An Australian Government Initiative

Primary Health Networks' Response: Delivering Quality Care More Efficiently Public Inquiry Interim Report

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Contents

Executive Summary

This submission provides a coordinated PHN response to the Interim Report of the Productivity Commission's Inquiry into Delivering Quality Health Care More Efficiently. It strongly supports Draft Recommendation 2.1 of the Report, which recommends that Governments should embed collaborative commissioning to address system fragmentation within care. It also supports the Report's suggestion of an initial focus on requiring Local Hospital Networks (LHNs)[1] and PHNs to collaborate through a joint governance framework under the National Health Reform Agreement (NHRA). Our submission offers a regional perspective on addressing current barriers to joined up governance and funding arrangements to enable genuine collaboration.

PHNs are 'meso-level' organisations which play a lead role in regional coordination, commissioning and capacity building within the primary care system. They are uniquely placed to support reform towards a more integrated system of regional health care. PHNs have also had extensive experience of co-commissioning with LHNs in areas such as chronic illness, mental health and Covid-19. This submission recommends that through the forthcoming NHRA addendum, Commonwealth and State Governments should support implementation of genuine collaborative commissioning by:

- Embedding a joint governance framework which covers the entire planning cycle from needs assessment and planning, through funding and implementation, to evaluation and review;
- Giving recognition, authority and shared accountability for outcomes in the NHRA to PHNs and LHNs as local agents and leaders in commissioning regional health care services;
- Providing authority and resources for consistent data collection and sharing against a national outcomes framework to enable joint monitoring and reporting; and
- Addressing the need for dedicated resources for PHNs and LHNs to support governance arrangements and where appropriate, pooled funding for collaborative commissioning.

The levels of dedicated resourcing for LHNs, PHNs and ACCHOs required for enhanced joint governance requirements will vary from region to region, particularly for PHNs who liaise with multiple LHNs. PHNs agree with the Report's recognition that "to embed collaborative commissioning, PHNs require secure, longer-term funding agreements". Short term funding for programs and organisations impedes reform. PHNs also support the importance of engaging with and resourcing ACCHOs as key partners throughout the cycle of collaborative commissioning. We note the presence, capacity and reach of ACCHO services to Aboriginal people may vary across regions and a flexible approach to engagement needs to be negotiated. Consideration of indigenous data sovereignty issues by governments will also be important to progress data sharing.

PHNs recommend that joint governance arrangements should be underpinned by agreed core principles which support respectful collaborative arrangements. PHNs suggest these principles should include equity, transparency, mutual accountability, enduring commitment, a one system approach to health care, a focus on outcomes and flexibility to support place-based models of care. Whilst capacity for pooling funds is worth exploring and may be appropriate where funding programs align with shared priorities, this submission emphasises it is not essential for collaboration. Coordination of separate program funding may also support shared local priorities and outcomes.

There is enormous potential, if genuine collaborative commissioning and shared attribution of accountability is embedded at a regional level, to jointly address potentially preventable hospital admissions but also other health challenges through an integrated one system approach.

[1] For the purpose of this submission, the term Local Hospital Network (LHN) is also intended to encompass organisations known as Local Health Districts (LHDs) in some jurisdictions.

Introduction

This submission has been prepared by the PHN Cooperative to provide coordinated input from 30 Primary Health Networks (PHNs) across Australia to respond to the Interim Report of the Delivering Quality Care More Efficiently Inquiry being undertaken by the Productivity Commission. The PHN Cooperative was formed in 2017 by the CEOs of PHNs. It is a joint initiative of PHN CEOs from 30 PHNs and a commitment to collaboration and delivering on the national agenda in primary health priority areas.

This Cooperative broadly supports all three draft recommendations in the Interim Report. However the focus of our response is on Draft Recommendation 2.1 of the Interim Report which proposes *"Governments should embed collaborative commissioning, with an initial focus on reducing fragmentation in health care to foster innovation, improve care outcomes and generate savings.*[2]*"*

PHNs strongly support and commend this recommendation and agree it identifies a much needed system change required to address fragmentation and duplication and enable more efficient use of health care resources. We also strongly support the suggestion that collaboration between PHNs and LHNs should be the starting point for this, working in partnership with NACCHOs.

Background

About PHNs

Over the last 10 years, the PHNs across Australia have become a core element of the primary care system as 'meso level' organisations well-placed to promote coordination and integration. They are the key regional commissioning organisations within the Australian primary health care system. PHNs have proven that they can effectively plan, coordinate and facilitate implementation of agile, integrated responses to public health challenges, including emergency situations.

PHNs are uniquely positioned to support a 'one system' approach to regional health care through:

- System coordination and integration – reducing fragmentation and enhance coordinated, integrated care by working across services and sectors;
- Collaboration and building relationships – PHNs have well developed networks and relationships with LHNs, ACCHOs, service providers and the community;
- Regional commissioning of place-based services to target community needs;
- Collation of data and local intelligence to inform planning and commissioning;
- Capacity building – working with the primary care workforce to enhance their capabilities;
- Communication – offering a conduit to the regional primary care system.

What is co-commissioning and collaborative commissioning?

The draft interim report appropriately describes collaborative commissioning as "*organisations working in partnership to identify needs, design solutions, procure services and evaluate outcomes*". The report also highlights the expectation that in some cases combined funding should be involved. It is important to differentiate collaborative commissioning from other less integrated ways of working together, as PHNs have experienced confusion on the ground about this. Not all partnerships between PHNs and LHNs involve or require collaborative commissioning as they can work together in various ways. And conversely, simple information sharing or consultation, or sub-contracting services to PHNs does not represent collaborative commissioning.

[2] Delivering Quality Care More Efficiently Interim Report, Productivity Commission, 2025, p.30

Brisbane North PHN's submission to this Inquiry identified the below spectrum of co-commissioning which was developed through their Health Alliance with Metro North Health. This spectrum recognises that different commissioning activities may require different approaches, or some initiatives may benefit from a combination of approaches at different stages, including collaboration.

The spectrum highlights that collaboration involves working together on shared goals, processes and decision making. Combining funding is a higher level of collaboration which is not always required.[3]

PHN experience and achievements in collaborative commissioning

PHNs have had considerable experience in different types of co-commissioning at a local level. In the mental health and suicide prevention area, in particular, PHNs have been given a role through previous and current mental health and suicide prevention agreements in facilitating joint regional mental health planning in partnership with LHNs. Through these planning arrangements, some siloed funding has been broken down and programs of activity have been jointly planned and implemented. However, collaboration under these plans has often depended on relationships and goodwill between individuals in LHNs and PHNs and has not been supported by delegated and consistent recognition by the Australian and state governments and LHNs of the role and stewardship of PHNs at a regional level.

PHNs also demonstrated their role in coordination and collaborative commissioning in the response to COVID-19. PHNs enabled the rapid mobilisation of a coordinated primary care response at a local level, integrated with state funded services, including vaccination, PPE package distribution, and public health messaging. They also co-commissioned mental health hubs in partnership with LHNs to assess and respond to mental health needs. [4]

The role of PHNs in collaborative commissioning and their potential to play a greater role as local change agents to achieve integrated health outcomes has been recognised in a range of recent reports including Unleashing the Potential of Our Health Workforce, 2024[5], Australia's Primary Health Care 10 year Plan[6], the Mid Term Review of the National Health Reform Agreement (NHRA). 2022-2032[7], and the Strengthening Medicare Taskforce Report[8].

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[3] Brisbane North Primary Health Network Submission to Delivery Quality Care More Efficiently Enquiry, June 2025.

4 Covid-19 Response Inquiry: PHN Cooperative Joint Submission, December 2023

5 https://www.health.gov.au/resources/publications/unleashing-the-potential-of-our-health-workforce-scope-of-practice-review-final-report.

6 https://www.health.gov.au/resources/publications/australias-primary-health-care-10-year-plan-2022-2032

7 https://www.health.gov.au/sites/default/files/2023-12/nhra-mid-term-review-final-report-october-2023.pdf

[8] https://www.health.gov.au/sites/default/files/2023-02/strengthening-medicare-taskforce-report_0.pdf

Benefits of collaborative commissioning

This submission strongly supports the Productivity Commission's assertion that "*collaborative commissioning can support more integrated care by helping to align the planning and provision of services between different organisations and types of care, contributing to a more seamless experience for care users, particularly people with chronic or complex conditions*". The report also recognises benefits for productivity through more efficient use of available government funding, reduced duplication and potentially reduced need for hospital services. PHNs would like to highlight additional benefits which can ensue from formalised collaborative commissioning between PHNs and LHNs in relation to management of complex conditions:

- More optimal use of a maldistributed health workforce can be achieved through collaborative commissioning, particularly in rural and remote areas or other places experiencing thin markets.
- Where collaborative commissioning results in better management of chronic conditions, significant productivity gains can be achieved as individuals are more likely to participate in the workforce.
- Place-based, integrated service options which are informed by an understanding of local needs are more likely to achieve better outcomes, particularly for diverse populations.
- The agility to quickly mobilise joint action to respond at a regional level to public health emergencies in the event of disaster or a pandemic.
- Embedding architecture for collaborative commissioning also lays a foundation for innovation.

Barriers to collaborative commissioning

Despite the in-principle support for collaborative commissioning in the above key reports and agreements, there have been entrenched barriers to embedding it at a regional level. Overall, PHNs identified the lack of formalised and clear governance structures and attribution of accountability at a regional level to drive joint planning and commissioning as the key limitation to the implementation and operational success of reforms aimed at integrated care within the current NHRA Addendum[9].

Other significant barriers experienced by PHNs in collaborative commissioning have been:

- A lack of consistent recognition and understanding within LHNs and state governments of the role of PHNs as regional commissioning agents;
- A lack of shared understanding of genuine collaborative commissioning, as opposed to consultation, information sharing or sub-contracting;
- The lack of an authorising environment in which PHNs and LHNs can proceed with clarity and confidence to sustain collaborative commissioning arrangements; (See Table 1)
- Inflexible funding arrangements for both PHNs and LHNs. Funding priorities are often dictated or 'ring-fenced' by Commonwealth or State Government imperatives;
- Short funding cycles for initiatives and for PHNs themselves;
- Lack of dedicated funding for governance and collaboration;
- Restrictions impeding or delaying data sharing;
- Absence of up to date, official guidance for PHNs and LHNs on collaborative commissioning.

[9] PHN Cooperative Submission to Mid-Term Review of the National Health Reform Agreement, May,2023

Embedding new joint governance arrangements to support collaboration

What factors to establish a consistent joint governance framework should be considered?

PHNs strongly agree that Commonwealth and State/Territory governments should put "*architecture in place to enable collaboration to become business as usual"* as suggested in the Interim report[10]. Requiring LHNs and PHNs to collaborate through a joint governance framework is an excellent starting point. To achieve this, first and foremost, an authorising environment for LHNs and PHNs must be established which provides clear recognition, permission and expectations of collaboration, as set forth in the below table.

Table 1 - Towards an authorising environment for collaboration between PHNs and LHNs

	From	To
Recognition of regional PHN role	Variability in understanding the regional role of PHNs among jurisdictions and LHNs	Formal recognition by jurisdictions of the role of PHNs as regional commissioning agents for primary care at a regional level
Requirement to collaborate	LHNs and PHNs encouraged to communicate and consult on their respective activities and goals	PHNs and LHNs required, directed and assisted through agreements to collaborate on implementing shared priorities in NRHA and required to jointly report on outcomes
Authority to combine or coordinate funding	Priorities and service structure driven at a state or federal level, with inflexibility to combine funding at a regional level	Authority and flexibility for PHNs and LHNs to combine or coordinate funding as needed to jointly respond to priorities identified in NRHA
Data sharing	Delays in monitoring and evaluating outcomes due to data sharing barriers	Authority for data sharing between PHNs and LHDs should be embedded in the NRHA

Importantly, a joint governance framework must cover the entire planning cycle from needs assessment and planning, through funding and implementation, to evaluation and review. In the past, attempts at collaborative commissioning have achieved joint planning, but a failure to achieve shared accountability for implementation. The framework should also recognise there may be a need for specific working groups on planning, data and management of joint funding arrangements.

In addition clarity should be provided in the NHRA of the broad priority areas to be targeted through collaborative commissioning, without being prescriptive. Flexibility should be given to LHNs and PHNs to develop appropriate service responses to address local needs within these priority areas.

Finally, joint governance arrangements should be underpinned by agreed core principles which support respectful collaborative arrangements. PHNs suggest these principles should include:

- *Equity*: Ensuring fair, inclusive and collaborative engagement through respecting and managing differences in roles, resources, levels of risk, and capacity.
- *Transparency*: Commitment to partnership through transparency and a spirit of cooperation.
- *Mutual accountability*: Through agreed actions and addressing challenges collaboratively and shared inclusive decision making.

[10] Productivity Commission, 2025, p.35.

- *Enduring commitment*: Participation in the full cycle from needs assessment and planning through implementation to evaluation and review.
- *A 'one system' approach to health care*: Commitment to working towards an integrated and seamless system of care.
- *Place-based models of care*: Jointly working towards better meeting the needs of local populations and making optimal use of the regional workforce.
- *An outcomes focus*: Identifying and working towards clearly defined shared outcomes.

How should an outcomes framework be designed for joint monitoring and reporting?

Development of an outcomes framework should involve engagement with representatives of PHNs, LHNs and ACCHOs. In general the framework should consider outcomes relating to system capacity, efficiency and consumer outcomes. It should also consider a suite of indicators including but not limited to the number of potentially preventable hospital admissions, given the difficulty attributing any positive or negative changes in outcomes. Interim indicators should be included which include consumer reported perceptions of wellbeing and of the seamlessness of the care experience. Other interim measures of integration may also be possible. The framework should identify core outcomes to be sought and allow for secondary outcomes to be developed at a regional level specific to place-based needs and priority populations by LHNs and PHNs.

Towards shared data

In developing new joint data sets, arrangements must be in place for more agile data sharing between hospitals and PHNs to enable joint monitoring of individual patients and evaluation of patient outcomes. This will require more flexibility by the Australian Government as well as jurisdictions. If a focus is to be on collaborative commissioning services aimed at a cohort at risk of Potentially Preventable Hospital Admissions, a shared data set will be vital to enable shared management, swift interventions in the event of escalation and evaluation of outcomes. The experience of PHNs has been that there have been significant delays in the release of patient data to inform evaluations, and that systems are not currently in place to support this level of collaboration and the timeframes required for monitoring patient outcomes. The NHRA Addendum must authorise and support consistent data collection and sharing against a national outcomes framework.

How should LHNs and PHNs partner with ACCHOs and other organisations?

PHNs strongly agree with the importance and value of engaging with ACCHOs as key partners throughout the cycle of collaborative commissioning. Engagement with ACCHOs should be undertaken in a way which ensures early input to needs assessment and service planning and supports key principles of self-determination. Guidance for governance arrangements will need to recognise that the presence, capacity and reach of ACCHOs may vary across regions and a one size fits all approach to engagement may not be practical. For example in some PHN regions, the ACCHO's geographic reach may be limited to a small part of the region. Just as additional resources are required for PHNs and LHNs, additional resources for ACCHOs to enable them to participate in local governance arrangements will be critical.

Indigenous data sovereignty will be an important issue for ACCHOs in the context of shared data, and an important consideration for governments as well as regional organisations. Resolving this will require time and negotiation with ACCHOs but should not delay progress to collaborative commissioning. Supporting guidance for collaborative commissioning developed by governments should include input and advice from NACCHOs on this issue.

Engaging with other key stakeholder organisations, including health consumer organisations, NGOs, mental health organisations, and representatives of Culturally and Linguistically Diverse (CALD) communities and other local population groups is also important. Flexibility should be provided in the way in which this is achieved to reflect the variation across regions.

Funding arrangements for certainty and flexibility

PHNs strongly agree with the Interim Report's suggestion that "to embed collaborative commissioning, PHNs require secure, longer-term funding agreements" and that "LHNs and PHNs need some flexibility to collaboratively commission services that meet local needs". PHNs also can confirm that modest additional dedicated funding will be needed to implement and sustain new joint collaborative commissioning governance arrangements and data sharing initiatives.

What levels of resourcing are required?

Both PHNs and LHNs will require dedicated funding to support collaborative governance arrangements. The levels of resourcing required to support enhanced joint governance requirements is likely to vary from region to region, particularly for PHNs. A critical factor for the level of PHN governance funding will be the number of LHNs with whom the PHN needs to collaborate. Some PHNs have 3 or more LHNs in their region, requiring as many individual governance structures. The current lack of dedicated funding within LHNs for collaboration with PHNs through governance arrangements or to develop shared data bases has been a barrier to genuine collaboration.

The level of dedicated funding for joint service delivery required will also depend on factors like rurality, socioeconomic demographics of the region, population and any workforce shortages as well as the scale of the problem (eg rate of preventable hospitalisations in the region). PHN funding from the Commonwealth is already subject to a formula which builds in some of these factors in relation to mental health and other discrete program funding.

What types of funding could be pooled?

Whilst capacity for combining funds is worth exploring, this submission emphasises it is not essential for collaboration. If PHNs and LHNs collaborate towards shared goals, processes and review, separate funding can be coordinated to achieve integrated services and better outcomes. Pooling could be considered if funding programs align with shared priorities, and combining available funds in an area enables more optimal use of available workforce and supports integrated service delivery. This might be the case, for example in more remote areas. However there are some programs for which fund pooling would not be recommended within primary care. For example headspace services, or Medicare Mental Health services, for which the integrity of the service model needs to be preserved. In general, there is not significant dispensable funding in PHNs which could be pooled.

What additional supporting actions by governments are needed?

What else needs to be considered by governments to implement the reform?

Overall PHNs strongly support the proposal in the Interim Report that "In the next addendum to the National Health Reform Agreement, governments should agree to governance and funding arrangements that support better collaboration between Local Hospital Networks (LHNs), Primary Health Networks (PHNs) and Aboriginal Community Controlled Health Organisations (ACCHOs)." We recommend in this context that the next addendum must also embed an authorising environment for PHNs and LHNs in relation to regional planning and collaborative commissioning as outlined above.

In addition, on a State-by-State basis, a joint declaration, or heads of agreement between State/Territory Departments of Health, PHNs, LHNs and the Commonwealth Department of Health, Disability and Ageing should be established. This would detail how parties will work together on joint planning and commissioning approaches, with a growing program of work. Representation should be balanced to ensure balance of power. A critical factor in implementing the reform will be securing support of states and territories both to new joint collaborative arrangements and identifying existing or new program funding which would be suitable for fund pooling.

To enable collaborative commissioning to become 'business as usual', practical guidance should be jointly developed for LHNs, PHNs and other regional stakeholders. This should be supplemented by funding and information on available data to be used and shared to support collaborative commissioning. In 2018, through implementation of the Fifth National Mental Health and Suicide Prevention Plan, a comprehensive Guide on Joint Regional Planning for Integrated Mental Health and Suicide Prevention Planning was prepared for LHNs and PHNs.[11] This was supplemented by a data compendium providing advice on regional data available. While this guide is now out of date, it indicates there have been precedents to collaborative development of guidelines of this nature.

The mismatched boundaries will present more of a problem to PHNs than to LHNs. If realignment isn't possible, resourcing for governance arrangements and commissioning processes must recognise the additional resources required by those PHNs in regions of multiple LHNs.

Finally, effective and coordinated workforce planning will be vital to the success of any longer term collaborative commissioning initiatives and should be informed by needs assessments undertaken through collaborative governance arrangements.

How can this proposed reform be employed to further integrate services across the care sector?

There is enormous potential, if genuine collaborative commissioning arrangements are embedded at a regional level to jointly address other health challenges through an integrated one system approach. Within health this could include mental health and suicide prevention activity, rural and remote health challenges and public health disaster responses. The current focus on building multi-disciplinary teams in primary care to better manage chronic illness holds significant potential for collaborative commissioning. More broadly robust governance structures established through this process could also support liaison between PHNs, LHNs and other care sectors, particularly aged care and disability services to achieve whole of government outcomes for particular underserved priority populations.

11 https://www.google.com/url?sa=t&source=web&rct=j&opi=89978449&url=https://www.health.gov.au/sites/default/files/documents/2020/11/joint-regional-planning-for-integrated-mental-health-and-suicide-prevention-services_0.pdf&ved=2ahUKEwjslMypxcCPAxWFSWwGHZPiHyUQFnoECBMQAQ&usg=AOvVaw2wTmhljoFrL9P8634MkVL1