciplinary teams in primary care settings
- First large-scale use of the (then new) Initial Assessment and Referral Decision Support Tool (IAR-DST)
- Use of defined PREMS (available across the statewide program)
- Fit for purpose data system and data insights (delivered through a single system)
- Iterative developments to the phone service to support consumers to access the best service for them, regardless of funding source.

Since its inception, the H2H service in Victoria has handled 63,223 calls, with 18,659 consumers receiving 215,237 clinical sessions. A significant majority of clients reported positive experiences with the intake process and care received.

The initiative showcases the core functions of PHNs (Coordinate; Commission; Capacity-build) and the efficiency and economies of scale delivered by Victorian PHNs, which now benefit the national network through the Head to Health national telephony and data system.

Enabling PHNs to have greater flexibility in making commissioning decisions and designing program specifications, in line with clearly defined objectives, can support the quintuple aim of health reform.
(please refer to Page 114 for the detailed case study)

6.2.2 Effectiveness

PHNs have generally proven effective in their role as independent regional commissioners due to their deep understanding of local communities and their ability to design services that fit regional needs. By commissioning services that reflect the unique demographic, cultural, and socio-economic characteristics of the regions they serve, PHNs contribute to creating a locally integrated system of mental health and suicide prevention care. This includes services that are connected across primary, secondary, and tertiary care pathways, which is essential for continuity of care. Additionally, PHNs play a pivotal role in embedding evidence-based practices and developing collaborative care models that enhance service delivery. The PHN ability to use data-driven insights and outcomes frameworks to shape services also supports the refinement of the mental health system.

Although PHNs do experience some challenges in this work, which include:

- **Effectiveness measurements not standardised across PHNs** - DoHAC has also not defined these and the National PHN program's current measures do not measure this in a meaningful way
- **The absence of an outcomes framework** for primary mental health means defining 'effective' is challenging and subjective



- **The allocated funding for different "steps"** within the Annexure D, e.g. Low Intensity Services can limit flexibility to respond to place-based needs, or to commission more integrated services that would better meet community needs.
- Locally, PHNs have examples of highly effective programs that have a system view that translate at a local level. Conversely, PHNs have examples **of ineffective programs that have been efficiently addressed by rapid re-allocation of investment, demonstrating agility and responsiveness**, resulting in programs with QI learnings built-in a manner that State or Commonwealth (direct to provider) cannot replicate in such an adaptive and expedited way.
- In the Victorian context, the broader system work is challenging due **to State government challenges in truly partnering with PHNs, and accountability in delivery against the National Mental Health and Suicide Prevention Agreement**, associated bilateral agreements and bilateral implementation plan. In addition, Victoria is attempting whole system redesign to implement the recommendations of the Royal Commission into Victoria's Mental Health System, often excluding consideration of Commonwealth funded initiatives, resulting in duplication of services or service gaps. This instability has impacted relations with PHNs and led to significant issues in supporting effective system and consumer transition from Head to Health Centres to Victorian Locals and attempts to progress partnership approaches for regional planning.

Improving provider capacity to understand Suicide Risk reporting

Gippsland PHN aimed to improve its performance on the App-3 Suicide Risk Follow Up KPI by enhancing provider understanding and reporting accuracy. In 2019-20, Gippsland PHN scored 34% on the App-3 Suicide Risk Follow Up KPI, indicating a failure to ensure timely follow-up for individuals at risk of suicide.

The PHN conducted consultations with service providers, revealing misreporting issues. They implemented an education program, including online training and email reminders, to clarify the KPI's correct usage. Despite improvements, the KPI did not reach 100% immediately due to external factors like consumer availability. Additional improvements were implemented, such as an outcomes-based payment system developed in accordance with provider feedback. Continuous efforts included capacity building and monitoring by the PHN staff.

The initiatives led to a reduction in misuse of the suicide risk flag and improved the KPI performance to 100% since 2022-23. This case study highlights the important role PHN's play in improving data quality in an ongoing and sustainable manner. *(please refer to Page 116 for the detailed case study)*

6.2.3 How the Role Could Evolve

To increase the efficiency and effectiveness of PHNs within the MHFFS, a few key steps can be taken. These steps would need to be designed with, and support by, DoHAC to realise benefits.

- **Clearly Defined Systemic Purpose:** The MHFFS program would benefit significantly from a clearly defined purpose that aligns with the broader goals of DoHAC's vision for equity of access to mental health services. PHNs, as trusted regional commissioners, can take on a more strategic role in driving equity outcomes if they have a clearer mandate aligned with national policy objectives. This would empower PHNs to plan and commission services in ways that directly contribute to improving access to care for underserved populations.
- **Equity-Based Planning Tools:** Collaboration between PHNs and the State Departments to develop tools that support equity-based planning is crucial. This could include the creation of comprehensive population definitions, data systems, and reporting frameworks. These tools



would enable PHNs to measure and address disparities in access to mental health services, particularly for vulnerable groups, and ensure that funding is allocated to areas of greatest need.

- **Innovative Care Pathways:** PHNs can innovate and co-design care flow pathways with local stakeholders to reduce fragmentation in the mental health system. A key part of this is ensuring that people with mental health challenges do not have to repeatedly share their personal stories. By embedding integrated assessment tools, such as the IAR-DST (Integrated Assessment and Referral Decision Support Tool), across general practice, school wellbeing programs, and tertiary health services, PHNs can ensure that people are referred to the right level of care in a seamless and coordinated manner.
- **Data Integration and Monitoring:** PHNs are well-positioned to negotiate and integrate various data systems to track activity, outcomes, and the impact of mental health services. A system that consolidates data across care levels would enhance the ability to monitor the effectiveness of services and drive improvements in real-time. This data would also support the ongoing evaluation and performance assessments needed to meet national mental health and suicide prevention objectives.
- **Leadership in Service Reform:** PHNs should continue to play a leadership role in driving the changes needed to align regional mental health services as per National Mental Health and Suicide Prevention Agreement. By using outcomes frameworks and performance evaluations, PHNs can refine the service focus to address emerging needs and policy goals, such as improving mental health access and outcomes across different communities.

Victorian Suicide Prevention Service and System Analysis

The Victorian Suicide Prevention Service and System Analysis case study highlights the value-add of PHNs in the collaboration between the Commonwealth and Victoria to improve mental health and suicide prevention outcomes. Despite significant funding being transferred to the Victorian government, the bilateral governance structure was ineffective in supporting the implementation of initiatives. In response, the Victorian PHNs, through VTPHNA, proposed a collaboration with the Victorian Suicide Prevention and Response Office (SPaRO) to improve system integration and trial joint ways of working.

The intervention involved a project jointly funded by SPaRO and Victorian PHNs, with NWMPHN's Research and Evaluation team delivering the project. The project included developing a detailed register of current suicide prevention services, analysing suicide and self-harm patterns across Victoria, and exploring how service register findings could be integrated with hospital and mortality data. The analysis revealed that the suicide prevention system in Victoria is not well integrated and difficult to navigate.

The final report, delivered to SPaRO and Victorian PHNs, provides valuable insights and evidence for improving system integration, addressing gaps, and minimising service duplication. PHNs have demonstrated capability in system leadership through rapidly developing translatable and useful statewide and regional system and population health analyses which enable practical actions. Early engagement of PHNs adds value in leading system reform planning and initiatives that are relevant to the jurisdictional and regional contexts. *(please refer to Page 119 for the detailed case study)*



6.2.4 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?

Since the introduction of the MHFFS in 2016, the landscape of mental health and suicide prevention in Australia has undergone significant changes, shaped by both policy shifts and evolving societal needs. Key trends influencing this landscape include:

- **Increased Complexity of Consumer Presentations:** There has been a rise in the complexity of mental health presentations, driven by higher rates of co-morbidities and multi-morbidities. This trend increases demand for a more skilled, multi-disciplinary workforce. However, this has also led to challenges as the existing workforce is often mismatched with the changing needs of the population, impacting service delivery across various levels of care.
- **Unmet Needs due to NDIS Changes:** Changes in Commonwealth and jurisdictional mental health funding arrangements, particularly related to the National Disability Insurance Scheme (NDIS), have resulted in unmet needs for psychosocial supports within the community. This has heightened demand for alternative care and support, driving increased reliance on PHN-commissioned mental health programs to fill the gap and deliver essential services.
- **Post-COVID Mental Health Surge:** Following the COVID-19 pandemic, there has been a notable increase in mental health issues, particularly among younger populations. This surge in demand for services has led to rising rates of mental illness, accompanied by a notable increase in primary care presentations, placing additional strain on the existing mental health infrastructure.
- **Workforce Pressures and Distribution Challenges:** Persistent workforce pressures continue to challenge the mental health system, with significant disparities in the distribution of professionals across urban, regional, rural, and remote areas. This inequitable distribution impacts the accessibility and quality of care in non-urban areas, exacerbating health disparities.
- **Increased Consumer Choice and Coordination Needs:** With greater Commonwealth investment in national mental health programs, including digital mental health services and the National Early Intervention Scheme, there has been an expansion in consumer choice. However, this has also increased the need for better coordination, navigation, and referral pathways across primary care, the MHFFS, and other health and disability systems. The need for seamless integration across these systems has become a critical focus.
- **State-Level Implementation Gaps:** The Royal Commission into Victoria's Mental Health System called for a comprehensive, whole-of-system approach, but the Victorian State's implementation has focused primarily on State-funded acute and community sectors, neglecting collaboration with primary care systems. They have also taken a 'project-by-project' approach to address the Commission's findings which has hindered broader systemic reform and resulted in missed opportunities for co-design, co-investment, and effective collaboration between primary care and mental health services. Moreover, the State has accumulated significant debt, halting many actions from the Commission's recommendations, along with causing significant issues for DoHAC and PHNs due to the slow rollout of the



Victorian Mental Health and Wellbeing Locals, and DoHAC and PHNs having to identify funding sources to keep PHN commissioned services running to address this issue.

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

The mental health and suicide prevention landscape is expected to evolve further in response to ongoing shifts in both demand and service delivery models. Potential changes and the corresponding adaptations for the MHFFS might include:

- **Clarification of Mental Health and Psychological Distress:** As mental health care systems increasingly distinguish between psychological distress and clinical mental illness; the use of clinical staging will become more widespread. This approach helps match the right level of care with the right workforce competency. The MHFFS could adapt by ensuring that commissioned services align with clinical staging, facilitating more tailored and effective care pathways.
- **Intentional Service Commissioning:** There will be a shift towards commissioning services with specific, intentional outcomes for targeted populations. This includes improving mental health care for marginalised groups such as Indigenous communities and addressing the increasing mental health challenges among young people. The MHFFS can support this by prioritising services designed for distinct population needs and ensuring that services are outcome driven.
- **Data Linkage and Broader Suicide Prevention:** Expanding data linkage across sectors will be critical in understanding the broader factors contributing to suicide risk, beyond mental health service responses. This includes linking data across education, housing, welfare, policing, and other community sectors. The MHFFS should adapt by incorporating cross-sector collaboration into commissioning processes, ensuring a more comprehensive approach to suicide prevention and mental health support.
- **Primary Care Reforms:** With the rising rates of mental health presentations in primary care and the growing adoption of multi-disciplinary team models in primary mental health care, the MHFFS will need to support and integrate these models into commissioned services. This could involve funding initiatives that facilitate seamless collaboration between mental health specialists, general practitioners, and allied health providers, ensuring integrated care pathways across the system.
- **National Early Intervention Service:** The National Early Intervention Service will create a need for more low-intensity mental health services. The MHFFS could adapt by revising its commissioning approach to support these services, focusing on prevention and early-stage interventions, particularly through digital platforms, peer support, and other low-intensity care models.
- **Aboriginal and Torres Strait Islander Wellbeing:** The transition of commissioning responsibility for Aboriginal and Torres Strait Islander wellbeing programs to community-controlled organisations will require a redefinition of the MHFFS role in this context. The MHFFS will need to work closely with First Nations Peoples organisations to co-design culturally appropriate services, ensuring greater community control and engagement, and support mainstream services in culturally safe care.



- **Suicide Prevention Sector Growth:** As the suicide prevention sector continues to expand, integrating these services within the broader mental health framework will pose challenges. The MHFFS should adapt by establishing clearer models for integrating suicide prevention into regional mental health service planning, ensuring that suicide prevention is not siloed but incorporated into a holistic system of care.
- **Leveraging the Lived Experience Workforce:** The growth of the lived experience workforce presents an opportunity to deliver more inclusive, consumer-centric services. The MHFFS can adapt by prioritising services that involve lived experience workers in decision-making processes, enhancing service delivery and fostering a more empathetic and person-centred approach to mental health care.
- **Intentional peer work:** The growth of the lived experience workforce offers a valuable opportunity to enhance mental health services through more inclusive and person-centred care. However, to fully realise its potential, there is a need for intentional peer work with clearly defined scopes of work. This ensures that peer workers are utilised for their unique strengths—such as empathy, lived experience, and authentic connection—rather than being misused for financial purposes. Clear boundaries and roles must be established to prevent exploitation and ensure that peer workers contribute meaningfully to care teams, enhancing both service delivery and consumer outcomes.
- **The realignment of Medicare Better Access funding** for structured psychological interventions to the Mental Health Flexible Funding Stream would enable a more strategic reconfiguration of the workforce based on regional priority needs. By integrating the IAR-DST, this approach would ensure that care is appropriately aligned with the level of need, minimising the misuse of funding. This would facilitate more efficient use of resources, ensuring enhanced access to mental health services for those most in need, and fostering a more targeted and effective mental health care system.
- **Responsive Commissioning for Natural Disasters and Emergency Response and Preparedness:** There is an increasing need for responsive commissioning in the face of emergencies, disasters or international crises. The MHFFS can evolve by creating flexible funding mechanisms that allow for rapid deployment of mental health and suicide prevention services in times of crisis, ensuring that communities receive timely support when they are most vulnerable.
- **Workforce Distribution Challenges:** Persistent challenges in the distribution of the mental health workforce across urban, regional, rural, and remote areas will require ongoing attention. The MHFFS can play a key role in addressing this by commissioning services that support care navigation, telehealth, and digital interventions, which can bridge geographical gaps in service access.
- **Expansion of Digital Health Interventions:** The growing use of digital health tools such as telehealth, apps, and self-directed learning platforms offers new opportunities for mental health service delivery. The MHFFS should adapt by supporting the integration of these technologies into regional service systems, ensuring that they complement traditional in-person care and expand access to mental health support, especially in underserved areas.



6.2.6 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?

PHNs face several challenges in delivering their role within the **MHFF**, which impede their ability to effectively plan, coordinate, and deliver mental health and suicide prevention services. Key challenges include:

- **Limited Flexibility in Local Planning:** The MHFFS requires PHNs to follow pre-determined intervention sets (e.g., psychological therapies for moderate intensity, care coordination for high intensity), restricting their ability to plan and respond flexibly to local needs. This limits the adaptability of services in line with regional priorities and emerging issues.
- **Lack of a Clearly Defined Systemic Purpose:** The MHFFS lacks a clearly defined systemic purpose that aligns with equity-based planning methodologies and measurable outcomes. This undermines PHNs' ability to demonstrate outcomes and accountability, hindering their effectiveness in meeting local mental health needs.
- **Program Complexity and Siloed Funding:** The complexity of the MHFFS, including multiple mandated service models, activities, and priority populations, stifles innovation and scalability. Additionally, inflexible funding streams contribute to a siloed system, increasing reporting burdens, care commissioning costs, and inefficiency in delivering integrated care. This is exacerbated by the limited alignment of strategic planning between policy areas, and within policy area subgroups.
- **Lack of National Coordination and Governance:** There is a significant gap in formal processes for PHNs to share data, compare best practices, and improve methodologies across regions. This lack of collaboration and information-sharing impedes resource allocation, planning, and commissioning decisions, preventing PHNs from leveraging collective knowledge and improving service delivery. Furthermore, the absence of a Regional Governance Structure to oversee the implementation of priority initiatives, particularly under the Bilateral Agreement with state governments, limits PHNs' ability to drive reform in collaboration with state health departments.
- **Challenges in Integration and System Guidance:** PHNs face difficulties in implementing an integrated system of care, with no clear guidance on what a '**One Health System**' construct looks like in practice. **The lack of state-level collaboration**—especially in Victoria, where the Victorian Department of Health has excluded primary care from reform efforts—further complicates PHNs' role in achieving system-wide integration and holistic service delivery.
- **The National Mental Health and Suicide Prevention Agreement is being reviewed in 2025,** prior to negotiation. This may influence further changes in the national mental health and suicide prevention system. Whilst PHNs are not part of the negotiations of these agreements, nor signatories, PHNs as the 'arms and legs' of the Commonwealth are expected to have key roles in the implementation of the work and are also impacted by agreements between the Commonwealth and States in relation to funding distribution. For example, in Victoria, flowing from the 'National Mental Health and Suicide Prevention Agreement' there is the Victorian bilateral agreement and a very detailed implementation plan, with clear funding attributions. Within this plan, PHN-commissioned Head to Health Centres were supported to be transitioned to Victorian Mental Health and Wellbeing Locals (Locals). This has been



problematic for PHNs (and the Commonwealth) due the slow rollout of Victorian commitments and activities. This has resulted in the Commonwealth and PHNs having to find funds (c. \$8M in 2024/2025) to continue mental health services as the State has not been able to deliver its proposed services on time.

6.2.7 How can these challenges be addressed to improve outcomes? & How could that [PHN] role evolve to be more efficient and effective?

To address these challenges and improve outcomes, the following steps are needed:

- **Increase Flexibility in Service Planning:** Allow PHNs more autonomy to design locally tailored interventions that respond to the unique needs of their communities. This flexibility would enable PHNs to allocate resources more effectively and drive better outcomes.
- **Clarify Program Purpose and Accountability:** Define a clear, equity-focused purpose for the MHFFS, with outcome-based goals that align with regional needs. This would provide PHNs with a stronger framework to demonstrate accountability and effectiveness in their work.
- **Simplify Service Models and Funding Mechanisms:** Streamline service models and adopt more flexible funding structures that reduce administrative burdens, enable scalability, and encourage innovation. This would allow PHNs to implement services that better meet the mental health needs of their regions.
- **Create National Platforms for Collaboration:** Establish formal mechanisms for PHNs to share data, benchmark practices, and collaborate across regions. This would improve decision-making, enhance resource allocation, and promote the sharing of successful commissioning methodologies.
- **Strengthen Governance and Collaboration:** Develop a Regional Governance Structure to oversee the implementation of MHFFS initiatives and ensure authentic collaboration between PHNs, state health departments, and other sectors. This would enable more coordinated planning and delivery of services. Learnings from the current Agreement and associated bilateral agreements and implementation plans strongly demonstrate the need **for definitive authorising environments for jurisdictional and regional governance models.**

6.3 Opportunities for improvement

- **Clarify Program Purpose and Accountability:** Define a clear, equity-focused purpose for the MHFFS, with outcome-based goals that align with regional needs. This will strengthen the framework for PHNs to demonstrate accountability and effectiveness in their work.
- **Increase Flexibility in Service Planning:** Allow PHNs more autonomy to design locally tailored interventions that respond to the unique needs of their communities. This flexibility would enable PHNs to allocate resources more effectively and drive better outcomes.
- **Simplify Service Models and Funding Mechanisms:** Streamline service models and adopt more flexible funding structures that reduce administrative burdens, enable scalability, and encourage innovation. This would allow PHNs to implement services that better meet the mental health needs of their regions.



- **Create National Platforms for Collaboration:** Establish formal mechanisms for PHNs to share data, benchmark practices, and collaborate across regions. This would improve decision-making, enhance resource allocation, and promote the sharing of successful commissioning methodologies.
- **Strengthen Governance and Collaboration:** Develop a Regional Governance Structure to oversee the implementation of MHFFS initiatives and ensure authentic collaboration between PHNs, state health departments, and other sectors. This would enable more coordinated planning and delivery of services. Learnings from the current Agreement and associated bilateral agreements and implementation plans strongly demonstrate the need for definitive authorising environments for jurisdictional and regional governance models.
- **Adaptation to Workforce and Community Needs:** Address evolving challenges such as workforce demands, unmet needs from NDIS changes, and rising mental health concerns post-COVID by ensuring ongoing flexibility and adaptation in the MHFFS program.
- **Enhance Coordination Between Levels of Care:** Improve coordination between different levels of care, particularly in states like Victoria, to promote a more integrated and collaborative approach to mental health system reform.



7 KEY REVIEW QUESTION 6: Adequacy of the PHN mental health funding stream

How can the mental health flexible funding stream funding model be updated to meet the evolving role?

OPPORTUNITY: *Person-centred mental health care is a way of providing care that is tailored to each person's needs, preferences, and goals. Service continuity, workforce stability, and supported navigation through the health system improve the experience of care and health outcomes. Updating the MHFFS funding model to support co-commissioning, implementing longer-term funding cycles, and integrating it with related policy areas such as Alcohol and Other Drugs (AOD) and family domestic violence would better meet the evolving needs of the community and promote a more holistic approach to care. The funding model should focus on commissioning for outcomes and be supported by meaningful performance indicators. The revised MHFF Program should be a lever that assists integration with other related programs, fosters collaboration and accountability, is long-term, supports workforce stability, and results in innovative and value-based care.*

7.1 Overview

The Mental Health Flexible Funding Stream (MHFFS) plays a critical role in supporting Primary Health Networks (PHNs) to commission regionally tailored mental health services in alignment with the unique needs of local communities.

This chapter presents the response to Key Review Question 6 focusing on the utility of the PHN Mental Health Flexible Funding Stream highlighting key issues and opportunities for improvement of the MHFF program.

7.2 Key issues

7.2.1 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?

- **Misalignment with program objectives:** The current funding allocation under MHFFS has not fully supported PHNs in meeting the evolving objectives of the program, as community needs and priorities have shifted over time. Whilst the MHFFS has grown in complexity, the alignment between the program's purpose, funding, and outcomes has not kept pace with these changes. This misalignment has resulted in an administrative and reporting requirements that hampers the efficiency of PHNs and limits their ability to focus on outcomes rather than activity-based funding.
- **Rigid funding and evolving community needs:** PHNs require more flexibility in how funding is allocated and used to meet changing community needs. The current structure, which prescribes specific interventions and activities, often leads to perverse incentives and high



compliance costs for providers. Additionally, the funding model's focus on activity rather than outcomes does not allow PHNs to effectively commission services based on local needs. For example, the strict guidance on funding usage often results in the deployment of high-cost professionals for non-complex mental health care, diverting resources from addressing more pressing, complex needs.

- **Activity streams and priority populations:** A reduction in the number of activity streams and prescribed priority populations would allow for greater efficiency and effectiveness, enabling PHNs to commission services that align with the true needs of the community. This could also help decrease the reporting burden and better integrate mental health system planning and reform, recognising the PHNs' evolving role in this process.
- **Outcomes rather than interventions:** The application of MHFFS funding should evolve to focus on outcomes rather than prescriptive interventions. A clearer demarcation between mental wellbeing (psychological distress) and mental illness is essential to avoid pathologizing normal responses to complex experiences. Funding aligned to outcomes would allow for evidence-informed, appropriate interventions tailored to individual needs, rather than rigidly fitting the prescribed service models. This approach would provide a more accurate understanding of local needs and the effectiveness of the interventions being applied.
- **Burdensome measures:** A review of program KPIs, data collection, and PHN performance measures is needed to ensure that these metrics do not unintentionally create barriers to effective care or increase costs for service providers. By focusing on the real needs of consumers and reducing unnecessary administrative burdens, PHNs can more effectively contribute to the integration of mental health services and achieve better outcomes for the community.

Step Thru Care: blending mental health & AOD policy requirements, and national and state strategies with local needs

The Step Thru Care (STC) model was developed by WVPHN to create a fully integrated system of care for mental health and Alcohol and Other Drugs (AoD). The model is designed to be place-based, outcomes-focused, and partnership-led, flexible to addressing the specific needs of subregions and local government areas. It aims to provide continuous adaptability and improvement, clear program logic and evaluation strategies, and formal partnerships to promote service integration at the local level.

The STC model was commissioned in four subregions of the PHN and developed collaboratively with the community over a 12-month period. It serves individuals from childhood up to those under 65 years old, focusing on those most at risk of falling through service gaps. The model ensures equity of access and treatment through a multi-modal system, including face-to-face, telehealth, video conferences, and online interactions. Standardised intake and assessments provide a consistent user experience, and the Initial Assessment and Referral Decision Support Tool (IAR) is mandatory for all commissioned services.

The impact and outcomes of the STC model have been significant, with positive changes in mental health outcomes, high achievement of mental health KPIs, and effective partnerships between service providers. Consumer stories highlight the benefits of the blended mental health and AoD model, showcasing improved management of conditions like bipolar disorder and alcohol use, as well as flexible and family-oriented care. The model's data-driven approach and continuous evaluation support its effectiveness and adaptability to evolving community needs.

The case study highlights the skill of PHNs to develop customised models through co-design with the community, emphasising the need for flexible funding and clear program logic. The STC model serves as an example of PHNs moving beyond predetermined policy requirements to develop models aligned with PHN Program objectives. The recommendations include providing strong governance and support,



ensuring flexible funding schedules, and collaborating with PHNs to develop clear communication and stakeholder engagement plans.

This case study demonstrates that whilst there may be a discrepancy between the requirements of the PHN Program objectives and the actual governance and implementation of the PHN Programs, PHNs can act as system multipliers to effect meaningful change for the better. *(please refer to Page 121 for the detailed case study)*

ment Initiative

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

To better support PHNs in addressing evolving needs and achieving the objectives of the MHFFS, several changes to the funding allocation are required:

1. **Alignment between National Purpose, Funding, and Outcomes:** A clearer connection between the program's purpose, funding allocation, and outcomes is essential. This alignment will ensure PHNs can focus on achieving meaningful outcomes rather than adhering to activity-based requirements. Outcomes Frameworks should be developed to guide the intentional goals of services, and Performance and Evaluation Plans should inform the scope of work, ensuring services are measured against these desired outcomes.
2. **Streamlining Activity Streams and Priority Populations:** The complexity of the current funding model, with multiple activity streams and numerous priority populations, limits PHNs' ability to deliver effective, regionally tailored services. A reduction in the number of activity streams and priority populations will simplify the commissioning process, increase efficiency, and allow PHNs to focus on outcome-driven commissioning to local populations where it is most needed i.e. where the PHN and community have identified this need.
3. **Recognising PHNs' Role in Integration and Reform:** The evolving role of PHNs in mental health system integration, planning, and reform should be recognised and supported within the funding model. Providing funding to enable PHNs to fulfill this role will enhance coordination across service providers and ensure a more cohesive and integrated mental health system.
4. **Reviewing KPIs, Data Collection, and Performance Measures:** Current MHFF Program KPIs, data collection processes, and PHN performance measures should continue to be reviewed to reduce perverse incentives and avoid the high compliance costs that burden providers. These measures should focus on outcomes rather than activity and avoid unnecessary administrative tasks that may detract from service delivery, ultimately improving consumer care and service effectiveness.

By implementing these changes, PHNs will be better equipped to meet the evolving needs of their communities whilst driving the **intended outcomes** of the MHFFS program.

7.2.3 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?

Service providers face several challenges in delivering mental health services under the MHFFS, including:

- **Complexity of the Funding Model:** The MHFFS has become increasingly complex, with numerous mandated service models, interventions, and priority populations, which can limit flexibility and innovation. Providers are often burdened by administrative requirements and



strict guidelines, resulting in high compliance costs and potential misalignment with local needs. To resolve this, simplifying the funding model by reducing the number of activity streams and priority populations would allow providers to focus on delivering outcomes that meet community needs more effectively.

- **Rigid Service Delivery Requirements:** The program's prescriptive approach to service delivery—such as specific intervention sets for different levels of care—can limit providers' ability to tailor services to the unique needs of consumers. To address this, introducing more flexible funding arrangements and allowing for context-specific service models would empower providers to innovate and adapt to local demand.
- **Inefficient Use of the Workforce:** A significant proportion of funding is spent on high-cost professionals for non-complex cases due to the activity-based funding model. This results in inefficiencies and may not provide the best value for consumers or the system. To resolve this, funding should be aligned with outcomes, ensuring that resources are directed to the appropriate level of care, and enabling a more effective use of workforce skills.
- **High Reporting Burden:** Providers face a high reporting burden, which can detract from time spent delivering care. Simplifying and streamlining data collection and reporting requirements would reduce administrative overhead and allow service providers to focus more on patient care.
- **Lack of Integrated Systems:** There is a lack of formal processes and mechanisms for sharing data and best practices across regions, which hampers service coordination. Establishing a national platform for sharing performance data, cost information, and improvement methodologies would foster collaboration, reduce duplication of efforts, and improve system integration.

By addressing these challenges through streamlined funding models, flexible service delivery, better use of workforce resources, reduced administrative burden, and enhanced system integration, service providers will be better equipped to deliver more effective, consumer-centred mental health services under the MHFFS.

7.2.4 How can the Mental Health Flexible funding stream funding model be updated to meet the evolving role?

In addition to the issues highlighted above, other considerations for updating the MHFFS include:

- Build accountable mechanisms into national agreements that enable or incentivise co-commissioning between PHNs and jurisdictions
- Have an outcomes framework that underpins the expectations of schedule
- Have clear program logics that consider short medium- and long-term outcomes at:
 - The individual program level
 - National policy area strategy level
 - With consideration and alignment to the national PHN program strategy level and other related policy strategies i.e. AOD, Family domestic violence etc.



- Lead to development of national outcomes and performance frameworks that speak to, and consider, the variation across metro vs regional/rural vs remote conditions (i.e. cost efficiency of a rural FIFO workforce needs to be benchmarked against other FIFO models).
- Funding and reporting that is:
 - Highly flexible; and allows for blended/integrated models e.g. Mental health, Alcohol and other drugs and family violence funds in the one model. This would mean policy areas' funding duration, reporting periods, and reporting mechanisms would align.
 - Longer term. Funding cycles of five-year contracts that support positive and measurable change.
 - Allows greater funding flexibility for evaluation of programs across the full funding cycles so that PHNs can truly understand the impact of programs at local level.
 - Adopts budget planning and acquittal processes to reflect the funding term and promote flexibility. i.e. 5 years of funding needs to be spent over 5 years, rather than allocated to a specific FY with need for annual roll over approval.
 - Recognises the time and investment required for the establishment of new initiatives if they are to be successful, to encourage system reform and support new ways of working.
 - Incentivises innovation and value-based care.

7.3 Opportunities for improvement

- **Align MHFF Program purpose, funding, and outcomes** more closely to address the evolving role of PHNs and the Program.
- **Reduce the number of activity streams** and priority populations to increase the efficiency and effectiveness of the MHFF Program, allowing PHNs to commission for outcomes.
- **Recognise and fund the role of PHNs** in mental health system integration, planning, and reform within the MHFF funding model.
- **Review and revise MHFF Program KPIs, data collection, and PHN performance measures** to minimise perverse incentives, lower compliance costs for providers, and avoid negative impacts on consumer care.
- **Ensure the revised MHFF Program supports integration with other related programs**, fosters collaboration and accountability, promotes long-term planning, and encourages innovative and value-based care.

Visual representation of areas of DoHAC that PHNs interact with¹²



Please note this figure aims to demonstrate the reach of PHNs into DoHAC areas, rather than highlighting each specific area. Therefore, ability to read the text is inconsequential to the key message of the image.

¹² <https://www.healthservicesdaily.com.au/phn-review-a-waste-of-2m-theyre-not-the-problem/23138>



Appendix B: Detailed Case Studies

B.1 Primary Care GP POLAR Data

Case Study Title	Digital – Primary Care GP POLAR Data
PHN	South Eastern Melbourne PHN
Problem Statement:	The increasing need for data-driven healthcare solutions and digital transformation in general practices represents a significant opportunity for PHNs to strengthen their role in healthcare delivery. Supporting general practices in adopting digital tools and systems such as <i>POLAR</i> and <i>Florence</i> enables better patient management, proactive health interventions, and more efficient service delivery. PHN participation in the Data Linkage pilot with the Victorian Department of Health is an opportunity to bridge gaps between primary and acute care, improving overall healthcare coordination. This initiative provides a chance to not only improve general practice capabilities but also demonstrate the effectiveness of devolved governance in driving digital transformation and data-informed decision-making to improve population health outcomes.
Intervention:	SEMPHN has supported general practices in adopting the POLAR system, with around 90% of practices now using the system in 2024, a significant increase from approx. 30% in 2018. This initiative focuses on building general practice workforce, digital capabilities, and data quality and proficiency. The intervention aims to improve data sharing, enhance patient care, and support evidence-based commissioning. In addition to POLAR, SEMPHN has actively supported practices and other healthcare providers in implementing digital solutions like RediCASE (for mental health reporting) and Florence (for patient monitoring). These digital tools automate clinical engagement and patient management, ultimately enhancing both the clinical experience for health professionals and the quality of care provided to patients. The Data Linkage pilot, which connects cardiovascular-related emergency patient data with general practice information, is another key intervention. It allows for more proactive monitoring and intervention for patients at risk of chronic diseases, such as cardiovascular disease, through better integration of data from both acute and primary care services. This initiative positions SEMPHN to better plan, design, and deliver healthcare interventions tailored to the needs of its population.
Impact and Outcomes:	The impact of SEMPHN's initiatives has been substantial, with the adoption of POLAR by 90% of general practices enabling improved data capture and better decision-making for clinicians. This level of digital adoption in practices has led to more informed patient management and enhanced healthcare coordination across the region. Additionally, for the first time in the 2024 Health Needs Assessment this data has been used to support identification and prioritization of primary care population health needs in south eastern Melbourne. The Data Linkage pilot provides valuable insights into patient interactions with acute services, allowing SEMPHN to work with general practices to proactively monitor and intervene for patients at risk of cardiovascular disease. Early indicators suggest that this initiative could lead to a reduction in hospital admissions and improve chronic disease management, with the potential for long-term cost savings in the healthcare system. The implementation of RediCASE and Florence has been successful in automating patient clinical engagement, thereby improving both the patient experience and clinician workflow. These digital tools have also enhanced SEMPHN's ability to monitor and evaluate healthcare programs more



	effectively, ensuring evidence-based commissioning and continuous improvement. Stakeholders, including healthcare providers and practice staff, have reported improved clinical experience and better integration of patient data, supporting more comprehensive and efficient care. Early feedback from patients has been positive, highlighting improved access to care and more timely interventions. SEMPHN has a dedicated provider support team that helps providers implement digital solutions toward improving patient care and management.
Implications and recommendations	SEMPHN's experience in driving digital transformation and supporting general practice capability provides valuable insights into the future direction of the PHN governance model. The ability to scale up these digital initiatives across the region demonstrates the effectiveness of devolved governance, where local flexibility supports innovation in service delivery. More structured governance around data privacy and security is essential to ensure that health data is used responsibly and in compliance with regulatory standards. The current service level agreements (SLAs) should be updated to include specific provisions for data privacy, ethics, governance, integration and digital health initiatives, providing clear levers and accountability mechanisms to guide and enforce program delivery consistently across Australia.



B.2 Aged Care priority area commissioned programs

Case Study Title	Aged Care priority area commissioned programs
PHN	SEMPHN
Problem Statement:	Aged Care priority area programs aim to ensure that seniors, particularly vulnerable individuals, have access to integrated, appropriate care services that maintain their well-being in the community. The aging population is growing rapidly, with the number of Australians aged 65 years and over expected to more than double, and those aged 85 and over expected to triple. This demographic shift places increasing pressure on the healthcare system, especially for services tailored to seniors. Currently, the PHN commissions a range of aged care programs, including local referral pathways, vaccination services, dementia support, rehabilitation programs, telehealth, and after-hours care, ensuring that services are aligned with both funding requirements and the specific needs of the local population.
Intervention:	The target cohorts for these programs include older adults in South Eastern Melbourne, especially those aged 65 and over, with a focus on individuals with dementia, rehabilitation needs, and those in vulnerable or complex health situations. This intervention also targets carers and healthcare providers. The program involves coordinating local referral pathways, developing and commissioning local services for vaccination, dementia support, rehabilitation, and after-hours care, as well as telehealth services for aged care homes. The model was developed in collaboration with local health providers and services to ensure it is tailored to the unique needs of the region, which includes metropolitan and non-metropolitan areas such as Frankston, Dandenong, and Casey. The intervention aligns with the PHN three C's framework: • Commissioning: Local programs were commissioned based on the specific needs of the community and aligned with various funding streams. • Coordination: Service providers, including general practices, aged care homes, and rehabilitation specialists, were coordinated to ensure seamless patient referrals and care pathways. • Capacity Building: Health professionals and carers were supported with training and resources to enhance their ability to deliver high-quality care for seniors.
Impact and Outcomes:	The interventions led to improved care planning for seniors, enhancing the delivery of services and preventing avoidable hospital presentations. The 12-week rehabilitation program showed measurable improvements in patient outcomes, with individuals moving toward greater independence and self-management. Telehealth services in aged care homes reduced the need for in-person visits, making care more accessible. Survey feedback from staff, patients and carers highlighted an increase in confidence and satisfaction with the care provided. • "The program helped me a lot, just knowing that I'm doing the right thing," • "To anyone given the opportunity to join, we would say embrace it with open arms and don't let it go!" • "The telehealth equipment has been used multiple times for VVED consultations to support elders to receive the right care in the right place. Unnecessary transfers to hospital have reduced due to timely assessment and treatment plans for elders on site. The equipment enables bedside consultations to be conducted with ease. SEMPHN were great with the equipment provided and follow up with offers for support as required".



Implications and recommendations	This case study demonstrates how a local PHN can scale services to meet the aging population's needs. It highlights the importance of local commissioning, coordination, and capacity building to support effective care models and prevent unnecessary hospital admissions. With the number of Australians aged 65 years and over expected to more than double, and the number aged 85 and over expected to triple, PHNs are locally placed to scale services that will keep senior residents healthier for longer and out of hospital.
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B.3 COVID emergency response & ongoing vaccination program

Case Study Title	COVID emergency response & ongoing vaccination program
PHN	SEMPHN
Problem Statement:	The COVID-19 pandemic presented a critical challenge, but also an opportunity for PHNs to demonstrate agility, responsiveness, and flexibility in supporting vulnerable populations and healthcare providers. Through strategic partnerships, resource mobilization, and rapid program implementation, PHNs significantly enhanced vaccination access, testing, and support for general practices and aged care facilities. This ability to quickly adapt to a rapidly evolving public health crisis highlights the PHN capacity to respond to emergencies and manage population-wide health initiatives effectively. Their success in navigating the complexities of the pandemic provides a model for future public health crises and opportunities to strengthen governance structures in a way that prioritizes flexibility and responsiveness.
Intervention:	The SEMPHN response to the COVID-19 vaccination responsibilities included the following key interventions: • GP Vaccination Hubs played a pivotal role in increasing COVID-19 vaccination access for vulnerable groups throughout the region, including people experiencing homelessness, non-Medicare cardholders, people with disabilities, First Nations Peoples, and others who faced barriers to accessing traditional vaccination sites. The establishment of pop-up clinics, after-hours sessions, and low sensory vaccination spaces helped address the unique needs of these populations. • Coordination of COVID-19 vaccination efforts in Residential Aged Care Homes (RACHs), ensuring these facilities had access to primary care providers for timely vaccination delivery. The rollout of vaccines in these settings was managed with attention to the latest guidelines, ensuring the safety and wellbeing of residents. • Development of the Childhood Immunisation In-Reach Pilot Program to support families in Greater Dandenong and Casey, areas identified with higher levels of under-vaccinated children. This initiative involved at-home immunisations to reduce barriers related to socioeconomic challenges, ensuring that children in these communities could stay up to date on essential vaccinations. • Implementation of a comprehensive COVID-19 communication strategy. They kept over 1,500 health professionals informed through weekly newsletters, text updates, and educational webinars. This resource-sharing helped healthcare providers stay informed of the latest vaccination processes, clinical protocols, and public health updates. • Localised COVID-19 Positive Pathways to guide GPs in community-based care, reducing unnecessary hospital admissions and promoting timely interventions.
Impact and Outcomes:	SEMPHN's response to the pandemic had significant, far-reaching impacts, particularly in increasing vaccination rates among vulnerable populations. The GP Vaccination Hubs, with their targeted outreach and flexible models, helped ensure that over 1,100 homebound individuals and residents in aged care facilities received COVID-19 vaccinations. This intervention not only increased access to vaccines but also contributed to lowering the risk of disease transmission in high-risk communities. The Childhood Immunisation In-Reach Pilot Program successfully reached children in under-vaccinated communities, helping to safeguard public health by preventing future outbreaks. Early data suggests that these efforts contributed to a decrease in vaccination gaps for children in these regions. Furthermore, SEMPHN's ongoing communication efforts kept healthcare providers updated with timely information, ensuring that local general practices were well-equipped to handle COVID-19-related challenges. The use of digital platforms and



	newsletters also ensured that public health messages reached a wide range of professionals across the region, enabling coordinated and effective care. The partnerships formed during the pandemic between SEMPHN, local GPs, pharmacies, and Aboriginal Community Controlled Organisations (ACCOs) significantly improved the accessibility and efficiency of vaccine distribution, delivering 743,631 PPE units to frontline healthcare workers and supporting multiple respiratory clinics that triaged over 240,000 individuals. The eight state-funded GP Respiratory Clinics (GPRCs) set up in SEMPHN's catchment area became vital components of the region's response to COVID-19, helping to alleviate pressure on hospitals and allowing for the triage, testing, and treatment of thousands of individuals, ensuring that resources were directed where they were most needed.
Implications and recommendations	The success of SEMPHN's COVID-19 response highlights the importance of agile governance and flexible service delivery models in managing health emergencies. This approach can serve as a blueprint for future crisis management, where the ability to quickly mobilize resources and adapt to rapidly changing circumstances is critical. Moving forward, SEMPHN's ability to quickly implement and scale programs in response to emergencies should be built into the broader PHN governance framework. The PHN model could benefit from further streamlining decision-making processes to ensure that similar responses can be rapidly mobilized across all regions, particularly in times of public health crises. This may include the development of pre-established frameworks for resource allocation, emergency response protocols, and partnership-building strategies that allow PHNs to scale up services quickly when needed. Additionally, the expansion of digital communication platforms, like the weekly newsletters and webinars SEMPHN used, could be a key strategy for disseminating information during public health emergencies. Ensuring that all health professionals are equipped with timely and accurate information enhances decision-making and patient care. The success of SEMPHN's partnership with other health entities, such as GPs, RACFs, and local health units, underscores the need for continued collaboration and integration of services to improve population health outcomes at a local level. Stronger inter-agency collaboration, along with streamlined data sharing and joint service planning, will be essential for managing future health emergencies. Finally, the mental health and wellbeing of healthcare workers must be prioritized, as demonstrated by SEMPHN's Employee Assistance Program (EAP) for general practice staff. Ongoing support for frontline workers, especially during crises, will help mitigate burnout and improve workforce sustainability.



B.4 PHN role in Primary Care Reform: General Practice Aged Care Incentive

Case Study Title	General Practice Aged Care Incentive (GPACI)
PHN	Murray
Problem Statement:	In 2023 and as part of Strengthening Medicare the GPACI program was announced and in response to the Royal Commission into Aged Care Quality and Safety. This National program requires relationships with consumers and carers, GPs, Residential Aged Care Homes (RACH). The increasing workforce challenges in rural and regional Australia are being felt across the primary care system and in some areas causing reducing access to timely health care. The impact on residents in RACH and acute system is particularly evident and requires complex local relationships to be navigated and negotiated to ensure the resident remains in their home and can receive quality health care. For GPACI to be successful, it requires locally based GPs to connect with the local primary health care system and aged care to meet care demands and minimize pressure on the hospital system that is already stressed.
Intervention:	Murray PHN has worked collaboratively with all stakeholders across the catchment, PHN peers in Victoria and contributed strongly to the National MyMedicare project led by Brisbane North. General Practice Engagement teams have positive working relationships with General Practices that enables regional planning and facilitation of effective communication and engagement among various stakeholders, including Residential Aged Care Homes (RACH). This engagement occurred through a cross-collaboration of internal primary care, primary care response and digital health teams Several barriers were identified and addressed with the following engagement methods: • Four Aged Care Forums, • Three General Practice Webinars, • Inclusion at four Practice Manager Networking meetings, • Four Community Advisory Council presentations, • One Clinical Advisory Council presentation, • Regular communications including resources have been circulated through eNews, GP Update, Residential Aged Care Home Newsletters. • In addition, a specific GPACI webpage has been added to the Murray PHN website. • Ascertained current aged care access issues and allowed focus of work and data support for Thin Markets This work will be continued to ensure success with local communities and health care providers to ensure coordinated and efficient delivery of this program. Engagement with Aboriginal and Torres Strait Islander communities and RACHs has been crucial to understand the unique challenges faced in accessing information and promoting equity.
Impact and Outcomes:	The integration of national, state and local efforts has been crucial for advancing the GPACI program. PHNs have been pivotal in the integration, aligning national policy with local delivery to enhance efficiency and encouraging GPs to provide regular, proactive care to aged care residents. At the State level PHNs have worked collaboratively to ensure this national initiative is implemented to meet the specific health landscape of each region. This collaboration has involved resource allocation, shared learning with stakeholders and support for RACHs and GPs to ensure consistency of policy implementation. At the local level PHNs have access to health needs assessments and commission services accordingly. They work directly with local RACHs, GPs and



	allied health professionals to utilise local relationships to implement GPACI effectively within local communities. Shared learning and collaboration across National, State and Local levels has enabled 1. Resource optimisation, demonstrated with pooling of knowledge and resources such as education, stakeholder information and tool kits. This ensures consistency and best practice whilst reducing duplication. 2. Enhanced care coordination with collaboration between PHNs to facilitate seamless transition to implement GPACI. 3. Capacity building with joint training and professional development.
Implications and recommendations	This case study demonstrates the capability of PHNs to deliver national policy initiatives in local communities. PHNs have been critical in tailoring GPACI to local context using regional knowledge and experience. This is specifically • Needs assessments where PHNs identify the unique health needs of their communities, ensuring GPACI as a national initiative is effective locally. • Service commissioning based on the needs assessments. PHNs commission services that address specific local health priorities whilst aligning with policy objectives. • Stakeholder engagement where PHNs engage with local RACHs, GPs and other health care providers. At the individual PHN level, integration and coordination across aged care, health service partnerships and GPs to implement GPACI is demonstrated through Care Coordination where PHN has facilitated coordinated matching of GPs to residents and aged care providers with local knowledge and insights and Collaboration with PHNs establishing and supporting networks that bring together various providers and stakeholders to share insights, discuss challenges and develop strategies tailored to local communities. Through these mechanisms, PHNs ensure that national primary care reforms such as GPACI are effectively implemented within local contexts, leading to improved health outcomes and more efficient health care systems.



B.5 WVPHN Population Health ECHO network Women's Health Series

Case Study Title	WVPHN Population Health ECHO network Women's Health Series.
PHN	Western Victoria Primary Health Network
Problem Statement:	Clinicians mostly undertake continuing learning opportunities within their own specific field or discipline. Whilst useful, it often omits perspectives and knowledge in the continuum of care that extends across various disciplines, many of which may be treating a patient in isolation of each other. Multidisciplinary clinical education enables learning from clinicians with a variety of expertise, allowing the clinicians to consider a person's treatment needs in greater breadth and depth. In 2023, WVPHN Population Health ECHO ran the Women's Health Series to address reproductive health issues in women. This initiative was guided by the Victorian Women's Sexual and Reproductive Health Plan 2022-2030, the National Women's Health Strategy 2020-2030, and recent federal and state funding for persistent pelvic pain clinics. A review of local data and stakeholder discussions identified three key issues in our region, highlighting a health priority that could be addressed with effective communication and engagement with stakeholders: • Cervical Screening: Western Victoria has seven of the most under-screened LGAs for cervical cancer in the state. • Persistent Pelvic Pain (PPP): affects an estimated 15-25% of women, causing significant physical, psychological, and social impacts. • Access to Early Medical Abortion: Large gaps in service provision, with many women in the Grampians catchment area seeking termination services outside the region, such as in Melbourne or Geelong, where services are more readily available.
Intervention:	ECHO is an online learning platform, that is presented in a didactic format with an in-depth case study presented by clinical experts. The WVPHN Population Health ECHO Network – Women's Health Series targeted primary care workers within the western Victoria catchment area. The focus was on addressing the reproductive health needs of women, particularly in under-screened and underserved regions. The Women's Health Series was co-designed using a learning health system approach, incorporating both learning labs for clinicians and design labs for health administration teams and leaders from partner organisations (research, health services, public health units, health promotions, etc.). The series aimed to improve knowledge and practices related to cervical screening, persistent pelvic pain, and access to early medical abortion and long-acting reversible contraception (LARC). Clinical presentations by local primary care and tertiary health services were delivered, including: a 10–15-minute didactic session, followed by a Q&A and case presentation; two sessions on cervical screening tests and self-collection; five sessions on persistent pelvic pain; and three sessions on early medical abortion and access to LARC. There was an average of 33 participants per session. This comprehensive approach ensured that the Women's Health Series effectively addressed the reproductive health needs of women in western Victoria, improving access to care and enhancing the capabilities of the primary care workforce.
Impact and Outcomes:	Through the Women's Health Series, WVPHN integrated the focus on women's health into a suite of quality improvement resources for practices and clinicians to create Plan-Do-Study-Act (PDSA) projects for Quality Improvements Practice Incentive Payment Programs (QI PIP) and Continuing Professional Development



	(CPD). WVPHN also became the first PHN to create a cervical screening test, Measuring Outcome (MO) accredited activity, approved by RACGP. HealthPathways pages were updated and reviewed with new recommendations on PPP. Clinicians recognised PPP as a diagnosis. They felt confident in taking additional actions for patients while waiting to see a gynaecologist. Leading to improved patient outcomes through better diagnosis and management of PPP. This series brought together a diverse range of stakeholders to work together on early medical abortion. We were able to address gaps in surgical services and identified GPs for referral support and promote available services and build health literacy around contraception and prevention. Evaluations from the series were overwhelming positive from participants, and speakers. Qualitative data includes quotes from attendees: <i>"It is just the best source of information - and to help attain those MO CPD points"</i> <i>"This was a really practical guide to approaching these issues"</i> <i>"very practical factual information, useful to my daily practice"</i>.
Implications and recommendations	Project ECHO brings together a diverse range of primary care clinicians to discuss regional issues and enhance education, leading to improved patient outcomes. We used stakeholder feedback to tailor education sessions to the unique health needs of our community. Project ECHO facilitates a solid community of practice, enabling effective communication and ongoing support. Engaged primary care practitioners and specialists collaborate to improve health outcomes, demonstrating strong stakeholder engagement. Enablers include primary care practitioners who are invested in their community and support their colleagues. In planning for this ECHO series, specialists from local health services and universities came together to motivate and upskill primary care providers, improving women's health outcomes. However, limited funding remains a barrier, affecting the ability to expand and continue certain sessions. Further funding would allow for increased attendance and a broader range of clinical topics, addressing other health issues in our region and compensating specialists for their time and knowledge.



B.6 Supporting governance for place-based health planning

Case Study Title	Supporting governance for place-based health planning
PHN	Primary Health Tasmania
Problem Statement	People living in rural and remote areas often face additional barriers to effective health care. Small communities, however, often know exactly what the problems are and what is needed to support them but lack the capacity to coordinate. One local government area in Tasmania – Tasman Peninsula – was particularly challenged in terms of access to and coordination of health services, as well as wrap around supports.
Intervention	Primary Health Tasmania began working the Tasman community in 2019 establishing a collaboration with the Tasmanian Health Service (Tasmanian Government), Health Consumers Tasmania, and the Tasman community – including service providers, service users, local council, and other community members to look at what we can all do to improve the health of the local community in a sustainable way. The collaboration initially achieved: • a thorough community and workforce consultation on the healthcare needs of the Tasman community, using the findings to inform future planning for health services in the region • completion of an action plan and a community governance structure with both a Clinical Service Action Group and the Community Health and Wellbeing Advisory Committee.
Impact and Outcomes	Extensive engagement has led to revision of community advisory governance arrangements locally and a clinical services action group established to focus on local service system improvements. On the ground the community now benefits from: • Youth Mental Health Worker • Increased psychologist and physiotherapist referrals • Raised awareness of Healthdirect and GP Assist • Telehealth facility established • Funded podiatry chair and consultation room • iStat machine funded and staff trained • Right Place initiative and Tasman Connect directory introduced • Training for wound, palliative and dementia care, and Mental Health First Aid • Mapping of after-hours patient journey. Whilst Population Health Planning is not novel as a concept, the implementation in the Tasmanian context has sparked interest across local government and the health industry, including the Tasmanian Department of Health committing to establishing a place-based framework to be able to work more effectively with rural and regional areas. Leading this work alongside key stakeholders has resulted in increasing interest from health systems partners, politicians, and other communities, including a joint (successful) application for the Australian Department of Health and Aged Care's Innovative Model of Care trial.
Implications and recommendations	PHNs are ideally placed to lead and facilitate place-based work at a community level bringing together agencies, service providers and community. The level of resourcing for PHNs, however, required to sustain engagement and continue working alongside a community is significant. Building capacity does not fit neatly in to project funding blocks it needs to be flexible with PHNs able to scale up (intensive level of engagement) or scale down (supporting engagement).



B.7 Clinical and Community perceptions and advice

Case Study Title	Clinical and community perspectives and advice
PHN	Primary Health Tasmania
Problem Statement	The 2015 Australian Government PHN operating guidelines stipulated clinical (council) and community (committee) advisory structures for each PHN as a uniform governance approach. PHT, as a single-state PHN put in place one Clinical Advisory Council and one Community Advisory Council as standing advisory bodies to the Board to provide informed professional and local perspectives on how to improve Tasmania's health system and the unique health needs of our local communities. Ensuring the council structure was fit for purpose and operating efficiently and effectively was initially very resource intensive – and sustaining the council structure requires significant ongoing care and attention.
Intervention	Despite the Government requirements specifying the separation of councils, during their first year of operation in 2016 both councils, at their own mutual request, were integrated, meeting and working together. Each council retained its own membership, an independent chair, and a dedicated board director representative. Meetings and the way consultation and advice were sourced was constructed so that the councils worked on the same challenges and opportunities and advised on the same issues and risks – reporting to each other as well the Board. PHT's council structure was externally reviewed in 2018, and the collaborative nature was a highlight. The opportunity to hear and understand the perspectives of the other council members across clinical and community was cited as a major point of attraction and benefit. This approach has also ensured that advice to the Board was harmonised and differences in perspective across both community and clinical spaces was discussed and debated. Often, consensus was able to be reached on specific matters of advice and a more rounded and considered view presented to the Board.
Impact and Outcomes	PHT's council structure and integrated model has been very successful in supporting the Board in its decision-making role but also ensuring broad perspectives are heard. Councils have been particularly valuable in: - contributing to submissions on national and state health policy including assessing the impact of changes - monitoring the organisation's performance in procuring services and achieving health outcomes - providing advice on engaging with service providers and assessing the Tasmanian community's health needs.
Implications and recommendations	The decision as to the nature, scope and composition of specific governance advisory processes should be a matter for each individual PHN's Board. Over time the rigidity of these requirements has been relaxed by Government and PHNs have increasingly been permitted to take their own paths. PHN clinical and community council structures have experienced varying degrees of success and prescribing advisory structures has not proved optimal. PHNs have evolved multiple mechanisms to secure community and clinical advice, and the contractual requirement to have separate specific councils may be seen externally as duplicative and inefficient and ignorant of networks that are already well established – it's a fine line. For PHNs, sourcing council advice is a significant investment in terms of staff support and sitting fees. It takes a lot of time to recruit and induct members and ensure they remain well informed and connected to the organisation and that their skills and expertise are being used effectively.



	PHN business and governance models have expanded and matured significantly over the past 10-years and within that context it is entirely reasonable that PHN Boards are able to make appropriate and responsible decisions as to the most suitable mechanisms to source clinical and community advice. This level of advice needs to be carefully considered within the broader context of advice provided during program and service design and delivery in the PHN operating context. The suitability of the Commonwealth guidance regarding Clinical and Community Councils should be revised to reflect current capability and contexts.
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B.8 PHN Governance review at different levels

Case Study Title	PHN Governance review at different levels
PHN	SEMPHN
Problem Statement:	Regular reviews of the governance framework for a company limited by guarantee are essential to ensure it remains fit for purpose, accountable, and aligned with its constitution and strategic goals. Internally, a review of the governance of the board and operational structures supports continuous improvement in decision-making and accountability. Externally, a review commissioned by the funder ensures transparency and compliance with funding requirements and public accountability. Furthermore, assessing the governance of collaborative alliances between PHN's ensures effective coordination, accountability, and alignment with shared objectives. These reviews provide an opportunity to strengthen governance practices and maintain stakeholder confidence.
Intervention:	Three reviews took place: • <u>Internal review</u>: SEMPHN commissioned an external consultant to undertake governance review and board evaluation. • <u>External review</u>: Under a rolling audit program of PHNs, the Commonwealth engaged McGrath-Nicol to undertake a review of SEMPHN to determine the extent to which it has complied with its performance and financial management obligations under the Funding Agreement. • <u>VTPHNA Alliance external review</u>: In 2023 the Chairs and CEO's of VTPHNA initiated a review of the VTPHNA governance and operating model focused on strengthening the strategic alignment and successful engagement in shared objectives and projects.
Impact and Outcomes:	The <u>internal review of governance and board evaluation</u> had a significant positive impact on its operations and leadership, especially within the context of its local and regional environment. The review provided the Board with a structured opportunity to assess its effectiveness, decision-making processes, and alignment with the organisation's mission, values, and local needs. The review identified key strengths, such as a committed and skilled leadership team, while also uncovering areas for improvement in governance practices, roles, and responsibilities. Importantly recommendations and implementation of these focused on strengthening the Board's line of sight between the objectives of national policy, programs and funding, the objects of the CLG's constitution and the outcomes on the ground for patients and communities and service providers. The review also highlighted variability and the importance of this variability across the PHN to respond to local needs. By addressing the gaps, the organisation enhanced its accountability, transparency, and overall governance structure, improving relationships with stakeholders. This context-driven approach to governance has allowed the organisation to remain responsive and adaptable to its community while demonstrating a commitment to continuous improvement and ethical leadership. Moreover, the evaluation process highlighted the need for ongoing Board development and succession planning, ensuring that the organisation is well-prepared to navigate future challenges specific to its region. Ultimately, the internal review fostered a more effective, compliant, and forward-thinking governance framework, better positioning the organisation to achieve its mission and sustain long-term impact across its regional network. The <u>external audit process</u> has proven to be a critical tool for ensuring the PHN's alignment with the funder's requirements and strategic objectives, while also fostering a culture of continuous improvement and accountability. For



	SEMPHN, the review provided valuable insights into several key areas of its operations including its financial management, compliance with legal and regulatory frameworks, and overall performance in meeting agreed-upon objectives. The continuous feedback loop established through the audit process enabled the SEMHN to introduce timely and informed adjustments, ensuring that it stayed on track to meet both its local goals, and the broader aims set out by the Commonwealth. Key outcomes of external review included: • Strengthening Board Capability and Strategic Decision-Making via regular training and development for Directors to fill identified skills gaps. • Constitutional review and membership structure via ongoing consultation with stakeholders and regular assessment of the constitutional model to ensure responsiveness. • Development of a comprehensive reporting framework with periodic performance updates to ensure alignment with the strategic objectives. • Ongoing investment in risk management systems and further strengthening of internal audit capabilities. • Prioritising the external cybersecurity assessment to ensure robust protection against evolving threats. Key outcomes of the <u>VTPHNA review</u> and subsequent program of work included: • The value and strength of the regional and local focus in the translation of national policy, programs and the capacity of each Board to formulate strategies to achieve this. • Strengthening areas where greater value is created by working together for our 4 key stakeholders (namely 1. governments & health departments, 2. patients and local communities and 3. local providers and service systems, 4. local workforces) This collaborative work included shared: • Program data, reporting, and community of practice that drives continuous improvement for programs i.e. Head to Health, PPCC/UCC. • Planning and projects that drives consistency and continuous improvement in Commissioning and Capacity Building across the jurisdictions. • Strategic analysis that drives strategic alignment and engagement between PHN's and between PHN's and key stakeholders.
Implications and recommendations	The Company Limited by Guarantee (CLG) structure offers a solid foundation for Primary Health Networks (PHNs) to achieve their dual objectives of autonomy and accountability. Leveraging this structure can enhance stakeholder engagement, fostering deeper collaboration with healthcare providers, local governments, and community representatives. Such an inclusive approach ensures that the governance of each PHN is aligned with both local and national health priorities, providing a more responsive and representative voice in shaping health system priorities. Key opportunities: • <u>Scheduled Review Cycles to Optimize Resource Allocation</u>: Establishing a regular, planned review cycle presents an opportunity to streamline evaluations and reduce resource strain. By having consistent reviews, PHNs can better manage human and financial resources, ensuring that necessary improvements are implemented in a timely manner, enhancing both governance effectiveness and operational efficiency.



	• <u>Clear and Timely Implementation of Action Plans</u>: Introducing a defined schedule for implementing action plans following reviews and audits offers an opportunity to create more structured and focused efforts. By clearly defining the scope and integrating action plans into daily operations, PHNs can ensure that improvements are consistently executed, leading to more effective governance and better overall performance. • <u>Enhanced Collaboration Across PHNs</u>: Developing an enabling environment that supports and authorises collaboration across PHNs opens the door to maximising collective impact, achieve economies of scale, share best practices, and optimise resources, ultimately improving service delivery and health outcomes across regions.
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B.9 2024 COVID-19 vaccination campaign for the 65+ community

Case Study Title	2024 COVID-19 vaccination campaign for the 65+ community
PHN	VTPHNA
Problem Statement:	COVID-19 vaccinations and resources were supported by both the State and Commonwealth Governments in 2021-2023. During 2023, there was a shift in the responsibility for delivery of vaccines onto primary care providers. Communities had previously been supported by a range of communications on how to access vaccinations and support. Vaccination data demonstrated a seasonal drop-off in vaccination numbers from June 2023 onwards. For example, in 2023 there was a 79% reduction in 65+ COVID-19 vaccinations from June (n = 73,000) to August (n = 15,166). A gap in COVID-19 vaccination information and resources was identified for communities despite fluctuating waves of COVID-19 cases. The aim of PHNs across Victoria, particularly within communications teams, was to provide continuation of COVID-19 resources to our communities ensuring they have access to this information to stay protected from COVID-19. Victorian PHNs worked together (each contributed funding) to ensure information and support was available to this vulnerable cohort to help alleviate the pressure on primary healthcare providers. An agency was contracted to develop the campaign, and the project was managed by WVPHN Marketing and Communications. In the context of a large decline in vaccination numbers nationally the overall objective was to influence and increase the COVID-19 vaccination rates for the 65+ community.
Intervention:	The target audience was Victorians aged 65+. Within this demographic group the following sub-groups were identified: First Nations people, people from culturally diverse backgrounds, older Victorians who were still highly active, and older Victorians who were grandparents. The approach of this campaign used real people (not actors) and depicted four lifestyle moments that were culturally relevant for the people involved, but also universally relatable. The call to action was <i>'Speak to your GP or pharmacist or find your closest provider at Health Direct'</i> with a QR code included on all collateral. The campaign included web and display content separately branded for each Victorian PHN with website assets, social media posts and banners, google ads, videos, posters, postcards, newspaper advertisements, radio ads and media releases. Each Victorian PHN then used their collateral packs to schedule campaign materials across their regions at their own cost. It was agreed that the campaign would run from mid-June to the end of August across Victoria.
Impact and Outcomes:	Following the campaign, from June through August 2024, there was notably less drop-off than the previous year (57% vs 79%) in Victoria. This resulted in "bucking the trend" - with August 2024 vaccination numbers <u>exceeding</u> those for 2023, despite an overarching reduction in vaccinations from 2023 to 2024.



	Number of Vaccinations for 65+ in Victoria (2023 vs 2024) <table><thead><tr><th>Month</th><th>Victoria (2023)</th><th>Victoria (2024)</th></tr></thead><tbody><tr><td>June</td><td>72,000</td><td>53,000</td></tr><tr><td>July</td><td>32,000</td><td>40,000</td></tr><tr><td>August</td><td>18,000</td><td>25,000</td></tr></tbody></table> This translates to an increase of over 16,000 people (65+) receiving vaccinations during July and August 2024 – compared to the same time in 2023. Tracking codes were included in the QR code for Health Direct link. A total of 39,840 click-throughs were recorded to the site for the duration of the campaign.	Month	Victoria (2023)	Victoria (2024)	June	72,000	53,000	July	32,000	40,000	August	18,000	25,000
Month	Victoria (2023)	Victoria (2024)											
June	72,000	53,000											
July	32,000	40,000											
August	18,000	25,000											
Implications and recommendations	This campaign is an excellent example of how PHNs can work together to not only produce impactful campaigns and programs, but to provide cost effective solutions whilst also maintaining localized outputs and scheduling. This approach could be used for other state-wide communications and marketing campaigns to inform and influence behavioural change for communities on health-related matters.												



B.10 Care Finder Program – VTPHNA approach

Case Study Title	Care Finder Program – VTPHNA approach
PHN	VTPHNA
Problem Statement:	To meet individual organisational expectations and local needs, PHNs often tender out the same programs with different tender requirements across each PHN. Whilst aiming for consistency, it is evident that each PHN has different processes for commissioning, contract management and evaluation. Where health services and providers span multiple PHN regions, the PHN-level differences are frustrating and time-consuming for providers. To get the best response from suppliers, VTPHNA convened a specific Care Finders working group to ensure consistency in commissioning approach, requirements, and messaging where possible.
Intervention:	Through the VTPHNA Care Finder Working Group, several sub-working groups were established that included communications, commissioning with oversight from the PHN Primary Care Executive Group. Members of these groups worked together to develop consistent messaging, consistent key performance indicators for inclusion in the specifications and contracts and have developed a shared VTPHNA Community of Practice for both states. Following the establishment of the program the VTPHNA Care Finder Working Groups were collapsed into a single Working Group who have continued to meet to discuss shared issues around service delivery and contracting.
Impact and Outcomes:	Each PHN is unique, with varying levels of risk appetite and commissioning approaches, yet the VTPHNA PHNs were able to agree on a consistent set of KPIs for use in contracts, resulting in consistency for suppliers in delivering the service. Consistent communications and coordination of the VTPHNA quarterly Community of Practice provides efficiency for suppliers and an opportunity for shared learning. The Department of Health and Aged Care attends these meetings, so efficiency is also provided for the funder.
Implications and recommendations	The Care Finder Program Guidelines were very specific, allowing PHNs to deliver a consistent program across the country. External evaluation through Australian Healthcare Associates has provided an evaluation framework and all suppliers are contributing to this. Whilst there are differences in how PHNs manage commissioning and contracts, this process has achieved uniformity in how the program is being rolled out across both Victoria and Tasmania.



B.11 Head to Health (H2H) Data Management System and National Analytics and Reporting Project

Case Study Title	Head to Health (H2H) Data Management System and National Analytics and Reporting Project
PHN	North Western Melbourne PHN
Problem Statement:	In late 2020, the mental health toll of the COVID-19 pandemic was becoming increasingly evident across Australia. Victoria, in particular, experienced the most severe impact, as the virus spread rapidly and strict lockdowns exacerbated the strain on residents' wellbeing, with Melbourne ultimately becoming the most locked-down city in the world. At the same time, Victoria's mental health system struggled to meet the overwhelming demand for support, resulting in growing waitlists and immense pressure on the hospital system. This challenge quickly escalated into a national concern, with New South Wales and the Australian Capital Territory seeking solutions, followed by other regions soon after. DoHAC and PHNs did not have the data to fully understand nor respond quickly to service demands, and there was no Commercial Off-The-Shelf solution that could meet all requirements.
Intervention:	Department of Health and Aged Care (DoHAC) and PHNs across Victoria responded by establishing the HeadtoHelp mental health intake, assessment and referral service, supported by intake data collection software (the Data Management System) developed in-house, enabling comprehensive data reporting to the DoHAC and PHNs. Recognising the effectiveness of consistent data collection and reporting in Victoria, DoHAC expanded the service to New South Wales and the Australian Capital Territory in October 2021, followed by a national rollout in July 2022. North Western Melbourne Primary Health Network (NWMPHN) was appointed the national lead for H2H's telephony infrastructure and is responsible for providing systems, data and analytics services to the national PHN network. Specific responsibilities include: • Administration of the national telephony infrastructure, including contract and relationship management with the telephony provider on behalf of all PHNs, and providing national activity reporting to DoHAC. • Management of the intake and assessment data for PHNs who opt-in. • Delivering timely analytics and reporting to PHNs and DoHAC, utilising H2H intake and assessment data.
Impact and Outcomes:	The H2H telephony and data management system helps DoHAC offer a seamless care pathway for consumers to receive the right level of care at the right time to meet their mental health needs. The in-house development of a system by a PHN for use by the PHN Network has realised significant benefits for efficiency, collaboration, agility, and economies of scale. For DoHAC and PHNs: • Reports were available within the first month of system launch. • Ongoing daily, weekly, monthly, quarterly, and 6-month reports on service usage and insights. • Ad hoc reports created for local PHN/jurisdiction needs. For clinicians and consumers: • Efficient consumer referrals and consistent collection of intake and assessment data, including IAR-DST integrated into the Data Management System.



	• Reduction in Clinician burden through integration (e.g., APIs) that reduce double handling, making workflows more efficient. • Embedding consumer experience survey in the care pathway, ensuring that consumer feedback is part of the design from the outset to feed into quality improvements of the service at the Intake level. For the PHN Network: • Collaboration on a nationally consistent solution fostered strong relationships across the PHN Network. • Centralised coordination of issues management and development with a consistent response. • Agility and responsiveness to adapt quickly to major changes • System innovations from localised model changes are regularly offered and quickly adopted by other regions. • Provides PHNs with enhanced visibility of service usage and mental health service need in PHN catchment and jurisdictional areas, consumer experiences, and aids in service planning. • Requests for new functionalities are streamlined through system-embedded request processes and responses are quick. • Collaboration through established communities of practice. • Continuous feedback loop from PHNs to improve the system. Benefit of in-house development of a national system: • NWMPHN coordinates development across PHNs, jurisdictions, and nationally, allowing flexibility. • Consistent and secure data governance across the network. • Avoidance of system interoperability issues due to a single system in place. • Streamlined licensing and costs funded through NWMPHN. Uptake of the H2H Data Management System has been widely successful with: • 27 of 31 PHNs (87%) using the Data Management System for their intake services with 1 PHN providing data via an API for national reporting. • From 600 active users when launched nationally to approximately 800 active users, indicating usage is not just maintained but is increased as trust builds, and functionality is expanded. • 29 of 31 PHNs (94%) are using the Consumer Experience Survey to measure consumer satisfaction with the Intake process. • 31 of 31 PHNs (100%) contributing to H2H Intake QI and Data communities of practice. • 250 PHN and DoHAC personnel have access to one or more of the current reports.
Implications and recommendations	• The impact of the H2H Data Management system would not have been possible if the work was outsourced to a third party. This is because: ○ PHNs understand the system and data and what is required to realise efficiency, and translate data to insights for performance and planning ○ By allowing a PHN lead development of the system, it has resulted in a system that is suitable, an efficient approach to development, and the ability to adapt they system as the service evolves. • The experience from this project has been leveraged to develop other mental health intake and assessment services at some PHNs, such as their Stepped Care programs.



	• This case study is an example of how this can be done efficiently through national coordination and collaboration. It also reinforces the case for reinforcing PHNs' software development capabilities.
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B.12 After Hours Commissioning

Case Study Title	After Hours programs
PHN	South Eastern Melbourne PHN
Problem Statement:	After Hours care provides accessible primary health care outside of normal general practice opening hours. Currently 85 general practices are commissioned to provide After Hours access in south eastern Melbourne. The PHN has sought to guide and commission After Hours programs that are consistent with various funding requirements across multiple funding 'buckets' that meets the local population need and incentivizes general practices to provide appropriate access. Short term funding also risks system disruption and ultimate loss of services where funding is unable to be continued.
Intervention:	The target patient cohorts for After Hours include localities with identified high need for primary care, including older people, homelessness, diverse, and relatively lower access to primary care in non-metro areas (e.g. Frankston, Mornington, Dandenong, Casey, Cardinia). The After-Hours model works with primary care including general practice and community service providers to offer greater availability of appointments through extended and out of normal hours services, as well as a connecting service for patients to support patients to access primary care. The model was developed in collaboration with Monash University and through provider engagement to commission according to local need, which varies across the metro, non-metro, and regional geography of south eastern Melbourne.
Impact and Outcomes:	Over time and with continuous improvement and maturation, the model has evolved to include more practice hours, building the capacity primary care in south eastern Melbourne. The After-Hours program was estimated to have saved almost \$5.5 million and 10,000 potentially preventable hospitalisations with a return of 353% in 2018-19. The program continues today through multiple separate pieces of funding for different aspects of after-hours care (e.g. multicultural, MH, GP, homelessness, priority populations, etc), policy changes, and periods of alternative and creative funding to support continued service delivery and cover funding gaps.
Implications and recommendations	The After-Hours programs demonstrate the agility of the PHN to commission, adapt, and sustain delivery through multiple rounds and buckets of funding to improve access, availability and capacity of primary care. Challenges to guiding and enforcing ongoing delivery as well as expanding the program have been the multiple rounds and buckets of funding, which have presented challenges to embedding After Hours care where the risk of loss of future funding has been a barrier to provider uptake. Implementation and transformation with the sector have been incremental over time as and when funding requirements become available. More realistic commissioning and service procurement timeframes would at a minimum require c.3 months for a 'light touch' service planning and design approach (followed by procurement), and c.12 months for full priority area stream population-wide regional planning and stakeholder consultation, plus time for procurement and implementation toward the agreed model over a 2-3 year service transition period as and when contracts end or are able to be recommissioned under the new approach. Ideally commissioning would enable sustainable long term funding approaches and review of resource allocations that could then be adjusted over longer term periods to account for continuous service and clinical improvement; and where required whole-scale stream re-planning, re-design, and re-procurement where best practice drastically changes.



B.13 Regional Planning - PHN role in the Local Health Services

Case Study Title	Regional Planning - PHN role in the Local Health Services
PHN	SEMPHN
Problem Statement:	Healthcare systems often face fragmentation between primary care providers, hospitals, and specialist services. There has been a great need to embed a more collaborative approach to system priorities, planning and delivery of care across these systems within a geographic region.
Intervention:	The South East Metro Health Service Partnership (SEMHSP) was formed in July 2021, as one of eight Health Service Partnerships (HSP) established across Victoria in alignment with statewide services and facilities, and the local geographies they serve. Recognising the benefits of a connected health system for patients, the South Eastern Primary Health Network (SEMPHN) teamed up with the three acute health services in 2021, to form the SEMHSP Governing Council. In 2022, the leading independent community health provider, Better Health Network (BHN) also joined and linkages with the South East Metro Mental Health Interim Regional Body (IRB) were also formed. This primary-acute collaboration illustrates the SEMHSP drive to innovation beyond the expectations of a HSP toward more integrated and joined-up, person-centred care.
Impact and Outcomes:	The Health Service Partnerships were established at a time of great need during the COVID years and established operational governance to support primary, community and acute services to quickly develop and deliver the COVID Positive Pathway Program. The COVID pathway focused on vulnerability in the community and the Partnership quickly realised how collaboration could better support the care needs of those most at risk. Since October 2022, over 11,000 of the most vulnerable members of the community received social and clinical care via an integrated model between the SEMHSP primary, community and acute health partners ensuring patients received the right care in the right place. This collaborative approach laid the foundations for future service integration with the agility to respond to community needs, in which SEMPHN has continued to proactively participate and drive collaboration for more innovative and integrated approaches in response to the local population, workforce, and health service challenges. Key initiatives driven by the SEM Primary Health Network as an outcome of the partnership: • <u>Joint SEMHSP Joint Primary Care and Population Health Advisory Committee (JPCPHAC)</u>. SEMPHN initiated the review project that proposed the establishment of the SEMHSP JPCPHAC. This initiative, aimed at providing HSP-wide leadership and setting a unified direction for primary care and population health in the region, received strong support. As a result, the committee—the first of its kind in Victoria—was successfully established, following the agreement of health service boards to dissolve local committees. This structural reform represents a significant step toward fostering regional collaboration and alignment on key health priorities. This in turn led to Population Health project under the Primary Care Bilateral Agreement between Vic State and the Commonwealth with SEMPHN being a project lead. • <u>Priority population project</u>. On behalf of the Interim Regional Body, SEMPHN conducted a groundbreaking needs assessment on mental health for priority populations within the region. This report, the first of its kind, employed a geospatial approach to triangulate data from general practice, emergency departments, and hospital admissions. It also incorporated



	insights from stakeholder consultations, providing a detailed analysis of needs and gaps at the most granular geographical level. • <u>Residential In Reach skills training.</u> SEMPHN delivered Residential in Reach skills training days for residential aged care homes (RACHs) on behalf of SEMHSP. Led by teams from Alfred, Peninsula, and Monash Health Networks, along with geriatricians, senior pharmacists, and Dementia Australia representatives, the sessions received positive feedback. 84% of participants were very satisfied, and 16% were somewhat satisfied. All respondents rated the workshop content as relevant or highly relevant to their roles, with valuable insights on recognising deterioration, dementia, and palliative care. Special presentations were provided by Dementia Australia and the Victorian Virtual ED. Due to the session's success, a follow-up session is planned for May 2025. • <u>Referral systems between Primary Health and Public Specialist Clinics.</u> Research on the major inhibitors and enablers to a more effective referral system have research has included the views of patients, general and specialist practitioners, practice and specialist clinic managers and administrators. Once completed this will form the basis for a major program of work to improve effectiveness and efficiency of the referral system between different parts of the health system in the region The South East Metro Health Service Partnership (SEMHSP) received the 2023 Victorian Public Healthcare Award for Health Service Partnership of the Year.
Implications and recommendations	The SEMHSP case study aligns closely with the PHN Program Business Model Review by addressing critical questions about collaboration, system integration, and responsiveness to local needs: • <u>Collaboration:</u> The partnership exemplifies how PHNs can work beyond their traditional scope by connecting primary, acute, and community health services under a shared governance structure. • <u>System Integration:</u> SEMPHN's role in establishing the SEMHSP Governing Council and leading joint initiatives such as the COVID Positive Pathway Program showcases the effectiveness of integrated models in delivering coordinated care. • <u>Responsiveness to Local Needs:</u> Through initiatives like the priority population needs assessment and Residential in Reach skills training, SEMPHN demonstrated its ability to adapt to emerging health challenges, aligning resources to address gaps in care at the community level. Key Barriers: • <u>Role in regional planning:</u> Under the current governance and funding arrangements, the PHNs are not recognised for their role in joint regional planning, particularly with LHNs. • <u>Resource Constraints:</u> Collaborative projects required significant time and resources, which were stretched thin due to PHN funding limitations and competing priorities. • <u>System Complexity:</u> Aligning priorities and processes across diverse stakeholders (primary, acute, and community services) was challenging and required substantial coordination efforts. • <u>Workforce Capacity:</u> The need for rapid upskilling of personnel and development of robust shared systems created additional strain. • <u>Policy Alignment Challenges:</u> Navigating state and federal policy requirements sometimes slowed progress, particularly for initiatives spanning multiple sectors. Key Enablers:



	• <u>Strong Leadership:</u> The engagement of Chief Executives and operational leaders ensured high-level commitment and support for initiatives. • <u>Governance Structure:</u> The SEMHSP Governing Council provided a clear framework for collaboration and decision-making, enabling agility and alignment. • <u>Established Relationships:</u> Pre-existing trust among SEMHSP partners facilitated smooth communication and effective implementation of joint initiatives. Recommendations • <u>Embed Dedicated Collaboration Support:</u> Establish dedicated resources and funding streams to support collaborative functions, ensuring PHNs can sustain partnerships and shared initiatives without overstretching existing capacities. • <u>Strengthen Funding Models for Integration:</u> Introduce flexible, multi-year funding arrangements that prioritise integrated care models, enabling PHNs to plan and execute long-term projects effectively. • <u>Enhance Governance Flexibility:</u> Expand the governance framework to allow for tailored regional solutions, empowering PHNs to address unique local challenges while aligning with national health priorities. • <u>Leverage Technology for Efficiency:</u> Invest in digital infrastructure to streamline data sharing, reporting, and communication between stakeholders, reducing administrative burdens and enhancing collaboration.
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B.14 West Metro Health Service Partnership's Population Health Needs Assessment

Case Study Title	West Metro Health Service Partnership's Population Health Needs Assessment
PHN	North Western Melbourne Primary Health Network
Problem Statement:	The West Metro Health Service Partnership (WM HSP) brings together some of Victoria's premier health services and organisations to collaborate on systems reform. As well as North Western Melbourne Primary Health Network (NWMPHN), these include the Peter MacCallum Cancer Centre, the Royal Children's Hospital, the Royal Women's Hospital, the Royal Melbourne Hospital, Western Health and Werribee Mercy Hospital), and the Western Public Health Unit (WPHU). Since its establishment 2 years ago, the partnership has supported the COVID Positive Pathways work for our region, established and grown the Better at Home initiative, supported the delivery of the Victorian Government's planned surgery recovery and reform program. Most recently, NWMPHN has also partnered with the WM HSP to undertake a population health project to better understand the health needs of the population in the West Metro catchment. Collaborating to move beyond health services and catchments and think about health needs from a whole of system and population perspective, the Project has delivered a comprehensive and system-wide view of the health needs of our region, providing the foundation for better priority setting, investment and coordination and stronger system relationships.
Intervention:	The Project delivered a comprehensive HNA, published in October 2023 and available on NWMPHN's website and to health service employees through their intranets. It was delivered using an evidence-based approach to defining need, which considered four types of need (comparative, normative, felt, and expressed need) through the examination of three types of evidence (quantitative data, and qualitative data collected via community consultation and health provider engagement). In determining need, the analysis considered base need (as determined by population size) and adjusted that need based on the social determinants of health (sociodemographic factors, risk factors, access and geographic environment, and health conditions and consequences). The population health data was grouped into these metrics, each with distinct indicators researched and assessed against a set of key criteria. The Project included a 'deep dive' analysis into four priority cohorts (older people over 65, children aged 0 to 9, women and females aged 20 to 39 and people currently unwell with cancer) and two focus areas (potentially preventable hospitalisations and avoidable emergency department presentations) (examples of data included in the supporting information in figure 4 and 5). This deep dive analysis was particularly valuable for the acute health services, which include several speciality services. This project brought together not only the 6 health services servicing the west metropolitan region, but also the local NWMPHN and WPHU. It involved engagement with primary care, community health and other community groups. As such, it was a truly cross-system initiative. All partners remained actively engaged throughout the project, aided by the inclusive approach taken to leadership and governance. Constant communication and flexibility were key to the success of the project.
Impact and Outcomes:	At the time of publishing, the findings of the HNA were communicated via a roadshow across all six health services. The roadshow featured all partners in



	the project, along with experts from each health service reflecting on the key findings for their service and how their service will use the HNA. The findings of the project have helped strengthen relationships across the WMHSP and system partners, NWMPHN and WPHU. They are helping to inform priority setting and coordinated action in response to need. For example, acting upon a finding within the HNA that showed declining rates of vaccinations and increased hospitalisation due to vaccine preventable disease, NWMPHN, WPHU and three of the WMHSP's acute hospitals (the Royal Children's Hospital, The Royal Melbourne Hospital and Peter MacCallum Cancer Centre) collaborated to undertake a targeted campaign aimed at encouraging health care providers to recommend COVID and flu vaccinations to certain population groups. Health services are also using the HNA to inform strategic and service planning, including for major infrastructure projects. The results of the HNA were recently the key topic for the inaugural meeting of the newly formed Parkville Primary Care and Population Health Advisory Committee who are planning to use the findings to identify the population health focus for that committee. And it is a valuable resource for the NWMPHN and WPHU in fulfilling their respective roles.
Implications and recommendations	Significant investments were made into the project by all partners, including in expertise, staff time and financial resources. The WMHSP invested funding to support NWMPHN to resource the HNA data collection, analysis and report writing. All partners contributed in-kind resources to support project leadership, management and communications. More than 15 staff from across all partners contributed to this work to enable its delivery. The project has delivered a common view of the health needs of our region, which is accessible and relevant to all system partners. WMHSP leaders are using the outcomes of the project to inform priority setting and investment for the HSP. Specific findings of the project are being responded to in a coordinated way. The project has demonstrated the value of a coordinated, system-wide approach to population health and how it can be done well. It provides a model for future collaboration across our system. The project provided WPHU, one of nine local public health units, which was very newly formed at the project's inception, with new insights into the demographics, trends and health needs of the communities in its catchment. Another benefit of the HNA is the development of an evidence-based, rigorous and repeatable methodology. NWMPHN is now using this methodology to support the development of their regional HNA which is being undertaken in collaboration with Eastern Melbourne Primary Health Network (EMPHN). It has also led to discussions with the North Eastern Health Service Partnership (NE HSP) and North Eastern Public Health Unit (NEPHU) about the opportunity to undertake a joint needs assessment for that region.



B.15 Community Led Integrated Healthcare Program - demonstrating effective use of core flex funds

Case Study Title	Community Led Integrated Healthcare Program - demonstrating effective use of core flex funds to meet local need, using a place-based solution that was codesigned with the community
PHN	Gippsland PHN
Problem Statement:	Gippsland has a high prevalence of chronic conditions, high levels of socio-economic disadvantage and lower access to allied and other health services when compared to other regions in Victoria. As a response, Gippsland PHN undertook work to more fully explore an integrated, place-based model of primary care in a rural/remote region of Victoria. Evaluation of existing commissioned services identified an opportunity to shift focus to a value-based approach for outcomes. We wanted to understand the range of elements that make up a contemporary, safe model of care that can be more accessible, utilise workforce more effectively, be more efficient, and be available to everyone. As such, we wanted to trial the delivery of an innovative multi-disciplinary team-based care service to: • meet local community need. • be underpinned by Australia's Primary Health Care 10-year Plan 2022-2032 and Deloitte Australia's Health Reimagined White Paper; and • be future focused to address regional access barriers and disparities in health outcomes, in alignment with the Quintuple Aim for improved primary health care.
Intervention:	The project was phased across four components: Analysis, Discovery, Design and Commissioning. The first phase involved an analysis of the regions Health Needs Assessment, Health Priorities and relevant literature including Australia's Primary Health Care 10 Year Plan 2022-2032. The Discovery stage engaged rural community, service providers and sector professionals to participate in workshops, interviews and surveys. The Design stage involved working with rural community and health care professionals to design care models and draft the tender specifications. The final Commissioning stage carried out a procurement, culminating in contracted services. The co-developed model is a health care hub that provides team-based person-centred care, constructed around locally based professionals who work together as regionally collaborative, multidisciplinary teams supported by telehealth where needed. The model of service delivery was designed to be flexible to the needs of the community so that the commissioned service/s and agenda for change could be led by the community experiencing a health need. Service model outcomes include "I" Statements, e.g., "I want to access to services in one place as it is very difficult to face access issues when you are feeling unwell or damaged, especially when you are older". The model of care is designed to be patient-centred and includes professionals from a range of health disciplines working together to deliver comprehensive care that addresses as many of the patient's needs as possible. The model also includes the requirement for commissioned services to include community members in evaluation and review of the programs to ensure they continue to meet the needs of that community.



	A health care hub model provides team-based person-centred care, constructed around locally-based professionals who work together as regionally collaborative, multidisciplinary teams, supported by telehealth where needed. Hubs can be an integrated physical service or co-located services or a virtual integration. phn GIPPSLAND An Australian Government initiative May focus on specific population / issue The model will support: • Integrated service delivery • System navigation • Continuity of care • Addressing social determinants • Workforce satisfaction • Reducing avoidable hospitalisations • Care coordination • Data sharing • Discharge gaps • Consumer satisfaction • Integrating pharmacy Two services were commissioned within the program and each service targets a distinctive cohort. One services vulnerable children (aged up to 5 yrs) in the Latrobe LGA, and the other services remote communities in the Tubbut and Bendoc area. The two services: Latrobe Valley – Latrobe Community Health Service and Berry Street The Latrobe Valley model is a clinic for children from disadvantaged backgrounds that provides care coordination, transport assistance and a multi-disciplinary approach to address family needs. Based at Latrobe Community Health Service’s Churchill site, this innovative clinic is an integrated health and welfare service model for vulnerable children and families living in Latrobe. They also support families experiencing violence, new parents and young children by identifying patients at risk. Far East Gippsland – Orbost Regional Health and Deddick Valley Isolated Community Group Orbost Regional Health and the Deddick Valley Isolated Community Group are delivering a new model of care that has seen Service Hubs set up in local communities. A care coordinator visits these hubs to support residents with chronic health conditions, monitoring and evaluating their symptoms and connecting them to specialists for diagnosis. The care coordinator supports residents with disabilities in identifying and advocating for their needs, helping with access to services, funding and care plans.
Impact and Outcomes:	The impact of the program is demonstrated by the following consumer story: • CHILD was a warm referral from our Children’s Services. She presented as very complex both in terms of health and social wellbeing. • CHILD is 5 years old. She lives at home with her parents and older siblings. There is a gap of ten years between her and her siblings. Her contact with the outside world had been extremely limited. She hadn’t attended daycare or Kinder. She rarely left the home environment. • Full assessment was carried out by the care coordinator and an initial Care Plan was devised with the parents. • She was assessed for hearing, speech, gross and fine motor skills, diet and continence. All agreed there was a significant delay, and it was suggested that an application be made to NDIS. • During this process it came to light that both parents didn’t have their birth certificates and that CHILD’s birth had never been registered. Parents now have theirs and CHILD has been registered and we’re awaiting her certificate.



	• Contact was made with the Department of Education as to what would be the best option for CHILD in terms of starting her education journey. They suggested that she be enrolled in her local primary school. After many emails and school visits with the family, this was finally done, and CHILD commenced her education journey through a modified curriculum. She initially attended 4 days a week for an hour. • At school she was assessed for funding to help meet her needs and ensure she gets as much as possible out of her education journey. • She also continued to attend counselling and sensory sessions at (provider) to help her manage her big feelings in a more appropriate and constructive way. Her parents also get the support they need through the NDIS. • Latest report is that this child is happy and healthy and enjoying school with extended hours now and will be attending full time in 2025. Client feedback also demonstrates the program's effectiveness: • For the first time in many, many years I feel supported. Feeling that I have an advocate for my health has definitely changed my life and given me hope. The way I feel about myself now has completely flipped. I care now. If I see a Doctor I can only talk about one aspect of my health and I am not seen as a whole person. I have changed from hopeless to hope. My mental health, my entire being has changed. Thank you. • "It is so refreshing to have someone who genuinely wants to help my family. The Care Coordinator listens to me. I'm not told what I need. It feels as if I am in control and not being controlled. If the Care Coordinator says something will be done, it is. No excuses. As a family we have been through so many different programs and none of them has had the impact that CLHHC has had. I feel more confident in my abilities to parent and that decisions I make are valid. I know closure is coming, and that makes me sad." • "It was so good to have someone finally listen and hear me. I believe I have a diagnosis of ADHD myself and this makes it particularly difficult for me to deal with my child's behaviours. The Care Coordinator has not only assisted in accessing the assessments my child needs, she has assisted me to access the care I need too. I call frequently but I'm always met with kindness and understanding. There are no "stupid" questions. I'm so glad I finally let this program in. The changes they have helped with are amazing." • This service is amazing. It should be available to all parents who are struggling to negotiate the early years' system. I'll be telling my friends all about it. I can't recommend it too highly" • "Everything happened so quickly. N was in and assessed within a week. It was so good to have the Care Coordinator come to the appointment with us and explain anything we weren't sure of. To not have to go away and do all these assessments then come back and hopefully get a diagnosis is just amazing. N started medication right away. We now know the cause his issues. The Care Coordinator is always on the end of a phone and checks in regularly. What a service"
Implications and recommendations	The Community Led Integrated Healthcare program demonstrates effective use of Core Flexible funding to meet local need, using a place-based solution that was codesigned by the community experiencing the health need. The hub provides team-based person-centred care, constructed around locally based professionals who work together as regionally collaborative, multidisciplinary teams supported by telehealth where needed. Utilising the PHN Core-flex funding stream enabled development and commissioning of a bespoke service delivery model that was designed to be flexible to the needs of the community so that the commissioned service/s and agenda for change could be led by the community experiencing a health need.



	Supporting PHNs to respond to local health needs with flexible funding and clear outcome expectations will promote improved health outcomes through better targeting and design of services that suit the community needs and workforce capacity.
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B.16 Using digital health technology to improve integration of care across the Tasmanian health system

Case Study Title	Using digital health technology to improve integration of care across the Tasmanian health system – PHN capability to lead innovation
PHN	Primary Health Tasmania
Problem Statement	Prior to the implementation of eReferrals in Tasmania, referrals from primary care providers to state hospital services were paper-based and predominantly faxed. This system was inefficient, not secure, and plagued by human error and distrust from providers. Similarly, managing patient information and referrals at the hospital end was also an administrative burden with limited ability to triage appropriately. The eReferral project began after research conducted by Primary Health Tasmania identified low awareness of available referral pathways among providers and a lack of standard and secure tools to support electronic communication between healthcare providers. Well known barriers and enablers to eReferral and digital health applications included: included peer behaviour, software factors, security issues and workplace culture.
Intervention	Primary Health Tasmania funded and led the eReferral proof of concept trial starting with a select group of general practices, which quickly grew to include all Tasmanian general practices that wanted to send eReferrals to the Royal Hobart Hospital's cardiology and gastroenterology departments, as well as the Launceston General Hospital's renal clinic. The trial was planned, designed and driven as a collaboration between PHN, State Government, LHNs and leading community clinicians. An evaluation report was delivered in March 2021. This report showed end user feedback provided has been overwhelmingly positive, with 94% of GPs endorsing eReferral through their surveys. Over 2020 and 2021, PHT focussed on connecting private medical specialists to the system in preparation for rollout once THS integration was completed. Additionally, the system was trialled further trialled with allied health organisations to inform further template development to support allied health referral and communication from general practice. In 2023 and because of the successful trial and evaluation, the Tasmanian Government determined to fully adopt and commence staged rollout e-referral to all Tasmanian hospitals, GPs and health services. At the end of June 2024 over 100,000 eReferrals had been received by Tasmanian hospitals.
Impact and Outcomes	The eReferral rollout is a tangible example of PHN and jurisdictional collaboration to improve coordination of care across the Tasmanian health system. It has delivered a statewide system that: • is secure • has improved the quality and efficiency of the referral process by reducing delays, errors, and duplication • makes patient care more efficient by streamlining patient communication and kickstarting the triage process with a clear acknowledgement of receipt • continues to expand across the primary health sector, working in partnership with other parts of Tasmania's health system.
Implications and recommendations	With a focus on innovation, PHT was in a unique position to lead this fundamental digital health initiative for the state. The proof of concept enabled an injection of funding and engagement outside the scope of the Tasmanian Government. The full risk profile sat with PHT initially.



	In 2025, eReferral remains a collaborative partnership in full rollout and has been built into the Tasmanian Government's 4 year Transforming Outpatient Services Strategy and its 10-year Digital Health Transformation, which is delivering a new statewide fully integrated care platform. This is a great example of a PHN funded, led and supported major project that has been successfully translated into permanent whole of system change. PHNs should continue to be flexibly supported and resourced to drive system level innovation and change.
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B.17 Transitioning from PPCCs to UCC

Case Study Title	Transitioning from PPCCs to UCC
PHN	VTPHNA
Problem Statement:	The roll out of urgent care clinics in Victoria commenced in September 2022 with the opening of the first state funded Priority Primary Care Centres (PPCCs). The Department had already identified the Emergency Departments that the clinics were to support and Victorian PHNs were contracted by the Victorian Department of Health (Vic DH) to commission these services. Victorian PHNs were involved in establishing the specifications and are also represented on the Clinical Advisory Committee. In July 2023, Victoria entered into a Federation Funding Agreement with the Commonwealth as part of the Medicare UCC program. This meant that the funding that in other states went to PHNs to commission UCCs in their region instead was directed to the Vic DH. Vic DH continued to contract the PHNs to commission the services. Initially nine of the existing state funded PPCCs transitioned to a co-funded (state and Commonwealth), and the final UCC was commissioned. Co-funded UCCs were provided funding only for one year, despite the funding for UCCs in other jurisdictions being offered two years as Vic DH could not confirm funding beyond June 24. In January 2023, all clinics received a reduction in funding pro-rata to fit with a reduction in opening hour expectations from 16 hours per day to 14. In April 24, the Vic DH offered clinics an extension for FY24-25, with a reduction in funding for most clinics with no change in expectations. This included transitioning an additional 7 clinics to cofunded UCCs, in some cases, this was a 27% reduction in the monthly operating grant. Commonwealth co-funded clinics were only offered 12 months of funding that did not meet the Commonwealth's expectation of 2 years of funding for UCCs. This offer was rejected by all but 2 clinics. In addition, the methodology being used in Victoria to calculate the funding for clinics was different to that being used by the Commonwealth in other jurisdictions. A short-term extension was offered by Vic DH for 2 months (July-Aug) to allow time for further negotiation between the state and the Commonwealth. This had to be delivered by PHNs with very tight timelines to ensure there was no disruption to service. The flow of funding from Commonwealth to state and then to PHNs for Commonwealth funded commissioning added further complexity to the roll out of urgent care clinics in Victoria. In some cases, PHNs were contacted directly by the Commonwealth asking questions about implementation that were in contradiction to what the state were requesting or allowing through their arrangements. This meant managing provider, sector and community expectations was difficult for PHNs.
Intervention:	Following the Vic DH initial funding offer for 24-25 financial year, 27 out of 29 clinics had rejected the offer, putting the urgent care program at huge risk in Victoria. Co-funded clinics were only being offered a contract for a year which was out of step with UCC funding across the other jurisdictions. Victorian PHN CEOs took on a coordination role to bring together Vic DH, DoHAC and PHNs together to work through the funding methodology, including estimated MBS calculations to try and come to an agreement that would support the continued delivery of urgent care in the state. The Victorian roll out and subsequent transition of 60% of clinics to co-funded clinics was supported by statewide clinical and project governance, providing clinical oversight and direction setting and supporting a consistent approach to development and implementation of the PPCC model. Local project working groups support translation of the model into practice at each site, enabling integration with Ambulance Victoria, the Victorian Virtual Emergency



	Department and local hospitals through established pathways and protocols to ensure timely access to the right care in the right place. A statewide community of practice was established to enable knowledge sharing, identification of statewide clinical and operational issues for shared problem solving and advocacy and providing a space to foster innovation. This model formed the basis of the Commonwealths community of practice for UCCs.
Impact and Outcomes:	The coordination by Victorian PHNs was successful with all clinics agreeing to the new terms, and the UCCs being provided funding for the full two years. Victorian PHNs successfully managed the transition of a total of 17 clinics to co-funded Commonwealth clinics, including supporting the clinical readiness assessments and additional requirements of the Commonwealth clinics that differed from the Victorian model including the transition of reporting systems, with no interruption of service or reporting. Consumer and sector sentiment towards the urgent care clinics remains high.
Implications and recommendations	The statewide coordination role established across Victorian PHNs in both operations and data/reporting has created efficiencies across the PHNs, that also informed the Commonwealth UCC roll out. PHNs have well established processes to undertake commissioning on behalf of the Commonwealth. For future programs delivered in partnership with jurisdictions, PHNs should be funded to support the commissioning in line with the other Commonwealth commissioning processes, rather than contracting the state to then contract PHNs. This would reduce duplication and delays that exist in the current model.



B.18 Commissioning impact of deeds not arriving in a timely manner

Case Study Title	Commissioning impact of deeds not arriving in a timely manner
PHN	EMPHN
Problem Statement:	PHNs consistently receive funding with timing that makes it difficult (or sometimes not possible at all) to deliver thoughtful, participatory and well managed commissioned services, which results in inefficient use of funds and likely poorer health outcomes for some of the most vulnerable in the community. Eastern Melbourne PHN (EMPHN) have provided an example using psychosocial funding to exemplify the impacts of this practice on consumers and providers. This example has two key complexities: timing (i.e. late receipt of Deeds), and timeframe (i.e. rolling one-year Deeds). This example is used to highlight the issue for the Commonwealth Psychosocial Support Deed. However, the same issue of delayed funding is at play in several programs; for example, targeted Aboriginal and Torres Strait Islander funding (e.g. integrated team care), alcohol and other drugs funding, urgent care centres. (NB. This example is not intended to speak to the impact of carry forward practices, which have a range of different complexities and PHN drivers at play).
Intervention:	Example of Psychosocial Support Services Psychosocial Support Services (PSS) assist people with severe mental illness who do not qualify for the National Disability Insurance Scheme (NDIS) to participate in their community, manage daily tasks to secure stable employment or housing, and connect with family and friends. Services are varied and specific to the consumers' needs. This can include mental health, alcohol and other drugs or broader social and life skills support. Services commonly have a prolonged 'episode of care'. In Eastern Melbourne PHN, PSS services are delivered by Neami National and Wellways Australia. Over the course of FY22 and FY23, providers sought clarification about ongoing funding for PSS a number of times from EMPHN. EMPHN was in turn waiting for confirmation from DoHAC about the status of future funding, and so was unable to provide updates to the providers. Providers then alerted the PHN that they were planning to suspend services (i.e. they were no longer going to accept new patients). This decision was taken by providers due to (a) the clinical risk of accepting new patients into a program that might be de-funded and (b) the financial risk they would carry in underwriting the program without a contract. Letters of comfort were provided late in both financial years. However, letters of comfort, while a useful lever to commence planning, are not sufficient for PHNs or providers to 'act' in any meaningful way. For example, EMPHN's risk appetite does not allow the PHN to enter a contract extension without having an appropriate income Deed. This is in keeping with the governance requirement and Corporations Law to avoid the risk of trading insolvent. Timing of funding and communication from DoHAC As noted, in the last number of financial years, EMPHN has received Commonwealth Psychosocial Support Deeds in retrospect (i.e. with a commencement date prior to the receipt of the Deed). This does not allow any time to conduct fundamental commissioning processes, including: Considering the option to decommission current services. Should performance be poor, or if the model of care was not displaying appropriate impact, decommissioning of service may be appropriate. However, this takes time to plan for and implement and needs to be conducted in alignment with the establishment of new services.



- Market sounding, and potentially re-approaching the market. This might be conducted to identify a more appropriate service, test value for money or due to a changing market landscape (e.g. new players).
- Re-design of existing services. Opportunities often exist to improve existing services or drive different provider behaviours through new KPIs or changed models of care. This takes time to co-design with providers, clinicians and consumers.

The chart below outlines the historical pattern of communication and provision of Deeds from DoHAC, compared to a 'best practice' approach to commissioning. One can see the discrepant timings between the two.

Impacts of delayed funding on Psychosocial Support Service Commissioning

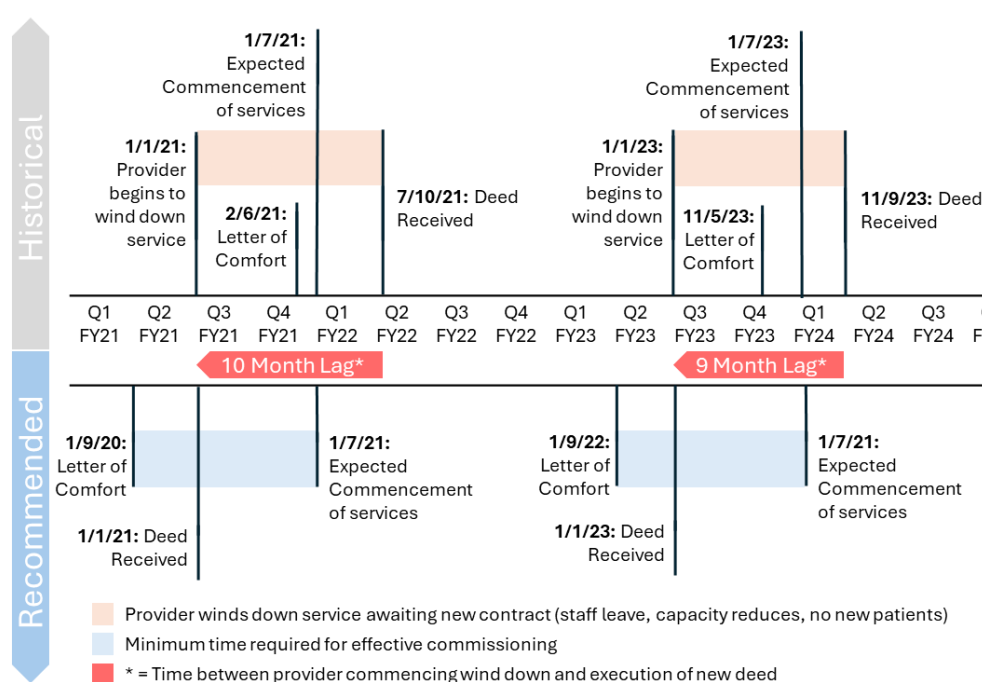


Figure 1. Historical and recommended timelines relating to the Commonwealth Psychosocial Support Deed.

Impact and Outcomes:

The practice, as it has played out, has significant downstream impacts on the PHN, service providers, and critically, the community members who rely on these services.

The impacts of this on the PHN are:

- Reduction in the pure volume of services delivered, impacting a range of DoHAC KPIs. The 'dip' in service can be seen in the volume trends in the chart below.
- Reduced ability to expend funds within the financial year, due to decreased delivery rates.
- Inability to decommission or redesign the program to ensure it continues to meet Eastern Melbourne catchment needs.
- Inability to effectively understand, analyse and manage provider performance as staffing and 'wind down' results in an inability to meet assigned KPIs.
- Reduced trust in the PHNs by providers, as they effectively must choose to underwrite a Commonwealth funded program

The impacts of this on the provider network are:

- Inability to retain workforce due to uncertain future funding. This resulted in loss of key staff for both of EMPHN's PSS providers in FY22 and FY23.



- The need to invest in significant training and upskilling of new staff. Providers have noted that they have needed to replace staff with those less experienced in the psychosocial space to maintain caseloads. This has resulted in reduced throughput during the time required to upskill.
- Inexperienced staff driving data and other recording issues. Providers have noted that new staff have a lower rate of data completion and outcome measurement while they learn appropriate systems.
- Inability to work with the PHN to reconsider the program design, and work to improve services.

Critically, the impact on the community is gaps in service, longer (or potentially absent) waitlists, shortage of service provision, clinical staff less experienced in delivering care to complex patients.



Figure 2. EMPHN's Commonwealth Psychosocial Support programs volume trend showing a 'dip' in services in Q4 FY22 and FY23 due to funding instability.

Implications and recommendations

Recommendations relate to both the timeliness and timeframes of funding to ensure best practice (or at least 'better practice') commissioning can be provided. It is recognised that some of these recommendations are already in train (e.g. PHN outcome measurement) and are provided here for completeness.

It is noted that there are pressures within the DoHAC environment that this case study does not consider. For example, the need for a great many orchestrations within the Department to ensure that the PHN Branch enacts the strategic objectives of other Branches. Recommendations below may assist with these additional complexities.

It is recommended:

1. Funding is provided in a more 'joined up' way, providing larger funding pools that enable more flexibility.
2. Deed funding (i.e. not innovation focused) is provided over a minimum of three or four years, ensuring a greater ability for forward planning and working strategically with providers and local markets.
3. Outcome measurements (i.e. PHN KPIs) are simplified (e.g. throughput, output, outcome) to ensure that the PHN and other Branches of the Department are confident that PHNs are delivering on their requirements.
4. Deeds are received no later than six months (ideally nine months) prior to the desired commencement of services. This will ensure the ability to consider existing programs and make adjustments that are appropriately co-designed and market informed.



	5. It is acknowledged that late Deeds essentially result in the health sector (PHNs and Providers) having to underwrite Commonwealth funded programs as well as take on the clinical and other risks related to the uncertainty created by late and short-term Deeds.
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B.19 Establishment and delivery of Head to Health services

Case Study Title	Establishment and delivery of Head to Health services
PHN	VTPHNA
Problem Statement:	In late 2020, the mental health impacts of the COVID 19 pandemic were being felt throughout Australia. The spread of the virus in Victoria was particularly pronounced, with lockdowns further impacting the wellbeing of the population and Melbourne becoming the most locked-down city in the world. The mental health system in Vicotria was unable to meet demands for support, with waitlists growing and the hospital system under tremendous pressure.
Intervention:	From September 2020, Victorian PHN's worked collaboratively to put in place new mental health services in response to the mental health impacts of the COVID 19 pandemic. Victorian PHNs mobilised, during lockdown, to design, procure and stand-up 12 multidisciplinary clinics across Victoria, supported by a phone assessment and navigation service. Services used a shared data system, and common model of care for both the clinics and the phone navigation system. Common service models were implemented flexibly according to local contexts. The phone service operated from a single 1800 phone number and embedded the Intake Assessment and Referral (IAR) tool to identify the best-fit service for consumers. These services catered for all ages, with immediate uptake including for young people, and people from Aboriginal/ Torres Strait Islander backgrounds. At the time the services were known as HeadtoHelp and subsequently were rebranded to HeadtoHealth. By October 2022, Head to Health services were a cornerstone of primary mental health care in Victoria. At this point, the intake service had handled over 31,000 enquiries and delivered over 15,000 IAR assessments, with high levels of satisfaction from consumers (83% of consumers reported that contact was worthwhile and 87% agreed that they were listened to). The most common source of referral was self-referral, followed by referral from a GP. Following the Victorian example, the Head to Health model was scaled and adopted across Australia, using the same service model, phone access point and data system. The common data system, used by majority of PHNs, delivers economies of scale and a platform for further enhancement including e-referral. This enables high quality reporting and sharing of performance and data insights across PHNs and with Government and other stakeholders.
Impact and Outcomes:	Services were established in just 4 weeks from the date of the request from Government, with a joint Victorian PHN project office coordinating and leveraging PHN knowledge, experience and insights. Victorian PHNs effectively led innovation in several areas which are now embedded in primary care and reform: • Multi-disciplinary teams in primary care settings • First large-scale use of the (then new) Initial Assessment and Referral Decision Support Tool (IAR-DST) • Use of defined PREMS (available across the statewide program) • Fit for purpose data system and data insights (delivered through a single system) • Iterative developments to the phone service to support consumers to access the best service for them, regardless of funding source. An Independent evaluation, undertaken by Nous in 2022, identified:



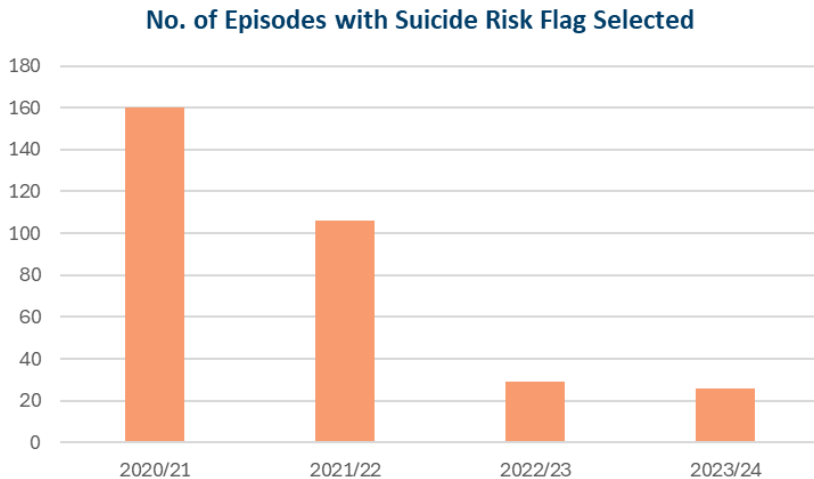
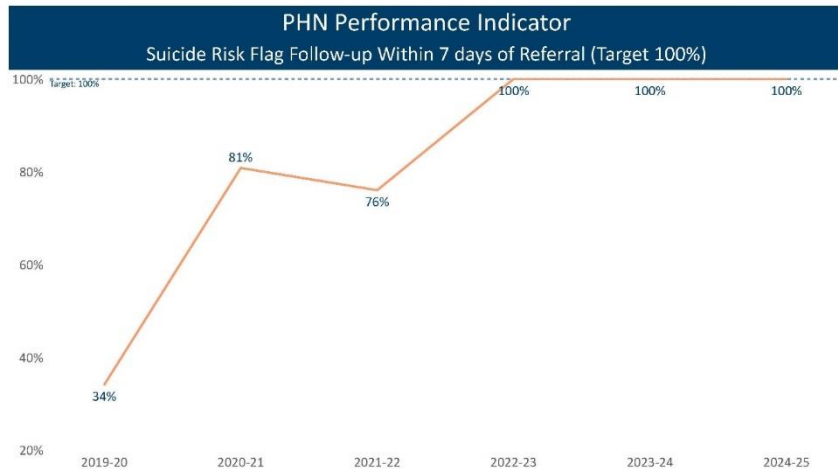
	• HeadtoHelp hubs were rapidly established in a commendable and highly effective display of Primary Health Network (PHN) collaboration and effort. • Positively, HeadtoHelp drove an unprecedented degree of collaboration – through both governance and goodwill – that PHNs are keen to replicate in other programs. In particular, the shared-service model was positively viewed by stakeholders as a pragmatic, efficient and effective structure to support establishment, which entrenched trust, joint ownership, and collaborative ways of working • HeadtoHelp is being accessed by the ‘missing middle,’ however, aspects of service use have differed from what was anticipated. Qualitatively, hubs reported that over time, participants were younger, with more severe needs than expected • The majority of participants and support people were satisfied with the service they received. Factors determining high satisfaction included a client-centric system, staff competence and personal qualities, timeliness, cost, proactive communication and follow up, responsiveness to diversity, and the ease with which clients were able to access HeadtoHelp • Comparison of overall HeadtoHelp efficiency with headspace costs per occasion of service indicates that despite differences in efficiencies between PHNs, HeadtoHelp is reasonably efficient across the board.
Implications and recommendations	This case study demonstrates the capability of PHNs to rapidly mobilise effective health commissioning, with accountability and fidelity in model, in response to environmental and situational events, using regional knowledge, insights and expertise. Since inception, the service in Victoria has handled 63,223 calls, with 18,659 consumers receiving 215,237 clinical sessions from clinics. 87% of clients providing feedback on their intake experience (n=1439) reported a positive experience, and 78% (n=877) of consumers receiving care from the clinics reported a positive experience of care. The 3 C’s describing the core functions of PHNs (Coordinate; Commission; Capacity-build) are well demonstrated through this initiative along with the efficiency and economies of scale delivered by Victorian PHNs and now benefiting the national network, e.g. through the Head to Health national telephony and data system. Enabling PHNs to have greater flexibility to make commissioning decisions and design program specifications, in line with clearly defined objectives, can enable the quintuple aim of health reform.



B.20 Improving provider capacity to understand Suicide Risk reporting

Case Study Title	Improving provider capacity to understand Suicide Risk reporting
PHN	Gippsland PHN
Problem Statement:	In 2019-20 Gippsland PHN reported a result of 34% on App-3 Suicide Risk Follow Up Key Performance Indicator (KPI), see Figure 1. The purpose of this KPI is to ensure individuals who recently attempted suicide or are at risk of suicide are promptly followed up within 7 days to ensure they have timely access to the required care. Failure to achieve this KPI has potential implications for consumers, their social network, the wider community, providers, and emergency services. Gippsland PHN's role in commissioning these services is to ensure they are meeting the needs of the community, including delivering best practice for community members experiencing suicidal thoughts; therefore, Gippsland PHN undertook an investigation to understand the contributing factors and to identify improvement opportunities.
Intervention:	Following analysis of the 2019-20 result, consultation was undertaken by Gippsland PHN with commissioned service providers in the region which revealed that a significant number of practitioners were misreporting against the KPI, collectively believing that the KPI's intended use case was to capture data on all history of suicide attempts or suicidality in the region. However, as per the definition the correct purpose is to ensure that all referrals related to individuals who had <u>recently</u> attempted suicide or were <u>at risk of suicide</u> were followed up within 7 days. To respond to the consultation findings, Gippsland PHN focussed on enhancing collective internal understanding of the KPI. This was followed with an education program targeting commissioned service providers and practitioners through online training sessions and regular email reminders. Whilst this initial focus on capacity building improved results, the KPI did not immediately return to 100% (Figure 2), rising from 34% in 2019-20 to 81% and 76% in 2020-21 and 2021-22, respectively. Continuing consultation with commissioned service providers identified occurrences where practitioners had actioned the suicide referral promptly; however, the consumer was unable to schedule a service contact within 7 days, resulting in the KPI not being met. Practitioners advised that these situations arose when they were either unable to establish contact with the consumer not responding to contact attempts, or consumers were contacted but not available to schedule a services contact within 7 days. Gippsland PHN continue to invest in ongoing capacity building regarding data quality with all training of new practitioners delivered by Gippsland PHN's Commissioned Services Data Officer; this allows ongoing reinforcement of the purpose of the suicide referral flag and reporting requirements. Data quality is additionally monitored by the Commissioned Services Data Officer through primary Mental Health Care Minimum Data Set (PMHC-MDS) reports and providers actively followed up to ensure data is entered correctly. To complement the internal and external capacity building, with a focus on improving data quality, Gippsland PHN also implemented an outcomes-based payment system for our clinical commissioned services in 2021-22. This system linked provider payments to achieving KPI's linked to PHN performance indicators, such as the App-3 Suicide Risk Follow Up KPI. In consideration of the subsequent feedback from providers, payments are not withheld where providers can demonstrate successful attempts to meet the KPI, recognising that some aspects are outside the providers' control, as detailed above. Gippsland PHN worked collaboratively alongside all providers reporting through the PMHC-MDS to assist in the transition to the outcomes-based reporting



	approach, which included a 12-month implementation phase where provider payments were not impacted. This included building relationships between the Gippsland PHN contract managers and the PMHC-MDS program providers as well as ensuring that all providers were aware of their contractual obligations and the reporting requirements going forward, which are facilitated through face-to-face contract management meetings each quarter. This collaborative approach ensured program payments were processed in a systematic and standardised way across all programs.																								
Impact and Outcomes:	Education and follow up with providers were successful in reducing the misuse of the suicide risk flag which saw a dramatic reduction in the number of episodes of care where the suicide risk flag was selected in commissioned services reporting to the PMHC-MDS, dropping from 160 in 2020/21 to 29 in 2022/23 (Figure 1); this trend has remained consistent, with 26 episodes recorded in 2023/24. The combination of capacity building and commissioning strategies implemented has seen Gippsland PHN improve the App-3 Suicide Risk Follow Up KPI from 34% in 2019-20 to 100% since 2022-23 (Figure 2) Figure 1. Number of episodes with a suicide risk flag for commissioned services* reporting to the PMHC-MDS, by financial year.  <table border="1"> <caption>No. of Episodes with Suicide Risk Flag Selected</caption> <thead> <tr> <th>Financial Year</th> <th>No. of Episodes</th> </tr> </thead> <tbody> <tr> <td>2020/21</td> <td>160</td> </tr> <tr> <td>2021/22</td> <td>105</td> </tr> <tr> <td>2022/23</td> <td>30</td> </tr> <tr> <td>2023/24</td> <td>26</td> </tr> </tbody> </table> *data excluding The Way Back which ceased 30th June 2023. Figure 2. Gippsland PHN performance indicator: Suicide risk flag, 2019-20 to current.  <table border="1"> <caption>PHN Performance Indicator: Suicide Risk Flag Follow-up Within 7 days of Referral (Target 100%)</caption> <thead> <tr> <th>Financial Year</th> <th>Performance (%)</th> </tr> </thead> <tbody> <tr> <td>2019-20</td> <td>34%</td> </tr> <tr> <td>2020-21</td> <td>81%</td> </tr> <tr> <td>2021-22</td> <td>76%</td> </tr> <tr> <td>2022-23</td> <td>100%</td> </tr> <tr> <td>2023-24</td> <td>100%</td> </tr> <tr> <td>2024-25</td> <td>100%</td> </tr> </tbody> </table>	Financial Year	No. of Episodes	2020/21	160	2021/22	105	2022/23	30	2023/24	26	Financial Year	Performance (%)	2019-20	34%	2020-21	81%	2021-22	76%	2022-23	100%	2023-24	100%	2024-25	100%
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Implications and recommendations	This case study highlights the important role PHN's play in improving data quality in an ongoing and sustainable manner. Gippsland PHN continue to implement the reporting and monitoring framework, and outcomes-based																								



	contract management reporting process to ensure new providers and practitioners continue to receive the correct information and support regarding data entry and reporting requirements of the PMHC-MDS. Gippsland PHN acknowledge provider and practitioner feedback that external factors can result in failure to achieve this KPI, which may result in Gippsland PHN not being able to maintain 100% in the future. These external factors may also influence the results of other PHN's, the magnitude of which will be influenced by PHN size and volume of services delivered. Adaptation of the KPI definition or targets should be considered where they do not compromise the delivery of evidence-based care.
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B.21 Victorian Suicide Prevention Service and System Analysis

Case Study Title	Victorian Suicide Prevention Service and System Analysis
PHN	VTPHNA
Problem Statement:	The bilateral schedule on mental health and suicide prevention sets out an intent for The Commonwealth and Victoria to collaborate on improving mental health and suicide prevention outcomes and addressing gaps in the system. The bilateral transfers significant funding for suicide prevention, some previously invested though PHNs, to the Victorian government. However, the bilateral governance structure has not proven to be an effective mechanism to support and oversee implementation of initiatives. In the absence of an effective governance or planning mechanism between the Victorian Mental Health and Wellbeing Division and PHNs, the Victorian PHNs collectively, through VTPHNA, approached the Victorian Suicide Prevention and Response Office (SPaRO) with a proposal to collaborate to improve integration in the suicide prevention system, and to trial joint ways of working between Vic DH and PHNs to demonstrate the value and benefits of collaboration. This led to agreement to undertake foundational work which would build shared insight to the suicide prevention and response system in Victoria, including insights to: • what the scope and distribution of suicide prevention services and programs is across Victoria • how these relate to and integrate with each other • to what extent there might be duplication • whether consumers might reasonably experience a comprehensive suicide prevention and response system.
Intervention:	Scope for a project, jointly funded by SPaRO and Victorian PHNs was agreed and market testing undertaken for delivery of the project. Known suicide prevention research and peak organisations were approached to undertake the project but advised they did not have the required capacity. NWMPHN's Research and Evaluation team were identified to deliver the project and a governance structure established, including: • Project Control Group comprising representatives from SPaRO, x2 PHN representatives; Lives Experience Members (with one as co-chair) • Project Advisory Group comprising key personnel working in suicide prevention policy and planning from SPaRO and PHNs, including Lived Experience senior leaders. The project comprised three elements: 1. Development of a detailed register of current suicide prevention services, capturing information about type, availability, and delivery that highlight where gaps may exist and opportunities for system integration 2. An in-depth analysis of suicide and self-harm patterns across Victoria in acute care settings in PHN regions, with a specific focus on identified, or focal, LGAs; and 3. An exploration of how the service register findings can be integrated with suicide and self-harm hospital and mortality data to better understand the service landscape, need, and opportunities for integration within focal LGAs. The services and systems analysis reveals that the suicide prevention system in Victoria is not well integrated and is difficult to navigate.



	The report provides valuable insights and evidence, as a starting point for documenting joint plan and aligning efforts related to Coordination; Commissioning; and Capacity-building between SpaRO and PHNs, to improve integration and work towards one effective suicide prevention system.
Impact and Outcomes:	The final report has been delivered to SpaRO and Victorian PHNs with workshops planned for February 2025, to include senior leaders from SpaRO and PHNs, to begin the process of developing joint intentions and plan. This work creates a solid foundation: • for improving system integration • addressing gaps • minimising service duplication (including between Victorian and Commonwealth/PHN investments) Feedback from senior managers at SpaRO, and the Lived Experience participants, has been positive regarding the system thinking contributed by PHNs in addition to the regional system and population insights PHNs hold to add context which compliments their analytics capability.
Implications and recommendations	Despite the challenges and slow pace of Bilateral governance, PHNs have demonstrated capability in system leadership through rapidly developing translatable and useful statewide and regional system and population health analyses which enable practical actions. Earlier engagement of PHNs adds value in leading system reform planning and initiatives that are relevant to the jurisdictional and regional contexts.



B.22 Step Thru Care: blending DoHAC mental health & AOD policy requirements; blending national and state strategies with local needs

Case Study Title	Step Thru Care: blending DoHAC mental health & AOD policy requirements; blending national and state strategies with local needs
PHN	WVPHN
Problem Statement:	Utilising the available data, skills, and systems thinking that Primary Health Networks (PHNs) have at their disposal, WVPHN wanted to develop a fully integrated system of care for mental health and Alcohol and Other Drugs (AoD), rather than merely offering siloed services. Therefore, WVPHN sought to develop a new commissioning model for mental health and AoD care that is place-based, outcome-focused, and partnership-led: • Place-based: The model would be designed around the specific needs of subregions and local government areas (LGAs) and must be adaptable as new needs arise. It requires service providers who prioritise continuous adaptability and improvement to effectively meet community requirements. • Outcomes-focused: The model should include clear program logic and evaluation strategies that extend over the life of the contracts (3 years + 3 years + 3 years). This will help understand the model's impact and inform future investments. Contracts should clearly define the expected outcomes for both the model and the consumers. • Partnership-led: The model must require formal partnerships to promote service integration at the local level. Additionally, it should aim to build a network of service providers that align with the integration mindset of the PHN to enhance recruitment and alignment of local services. The model should be co-designed that is informed by data and the community's voice, aiming to meet the needs of the entire community, including consumers, families, health clinicians, and health providers. • The model should address the community's needs while being practical to implement, considering the specific challenges faced by the PHN i.e. peri-urban and regional PHN, including a limited workforce and long travel distances. • The model should also ensure that the lack of alignment between the Department of Health and Aged Care's (DoHAC) mental health and AoD policy areas is not a concern for the community. Instead, it is the responsibility of the PHN to manage and address any associated risks. The model should have longevity and not only meet the local needs, but aligns to and leverages national and stage strategies • National strategies and plan: National mental health and suicide prevention plan; National Drug Strategy, National Alcohol Strategy, National Ice Action Strategy, National Mental Health Workforce Strategy, Head to Health infrastructure plans, IAR implementation plans • State strategies and plans: Reform agenda as per the recommendations of the Royal Commission into Victoria's Mental Health and Wellbeing System e.g. Victorian Suicide Prevention and Response Strategy 2024-2034. Statewide AoD Action Plan. The model should also overcome the confusion for the community and referrers of differing eligibility criteria, lack of clarity between Commonwealth/ State service offerings and so forth • The model has no wrong door in the truest sense. There is no expectation that the community must navigate the often siloed and confusing mental health/ AoD systems. This is the role of the model's service providers- to assess all those that come, treat as appropriate or warmly transfer them to the right service ensuring their care is started. No one is turned away.



Intervention:	The commissioning of a blended mental health and AoD model, known as Step Thru Care (STC), occurred in four subregions of the PHN. This model is designed to be accessible to the entire community and is operated in partnership with various providers. It was developed collaboratively with the community over a 12-month period, incorporating multiple rounds of validation and feedback. This stepped model of care serves individuals from childhood up to those under 65 years old, with eligibility determined by local data derived from the PHN health needs assessment. The focus is on those who are most at risk of falling through the gaps in service. Equity of access and treatment is ensured through a multi-modal system, which includes options for face-to-face, telehealth, video conferences, and online interactions. The Head to Health central intake architecture is utilised across the entire PHN for all mental health and AoD programs—not just for the Head to Health (now known as the Medicare Mental Health Centre) model. Intake and assessments are standardised to provide a consistent user experience, regardless of whether referrals come from the client themselves or from a clinician. This consistency is crucial, especially for community members who may move between subregions or live in border areas. Consistency is achieved through the Initial Assessment and Referral Decision Support Tool (IAR), which is applied using a systems approach within the PHN region. This tool is mandatory for all commissioned services, and training and implementation approaches are provided to all interested general practitioners (GPs). Additionally, the PHN supports public and not-for-profit organisations in utilising the IAR to promote a unified system approach. Consistency is also ensured with agreed-upon outcome measurement tools across the mental health and AoD sectors, replacing the previous service-by-service approach. Clear outcome frameworks and key performance indicators (KPIs) for the model are established and actively monitored. The data systems have been completely redesigned to allow providers and the PHN to track effectiveness and impact on demand. This enables adaptation of the model and service offerings as community needs evolve. For example, large-scale state services may be established, affecting local service and access requirements. Additionally, changes in national and state strategies, along with the addition or removal of new investments, will also influence the system. Workforce credentials and intervention types are grounded in best practices. By incorporating quality improvements into contracts and selecting service providers who share this commitment to quality, the PHN can foster adaptive learning and utilise emerging evidence to keep the model up to date. For example, the inclusion of a lived experience workforce plays a significant role in this model. All aspects of the model are data driven. A side-by-side evaluation of the model is being conducted during each phase of the contract period, which spans three 3-year contracts. This evaluation aims to support the investment decision regarding the model, determine when changes are needed in the current model, or identify if a new model is necessary. It will also help assess whether the intended impact on the community and the system has been achieved.
Impact and Outcomes:	<u>Service level outcomes</u> • Significant positive change in mental health outcomes demonstrated by an average 6.4 score change in K10 scores pre and post intervention • Mental health KPIs achievements (as per PHN performance and quality framework) ○ MH 5: 95% of flagged at risk suicide referrals engaged in 7 days. Expected to reach 100% this financial year ○ MH 6: Over 90% of pre and post outcome assessment completed. Expected to reach 100% this financial year • Partnership tool survey findings (Tool used to measure effectiveness of partnerships between STC model providers) found that while partnership models



	are initially challenging to establish, the net belief is that partnership models will provide more coordinated service for clients AND support the broader shift on the local service provider market for greater integration • PHN Provider tool survey findings (Tool used to measure effectiveness of the PHN in supporting STC providers) found the provider organisations are highly satisfied or satisfied in working with the PHN on this new model approach • Consumer stories ○ The following consumer story highlights the benefits of a blended mental health and AOD model that encourages dual diagnosis clinicians. <i>‘Dual diagnosis client- 42-year-old male, diagnosis of Bipolar with extensive history of admission into Acute MH services and binge drinking during episodes of mania. Has been attending weekly sessions with clinician to address concerns around management of mania/depressive periods, along with alcohol use. Weekly sessions have been focused on safety planning for these episodes and adaptation of regular routine to effectively manage this cyclic pattern (every 5-6 weeks). Strategies discussed with client around urge surfing and identification of triggers in relation to alcohol which has resulted in client having a reduction in amount of alcohol consumed and periods where cravings are effectively managed. Client is more confident in their ability to manage these episodes associated with Bipolar and has a strong commitment to attending weekly sessions. Client has not needed to access acute MH services recently and case management work is being undertaken with the client to link in with a psychiatrist for medication review ‘.</i> ○ The following consumer story highlights the adaptive and flexible approach of the model to meet the broad needs of the PHN community as partners within the STC model can provide a range of skills and supports. <i>‘As an example of flexible and family orientated / integrated care a referral came in for the under 12 child and was allocated to {STC provider partner name removed} for waitlist support. During this time the mother found it useful and self-referred to {STC provider partner name removed} for her own support. As situations within the family become more challenging the mother discussed getting support as a couple with her husband. The husband then self-referred to STC. {STC provider partner name removed} will continue to support the family while waiting for {provider name removed} and the mother (as per her current wishes - to step up in support as home situation becomes more stressful) and {STC provider partner name removed} will see the husband for psychological counselling. Then {STC provider partner name removed} will internally refer mother to {STC provider partner name removed} for individual counselling. {STC provider partner name removed} will then also provide couples counselling to the family.’</i> ○ The following consumer story highlights care co-ordination within the model. This example is of an acute consumer who has needs greater than the STC model can provide alone. It shows how a consumer can move between STC and other services to continue to meet their needs i.e. no wrong door and warm transfer between services. <i>‘A young man struggling with alcohol and mental health issues presented with previous suicidal thoughts and admission to emergency before Christmas. {STC} Clinician initially supported then linked him in with a GP and Psychiatrist. He has now been seen and taking regular medication and connected with {a specialist} mental health nurse. He reaches out when needed and {STC} provides support for MH and AOD. His mental health has improved, and he’s reduced his alcohol significantly. He stated he will</i>
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	<i>reach out [to STC] when needed and focus on acute MH treatment ongoing at this time. A good outcome overall.'</i> <u>Service level outcomes</u> • PHN wide usage of Head to Health central Intake architecture, and system wide approach to embedding IAR has ○ Anecdotally supports an easier to access 'no wrong door' approach on a larger scale. ○ Anecdotally supports greater referral acceptance across local service providers i.e. less re-asking of the consumer story. ○ Decreased previous GP complaints around difficulty in referring into PHN commissioned services • Supported PHN broader discussion with local providers of opportunities of integrated care with STC as a demonstration model of what is achievable • Supported PHN broader discussion with the state in preparation for commonwealth/PHN and state funded service that can complement each other, and fill gaps i.e. work together with a local systems view rather than a siloed service view
Implications and recommendations	The role of PHNs should be to develop customised models through co-design with the community. The effectiveness of this approach has varied and has often been hindered by rigid funding requirements, which tend to impose predetermined models for PHNs to commission instead of allowing them to design and then commission them. STC is an example of PHNs working to move beyond the constraints of predetermined policy requirements and is instead focusing on developing models aligned with the intent of the PHN Program objectives. However, achieving this has proven to be challenging, as noted in the previous responses. It is recommended that flexible funding truly be adaptive. The Commonwealth should develop clear program logics and outcomes to be achieved, rather than imposing predetermined ideas and requirements. This would enable PHNs to design tailored local models while still aligning with broader national PHN Program strategies. In summary, STC is an example of PHNs designing local models, drawing from national and state strategies. Its goal is to leverage this model to influence the broader system for co-commissioning opportunities, improve coordination and system thinking within the service market, and enhance capacity building across the local health sector. To support such models, the following actions are recommended: • Provide strong and coordinated governance and support for PHNs through the PHN branch. The PHN branch should coordinate with all policy areas before any work is assigned to PHNs. • Offer aligned schedules to ensure a cohesive approach. • Ensure truly flexible funding based on operational program realities, rather than Treasury requirements online. This should include a minimum of 3-5-year funding schedules that are updated at least one year (preferably two years) in advance. • Provide clear program logic and strategic direction, rather than imposing predetermined activities. • Collaborate with PHNs to develop clear communication, marketing, and stakeholder engagement plans. This will ensure clarity among national bodies e.g. RACGP; jurisdictions e.g., state governments; and local service providers regarding how PHNs operate. It is important to build mechanisms that enable stakeholders to operate effectively across the Commonwealth, National PHN Co-ops, jurisdictional PHN alliances, and local PHNs to ensure the success of the Triple Cs and broader PHN Program objectives.