

PHN BUSINESS MODEL REVIEW AND MENTAL HEALTH FLEXIBLE FUNDING STREAM REVIEW SUBMISSION

MIFA | 22 January 2025

INTRODUCTION

MIFA is a national advocacy body for people with high-need mental health challenges. Our six member organisations represent community-based mental health care organisations working in different parts of Australia.

MIFA works closely with our members, the service provider community, mental health peak bodies and government to advance positive outcomes for people with high-need mental health challenges and those that walk beside them.

As Primary Health Networks managed two well regarded former psychosocial support programs (Partners in Recovery and Personal Helpers and Mentors), fund and commission the current Commonwealth Psychosocial Support Program (funding for this program was recently extended for two more years) and may play a role in future psychosocial programming as the Commonwealth, States and Territories work to close the psychosocial support gap¹ for people with high-need mental health challenges, MIFA has a specific interest in ensuring both legacy programs and the next phase of psychosocial support programming works for consumers, those that walk beside them, organisations and frontline workers.

To this end, we advocate for a range of reforms to the PHN model, and for government to consider, as part of an end-to-end, systems-informed psychosocial support co-design process, whether alternative commissioning models may work better for non-clinical, holistic, Recovery-focused programs.

DOCUMENT STRUCTURE

This document covers a range of topics which emerged through stakeholder consultation. It outlines key points and provides supporting quotes. Some of these align with the Discussion Document provided by government, others do not. All provide useful feedback and perspective on the functionality of PHNs. The final section outlines recommendations based on the learnings contained in the body of the submission.

¹ A Health Policy Analysis report (2024) on the unmet need for psychosocial support services outside the NDIS for people with high-need mental health challenges found that over 230,000 Australian are currently missing out on these supports.

SILOS

31 PHNs. 31 ways of doing business.

- Australia's 31 PHNs can be tasked with commissioning the same, or like for like programs
- Providers may be contracted to deliver the same, or like for like, services across multiple PHN regions.
- Each PHN will issue a discrete contract for the same service
- The contracts may significantly diverge despite the fact that they are each for the same service.
- The impact of this model on providers includes:
 - Increased complexity
 - Increased administrative burden
 - Limited funding going on administration rather than frontline services
- The impact of this model on the health budget includes:
 - Running 31 separate PHNs, many of which are administering the same programs
 - Limited funding going on administration rather than frontline programs

"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, outcome measurement, data collection and pricing, including approaches to indexation. The significant variation in these practices for similar or same services is inefficient for service providers, fails to build on collective knowledge."

"31 PHNs is too much. You cannot achieve consistency in approach/governance and strategy across 31 PHNs, however there is value to the regional approach of PHNs, so ensuring that there is still a regional approach in the new model is important."

"About five years ago I was delivering two particular services to three to four PHNs that bordered each other. Each one had very different reporting requirements. I was meeting with them all separately and it was difficult to find efficiencies as everything had to be separate whereas if they had combined we could have delivered the service for less and in a more seamless way for people in the community."

"We've advocated pretty heavily for localised, place-based need but do we need to have a system which is 31 different procurement agencies doing 31 different types of procurement? This goes right down to legal expectations... you can't have 31 of them because the administrative burden is huge."

"There can be waste or inefficiencies when PHNs are commissioning the same services. When this happens you are looking at multiple management fees or implementation costs due to multiple the reporting, systems and processes, meaning less services for the people who need them."

"PHNs are increasingly commissioning prescriptive Commonwealth government funded programs (tied funds) such as Head to Health, headspace, and the National Psychosocial Support Measure – with PHNs all using different commissioning templates (guidelines, application forms, assessment processes, and the like), funding agreements, reporting templates/obligations, data portals, etc – what a waste. An unnecessary duplication that adds a costly administrative layer to a process that should be both nationally consistent and a doddle for government agencies to undertake as part of their core business."

Hard borders

- What is available in one area often differs significantly from the offering in another area, even if these areas are next to each other.
- While it is important to localise and tailor service responses to meet specific community needs, significant variation within the same geographic area creates confusion for consumers.
- The impact of this model on consumers includes:
 - Difficulty navigating or understanding what services are available to them
 - Missing out on services because the service is over the 'border.'

"South Brisbane PHN and Brisbane North PHN, which are divided by the Brisbane river, have historically operated quite differently. In the past, individuals living on one side of the river have sometimes been unable to access services located just 10 km away because they were in a different PHN area."

"There is a problem with hard borders. There was a great telehealth program available in one PHN region in South Australia which was not available to a community 12 km over the 'border'.

"A program that operates well in the metro environment and would benefit from expansion to nearby PHN regions will not be considered between PHNs as a joint funding activity."

Data

- PHNs often have discrete reporting and data collection systems and processes. This disadvantages providers commissioned by more than one PHN, and makes the process of consolidating, using and sharing data considerably harder for PHNs.
- There is a reported lack of minimum data standards.
- PHNs collect data from service providers but do not explain what they are using it for, or how the data contributes to local health impacts.

"We have contracts with multiple PHNs and it's impossible to use data, to collect data effectively. They use different forms of data; they use different data systems. We've got several versions of the same program and one's using rediCASE and one's using something else."

"PHNs should not be collecting data unless they are going to do something with it. There has been no investment in strategy around data since their inception."

"When you have 31 PHNs, there's no consistency, there's no minimum standards, there's no minimum safety and quality standards, there are state and Territory standards, but clinical governance is clinical governance, and we need national standards."

“Even though a provider may be delivering the exact same program across a number of PHNs, the terms and conditions of funding, reporting obligations and deliverables, data portals and the like can be very different. Additionally, PHNs reporting requirements tend to be overly onerous, and seem to grow exponentially each year – with more and more quantitative and qualitative information and compliance information required of providers, without any obvious benefit to anyone.”

“Data provided to PHNs is not shared with service providers so there’s no transparency about service outputs or the possibility of benchmarking for service providers. Service providers provide rigorous and comprehensive data sets to PHNs and there is a lack of communication back about what is done with all of the data and the overall impact of the services that are being provided.”

Cost

- Each PHN costs a significant amount to run.
- There are 31 PHNs, many of which run the same, or like for like, programs.
- Every entity, and every duplicative process, reduces the amount available for frontline services.

“While there has been some innovation that has resulted from the establishment of PHNs, this arguably could have occurred through effective Commonwealth and State Government planning and consultation at much less cost to the taxpayer than that required to maintain PHNs.”

Co-Design

- PHNs are tasked with ensuring people receive the ‘right care in the right place at the right time’.²
- This can only be achieved through genuine, comprehensive, and ongoing co-design processes to ensure programs work for a diverse range of consumers, those that walk beside them, organisations and workers.

Collaboration with the States and Territories

- Lack of strategic alignment between the Commonwealth, states and Territories and the PHNs.
- Bilateral Agreements (under the National Mental Health and Suicide Prevention Agreement) between the Commonwealth and States and Territories sets out roles and responsibilities and expresses intent but does not underpin / generate strategic alignment.

“There is no consistency on how the 31 PHNs are strategically planning with States and Territories. So, suicide prevention, when I was at the PHN, we had just done the Way Back model pilot, and we were transferring it back into the Universal Aftercare models. The State was also looking at some suicide prevention models and we went to them and said let’s look at suicide prevention in Tasmania and they said they had other priorities. The problem is that when there is no alignment nationally, or on a State-level with PHNs, how can you get true systems integration?”

“Every PHN is required to do a Needs Assessment every three years and that assessment determines how PHNs spend their money. *Why is that not done with the State?* We have one PHN in Tassie and one Health and Hospital district – you’d think we’d get it right. If they were doing that together, they could have strategically aligned priorities, they could build a better health system together.”

² DoHAC, 2024

Collaboration with Health Stakeholders

- Despite PHNs remit to coordinate and integrate local health services, this responsibility is often delegated to build the relationships on which integration relies.
- Lack of provider clarity around collaborative planning development, outcomes and impact.

“From a provider’s perspective it is very unclear how PHNs undertake regional planning, how key stakeholders in a region can both inform and contribute to such planning, what outcomes regional planning has achieved, and what therefore needs to be improved. Without transparency in regional planning, it is difficult to determine outcomes achieved and their effectiveness.”

“Our PHN does not work to bring key stakeholders together cohesively and collaboratively. In fact, PHNs can at times be a barrier rather than an enabler to stepped care service models, particularly when they do not have constructive and productive relationships with key state government stakeholders.”

“The expectation that PHNs coordinate and integrate local health care services, and who have the relationships and knowledge of their local communities to identify gaps and priorities, is generally under-strain and difficult to do. PHNs are reliant on the cooperation of relevant Local Hospital Networks/health services and primary care/general practice for the delivery of good outcomes in this area. Increasingly, PHNs rely on commissioned service providers to build these relationships rather than service providers being able to build and rely on, the PHN to facilitate these.”

PROVIDER FUNDING

Providers expressed concerns around:

- How PHNs communicate funding arrangements to service providers
- The ways in which PHNs negotiate timelines and processes for securing tenders
- Delays in informing service providers on whether contracts would be renewed
- Funding not covering service costs
- Inability to report losses
- Insufficient and inconsistent overhead budgets
- Indexation not being passed on, or fully passed on, and the impacts of this shortfall in service provision
- Restrictions on collaborative funding-arrangements
- Short-term contracts which have a significant negative impact on worker experience and worker retention and impact providers’ ability to build a mature, highly-skilled mental health workforce.

“Funding offered by PHNs is not always commensurate with the service levels demanded of providers. In this context, it is not uncommon for organisations to subsidise programs to meet service levels and maintain the quality and safety of commissioned services. For smaller organisations this is neither equitable nor sustainable. This is compounded by PHNs not enabling service providers to report a loss on a funded project – as there is no record of underfunding.”

“Overhead budgets set by PHNs tend to be insufficient and arbitrary, and do not reflect the actual costs of service delivery – pushing providers to the limit. These budgets also fail to consider economies of scale that can be achieved in very large organisations but not replicated in smaller operating environments. Should PHNs continue, a nationally consistent approach to overheads funding should be adopted, that takes into consideration organisation size and does not disadvantage smaller organisations.”

“My way or the highway approach – there has been at least one instance where a service provider was successful in winning a tender but was then not commissioned by the PHN. When the provider was advised of the win and sought to negotiate service levels that were consistent (and safe) within the tender funding envelop the PHN ceased all communication with the provider. The PHN then funded another provider and revised the service levels downwards for that provider after the contract was awarded. The lack of accountability and effective monitoring of PHNs in the administration of public monies appears to enable this.”

“During the height of the COVID pandemic the State Government sought to expand a telephone service we delivered to support the heightened mental health and wellbeing concerns during this period. The State government sought to provide additional funding to increase operations of the service. On being informed of this, the PHN subsequently accused us of “double dipping” much to our concern, and the concern of the State Government. In the end, we declined the offer of additional funding from the State for fear of retribution from the PHN.”

“I used to work in a Commonwealth Psychosocial Support program that was funded by a PHN (through the federal budget). A major challenge we faced was the insecurity of funding for our organisation. We had numerous instances of the contract not being extended until the day it was due to expire (even though the funds were available to the PHN). This meant we experienced HUGE staff turnover, staff dissatisfaction and poor wellbeing as workers due to job insecurity. In some instances, consumers had more churned through more than four workers in less than 12 months!”

PHN FUNDING

- Federal funding model incurs critically short timeframes on PHNs to deliver against their funding
- This impacts on PHNs ability to make considered, collaborative and effective investment

“When I was at the PHN we had endometriosis and pelvic pain money we had to get out to the community. We had *six weeks* to do that. Had we had the time to plan, to collaborate with the State and do it the right way, maybe there was a need for GP education so they could diagnose correctly and refer into the clinics.”

TRANSPARENCY

- PHNs do not provide a rationale for the distribution of funds across a region.
- For example, the 2023-24 allocation of National Psychosocial Support Measure funding for Far North Queensland sees nearly half the budget allocated to the Cairns region while Townsville and Mackay receive 15%. This is despite the Townsville region having a similar population to Cairns, while Mackay has around half the number of people as the other two locations.³

FUNDING SCHEDULE:

National Psychosocial Support Measure

STREAM / ACTIVITY	WHAT	WHERE	WHO
Service delivery	⊖	⊖	⊖
Access enablers	⊖	⊖	⊖

Legend

✔ FLEXIBLE FUNDING
 ⊖ PARTIALLY PRESCRIBED FUNDING (within specific parameters)
 ✘ FULLY PRESCRIBED FUNDING
 N/A NON-COMMISSIONED ACTIVITY

Geographical distribution of funding

HHS region	2023-24 total sum	Percentage
Torres and Cape	\$1,181,067.63	24%
Cairns and Hinterland	\$2,328,729.37	46%
Townsville	\$755,637.70	15%
Mackay	\$755,637.70	15%
TOTAL	\$5,021,072.40	100%

³ The Report for NQPHN Members on the geographical distribution of funding 2023-24 Financial Year, from which this data and diagram was extracted, notes: 'Given the complexities of the funding and our contract management system, the figures provided throughout this document are indicative only and provided for illustrative purposes. All data is extracted from internal systems for commissioned services and is to be used as indicative data only and will not reconcile with the financial statement.'

PERCEPTION OF BIAS

- While acknowledging the competitive nature of tendering, there is a perception that PHN commissioning is underpinned by favouritism and bias.
- This is based on the lack of transparency on how funding is allocated referenced above, and the experience of providers which regularly win contracts from other funders, while having no success when tendering with their local PHN.

The lack of success, attributed to bias, has a chilling effect on broader service provision. One Queensland provider, embedded in regional communities, cited a case where a national provider was commissioned by the local PHN to provide a Queensland service.

“We are a highly successful organisation. We want to grow our business in Queensland and expand our services in rural and remote communities. Do you really think this national provider has an interest in remote Queensland?”

“Commissioning processes have historically been relational and biased and vary significantly between PHNs. I wonder at a national level how they moderate/audit the commissioning of funding and where organisations and people accessing service can escalate complaints beyond the PHN. I have personally completed many pages of reports for PHNs... there is no feedback loop, national trends or transparency. The reports just seem to go into the void.”

“That is the whole issue with the PHNs, big fish in little ponds who favour specific organisations.”

“There is a noticeable tendency for PHNs to continually select the same organisations -“favourite players” - to deliver PHN projects (this may be evidenced by the distribution of limited funds between a small handful of providers in any region). Further, at times no approach to the market conducted, with public funds directly offered to an organisation without any formal procurement process whatsoever. In this context, commissioning opportunities are limited for organisations that do not have a close relationship with PHNs.”

SPECIAL CONDITIONS

The chilling effect also results from special conditions placed on services in the Northern Territory.

- In the NT, providers must agree to adopting the Aboriginal Peak Organisations Northern Territory (APO NT) Principles⁴ in order to be eligible for PHN funding
- This disadvantages small organisations who may not have the capacity to manage the implications of adopting the APO NT principles
- It advantages large organisations who do have this capacity.
- The result is that small, locally embedded organisations remain locked out of PHN funding while larger providers, with no history in, or connection to, a particular region, are able to win contracts

⁴ APO NT, 2017, APO NT Partnership Principles for working with Aboriginal organisations and communities in the Northern Territory

PERFORMANCE ACCOUNTABILITY

- We are not aware of any PHNs which publish the performance data of services which they commission
- This means the public, and other interested stakeholders, have no means of assessing whether a PHN investment decision was successful against key criteria

GOVERNANCE

Standards

- PHNs are regulated by the Australian Charities and Not-for-profits Commission (ACNC)
- Given the size of PHN budgets and the direct impact on community of PHN decisions, PHNs should be subject to more stringent governance and accountability standards than are currently in place.

“PHNs... should operate with the same level of accountability as government agencies with regard to distributing and managing public funds...”

Representation

- There is a perception that PHN Boards represent the clinical view
- There is a perception that PHN Boards do not include people with Lived Experience of mental health challenges, those who walk beside them or community sector representatives.

Risk

- Lack of policies and procedures
- Lack of minimum data standards

LIVED EXPERIENCE

- There is a perception that PHNs have varying levels of embedded Lived Experience at Board and operational levels.

PSYCHOSOCIAL COMMISSIONING

- PHNs were handed the administration of well-regarded psychosocial support programs Partners in Recovery (PiR) and Personal Helpers and Mentors (PHaMs) when the NDIS was introduced.
- The funding for these programs eventually ceased, based on the belief that people with high-need mental health challenges in need of psychosocial supports could access it via NDIS.
- In reality, the barriers to accessing the NDIS for this cohort were so significant a new program needed to be established. The new program – the Commonwealth Psychosocial Support Program – is currently administered by PHNs and services around 25,000 people with high-need mental health challenges.
- Despite this program, state-based psychosocial programs, and the NDIS, around 230,000 people with high-need mental health challenges receive no psychosocial supports whatsoever.
- While outside the scope of this review, it is important to note the live debate around the funding, commissioning and delivery of the quantum of psychosocial supports. Federal psychosocial support funding is channelled through the NDIS, and the Commonwealth Psychosocial Support Program which is administered by PHNs and delivered by mental

health service providers. State and Territory psychosocial services, in Queensland only accessible via Community Mental Health service, are commissioned via Local Hospital Networks and delivered by mental health service providers. As mentioned above, work is underway federally to address the gap in psychosocial supports, as well as on Targeted Foundational Supports (administered, as far as I know by DSS) to provide psychosocial support outside the NDIS.

- As work on closing the psychosocial support gap gains momentum at a Commonwealth-level, it is a timely to consider an end-to-end, nationally integrated model of psychosocial support including a best-practice, Lived Experience-led commissioning and delivery model.
- Right now, there are many views on a preferred commissioning models.
- MIFA's position is that PHNs are *one* component of the current, fragmented, psychosocial support system and need to be viewed *as part of this larger system* when considering their value in relation to psychosocial support services. This is a vital step in the journey to co-design an end-to-end psychosocial support response including a fit for purpose, best-practice commissioning model⁵ needs.

"We don't think PHNs should do any psychosocial commissioning – that should be stripped out. There should be a new commissioning body for any psychosocial services including the recently extended Commonwealth Psychosocial Support Program. The new body should also commission the Targeted Foundational Supports. I would like to see anyone with psychosocial support needs able to get services through a single commissioning agency. This would mean people would not need to utilise the NDIS which is patently unsuitable for people with a psychosocial disability, and their families and carers."

"We have consistently advocated that psychosocial supports must continue to be included in the NDIS *and* that commissioning of supports outside the NDIS should be improved (we've pragmatically called for governments to leverage existing mechanisms, which could look different in each State and Territory, and capability uplift for PHNs on commissioning and better coordination with Local Health Networks)."

"Foundational or additional funding coming into the mental health or psychosocial support system should not go through PHNs, rather it should be provided to Commonwealth / State government agencies that have the capacity to effectively administer such funding in a nationally consistent and cost-effective manner. Existing tied funding should return to the Commonwealth for administration (headspace program, etc.) and untied funding currently provided to the PHN should be taken back into the Commonwealth and reserved specifically for the purpose of fostering innovation and supporting pilot projects in the mental health/psychosocial sector that cannot be supported under other programs."

"A lot of people seem to think State-funded is the way to go. My concern is that it will just further add to the fragmented system. My gut feeling is just that it is already complicated and confusing having various State-funded programs. In WA you can only access certain programs if you live in the northern suburbs, but not if you live anywhere else. People in regional communities have hardly anything. Remote is even worse. State-funded, I guess, would mean our regions could be better supported but like I said, would it not just because further fragmented and confusing? If someone moves from Victoria to WA or vice versa they would have an entirely new system to navigate."

⁵ Stewart Briggs et al (2019, p.119) in his paper on PHN innovation, recommends an openness to '...different models of care being funded and different funding models being used.' This approach means developing the most fit for purpose models to improve consumer outcomes. Taken to its logical conclusion this means we may need to think outside the PHN-box to find the best model for psychosocial support programming.

RECOMMENDATIONS

1. Minimum lead in times for PHNs to deliver against Commonwealth priorities to enable effective outcomes
2. Consideration given, at a Departmental-level to achieving a better balance between funding national priorities and responsive, place-based opportunities⁶
3. Consistent procurement, reporting and data management and sharing processes across the PHN network.
4. Data to be shared with providers.
5. Longer contract periods consistent with maintaining quality of service
6. Provider funding to be fully indexed, cover the costs of service delivery including service overheads
7. Make provider losses reportable
8. Consideration given to reducing the number of PHNs by decoupling localised design from program, rather than region-based, administration
9. Improved collaboration with multi-jurisdictional health and social determinant stakeholders to enable the shared goal of an integrated, seamless health system
10. Representative co-design teams, and ongoing co-design work, to ensure legacy and newly commissioned programs are accessible and culturally safe and work for the people who need them including consumers, those that walk beside them, organisations and workers⁷
11. Representative Boards with mandatory Lived Experience and Carer / Chosen Supporter positions
12. Publicly available performance data (based on meaningful, co-designed indicators and collected in ways which work for consumers⁸).
13. PHNs are one component of the current, fragmented, psychosocial support system and need to be viewed *as part of this larger system* when considering their value in relation to psychosocial support services.
14. An end-to-end psychosocial support response including a fit for purpose, best-practice commissioning model⁹ needs to be co-designed without any assumptions / pre-determined components.
15. Consideration given to whether equivalent value could be obtained more cheaply and efficiently by enabling the Commonwealth, States and Territories to administer mental health programs supported by place-based planning and design teams

⁶ Bates, Wright and Harris-Roxas (2022, p.588) note “[The funding is] fairly much ring-fenced. So, [national] priorities need to become the PHNs priorities. ... I think our stakeholders don’t realise how little of our funding is actually funding that we are able to use flexibly.” Henderson et al (2017, p.85) records concern that ‘...PHNs are provided with particular streams of funding that are the same old types of services, and they’re not resourced to be able to be innovative and reform in ways that doesn’t just leave us with just a few pieces shifted around the chess board.’

⁷ Coombs (2017, p.42) highlights concerns about PHNs commissioning non-First Nations organisations to provide services to First Nations communities, ‘Who is PHN to say that an organisation is culturally safe or culturally appropriate? ... And who says *they’re* culturally appropriate?’

⁸ ‘[Clients] can have five or six people asking them the same K-10 survey... and that’s without any of the other measures... I don’t think it’s very recovery orientated’ (Bates et al, 2022, p.589).

⁹ Stewart Briggs et al (2019, p.119) in his paper on PHN innovation, recommends an openness to ‘...different models of care being funded and different funding models being used.’ This approach means developing the most fit for purpose models to improve consumer outcomes. Taken to its logical conclusion this means we may need to think outside the PHN-box to find the best model for psychosocial support programming.

ABOUT MIFA

The Mental Illness Fellowship Australia (MIFA) is a national advocacy organisation for people with high-need mental health conditions.

MIFA has six mental health service providers as its members. Our members come from across the country and include small, medium and large organisations working across metropolitan, regional, rural and remote settings.

MIFA also works closely with a range of mental health peak bodies including Mental Health Australia, Mental Health Carers Australia, Mental Health Consumers Alliance, Community Mental Health Australia and Gayaa Dhuwi.

CONSULTATION

MIFA consulted with a range of stakeholders to develop this submission including advocates, peak bodies and service providers. A number of participants had previously worked at PHNs.

REFERENCES

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