The Health Alliance

Submission - Productivity Commission interim report

Delivering quality care more efficiently

September 2025

phn BRISBANE NORTH
An Australian Government Initiative

Queensland Government
Metro North Health

Thank you for the opportunity to provide feedback on the Productivity Commission's interim report '*Delivering quality care more efficiently*'. This submission is provided by the Health Alliance, a joint initiative of Metro North Health (MNH) and Brisbane North PHN (the PHN).

About the Health Alliance

The Health Alliance was established in 2017 by Brisbane North PHN and Metro North Health to identify health system reform opportunities to jointly address complex challenges facing the North Brisbane health system. The Alliance facilitates the relevant parts of the health sector in North Brisbane to work together to address issues that transcend the mandate of any one organisation or part of the sector.

The Health Alliance uses a collective impact approach where participants develop a common agenda for change including a shared understanding of the problem and a joint approach to solving it through agreed upon actions.

Governance oversight is provided by a Joint Board Committee, drawing members from both the Brisbane North PHN and MNH Boards as well as the two Chief Executives. The Joint Board Committee provides strategic advice and direction to the Health Alliance.

About Brisbane North PHN

Brisbane North PHN's vision is a community where good health is available for everyone. The PHN supports clinicians and communities in Brisbane's northern suburbs, Moreton Bay Regional Council and parts of Somerset Regional Council. It covers approximately 4,100 km2 of urban, regional and rural areas, with a population of over one million.

The PHN works with local communities, consumers, carers, health professionals, hospitals and community providers to understand our community and their needs. The PHN then engages stakeholders to design and commission programs and services to meet those needs.

The PHN's goals:

- Be informed and led by community
- Facilitate care closer to home
- Address health gaps and inequities
- Transform and connect primary healthcare
- Drive organisational excellence.

About Metro North Health

Metro North Health's vision is creating healthier futures together – where innovation and research meets compassionate care and community voices shape our services. Delivering outstanding health services is just one of the ways that MNH cares for the community. MNH's passion for people is reflected in the way we do our work and live our values every day. We value and nurture our team members so that they can provide quality value-based care to patients across our diverse

organisation. Our focus on Value Based Healthcare means we expect our staff to deliver the care the patient needs, no more and no less, to achieve the best quality of life for our community. This passion fuels our collaborative culture of innovation and research.

MHN embraces the diversity of local and greater communities as we provide services to people throughout Queensland, northern New South Wales and the Northern Territory, in all major health specialities including medicine, surgery, mental health, cancer care, trauma, women's and newborn care, and more than 30 sub-specialities. Metro North services include rural, regional and tertiary hospitals, and community and oral health services.

Draft Recommendation 2.1 - Health Alliance response:

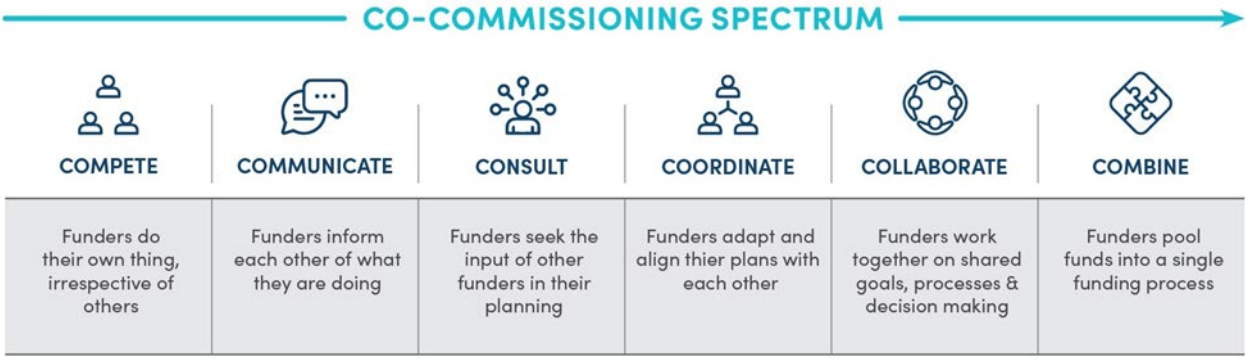
The Health Alliance supports draft recommendation 2.1. The next National Health Reform Agreement provides an important opportunity to strengthen the enabling environment for local collaborative commissioning and to widen and deepen the work that LHNs and PHNs are already doing together.

Metro North Health and Brisbane North PHN have produced three joint regional needs assessments, now underpinned by a data sharing agreement and local governance arrangements. The process of producing the assessments and developing responses has created a range of connections across our organisations, increased joint planning and implementation, and built a solid foundation of partnership working that continues following changes in leadership. Collaborative commissioning is not just a set of governance structures and joint outputs, but more importantly it is a culture across our organisations of working together.

We continue to be very committed to the First Nations health equity agenda, through a shared health equity strategy in Metro North, and by partnering with HHSs, PHNs and ACCHOs in South East Queensland, facilitated by the Institute for Urban Indigenous Health, to develop and implement a regional plan.

While we have been successful in jointly assessing needs and planning responses, we have been limited by a lack of funds to address issues of shared concern and a lack of flexibility in the funds that we do have. This is particularly the case for people who need more than primary care can currently provide, but don't (yet) need acute care (e.g. people with chronic conditions). We support establishing a joint fund, focused initially on potentially preventable hospitalisations, linked to our needs assessment and an agreed plan of work.

We see co-commissioning on a spectrum, where the nature and purpose of individual commissioning activities is matched to the appropriate type of co-commissioning. Not all commissioning that PHNs or LHNs do needs to be collaborative.



Compete

- do not 'compete' for funding, unless mutually discussed and agreed.

Communicate

- at a minimum, inform each other of new or changed funding and of any upcoming procurement processes.

Consult

- consult each other in regard to new or changed funding and on any upcoming procurement processes.

Coordinate

- share information on what we fund, the level of funding and type and quantity of service provision.
- use information shared to inform our own procurement plan and decisions, including adapting current/planned activity considering the activity of others.
- where possible, align procurement timelines, processes, taxonomies, assessment criteria, KPIs and contract lengths.

Collaborate

- where new funds are made available for the region, we will discuss and agree on the best use of the funds (particularly considering the Joint Regional Needs Assessment).
- ensure that our funding and procurement activities complement the activities of others.
- jointly plan upcoming procurement activities, including contributing to procurement documents, processes and assessment criteria.
- participate in each other's procurement assessment processes, where relevant.

Combine

- explore and respond to opportunities to make combined funding proposals to government.
- explore options to combine funding into one procurement process, for relevant activities where appropriate.
- one member may lead a procurement activity on behalf of others.
- enter into formal, legal agreements in relation to any lead procurement activities (i.e., to facilitate the transfer of funds between members).
- share single reporting processes (by funded providers) to reduce reporting burden.

Information request 2.1

- *What additional factors to establish a consistent joint governance framework should be considered?*
- *How should an outcomes framework be designed to support joint monitoring and reporting? What other factors should be considered for joint monitoring and reporting?*
- *How should LHNs and PHNs partner with ACCHOs and other organisations?*

Health Alliance response:

The *functions* of joint regional governance should be mandated in the next National Health Reform Agreement (NHRA), but the *form* that governance takes should be left to local decision making. Given the differing contexts across each state and territory and the varying levels of maturity in LHN-PHN partnerships, there should be local flexibility in deciding on local governance arrangements and how to deliver the required outputs/outcomes.

The Queensland Commonwealth Partnership (QCP) has developed a framework (https://www.health.qld.gov.au/__data/assets/pdf_file/0032/1376654/qcp-thought-leadership-paper-and-framework.pdf) to support joint regional governance, based on a review of evidence on the enablers and elements of success. This provides a good foundation on which to build local governance arrangements. Some degree of state and territory-based consistency may be useful (e.g. expressed through a bilateral agreement under the NHRA), while also retaining space for local flexibility.

An outcomes framework to support joint monitoring and reporting is a good idea, however this would need to be agreed by federal and state governments and be comprehensively used. The danger is that outcomes reporting on joint governance activities would be different and additional to reporting on hospital, primary care and ACCHO activity, thereby creating an additional reporting burden. We also suggest considering the Quintuple Aim as an organising framework for outcomes as this is widely used and understood across health organisations.

In keeping with our thoughts above, how LHNs and PHNs partner with ACCHOs should be left to local decision making and flexibility. Regional governance agreements should specify how partnership will occur at all stages of the commissioning cycle; however, this may look different at different stages (e.g. how ACCHOs contribute to the needs assessment may be different to how they contribute to procurement decisions).

Information request 2.2

- *What levels of resourcing are required to: first, support enhanced joint governance requirements; and second, provide sufficient dedicated funding for collaboratively commissioned services?*
- *What types of funding could be pooled to support collaborative commissioning?*
- *How should the funding adjustment be implemented in practice? What unintended consequences could a funding adjustment to incentivise collaborative commissioning have? Are there outcome measures beyond potentially preventable hospitalisations that should be targeted with the incentive? [chronic disease, mental health, transitions of care, efficiency, homelessness]*
- *What are the costs of existing collaborative commissioning programs? Is there other information that could inform estimates of the benefits of collaborative commissioning?*

Health Alliance response:

LHNs and PHNs each already have staff and resources that deliver all of the stages of the commissioning cycle. However, this primarily focuses on their own internal planning purposes. Joint commissioning often happens on top of this, using (stretching) those existing resources. At Brisbane North PHN and Metro North Health, virtual teams are brought together to undertake specific pieces of work (e.g. health needs assessment). This allows each organisation to retain their own commissioning capacity, but also to bring this together for joint tasks.

At a minimum, the Health Alliance would recommend the following resourcing:

- **Joint governance lead** – a position accountable to both organisations and responsible for driving and coordinating local governance and collaborative commissioning activities. At the

Health Alliance this is a General Manager, at a senior level, jointly funded by the two organisations.

- **Data lead** – a position that can work across both organisations and the wider sector to help coordinate the joint needs assessment and ongoing reporting of impact and outcomes. The Health Alliance does not currently have this position, relying on the goodwill of staff in the PHN and MNH.
- **Project worker/s** – capacity to pursue joint activities arising from the needs assessment. May include understanding the issue, engaging with stakeholders, project/service design, project/program management, procurement and contract management, monitoring, reporting and evaluation. At the Health Alliance we have one 'generic/core' Program Manager, and occasional fixed term staff working on specific separately funded projects.
- **Admin & Operational funds** – a modest budget to pay for administrative costs and operational activity, including bringing stakeholders together, publishing the needs assessment and plans and buying in expertise for specific pieces of work.

Dedicated funding for collaboratively commissioned services should be based on local population numbers and demographics along with health status and access to health services (i.e. needs based, weighted population). In a region like Metro North/Brisbane North with a population of 1.1 million, 6 public hospitals, 6 private hospitals and 300+ general practices, we would recommend a minimum of $5 million. This would allow for 2-3 service delivery programs at a reasonable scale. Additional funding could be made available through an application process run by state and territory governments (similar to the Connected Community Partnerships program in Queensland) and by increasing the flexibility of LHN and PHN existing funds to enable them to be pooled for joint activity.

Below we present two additional case studies of joint projects that are making a difference: Working Together to Connect Care (identifying and providing support in the community to frequent presenters to Emergency Departments) and Safe Spaces (providing out of hours support for people in distress).

We support making ongoing funds for local governance and collaborative commissioning conditional on delivering ongoing outputs and outcomes. There should be both process/output milestones (especially in the early stages of establishing local governance arrangements) as well as outcome indicators for collaboratively commissioned services. Success in achieving outcome indicators should not lead to a reduction in funds (e.g. need has gone down, therefore don't need as much funding), but rather an increase in funds given evidence of success. This could then be applied to other needs arising from the joint needs assessment. As this is primarily money for direct service delivery, once it is allocated (and assuming it is effective) it is difficult to stop funding it, which then prevents other needs being addressed. Where there are established and mature governance and commissioning relationships, LHNs and PHNs should be able to access funds for both immediately (i.e. in same financial year), rather than forcing all to go through the same step-by-step process.

Information request 2.3

- *What else needs to be considered to implement the reform? How should the mismatched boundaries between LHNs, PHNs, ACCHOs and other organisations be addressed in implementing the different elements of the proposed reform?*
- *Are additional supporting actions by governments needed? How can state and territory governments best support and lead change?*
- *How can this proposed reform be employed to further integrate and expand place-based approaches across the care sector?*

Health Alliance response:

Metro North Health and Brisbane North PHN significantly benefit from having a one-to-one relationship with coterminous boarders. Those PHNs that have a one-to-many (2 or more LHNs) relationship will likely need additional resourcing to develop local governance arrangements and plans with multiple HHSs. We also benefit from the Institute for Urban Indigenous Health (IUIH) acting as a peak body of ACCHOs (specifically AMSs) in the region.

Given the significant impact of state & territory priorities and ways of working, it would be useful for LHNs and PHNs to be brought together especially in the larger states (Qld, NSW and Vic) by state health departments to develop consistent state-based approaches and to share best practice and support. This has worked effectively in Queensland through the Queensland Commonwealth Partnership.

While the focus of activity will be on health services, the social determinants of health will also need to be addressed in both joint regional needs assessments and the plans of work. This will require relationships with other government departments at the state and federal level. Ideally governments would set an expectation for their departments (not just health) to co-operate with PHNs and LHNs, including data sharing. This would allow for a wider place-based approach to the health and wellbeing of communities. Local government is also a key partner for PHNs.

Case Study: Working Together to Connect Care (WTTCC)

What is WTTCC?

The Working Together to Connect Care (WTTCC) program is a joint initiative of Brisbane North PHN and Metro North Health, delivered in partnership with community organisations Footprints and Micah Projects. It supports people who frequently present to Emergency Departments (EDs)—five or more times in a 30-day period—by addressing both their health and social needs through coordinated, multidisciplinary case management.

WTTCC uses the *FrequentED* digital platform to identify patients in real time and link them to a structured model of care spanning hospital, community, and social supports. Care is individualised and includes housing, mental health, alcohol and drug support, NDIS access, and psychosocial assistance.

Results Achieved

Improved system efficiency

- 11% reduction in avoidable ED presentations (22% at TPCH; 6% at RBWH)
- 34% reduction in hospital admissions (≈438 fewer in 6 months)
- 14% reduction in ED length of stay, 10% reduction in inpatient length of stay, and 7% reduction in ambulance arrivals

Better outcomes for patients

- 203 patients enrolled (from 299 identified), with 6,782 service contacts across NGOs.
- Over half (57%) required housing support; 58% of participants gained or maintained stable housing despite the housing crisis.
- 99% reported positive experiences of care, and 86% demonstrated improved outcomes (CANSAS tool).
- Case studies show patients avoided repeated ED cycles through stable housing, NDIS packages, and community support

Equity impact

- 17% of participants identified as Aboriginal and/or Torres Strait Islander—well above the 2.6% Metro North population benchmark—demonstrating targeted reach into priority populations

Partnership in Action

- **Metro North Health**: provides hospital-based screening, nurse navigators, clinical governance, and integration with ED workflows.
- **Brisbane North PHN**: commissions NGOs, manages contracts, oversees governance, and ensures community integration.
- **NGO partners** (Footprints and Micah Projects): deliver intensive case management, outreach, and housing/psychosocial supports.
- **Queensland Ambulance Service and community providers**: contribute to care coordination and consistent management plans.

Partnership is underpinned by a joint protocol, data sharing agreements, and regular operational and governance meetings, ensuring a seamless patient pathway between acute and community sectors

Key Lessons

- Integrated governance across PHN, HHS, and NGOs is critical for sustained impact.
- Stable housing and social supports are as important as clinical care in reducing ED presentations.
- The model is cost-effective, scalable, and strongly supported by staff and patients, with potential to expand across all Metro North EDs

In summary, WTTCC demonstrates how strong PHN–HHS–NGO collaboration can transform care for vulnerable frequent ED presenters—improving lives, achieving health equity, and reducing pressure on hospitals.

Case Study: Safe Spaces

What are Safe Spaces?

Safe Spaces are welcoming, non-clinical, after-hours community environments for people experiencing emotional distress or suicidal crisis. Co-designed with people with lived experience, carers, Metro North Health and community partners, they offer an alternative to Emergency Departments (EDs), which can be overstimulating and ill-suited for managing psychological distress.

Launched in 2022 with Commonwealth funding, four Safe Spaces now operate in Bardon, Caboolture, Strathpine and Redcliffe—one in each Metro North hospital catchment. They are staffed by peer workers, supported by clinicians, and embedded in their local communities through "Compassionate Villages" of connected organisations.

Outcomes Achieved

- Reach and accessibility: Nearly 2,500 guests supported across 10,560 visits (Apr 2022–Sep 2024), including cohorts often underserved by clinical services (First Nations, LGBTQIA+, culturally and linguistically diverse groups, people facing housing or financial insecurity).
- Impact on distress: 86% of guests reported reductions in distress; many attributed Safe Spaces with saving their lives. Guests valued the empathy, safety, and practical supports offered.
- System benefits: Safe Spaces avoided ~1,600 ED presentations, saving the health system an estimated $16.3 million. On an ongoing basis, they are projected to prevent ~895 ED presentations per year, producing a net annual saving of $5.4 million after operating costs.
- Suicide prevention: Safe Spaces became integral to safety plans, with 78% of guests feeling more confident to create safety for themselves.

Partnership and Collaboration

The Safe Spaces initiative exemplifies strong cross-sector collaboration:

- Brisbane North PHN commissioned and coordinated the program, ensuring alignment with regional mental health planning.
- Metro North Health provided strategic support and system integration, helping align Safe Spaces with hospital catchments and referral pathways.
- Community organisations (e.g., Communify, Stride, Neami National, Redcliffe Youth Space) each operate a Safe Space, embedding them in local communities.
- Compassionate Villages networks extend the model beyond health—linking guests to housing, employment, libraries, gyms, and social services, strengthening community responses to distress

Key Lessons

- The peer-led, non-clinical identity is critical to success and must be preserved.
- Safe Spaces complement but do not duplicate clinical services, filling a crucial system gap.
- Ongoing sustainability depends on secure funding, workforce support, and strong community networks.

In summary, Safe Spaces in Brisbane North demonstrate that compassionate, peer-led, community-based alternatives can save lives, reduce pressure on hospitals, and foster stronger partnerships across PHNs, HHSs and community sectors.