AHHA Response to the ANAO Audit of the DHAC Performance Management of the PHN Program

Submission

30 November 2023

OUR VISION

The best possible healthcare system that supports a healthy Australia.

OUR PURPOSE

To drive collective action across the healthcare system for reform that improves the health and wellbeing of Australians.

OUR GUIDING PRINCIPLES

Healthcare in Australia should be:

Outcomes-focused
Evidence-based
Accessible
Equitable
Sustainable

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INTRODUCTION

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to contribute to the Australian National Audit Office (ANAO) audit of the Department of Health and Aged Care's (DHAC) performance management of the Primary Health Network (PHN) program.

This submission builds on consultation undertaken with health system leaders in developing a blueprint for health reform towards outcomes-focused, value-based health care, and AHHA's operating model of continuously listening to and engaging with the experiences and evidence from our members and stakeholders, as we contribute to the evolution of our health system.

ABOUT THE AHHA

For more than 70 years, AHHA has been the national voice for public health care, maintaining its vision for an effective, innovative, and sustainable health system where all Australians have equitable access to health care of the highest standard when and where they need it.

As a national peak body, we are uniquely placed, in that we do not represent any one part of the health system. Rather, our membership spans the system in its entirety, including – public and not-for-profit hospitals, PHNs, community, and primary healthcare services.

Our research arm, the Deeble Institute for Health Policy Research connects universities with a strength in health systems and services research, ensuring our work is underpinned by evidence.

In 2019, AHHA established the Australian Centre for Value-Based Health Care, recognising that a person's experience of health and health care is supported and enabled by a diverse range of entities, public and private, government and non-government. The Centre brings these stakeholders together around a common goal of improving the health outcomes that matter to people and communities for the resources to achieve those outcomes, with consideration of their full care pathway.

Through these connections, we provide a national voice for universal high-quality health care. It is a voice that respects the evidence, expertise, and views of each component of the system while recognising that siloed views will not achieve the system Australians deserve.

OUR RESPONSE

Australia's 31 PHNs have the important role of improving the efficiency and effectiveness of care in their regions, prioritising those at risk of poor health outcomes, and improving care coordination in the primary care sector. They do this through the mechanism of commissioning; a continual and iterative cycle involving needs assessment, planning, co-design, procurement, monitoring and evaluation. They aim to achieve the best outcomes for the costs of achieving those outcomes, using local knowledge and relationships within the community.

The issues and challenges faced by the primary care sector, particularly in rural and remote areas, render the need for the PHNs commissioning model to meet its full potential to be even more vital. There are numerous examples of innovative, impactful PHN programs and initiatives that address

local need, involve collaboration with other parts of the health system and utilise limited resources[1]; but these achievements occur *despite* funding and operational constraints, and often as an outcome of PHN staff's knowledge, experience, and relationships with local providers and community[2].

Three of the seven principles underpinning the *PHN Performance and Quality Framework*[3] are particularly important to the unique role PHNs play in the health system, and AHHA believes they need to be key considerations within this audit process; (1) minimise burden, (2) outcome-based and (3) flexibility. Steps have been taken towards implementing these principles in practice, but the common issues reported during stakeholder consultations and in evidence specifically relate to these three principles.

PRINCIPLE 1: Minimise Burden

As a meso-level organisation with a unique role to play in the Australian healthcare system, we have witnessed how the management of PHNs by the DHAC can have a significant impact on the effectiveness and sustainability of local health services. Financial and administrative burdens on service providers in rural and remote areas are two impacts that have resulted from the context in which the management of the PHN program occurs – inadequate funding structures and the siloed nature of the health, social, aged care and disability sectors.

We understand that this may be outside the scope of the ANAO audit; however, the ability of PHNs to meet performance indicators is tied to funding arrangements as well as how they integrate (or don't integrate) with other funding mechanisms. Thus, the design of Commonwealth funding arrangements should be considered in the context of this audit.

ISSUES

Funding uncertainty

One of the issues local service providers are experiencing, particularly in rural and remote areas (in thin markets), is the instability and uncertainty caused by short-term contracts and contract obligations. PHNs commission service providers on short-term contracts because PHNs themselves receive short-term funding from the Commonwealth. However, local service providers may be recipients of multiple funding streams (MBS, commissioned funds, NDIS etc.), particularly those providing services to priority populations. It was recently reported to AHHA from a service provider in Queensland that they were managing 37 different funding streams. These services then use this mixed funding to develop a service offering that not only meets the contractual obligations of each funding stream, but meets community need and provides a coherent employment model for their workforce.

The viability of the service offering as a whole is often then dependent on maintaining all of the funding streams. The misalignment of contractual obligations and reporting requirements make the management of the various funding a high burden on service providers. Furthermore, the short-term (often 12 months) nature of some funding streams make the sustainability of the service uncertain year on year.

Administrative burden of reporting arrangements

The administrative burden of current performance management arrangements on PHNs is substantial and extends to the wider primary care sector and is a barrier to the very objectives of the PHN program. The current frequency of performance reporting of six and twelve months cycles, paired with the level of operational funding provided to PHNs, is so rapid that it is negatively impacting the ability of PHNs to strategically address their regions needs as it leaves little time to forward plan and undertake meaningful co-design and collaboration with communities.

In addition, the frequency by which PHNs must submit performance information has a direct impact on the frequency by which services commissioned by PHNs must undertake performance reports and what information is required to be reported. Considering the numerous and diverse reporting arrangements of the different funding streams service providers rely on, the administrative burden of current arrangements is contributing to major inefficiencies in primary care.

Duplication of services

Inadvertent duplication of services within regions has also been reported as a result of the various funding streams and lack of coordination[4]. This causes confusion to consumers and health professionals, ultimately impacting the effectiveness and efficiency of funded programs.

SOLUTIONS

What we observe in Australia is governments applying their stewardship of thin markets in silos (between health, aged care and disability sectors; between levels of government; and between programs within each level of government). Instead, we need collaborative, place-based approaches to longer-term planning, investing in and evaluating of healthcare models.

The operational and governance arrangements of the various government funding streams that local services rely on must be aligned to reduce the burden on health providers, creating efficiencies in the system.

Longer-term funding must be provided to PHNs for local community co-design processes and collaborations with consumers and between sectors to be adequately facilitated.

PRINCIPLE 2: Outcome-based

Traditional approaches of measuring outputs rather than outcomes do not capture elements of quality and safety, nor do they place the person at the centre of the care provided. Recognising this, in recent years PHNs have been striving towards the implementation of value-based health care (VBHC). VBHC is a framework for restructuring health care to focus on facilitating the best possible improvements in the outcomes that matter to people and communities for the cost of achieving those improvements, across a full pathway of care.

VBHC promotes movement away from traditional data and measurement approaches that are solely focused on collecting and analysing process and volume metrics designed to demonstrate adherence to guidelines. Rather, VBHC reorients towards measurement approaches that focus on the outcomes that are important to people, families, and communities, and reflect how people actually experience

care. This shift aligns with the growing movement towards creating a wellbeing economy and measuring what matters.

ISSUES

Impact on community collaboration

For place-based, outcome-focused approaches to care to be achieved, there needs to be true co-design and collaboration within local communities, and between stakeholders from multiple sectors. PHNs can do this well, relying on staff knowledge and relationship building, but co-design processes and the relationships needed for successful collaboration are resource-intensive to maintain.

As such, another impact of the short term funding arrangements outlined previously in this submission is on the local community. In addition to not knowing if they will still be able to access a local health service year on year, consumers and community members can lose trust in the system and become unwilling to lend their time to engage in the collaborative activity and co-design needed to adequately plan, design and evaluate local services.

Lack of data available to effectively measure performance and outcomes

The effective performance monitoring and management of PHNs is limited by the availability of primary care data. The selection of national PHN performance framework indicators has been constrained by the lack of available data, with performance indicators largely reflective of measures that already exist (e.g., from MBS, PBS, AIHW, ABS). This has led to measurement gaps in important areas such as health literacy, cultural safety, patient-reported experiences[5].

In addition, research has suggested that the priorities of PHNs are indirectly shaped by this lack of data, as they are currently incentivised to undertake activities to meet performance indicators[6]. This would not be an issue except that those indicators are currently not fit for purpose due to data availability issues. As Anstey et al. suggest when referring to the national PHN performance framework indicators, 'What gets measured by funders is what gets done'[7].

SOLUTIONS

Health system unsustainability and the structural barriers that exacerbate sub-optimal care have led stewards of the Australian healthcare system, including PHNs, to reorient to a more value-based approach in aspects of health system design and service delivery. Therefore, to accurately measure the impact and progress of PHN activity towards outcomes, the performance management of PHNs should apply a VBHC lens, promoting a nationally unified approach that supports regional flexibility.

However, to effectively manage performance against outcomes, adequate data and digital infrastructure is required. Health data needs to accurately reflect care outcomes and be in the right format, timely, and of sufficient quality to support decisions and inform improvements in performance through all levels of the health system. Implementing the collection of patient reported experience measures (PREMS) and patient reported outcome measures (PROMS), as well as addressing health equity data gaps, is required to effectively measure the performance of PHNs in addressing health outcomes. Interoperable systems must be in place so that linked data, through

national minimum data sets both within and across care systems, can inform care delivery and design.

PRINCIPLE 3: Flexibility

Health services are inextricably linked to the wellbeing of their communities. Their impact is more than just the provision of health care, they also have influence on employment, investment and purchasing decisions within the local community. The decisions that are made about the way health care is provided thereby impacts the safety, vibrancy, and stability of those communities. As such, place-based approaches to health service design and delivery not only recognise that needs vary between communities, but also how assets and resources vary. This is particularly salient to PHNs operating in rural and remote regions, with thin or in some cases no markets, who must adopt innovative ways to ensure people in their communities receive the right care at the right place at the right time (see case study, page 8).

ISSUES

Focus on national rather than local priorities

In some cases, funding arrangements have enforced a focus on national priorities by PHNs which may not reflect local needs. PHN funding for delivery of mental health services is an example of this occurring, with PHNs receiving large amounts of Commonwealth funding in recent years which is quarantined for the commissioning of Headspace services. The preselection of a service provider without accounting for whether the provider is the right service for the region undermines the role of PHNs in delivering care based on an in-depth understanding of local markets and communities. Evidence presented to the 2019 Senate Committee on the Accessibility and Quality of Mental Health Services in Rural and Remote Australia showed how the enforcement of the 'stepped care model' in PHNs role in mental health worked well in metro areas, but was not appropriate to some rural and remote areas[8].

The 2019 final report of the Senate Committee on the Accessibility and Quality of Mental Health Services in Rural and Remote Australia details,

> 'The committee is of the view that the way mental health services are planned and commissioned needs serious review at a national, strategic level. It is not the role of any one PHN, government or organisation to be solely responsible for the planning and coordination of all mental health services in rural and remote Australia. Instead, frequent collaboration is needed between all stakeholders, including representatives of the community, to ensure that the right mental health services are available in the right place at the right time.'[9]

Workforce instability

The impact of short-term funding arrangements outlined previously in this submission (page 3-4) has wider effects on the available workforce, as with insecurity in funding comes insecurity in employment for health professionals. Lack of a diverse health workforce in thin markets and contractual obligations which specify the type of health professionals required to deliver a certain service, without providing flexibility, often mean that service is not delivered even when it is needed,

and it is possible for other health professionals to deliver it or a component of it within a different model.

Clinical governance

How clinical governance is managed by the Commonwealth and PHNs needs to be reviewed. Currently, Commonwealth contracts and funding obligations can actively influence clinical governance, which can stifle flexibility in the way that PHNs can commission local service providers and can contribute to uncertainty around the PHN's responsibility in clinical governance.

SOLUTIONS

Place-based flexibility is important in designing innovative models of care, with flexibility needed both in the way funding is used as a policy lever and in how skill-mix changes and workforce reform can support new models of care. Flexibility in program design and delivery can also be achieved through good clinical governance and outcome-focused evaluation, rather than prescriptive inputs defined in funding contracts.

The Commonwealth should facilitate the development of an evaluation model that is outcomes-focused and facilitate the diffusion of ideas within and between sectors through the development of standardised frameworks for evaluation. A framework is needed that not only identifies the outcomes achieved, but reflects the contextual factors on which those outcomes were dependent.

Meeting the local needs of communities must be prioritised above applying national approaches, with PHNs allowed sufficient flexibility to address national priorities using place-based approaches.

PHNs must be supported through the provision of time, resources and commitment for place-based approaches through a single, longer-term plan for a region's health system. Collaboration between Local Hospital Districts (LHDs[1]) and PHNs, and more broadly with service providers, consumers and other stakeholders, must be routine and resourced.

CONCLUSION

The indicators by which the performance of PHNs is measured are not fit for purpose, as they do not reflect the principles and objectives of the *PHN Performance and Quality Framework*. The lack of available primary care data is a significant contributor.

- The DHAC should lead initiatives to develop a national primary health minimum dataset. The right data needs to be made available to the right people at the right time and reflect the outcomes that matter to people and communities.

The implementation of the PHN program has inadvertently created high administrative burdens on health services and short term funding arrangements have contributed to economic and workforce instability in rural and remote regions.

[1] Also Local Hospital Networks (LHNs) and Hospital and Health Services (HHS).

- The DHAC should work collaboratively with the National Disability Insurance Scheme, Department of Social Services, and State and Territory governments to align the administrative and governance arrangements of the various funding mechanisms health services receive and progress a longer term approach to funding programs.

The performance management of PHNs does not capture outcomes and impact aligned with the shift towards value-based health care and a wellbeing economy.

- The DHAC should partner with the Australian Centre for Evaluation to develop an evaluation model that can be applied to PHN programs and initiatives to measure value and outcomes.

PHNs are not adequately resourced to undertake collaboration activities with other sectors and community co-design. In addition, meeting the local needs of communities must be prioritised above single national approaches, with PHNs allowed sufficient flexibility and support to address national priorities using place-based approaches.

- The provision of additional funding and updated governance arrangements are needed to properly support PHNs to meet their ambitious objectives and functions.

Case study – Healthy Outback Communities[10]

The very remote western corridor of Western Queensland, an isolated region that spans 220,000 sq km, equivalent to the size of Victoria, faces significant health and wellbeing challenges, with the average life expectance of the Aboriginal and Torrs Strait Islander population, 52 and the non – indigenous population, 54. Current service delivery does not adequately meet the essential needs of the 1,100 residents of these communities due to the absence of resident GPs, pharmacist and dedicated healthcare professionals.

To address this the Western Queensland PHN has developed the Healthy Outback Communities (HOC) a new, collaborative model of health and social care that aims to improve health access, equity, and outcomes in the very remote Western Queensland.

The model aims to build health and wellbeing through:

- Engagement – Transformational approach underpinned by co-designed individual and community wellbeing plans. Culturally- sensitive inclusive engagement focusing on universal wellbeing models.
- Navigation – Harnessing technology to reduce isolation. A virtual wellbeing hub provides continuity of wellbeing with clinical back up.
- Access - Workforce solutions that build local capacity through new ways of working with social prescribing consolidating local improvement. Improved inter-team collaboration and knowledge sharing.

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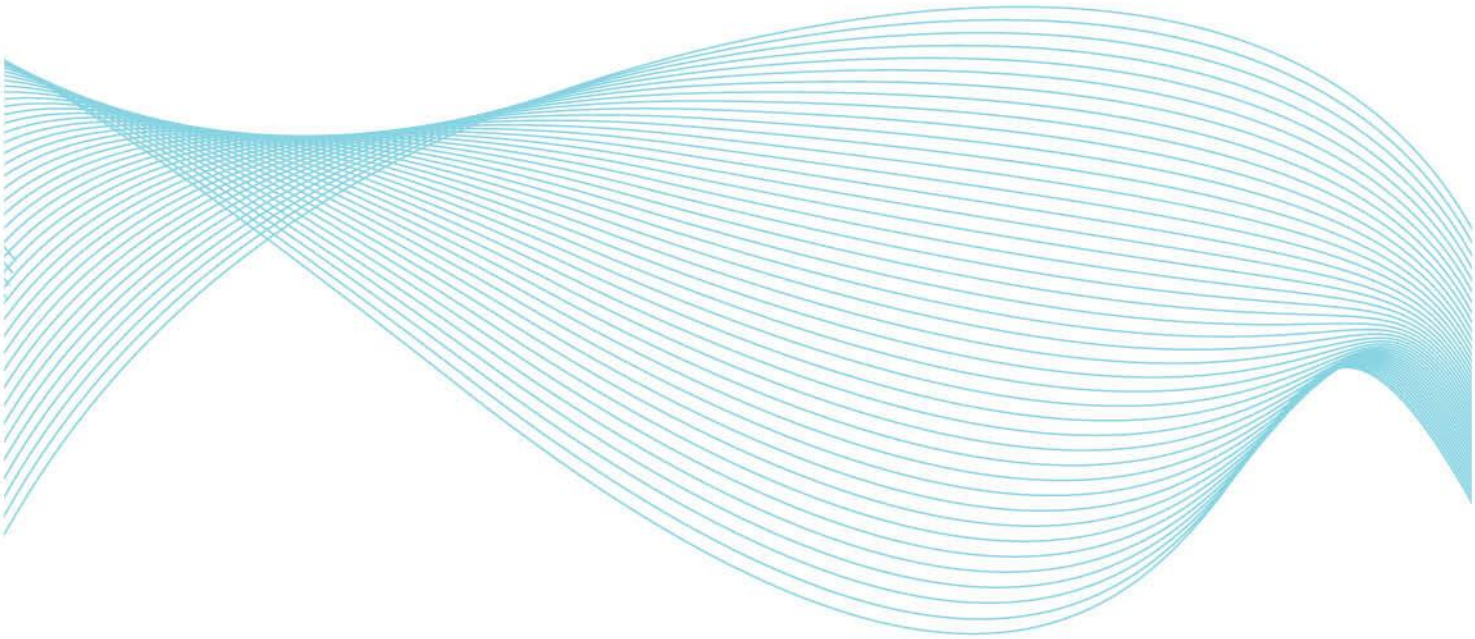

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