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Mental Health

Productivity Commission Draft Report

23 January 2020



OUR VISION

A healthy Australia, supported by the best possible healthcare system.

OUR MISSION

To conduct research, educate and influence the healthcare system to achieve better health outcomes, improved patient and provider experience, greater equity and sustainability.

OUR GUIDING PRINCIPLES

Healthcare in Australia should be:

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Accessible

Equitable

Sustainable

Outcomes-focused.

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INTRODUCTION

The Australian Healthcare and Hospitals Association (AHHA) welcomes this opportunity to provide this submission in response to the Productivity Commission Draft Report on Mental Health. It provides feedback on the draft report recommendations regarding workforce, the Medical Benefits Schedule, data, and local commissioning and funding structures.

AHHA is Australia’s national peak body for public hospitals and healthcare providers. Our membership includes state and territory health departments, Local Hospital Networks and public hospitals, community health services, Primary Health Networks and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high-quality healthcare to benefit the whole community.

As established by the draft report, mental health policy and service arrangements are highly complex and Australia’s need for localised integrated services is well established. In the wake of the recent national bushfire disaster, the need for efficient and effective mental health care is even more pressing, with a growing number of Australians requiring immediate and long-term support in the wake of such significant trauma. Governments must take action and prioritise the investment of a sufficiently resourced, patient-centred, integrated mental health system that is collaboratively commissioned and connected with the health and social care sectors more broadly.

AHHA agrees with the majority of the findings and recommendations contained in the draft report, including the stepped model of care approach. AHHA considers that making separate short term and medium-term recommendations is a constructive approach to addressing the immediate need and complex systematic problems documented in the draft report. We broadly support the long-term reform agenda outlined.

Recognition of the social determinants of mental health and suicide prevention also usefully extends the comprehensive nature of mental health care, although the inability of governments to have acted on the social determinants of health more generally over the many decades is noted. The proposal for the Council of Australian Governments (COAG) to develop a new whole-of-government National Mental Health Strategy to improve population mental health is supported and should give broader consideration to the social determinants.

One key area where AHHA does not agree with the Productivity Commission recommendations is with respect to regional commissioning. AHHA believes that the most appropriate way of managing the local commissioning of mental health services is through the coordinated actions of Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) or their equivalent.

The risks with the “rebuild model” proposed in the draft report are that the proposed regional commissioning agents would represent an extra layer of bureaucracy and cost, and that mental health could become increasingly “siloesd” and segregated from the broader health system in which it functions. The “renovate” model does not look to strengthen or redesign government roles and responsibility which the AHHA believes is a missed opportunity to redefine ineffective structures.

AHHA supports a third approach, a “Repurpose” model of funding, with regional coordinated planning and commissioning. Policy makers should capitalise on existing organisational structures embedded within communities, strengthening capabilities and increasing accountability mechanisms, to demonstrate a cost-effective, value-driven strategy focused on improving health outcomes



This approach builds on the intention of Commonwealth, state and territory governments for joint planning and funding of the health system at a local level. The Fifth National Mental Health and Suicide Prevention Plan is premised on PHN and LHN collaboration to implement integrated planning and service delivery at the regional level. The new National Health Agreement foreshadowed in the February 2018 Heads of Agreement between the Commonwealth, state and territory governments also commits these jurisdictions to joint planning and funding at a local level. This approach is also consistent with the Productivity Commission report *Shifting the Dial* that called for regional alliances between LHNs, PHNs and others.



LOCAL COMMISSIONING AND FUNDING STRUCTURES

As documented in the Productivity Commission draft report, there is a lack of managed and appropriate referral pathways, and coordinated care across primary, community and acute services for those in need of mental healthcare.

AHHA agrees with the Productivity Commission finding that mental healthcare services should be characterised by integrated planning and service delivery at the regional level. However, we do not support the proposed “rebuild” approach involving the creation of “Regional Commissioning Authorities” as a new tier of bureaucracy which would also likely create a mental healthcare silo. AHHA also does not agree with a “renovate” approach that does not include reform of intergovernmental roles and responsibilities.

To effect better planning for service delivery at the local level, the existing structures of PHNs and LHNs should be utilised. This draws upon existing organisational structures already embedded within communities, and builds on the intention of Commonwealth, state and territory governments for joint planning and funding of the health system at a local level.¹

PHNs were established by the Australian Government in 2015 to provide regional leadership for primary health services including mental health. Their commissioning role is underpinned by evidence that one-size-fits-all solutions imposed across a country and population groups as diverse as found in Australia do not work. Decisions by and with local communities produce better results – and PHNs together with regional health service providers and communities are well placed to plan and commission services at a local level.

The Fifth National Mental Health and Suicide Prevention Plan is premised on PHNs and LHNs implementing integrated planning and service delivery at the regional level. PHNs and LHNs aim to build the constructive relationships required to commission regionally responsive and relevant services in order to improve health outcomes and deliver the best care possible to people experiencing compromised mental health.

This approach is consistent with the Productivity Commission *Shifting the Dial*² report that called for regional alliances between LHNs, PHNs and others. AHHA has made similar recommendations in our proposed ten-year health reform proposal *Healthy people, healthy systems*.³ It also identified pooled funding arrangements supported by formal agreements between governments, PHNs and LHNs, as enablers to improve local and regional system performance and deliver integrated, consumer centred care. See Case Study 1 below which provides an example of how this works in practice in Victoria.

¹ Heads of Agreement between the Commonwealth and the States and Territories on public hospital funding and health reform, initially proposed by the Commonwealth Government on 9 February 2018. As at November 2019, all state and territory governments have signed on to this funding and reform agreement. Available at <https://www.coag.gov.au/about-coag/agreements/heads-agreement-between-commonwealth-and-states-and-territories-public-0>.

² Productivity Commission. 2017. *Shifting the Dial: 5 Year Productivity Review*, Report No. 84, Canberra. Available at <https://www.pc.gov.au/inquiries/completed/productivity-review/report>.

³ Australian Healthcare and Hospitals Association 2017, *Healthy People, Healthy Systems: Blueprint for a Post-2020 National Health Agreement*, Australian Healthcare and Hospitals Association. Available at www.ahha.asn.au/blueprint.



Case Study 1

Partnerships between the Victorian Department of Health and Human Services and Victorian PHNs

The six Victorian PHNs and the Victorian Department of Health and Human Services have established mechanisms for engagement and planning, formalised through shared strategies, scoped programs of work/proof of concepts and governance mechanisms. This includes an annual Victorian Department of Health and Human Services and PHN Strategic Directions Forum which is attended by senior state government leadership, PHN Chief Executive Officers and PHN Chairs. The Forum is chaired by the Secretary, Victorian Department of Health and Human Services.

Building on these collaborative structures, a memorandum of understanding (MOU) was executed between parties in 2018. The purpose of the MOU is to “confirm the commitment of the parties to a collaborative working relationship, in order to optimise the health outcomes of Victorians. [The] commitment will aim to support and enable the successful implementation of national and State health policies, strategies, plans and initiatives.” The MOU outlines shared principles of joint working, roles and responsibilities of the parties, monitoring mechanisms and other details. It is accompanied by detailed schedules focused on (i) joint planning and (ii) data management.

The MOU complements other arrangements between the two tiers of government such as the Bilateral Agreement 2018: Coordinated care reforms to improve patient health outcomes and reduce avoidable demand for health services.

It marks a formalised commitment to joint working which reflects a track record of engagement and delivery, outlined in detailed schedules. The suite of accompanying schedules may expand over time. Hence flexibility is afforded in response to changing circumstances.

The MOU framework provides a foundational framework for shared health efforts. There is the potential to scale this approach and apply it to other jurisdictional agencies that intersect with primary care to generate outcomes consistent with the biopsychosocial model of health. This includes but is not limited to justice, education, and regional planning and development.

While AHHA does not support the Productivity Commission’s proposed “rebuild’ model, we recommend consideration of a third option, a “Repurpose” model of funding and regional commissioning that leverages and builds on existing infrastructure, relationships and processes. This would capitalise on the capabilities of PHNs and LHNs, working in partnership with local providers and community groups, to implement appropriate supportive funding and accountability structures that enhance the provision of regionally based integrated care.

The introduction of levers and accountability structures that enhance and strengthen the role of existing organisational structures such as PHNs and LHNs which are already embedded within communities is a cost-effective strategy and delivers on the intention of Commonwealth, state and territory governments for joint planning and funding of the health system at a local level. Further, it recognises that many people requiring mental health care also have physical health requirements, and that holistic care will not be readily achieved should there be further fragmentation of mental health services from other parts of the health sector.



The work led by PHNs in partnership with regional health service providers and local communities over the past four years has made substantial inroads into what has long been a fragmented and underperforming system response to the mental health needs of their communities.

PHNs, LHNs and community service providers have extensive expertise and capacities in the provision, coordination and delivery of mental health care. They demonstrate significant leadership in this space, with many examples of the development of cross sector partnerships and governance relationships designed to promote integrated service delivery at a local level. The case studies throughout this document provide practical examples of how this can work, and how it is currently working, highlighting an opportunity to leverage these existing capabilities in the “Repurpose” approach.

Case Study 2

NSW/ACT PHN Commissioning Network: GP Psychiatry Support Line

The NSW/ACT PHN Commissioning Network, which meets on a quarterly basis and draws its membership from the commissioning and contracting managers across the PHNs, has collaborated to jointly develop and commission the GP Psychiatry Support Line. More than 500 NSW GPs have registered to use the free telephone-based service which links them to psychiatrists who can provide information and advice to assist with diagnosis, investigation, medication and development of patient safety plans.

Implementing our proposed “Repurpose” model will avoid a loss of momentum in planning and coordination at the regional level, protecting against the potential unintended consequence of change fatigue that could result from the ‘rebuild model’ approach. It is also consistent with broader whole of health system reform directions that are underway through the COAG National Health Agreement process.

Further details on this “Repurpose” model are contained in the submission by the Primary Health Networks Cooperative to the Productivity Commission on this inquiry.

The Productivity Commission draft report notes that cross-jurisdiction coordination on a broad range of mental health policies under the auspices of the Fifth National Mental Health and Suicide Prevention Plan is a work in progress and states that results so far have been mixed (Volume 1, page 131). This is not surprising as over the past four years the mental health system has experienced the introduction of PHNs and commissioning models, procurement of new mental health services, development of regional plans and introduction of the NDIS. These structures must be allowed sufficient time to consolidate and become embedded before another major reform is embarked upon such as the proposed “rebuild”. If we do not, we risk perpetuating a mental health sector frustrated by constant disruption and impeding the creation of durable governance, funding and service models which will improve mental health services.

The draft report also outlines the important role that GPs must play in the stepped model of care. However, it is recommending reforms that would give commissioning responsibility to a regional commissioning structure disconnected from the broader architecture in which primary care is



delivered. With 90 percent of Australians seeing a GP at least once a year⁴, and GPs increasingly reporting that psychological issues are their most common presentations,⁵ we contend that there is significant value in the nationally-funded PHNs and their GP-led Clinical Councils playing a lead role in decision making regarding the commissioning and strategic direction of mental health care.

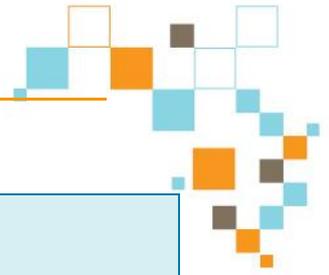
Greater regional control of mental health funding is required in conjunction with clarification and transparency around the roles and responsibilities of state, territory and Commonwealth governments. Commissioning responsibility should be jointly shared in a collaborative partnership between the Commonwealth through its PHNs and the states and territories: the “Repurpose” model would facilitate this.

To enable more impactful change and promote integrated care provision, PHNs should have greater regional autonomy over service provider funding. PHNs need to be supported through the provision of appropriate levers and accountability structures to facilitate collaborative partnerships and implement reform. Broader commissioning responsibilities for mental health should not be viewed as a ‘bolt-on’ activity. It is essential that funding mechanisms (including related to private provider MBS funding) should be developed to ensure more robust and responsive mental healthcare services at a regional level.

For example, commissioning services should be appropriately funded to fill service gaps and facilitate cross-sector local planning that incorporates consumer perspectives and are culturally appropriate, as demonstrated by the following case study.

⁴ Department of Health 2018. Annual Medicare statistics – Financial year 1984–85 to 2017–18. Canberra. 2018

⁵ RACGP 2019. General Practice: Health of the Nation 2019. East Melbourne, Victoria.



Case Study 3

Psychological Therapies for People from Chinese Cultural Background

The Northern Sydney Primary Health Network Needs Assessment identified a service gap for people from culturally and linguistically diverse backgrounds, in particular for those from a Chinese cultural background experiencing mild to moderate mental illness.

In 2017, New Vision Psychology was commissioned to deliver culturally appropriate individual and group psychological services for people from a Chinese cultural background. New Vision Psychology facilitates the provision of culturally safe services through experienced bilingual psychologists and appropriately trained and qualified mental health clinicians which deliver services in Mandarin, Cantonese, Shanghainese and English. Utilising a stepped care approach, staff ensure integration with other services through care coordination with other health service providers. New Vision Psychology provides support and advice to all GPs and other relevant practitioners in the Northern Sydney PHN region as well as delivering outreach services and advocacy as required.

Uptake of this service has been strong since establishment and consumers accessing New Vision Psychology have reported positive outcomes, as illustrated in the following consumer stories:

- New Vision Psychology actively engaged with an elderly Mandarin speaking consumer unable to speak English who was at high risk of homelessness. The consumer was unable to apply for appropriate housing due to a significant language barrier. Advocacy provided by New Vision Psychology staff assisted the consumer acquire appropriate housing. Having this need met allowed the consumer to more effectively engage in clinical treatment for his mental health condition.
- After initial contact with a consumer experiencing domestic violence, New Vision Psychology staff recognised the immediate need to link the consumer to services that could assist with broader psychosocial needs. A New Vision Psychology clinician supported the consumer to access the Early Childhood Centre and Family Referral Service. The New Vision clinician liaised with the other support providers to ensure that the consumer's comprehensive service needs were met during the period of removing herself from the abusive relationship and ongoing.

The length of the funding cycle for psychological supports and mental health peak bodies should also be extended to a minimum of five years in order to enhance planning, service delivery, evaluation and data collection. These five-year cycles should facilitate relevant service delivery streams commencing and ending at the same time. Currently the disjointed nature of funding cycles impedes efficient service procurement.

Furthermore, there should be a mapping process undertaken that identifies other government policy reforms where the opportunity for a more cohesive and "joined up" approach can be achieved in the delivery of mental health services. This is particularly relevant given current reviews of the aged care and disability sectors.

A contemporary example of the role that PHNs fulfil in facilitating the regional coordination of services is around local responses to the recent bushfire disaster. The Australian Government recently announced \$6.9 million in community wellbeing grants that will allow PHNs to commission mental health, wellbeing and recovery activities tailored to the local needs of a bushfire affected communities.⁶

⁶ The Hon Greg Hunt MP, 2020, 'Immediate mental health services deployed into fire affected communities,' *Media Release*, 12 January.



Mental health will be a significant ongoing issue in the wake of the national bushfire disaster. Action is needed that is specific and reflective of the local community needs. PHNs are best placed to guide the commissioning of mental health services and grant funding allocation in these areas as they are embedded within affected communities and are therefore able to design and deliver programs specific to the immediate and evolving needs of these communities.

An important component of effective regional planning to strengthen regional integrated service provision is the establishment of integrated governance structures. While the Heads of Agreement between the Commonwealth, states and territory governments promotes the need for integrated ‘systems and services to improve health outcomes’,⁷ no national integrated governance model or strategy of collaborative, cross-sector healthcare delivery exists.

AHHA has made detailed recommendations for a stronger health system in our Blueprint for Health Reform.⁸ Implementation of these recommendations would strengthen the capacity of governments, PHNs and community services to effectively work together to commission services that provide integrated care to improve mental health outcomes. Other commentators have similarly recommended frameworks for the establishment of outcome focused integrated care,⁹ including:

- joint planning;
- integrated information communication technologies;
- a shared vision, priorities and incentives;
- effective data measurement and evaluation;
- appropriate resources to support innovation;
- consumer and clinician engagement in planning and needs assessment; and
- collaborative workforce development and training opportunities.¹⁰

To further strengthen the capacity of regional commissioning, AHHA supports the Productivity Commission recommendation to establish a Mental Health Innovation fund. This would allow PHNs to trial new models of care based on community needs. Independent evaluations of these programs would increase the national mental health research evidence base, enabling innovative evidence driven programs to be transferred and scaled up.

The alternative “Repurpose” model of regional planning would provide both short- and long-term value if used to strengthen collaboration and further resource the existing structures. This will also enable the creation of a nationally unified though regionally controlled health system that puts patients and consumers at the centre.

⁷ Heads of Agreement between the Commonwealth and the States and Territories on public hospital funding and health reform, initially proposed by the Commonwealth Government on 9 February 2018. As at November 2019, all state and territory governments have signed on to this funding and reform agreement. Available at <https://www.coag.gov.au/about-coag/agreements/heads-agreement-between-commonwealth-and-states-and-territories-public-0>.

⁸ Australian Healthcare and Hospitals Association 2017, Healthy People, Healthy Systems: Blueprint for a Post-2020 National Health Agreement, Australian Healthcare and Hospitals Association. Available at www.ahha.asn.au/blueprint.

⁹ Nicholson, C., Jackson, and Marley, J 2014, Best-practice integrated health care governance-applying evidence to Australia’s health reform agenda’, *Medical Journal of Australia*, vol.201, no. 3 accessed 18 December 2019 <https://www.mja.com.au/journal/2014/201/3/best-practice-integrated-health-care-governance-applying-evidence-australias>.

¹⁰ *ibid.*



WORKFORCE

The workforce required to deliver mental healthcare services must be diverse to address the diverse needs of people seeking mental healthcare.

AHHA supports the provision of mental health care through a flexible, multidisciplinary, and responsive workforce with an increased level of specific mental health knowledge, skills and capabilities. AHHA agrees that there is a need for greater quantity and wider mix of skills in the health workforce and more efficient allocation of skills to specific services. This should recognise the importance of peer support, navigation services, therapy coaches and lower-intensity psychological treatments.

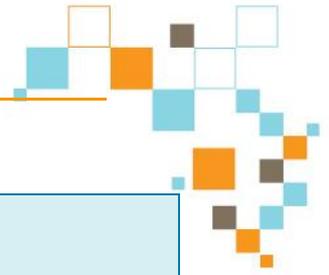
We believe careful consideration must be given to how specialisation is introduced to ensure that it does not create an overuse of specialisation and a de-skilling of the generalist workforce. This is particularly critical noting the already existing specialist workforce shortages in many locations. Workforce development, integration and coordination, through education, registration and funding models must be designed with consideration to generating the greatest net benefit for the community.

Workforce integration, collaboration and information sharing should be encouraged across health services, both within the mental health sector and across the health and social services sectors more broadly. This will facilitate the provision of care that is patient-centred, holistic and encompasses the broader social context in which mental health needs to be addressed.

Local workforce integration and identification of service gaps should be coordinated and administered through existing health and community structures. This should involve formalised cooperation between PHNs and LHNs. This is most effective when collaborative relationships are formalised through memorandums of understanding, collaborative governance structures and joint planning.

AHHA supports initiatives that lead to placements and internships being more representative of healthcare settings, including in the private sector and settings other than inpatient units. We also support initiatives that improve access to mental healthcare services in rural locations through a mix of workforce attraction strategies and ehealth programs.

The creation of a skilled, culturally diverse and culturally safe mental health workforce to match population needs must be prioritised by governments. An Aboriginal and Torres Strait Islander mental health workforce must be funded and supported to address the specific needs of local communities. This recognises the distinct needs and health inequities experienced by Aboriginal and Torres Strait Islander peoples and is essential for improving health outcomes as demonstrated in the case study below.



Case Study 2

Indigenous Way Back Support Service

The Hunter region of NEW has been a trial site for Beyond Blue’s Way Back Support Service, with Hunter New England Central Coast PHN (HNECC) providing some funding to support this initiative. Through a local Needs Assessment, a gap for Indigenous specific aftercare was identified. HNECC worked with the Way Back lead agency, Hunter Primary Care and the Hunter New England Mental Health Service to design and implement a specific Indigenous program. Similar to the Way Back trial program, the Indigenous program provides non-clinical support and aftercare following a suicide attempt. Referrals are generated from the Local Hospital District.

The relationships established through the pilot project and the Indigenous program will be leveraged for the implementation of the ongoing Way Back Support Service once a bilateral agreement has been signed.



MEDICARE BENEFITS SCHEDULE

Current funding arrangements are failing to appropriately support the continuum of care envisaged within the stepped care approach to mental healthcare need.

At many points along the stepped mental healthcare spectrum, insufficient funding ensures that services effectively remain capped and are rationed. This prevents consumers from being able to access the care they need, when they need it. This should include enabling PHNs to plan for and promote integrated stepped care mental health services in the region to address a spectrum of needs in an equitable way.

AHHA supports matching consumers with the right level of care. However, this should not be approached by having targeted proportions of people receiving care at different levels of intensity. The provision of mental healthcare services should instead be on the basis of a person's clinical need. In particular, the MBS should be adapted to be more flexible in meeting individual's need for mental healthcare services.

It is recognised that this could create the potential for over servicing or other types of inappropriate care. This should be prevented through appropriate monitoring of service providers. As noted in the draft report, PHNs could contribute by promoting best practice in initial assessment and referral, including the establishment of processes to monitor the use of services in accordance with the stepped care approach.

The PHNs as commissioning agencies should establish mechanisms for monitoring the use of services that they fund to ensure that consumers are receiving the right level of care and that appropriate health outcomes are being achieved. If service use is not consistent with estimated service demand, commissioning agencies may need to make changes to initial assessment and referral systems (or work with providers to do so).

AHHA supports an independent evaluation of the effectiveness of MBS-rebated psychological therapy. While mindful of the financial risk of open-ended entitlements to MBS-funded services, AHHA believes there should be flexibility with the number of psychological sessions an individual may have over a set period of time, with this instead being determined on the basis of clinical need.

There should be flexibility in how video conferencing healthcare consultations are funded. Living in a rural or remote area is not the only reason that a person requiring mental health care might not be able to access a mental health clinician for a face to face consultation. There are many other reasons such as clinician availability, disability, transport cost, time, family or work pressures.

AHHA supports MBS changes to allow an increase in the number of MBS rebated mental health individual and group sessions, along with the proposal to change the time period for receiving MBS sessions to a 12-month period as opposed to a calendar year. We also support the increased flexibility measures of MBS funded mental health sessions eg for group therapy, or couples and family counselling.

AHHA agrees that funding of mental health service providers should be conditional on and aligned with taking a stepped care approach to the provision of mental healthcare. However, AHHA does not see the merit of setting targets for the proportion of people referred to low-intensity services. The



proportion of people receiving mental healthcare across the spectrum should instead be on the basis of clinical need following a stepped care approach.

AHHA agrees that the MBS should be amended to include an item for psychiatrists to provide advice to a GP over the phone on diagnosis and management issues for a patient who is being managed by the GP. GPs should also be compensated for these consultations. However, we suggest that the effectiveness of any such new items should be evaluated after two years rather than the undefined several years.

Additional funding should also be allocated to improve the availability of community and after-hours mental health services as an alternative to emergency departments for people in need of mental healthcare.

AHHA agrees that a rigorous evaluation of MBS-rebated psychological therapies is appropriate, including the collection of outcome data from clinicians. While this evaluation to be conducted in the short term may only rely on a sample of clinicians, in the medium to longer term, AHHA supports the mandatory requirement for every provider that receives public funds for the provision of healthcare services to be required to provide a minimum level of patient and outcome data as a supplement to the service data they already provide to effect payment for their services.



DATA

The availability of centrally reported patient and outcomes data in the healthcare sector is poor. This inhibits understanding of population health, makes it difficult to monitor the appropriate provision of care and creates an excessively cautious environment for innovative policy development due to concerns over inappropriate use of programs and excessive claiming of payments.

Data collection and evaluation needs to be enhanced across the sector.

There are pockets of excellent data sharing and monitoring occurring throughout Australia as demonstrated by the case study below. Enhanced linkage of data and consistency of practice are essential to enhance the flow of information.

Case Study 3

NSW GP DATA LINKAGE PROJECT

The NSW GP Data Linkage Pilot Project was developed to provide a more complete picture of the provision of health care in NSW to enable a better informed design of the system and support general practice and local health district (LHD) services to improve care for patients.

Delivered in partnership by NSW Ministry of Health and NSW PHNs, the project links data sets of GP practices and hospitals to produce a data asset that:

- Provides a comprehensive patient journey across primary, acute and other healthcare settings
- Allows early identification of current and emerging population health issues
- Improves patient care and potentially constrains or reduces system costs
- Informs data-driven quality improvement and system re-design responses

To date, the four-year pilot project has linked general practice data of approximately 400,000 patients across 40 NSW practices to hospital admission, Emergency Department admission and mortality data held by NSW Ministry of Health. It has demonstrated that patient information can be securely extracted from general practices and linked with hospital and other data collections to generate new insights while safeguarding patient confidentiality.

Over the next three years, the Data Linkage Project, now called Lumos, will expand state-wide, linking data from up to 500 general practices across all 10 PHNs in NSW. This is the largest collaboration the NSW Ministry of Health has ever undertaken with the NSW PHN network, in terms of the nature of the collaboration, the number of PHNs involved and the scale of practices engaged.

It is anticipated that Lumos will generate insights on up to 4 million patient journeys across the NSW health system. This information will assist in:

- demonstrating the impact of primary care in preventing hospitalisations (comparing patients' journeys between those who have visited a GP and those who have not)
- identifying priority areas/areas of collaborative commissioning between PHNs and LHDs.

Healthcare providers already produce service data to effect payment for the services they provide. They should also be required to provide a defined minimum set of patient and outcomes data for services that receive public funding.

AHHA agrees that expanding the use of digital records in the mental healthcare system would facilitate greater information sharing and improve consumer experience. My Health Record could



provide an appropriate platform for information sharing between providers of mental healthcare services and healthcare more generally. However, AHHA does not support broadening the scope of My Health Record to encompass non-clinical and other support service providers.

Mental health treatment and service provision must be driven by an effective and up to date evidence base. Governments need to prioritise and incentivise mental health research, evaluation and data collection from patients, carers and health services. My Health Record should be more effectively utilised to enhance mental health data collection, with health services incentivised and encouraged to upload data to My Health Record.

AHHA supports the recommendation that treatment outcomes data should be forwarded to a patient's nominated GP or other health professional, where there is consent from the patient. This would enhance integration and patient-centred care.

Commonwealth, state and territory health departments should develop protocols for sharing information between health services. A degree of flexibility should be retained within these protocols allowing for regional variation.

Monitoring and reporting should be consistent, outcome-driven, patient-centred and fit for purpose.

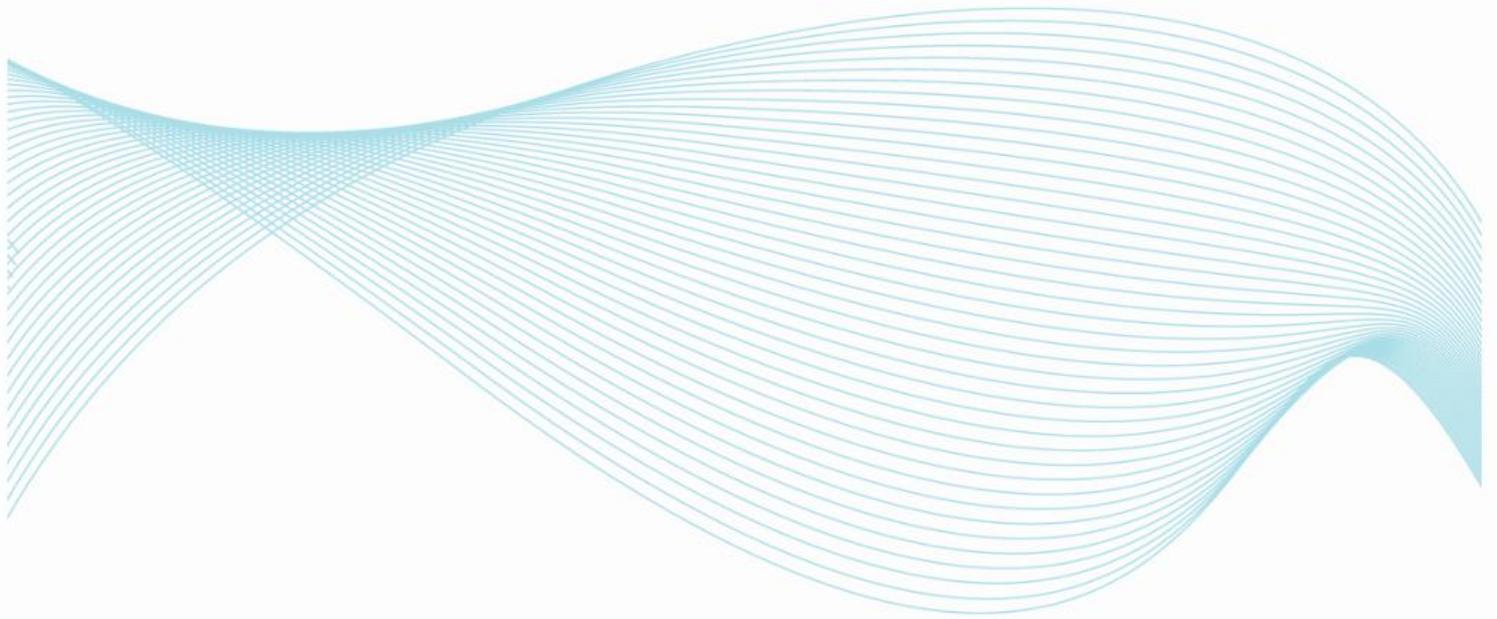


CONCLUSION

The AHHA broadly supports the recommendations of the Productivity Commission draft report on mental health. We recognise the need for sector wide systemic reform to improve mental health outcomes. While we support the need for change, we contend that the most appropriate, efficient and effective strategy for reform is through the strengthening of existing capabilities and structures, including formalised regional governance arrangements between PHNs and LHNs, and embedding funding and accountability mechanisms that facilitate a joined-up approach integrated service delivery. AHHA warns against the rebuilding of structures and the development of new regional commissioning structures as overly resource intensive and likely to result in further fragmentation and the creation of mental health silos.

True integrated care will require governments to incentivise and invest in cross sector collaboration, workforce development and interconnected governance arrangements. Fostering the development of appropriate system levers and accountability measures will enable care to be delivered through the most appropriate patient-centred models of care, at the right place, at the right time.

Clinical need should be the driver of effective mental health care. The prioritisation of a mental health sector that is data driven, incorporates effective monitoring processes and is serviced by a diverse workforce that reflects patient need, will aid the creation of an integrated system that promotes long term, outcomes driven mental health care for all Australians.



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