College Submission

28 Jan 2025

PHN Business Model Review and Mental Health Flexible Funding Stream Review

About the Australian College of Rural and Remote Medicine (ACRRM)

ACRRM's vision is ***healthy rural, remote and First Nations communities through excellence, social accountability and innovation***.

The College works to ***define, promote and deliver quality standards of medical practice for rural, remote and First Nations communities through a skilled and dedicated Rural Generalist profession***. We provide a quality Fellowship program including training, professional development, and clinical practice standards; and support and advocacy services for rural doctors and the communities they serve.

ACRRM has more than 5000 rural doctor members including 1000 registrars, who live and work in rural, remote, and Aboriginal and Torres Strait Islander communities across Australia. Our members provide expert front line medical care in a diverse range of settings including general practices, hospitals, emergency departments, Aboriginal Medical Services, and other remote settings such as RFDS and Australian Antarctic Division.

General Comments

This College submission focuses on broader comments which are based on feedback received from members. The Primary Health Networks (PHNs) concept is characterised by its variability across the country. ACRRM acknowledges that these member experiences and insights therefore may not be representative of the views of all members or reflect the operations of all PHNs, however the comments documented in this submission reflect some key recurring themes, echoed by a number of contributors.

Given the remit and membership profile of the College, comments are focussed on those PHNs which have a rural and remote, or primarily rural and remote, constituency.

As an organisational stakeholder, the experience of the College in working with PHNs has largely been positive. ACRRM has membership of a number of rurally based PHNs and works with PHN representatives on regionally based projects where appropriate. The College supports PHN communications and encourages members to be involved in the governance and other activities of their respective PHNs. There is also engagement at the national level through the national PHN peak body.

There appears to be significant variation in the performance and capacity of PHNs nationwide, and particularly within those PHNs which have a predominant rural and remote footprint. In the view of the College, this partially arises because of the increased challenges faced by these PHNs, particularly if they operate over a large geographic area which includes a range of communities from remote to inter regional.

For example, the Hunter, New England, and Central Coast PHN covers a region of over 130,000 square kilometres, incorporates 23 local government areas and serves a population of 1.2 million people living in communities ranging from rural and remote, to regional towns and urban centres. Other PHNs, particularly those with a predominantly rural and remote footprint, are challenged in meeting the needs of communities which are sparsely populated, poorly resourced and separated by long distances.

ACRRM recognises that it is challenging and expensive to visit, consult and support all communities, practices, and practitioners, particularly when these locations are geographically dispersed. However, it is even more important that rural and remote communities receive this support. This should be considered in the context of PHN roles and responsibilities, funding allocations and the way in commissioning of services activities are undertaken and evaluated.

Consultation Questions

1. **Program Objectives and Activities - Are the roles of PHNs clear and understood by stakeholders, including your own organisation? How will the relative importance of the different roles need to evolve to meet broader changes in health policy and delivery?**

   The College notes the three core functions of PHNs as described in the Department of Health and Aged Care's *PHN Strategy 2023-24*:

   - **coordinating** and integrating local health care services in collaboration with Hospital and Health Services to improve quality of care, patient experience, and resource efficiency.
   - **commissioning** primary care and mental health services to address population health needs, fill service delivery gaps, and improve access and equity.
   - **capacity-building** and providing practice support to primary care and mental health providers to support quality care delivery.

   The Strategy outlines the "*crucial role that PHNs play in supporting health reform by driving local innovation to meet specific local health needs and supporting consistent local delivery of national and co-commissioned programs.*"

   The document lists approximately twenty core PHN functions and activities across four core funding and seven program funding initiatives. Each of these appears to present a large and challenging role, particularly in rural and remote areas which are often faced with different and more complex challenges than their more urban counterparts. It must also be extremely time consuming and resource-intensive for the PHN to manage and meet the expectations of the many different funding streams and processes, many of which are managed by different business units with the Department.

   Feedback from College members indicates that there are many who do not have a clear understanding of the various roles of the PHN. Given this extensive range of PHN roles, this is hardly surprising.

ACRRM member responses include:

"I don't really have much meaningful commentary other than I don't really understand the role and remit of PHNs… I think if you asked most practitioners about PHNs they would struggle to explain their role and remit."

"The roles of PHNs do not appear to be clear to the PHNs themselves or to their stakeholders. My experience is that PHNs appear to be tasked with roles by the federal government that they do not have the organisational capacity to fulfil."

Given that there is not a clear understanding particularly of the scope and limitations of PHN funding arrangements, stakeholders often lack an awareness of what their local PHN is actually capable of initiating and funding in terms of local projects and meeting the needs of both the community and the primary care providers within those communities. This can result in disenchantment and disengagement with the relevant PHN when it fails to meet expectations.

As an organisational stakeholder, the College does have an understanding of the roles and responsibilities of PHNs. As such, we do have concerns about the tendency to assign increasing roles and responsibilities to PHNs, seemingly without consideration of their overarching operational framework and resource capabilities.

To enable PHNs to play an integral role in the health reform process, their structure and operating context, together with their associated funding arrangements, must reflect overall health system aspirations and desired outcomes. Funding and other resource allocations should reflect the more complex needs and operating environments of rural, remote and First Nations communities and enable PHNs to better support rural and remote practitioners and communities.

2. Program Governance - Is the governance of PHNs and the broader PHN Program appropriate, efficient and effective?

ACRRM understands that PHNs operate as independent companies limited by guarantee and registered charities, adhering to the Corporations Act 2001 and Charities Act 2013. These arrangements are intended to facilitate robust governance and accountability. However, it does mean that the designation and the operational functions are slightly misaligned, and this could potentially present complications and conflicts.

Similar to the overall PHN performance, there appears to be significant variation in the organisational structure of the various PHNs, particularly with respect to their membership structures. For example, some PHNs have a very limited number of organisational members, all of whom play an active role within governance, while others have a much broader member base which includes numerous individual members. While this can provide flexibility, it can also engender confusion and can be challenging to navigate, particularly for a national organisation such as ACRRM which also values community and stakeholder engagement at the regional level.

The College is not aware of the extent to which its members are individually engaged in the governance of PHNs, including through membership of clinical councils and other advisory groups. However, we suspect that a number of factors, including lack of PHN engagement together with the

relatively heavy workloads and geographic isolation of many rural and remote practitioners, may be barriers to involvement.

A number of members expressed concern about the level of transparency of PHN operations to the wider community. Although PHN activities and programs are intended to deliver services and serve practitioners, patients and the wider community, under current arrangements they are not directly accountable to those communities.
Likewise there are limited avenues and opportunities for community members to provide feedback regarding PHN operations, particularly to the respective government funding bodies.

3. **Regional Planning, Communication and Engagement - Does the PHN Program support regional planning, effective communication and engagement between relevant stakeholders?**

The College is aware of the regional planning undertaken by PHNs. Once again, the level of ACRRM engagement in these processes is extremely variable between PHNs, ranging from active involvement as an organisational stakeholder, to minimal or no engagement.

ACRRM does have concerns about the number of College members who are either completely unaware of the existence of PHNs, or who have had minimal engagement with them. There are indications that this lack of awareness is much greater in rural and remote areas. This is concerning as PHNs are being increasingly regarded as 'the voice of general practice', with governments viewing consultation with PHNs as equivalent to consulting with the general practice/primary care sector more broadly. Given the reported lack of PHN on-ground engagement with general practice/primary care in some areas, PHN feedback may not reflect the views and experiences of this sector.

Likewise, PHNs are often charged with providing support to general practices in a range of activities, including practice accreditation, IT and telehealth support and in coordinating the distribution of information, resources and even equipment and supplies, as happened during the COVID pandemic. It is essential that they have strong engagement with rural and remote practices and communities to facilitate efficient and effective delivery of these services.

As with PHN awareness, the level of PHN engagement with College members also appears to be variable.

One member reported:

"It is not clear who the PHN stakeholders are as they do not appear to consider General Practice, GPs or community members as stakeholders. It appears that the federal government is the main Stakeholder and that gaining data from the community to pass onto the federal government is the purpose of the PHN."

To address this situation, the College recommends that engagement with general practice and practitioners be prioritised in terms of KPIs and outcomes measures for PHNs; and that there be consistent national standards and principles regarding the quantity and quality of this engagement.

ACRRM also recommends that strong consideration be given to revitalising the PHN brand to ensure there is a clear understanding of their purpose and role amongst primary care professions, health sector and systems, and community members. This will significantly assist stakeholders navigating and engaging with the right primary care support. It will also enhance overall engagement and understanding.

4. **PHN Program Funding Arrangements - Do the current PHN Program funding arrangements support effective delivery of the objectives?**

It appears that PHNs are funded for multiple projects and through multiple processes and across multiple timeframes. In the view of the College, this somewhat piecemeal approach does not result in optimal outcomes, particularly as there is a tendency to view each project or program as a stand-alone initiative, rather than a component of a more holistic approach. Long-term systemic issues may fail to get attention in favour of immediate issues which may have an urgency or a high government priority.

This was summarised by one member:

"Missing is the ongoing connection with populations of concern to develop long-term plans that are supported, monitored and funded over time to achieve systemic change. PHN funding is too often short-term. Where PHNs are catalysts to partnerships (community, philanthropic, businesses), better long-term outcomes are achieved."

PHNs have limited capacity, especially to fund projects to address local population health needs. They are significantly driven by the agenda of the current government and funding made available for particular silos, e.g. aged care, chronic care, mental health. This leads to skewing of programs based on funding made available, and to partial solutions rather than comprehensive outcomes for communities.

Likewise, some communities within the PHN footprint may miss out on receiving the full range of PHN services when funds and staff resources are allocated to other areas for disaster response or other immediate needs. This can be especially problematic in terms of managing resource allocations for rural and remote communities, where higher expenditure of PHN time and resources is required in order to service a much smaller population of practitioners and communities, as opposed to more populated centres, where a large number of people can receive services for a relatively lower cost.

The College and its members do have concerns regarding the effectiveness of commissioning in rural and remote communities. There appears to be a clear preference with respect to PHNs for commissioning single large organisations rather than multiple smaller entities which are located within communities. This results in services being provided in regional areas that have no reach to rural and remote areas of their catchment. This is despite the importance of placed-based funding and innovation in the ability for rural and remote health services to support their communities to any sort of comparable standard to more metropolitan counterparts.

The College recommends that consideration be given to providing PHNs with a larger and longer-term funding allocation for projects that address local population and community health needs, acknowledging the need for projects where outcomes can be measured. Funding allocations should be cognisant of the additional needs and complexities of the rural and remote context.

Conclusion

ACRRM acknowledges the work and commitment of PHN staff, committees and board members. In the view of the College, the majority of PHN shortcomings are the result of their operating and funding constraints rather than a lack of commitment from PHN staff and members to improving health care services in the communities they serve.

ACRRM believes a network of rurally-based hubs can play an important role in strengthening primary healthcare services across the country. However, for the PHNs to reach their potential, positive steps should be taken to address some key barriers.

- ***Sufficient resourcing to manage large geographic footprints, diverse communities and community needs -*** in many cases, the geographic area and diversity of communities PHNs are charged to service is too large, particularly in rural and remote areas, and current funding and engagement does not necessarily reach areas in need.
- ***Funding mechanisms that support impactful and sustainable change –*** much PHN funding appears to be project-based, short-term, siloed, uncoordinated. This significantly hinders a holistic approach and the achievement of longer-term and sustainable outcomes and services.
- ***Strong stakeholder engagement especially with rural doctors –*** to raise awareness of PHN activities both within the general practice/primary care sector and within the wider community, particularly in rural and remote areas. The College acknowledges the constraints arising from the tyranny of distance, but it does mean that there is a danger that the needs and issues of rural and remote communities and practitioners are overlooked. Likewise, lack of engagement carries a significant risk that PHNs may not reflect the views, insights and needs of their stakeholders and constituent communities.
- ***Robust evaluation and transparency –*** accountability is limited due to the narrow and disjointed nature of funding and evaluation mechanisms. PHNs are required to report on numerous funding streams, with acquittal mechanisms being driven by numbers rather than qualitative, long-term outcomes, which can be detrimental to achieving outcomes for rural and remote practitioners and communities. By integrating both quantitative and qualitative evaluation measures, PHNs can ensure accountability, reflect community impact, and achieve more meaningful, long-term health outcomes. Expanding the scope of evaluation to consider the broader community and long-term effects will foster stronger, more effective programs for rural and remote communities.

The College is happy to contribute its experience and expertise to address these challenges, enabling PHNs to reach their full potential. By doing so, PHNs can play an integral role in implementing and enhancing health care reforms which result in better health outcomes for rural, remote and First Nations communities.

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ACRRM acknowledges Aboriginal and Torres Strait Islander peoples as the custodians of the lands and waters where our members and staff work and live across Australia. We pay respect to their elders, lores, customs and Dreaming. We recognise these lands and waters have always been a place of teaching, learning, and healing.