



Submission from

**COORDINARE - South Eastern NSW
Primary Health Network**

To the Productivity Commission:
Mental Health Draft Report

January 2020

CONTENTS

- 1. EXECUTIVE SUMMARY 3
- 2. ROLE OF COORDINARE - SOUTH EASTERN NSW PHN..... 5
 - 2.1. Achievements of COORDINARE in mental health care services 5
- 3. TIMELINE REQUIRED FOR MENTAL HEALTH REFORM..... 6
- 4. COORDINARE IS SUCCESSFULLY PARTNERING WITH LHNs: THE REPURPOSE MODEL 7
 - 4.1. Strong collaborative relationships and governance arrangements..... 7
 - 4.2. Co-commissioning arrangements in health care..... 8
- 5. THE REBUILD MODEL WILL REINFORCE SILOS AND HINDER REFORM 9
 - 5.1. Rebuild model will lead to loss of momentum and workforce experience..... 9
 - 5.2. Rebuild model will deepen and reinforce the silo between physical and mental health 9
- 6. REGIONAL COMMISSIONING MUST REMAIN INDEPENDENT TO BE EFFECTIVE 11
 - 6.1. State/ territory government RCAs would stifle innovation..... 11
 - 6.2. RCA funding would be at risk of state/ territory government budget cuts..... 12
- 7. PHN MODEL ENCOURAGES SUSTAINABILITY, FLEXIBILITY & ACHIEVEMENT OF OUTCOMES..... 12
- 8. THE PHN GP PSYCHIATRY SUPPORT LINE 13
 - 8.1. Rationale for PHN GP Psychiatry Support Line..... 14
 - 8.2. Costs of PHN GP Psychiatry Support Line 14
- 9. CONCLUSION 15

1. EXECUTIVE SUMMARY

The Productivity Commission's suite of proposed reforms outlined in the *Mental Health Draft Report* (released 31 October 2019)¹ that emphasize the importance of the primary health system and a stepped care approach to mental health care are welcomed by COORDINARE - South Eastern NSW Primary Health Network (PHN). We are also pleased that the Productivity Commission supports a move towards regional commissioning, rather than centralised planning and delivery. We also support the recommendation to establish a Mental Health Innovation Fund, which could encourage the trialling of innovative models of care and funding models such as capitation or bundled payments.

The PHN national body, the PHN Cooperative, has provided a comprehensive submission to this inquiry and has responded to specific recommendations and requests for information regarding integrated care, the incentives driving provision of mental healthcare services, workforce issues, data and evaluation, and MBS funding reform. We would also like to particularly reinforce the PHN Cooperative argument that PHNs are specifically funded to implement a person-centred, stepped care framework of mental health care, which by its very nature reduces avoidable hospital admissions.

COORDINARE supports the PHN national response to the *Draft Report*, including the alternative '**Repurpose**' model they have outlined that involves a closer collaboration between LHNs and PHNs as well as other regional stakeholders.

This COORDINARE submission is supplementary to the national PHN Cooperative submission; we have taken this opportunity to expand on mental health care service provision in the South Eastern NSW region and provide more detail regarding our particular local context. COORDINARE is grateful for the advice and input from people with lived experience of mental health issues, including people with lived experience from the Aboriginal community which informs and influences our approach to achieving integrated health care across our region.

South Eastern NSW has relatively high rates of mental health issues, behavioural disorders and psychological distress among its population, with a greater burden borne by Aboriginal people and people living in rural areas. Extensive community consultation has given us insight into the inequitable distribution of services across our region.

In this submission we emphasize the achievements and successes to date of COORDINARE in commissioning mental health services and our ability to provide innovative solutions as part of a person-centred, stepped care framework and in response to our local needs. We have provided evidence of our **agility and flexibility**, for example in providing mental health services in response to the recent NSW bushfire crisis, and the importance of the **GP Psychiatry Support Line** which provides GPs with quick telephone access to specialists for advice regarding best practice treatment. This initiative also has the added benefit of increasing knowledge at the primary care level, and reducing the need for further referral to specialists, and unnecessary hospitalisations. Importantly, PHN-commissioned services are unique in that they are **routinely monitored for outcomes** and effectiveness, whereas those that are subsidised by MBS billing such as Better Access are only required to report on activity.

As an alternative to the models proposed by the Productivity Commission, the Repurpose model described by the PHN Cooperative aligns well with COORDINARE's **existing strong governance and collaborative arrangements** with our LHNs; we have already put in place the governance structures with each LHD that are needed to jointly implement solutions to local health care issues. COORDINARE has also successfully co-funded mental health services, and co-commissioned health services with our partner LHNs. Therefore, implementing the Repurpose model in our area would involve very little disruption to the health care workforce and service delivery.

We are particularly concerned that the *Draft Report* proposal to move mental health funding to a state/territory government-funded Regional Commissioning Authority (the Rebuild model) would have serious implications for the primary health care sector and for people living with mental health issues

¹ Productivity Commission (2019). *Mental Health Draft Report*. Australian Government: Canberra.

and the wider community. PHNs have had just over two years to implement the initiatives outlined in the Commonwealth Government's reform agenda; any restructuring of the system so soon would seriously **damage the reforms gained** so far and have a deleterious impact on the mental health and commissioning workforce due to change fatigue and ongoing uncertainty.

By moving mental health provision into state-based RCAs, and away from the primary health care sector, the **silo between mental and physical health** would be deepened and reinforced. PHNs were established by the Commonwealth Government as 'meso level organisations' in order to cut across silos and enable delivery of coordinated and integrated services between macro level government agencies and **micro level providers and organisations**. Moving mental health funding to the state-governed RCA and away from meso organisations with integrating and coordinating ability would further reinforce the fragmentation of this system.

It is essential that regional commissioning remains in the hands of **independent organisations** in order to be effective, rather than controlled by state/ territory governments. Governments are notoriously risk-averse, and are primarily incentivised to spend money on acute care to reduce hospital waiting lists. On the other hand, PHNs are arms' length from large bureaucracies and service provision, and have a history of implementing **innovative solutions** and funding services which carry some risk as they address the existence of 'thin markets,' long lead times, populations that are difficult to reach due to physical isolation, for cultural reasons or because they are at-risk of serious health issues or have high needs. The Rebuild model would also risk entrenching the **funding inequity** that currently exists between the states and territories.

We do not believe that the *Draft Report* has provided enough justification for the substantial and disruptive changes that would ensue under the Rebuild model, and we encourage the Productivity Commission to provide more information and stronger evidence that they have considered the **unintended consequences and perverse incentives** that will be caused by the change in funding and governance arrangements. We also recommend that the Productivity Commission examines how the Rebuild model could ensure greater equity across the states/ territories regarding mental health care funding, how it would overcome **entrenched issues of federalism** and ensure that the reforms would be sustainable in the long-term.

Dianne Kitcher

Chief Executive Officer

1300 069 002

CEO@coordinare.org.au

2. ROLE OF COORDINARE - SOUTH EASTERN NSW PHN

South Eastern NSW has relatively high rates of mental health issues, behavioural disorders and psychological distress among its population, with a greater burden borne by Aboriginal people and people living in rural areas. Extensive community consultation has given us insight into the inequitable distribution of services across our region.

Mental health is a key strategic area for COORDINARE. As an independent organisation, COORDINARE commissions **innovative health services** that meet the identified and prioritised needs of people in our region and to address **identified gaps** in primary health care services. Working closely with our GP-led Clinical Councils, our Community Advisory Committee, and through our strategic alliances with two Local Health Networks (LHNs), the Aboriginal Community Controlled Health Services in our region, and other stakeholders, **we act as change agents** to set clear local priorities and implement strategies to implement the national mental health reform agenda. Working with our providers to ensure data capture of service delivery and outcomes, as part of a continual process of **monitoring and evaluation**, is a key feature of ensuring our commissioned services demonstrate their effectiveness. COORDINARE commissions health related services, focusing on those most at-risk of poor health outcomes, rather than providing health services directly.

COORDINARE works at four levels within the health system to achieve person-centred care:

1. **Involving consumers** including people with lived experience of mental health issues, in decision-making and co-design of services both at an individual level – around people’s own health, treatments and management, and at an organisational level – around policy development, service design, delivery and evaluation.
2. **Supporting general practice** as the cornerstone of primary care through: helping GPs unlock the potential in their own practice data to better understand community health needs; supporting GPs to access and use the latest technology (e.g. telehealth services); working with GPs to improve the quality of care; and supporting GPs to help people make necessary lifestyle changes and manage their own conditions.
3. **Working within local communities** to understand local needs and to ensure we commission services which improve outcomes for at-risk, high needs groups.
4. **Building system enablers and designing service improvements** to optimise pathways for consumers and coordinate their care. This involves bringing together general practice, hospitals and other providers to develop better ways to coordinate the care of people who receive care from multiple providers, and working with Local Hospital Networks (LHNs) to use benchmarking and other performance data to focus system improvement efforts.

2.1. Achievements of COORDINARE in mental health care services

Since the mental health flexible funding pool was transferred to PHNs in July 2016, COORDINARE has successfully commissioned a range of innovative solutions designed to cover gaps in mental health care services that are appropriate for our region and co-designed with community representatives and health care providers. For example, since July 2016, COORDINARE has:

- Conducted a comprehensive needs analysis of mental health service requirements in the local area.
- Developed and commenced implementation of a Regional Mental Health and Suicide Prevention Plan with two LHNs.
- Successfully commissioned a range of mental health services in alignment with our locally-developed stepped care continuum and based on local needs and consumer input (eg. Aboriginal mental health services, digital ehealth coaching services, headspace services, a complex mental health integrated recovery service, aftercare support services for people who have attempted suicide, non-NDIS psychosocial support services and telehealth counselling services for children).

- Increased access to and appropriateness of services for people in rural areas where there are ‘thin markets’ and for underserved population groups such as Aboriginal communities. This includes reallocating resources to underserved areas and investing in alternatives to face-to-face services such as telehealth and app-based therapies.
- Successfully commissioned a range of services that involve peer workers in the provision of services and supports including a physical health coaching service (Neami National), a suicide prevention after-care service (Next Steps), an integrated recovery service for people with complex mental health needs, and a psychosocial recovery program for people not eligible for NDIS (Flourish Australia). A dedicated mental health peer worker coordinator has been employed to work closely with commissioned providers and their peer workers.
- Partnered with six other PHNs to establish a GP Psychiatry Support Line to enable GPs to obtain specialist advice regarding mental health conditions with close to 25% registration to the service by GPs. The service has expanded to currently include eight PHNs and has also increased the number of GPs registered from 774 registrations in December 2018 to 1,816 registrations by the beginning of December 2019.
- Up-skilled primary health staff and service providers in the use of ehealth platforms such as My Health Record, HealthPathways and Primary Mental Health Care Minimum Data Set reporting requirements.

In addition, we have very recently developed a bushfire response plan regarding primary care and mental health services, demonstrating our quick and agile ability to respond appropriately to rapid and emerging local needs (see case study in Section 7).

3. TIMELINE REQUIRED FOR MENTAL HEALTH REFORM

The National Mental Health Commission’s 2014 review of mental health programs and services ‘*Contributing Lives, Thriving Communities,*’ and the Australian Government response to the review (released November 2015), both highlighted the existing complexity, inefficiency and fragmentation of the mental health system and acknowledged that a long term commitment to continuing reform would be required to achieve sustained and systemic reform to mental health programs and services.

As the *Draft Report* has noted,² PHNs and other stakeholders are only mid-way through implementing the reform agenda outlined in the *Fifth National Mental Health and Suicide Prevention Plan*, which was agreed to on 4 August 2017 and established a national approach for collaborative government effort covering the period **2017 to 2022**. The PHNs were established in **2015** by the Australian Government as a key element in their strategy to fund independent meso level organisations that bridge the Commonwealth/ state health care divide and improve the efficiency and effectiveness of primary health care. PHNs were further strengthened in the government response to the National Mental Health Commission (NMHC) report, *Contributing Lives, Thriving Communities*, which supported and extended the role of PHNs in delivering person-centred stepped care to local communities.

In July **2016**, the role of coordinating mental health services was devolved to PHNs when funding from a number of centrally held programs (ATAPs etc.) was consolidated to form the mental health flexible funding pool. The first phase of this transition involved **a year of prescribed service continuity**. The *Fifth Plan* was then developed and released in August 2017. Therefore, PHNs are realistically just over **two years** into our reform journey to implement the suite of reforms described by the *Fifth Plan* and the Australian Government’s response to ‘*Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services*’.

A recent evaluation of PHNs conducted by Ernst and Young concluded that despite their infancy, PHNs are “maturing at an appropriate rate” and are “bringing value to the system by proactively working to

² *Draft Report*, Section 1.5, pg. 131

help improve service integration and address health service needs and gaps.”³ In addition, leading health academics have concluded that PHNs currently provide the only possibility for delivering meaningful reform to the primary health care system, and have applauded the “examples where local innovative efforts are responding to local needs, led by local expertise and making a difference to community outcomes.”⁴

4. COORDINARE IS SUCCESSFULLY PARTNERING WITH LHNs: THE REPURPOSE MODEL

RESPONSE TO DRAFT REPORT SECTION 23.2: CO-COMMISSIONING ARRANGEMENTS

The *Draft Report* has highlighted that a few PHNs have struggled with establishing relationships with their LHNs and will face barriers in forming successful co-commissioning relationships.⁵ Although this may be an issue in a few regions, the majority of PHNs, including our own in the South Eastern PHN region, have established mature, productive relationships with their partner LHNs. This has enabled us to successfully develop collaborative, joint-funded initiatives as well as co-commission health services with our two LHNs and other stakeholders.

In its submission to this inquiry, the PHN Cooperative has outlined an alternative funding and governance model to those proposed by the Productivity Commission. The **Repurpose model** proposes that PHNs and LHNs (and potentially other key stakeholders) join together to create a ‘**Regional Commissioning Function**’, with an agreed shared governance structure, in order to develop an informed regional plan and investment strategy regarding the implementation of place-based health care systems to improve the health of the communities they serve. The Repurpose model aligns well with COORDINARE’s existing relationships and governance arrangements. Therefore, implementing the Repurpose model in our region is achievable in a timely manner and would involve very little disruption or cost to the existing health care workforce and service provision.

4.1. Strong collaborative relationships and governance arrangements

COORDINARE’s approach to achieving improved health outcomes for our community is based on a strategy of developing **ongoing and collaborative relationships** with service providers and funding partners: we work together to ensure that projects are successful and that contracted deliverables and quality standards are monitored and achieved. As such, COORDINARE has established strong, effective relationships with our two LHNs, primary health care providers, community health services, and Aboriginal Community Controlled Health Organisations.

Importantly, we have **already put in place the governance structures** with each LHN that are needed to jointly implement solutions to local health care issues. Our governance structures formally establish our collective roles and responsibilities and provide appropriate oversight for the management of projects that involve pooled funding or shared resources. Our mutually developed and agreed Integrated Care Strategy, supported by MOUs and executed agreements, encompass arrangements that clearly outline the expectations, outcomes and mutual accountability of each organisation in order to deliver health benefits to our communities. Formal governance and reporting structures are in place with regular briefings held at the Board, executive and operational level to share lessons learned and ensure that service response implementation is as effective as possible.

For example, COORDINARE has signed a separate **Integrated Care Strategy** with each of our LHNs which promotes clinical leadership and ensures that health services are coordinated across the continuum of care, and are safe, high quality, accessible, timely and efficient. Our three Boards have also entered into a tripartite **Mental Health and Suicide Prevention Plan** (see case study below).

³ UNSW, Monash University and Ernst & Young (Australia). (2018) *Evaluation of the Primary Health Networks Program – Final Report*. UNSW: Sydney.
[www1.health.gov.au/internet/main/publishing.nsf/Content/69C162040CFA4F7ACA25835400105613/\\$File/PHN%20Evaluation%20Final%20Report.pdf](http://www1.health.gov.au/internet/main/publishing.nsf/Content/69C162040CFA4F7ACA25835400105613/$File/PHN%20Evaluation%20Final%20Report.pdf)

⁴ Russell L, and Dawda P. (2019). *The role of Primary Health Networks in the delivery of primary care reforms*. Retrieved from Analysis and Policy Observatory Website: <https://apo.org.au/node/220956>

⁵ *Draft Report*. Section 23.2, pg 941-943.

CASE STUDY: South Eastern NSW Regional Mental Health and Suicide Prevention Plan

COORDINARE led the development of the first joint South Eastern NSW Regional Mental Health and Suicide Prevention Plan, in collaboration with our two LHN partners, Illawarra Shoalhaven LHD and Southern NSW LHD. The Plan is a blueprint for collaborative action for mental health service development over five years and is based on a stepped care approach to provide a continuum of interventions that are required to most efficiently provide support to people based on their level of need.

Our commitment to work together to improve mental health services for our communities began in 2016, with the CEOs of all three organisations agreeing to make mental health one of two joint regional priorities. Subsequently, developing a Regional Mental Health and Suicide Prevention Plan became a requirement for PHNs and LHNs under the *Fifth National Mental Health and Suicide Prevention Plan*. As a result, South Eastern NSW was the first region in NSW to have this plan approved by the three respective Boards (in December 2018).

Consumers are at the centre of our Plan, from the development through to implementation and ultimately evaluation. Three people with lived experience of mental health issues were an integral part of the working group overseeing development of the Plan from the very beginning. Formal implementation of the Plan has commenced and has been expedited with the employment of a dedicated implementation coordinator. The initial planning working group has evolved into an Implementation Coordination Committee, with broader representation being sought.

Already the Plan is making a difference locally. We have been able to build on our strong relationships and shared commitments to jointly and quickly roll out important new initiatives for people living with mental health conditions, including psychosocial support, psychological services for residents of aged care facilities, and drought support initiatives. This will also include implementation of the recently announced bushfire recovery initiatives. The tripartite partnership has also received funding from the NSW Ministry of Health to develop a **Peer Workforce Framework** for use across the state. This recognises both the commitment of our three organisations to growing the consumer-led peer workforce as well as confidence that our local collaboration can deliver initiatives worthy of statewide application.

4.2. Co-commissioning arrangements in health care

COORDINARE has also begun to **co-commission health care** services with our partner LHNs (see text box below). **Commissioning** involves a strategic approach to purchasing services from providers, using information gathered from our needs assessments, which includes hard data as well as consumer input, and analysis of local provider markets. The commissioning model, based on evidence from the United Kingdom and New Zealand, is designed to **build the momentum for reform** from the ground up by commissioning innovative services and supporting the redesign of systems. Our success achieved to date of co-commissioning health care services, built on our strong relationships with our local stakeholders, means that **extending the co-commissioning model** to the mental health care sector is highly likely to be successful.

CASE STUDY: Co-commissioning health services with LHNs

COORDINARE has commenced building our capabilities in **co-commissioning**, drawing on the learnings from the United Kingdom and New Zealand. For the South Eastern NSW region, we have pooled funding and made strategic investment in several projects with the two neighbouring LHNs. This has resulted in the co-commissioning of a number of joint ventures, for example, the **Connecting Care Program** with Illawarra Shoalhaven LHD and pooled resources for the **drought response in Southern NSW**. We are finalising our proposal for funding support from the NSW Ministry of Health for a proposed tripartite co-commissioning approach involving the PHN and two LHNs for a **virtual care coordination model** to facilitate improved health outcomes across the region.

As an example, **the Connecting Care Program** was designed by NSW Health to provide care coordination and self-management support to help people with chronic disease to better manage their condition and access appropriate services. The program aims to improve health outcomes, prevent complications and reduce the need for hospitalisation. While the program is a state-wide initiative, implementation models are localised and COORDINARE has co-commissioned local implementation of the Connecting Care Program with Illawarra Shoalhaven LHD.

The two parties have successfully developed and implemented a joint governance approach to implementing the commissioned service, where all parties foster a commitment to system leadership and accountability for system change and to achieve outcomes.

5. THE REBUILD MODEL WILL REINFORCE SILOS AND HINDER REFORM

RESPONSE TO DRAFT REPORT INFORMATION REQUEST 23.1 — ARCHITECTURE OF THE FUTURE MENTAL HEALTH SYSTEM

One of the most significant recommendations made in the Productivity Commission’s *Draft Report* is to present two possible reform models (the Rebuild model and the Renovate model). COORDINARE is particularly concerned that the Productivity Commission has not provided a strong enough justification for the major changes to the mental health care sector that would ensue under their preferred **Rebuild model** – in which mental health care funding would be held in regional funding pools controlled by each state/ territory government and administered by Regional Commissioning Authorities (RCAs). We have outlined some of the **unintended consequences and perverse incentives** that would be created if funding and commissioning responsibility was transferred to state/ territory governments (outlined in Sections 5.1 and 5.2 below) and why regional commissioning should remain in the hands of independent organisations (Section 6).

5.1. Rebuild model will lead to loss of momentum and workforce experience

Importantly, moving resources to a Rebuild model, would discard the years of expertise and market development that have been achieved to date by PHNs and key stakeholder partners. COORDINARE is concerned that the Productivity Commission has not considered the **timeline required** for significant mental health reform, and that any restructuring of the system would significantly **disrupt the reforms gained** so far and would seriously risk losing **skilled members of the workforce due to change fatigue and ongoing uncertainty**. The damage this would cause to our sector, that has already undergone several recent rounds of reform and restructure, would be long-term and have far-reaching implications. In addition, Commonwealth-state joint initiatives as described by the Rebuild model, would take years to negotiate, and once established, are difficult to redirect. Establishing the Rebuild model would further delay reforms, in reality by several years.

There is also ongoing concern that some mental health services are struggling to survive after their funding was shifted to the National Disability Insurance Scheme, despite being designed to serve a wider group than the 64,000 people with psychosocial disabilities thought to be eligible. PHNs have been commended for picking up some of the funding responsibility for services for people deemed ineligible for NDIS funding who were previously eligible for the funding schemes Partners in Recovery (PIR), Support for Day to Day Living, and Personal Helpers and Mentors (PHaMs). Despite the efforts of PHNs to overcome the funding issues, the workforce is considered fragile and at risk of collapse due to the confusion regarding the NDIS eligibility for their clients and the short contract timeframes for the providers.

5.2. Rebuild model will deepen and reinforce the silo between physical and mental health

It has been well established that adults with severe mental health issues have a higher burden of multiple and chronic conditions but also have poorer access to general health care compared to people without mental health issues. Because a key contributor to this situation is the separation between the mental health care and the general or physical health care sector, bridges to connect these two areas of the health system need to be reinforced and strengthened.

The United Kingdom, Canada, New Zealand, and more recently Australia, have devolved power to local meso level health care organisations in order to break down silos by facilitating better health system integration, coordination of care and health system planning. **Meso level** organisations are positioned between government agencies (**macro level**) and **micro level individual providers and organisations** who provide services directly to patients and other service users. Primary health care providers (micro level organisations) such as general practitioners, and private specialists such as psychologists and psychiatrists, operate as small and independent businesses.

PHNs were established by the Commonwealth Government as meso level organisations to build on the work of their predecessors, Medicare Locals and Divisions of General Practice, in order cut across silos

and enable delivery of coordinated and integrated services across the different levels of the health system.

By moving mental health provision into state-based RCAs, and away from the primary health care sector, the silo between mental and physical health would be further entrenched. The Rebuild model would reinforce the fragmentation of the health care system as well as reinforce the gap between general practice and hospital-based services.

As meso organisations, PHNs are uniquely placed to integrate and coordinate primary health care services for the following reasons:

- PHNs have been established specifically to become the **experts in commissioning** primary care services, including primary mental health services. Our expertise in this area has been developed over the previous years; this expertise would be lost if funding was moved to a new RCA body.
- A critical aspect of our work involves a **close link with general practice**, which is where the majority of care is delivered, both physical and mental, and includes preventative through to curative care. General practice is also where physical and mental health issues are treated together. PHNs work closely with general practitioners to build the capacity of primary health care services to enable the delivery of high quality, integrated and coordinated patient care and health outcomes. General practitioners are represented on the boards of all PHNs and have a **strong leadership role** in the commissioning of services including coordination services. Shifting commissioning responsibility to state/ territory governments would break the connection with GPs and local commissioning and reduce the importance and leadership role of GPs as a cornerstone of primary mental health care services.
- We commission services that are informed by the needs identified by people with **lived experience of mental health issues**, as well as by evidence-based data, so we are well placed to ensure that people receive care in the community that they require, rather than in hospitals. In contrast, state-based health systems are the experts at providing bed-based, secondary and tertiary acute care. State-based systems are highly specialised and treat people by condition or speciality rather than as a whole person. Shifting commissioning responsibility to state/ territory governments would therefore run a significant risk of increasing the focus on secondary and tertiary care, and the further distancing consumers from primary holistic care.

This would further increase the risk of **diminishing incentives** to provide out of hospital care – state health authorities have a long established history of NOT being able to achieve shifts to out of hospital care because the entire system is designed around the provision of acute care in hospitals.

CASE STUDY: HealthPathways portal integrates physical and mental health

Part of the challenge of developing an effective mental health system is care coordination and integration, both within the system and holistically across different services. PHNs work with GPs and LHNs to map local navigation pathways between services to ensure appropriate referrals are made. The HealthPathways online portal provides information to GPs and other clinicians about local referral pathways.

COORDINARE manages two different HealthPathways partnerships; one covers clinical referral pathways across Southern NSW and ACT, and the other for the Illawarra Shoalhaven region. Both partnerships have a small team of staff who undertake program management and oversee the continuous process of updating the online portal. COORDINARE has also employed approximately 10 GPs on a part-time basis to undertake service pathway mapping and clinical editing. For example, the HealthPathways online platform has been rapidly updated in response to the bushfire crisis in our region, in particular for referral pathways relating to burns, respiratory illness, disaster management and trauma.

Importantly, HealthPathways includes both mental and physical health care referral pathways; this reduces the silos that exist between the two paradigms. Splitting mental health care into a separate state-funded Regional Commissioning Authority would risk disconnecting these two systems and widen the silo between physical health and mental health.

6. REGIONAL COMMISSIONING MUST REMAIN INDEPENDENT TO BE EFFECTIVE

RESPONSE TO DRAFT REPORT INFORMATION REQUEST 23.1 — ARCHITECTURE OF THE FUTURE MENTAL HEALTH SYSTEM

6.1. State/ territory government RCAs would stifle innovation

The importance of PHNs as meso level organisations that are independent from both state/ territory governments and service providers cannot be overlooked. **Independence from service delivery** was seen as an essential component of PHN architecture by the Horvath review when recommending the transitioning from Medicare Locals.⁶ The Horvath review recommended that commissioning bodies should only become service providers where there was a “demonstrable market failure, where services do not exist or where there is insufficient access to services” which is essentially how PHNs operate. PHNs also operate and **create competitive markets** that are answerable to consumers and stakeholders, who form an integral component of the structure of PHNs (through board representation, co-design of services and systems as well as a process of ongoing community consultation).

PHNs are **change agents**, and have responsibility for developing and trialling **innovative services**. We operate in an environment of carefully considered and managed risk. PHNs work closely with state-governed LHNs as influencers to encourage them to co-commission projects of particular value to their local areas. If services are not found to be effective, PHNs are able to decommission them. An essential component of evaluation is monitoring for effectiveness.

Governments are **notoriously risk averse**. As many inquiries and reviews have confirmed, governments and their departments operate in a ‘zero risk’ environment.⁷ Innovation and cultural change are difficult to undertake. The Commonwealth Government has recognised the need for innovation in the health sector and placed the responsibility for trialling innovative or higher risk projects in the hands of independent commissioning organisations - the PHNs. Moving to a state-governed RCA would stifle innovation and increase the risk of not implementing services that are aimed at difficult to reach population groups.

In addition, PHNs have clear **organisational aims and priorities**. State/ territory governments have many competing interests and aims. PHNs can take on projects that have a strong evidence base but may be politically sensitive for governments.

It is important that commissioning initiatives involve a **consensus among parties**, rather than forced agreement. Consensus is difficult and takes more time, but ultimately leads to more sustainable initiatives. In negotiating with stakeholders, the smaller size of PHNs is actually an advantage - we come to the table as **equal partners**, rather than using a traditional ‘command and control’ approach to procurement of services.

NGOs and independent organisations take on the responsibility for trialling and evaluating innovative approaches to health care. Ideally, the most successful of these, which have clearly demonstrated outcomes, **can then be transitioned to governments** or other agencies to conduct as routine health care. As time progresses, PHNs will develop a greater ability to influence our stakeholders and will effect more change in the difficult sphere of mental health care.

To gain more ability to influence we need **time** to prove that the change implemented works with a clear and deliberate plan to translate and scale up success, **evidence** that the initiatives are effective and the **trust** of the community, providers and government which will flow from our knowledge of the local health systems as well as from our independent status.

⁶ Horvath, J. (2014). Review of Medicare Locals: Report to the Minister for Health and Minister for Sport.

⁷ Most recently: Independent Panel of the APS review (2019). *Our Public Service, Our Future. Independent Review of the Australian Public Service*. Commonwealth of Australia: Canberra. Pg 80-82.

https://www.pmc.gov.au/sites/default/files/publications/independent-review-aps_0.pdf

6.2. RCA funding would be at risk of state/ territory government budget cuts

The Productivity Commission has suggested that states have a financial incentive to increase out-of-hospital/ community care. However, this ignores the political reality that state/ territory governments are primarily incentivised to reduce hospital waiting lists by providing more acute care services, rather than looking at innovative, community-based models. Even as recently as last year, several state and territory governments cut funding to their community and prevention mental health services.⁸

Shifting to a state-based funding system could reinforce the inequities in funding between the states and territories that already exist. In 2016/17, Western Australia (WA) had the highest per capita funding mental health services (\$305 per person); the state with the lowest amount (Victoria) allocated 30% less towards mental health services per capita than WA, at only \$206 per person.⁹ It would be difficult for the sector to monitor the total volume of budget cuts and cost-shifting across the eight main states and territories in order to ensure equity of access for people living with mental health issues in each area.

The funding for each RCA would be subject to the policy priorities and therefore directives of their respective state or territory government. The Rebuild model also carries the risk of cost-shifting across the system. In addition, as recently as last year, the NSW Government complained about the difficulties in negotiating state-federal initiatives and called for a review of state-federal funding arrangements.¹⁰ We recommend that the Productivity Commission examines how the Rebuild model will ensure equity across the states/ territories regarding mental health care funding, overcome entrenched issues of federalism and ensure that Commonwealth-state negotiations could occur in a timely manner and be sustainable in the long-term.

7. PHN MODEL ENCOURAGES SUSTAINABILITY, FLEXIBILITY & ACHIEVEMENT OF OUTCOMES

PHNs are funded by the Commonwealth Department of Health to coordinate and strengthen the health system in their local region. PHNs commission services that are not merely designed to provide services but are designed to **build capacity and grow markets** in each local area. Based on the commissioning model, PHNs are flexible and able to respond rapidly to local issues. A systems approach to health care planning brings together a large number of stakeholders to collaborate and purchase integrated 'place-based' services to deliver desired outcomes. Importantly, PHN-commissioned services are unique in that they are **routinely monitored for outcomes and effectiveness** whereas those that are subsidised by MBS billing such as Better Access are not required to monitor and report on outcomes. Routine monitoring also means that PHN services can be decommissioned if they are not found to be adequately meeting local needs. The importance placed on monitoring and achievement of outcomes is critical to ensure the effective use of tax-payers' money.

A key component of commissioning is its **flexibility** in response to both expected and unforeseen local needs, for example in response to the recent bushfire crisis in NSW (see text box below). Our local work helped to inform the Australian government funding package that has just been announced. We are now the implementation mechanism for Commonwealth funding in our area that will increase access to tailored mental health services and small grants for community connectedness and recovery. We are also playing a large role in supporting other providers, by determining what has been the impact on general practice and other primary care providers, and how we can support them in increasing capacity and aligning to bushfire related needs.

⁸ For example: Tasmania 2019 Budget: www.miragenews.com/government-fails-to-rule-out-further-cuts-to-adolescent-mental-health-services/. WA 2019 State Budget: www.newsport.com.au/2019/july/letter-the-liberals-cant-be-trusted-with-mental-health/. Qld: www.newsport.com.au/2019/july/letter-the-liberals-cant-be-trusted-with-mental-health/

⁹ Australian Institute of Health and Welfare (2019). *Mental health services in Australia*. AIHW: Canberra. www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/specialised-mental-health-care-facilities

¹⁰ www.theguardian.com/australia-news/2019/jun/20/nsw-revolts-against-commonwealth-and-states-cost-shifting-mess

CASE STUDY: Enhanced Primary Care Support Plan for Bushfire Recovery

The recent bushfire crisis has had an unprecedented and catastrophic effect on South Eastern NSW.

Because of the strong collaborative partnerships that COORDINARE has already established in our region, including with primary care organisations, LHNs, service providers, community groups, and non-health agencies, we were able to rapidly and effectively compile and implement the **Enhanced Primary Care Support Plan for Bushfire Recovery in South Eastern NSW** in response to the recent bushfire crisis, which has a strong emphasis on mental health support for those affected. This plan has built on our experience with the Tathra bushfires as well as our work in supporting drought affected areas.

COORDINARE had identified that increased demand for mental health services, as well as general primary care services, would be expected to commence in early January and continue for months and even years after the initial bushfire event (based on experience with Tathra and evidence from the Victorian Black Saturday bushfires). We are working closely to support the LHNs and emergency response agencies, who have frontline roles in emergency management, to ensure that any resources we can source are provided in a coordinated way. For example, we worked with LHNs to immediately deploy ‘farm gate’ mental health counsellors to the evacuation and recovery centres in the bushfire affected areas.

COORDINARE’s immediate focus is on coordinating additional support for general practices and additional mental health services. COORDINARE has identified the mental health services which may be needed, ranging from low intensity psychological support (including phone based support), through to intensive support for people who have experienced severe grief or trauma, or who for other reasons (including previous trauma or a pre-existing mental health issue) are more significantly impacted. The HealthPathways online referral pathway portal has been rapidly updated, in particular for referral pathways relating to burns, respiratory illness, disaster management and trauma. COORDINARE has also responded quickly in providing tailored information for the local community, which was disseminated in evacuation centres, amongst service provider, via our website and social media channels.

8. THE PHN GP PSYCHIATRY SUPPORT LINE

RESPONSE TO DRAFT REPORT RECOMMENDATION 5.1: PSYCHIATRIC ADVICE TO GPs

The *Draft Report* recommended introducing a fee-for-service approach, **via a new MBS item**, to fund a GP directly contacting a psychiatrist or going through a service provider whose function is to arrange psychiatric advice over the phone or videoconference (Draft Recommendation 5.1). The *Draft Report* implied that the new MBS item would replace the need for services such as the **PHN GP Psychiatry Support Line**, which is a telephone ‘hotline’ service established by PHNs whereby GPs can contact a psychiatrist and receive immediate advice regarding the management of people who have complex or serious mental health needs.

COORDINARE supports the introduction of the MBS item, but would like to highlight that it is impractical to suggest it can replace the PHN GP Psychiatry Support Line for several reasons:

- Australia has a severe shortage of psychiatrists, especially in non-metropolitan areas, which has led to waiting lists of six weeks or more for people to obtain an appointment. This cannot be solved in the near future due to the lag-time of 11 years for medical training. GPs would also be subject to waiting lists when seeking advice.¹¹
- GPs require immediate advice; waiting lists or a booking system are not feasible stand-alone models.
- A current MBS item already exists for consultation-liaison services (MBS item number 291), however it is not widely utilised due to the unavailability of psychiatrists.¹²

¹¹ *Draft Report*, Section 11.1, pg. 370.

¹² *Draft Report*, Section 7.4, pg. 297. The RACGP stated that although MBS item number 291 allows funding for psychiatrists to provide an assessment consultation for referred patients, with a written plan for their GP or psychologist, obtaining such advice has been difficult in practice and that psychiatrists are often unwilling to perform this type of consultation. This was consistent with the findings of the COORDINARE surveys of GPs.

- The costs suggested by the *Draft Report* (\$66 per 15 minute call) are not realistic for psychiatrists providing advice and support to GPs. For instance, newly graduated GPs may benefit from more time (an hour or more) with the psychiatrist if they are treating a person with complex or serious mental health issues.
- The GP Psychiatry Support Line is not considered as a replacement for other models of integrating psychiatric care in primary health care; rather it can be seen as one component of a strategy to improve GP access to specialist advice and as a complement to other services.

8.1. Rationale for PHN GP Psychiatry Support Line

Previously, a free national advice service was overseen by the RACGP - the **GP Psych Support** service, fielding approximately 1,000 requests from GPs each year, at a cost of \$900 per inquiry.¹³ This service was discontinued in 2013.

Since this time, GPs from six under-served areas expressed their urgent need for a support line service, in several rounds of consultation with their PHNs. COORDINARE subsequently led the co-commissioning of a **GP Psychiatry Support Line** which commenced in 2018 by the service provider ProCare Mental Health Services, a not-for-profit provider based in Newcastle. The PHN GP Psychiatry Support Line was initially co-commissioned by six PHNs based in NSW: Central and Eastern Sydney PHN, Hunter New England Central Coast PHN, Murrumbidgee PHN, South Eastern NSW PHN, Sydney North PHN, and Western NSW PHN. Two additional PHNs have recently signed up to the service (North Coast PHN and Nepean Blue Mountains PHN) at no additional operating cost.

A main aim of the **GP Psychiatry Support Line** is to overcome waiting time issues and ensure that appropriate mental health care can continue to be provided in the community setting. The support line is not about triaging or referring people to a psychiatrist, but rather keeping people whose conditions are able to be treated within primary care under the care of their GP. This will ensure appropriate treatment in the community and can help avoid unnecessary referrals to specialists or hospitalisation. A continued or expanded service such as the **GP Psychiatry Support Line** is valuable to ensuring GPs can provide appropriate mental health care support in the community setting.

8.2. Costs of PHN GP Psychiatry Support Line

The Productivity Commission compared the cost of the telephone PHN GP Psychiatry Support Line service (\$750 per inquiry) to that of the average fee charged by private psychiatrists for a consultation with a mental health consumer lasting less than 15 minutes, which they stated was approximately **\$66** (including both the MBS rebate and the co-payment).¹⁴ However, the cost of the support line service is representative of the cost during the establishment phase when start-up costs are considerably higher. As more GPs become aware of and utilise the GP Psychiatry Support Line service, the cost per call will be expected to decrease.

In addition, the two costs **cannot be directly compared**, as the services have different aims. The aim of the GP Psychiatry Support Line is to support GPs and improve their access to specialist advice and build their capacity in mental health care treatment. This will have long-term positive outcomes for the community as each GP accessing the service will become more knowledgeable in this field. The \$66 service referred to above is for psychiatrists to give one-on-one consultation to a person with a mental health issue, whom they already have a history of treating.

The cost per call to the PHN GP Psychiatry Support Line service continues to fall since the establishment of the service. Importantly, in a 12-month period, the GP Psychiatry Support Line has **more than doubled its registration of GPs**, from 774 GPs registered in December 2018 to 1,816 registrations by the beginning of December 2019. Nearly **25%** of all GPs in the initial six PHN areas have signed up to the support line service.

¹³ *Draft Report*. Chapter 5.1, pg 207.

¹⁴ *Draft Report*, Section 5.1, pg. 207.

We are expecting a surge in calls to the service as a result of the mental health issues experienced in areas affected by the recent bushfires. As additional GPs continue to sign up and use the service, the cost per call will decline.

CASE STUDY: Features of the PHN GP Psychiatry Support Line

- A pool of psychiatrists is available to take calls from GPs from Monday to Friday, 9am to 5pm.
- GPs can receive advice via their choice of telephone or secure messaging.
- Where possible, a psychiatrist provides *immediate* phone advice followed up with a written record of the advice. If not immediately available, a psychiatrist will return the call as soon as possible.
- All consultations are documented, and wherever possible uploaded to My Health Record (with consumer consent).
- The GP may choose to make a documented recording of the phone calls.
- The advice can include advice on particular mental health matters from medication issues to general management advice.
- Wherever possible, the GP is able to receive advice from a psychiatrist with specialist knowledge such as in adolescent or child psychiatry.
- Understanding that the overarching responsibility for each consumer's care is the GP. The service and staff of the support line must have an understanding of the principles of stepped care.
- Prior to commencement, testing of telecommunications infrastructure, training of service staff (those operating the phone line as well as the psychiatrists), and promotion of the forthcoming service to general practices in the catchment area are undertaken.

9. CONCLUSION

In conclusion, COORDINARE supports recommendations by the Productivity Commission in the *Mental Health Draft Report* aimed at shifting the focus of our health system towards preventative health care in the community and ensuring people are able to access the right level and intensity of mental health care, overlaid with care coordination and integration with other services such as housing and education. However, COORDINARE believes that PHNs, with their close alliances with GPs, LHNs, and strong community representation, are ideally placed to implement the health reform agenda relating to primary mental health care.

The independence of PHNs from state/ territory governments and service providers, and their role as a meso level organisation that integrates and coordinates services, are key assets in ensuring that innovative initiatives, which move away from the current supply-driven fee-for-service model, are able to be commissioned, implemented and monitored to meet the unique needs of local communities.

We do not believe that the *Draft Report* has provided enough justification for the substantial and disruptive changes that would ensue under the Rebuild model, and we encourage the Productivity Commission to provide more information and stronger evidence that they have considered the unintended consequences and perverse incentives that will be caused by the change in funding and governance. We also recommend that the Productivity Commission examines if the Rebuild model could ensure greater equity across the states/ territories regarding mental health care funding, how it would overcome entrenched issues of federalism and ensure that the reforms would be sustainable in the long-term.