NORTH COAST COLLECTIVE

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Shared Investment for Population Health on the North Coast

A Concept Paper for Partners

26-10-2018

NSW GOVERNMENT
Mid North Coast Local Health District
Northern NSW Local Health District

phn NORTH COAST
An Australian Government Initiative

healthy north coast

Contents

Joint letter of invitation to Partners

On behalf of Mid North Coast Local Health District (MNCLHD), Northern NSW Local Health District (NNSWLHD), and North Coast Primary Health Network (NCPHN), we are extending a request for your partnership in ***shared health investment***.

Our organisations are responsible for the allocation of substantial health care funding for North Coast communities. But we recognise that our communities' health cannot be assured by the health care sector alone. The health care system is largely oriented to disease treatment and recovery.

The evidence shows that health is largely created and maintained in other settings: in the home, schools, workplaces and neighbourhoods. Your understanding of, and investment in, these settings is vital to create the conditions for healthy, enriched and productive lives.

As partners in population health, there are systemic issues that we need to collectively resolve. For instance:

- We accept the significance of health determinants outside of health care, yet our sectors work largely in isolation with high potential for duplication, inefficiency or gaps in needed services.
- In the face of growing service demand, health care budgets are steadily increasing. But we have not recalibrated the balance between 'upstream' (i.e., preventative) and 'downstream' (e.g., disease management) approaches to improve outcomes and save costs.
- Rapid technological change has altered the how we live and engage with one another, but technology has had limited inroads into models of care and service delivery;
- Some of our communities suffer disproportionately from circumstances that limit their health and life opportunities. We have not yet mastered approaches to reduce health and social inequity.

This paper, developed by NCPHN, describes s*hared investment* as a cross sectoral approach to optimising population health outcomes in our region. *Shared investment* involves joint planning and priority setting, shared resourcing, and commitment to pursuing the best return on investment for health outcomes. *Shared investment* is a solution that can be shaped with your involvement. Together, we can address the full spectrum of health determinants and needs through efficiently targeted programs and services.

With your involvement we can embark on the *shared investment* process immediately, with mental health and substance misuse as the initial pilot program. These conditions have a substantial burden on our communities' health and are significantly influenced by factors outside of health care.

There is urgency in timing. In order to more optimally direct our resource allocation by 1 July 2019, we must commence the *shared investment* process now.

We welcome your feedback on this concept paper and your input into a Memorandum of Understanding to solidify the partnership.

Yours in health

Stewart Dowrick	Wayne Jones	Julie Sturgess
Chief Executive	Chief Executive	Chief Executive
Mid North Coast Local Health District	Northern NSW Local Health District	North Coast Primary Health Network

I. Overview

This concept paper promotes *shared investment* as a platform for improving population health in the North Coast. North Coast Primary Health Network (NPCHN) developed this paper following discussions with our Local Health District partners about collaborative planning. The paper is written from NCPHN's perspective.

The paper aims to inform discussion with our cross sectoral partners in Health, Family and Community Services, Education, Police and Emergency Services, Justice, Indigenous Affairs and the Aboriginal Community Controlled sector, and to ultimately encourage joint action.

We know, inherently, that each of our service sectors has a critical role to play in addressing the wellbeing of community members and optimising health outcomes. The determinants of health and disease – including income, education, living and working conditions, housing, food security, safety, and social integration, among others – equally impact all of our clients and their families.

Working largely in isolation, our service sectors have attempted to optimise programming to meet community members' needs – needs which, we can acknowledge, may be better met through an 'upstream' response or in coordination with other services.

Even by delivering 'best practice' programming in our relative sectors, we may be unable to provide joined up services which consumers can navigate and which result in optimal population health and wellness. A cross sectoral approach is required to direct some of the vast resources we collectively hold to improve our return on investment. In fact, through better targeted investment, benefits will not be limited to health outcomes alone. More broadly, we will also be contributing to:

- Improved productivity at work, home and school
- Better social engagement
- Less violence and crime
- Improved quality of life

These outcomes benefit our communities as a whole. F
action is required to influence the determinants of pop

Figure 1. *Determinants of health*

In order to achieve NCPHN's Vision of *Healthy People in North Coast Communities*, our mandate is to broker cross sectoral action for population health outcomes. We are requesting your involvement in a partnership that jointly progresses this aim.

This concept paper articulates a pathway and process for our partnership – what we have called a *shared investment* approach – which will bring together our diverse sectors with the common goal of improving health. We are interested in the broadest definition of health, being a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.[1]

This document aims to:

- Create a **shared understanding** of NCPHN's current approach to health commissioning investment including its limitations;
- Contribute to a **vision** for *shared investment* as an approach to improve health and achieve related outcomes in other sectors;
- Garner **commitment** from partners to embark on a program for *shared investment* for better health outcomes in the North Coast.

As a primer for the proposed partnership, this concept paper includes:

Section II: An introduction to health investment

Section III: Foundations for *shared investment*

Section IV: Proposed program of work and next steps

Appendix A: The need for *shared investment*: A case study of mental health and substance misuse

[1]World Health Organisation. Constitution of WHO: Principles. Accessed at: http://www.who.int/about/mission/en/

II. Health investment – an introduction

This section provides a basic overview of the current state of health care funding and describes the contribution of other sectors to population health. A *shared investment* approach is introduced as a more effective approach for joint action on population health.

a. Health care spending

Total health care expenditure in Australia is rising faster than inflation and population growth, comprising $170 billion in 2015-16. Growth in spending has been fuelled by factors including the growing prevalence of chronic disease and an aging population, and is exacerbated by workforce challenges and an increasingly complex service sector. Nearly three-quarters of total health expenditure is consumed by public and private hospitals (39%) and primary health care (35%).[2]

Funding for the health care system derives from:

- The Australian Government, which is largely directed towards medical services, public and private hospitals, and subsidised medications;
- State or Territory governments, which includes funding for public hospitals and community health services; and
- Private funding (i.e., individuals, private health insurers, compensation schemes), being especially significant for medications, dental services and non-referred medical and health services.

Figure 2 depicts a highly condensed picture of healthcare funding. Even with this simplification, the complexity of the system is apparent.

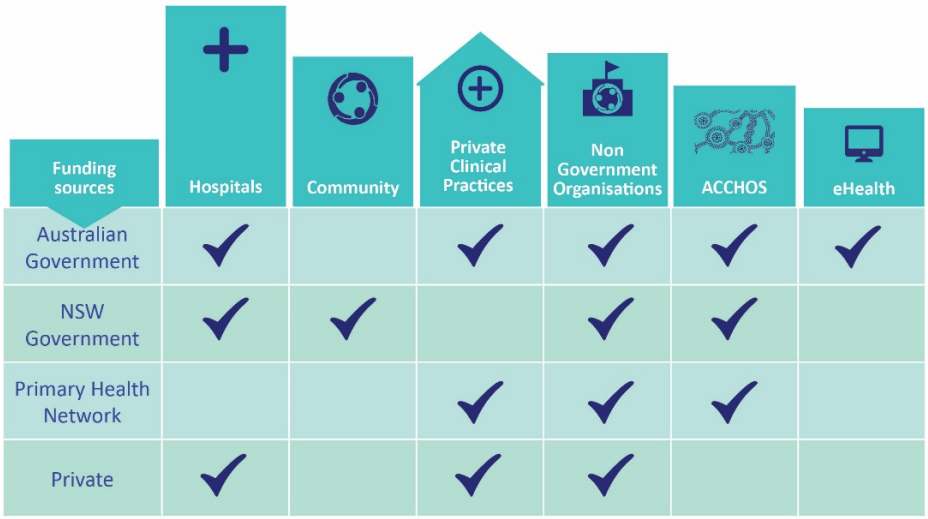

Figure 2. *Health care funding landscape*

[2] Australian Institute of Health and Welfare. Australia's Health 2018. Chapter 2.2: How much does Australia spend on health care? Accessed at: https://www.aihw.gov.au/getmedia/941d2d8b-68e0-4883-a0c0-138d43dba1b0/aihw-aus-221-chapter-2-2.pdf.aspx

b. Other investment in population health

Figure 1, as informative as it is, fails to depict the contribution of other funding streams to population health. Siloed approaches to health funding have created administrative ease but have limited joint responsibility and action for population health outcomes.

By way of example, the National Disability Insurance Scheme (NDIS) is a social insurance initiative jointly funded by the Federal and State and Territory governments which provides essential services to eligible people with disabilities. The annual cost for the NDIS is approximately $14 billion though forecasts indicate significant year-on-year increases.[3] The duplication and gaps created by the NDIS are still coming to light.

Research shows that healthcare is only a modest factor in preventing premature death – e.g., only 10% of the contribution to premature death in the United States.[4] While conclusive figures are not available for the Australian context, it is widely accepted that in Western countries the influence of medical care on health outcomes may not be as great as is popularly held.[5]

Population health[6] is the result of collective action on health determinants.

> **Population health** refers to the health of a population as measured by health and other key indicators and as influenced by determinants including social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services.
>
> As an approach, population health focuses on taking action on the interrelated conditions and factors that influence the health of populations over the life course.

Healthcare reform agendas have emphasised a whole-of-government approach to achieve improved population health.[7] Applying resources from other sectors would have a substantial multiplying factor on Australia's health investment.

Figure 3 provides an alternate picture of cross sectoral investment in population health. Here, it is clear that many sectors make significant contributions to health needs across the continuum of care. As a mock up, the figure indicates the probability of service duplication and service gaps when investment is considered collectively.

Accordingly, this paper promotes *shared investment* as a way to leverage cross sectoral action on shared health determinants and outcomes. Section III presents shared investment in more depth.

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[3]Dickenson, H. (2018). Explainer: How much does the NDIS cost and where does this money come from? The Conversation. Accessed at: https://theconversation.com/explainer-how-much-does-the-ndis-cost-and-where-does-this-money-come-from-95924

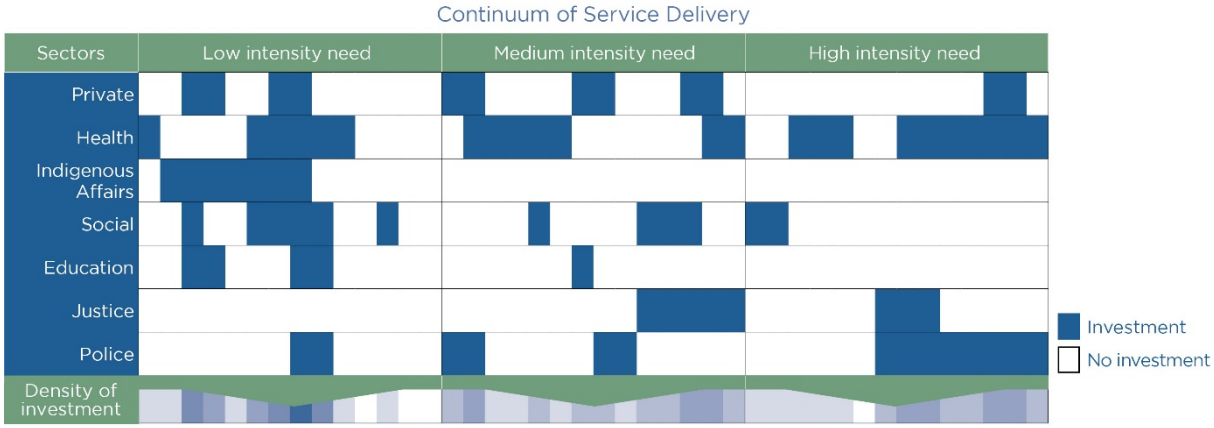
[4] New England Journal of Medicine (2007). We can do better: Improving the Health of the American People. 357: 1221-1228. Accessed at: https://www.nejm.org/doi/full/10.1056/NEJMsa073350

[5] Public Health Reports (2014). The social determinants of health: It's time to consider the causes of the causes. 129 (Suppl 2): 19-31. Accessed at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863696/

[6]Government of Canada. What is the population health approach? Accessed at: https://www.canada.ca/en/public-health/services/health-promotion/population-health/population-health-approach.html

[7] Bartlett C, Butler S and Haines L (2016). Reimagining health reform in Australia: Taking a systems approach to health and wellness. Pricewaterhouse Cooper. Accessed at: https://www.strategyand.pwc.com/reports/health-reform-australia

Figure 3. *Cross sectoral investment in the health continuum.*



III. Foundations for shared investment

Shared investment is a concept that can be used by NCPHN and its partners to define how to best support population health. Most centrally, shared investment requires partners' commitment to reorient available resources to meet mutually defined aims.

Shared investment is the application of resources made available across service sectors in order to meet population health outcomes. It requires joint development of strategy, including agreed principles to guide investment and disinvestment. As a key feature, shared investment requires ownership and accountability in proportion to the partner organisation's budget and potential impact.

Shared investment requires an understanding of population health needs, service gaps and duplication, and evidence about interventions that can achieve high returns.

As a result of shared investment, program and services are delivered by the most appropriate providers to achieve outcomes; this may require market and workforce development.

The shared investment process is an iterative cycle, and implies continuous quality improvement over a long time frame.

Figure 4 introduces shared investment as a process to achieve efficient, effective and appropriate resource allocation for population health.

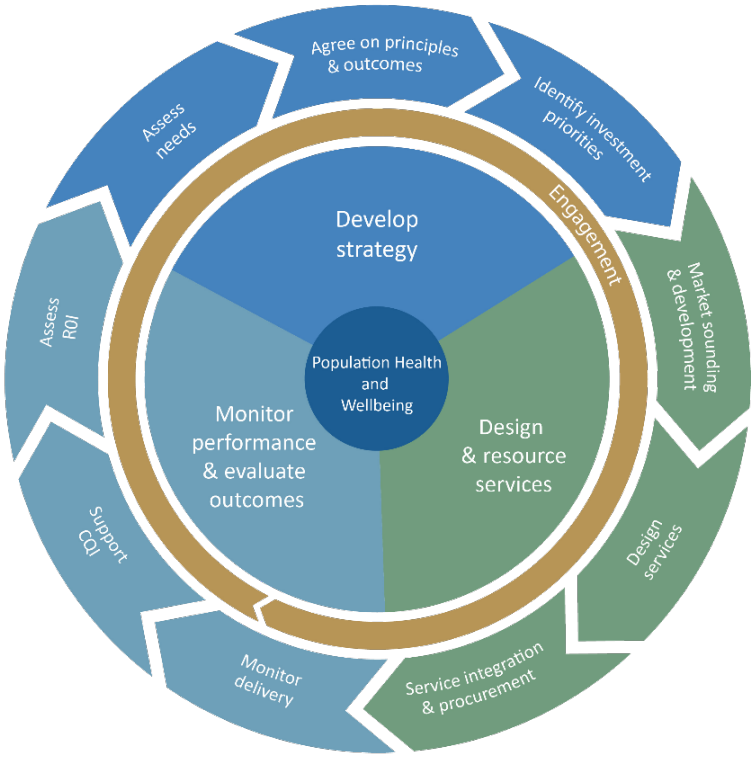


Figure 4. *Shared investment cycle*

a. Sources of funding

Shared investment is not the same as co-commissioning, which implies that commissioning funds are the sole resources available for allocation. Instead, shared investment assumes that partners are directing diverse sources of funding to an agreed strategy in order to best meet the population's health needs.

The source of available funding may vary amongst partners. For NCPHN, the source of funding will be all commissioning funds (value: over $23 million in 2018-19), which is the majority of NCPHN's operating budget. Other partners may not have as much discretionary funding relative to their overall budget.

To some extent, the funding available for shared investment will become available through disinvestment in certain programs or services. A partner organisation may opt for disinvestment in cases where the funded program/service conflicts with the collectively agreed principles or priorities – for instance, duplication or poor return on investment.

b. Requirements for shared investment

Shared investment differs from NCPHN's previous attempts to co-plan. Instead, shared investment is driven by implementation, with planning as only one stage of a clearly scoped joint process.

As understood from other settings,[8] shared investment requires:

- Cross sectoral partnership at the highest level of decision making;
- Trust between partners, including time to build relationships;
- Willingness to share decision making amongst stakeholders, including involvement of communities (i.e., consumers, carers, those with lived experience);
- Mechanisms for joint ownership and responsibility, where all partners are 'shareholders';
- Common language, goals, principles, strategies, measures of success and criteria to drive decision making;
- Long term time frame (including long-term contracts) to see through cycles of investment, evaluate results, and to make improvements for future cycles;
- Good data and information to inform a thorough understanding of population health need and the services landscape, and to measure outcomes and attribution;
- Knowledge of high return interventions and willingness to test and evaluate in the absence of good evidence;
- Agreement on and application of methods to assess return on investment;
- Coordination of investments in service delivery with investment in infrastructure and technologies; and
- Skilful facilitation through the full cycle (i.e., including planning, implementation and evaluation).

[8] European Commission Directorate General for Health and Food Safety (2017). Report. Seminar on "Strategic investments for the future of health care." Accessed at: https://ec.europa.eu/health/sites/health/files/investment_plan/docs/ev_20170227_mi_en.pdf

c. Principles for shared investment

Principles play a key role as decision making criteria in shared investment.

Principles for shared investment must be jointly identified by partners and may include some of the following:

- Focus on defined goals – e.g., health outcomes and health equity
- Invest in high return programs based on evidence of the determinants of health
- Disinvest in low return programs where possible and appropriate
- Focus on cost effectiveness rather than reducing costs
- Eliminate service duplication and waste
- Promote service integration and coordination
- Support the role and experience of clients, carers and families
- Build the workforce
- Support culturally appropriate and competent service delivery
- Measure results and demonstrate accountability
- Enhance databases and share data

A case study of Collective Impact from the US social sector[9] captures some of the requirements and principles suggested here for the shared investment approach.

Requirements and principles in action: A case study of Collective Impact

School achievement was a significant issue in Cincinnati and across northern Kentucky. Stakeholders recognised that the crisis could only be resolved through a 'cradle to career' approach which spanned the education sector and beyond.

Coordinated by a single organisation, a group of more than 300 local stakeholder organisations (including school districts, universities, NGOs, private foundations and government officials) agreed to participate in a 'collective impact' process.

Stanford University researchers studied the process and identified five elements of collective success: (1) common agenda; (2) shared measurement system to measure impact; (3) mutually reinforcing activities that capitalise on each participants' scope of practice; (4) continuous and structured communication; and (5) backbone support organisation with dedicated staff to coordinate the process.

[9] Kania J. and Kramer M (2011, Winter). Collective Impact. Stanford Social Innovation Review. Accessed at: https://ssir.org/images/articles/2011_WI_Feature_Kania.pdf

d. Business approaches for shared investment

Partners will be familiar with some of the business approaches to support shared investment, particularly mechanisms for sharing resources across organisations or government departments.

Definitions for some approaches are provided in Table 1 to inform discussion; these draw mainly from their application in the National Health Service UK. The actual business approaches used by partners will be identified through the shared investment process.

Table 1: *Business approaches that may be used to support shared investment*

Term	Definition
Lead commissioning	One partner leads commissioning of services as delegated by other partners.[10]
Pooled budget	Each partner makes contributions to a common fund for spending on agreed projects or services.[11]
Alliancing	A co-operative form of contracting where the participants enter into a relationship (alliance) which is designed to align the interests of the participants. Each participant in the alliance will share in the success or failure of the project and in decision making and risk management. [12] [13]
Transfer payments	Redistribution of funding between governments or departments. May be required to cover costs of delivering optimised programs – e.g., higher cost of social housing to support mental health.[14]
Social impact bonds	A government contract with the public sector in which a commitment is made to pay for improved social outcomes that result in public sector savings.[15] *Note: used by NSW Family & Community Services (social benefit bond)*

e. Expected outcomes of shared investment

Shared investment is promoted in this paper as a way to optimise investment across service sectors in order to achieve desired outcomes. The breadth of outcomes remain to be defined by partners through a strategic planning process.

Evaluation of the shared investment approach, therefore, will be critical to inform quality improvement and establish the benefits of this approach in the longer term. Such an evaluation could span the entire program of shared investment, or selected services.

At its core, the evaluation will test the presumed relationship between shared investment and the desired outcomes. Figure 5 provides a basic program logic for illustration of this concept.

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[10] Mason A, Goddard M and Weatherly H. (2014) Financial mechanisms for integrating funds for health and social care : an evidence review. Discussion Paper. University of York, Centre for Health Economics. Accessed at: .http://eprints.whiterose.ac.uk/78222/1/CHERP97_Financial_mechanisms_integrating_funds_healthcare_social_care_.pdf

[11] Integrated Personal Commissioning Programme. About pooled budgets. Accessed at: http://www.ipcprogramme.org.uk/topics/financial-model/pooled-budgets/about/

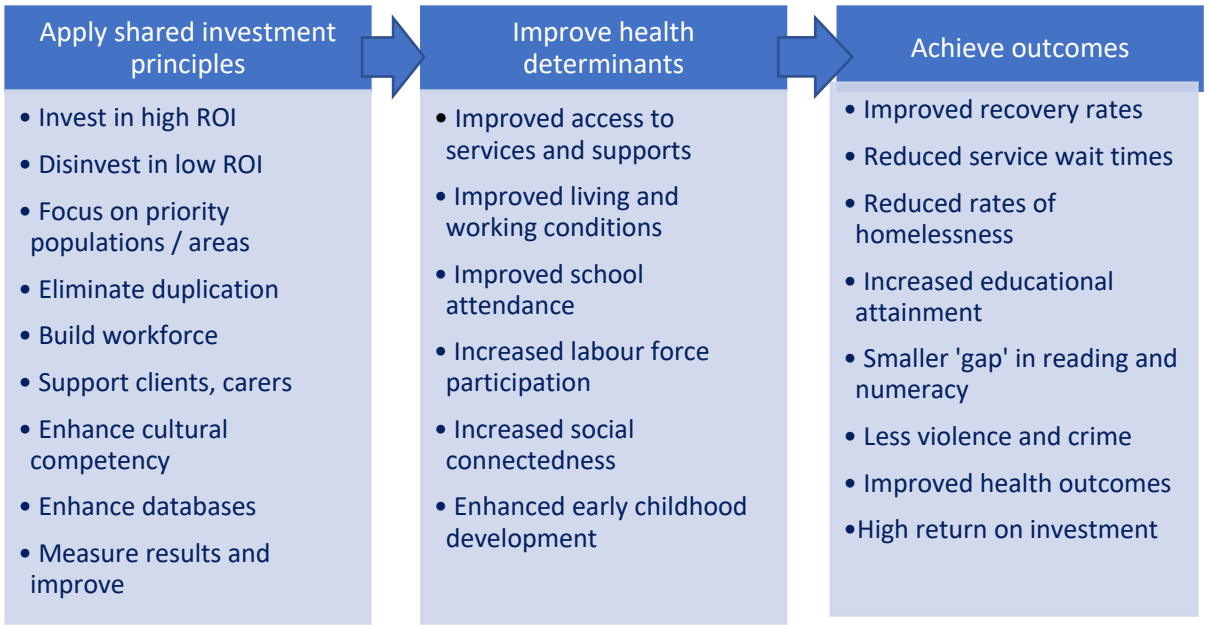
[12] LHAlliances. What is alliancing? Accessed at: http://lhalliances.org.uk/what-is-alliancing/

[13] McNair, D (2016). Alliancing. Investing in Infrastructure: International Best Legal Practice in Project and Construction Agreements. Accessed at: https://www.pwc.com.au/legal/assets/investing-in-infrastructure/iif-21-alliancing-feb16-3.pdf

[14] KPMG (2014). Paving the way for mental health. Accessed at: https://www.mentalhealthcommission.gov.au/media/119874/Paving%20the%20way%20for%20mental%20health%20-%20KPMG.PDF

[15] Pandey S, Cortes J and Pandey S (2016). Social impact bonds, explained. The Conversation. Accessed at: https://theconversation.com/social-impact-bonds-explained-95504

Figure 5. *Early program logic for shared investment.*



IV. Proposed approach and next steps

NCPHN proposes a staged approach to shared investment commencing in September 2018 with an initial pilot: mental health and substance misuse. Appendix A provides a case study which substantiates collective investment in this area. Insight gained from monitoring and evaluation of the shared investment approach will inform subsequent programs of work.

We suggest the following project staging and timelines (Table 2) as next steps.

Table 2. *Shared investment project stages and activities (proposed)*

Stage	Component	Critical Milestone	Deadline
Initiation	Engagement	• Agree in principle to embark on shared investment	12 October 2018
	Establish governance	• Develop and execute MOU as formal commitment including governance model and core principles.	19 October 2018
	Engage facilitator (consultant)	• Develop and launch RFP for consultant	19 October 2018
		• Close RFP and commence evaluation	2 November 2018
		• Negotiate and contract with preferred provider	9 November 2018
	Agree to process	• Endorse consultant's project plan	23 November 2018
Develop strategy	Take stock	• Assess needs and service landscape • Forecast future service demands • Forecast outcomes	31 December 2018
	Develop investment strategy	• 'Shared Investment Workshops'. Agree on aims and measures of desired outcomes • 'Prioritisation Workshops'. Identify priorities for investment / disinvestment using agreed principles and criteria • Identify financial contribution and funding mechanisms • Identify and establish business approaches to manage shared resourcing	14 February 2019
Apply resources (pilot investment)	Build market	• Manage change with existing providers • Build market capability and capacity where required	November 2018 to June 2019
	Apply business approaches	• Procurement processes and other business approaches	14 February 2019 - ongoing
Monitor & evaluate	Evaluate shared investment strategy	• Monitor and evaluate implementation of shared investment approach • Make recommendations for improvement	1 July 2019 - ongoing
	Monitor services	• Monitor services and support service providers • Evaluate outcomes of funded programs / services • Apply improvements to ongoing investment	

Partners are invited to provide feedback on this concept paper to NCPHN CEO Julie Sturgess at meetings scheduled for this purpose in October. Input from partners will be used to draft the partners' Memorandum of Understanding and consultants' Request for Proposal.

Appendix A: A case for shared investment: Mental health and substance misuse

Mental health and alcohol and other drugs (AOD) programming is a useful case study of the promise of shared investment. A joint approach is warranted as other sectors stand to gain significantly from reduction of these disorders in the population.

The following characteristics are explored:

- Mental health and substance misuse disorders have considerable impact on the health of our population;
- Mental health and substance misuse may be co-occurring conditions, are related in their determinants, and imply a cross sectoral response;
- Strategic direction for mental health and AOD programming is crowded with a complex array of strategies, frameworks and plans, and investment priorities are not clear;
- Mental health and AOD services are provided across a wide ranging service landscape, involving many types of provider organisations;
- Joint action on mental health and substance misuse will lead to improved outcomes in other sectors, including greater educational attainment, increased labour force participation, reduction in violence and crime, and improvements in Closing the Gap indicators;
- Mental health and AOD programs/services constitute a significant area for investment by NCPHN; and
- NCPHN's current commissioning approach is fragmented and limited in driving improved outcomes.

a. Prevalence and impact of mental health and substance misuse

The World Health Organisation defines mental health as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.[16]

Problematic use of alcohol or other drugs (also known as substance misuse) refers to the harmful or hazardous use of psychoactive substances, including alcohol, tobacco, prescription drugs and illicit drugs. In this paper, the term 'substance misuse' refers to the disorder and 'alcohol and other drugs' ('AOD') refers to programmatic responses.

[16] World Health Organisation (2014). Mental health: a state of wellbeing. Accessed at: http://www.who.int/features/factfiles/mental_health/en/

It is estimated that up to a half of all Australians with mental health problems will experience comorbid substance use disorders,[17] though prevalence of comorbidity varies with the type of substance being used and type of mental disorder.[18] While some sources have indicated that dual diagnosis is the 'expectation not the exception'[19] it is important to recognise that mental health disorders and substance misuse often do not always co-occur.

Mental health disorders and substance misuse contribute to a significant burden on the Australian society, being responsible for an estimated 12% of the total disease burden, with suicide and self-inflicted injuries contributing an additional 2.5%.[20] Related social problems are broad ranging – including, for instance, reduced economic productivity, homelessness, domestic violence, crime, transmission of infectious disease and premature death.

Australian and NSW Government spending on mental health (estimated at $9 billion in 2015-16[21]) and AOD treatment services (estimated at $1.2 billion in 2012/13[22]) is considerable. At the same time, the health and social costs of mental health are many times higher - estimated at over $60 billion per year in Australia,[23] while the parallel costs of alcohol alone are $14 billion per year.[24]

The following table provides a snapshot of the prevalence and impact of mental health and substance misuse in Australia and the North Coast region.

[17] Teeson, M (2014). Mental health and substance use: opportunities for innovative prevention and treatment. Mental Health Commission of New South Wales. Accessed at: https://nswmentalhealthcommission.com.au/sites/default/files/assets/File/NSW%20MHC%20Discussion%20document%20on%20comorbidity%20cover%20page.pdf

[18] Burns L, Teeson M, Lynsky M (The epidemiology of comorbidity between alcohol use disorders and mental disorders in Australia. University of New South Wales National Drug and Alcohol Research Centre. Accessed at: https://ndarc.med.unsw.edu.au/resource/epidemiology-comorbidity-between-alcohol-use-disorders-and-mental-disorders-australia

[19] Commonwealth of Australia (2006). A national approach to mental health – from crisis to community First Report. Accessed at: https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Former_Committees/mentalhealth/report/c14

[20] Ibid.

[21] Australian Institute of Health and Welfare (2018). Mental health spending hits $9 billion, but retains steady proportion of government health spending. Accessed at: https://www.aihw.gov.au/news-media/media-releases/2018/february/mental-health-spending-hits-9-billion-but-retain

[22] Ritter A. (2015). AOD treatment spending in Australia. University of New South Wales National Drug and Alcohol Research Centre. Accessed at: https://ndarc.med.unsw.edu.au/news/aod-treatment-spending-australia

[23] National Mental Health Commission (2016). The impact of poor mental health: an economic issue. Accessed at: https://www.mentalhealthcommission.gov.au/media/181670/Economics%20of%20Mental%20Health%20in%20Australia%20MR%20(3).pdf

[24] Australian Institute of Health and Welfare. Australia's health 2018. Chapter 4.6 Alcohol risk and harm. Accessed at: https://www.aihw.gov.au/getmedia/8849198b-6b20-4e6e-bb46-c3bb754b8a40/aihw-aus-221-chapter-4-6.pdf.aspx

Prevalence and impact of mental health and substance misuse in Australia and NC NSW – a snapshot

Australia	North Coast NSW
In a 12-month period, mental health disorders are experienced by: • 20% of the adult population • 14% of the child and adolescent population[25] In 2015-16, there were 36 million mental health related prescriptions filled in Australia, with 69% being antidepressants.[26] Suicide and self-inflicted injuries are the fourth leading cause of fatal burden of disease in Australia.[27] Each week, on average, more than 100 Australians die and more than 3,000 are hospitalised as a result of excessive alcohol consumption.	The North Coast region is worse off than the NSW average in some key indicators of mental health: Rates of psychological distress[28] - NNSW: 18.9% - MNC: 10.0% - (NSW: 11.8%) Rates of self-harm hospitalisations, 15-24 yo (per 100,000)[29]: - NNSW: 619.5 - MNC: 364.4 - (NSW: 331.2) Rates of completed suicides (per 100,000)[30]: - NNSW: 17.8 - MNC: 16.9 - (NSW: 10.6)

Mental health issues are widespread in the North Coast according to self-reports from residents.[31] Twenty-four percent (24%) of survey respondents reported having a mental health issue, and of these, 34% reported the need for AOD services (versus 19% who did not report a mental health issue).[32]

Notably, mental health is the most commonly reported community health concern for the following cohorts: young people aged 15-24 years (65%), LGBTIQ individuals (62%), financially vulnerable persons (53%), people with a self-reported challenge with alcohol or other drugs (52%), and Aboriginal people (48%).[33]

[25] Australian Institute of Health and Welfare. Australia's health 2018. Accessed at: https://www.aihw.gov.au/reports/australias-health/australias-health-2018/contents/table-of-contents
[26] Australian Institute of Health and Welfare. Australia's health 2018. Chapter 7.20 Mental health services. Accessed at: https://www.aihw.gov.au/getmedia/407a9ed3-cbdd-4b71-afd8-5f7f15b2d2c8/aihw-aus-221-chapter-7-20.pdf.aspx
[27] Australian Institute of Health and Welfare. Australia's health 2018. Chapter 7.3 Suicide prevention activities. Accessed at: https://www.aihw.gov.au/getmedia/1ae10a4a-fa4b-4c22-b9d6-2065e1652ed7/aihw-aus-221-chapter-7-3.pdf.aspx
[28] Healthstats NSW High of very high psychological distress in adults. Accessed at: http://www.healthstats.nsw.gov.au/Indicator/men_distr_age/men_distr_lhn
[29] Healthstats NSW. Intentional self-harm hospitalisations. Accessed at: http://www.healthstats.nsw.gov.au/Indicator/men_suihos/men_suihos_lgamap
[30] Healthstats NSW. Suicide. Accessed at: http://www.healthstats.nsw.gov.au/Indicator/men_suidth/men_suidth_lhn
[31] North Coast Primary Health Network. 2018 Needs Assessment survey – preliminary findings (unpublished).
[32] North Coast Primary Health Network. Needs Assessment 2017.
[33] North Coast Primary Health Network. Needs Assessment 2018. Unpublished (preliminary findings).

b. Current state of Mental Health and AOD strategies

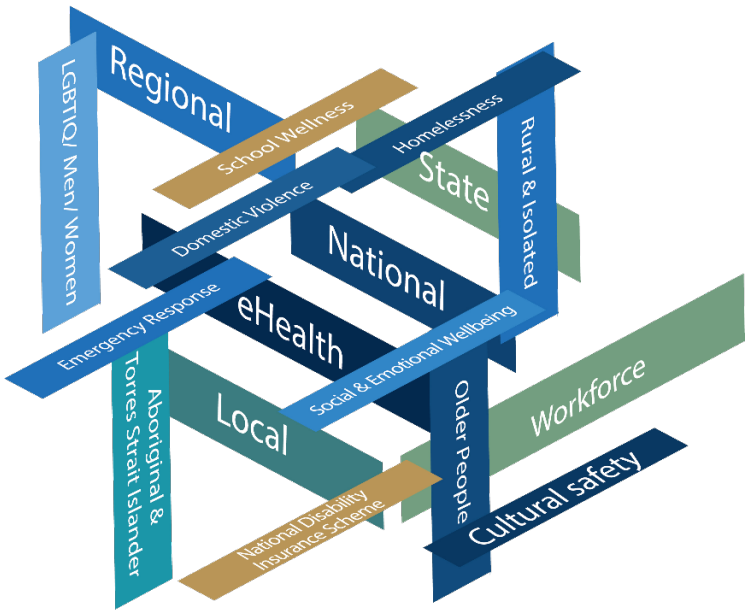
Mental health and substance use are burgeoning health issues and have garnered significant planning activity. This has resulted in a large array of plans, strategies and frameworks to guide action.

The complexity of the planning landscape for mental health and AOD includes:

- Geographic scope of plans/strategies ranging from national (e.g., *Fifth National Mental Health and Suicide Prevention Plan* 2017-2022) to local (e.g., *Our Healthy Clarence Action Plan*);
- Commonly, a separation of mental health, AOD and suicide prevention as discrete areas of action (e.g., *National Drug Strategy* 2017-2026, separate from the *National Mental Health and Suicide Prevention Plan*);
- Unclear integration with supportive strategies and plans (e.g., e-health, *Cultural Respect Framework*, health workforce);
- Additional plans for specific populations (e.g., *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* 2013-2023; *NSW Older People's Mental Health Service Plan* 2017-2027); and
- Related plans in other sectors which are not well integrated with the healthcare sector (e.g., *NSW Homelessness Strategy*; *NSW School Wellbeing Framework*; *NSW Domestic and Family Violence Blueprint*).

The following diagram depicts this complex planning matrix. Given the diverse strategic priorities, it challenging for organisations to ascertain how or where to prioritise investment to achieve the greatest gains.

Matrix of Strategies, Plans and Frameworks for Mental Health and AOD.



c. NCPHN's current Mental Health and AOD commissioning activity

Although the services funded by NCPHN only form a segment of the overall service landscape, NCPHN's mental health and AOD commissioning funds are significant, at approximately $14 million per year.

In investing these funds, NCPHN must conform to the Australian Government's requirements including implementation of a 'Stepped Care' framework for mental health. Stepped Care refers to an evidence based approach to planning and delivery of services to meet the needs of mental health clients based on their level of need and to aid their recovery.

NCPHN commissions programs and services across the Stepped Care continuum in mental health as well as separate streams in suicide prevention and AOD. Table 2 depicts NCPHN commissioning investment in 2018-19 (total: $14.1 million).

NCPHN's current MH &AOD investment, by service type, 2018-19 (estimates only, in $ millions)

<table>
<tr><th></th><th colspan="4">Mental Health Stepped Care Service Spectrum</th><th rowspan="2">Suicide Prevention</th><th rowspan="2">Alcohol and Other Drugs treatment</th></tr>
<tr><th>Target population (age cohort)</th><th>MH Promotion</th><th>Low Intensity Depression / Anxiety</th><th>Moderate Mental Illness</th><th>Severe Mental Illness</th></tr>
<tr><td>0-4 yrs</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>5-11 yrs</td><td></td><td>$0.2M</td><td></td><td></td><td></td><td></td></tr>
<tr><td>12-18 yrs</td><td></td><td rowspan="2">$1.9M</td><td>$3.3M</td><td>$0.2M</td><td></td><td></td></tr>
<tr><td>19-24 yrs</td><td></td><td>$1.7M</td><td rowspan="2">$1.9M</td><td>$0.7M</td><td rowspan="2">$1.1M</td></tr>
<tr><td>25-65 yrs</td><td></td><td rowspan="2">$0.6M</td><td></td><td></td></tr>
<tr><td>65+ yrs</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>All ages</td><td></td><td></td><td></td><td></td><td>$0.4M</td><td></td></tr>
<tr><td>Aboriginal and Torres Strait Islander people</td><td colspan="4">$1.1M</td><td>$0.3M</td><td>$0.7M</td></tr>
</table>

This high level summary of investment shows a pattern of NCPHN's resource allocation in certain areas. However, it does not serve as a gap assessment for shared investment, which would also require analysis of:

- Population health need;
- Current service landscape and the extent to which services meet health need; and
- Models of optimal investment – i.e., to achieve improvements to population health and health equity.

d. Limitations of NCPHN's current approach to Mental Health and AOD investment

Having been established in 2015, PHNs are relatively new entrants into the healthcare system in Australia. Through the last three years, NCPHN has made considerable efforts to carry out its commissioning role in mental health and AOD. It is clear, though, that effort alone will not enable NCPHN to achieve its mandate.

NCPHN's ability to optimise its contribution to health outcomes is limited by a number of factors, as presented in the following Table.

Limitations to NCPHN's current approach

Issue	Description	Result
Service fragmentation and lack of cross sector integration	NCPHN controls only a small segment of the mental health and AOD investment. Integration has not been attempted outside of the healthcare sector.	Duplication and waste. Unknown or suboptimal patient experience. Competing outcomes.
Lack of investment prioritisation	Unclear priorities for investment. Dispersed untargeted approach.	Resources are not optimally targeted to achieve outcomes. Multiple contracts with a provider.
Limited consumer participation in decision making	Planning has not meaningfully involved carers and those with lived experience	Inadequate understanding of needs; programming does not meet consumers' needs.
Limited execution of strategy	Existing plans have not been implemented to a large extent	Planning fatigue and potential cynicism amongst collaborators.
Perverse drivers	Planning timelines and process are to some degree driven by Commonwealth-prescribed timelines and reporting requirements	Not outcomes-driven. Short term contracts which cannot achieve outcomes and create instability for providers.
Inadequate data and analysis to inform an evidence based approach	Inadequate application of evidence/data to needs assessment, resource allocation and outcomes measurement. 'Dose' of intervention required to achieve health outcomes is unknown.	Unable to measure outcomes of investment (including contribution and attribution) Interventions may have insufficient dose.
Incomplete translation of conceptual framework	Stepped Care is not widely understood (inside and outside of healthcare) and may not be adequately translated to an Aboriginal context.	Poor implementation. Inadequate guidance for cultural safety. Inadequate investment in prevention and recovery.

While a shared investment approach can be the means to overcome these shortcomings it is apparent that NCPHN (with its partners) must deliberately build in approaches that will avoid the same pitfalls.

e. Investment prioritisation in MH and AOD

This section provides evidence that focussed and shared investment in mental health and AOD programming can yield significant savings in service delivery, as well as health, economic and social benefits. Mental health and AOD are addressed in separate sections here, reflecting the nature of the available literature.

Mental Health

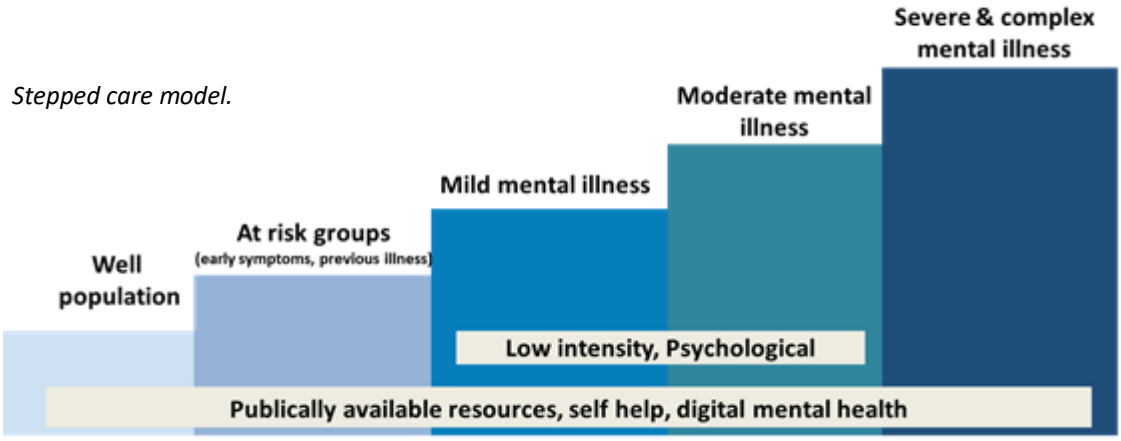
There is a strong body of evidence to inform investment prioritisation in mental health. Consistently, the literature emphasises that investing in mental health services, particularly 'upstream' interventions, yields high returns on investment.

A global return on investment analysis shows a benefit of between $3.30 and $5.70 for every $1 invested in treatment for depression and anxiety disorders.[34] Similarly, a recent Australian report estimates a savings of between $8.2 billion and $12.7 billion for an investment of under $4.4 billion in selected mental health interventions – or in other words, benefit of approximately $2 to $3 for every $1 spent.[35] In this case, savings were considered only across the health sector, justice sector and workforce productivity, and did not include measures of improved quality of life.

It is widely acknowledged that investing in prevention and early treatment of mental disorders yields the most significant economic, health and social benefits; however, the extent of such savings can vary by the type and severity of mental disorder.[36,37] It is also clear that focussed investment in primary and community care should not discount the recognised gaps in care at the more severe end of the spectrum.

The Stepped Care framework, introduced in an earlier section, provides a useful lens through which to consider investment prioritisation for mental health. Consider the following attributes:

- The cost of care significantly rises with severity of mental health disorders;
- The size of the affected population decreases with severity of disorders; and
- Interventions with high return on investment are clustered towards prevention and early intervention (i.e., lower severity or need)



Stepped care model.

[34] Chisholm D et al (2016). Scaling-up treatment of depression and anxiety: a global return on investment analysis. The Lancet, 3(5). Accessed at: https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366%2816%2930024-4/abstract

[35] https://mhaustralia.org/publication/investing-save-kpmg-and-mental-health-australia-report-may-2018

[36] KPMG (2014). Paving the way for mental health. Accessed at: http://www.mentalhealthcommission.gov.au/media/119874/Paving%20the%20way%20for%20mental%20health%20-%20KPMG.PDF

[37] National Mental Health Commission (2016). The impact of poor mental health: an economic issue. Accessed at: https://www.mentalhealthcommission.gov.au/media/181670/Economics%20of%20Mental%20Health%20in%20Australia%20MR%20(3).pdf

Alcohol and Other Drugs

Investment in substance misuse can also be considered through a continuum of interventions including prevention, supply reduction, harm reduction and treatment.

Currently, supply reduction through law enforcement responses, including incarceration, receive the greatest amount of funding. AOD treatment, though, is considered more cost effective in yielding health and social benefits.[38]

While cost-benefit ratios vary from study to study, AOD treatment programs are consistently identified as having high returns on investment.[39,40] Residential treatment has been particularly well studied in this regard. [41]

f. Summary of the case study

As outlined in this case study, mental health and substance use disorders encompass a diverse range of health issues and are inextricably connected to life and work settings.

NCPHN's current approach to mental health and AOD programming is characterised by a relatively immature approach to commissioning in a highly complex setting. Currently, strategy and resourcing occurs largely in isolation from social services, education and other sectors. The landscape of program delivery is highly fragmented, and the efficiency and effectiveness of programming in this context is likely to be sub optimal.

Shared investment an integrated planning approach that can remedy these deficiencies and channel investment to areas where impact will be greatest. Shared investment is not without its challenges and requires strong commitment from partners.

[38]Ritter A and Stoove M (2016). Alcohol and other drug treatment policy in Australia: We need more resources that are better spent. Editorial. Medical Journal of Australia, 204(4). Accessed at: https://www.mja.com.au/system/files/issues/204_04/10.5694mja15.01372.pdf

[39] Fox C (2010). Final reports from the Drug Treatment Outcomes Research Study (DTORS). Probation Journal, 57(3). Accessed at: http://journals.sagepub.com/doi/abs/10.1177/0264550510057003090 8

[40] Ettner SL et al (2006). Benefit-cost in the California treatment outcome project: does substance abuse treatment "pay for itself"? Health Services Research, 41(2): 613. Accessed at: https://www.ncbi.nlm.nih.gov/pubmed/16430607

[41] Health Policy Analysis (2005). The NSW alcohol and drug residential rehabilitation costing study. Accessed at: https://www.pc.gov.au/inquiries/completed/not-for-profit/submissions/sub066-attachment2.pdf