WA Primary Health Alliance Response to the Productivity Commission's Final Review of the National Mental Health and Suicide Prevention Agreement

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WA Primary Health Alliance
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Executive Summary

WA Primary Health Alliance (WAPHA) welcomes the opportunity to submit its views to the Productivity Commission's final review of the National Mental Health and Suicide Prevention Agreement (NMHSPA). In the context of the National Health Reform Agreement, the Review of the Primary Health Network Business Model and Mental Health Flexible Funding Model, it is an opportune time to strengthen the shared commitment between the Australian and State/Territory Governments and PHNs to transform Australia's mental health and suicide prevention system. Please note, WAPHA has participated in the formulation of the national PHN Cooperative submission to this Review. The responses detailed within WAPHA's submission are an adjunct to those in the PHN Cooperative submission and are intended to provide contextual detail relevant to WAPHA's unique whole of state PHN operating model.

On behalf of the Australian Government, WA Primary Health Alliance (WAPHA) operates the three Western Australian Primary Health Networks (Perth North, Perth South and Country WA) in the context of our three primary roles:

- Commissioning primary health care services to meet the needs of people in our regions and address gaps in primary health care;
- Building the capacity of the health workforce by engaging with general practitioners and other health professionals to deliver high quality care, and
- Coordinating health services at the local level to improve quality of care, encourage more effective use of health resources, and reduce service duplication.

WAPHA is a company limited by guarantee, governed by a skills-based Board of Directors. We operate a unique alliance model predicated on state and local interagency partnerships – with one PHN organisation responsible for the three Western Australian PHNs.

Introduction

Whilst WAPHA has contributed to, and supports, the key points made in the PHN Cooperative submission, we believe our experience as the single organisation responsible for all three PHNs in Western Australia provides a valuable additional perspective on managing PHN program objectives at scale through the auspices of the NMHSPA.

Recognising the substantial overlap between the recommendations from the Productivity Commission's *Inquiry Report on Mental Health* and the current evaluation of the NMHSPA this submission focuses on two matters in the Terms of Reference that differentiate the current review from the former: the attention to intergovernmental collaboration and the aims to strengthen the evidence base for policy development. WAPHA has structured our response accordingly.

Embedding the Role of PHNs in Future NMHSPAs

The NMHSPA's Governance section does not clearly define the role of PHNs – noting only that the Parties to the agreement (Commonwealth and States) would engage with 'other relevant bodies' as required to support the implementation of reforms.

To optimise the role of PHNs in supporting integrated mental health service systems at a regional level in future Agreements, PHNs must be:

- formally recognised as key partners in jurisdictional and regional mental health and suicide prevention planning and commissioning
- PHN expertise must be included in governance arrangements
- PHN role in coordinating primary mental health care services should be authorised and harnessed through a consistent authorising environment
- These roles should be resourced to align with the life of key agreements.

Governance Arrangements for Joint Regional Plans

PHNs are a subordinate party to the NMHSPA as Commonwealth contracted organisations and are referenced as such within a subset of sections. Accordingly, the sections of greatest operational relevance for PHNs are S133-143 with S134 and S138 detailing a set of expected actions by the subordinate partners to the Agreement "*Primary Health Network (PHNs), Local Health Networks (LHNs) and other commissioning bodies to develop and/or strengthen Joint Regional Plans with* ***an agreed terms of reference agreed by the Parties*** *to improve how they work together to*

a) *Determine the needs of local communities, including identifying gaps, duplication and inefficiency, within their region based on evidence and data and consultation within their communities, including consumers and carers with lived experience representative of local communities;*
b) *Plan, design and fund mental health care, suicide prevention and psychosocial supports to respond to the needs of local communities;*
c) *Coordinate and integrate care across the stepped care model and support transition between mental health and non-health services; and*
d) *Implement an agreed framework for ongoing monitoring, reporting and evaluation of regional plans."*

The development of Joint Regional Plans that meet these objectives provides a test of the conjoint governance and decision-making frameworks established between the relevant parties (Commonwealth and States). It is WAPHA's view, however, that "*an agreed terms of terms of reference agreed by the parties*" is neither sufficiently substantial nor compelling as the authorising framework for Primary Health Network (PHNs), Local Health Networks (LHNs) and other commissioning bodies to work in partnership to develop and/or strengthen Joint Regional Plans and the subordinate actions specified.

Under the current loosely bound arrangements, only PHNs are left with the contractually mandated obligation for developing these plans (including enablers to system-wide operationalisation) yet they require the discretionary commitment of State partners to successfully undertake the work. That these arrangements may be further determined through bilaterial agreements between the Commonwealth and States with minimal PHN involvement further obstructs the process for realising the "*effectiveness and operation of … programs and services in line with the National Agreement*", (Productivity Commissions Review of the NMHSPA, Terms of Reference, Scope of inquiry Terms of reference - Mental Health Agreement Review - Productivity Commission).

Lack of Clarity in the Agreement and Elsewhere about the PHN "Population"

Individuals and population groups disadvantaged by socio-economic circumstances and/or location have differentially higher rates of morbidity (illness) including multi-morbidity of greater and earlier onset, alongside disproportionately lower rates of access to care relative to avertable burden. The latter circumstance of unequal access is not a fault. It is, instead, an incorporated feature of both the Medicare rebatable (MBS) primary care and State funded secondary care systems.

If this is also the underserviced group that PHNs were established to support, as we believe it is, ("*identifying groups of people who are more at risk of poor health than others*" https://www.health.gov.au/our-work/phn/what-PHNs-do) the lack of a clearly established prioritised PHN reference populations in the NMHSPA (or any other of the PHN guidance materials) needs to be rectified. Since the demographic characteristics, as well as the evident geographical distribution of the disproportionate care gap, can be estimated using data available to principal signatories to the Agreement, we believe it can, and should, be done as a matter of priority.

Streamlining Needs Assessment, Planning, Commissioning and Resource Allocation

If an evidence-based definition of the NMHSPA priority populations is to be undertaken in a nationally consistent way that also accommodates localisation ("*individualised as required to the local circumstances of that state*" S.16), it is WAPHA's view it requires the development of more detailed nationally referenced guidance on the differential effectiveness, or otherwise, of interventions for these same populations in line with NMHSPA objectives. Such guidance would enable PHNs and the other partners to the agreement to align and substantiate needs assessment, planning, commissioning, and resource allocation decisions to be developed for scale and reach. Moreover, it would enable the parties to "*work together to assess and share evidence about the*

effectiveness of different models through testing and evaluating innovative planning and commissioning arrangements" (S.136).

This is a significant problem that cannot be systematically reconciled at the jurisdictional level under current PHN arrangements and WAPHA is not suggesting it is an easy problem to solve. However, building and socialising the evidence base for effective planning in this way is a crucial next step. As an example, WAPHA has a current project underway with the Health Economics Group at Monash University to develop an add-on to the National Mental Health Services Planning Framework-Planning Support Tool (PST) that estimates the burden of mental disorders in Western Australia that can be averted through routine interventions delivered in primary care at the sub-regional level (Statistical Area Level 3). Intervention specification will align with the National Mental Health and Suicide Prevention Information Priorities (https://www.aihw.gov.au/getmedia/084e998c-f2fc-42c6-b486-84151aeb17ed/national-mental-health-and-suicide-prevention-information-priorities-3rd-edition.pdf.aspx) using the Leginski (1989) questions of (i) who receives (ii) what care (iii) from whom (iv) at what cost (v) with what effect, abstracted from the NMHSPA Technical Implementation Plan. Moreover, to support the further development of this work as a national data asset, development releases of the computational model, reporting template and user interface will be made available on GitHub enabling licensed users of the PST in other jurisdictions to improve the user experience.

Developing Fit for Purpose Infrastructure Systems

Collective infrastructure generates measurable and cross sector benefits. These include economies of scale, sustainability and the ability to apply contemporary best digital and data practice.

By way of example, WAPHA is currently the national lead PHN for the operation and development of Primary Health Insights (PHI) and Primary Sense (PS). Unlike the development of these digital and data infrastructural systems, the development of planning infrastructure is far less systematically established, but it needs to be if the NMHSPA objective to "*....to use the National Mental Health Service Planning Framework (NMHSPF), and/or other tools appropriate for their local population, to support regional planning and commissioning*" is to be realised in practice (S.139). For example, there is merit in considering how the existing modern and certified data infrastructure such as PHI and PS can be leveraged to support contemporary national mental system reforms. WAPHA led the creation of the Mental Health data co-operative using the PHI data platform. Currently, it has record level data on around 250,000 unique patients from 18 PHNs across Australia. Amongst the toolkit that has been developed as part of the project is a "Leginski" dashboard, a refinement of some earlier work WAPHA had undertaken. It gives a view of what is happening across most of the PHN program, allowing PHNs to explore the features of different initiatives in other PHN jurisdictions

that may have local scale/application, It is, however, a singular perspective on one slice of the primary care spectrum, though it is not linked to other State health data sets. Unfortunately, the functional integration of different data information systems across the mental health care system is patchy, at best, and mirrors the compartmentalised and fragmentary nature of the system more broadly. Moreover, there is much information and collective knowledge we do not have access to because it is widely and unequally distributed. Thus, a more informed perspective of what is happening in reality across a local care system is not available to any of the key decision makers within the system (including clinicians, support staff, managers, planners, commissioners and funders) or for who's benefit the system is meant to prioritise (individuals, families, citizens). This works against any possibility of a systematic approach to the provision of effective, sustainable person-centred regional healthcare.

Systems can only be understood and improved for what they measure. WAPHA, and PHNs nationally, recognises the need for access to linked datasets. However, the infrastructure and expertise required to develop a program of record linkage and interpretation is only likely to be sustained when it is undertaken at the State level. Here again WAPHA has determined that data linkage is an integral part of the future work of WAPHA as a PHN organisation. Our data linkage future and capability are linked to, and will be governed as part of, our evolving tripartite collaboration with the WA Department of Health and DHAC. WAPHA has already leveraged PHI and Primary Sense in WA to automate data linkage which can link millions of patient records within hours at little cost. Our aim to develop a consolidated jurisdictional level perspective of individual care across the various separated systems of care that patients and families must navigate and negotiate is currently unachievable given the separate data we all collect.

We recognise the capability and capacity of WAPHA to take on projects with this level of scale and reach is one of the benefits of our statewide organisational presence. It enables us to build work streams within our organisation that integrates the commissioning cycle to achieve both scale and reach at state level. However, there is considerable latent capability and capacity across the entire PHN program that could be realised to further the NMHSPA objects. WAPHA, for example, did not develop the initial PS model. This work was undertaken by another PHN. WAPHA's contribution was to develop the system at scale. The PHN Mental Health PHI Co-operative was similarly a joint effort. The review of the NMHSPA provides a unique opportunity to consider how this type of work can be planned and embedded in a more systematic way across a more realistic time-horizon than the current short-term planning and funding cycles that incentive impermanent benefit, reinforced by key performance metrics.

Developing infrastructural systems and resources in this way that connects across the arc of commissioning will also help rationalise the current reporting and accountability arrangement that impose a significant burden on both PHNs and commissioned

providers and are effectively an unrealised cost against the care relative to benefits in terms of better outcomes (see S 138(d) Streamlining reporting and accountability requirements for service delivery organisations).

Summary

The lack of PHN role clarity and authority within the NMHSPA has contributed to an unstable implementation relationship at the regional level. PHNs have a strong mandate for action, but this is frustrated by the lack of regional implementation mechanisms, incentives and accountability frameworks that are commensurate with the Agreement's deliverables.

Future agreements should provide a stronger mechanism for regional implementation of Agreement deliverables, including a clearer authorising environment for PHNs and Local Hospital Networks (and jurisdictional equivalents) to plan, commission, and deliver the ongoing system reform agenda envisaged by the Agreement. Future agreements would be strengthened by aligning with other national Agreements, such as the National Health Reform Agreement, in which PHNs, LHNs, and Government parties are engaged in comparable planning, integration, and system reform activities. A requirement to strengthen the role and responsibilities of the PHNs and a commitment to joint planning and commissioning activities was recommended in the Mid-Term Review of the NRHA. WAPHA has consistently prosecuted the value of our unique whole-of-state PHN model in the context of this recommendation.

In alignment with the Australian Government's Strengthening Medicare Reform agenda, PHNs have a key role in workforce sustainability, including improving access in rural and remote communities and promoting multidisciplinary team-based care. The PHN role in change management and commissioning for system and service integration is vital to implementing regional mental health reform activity.

The institutional architecture required to meet the NMHSPA goal of "*providing a balanced and integrated mental health system for all communities and groups through monitoring progress and outcomes through detailed regional data*" requires a reform of the current NMHSPA governance and development of more detailed guidance, informational and technical supports if PHNs are to meet our contractual obligation for joint regional planning and all the related downstream dependencies in partnership with state bodies. Considerable latent capacity to assist the development of these resources exists within the PHN program, however, the current guidance materials and related supports are not sufficient for the task and require considerable work to make them so.