Response from Hunter New England Central Coast Primary Health Network to the Productivity Commission report on Mental Health January 2020.

Key Points:

Since their establishment in 2015, HNECC and other Australian Primary Health Networks are delivering or working towards delivery of the Mental Health Care in the manner that the Productivity Commission suggests this be done.

PHNs are:

- already commissioning, the significant range of primary care services including mental health services.
- already funding headspace services across the region.
- are already doing population health planning, co designing of services, place-based commissioning and, importantly engage with the range of clinicians and communities.

So, we make the emphatic statement that PHNs are in place and possess the valuable experience and expertise required to ensure those services are provided.

Introduction

This draft Report is extensive in its coverage of mental health in Australia but is not contemporary in its understanding of the significant role of PHNs in the delivery of mental health services across Australia.

The draft report attempts to set its review in the strategic contexts of a Federated health system, one that has distinct but also complementary roles between the Commonwealth and States and Territories. It also attempts to address the entrenched structural interests both within the health sector as well as across the public sector as well and to include socio – economic determinants that impact on individual and population health. The

recommended models proposed in the Report will do little to address the complications of the structures and in our view will further complicate the structures and their effectiveness.

Structural health reform often produces 'no measurable gains and puts things back by 18 months or more' and that One size fits all templates of change, represented by standardisation and generic strategies, too often fail and that big, at-scale interventions sometimes have little or no effects and that small initiatives can sometimes yield unanticipated outcomes [1,p.2.,4,5,6]

The extensive nature of this approach in this draft productivity report does not properly consider how health reform at a major structural level is difficult to achieve in Australia and internationally. International research into health reform ask the question as to 'whose interests are being served in this reform? Secondly, when advocates seek to implement change, health systems do not react predictably. Braithwaite suggests that

> 'the sheer number of variables and the unpredictability of their interactions make it hard to impose order. And health systems are indeterministic—meaning that the future cannot be predicted by extrapolating from the past.' [1, p.1]

The variables traversed in the draft report are immense and suggest that they will be very unpredictable in addressing mental healthcare reform while implementing structural and policy reform in the manner the draft report suggests.

The implications of this draft report will have significant detrimental effects on the viability of the recently established Primary Health Network System across Australia. The authors of the draft report are advised that nearly 80% of all contracts, the HNECCPHN have with the Federal Government are for mental health programs! This position is likely to reflect the position in all PHNs.

It is inconceivable that the Federal government and the Department of Health would consider the proposed models in the report after we have undergone extensive previous restructures of models to deliver PHC from Divisions of General practice and Medicare Locals and then PHNs to then create RCAs. If the objective is to completely alienate and disenfranchise GPs and to disengage community confidence in the health system, then adoption of these models and another bout of structural change is a great way to do it!

The lack of implementation of reforms proposed for the previous national health reforms [2] following extensive consultation and engagement are testimony of the resilience within the system to not easily accept reform.

Braithwaite suggests that 'meaningful reform pays much more attention to how care is delivered at the coalface, all meaningful improvement is local, centred on natural networks of clinicians and patients.' He goes on to say that 'the lone hero model does not work, and that collaboration underpins all productive change; and always starts with the patient at the centre of any reform measure'. He goes onto suggest that we could simply be humbler in our aspirations. Putting the myth of inevitable progress aside, we should recognise that big, at-scale interventions sometimes have little or no effects' [1, p.3] Braithwaite emphasises that

> Healthcare is governed far more by local organisational cultures and politics than by what the secretary of state for health or a remote policy maker or manager wants. [1, p.2]

This response to the draft report, addresses the strategic intent of delivering care in a Federated health system and how mental health should be viewed, secondly, this response demonstrates how HNECCPHN are already successfully implementing much of what the draft report wants to do and thirdly brings attention to the more detailed impacts that of the recommendations. **This response recommends that a third model where the PHN acts as a commissioner for State funded mental health services be adopted.** This recommendation saves the need to repair or rebuild or pool funds directly to yet another set of organisations!

1. Strategic intent

The strategic intent of the Productivity Commission Report suggests at the start that we consider two model options for future mental health funding/commission. It is of concern that without much evidence the two models seem to be an attempt to be a 'work around' of the strictures of Commonwealth and State funding, by the creation of another layer/level of bureaucracy!

In responding to the draft Productivity response, we need to ask what is it that we are talking about. Contemporary literature suggests that the answer is that we want to achieve

holistic, humane and integrated care. This means that we need to develop structures that reflect that response and that we adopt a care philosophy that acknowledges the existence of a very close relationship between body, mind and soul(spirit) that emphasises that every dimension of humans is distinctive, and unique and at the same time they are connected to each other. This requires changes to traditional medical approaches and a focus on integrated comprehensive care delivery. [6,7]

The proposed separation out of mental health is contra indicated given our view that healthcare is about integrating physical health, mental health and wellbeing and, not by ordering it to reflect sectional interests and ideologies. The draft report suggests this latter approach rather than patient centred care.

In the wider context of primary healthcare where we (HNECCPHN) see a role and purpose of 'healthy people and communities' [8] that:

> Values health above that of valuing healthcare [9]
>
> Engages people and communities in planning and decision making about their health and how they might access the care required
>
> Looks for innovative, across sector, approaches
>
> Consider localism, subsidiarity and distributed networks of practice (DNOP) as a means to engage and provide care [10,11]

The Commonwealth in the past few years have established and funded PHNs enshrined in the Governments National health reform agreement of 2010 and PHNs were operational by 2015. to

1. Identify and address health needs in communities – Population health planning
2. Support and develop improved health care amongst primary care providers, with a focus on general practice – Practice support
3. Develop and implement improved care pathways and models of care
4. Service co-design

5. Commission health services to communities – contracting with providers we do not directly deliver services other than practice support

6. Deliver improved health outcomes, experience and value for money for people and communities

7. Ensuring services are delivered in a way that is accessible and sustainable for providers and relevant to the community they are being delivered

In effect PHNs are already delivering what the Productivity report suggests should be done!

PHNs are:

- already commissioning, the funding of the significant range of primary care services including mental health.
- already funding Headspace.
- are already doing population health planning, co designing of services, place-based commissioning and, importantly engage with the range of clinicians and communities.

So, we make the emphatic statement that PHNs are in place and possess the valuable experience and expertise required to ensure those services are provided.

There is also no impediment to them accepting funding and a commissioning role on behalf of other agencies at the State, Commonwealth or from the private sector.

This could occur instantly by inviting States and Territories to utilise this already available facility and function. In fact, permission is not needed and the fact that the PHNs boundaries and those of LHDs are already consistent, gives permission or licence for this to occur. [7]

This approach consolidates an adherence to localism and the principle of subsidiarity on which PHNs were established!

We respectfully recommend that the Commonwealth and States confirm the potential dual roles of PHNs in the continuation of mental health commissioning,

including funding across State and territory services at the request of those agencies.

1.1 Wholistic person centred healthcare

The contemporary international view of health delivery is wholistic, person or patient centred/ based, situated within communities with some equality and certainly to be available in an equitable fashion. Contemporary care is increasingly being based on PHC, prevention and health promotion. It is increasingly focussed on the impact of SOECD determinates and UN SDGs. In the wholistic approach the 'carving out' of one dimension, being 'mental health' from physical and emotion wellbeing contravenes contemporary notions of collaboration, integrated and connected care. It makes access, equity and networking more difficult.

We recommend that systems of care and their funding should demonstrate characteristics of community access, collaboration codesign and integrated or nested and stepped care.

The two models in the system are named 'repair or rebuild' which are terms that denote some degree of negativism!

We recommend a model, a third model that would be better described as a model of 'building healthier people and communities' to emphasise the contemporary, integrated and value-based approaches described.

1.2 Resource constraints

The current and likely funding of the Australian health care system **cannot afford the establishment and funding of two competing commissioning organisations** when one can do both at, perhaps marginal additional costs.

1.3 Regional, rural and remote communities

The recommendation of a separate commissioning approach for mental health will weaken the available expertise currently available to PHNs. The experience of PHNs in commissioning rural services has demonstrated significant health workforce shortages that will become even more marginal if they delivered in separate competing services.

PHNs are working constructively with government to address workforce attrition to attract, sustain and retain that workforce.

The current HNECCPHN approaches to holistic, humane integrated models of care that promotes integration, collaboration and linking of services by a range of existing, mostly not for profit providers, who bids for funding to provide services. The process of funding includes:

- Rigorous assessment and planning
- Significant clinician, consumer and stakeholder consultation
- Tendering and contract management
- Service redesign
- Continuous quality improvements
- Evaluation against KPIs
- Analysis of future needs and,

Service design, including co-design, through

- Specialist Reference Groups
- Clinical Councils
- Community Advisory Groups
- Local Health District partnerships
- Consumers and Carers.

In the current context of drought and of the devastating bush fires it is **recommended that the available resources for regional, rural and remote health be conserved, if not increased to provide and improve equity of access to wholistic approaches to healthcare.** The advancement, sustainability and improvement to the viability of rural communities is critical at the moment and the health systems ability to respond should not be diminished.

2.Specific Responses to the draft productivity report into mental health

2.1. Renovate and Rebuild Models

It seems that funding for the RCAs, as proposed by the draft report would be dependent upon the Medical Benefits Schedule (MBS) rebates for the region's volume of current

Medicare rebates. This will have a detrimental effect on mental health services to areas where there are reduced mental health services due to workforce issues for GPs resulting in fewer referrals to mental health providers; where there are inadequate mental health service providers; where there are long waiting times to access mental health providers; where there are increased costs to access mental health providers, and where there are significant distances which will impact patient attendances. The concept of "pooled funds and having this transferred directly to RCAs" and "PHNs no longer commissioning mental health care" confirms this concern.

2.2 DRAFT RECOMMENDATION 5.9 — ENSURE ACCESS TO THE RIGHT LEVEL OF CARE

See our earlier comments about wholistic and integrated care and our concerns about separating out mental health care from the wholistic needs of individuals and communities.

Through the Mental Health redesign and reform process, a model of stepped care has been designed and implemented. The model is characterised by a Central Intake process that allows for standardised patient stratification and timely referral to the most appropriate service. If this continues to be the strategic direction for Mental Health, there are opportunities for expansion of the current service to include Aboriginal and Torres Strait Islander mental health services and psychosocial support services. There are also opportunities for greater integration with both the tertiary and community sectors.

Using the draft report funding models would preclude this development.

2.3 Recommendation 5.2 Assessment and Referral

Appropriate needs assessment for local needs is essential, but the overall success will be seen through "appropriate outcomes." This is what HNECCPHN is currently trialling with a number of service providers.

In July 2019, HNECC introduced a Central Access and Referral Service across HNECC funded primary mental health services. The model is underpinned by Department of Health Guidance on Initial Assessment and Referral. HNECC is also engaged in round

two the Department of Health's Initial Access and Referral trial to commence in 2020. At present, HNECC's strategic direction and commissioning align with this recommendation.

2.4 RECOMMENDATION 5.3 — ENSURING HEADSPACE CENTRES ARE MATCHING CONSUMERS WITH THE RIGHT LEVEL OF CARE

Headspace has created its own niche in mental health for younger patients but has proven very costly in its service provision. There could be opportunities for new providers to enter this space, but again, outcomes are an essential aspect of this program. HNECC has been working with all of the providers on wait list management strategies and will continue to work to integrate these services with other parts of the system.

HNECC have added Youth Complex services to the headspace continuum to promote the development of a youth specific headspace model. There are opportunities to further develop contract deliverables to include client activity targets across the spectrum of care. There are also opportunities to further explore how local models use low intensity platforms such as eheadspace and others to enhance and augment face to face services

2.5 RECOMMENDATION 5.6 — PRACTITIONER ONLINE REFERRAL TREATMENT SERVICE

The new access and triage system implemented on July 1, 2019, in HNECCPHN, seems to comply with this recommendation. This service has been over-subscribed already, with more than twice the referrals occurring than what was predicted. This indicates that the service is working well in its current format.

HNECC's Access and Referral Service currently offer online referral options. There are opportunities to further explore the PORTS model and its key features for the purpose of enhancing local services.

2.6 RECOMMENDATION 6.1 — SUPPORTED ONLINE TREATMENT OPTIONS SHOULD BE INTEGRATED AND EXPANDED

The concept of online mental health support has already been proven through psychiatric consultations and psychological counselling in numerous areas around Australia. For rural

areas, with workforce concerns, this may be appropriate, but it would be interesting to know of the potential differences between what would occur in a metro vs a rural area.

A selective request for proposal for a HNECC funded low intensity service has recently closed. In light of this and local consultation that occurred as part of the Mental Health redesign process, there is a current opportunity for HNECC to explore online treatment options and non-traditional providers in the low intensity space.

2.7 DRAFT RECOMMENDATION 5.1 — PSYCHIATRIC ADVICE TO GPs

This recommendation is supported. In collaboration with other NSW PHNs, HNECC currently co-commission a GP Psychiatry Line to support clients with mental illness who are being managed in primary care. This recommendation supports current commissioning

2.8 RECOMMENDATION 11.4 — STRENGTHEN THE PEER WORKFORCE

With the new Psychosocial funding received by PHNs there are current and future responsibilities and opportunities to develop the peer workforce. HNECC funded Psychosocial Support services utilise Peer Workers as do some of the Suicide Prevention and After Care programs HNECC currently fund Peer Work Scholarships to assist. However, there are other opportunities such as requiring peer workers in some programs and monitoring supervision and professional development needs for this workforce.

2.9 RECOMMENDATION 10.2 — ONLINE NAVIGATION PLATFORMS TO SUPPORT REFERRAL PATHWAYS

In collaboration with HNE LHD, HNECC fund Health Pathways in both the Hunter New England and Central Coast regions. Significant work has occurred on mental health and suicide prevention pathways recently. There are opportunities to look at the reach and scope of these directories outside of traditional health pathways. Care navigation pilot projects are in place and progressing.

2.10 RECOMMENDATION 21.1 — UNIVERSAL ACCESS TO AFTERCARE

With bilateral support from the NSW Government, HNECC are expecting to commission the Way Back aftercare service in 2020 in two sites. Dynamic Simulation Modelling has

also considered aftercare as a key element in local suicide prevention strategies. As such, it is possible that HNECC will commission further suicide aftercare services in the 2020/2021 financial year. HNECC's strategic direction and commissioning align with this recommendation.

2.11 RECOMMENDATION 21.2 — EMPOWER INDIGENOUS COMMUNITIES TO PREVENT SUICIDE

Suicide prevention, whether it be in the indigenous or non-indigenous communities is essential. However, the problem doesn't begin at the attempted or completed suicide – it has, in fact, started weeks, months or years previously, often due to a lack of appropriate mental health services in the region in which the patient resides.

AMSs provide excellent indigenous services across both our metro and rural areas; however, many rural towns in the HNECC PHN footprint do not have access to a local AMS, and there are significant distances for patients to travel to reach an AMS. It is estimated about 1/3 of our rural indigenous population access their care through an AMS, 1/3 through a local GP clinic, and the final 1/3 through the local hospital E.D. We need to be careful not to bypass the GP in their clinics, or the E.D.s as these areas are where the majority of the indigenous patients receive their primary health care, including their mental health care.

HNECC have developed Indigenous Commissioning Principles that align with the direction of the recommendation. There are opportunities to further strengthen capacity in the Aboriginal Community to deliver services. Current work with the Healing Foundation and Dynamic Simulation Modelling should further strengthen this work. This will enable local responses, but a National Strategy would be welcomed.

2.12 RECOMMENDATION 23.3 — STRUCTURAL REFORM IS NECESSARY

Structural reform for mental health is essential, but it is important for the Federal Government to understand that "one size doesn't fit all." Local needs must be addressed, and this is not just across the footprint of a PHN but must be on almost a town-by-town basis. HNECC is finalising an evaluation framework in this space to measure the impact of changes already made and to determine future approaches.

2.13 RECOMMENDATION 24.1 — FLEXIBLE AND POOLED FUNDING ARRANGEMENTS

The concept of pooled funding may seem appropriate, and the MBS rebated after-hours GP services are very idealistic, though appropriate. In our regional, and especially rural areas, the major workforce issues would make this impossible to achieve. This is not just GPs, but also allied health providers, as both these groups are already stretched in rural areas. All of this is dependent on being able get the health providers other than on the end of a computer terminal.

Adoption of this recommendation has implications for the way HNECC plans and funds services. PHNs have historically not been able to enter into co-pay arrangements as this was viewed as duplication. However, this may present opportunities for Commonwealth funding to be more efficiently distributed if combined with other funding sources. Payment models which include bundles have been trialled and are being assessed in an effort to determine sustainable models that include a variety of activity and outcome-based payments'

2.14 RECOMMENDATION 24.2 — REGIONAL AUTONOMY OVER SERVICE PROVIDER FUNDING

Particularly in rural areas there are only finite and limited mental health providers. Contestability in commissioning in these contexts has demonstrated that the only outcome is that the available health workforce changes to be employed or contracted by a new provider or become frustrated with the changing contexts and withdraw their services and only operate in a private practice context.

2.15 RECOMMENDATION 24.4 — TOWARD MORE INNOVATIVE PAYMENT MODELS

HNECC has adopted a policy position since its inception that all programs, including mental health should be evidence based and should demonstrate innovation. This approach has been found to be workable and effective. The HNECC PHN is uncertain why the draft report recommendations that this should be funded by cashing out Medicare benefits for allied health. An emphasis on innovation should be seen as normal business practice.

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