Australian Psychosocial Alliance

Submission to the Review of the PHN Business and Primary Care and Mental Health Flexible Funding Pool Model

January 2025

About the Australian Psychosocial Alliance

The Australian Psychosocial Alliance (APA) includes Flourish Australia, Mind Australia, Neami National, One Door Mental Health, Ruah, Stride Mental Health, Open Minds and Wellways Australia. We are specialist providers of community managed mental health and wellbeing services in Australia, with most registered as NDIS providers with a particular focus on psychosocial disability.

Members of the APA have extensive experience providing recovery-oriented care and support which focuses on personal goals, participation and living a meaningful life. We have evidence of what works, and combine this with service delivery wisdom, to provide recovery-oriented services that support people to manage their symptoms and build their capacity to participate in society and manage their lives. This includes support to sustain a tenancy, build the skills to live independently, find fulfilling work, and build social connections.

The people who access our supports come from diverse communities across Australia, with each of our organisations having a clear commitment to promoting community inclusion and participation. We have experience providing services to at risk groups, such as LGBTIQ+ individuals, culturally and linguistically diverse communities, and Aboriginal and Torres Strait Islander people, as well as young people. We recognise the value of lived experience and seek to co-design services and approaches wherever possible.

APA Submission to the Review of the PHN Business and Primary Care and Mental Health Flexible Funding Pool Models.

1. Summary

1.1 Overview

Across the APA we have relationships with the majority, if not all, of the PHNs to deliver health, mental health and wellbeing services across Australia. We provide Headspaces, Medicare Mental Health Centres, the Commonwealth Psychosocial Support Program, a range of programs under the "Stepped Care" model and various aftercare (postvention) and suicide prevention programs.

This submission reflects our collective experience of working with PHNs. As community managed mental health services, this submission predominately focuses on our experiences in providing mental health care and psychosocial support. APA agencies have also made separate contributions to this review through completing surveys and/or attending consultations.

At their best, PHNs are highly collaborative and connected with local providers, and other PHNs. This is evident within some areas of NSW where the NSW Health, NSW PHNs, Local Health and Speciality Networks "one health system" mindset has enabled a joint approach to delivering patient centred healthcare across NSW, and a shared commitment to improve healthcare experiences, population health outcomes and health system cost efficiency. This type of work speaks to the potential for Government to use PHNs to move towards a shared vision of a joined up and wholly integrated Australian health care system, including to develop and then leverage these local connections and service integration.

However, the NSW experience is not replicated across Australia, and even within NSW good outcomes are still dependent on good leadership within both the LHD and PHN. We identify that an issue for the PHNs is that there is no overarching strategic framework which supports the role and responsibilities of PHNs within the broader health and mental health service system, and that the contracting and accountability arrangements between the Department of Health and Aged Care (DoHAC) and the PHNs may not be fit for purpose.

We observe that:

- The expectation that PHNs coordinate and integrate local health care services, including building relationships and knowledge of their local communities to identify gaps and priorities, is generally under strain and difficult to achieve.
- There has been a shift in effort from service coordination and integration, to commissioning and contract management and relying on commissioned services to do this work.
- While PHNs need and should have some flexibility to respond to local need and explore innovative practice, there needs to be a common framework for commissioning, pricing outcome measurement and data collection. The significant variation in these practices for similar or same services is inefficient for service providers, fails to build on collective knowledge and ultimately affects price and effectiveness.

In relation to the mental health flexible funding pool, it is notable that none of the APA agencies knew with certainty what was being funded through this pool demonstrating a lack of transparency, clarity as to what it can be used for, and engagement of providers in contributing to determining priorities. However, the APA appreciates that given the significant change in the mental health sector over the last ten years, it is timely to consider how this funding can best be used to support a more comprehensive, accessible, and joined up primary mental health care service offering.

1.2 Recommendations

- That the PHN role refocus on system integration and coordination, with PHNs holding a general stewardship role which creates, holds and supports relationships to the benefit of the community.
- That the DoHAC and/or PHNs develop a more streamlined and consistent approach to commissioning. This includes:
    - Developing a contemporary "purchasing or commissioning framework" which supports consistent and realistic pricing and cost classification guidelines across all tenders, including uniform definitions for direct and indirect service costs and a consistently applied fair indexation policy.
    - Increased transparency in the tendering process with regards to pricing, with a focus on assessment for best value for money. This includes allowing providers to submit competitive pricing proposals without imposing arbitrary caps.
    - Committing to commissioning and contracting in a timely manner.
    - A collaborative approach to defining targets and workforce structures, reflecting service needs and operational realities.
    - At a minimum, contracts for service delivery should be for five years and continuity of care and/or service provision should be prioritised.
    - Reducing duplication through more joined up commissioning across PHNs and/or with health services, and/or for national programs, direct commissioning through the Commonwealth Department of Health, or through the State/Territory Departments of Health.
- The PHN funding model be reviewed with consideration to whether the current "contacting" arrangements are effective and efficient, and whether they provide appropriate leverage and accountability to the Government (and the community) to achieve the desired outcomes. This should include a review of the PHN Performance and Quality Framework and its administration.
- Consideration be given to reducing the number of PHNs through consolidation, or providing incentives to work collaboratively, with the aim of removing duplication and streamlining administrative and governance costs.
- The Mental Health Flexible Funding Pool to be overhauled to promote a coordinated approach to mental health care across Australia but which allows for local responsiveness. This should include ongoing commitment to those programs which have been shown to be effective, appropriate and offering value for money.
- Governments develop a clear national mental health strategic framework to provide such guidance to support PHNs to deliver a coherent and consistent mental health service offering, including clear entry points, and pathways to a coordinated system of mental health care, including those provided by the NDIS and States/Territories.
- That a new approach to measuring and reporting mental health outcomes be developed, which focuses on system functioning rather than individuals and individual program outcomes. A new outcomes framework must reflect those that are important to service users.
- The AIHW oversee the development collection and analysis of a national primary health and mental health care data set and consideration is given to consistent approaches in relation to data collection and reporting requirements. This should include allowing agencies to use their own data management systems.

2. Consultation Areas

2.1 Program Objectives and Activities

2.1.1 Coordinate and Integrate Local Health Care Services

PHNs should be well placed to coordinate and integrate health care services, including across primary care and mental health providers. However, the reality is that this does not occur consistently across the country. PHNs are reliant on the good will and capacity of health services and other primary care services to form meaningful partnerships, and have very limited authority outside those in which they have a funding relationship.

The APA agencies report that increasingly it is *they* who are pursuing partnerships and collaborative opportunities, sometimes because this is required as a tender specification, rather than the PHN using and/or investing in its networks to support such activity. This means that when service providers change following a tender process these partnerships need to be rebuilt. It is unclear whether the lack of PHN capacity to support partnership work is related to resources (and therefore the PHN passes on this responsibility) or capability.

Similarly, it is providers who are often tasked with promoting their services and responsible for getting people through the door (and sometimes being penalised for not meeting targets). As part of an integrated system, the responsibility for promoting a new service and establishing access pathways should be shared with the PHN and across the network, and where services are part of a national roll out, be a joint exercise with other PHNs and/or the Commonwealth more generally.

An example comes from the South West Sydney PHN ATAPS (called You in Mind) program. While the programs itself is highly effective, the referral pathways often do not work and are inflexible. Additionally, while agencies have moved to the compulsory IAR, the PHN forms still allow use of the K10 instead of IAR, causing confusion for doctors. The PHN website also continues to host outdated referral forms and doctors report finding the smart link forms difficult to use. When concerns have been raised about poor KPIs and referral numbers, the emphasis is always on the agency to better promote the program but without any additional commitment of resources to do this effectively.

In the Headspace Program, tensions between the PHN and Headspace National results in providers having to manage competing reporting and accountability demands.

There is scope for PHNs to have a broader stewardship role and be responsible for creating, holding and supporting relationships across primary health care to benefit the community.

Recommendation:

That the PHN role refocus on system integration and coordination, with PHNs holding a general stewardship role which creates, hold and supports relationships to the benefit of the community.

2.1.2 Commissioning

- ***Overview***

PHNs vary in their commissioning capability, and there is also significant variation between PHNs in their approaches to commissioning like services. PHNs individually "reinvent" the wheel, which is inefficient for them and inefficient for service providers who need to make changes, not in response to local needs which would be appropriate, but to different pricing and administrative requirements.

A recent example of an effective networked and systems approach was the collaboration of the NSW PHNs for a state-wide tender for Health to Health Intake and Assessment Services, with one PHN acting as a lead for the tender process.

Commissioning also appears to operate in a vacuum, without consideration of broader market structures or requirements or how it impacts broader government policy and objectives such as supporting and growing the health workforce or building a healthy and competent psychosocial support services market. Frequent commissioning also creates unnecessary competition and is contributing to the thinning of the market (for example, through agencies moving out of service provision in a particular geographical area; and workforce moving sectors).

In the mental health space, both PHNs and States/Territories commission a range of similar services, including those providing psychosocial support and suicide prevention. With slightly different but often overlapping target groups, service design and access pathways and/or geographical coverage, this adds a level of complexity for clients, referrers, and providers.

Consideration should be given to opportunities for joint commissioning arrangements between Local Health Districts (or equivalents) and PHNs, particularly in the context of programs/ funding agreed as part of the National Mental Health and Suicide Prevention Agreement. Joint commissioning provides a mechanism for improved collaboration, including to streamline purchasing arrangements and coordinate priorities.

A caveat is that there needs to be an uplift in commissioning capability, and for there to be an overarching framework to guide commissioning practices.

- ***Inappropriate administration cost caps and salary/non salary splits***

PHNs often impose arbitrary caps on administration costs or prescribe specific splits between salary and non-salary expenditure and what are sometimes defined as direct and indirect costs of service delivery. For example, sometimes facility-based costs (rent, outgoings etc) or ICT equipment are defined as direct costs and sometimes, including for like services, they are determined to be an indirect service cost. These caps and splits can also be unrealistic and unworkable. For example, a recent tender stipulated that 85% of the budget must be allocated to the direct workforce, leaving an insufficient 15% for all other costs.

The application of caps and how they are applied vary significantly between tenders, from PHN to PHN, and from program to program even for similar services.

This approach is problematic as it:

- limits flexibility and fails to account for essential expenses like rent, ICT equipment, telecommunications, travel (especially for outreach services), and corporate overheads.
- assumes a one-size-fits-all basis without any differentiation to service type. In practice, a facility-based service will have much higher level of non-salary expenditure due to infrastructure costs – property rental, maintenance, outgoings, security etc. compared to an outreach or phone-based service.
- prohibits the full cost of service delivery being funded and with value for money seemingly a primary commissioning objective, over time and increasingly, will impact on the quality and safety of service delivery, diminish capability of the sector with reduced investment in foundational enablers such as workforce training, development and supervision, quality systems, work health safety practices, research, evaluation and governance. Ultimately, it leads to providers adjusting pricing to meet tender requirements, rather than providing budget transparency or focussing on value for money.

- ***Inconsistent approach to pricing and indexation***

There is no uniformity in how PHNs pass on indexation or approach pricing. Specific issues include:

- Indexation being passed on at different rates, or more typically not being passed on at all. Providers are faced with a significant cost burden when PHNs do not pass on the Commonwealth funded levels of annual funding indexation that are essential to meet the costs of annual expenditure increases, such as award and Fair Work Commission determined wage increases.
- A lack of flexibility from most PHNs to modify EFT (Equivalent Full-Time) and targets in service specifications where funding has reduced in real terms. For example, over recent years costs have increased 17% with indexation funding (if passed on) only meeting 5-6% of this gap resulting in an erosion of the service and the need to renegotiate targets to remain sustainable.
- Limited understanding of workforce costs. Many PHNs demonstrate minimal understanding of workforce-related expenses, including mandatory WorkCover Insurance and, portable long service leave schemes or costs arising from the industrial requirement that staff be employed on permanent agreements rather than fixed term contracts.
- Excluding redundancy costs from pricing, despite contractual flexibility to do so and even when program funding surpluses are available. In this forced short-term funding environment workforce redundancies result at the cessation of every contract. This is an unavoidable cost due to industrial changes implemented by the Federal Government which means organisations typically do not (cannot) employ maximum or fixed-term staff.

- ***Inappropriate commissioning timeframes***

As with other areas of commissioning, there is great variation with regards to commissioning timeframes and processes. At the poor end are unreasonably short time frames, limited advance notice of tenders and limited submission windows. Examples include the October 2024 commissioning for the Campbelltown Medicare Mental Health Centre which had a three-week turnaround for a $9.4M contract; and the release of four tender in Western Australia over Christmas for submission in January.

- ***Inefficient (too short) funding cycles***

Commissioning of most services for less than three years is problematic and costly. There are costs associated with tendering, establishment and the wind down of services, such as retrenching staff, supporting clients to transfer to other supports and breaking leases.

It leads to instability in the workforce with staff leaving before contracts end, including out of the sector to other programs with longer term prospects; and contributes to the thinning of the market including because agencies move out of an area. While recommissioning may be justified when there are significant quality concerns or a change of program direction, consideration to a longer funding cycle will offer better value for money with agencies being able to retain and build on their existing competencies and resources.

There are examples of PHNs commissioning what should be, and is expected to be, an ongoing service but will only commit funding for one year. This recently occurred with a headspace service, with the successful agency then required to enter into a five-year lease agreement (the minimum available) despite only having a contract for one year. The arrangement relied solely on the good will of the agency and its ability to manage the associated risks. Inevitably, these risks translate into higher over all costs as agencies seek to minimise potential fallout from overcommitting.

There are also concerns about inadequate planning to ensure continuity of care or service provision when services are subject to recommissioning. For example, the WAPHN Choices program (a peer-based service in emergency departments) which had operated for five years was to be replaced by an “aftercare” tender.

However, 16 months after the cessation of the Choices program there is still no replacement and a significant service gap.

We understand that at times PHNs are constrained by Government budget cycles which lead to inappropriate timeframes and funding uncertainty. However, the practices do little to build provider good will and respect and the DoHAC has a responsibility to ensure that arrangements are in place to ensure that business practices are fit for purpose.

A significant proportion of both PHN and agency time is taken up with commissioning.

Extending commissioning time frames, subject to appropriate performance, could free up PHN capacity to invest in activity outside of commissioning with the opportunity to support efficiencies (and cost savings) within the service system.

- ***Contract management concerns***

We are not aware of any framework for contract management, or contracting standards for PHNs to which they are held accountable. Issues include:

- Not understanding implementation issues; including inappropriate micromanagement and timeframes insufficient to establish, lease premises and recruit.
- Punitive approaches when targets or KPIs are not met; rather than a relationship based approach which focuses on problem solving and provides support to address the issue. For example, at least one PHN has imposed financial penalties on a provider for failing to meet the KPI set to provide K10 matched pairs. This is particularly concerning given the KPI had no impact on service delivery or client experience, but financial penalties may.
- Delays in contract variations and business cases not received until after service delivery has commenced. This includes renegotiated contracts often not received until December of the contract year which leads to a scrambling to meet new KPIs and poor funding plans. In all these scenarios, service providers foot the bill based on loose verbal agreements until funding is approved.
- Inadequate notice of a program either being de-commissioned or continued. In the former situation it leaves services with insufficient time to arrange alternative supports for their clients and directs funding to meet closure costs rather than service delivery, and in the latter staff start to leave seeking job security elsewhere and client care is compromised.
- Different practices and responses to underspend and/or increasing demand. APA agencies report some PHNs unwilling to engage around alternative approaches to address KPIs or providing limited timeframes to submit budgets for contract variations.

Recommendations

That the DoHAC and/or PHNs develop a more streamlined and consistent approach to commissioning. This includes:

- Developing a contemporary “purchasing or commissioning framework” which supports consistent and realistic pricing and cost classification guidelines across all tenders, including uniform definitions for direct and indirect service costs and a consistently applied fair indexation policy.
- Increased transparency in the tendering process with regards to pricing, with a focus on assessment for best value for money. This includes allowing providers to submit competitive pricing proposals without imposing arbitrary caps.
- Committing to commissioning and contracting in a timely manner.
- A collaborative approach to defining targets and workforce structures, reflecting service needs and operational realities.
- Committing to longer funding cycles and providing timely advice regarding continuation or cessation of programs. At a minimum, contracts for service delivery should be for five years and continuity of care and/or service provision should be prioritised.

- Reducing duplication through more joined up commissioning across PHNs and/or with health services, and/or for national programs, direct commissioning through the Commonwealth Department of Health, or through the State/Territory Departments of Health.

2.1.3 Capacity Building

The PHNS are not well equipped for capacity building, often lacking the knowledge and expertise of the mental health sector. Contracting arrangements – such as short tenders, and contract management approaches based on targets rather than relationship building and establishing partnership arrangements works against PHNs excelling this space.

Additionally, the lack of a national data system and analysis capability means that PHNs do not necessarily have the data to understand how the service system is operating, and build benchmarks for comparison.

2.2 PHN Program Funding Arrangements

PHN funding arrangements do not always support effective delivery of the objectives. There is an ongoing tension between the Government utilising PHNs as an administrative arm for policy and funding decisions, and its expectation that PHNs also operate as independent contracted organisations with clear purpose and objectives to respond to local needs and priorities. It is a unique arrangement and the APA questions whether it is fit for purpose. Issues include the lack of funding certainty and continuity, which in turn flows through to short term contracts and a lack of funding certainty to service providers, and whether the Department has the contracting capability to manage a billion dollar program with such diverse elements.

The PHN Performance and Quality Framework dates from 2018, and it is also not clear that it is fit for purpose. The APA notes that there does not appear to be regular or consistent public reporting in any case against the framework, and question to what degree there is Ministerial oversight and/or clear accountability for performance of the PHN system. The APA also notes that PHNs need oversight by, and relationships with, multiple parts of DoHAC (and potentially also beyond) if there is to be a coordinated approach to service delivery, for example, in mental health PHNs need to be linked with those responsible for national mental health policy and the NDIS.

Additionally, as separate entities the costs of governance and administration in and of each PHN is relatively high for the service provided and from an agency perspective there appears to be significant duplication of effort across PHNs. There also appears to be significant variation in the overhead and administrative costs that PHNs apply to the business of commissioning and administration of grants, such that by the time grants may be available for service provision there has been multiple layers of administration costs removed.

As is the case with most community based agencies that have been forced to merge to be of a size to be most economically viable and efficient, consideration could be given as to the efficiency of fewer PHNs. This could include, for example, moving to a hub and spoke model. An alternative would be for PHNs to be incentivised to work collaboratively, including to reduce duplication and effort and to share resources.

Recommendations:

- The PHN funding model be reviewed with consideration to whether the current “contacting” arrangements are effective and efficient, and whether they provide appropriate leverage and accountability to the Government (and the community) to achieve the desired outcomes. This should include a review of the PHN Performance and Quality Framework and its administration.
- Consideration be given to reducing the number of PHNs through consolidation, or providing incentives to work collaboratively, with the aim of removing duplication and streamlining administrative and governance costs.

2.3 Regional Planning, Communication and Engagement

The level of regional planning, communication and engagement varies greatly and there are many instances where LHDs (or equivalents) do not engage effectively with the PHN, leaving providers and the PHN unable to run programs, particularly where they rely on referrals from the LHD. It can be made more complex when catchments or boundaries do not align, particularly where there may be more than one LHD per PHN.

There is a role for State/Territory Governments with the Commonwealth to come to an agreement about the role of PHNs and if appropriate hold LHDs to account to ensure appropriate participation and engagement; including around joint analysis and planning and for this to be better reflected in frameworks such as the National Mental Health and Suicide Prevention Agreement. It is possible that there may need to be different expectations in different jurisdictions.

2.4 Mental Health Flexible Funding Stream

The objective of the mental health flexible funding stream is generally sound; and having capacity within the health system to explore innovative solutions and develop responses to hard to reach groups is valuable. However, it is important that consideration of its future occur in the broader context of mental health service delivery.

The lack of an overarching framework or strategy to describe and guide the evolving mental health "eco-system" of care is an issue for the whole of the mental health service system, including PHNs.

It is notable that amongst the APA members there was not a good understanding of the purpose, the scope or what was being funded through the flexible funding pool and/or how to access the funding. It suggests a general lack of clarity regarding purpose and accountability.

2.4.1 A changing service environment

The service environment has become more complex since 2016. For mental health this has included:

- The introduction of the NDIS:
    - Transfer of community based mental health resources into the NDIS and retraction of access to psychosocial support services outside of the NDIS.
    - New and/or changed psychosocial support services to target people outside of the NDIS, including to provide support to assist access to the NDIS.
- Less stability in the community managed mental health sector, due to a combination of short term contracts, increasing costs and the disruption caused by the introduction of the NDIS (and pricing which does not recognise the costs of quality service delivery), with flow on effects to workforce supply and retention and organisational sustainability.
- Expansion of headspace with expectations that it provide a key gateway into health and mental health care for young people.
- Roll out of Medicare Mental Health Centres (previously Head to Health Centres), carer connect and perinatal mental health centres providing new options for mental health care; and a new platform to access mental health care and support (including referral). However, these are yet to be established in all areas.
- New service approaches in response to suicide prevention, including aftercare. And peer led responses targeting people who have attended the emergency department or to provide alternatives.
- Changes in the quantity, quality and acceptability of digital and online supports.
- A reduction in the number of new program types being commissioned nationally and an increase in the defunding of existing programs as governments in most jurisdictions operate in a constrained fiscal environment.

At the same time, the National Mental Health Commission 2024 Report Card is stating that Australia's mental health is in decline, and that the service system's ability to provide effective care is not improving.

With the release of the psychosocial unmet needs project, and impending changes to the NDIS and establishment of foundational supports, further changes are likely.

The psychosocial unmet need project report confirms a significant unmet need for psychosocial support outside of the NDIS, with PHNs through the Commonwealth Psychosocial Program currently contracting around 30% of support of the need that has been met. It would however have to increase 15 fold to even meet 50% of the unmet psychosocial support need for people experiencing mental health issues across the moderate to severe categories.

As Governments grapple with how to respond to this need, it is necessarily going to require significant coordination and consideration across this now very complex environment. The PHNs, along with other parts of our service system, require a framework and leadership to bring these elements together and to provide clarity around roles and responsibilities.

2.4.2 The need for a "mental health" framework

It is timely for the PHN mental health program, including the Flexible Funding Pool, to be overhauled to promote a coordinated approach to mental health care across Australia which can respond locally.

The APA is supportive of the retention of some flexibility to tailor supports and services to fill gaps in the service system or to adapt service models for local communities, for example in response to the presence of particular issues or workforce availability. Similarly, existing programs funded through the flexible funding pool which have been evaluated to be effective, offer value for money and meet the community needs – such as the NWSPHN You in Mind (ATAPS) and Primary Integrated Care Supports (PICS) programs – need to be identified, retained and replicated.

However, flexibility should not result in such different service offerings such that an individual living in one area is unable to access a service which they are otherwise eligible because it is not available in their area (including possibly the next neighbourhood) because of PHN commissioning choices.

Future purchasing needs to occur within a broader strategic framework which provides clear entry points, and pathways to a coordinated system of mental health care.

It is noted that while the PHN Strategy directs PHNs to focus on their region's health outcomes, there is limited guidance, governance or resources from the DoHAC to incentivise innovation or cross-PHN collaboration and connection. There is also no national mental health services framework which articulates the "eco system" of care for the delivery of mental health and psychosocial support services across Australia, including that provided through the NDIS, to provide such guidance.

2.4.3 Outcomes measures

The APA notes that it is timely to review the outcomes measures used within the PHNs for consistency and to ensure that they are meeting needs. Currently, different PHNs can require different outcome measures for the same or similar services, and/or at times include inappropriate outcome measurement expectations as part of contractual requirements. While this creates administrative burden, the key concern is that it is not useful – to clients or to the service and it appears, not to the PHN or the Government.

The APA understands the importance of outcome measurement, and each of our agencies invest significantly in outcome measurement at the client and service level to support service provision and quality improvement. The APA also understands that Government wants some indication that its services are meeting needs and achieving change. However:

- The tools that can (and are often used) to support client and service improvement, do not always yield useful data at a systems level. Providing data (for example a K10 matched pair) does little or nothing to improve service quality, and equally fails to deliver the system information required because the

analysis cannot accurately reflect the factors that impact on outcomes, such as demographics, other services or supports being used and individual experience.

- A "global" approach to outcome measure selection fails to recognise the diversity of programs, including those providing different levels or models of support, service user characteristics, or responsiveness along different points of a service user's journey. To date, these approaches have not properly engaged the lived experience of service users to identify what is working and what is not.
- Services are increasingly getting backlash from clients regarding the use of the K10 because they can't see how it is useful to them. We also note that many clients may complete multiple K10s over an episode of care – including with different providers.
- Good outcome measurement practice is essentially relationship based, and staff having the time and skills to support service users to understand what it is and/or administer in a respectful and non-obtrusive way. It needs to be costed and funded appropriately.

In line with the PHN objectives and purpose, PHNs should have expectations of its service providers around outcome measurement. However, these should be negotiated at the local level and be led by service providers. This maximises the capacity within services to implement and use measurement tools which yield the best data and outcomes, including to provide the flexibility to change these to target areas for improvement etc. A current example would be Neami's exploration of using client experience as a measure, and through this establishing how people are connecting with their services and receiving value[1].

At the same time there needs to be investment in a national approach to collect and coordinate data to support system level reporting which provides insights into outcomes, but also system functioning.

2.4.4 Consistent data collection and availability of data

The lack of a national primary health and mental health care user data set is a significant gap in the current health care system. The PHNs are well placed to support this, facilitate an understanding of service use trends, and inform system wide outcomes.

The AIHW already oversee and collate significant health and welfare data for Australia, and it would be appropriate that service use data from funded PHN programs be included in this work.

Data system (Client Management Systems) requirements are very inconsistent across the PHN commissioning landscape, with some PHNs directing providers to use a PHN owned/licensed system for client data collection. Other PHNs leave data management systems completely at provider discretion which is preferable for most service providers who have already invested heavily in their own systems. Inconsistency across PHNs in relation to client management data systems, data requirements and reporting methodologies that PHNs stipulate/require/specify in an inconsistent manner, is a material cost driver and inefficiency for sector providers. There is also a significant lost opportunity to realise the benefits, both at provider and sector level, of scale health data capture in a systemic way to inform effective program monitoring and management, evidence-based practice, research, innovation, planning and strategy.

Recommendations:

- The Mental Health Flexible Funding Pool be overhauled to promote a coordinated approach to mental health care across Australia but which allows for local responsiveness. This should include ongoing commitment to those programs which have been shown to be effective, appropriate and offering value for money.
- Governments develop a clear national mental health strategic framework to provide such guidance to support PHNs to deliver a coherent and consistent mental health service offering, including clear entry points, and pathways to a coordinated system of mental health care, including those provided by the NDIS and States/Territories.

[1] See https://alivenetwork.com.au/our-projects/head-to-health-implementation-co-evaluation for more information.

- That a new approach to measuring and reporting mental health outcomes be developed, which focuses on system functioning rather than individuals and individual program outcomes. A new outcomes framework must reflect those that are important to service users.
- The AIHW oversee the development collection and analysis of a national primary health and mental health care data set and consideration is given to consistent approaches in relation to data collection and reporting requirements. This should include allowing agencies to use their own data management systems.