12 March 2025

Mental Health and Suicide Prevention Agreement Review
Productivity Commission
GPO Box 1428
Canberra City ACT 2601

By electronic submission

Dear Commissioner

Subject: Productivity Commission Review of the National Mental Health & Suicide Prevention Agreement

The Western Queensland Primary Health Network ("WQPHN") appreciates the opportunity to provide feedback as part of the Productivity Commission Review of the National Mental Health & Suicide Prevention Agreement ("the Agreement"). WQPHN covers a vast region and faces unique challenges in terms of healthcare access, service delivery, and workforce sustainability, which we believe are critical considerations for the current Review of the Agreement.

Regional Context and Challenges

The WQPHN is geographically the fourth largest Primary Health Network (PHN) in Australia, with a total land area of 956,438 km^2 – equating to 55% of the total land mass of Queensland. All areas are classified as either remote, or very remote, and long distances are required to access services, frequently with no alternative to private transport. The demography is diverse with natural and environmental impacts major challenges, as both floods and droughts are common. The region's friable healthcare services operate in a very "thin" or no market environment and associated workforce shortages are longstanding and severe, particularly for general practitioners and mental health professionals. A recent NOUS (2025) report on the need for significant investment in remote and very remote health to address health inequities, states, "[t]he $6.5 billion annual budget underspend on healthcare services for rural, remote and First Nations communities, highlights their lower use of services, and points to the barriers they face in accessing affordable healthcare. This rural-urban gap widens substantially for consultant specialist services, which are especially costly and difficult to access outside of urban centres" (NOUS 2025, p7).

Rapid churn among the health-care workforce compounds the long-standing challenges. Only nine General Practices and four Aboriginal Community Controlled Health Organisations (ACCHOs) serve the entire region, with numerous communities over 1,000 kms distant from either and frequently lacking pharmacy or other services typically found in other rural and remote communities. This diverse and challenging environment requires tailored responses rather than a "one-size-fits-all" approach. A deep understanding of regional differences is essential to foster meaningful relationships and partnerships that can deliver mental health, suicide prevention and other services that are needed on the ground.

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Based on the 2021 Census data, the WQPHN region has an estimated population of approximately 63,678 residents, with 12,174 (over 19 per cent) identifying as Aboriginal and Torres Strait Islander peoples. The region also encompasses 34 Indigenous language groups, reflecting its rich cultural diversity. The diverse population groups covered by the PHN experience far higher risk of mental and physical ill health, avoidable hospitalisations, socio-economic disadvantage and all the factors that pre-dispose people to and correlate with increased mental health and suicide risk. While there are pockets of relatively high advantage, these are in stark contrast with the majority of the population and the prevalence of extreme disadvantage.

Key Western Queensland Mental Health and Related Statistics

Mental health is the highest recognised health needs domain in Western Queensland vis-à-vis other presenting primary health conditions (and often correlating with other issues especially alcohol and other drug use, and other primary health care issues).

In the context of remote/very remote areas serviced by 9 GP practices, 3 HHSs and 16 Primary Health Centres, the following key statistics from the Western Queensland Joint Regional Needs Assessment (2024) highlights key disparities in mental health in relation to the Qld average:

- Admission for mental health related conditions is **58% higher**
- Suicide and self-inflicted injuries are **22% higher**
- Potential years of life lost from suicide and inflicted injuries are **33% higher**
- Community mental health patients are **55% higher**
- 17 communities or **42.14% population without access** to:
  - A regular GP
  - Pharmacist
  - ACCHO.

WQPHN's Strategic Approach

To meet these challenges and inequities, WQPHN have established seven (7) unique Commissioning Localities (CLs) in consideration of primary care flows, funding, demographic and cultural considerations. The CLs provide a place-based regional framework to plan and provide a way for WQPHN and its partners to work together to enable access and tackle health inequality.

WQPHN works in partnership with the broader health system across the region, and plays a crucial role in facilitating better integration, coordination, access, and care pathways to address current and emerging needs. Such partnerships are essential given the sparse service presence. The relative maturity of Western Queensland's primary health networks joint governance arrangements — including our partnerships with Aboriginal Community Controlled Health Organisations (ACCHOs) and Hospital and Health Services (HHSs) – mean our region is a clear candidate to lead in delivering on more integrated, locally responsive and innovative approaches foreshadowed for the forthcoming National Health Reform Agreement.

Aspirations and Future Direction

Our intention is to deploy primary healthcare program funding arrangements that respond to community needs in a way that is genuinely flexible and outcome-focused, rather than simply as conduits for national health programs. With the unique strengths of WQPHN, we are primed to lead transformation of the local mental health and suicide prevention and related health system to meet prevailing high demand and future challenges. Our focus is to **deliver better outcomes for all rural, remote and very remote Western Queenslanders**. We are acutely aware that improving the impact and outcomes of metal health programs and services depends not only on the quantum of that investment but whether they are configured to optimise access, care continuity and outcomes for local people and the communities they live in.

We encourage the Productivity Commission to consider the key insights and recommendations outlined in **Attachment A**, which build on the PHN Co-operatives submission to this Review (outlined in our response); the recent WQPHN submission to the PHN and Mental Health Flexible Funding Review; and the National Health Reform Agreement review. Importantly, the recommendations reflect the lived experiences and operational realities of delivering primary healthcare in a remote/very remote context. In turn, they will provide a stronger basis on which to promote healthier, more connected, productive and sustainable communities in Western Queensland.

WQPHN remains committed to advancing health equity and ensuring all Western Queenslanders have access to the care they need. Please contact Deb Spanner, A/Head of Primary Health and Commissioned Services on deb.spanner@wqphn.com.au, or me at sandy.gillies@wqphn.com.au, if you have any further questions relating to this Submission.

Yours sincerely

Sandy Gillies
Chief Executive Officer
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ATTACHMENT A

WQPHN Submission to Productivity Commission Review of the National Mental Health and Suicide Prevention Agreement

Introduction

Primary Health Networks (PHNs) play a vital role in improving health services in Western Queensland by working to address local health needs and fostering integration across the system. However, much of the work undertaken as it presents at the local level is directed by more than one government and/or agencies and these do not always align consistently align or target local priorities or capacity.

Our ability to respond effectively to local need is hindered by multiple and sometimes competing requirements, together with limited funding flexibility and difficulty attaining influence in formal state and federal policy review and development. We are also frequently constrained in responding to emergent needs, such as disaster recovery, because funding programs do not reflect localised needs, including those identified through joint assessments. WQPHN believes it is possible to respond effectively to government priorities, focus on improving impact and responsive to community needs and remain accountable for public expenditure and with regard to program and policy objectives.

The National Health Reform Agreement[1] outlines six strategic objectives for PHNs:

- Identifying local health needs and developing responsive services.
- Commissioning health services to meet regional needs.
- Improving patient journeys through integrated services.
- Supporting clinicians and providers to enhance patient care.
- Implementing innovative primary health care initiatives.

Governance

WQPHN reiterates the PHN Cooperative's position, that:

- the Agreement's Governance section does not clearly define the role of PHNs – noting only that the Parties to the agreement (Commonwealth and States) would engage with 'other relevant bodies' as required to support the implementation of reforms. To date, the lack of PHN role clarity has contributed to an unbalanced implementation relationship at the regional level. PHNs have a strong onus for action, but frequently this is not enabled by regional implementation mechanisms, incentives, or accountability frameworks that are commensurate with the Agreement's deliverables.
- As we understand it, PHNs had very limited engagement with the Agreement's national governance forums and the various levels of jurisdictional governance. This has hampered our ability to access timely and relevant information and to inform our key role in regional planning and implementation.
- Future agreements should provide a stronger mechanism for regional implementation and collaboration around Agreement deliverables, including a clearer authorising environment for PHNs

[1] NHRA Addendum Schedule E, section 27.

and Local Hospital Networks (or Health and Hospital Services) to plan, commission, and deliver the ongoing system reform agenda envisaged by the Agreement.

- Future agreements would be strengthened by aligning with other national Agreements, such as the National Health Reform Agreement (as is being proposed), and ensuring PHNs, LHNs, and government parties are engaged in comparable planning, integration, and system reform activities.

Additionally, WQPHN submits that:

- The existing governance mechanisms informing the National MH & SP Agreement omit PHNs, yet they are expected to play in Australia's health system. To carry them out our responsibilities effectively, PHNs must be empowered with a seat at the table in policy development and supported by outcomes-based funding models. Greater funding flexibility would enable PHNs to address regional challenges, innovate locally, and measure long-term impacts. Multi-year funding cycles are also essential to provide stability and ensure sustainability, especially in environments where service providers must work together (as in Western Queensland) and avoidable disruptions in service continuity can have dire consequences in communities where few alternative supports are available.
- WQPHN has governance mechanisms in place that not only support joint regional planning, but also acts a conduit to prioritise activity, share resources and open transparent reporting.

Examples of effective and collaborative partnerships are:

- **Western Queensland Health Services Integration Committee (WQHSIC)** consisting of membership from HHS, ACCHOS, Queensland Office of Rural & Remote Health (ORRH); Queensland Reform Office (QRO) and WQPHN.
- **Nukal Murra Alliance** with membership between the four (4) ACCHOS and WQPHN.
- **South West Primary Health Care Alliance** is regional based with an emphasis on primary health care system of care in the South West region. Membership includes HHS, WQPHN, three (3) ACCHOS, Allied Health, QRO, private GP.
- **Mornington Island Health Partnership** – community-based governance committee consisting of local Mornington Island Health Council, North West Hospital Health Service (NWHHS); Allied Health, Local Government.

Other examples demonstrate the success of collaborative governance through joint regional plans, such as the current Western Queensland Five-Year Mental Health, Suicide Prevention, and Alcohol and Other Drugs Plan 2021-2026. Partnerships with Hospital and Health Services (HHSs), local councils, commissioned and non-commissioned service providers have strengthened integration and reduced health system fragmentation. This is particularly evident through the development under the Bilateral Agreement of the Universal Aftercare Services (UAS) across the three HHS regions covered by WQPHN – south-west, north-west and central-west - which results in deepened engagement in all sub-regional areas, and draws from the expertise of HHSs other providers, as well as people with a lived experience.

By advancing these strategic objectives, addressing funding constraints, and strengthening our voice in policy-making, remote and rural PHNs (in particular) can drive improved health outcomes for Queensland's diverse population and adapt to the complex challenges of a rapidly evolving health landscape.

WQPHN ensures that commissioning and co-commissioning is the best fit for WQ communities, always striving to achieve alignment between place-based needs arising from genuine engagement. Localised examples of strongly co-designed mental health initiatives, include: RHealth's Head to Health telephony service which has three place based connectors available in sub-regional areas to connect people with digital mental health and wellbeing supports, acknowledging the limited uptake of digital initiatives in our region for a range of reasons including poor digital and health literacy. Lives Lived Well's new Low Intensity Model for Western Queensland LIME, and Severe and Complex Mental Health co-ordinator's service provision in GP practices, were both modified (with agreement) from the national framework so as to meet the constraints of the overall mental health workforce across WQ communities.

Healthy Outback Communities (HOC) Alliance is a collective of both commissioners, policy leads, local government, service providers and state peaks representing consumers, workforce and health & wellbeing coming together to support an award-winning health system reform agenda in very remote WQ communities. The HOC Alliance discussions support regional planning, engagements and open and transparent communication about advancing primary health and mental health and wellbeing social impact.

WQPHN Recommendations:

- **Enhanced representation and governance at the policy-setting level of health reform** should assist in delivering clear communication and aligned policy interests. It would contribute towards addressing the siloed funding and program guidelines. The PHN entity may be the best-placed filter of program specific initiatives that enhance the primary mental health, and suicide prevention integrated care offerings close to home. This approach could also reduce competition and division in communities that frequently have trouble in gaining access and fragmented services and supports along the Stepped Care Model.
- Embed **culturally informed governance structures** across PHNs, leveraging partnerships with ACCHOs and HHSs to ensure that governance frameworks address social determinants of health.
- **Formalise the role of First Nations organisations and leadership in decision-making processes** to enhance trust, accountability, and service alignment, culturally safe, and tailored care addressing regional health disparities.
- Prioritise innovative and Values-Based Health Care funding models that recognise the higher delivery costs and complexities in remote and very remote areas, and that **embed meaningful measures of outcomes and collective social impact** of services and support to communities.
- **Support targeted, region-specific initiatives** (ideally with secure resourcing that promotes cross-agency assurance and attracts co-investment) to address workforce and service access gaps at a more structural and locally enabling level.

Regional Planning and Commissioning

WQPHN reiterates the PHN Cooperative's position, that:

- The role envisaged for PHNs in the Agreement's regional planning and commissioning deliverables was not routinely recognised by jurisdictions or LHDs. In general, there was some initial engagement in preparation of joint plans but a lack of ongoing commitment to implementation.
- PHNs have a track record in partnering with LHNs on emerging mental health issues, such as the demands of responding to COVID, or management of complex conditions. The issue is that LHDs are not routinely required or supported by jurisdictions to co-commission or to implement joint regional plans through contractual obligations.
- The Parties failure to deliver national Guidelines for Joint Regional Mental Health and Suicide Prevention Planning contributed to uncertainty at the regional level. The National Principles for Regional Planning and Commissioning of Mental Health and Suicide Prevention Services did not help to deepen regional frameworks for this activity
- The Agreement's deliverable of Joint Regional Mental Health and Suicide Prevention Plans is a necessary first step. However the Agreement lacks the necessary regional enablers and authorising environment for PHNs to translate the Plans into ongoing system integration and reform outcomes.
- The National Suicide Prevention Strategy recommends expanding joint regional planning and including additional stakeholders, such as local government. WQPHN strongly supports this view. To achieve this outcome, future Agreements will require greater recognition and investment in the resourcing, quality frameworks, and mechanisms to enable effective planning and ongoing system integration and reform programs

Additionally, WQPHN submits that:

PHNs have been established as regional commissioning bodies, specifically designed to improve health outcomes by linking Commonwealth-funded programs with local systems and stakeholders. Our commitment to responding locally is demonstrated through advocacy, enabling community progress, and fostering unity. By co-designing responses with communities, we ensure that health and wellbeing needs are met effectively.

Leveraging the PHN Strategy and the "Three Cs" (coordinate, commission, capacity build), PHNs can function effectively as local implementation partners, tracking and evaluating programs during rollout phases to shape and inform future programs and policy.

WQPHN proposes a stronger emphasis on early intervention and prevention, intersectional collaboration, and streamlined funding guidelines. Local solutions generated by the PHN as stewards through a genuine co-design role, enable communities to break through current barriers such as significant stigma and discrimination surrounding mental health, wellbeing and suicide prevention. By empowering PHNs with the resources and flexibility to lead innovative health solutions, we can transform our health system to better serve Queenslanders.

Despite working in adverse operational, funding and policy environments, WQPHN through our partnerships promote innovation within the constraints of government direction.

At any point in time, stakeholders should know what the role of the PHN is, recognising that this is a dynamic remit, particularly in remote and very remote areas. This requires more frequent engagement, which also has a resource implication that other PHNs may not face on a comparable scale.

Furthermore, the overall capacity of stakeholders is different. Higher level engagement in health policy objectives by a skilled and strategic workforce can be very thin, due to scale and paired back service delivery focused, which can result in a focus on day-to-day pressures and operational matters at the expense of the more systemic and strategic considerations, which are also needed in reconfiguring service systems to better deal with changing and future service demand.

WQ is a rural/remote PHN – the funding models do not reflect the instability and higher levels of severity and complexity held by practitioners who are often having to work well beyond the scope of their professions' colleagues. Beyond Blue's New Access program is a good case study in that as low intensity model, due to issues such as late help seeking behaviours, result in higher needs on presentation, complicated by workforce and capacity issues such as early-stage maturity and friable nature of the service system.

Peer workforce development and engagement, while highly important, is a challenge to implement in remote environments due to challenges in sustaining existing service systems. Operationalising the peer workforce is difficult due to issues of service infrastructure and knowledge/support, significant stigma and discrimination and a culture of stoicism and late help-seeking behaviours, isolation, supervision costs, lack of rural frameworks, and predominance of urban models that have been adapted without evidence to non-urban environments.

WQPHN Recommendations:

- Transition to an evidence-based **outcomes-based funding model** that incentivises high-quality, National and State peak bodies who advocate and influence national policy and funding should be tied in to PHN regional intelligence to inform the needs and gaps in mental health, suicide prevention and related services.
- Strengthen **co-design processes** by involving First Nations leaders and community representatives in all MHSP stages of planning and implementation.
- Tailor regional planning to address geographic, cultural, and demographic realities, ensuring a more equitable distribution of services.
- Establish long-term engagement frameworks to foster trust and improve service uptake.
- Support PHNs to co-design person-centred, flexible, locally informed and integrated mental health models, that: **consider realities** of WQ remote/very remote communities; **value add to existing service infrastructure** in ways that are effective, trauma informed and culturally and locally responsive for participants and service providers, and which **build up and sustain local mental health workforce capacity**; **create regional and centralised efficiencies**; develop service system responses that are **sites of workforce development and training excellence, supervision, innovation, and research and learning.**

Data Measurement and Accountability

WQPHN reiterates the PHN Cooperative's position, that:

- PHNs are custodians of mental health and suicide prevention data assets, which, together with our knowledge of regional mental health and suicide prevention systems, can be used to create scalable frameworks for national monitoring and reporting.

- As regional planning and commissioning bodies, PHNs are well placed to contribute to the technical implementation of the Agreement especially with strengthened national data collection, validation, quality, and conformance. This should be progressed through collaboration between DoHAC, AIHW, and PHNs linked to the Agreement's Technical Implementation Plan governance arrangements.
- National measurement and reporting objectives are constrained by the lack of a clearly defined target population who are intended to receive services from PHNs under the Agreement. By clearly defining the ordinate population who receives services, Governments, LHNs, and PHNs will have a key reference point for planning and commissioning decision-making, and can develop frameworks for consistent and commensurable regional, state, and national reporting; as well as the tools to monitor and adapt more effectively to shifts in population need, demand and other developments.
- Implementation of the Agreement may have been impeded in some instances by lack of regional data, particularly regarding workforce supply and demand. Joint regional mental health service planning requires this data to be fully effective.

Additionally, WQPHN submits that:

Many mental health service delivery and related data models have underlying assumptions (drivers) formulated by policy makers that do not reflect the evidence of remote/very remote context, and which produce output data that is decontextualised, and which does not measure what matters to remote/very remote communities.

WQPHN Recommendations:

- **Adopt a Value-Based Health Care Model**: Transition from commissioning for activity-based outcomes to focusing on measurable, meaningful outcomes that reflect improvements in health and wellbeing.
- Invest in **data infrastructure and analytics** to enable predictive modelling and tailored service delivery in remote areas.
- Develop tools that integrate data from PHNs, ACCHOs, and other local providers to improve planning, resource allocation, and performance monitoring.
- Fund flexible mental health models that allow for fit-for-purpose service responses; and support the use of **digital health platforms** to enhance communication, care coordination, and patient engagement across vast regions.