# Review of the Primary Care Partnerships Program

**Department of Health and Human Services**

10 February 2020

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**Inherent Limitations**

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# Glossary

| Acronym | Definition |
|---|---|
| CCG/s | Clinical Commissioning Group/s |
| CEO/s | Chief Executive Officers |
| COAG | Council of Australian Governments |
| DHHS | Department of Health and Human Services |
| ED | Emergency Department |
| EO/s | Executive Officer/s |
| GP/s | General Practitioner/s |
| G21 | Geelong Region Alliance |
| IHP | Integrated Health Promotion |
| LGBTIQ | Lesbian, Gay, Bisexual, Transgender, Intersex and Queer |
| MBS | Medicare Benefits Scheme |
| NDIS | National Disability Insurance Scheme |
| NHS | National Health Service |
| NSW | New South Wales |
| NSW Health | New South Wales Ministry of Health |
| NZ | New Zealand |
| PBS | Pharmaceutical Benefits Scheme |
| PCPs | Primary Care Partnerships |
| PHNs | Primary Health Networks |
| PIP | Practice Incentives Program |
| PIP QI | PIP Quality Improvement Incentive |
| UK | United Kingdom |
| VACCHO | Victorian Aboriginal Community Controlled Organisation |
| VicHealth | Victorian Health Promotion Foundation |
| VicPCP | Victorian Primary Care Partnerships |
| VTPHNA | Victoria and Tasmania PHN Alliance |

# Contents

# Implications of the Review of the Primary Care Partnerships Program

The Review of the Primary Care Partnerships (PCP) Program (the Program) has found that there are opportunities to realise greater value from the PCP investment.

A key finding is that the Program longer aligns with the original objectives, and there is considerable duplication between the current focus and function of PCPs and other structures and mechanisms.

The Program has few of the characteristics of mechanisms, structures or programs which demonstrate effectiveness in contemporary primary care landscapes, given that the scale of the partnerships and the projects is so small, and there is limited vested influence or authorising environment within the partnerships.

Partner engagement in PCPs is the single most important factor in delivering value. The findings of the review indicate that partner engagement is waning in some cases, and is likely to continue to decline, particularly as other mechanisms like The Orange Door and Regional Partnerships continue to mature and gain momentum.

There is no doubt that individual PCPs, and PCP staff, are highly valued and respected by many stakeholders. Stakeholder engagement and satisfaction with the Program is particularly high in regional and rural Victoria.

Of the five options presented and explored by the review, the evidence best supports one of the following courses of action:

- Reducing the number of PCPs across the state, and refocusing the Program objectives and key design elements (Option 2);
- Reducing the number of PCPs in regional and rural Victoria, and refocusing the Program objectives and key design elements, while commissioning high value functions in metropolitan Melbourne (Option 3 – a hybrid of Options 2 and 4); OR
- Identifying the high value functions and capabilities, and re-commissioning these within the system through alternative arrangements (Option 4).

Each of these options present the Department of Health and Human Services (DHHS) and the primary care sector with positive opportunities to refocus and consolidate efforts to address needs, and reduce duplication and system complexity. For example: consolidating and refocusing regional PCPs could provide DHHS with a useful platform to more effectively and sustainably support communities impacted by natural disasters and extreme weather events; and boosting investment in PHNs is an opportunity to progress a co-commissioning approach to addressing complex challenges.

Option 3 has considerable merit given that the review has found that the PCPs and PCP staff play a particularly valued and important role in regional and rural Victoria; helping to (for example) support and enable government responses to crises, and attract additional funding and resources to disadvantaged areas.

If pursued, funding high value functions of PCPs through alternative arrangements should be undertaken with consideration of a best practice approach, which should at a minimum involve some opportunity for co-design with the sector, and would ideally reflect a collaborative commissioning approach to allow for localised solutions and responses.

Stakeholder interest and engagement in the review has been substantial (illustrated by over 800 stakeholders responding to the survey), and decisions about the future of PCPs will generate a high level of interest in some locations, and some segments of the sector. It is therefore important that: there is clear and timely communication to the sector about future directions and timeframes; a comprehensive transition planning process is undertaken, particularly to manage the successful transition of valued local projects; and the impact on PCP partners, staff and auspice organisations is considered in developing reasonable timelines for transition arrangements.

# Executive Summary

Victoria's 28 Primary Care Partnerships (PCPs) were established in 2000 and are funded by the Department of Health and Human Services (DHHS) under the PCP Program. DHHS commissioned KPMG to undertake a review of the PCP Program to analyse the current state and impacts of the PCP Program, particularly in the context of a changing primary care landscape.

## Approach to the review

The purpose of the review was to:

- Establish a detailed and evidence based understanding of the current and historical implementation and impact of the PCP Program.
- Explore how the PCP Program operates within the current Victorian primary care landscape.
- Understand the extent to which the PCP Program is designed and equipped to address contemporary trends and challenges in the Victorian primary care landscape.
- Identify opportunities for DHHS to maximise the impact of the PCP Program investment, in order to improve health and wellbeing outcomes for Victorians, promote health equity and reduce unnecessary hospitalisations.

The review was guided by agreed review questions focused on: contextual factors relevant to the changing primary care landscape; the current state of the PCP Program; the impacts of the PCP Program; and options for the future of the PCP Program.

The Review was informed by the following data sources:

- A detailed review of PCP plans, reports and other documentation.
- A high level review of PCP financial reporting.
- An online survey of PCP partners / stakeholders.
- An online survey of PCP staff.
- Consultations with key stakeholders, identified in consultation with DHHS.
- More in-depth analysis of four PCPs from across Victoria.
- A rapid review of the current primary care and integration landscape in Victoria, and good practice examples of partnership platforms and approaches to integration.

## Key review findings – implementation and impact

The PCP Program was designed and implemented 20 years ago, and the Program has not been substantially reviewed or revised since that time, despite major changes in the operating environment. In relation to the current state of implementation of the PCP Program, the review has found that:

- Both the role and focus of PCPs have evolved over time, as PCPs have shifted away from system integration, hospital avoidance and chronic disease management, towards primary prevention, support for vulnerable population groups and the provision of 'backbone'[1] support.
- The original stated Program aims are no longer directly guiding PCP areas of focus, and PCP priorities are more likely to reflect the Victorian Health and Wellbeing Plan 2015-2019[2] (which is consistent with more recent guidance from DHHS).

[1] Backbone organisations or functions reference the collective impact framework, and refer to an organisation providing critical support and coordination.
[2] Noting that more recent plans and reports may have been updated to reflect the 2019-2023 plan.

- PCP priorities are highly diverse, as would be expected for a platform which represents and is guided by local partners. This diversity also reflects opportunistic alignment with emerging policy directions and, in some cases, the preferred interests or skill set of staff.
- Total revenue for the 28 PCPs from 2015-6 to 2017-18 was $44,206,238. Across this time period, **PCP Program core funding from DHHS made up 72 per cent of the reported revenue of PCPs**, while other DHHS funding contributed 15 per cent, and 13 per cent came from other revenue sources.
- Total DHHS core funding to the PCP Program in 2017-18 was **$10,666,927**. In 2017-18 PCPs reported an additional $2,419,632 from other DHHS sources (i.e. non-PCP Program funds), and reported an additional $1,815,857 in other revenue.
- From 2015-16 to 2017-18 spending by PCPs was made up of:
    - **63 per cent for Salaries and Wages**.
    - **25 per cent for General Expenses**.
    - **12 per cent for Project Expenses**.
- In 2017-18 the 28 PCPs reported spending $13,435,580 (**89.4 per cent of total spending**) on **Salaries and Wages and General Expenses** combined, and $1,596,883 (**10.6 per cent** of total spending) on **Project Expenses**.

In relation to measuring the impact of the PCP Program the review has found that:

- While PCP-led activities may broadly align with the Program aims to maximise health and wellbeing outcomes and promote health equity, there is limited evidence of attributable improved outcomes in these areas, and achievements are more likely to reflect promotion activities, community engagement or capacity building.
- The PCP Program is not effective in terms of addressing unnecessary hospitalisations, and this aim is no longer appropriate for the PCP Program in its current form.
- There is limited evidence that PCPs are having a meaningful positive impact on system integration, beyond fostering relationships and networking, which are important building blocks for integration.

Overall, it is very difficult to determine the impact of the PCP Program as a whole, and this somewhat reflects the design and operating model of the Program, as well as the diversity and scale of priorities and projects.

### Key review findings – the effectiveness of PCPs as a partnership platform

The Review has found examples of PCPs driving meaningful partnerships, often around specific projects or initiatives. However, the scale of what is being achieved through PCP-led or enabled partnerships is often limited, and both PCPs and partners consistently reported that they lack an authorising environment and meaningful levers to influence significant change. PCPs are, by design, reliant on their partnership for endorsement and authorisation, and this finding indicates that the PCP partnerships lack strength and may no longer be fit for purpose in terms of effecting significant change.

Many (not all) PCPs identify with collective impact as a framework for their partnership work. Central to successful collective impact is the commitment of partner organisations to 'the collective' and the shared agenda. The review has found that participation in PCP-led structures and activities is decreasing in some locations, and that this is likely to continue across some partner types including local government and PHNs.

### Key review findings – the PCP Program within the contemporary landscape

The Review has considered the PCP Program in the context of the current Victorian primary care landscape, and makes the following observations:

- There have been **significant changes in the primary care landscape** over the 20 years since the PCP Program commenced, including (but not limited to) large scale reforms in family violence including the implementation of The Orange Door initiative and the launch of Respect Victoria, and the move to legislate a role for local government in the health and wellbeing space.
- There is now **demonstrable duplication between the PCP Program and other existing structures and mechanisms**, including but not limited to: local government's role in place-based health and wellbeing planning and initiatives; PHNs in relation to population health planning, system integration and primary care capacity building; and Community Health Services in relation to leading local prevention initiatives as funded by DHHS under the Integrated Health Promotion program.
- The **Victorian primary care landscape is more complex than systems in other jurisdictions**, and PCPs contribute to that complexity, primarily through the duplication described above.
- Significant reforms in primary care and associated sectors including disability, aged care and mental health in recent years have contributed to emerging trends around market consolidation and provider business model changes, all of which are impacting on PCP partners and in many cases **reducing their capacity to engage in collaborative activities in the absence of direct business benefits.**

The implications for the PCP Program are that:

- While at the time of implementation the PCP Program no doubt played a useful role in helping to support a more joined-up, system-level approach to thinking about primary care, **other programs and structures are now better placed to tackle contemporary sector challenges.**
- There is a strong case to **reduce complexity and duplication** by reviewing PCP functions which are duplicative and either **divesting** of these PCP functions or **consolidating** these functions within more substantial and sustainable structures and mechanisms.
- The sustainability of the platform over time is questionable given the apparently **waning engagement** from some partners and stakeholders, which seems likely to continue to undermine the effectiveness of PCPs into the future.
- The **number and size** of PCPs creates onerous engagement requirements for partners who operate across multiple PCP catchments; makes scaling initiatives and learnings more difficult; and probably drives inefficiency in operating costs.
- There is a **lack of alignment** between the design and implementation of the PCP Program and features which are likely to support the Victorian primary health sector to meet current and future challenges, such as clear roles and responsibilities around progressing and responding to reforms, simplified planning to enable a focus on action and impactful collaboration around clear objectives.
- The challenges around **measuring the impact** of the PCP Program as a whole is a constraint in a health system under pressure, where there is a strong imperative for programs and services to demonstrate end-user outcomes and a clear case for ongoing investment.

### Key review findings – high value functions

The review has found that there are elements of the PCP Program which are both highly valued by stakeholders and objectively valuable in the contemporary landscape. These elements include backbone-like functions, particularly linked to:

- The capability and capacity to mobilise *place-based* primary prevention initiatives (where place-based is defined by areas of common need).
- The capability and capacity to mobilise local responses to unforeseeable events and time critical responses, for example to extreme weather events.
- Localised capability building, specifically in areas such as primary prevention, community engagement and health literacy (for example, identifying and addressing local training and capacity-building needs).

The review also notes that stakeholders generally hold PCP staff themselves in very high regard.

### Future directions

The Review has identified a case for change and an opportunity to maximise the value of the PCP investment. Five potential options have been identified:

1 Continue funding the 28 existing PCPs through the Program, and refocus the Program objectives and key design elements.

2 Continue funding the PCP Program, but consolidate and reduce the number of PCPs, and also and refocus the Program objectives and key design elements.

3 Reduce the number of PCPs in regional and rural Victoria, and refocus the Program objectives and key design elements. In metropolitan Melbourne, re-commission high value functions through alternative arrangements.

4 Discontinue funding the PCP Program, and fund priority PCP functions which are demonstrating continued value through alternative arrangements.

5 Cease funding the PCP Program and all existing PCP functions.

Figure 1 illustrates these options and identifies key considerations.

The Review findings do not support the continuation of the Program in its current form, but given that the review has also identified valuable aspects of the Program, the findings do not support complete divestment of all functions. The findings indicate that the best opportunities to maximise the impact of the investment can be realised through either:

- Reducing the number of PCPs across the state, and refocusing the Program objectives and key design elements (Option 2);
- Reducing the number of PCPs in regional and rural Victoria, and refocusing the Program objectives and key design elements, while re-commissioning high value functions in metropolitan Melbourne (Option 3 – a hybrid of Options 2 and 4); OR
- Identifying the high value functions and capabilities, and re-commissioning these within the system through alternative arrangements (Option 4).

Option 3 has considerable merit given that the review has found that the PCPs and PCP staff play a particularly valued and important role in regional and rural Victoria; helping to (for example) support and enable government responses to crises, and attract additional funding and resources to disadvantaged areas.

Stakeholder satisfaction is clearly higher in regional and rural Victoria, where 70 per cent of stakeholders / partners reported that they are highly satisfied with the current PCP Program and model, than in metropolitan Melbourne, where only 30 per cent of stakeholders / partners reported the same. The review finds that there is a compelling case to consider a different future path for PCPs depending on their location.

A comprehensive discussion of these options and relevant considerations, such as how high value functions could be reallocated, can be found in chapter 7.

Any continued investment, whether in PCPs or through alternative arrangements, should be guided by clear strategic direction and a contemporary program logic, and subject to ongoing monitoring and evaluation.

*Figure 1: Options for future investment*

# 1 Introduction and context

This chapter provides background and context for the review of the Primary Care Partnerships (PCP) Program.

## 1.1 Background and context

Victoria's 28 Primary Care Partnerships (PCPs) were established in 2000 and are funded by the Department of Health and Human Services (DHHS) under the PCP Program. PCPs are a partnership platform, bringing together local health and other agencies to progress work in line with shared priorities. PCPs were originally set up to work in partnership with local organisations to support integrated care, promote health equity, and improve local health outcomes, but their role and focus has evolved over time (this is further discussed in section 3.1).

The majority of PCPs are voluntary partnership alliances supported by auspice organisations. The PCP program also part funds two incorporated organisations: Enliven and G21 – the Geelong Region Alliance.

Collectively, Victoria's PCPs have engaged with over 850 organisations either formally (for example, under a Partnership Agreement), or less formally. These include organisations such as hospitals, Community Health Services, local government, and PHNs. Further background on the PCP program is provided in Appendix A.

## 1.2 Purpose of the review

Since the establishment of PCPs the landscape in which PCPs operate has changed significantly. Victoria has experienced population growth, an increasing burden of chronic disease, service reconfigurations and changing consumer expectations. Commonwealth and state level reforms have also led to a range of structural changes, including (but not limited to) implementation of The Orange Door initiative, the introduction of Primary Health Networks (PHNs) as regional commissioning agencies, and the establishment of Metropolitan and Regional Partnerships. Many of these new structures and mechanisms share some common aims and objectives with the PCP Program.

DHHS commissioned KPMG to undertake a review of the PCP Program to analyse the current state and impacts of the Program, particularly in the context of a changing primary care landscape.

The purpose of the review was to:

- Establish a detailed and evidence based understanding of the current and historical implementation and impact of the PCP Program.
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## 1.3 Approach to the review

The review was guided by agreed review questions focused on: contextual factors relevant to the changing primary care landscape; the current state of the PCP Program; the impacts of the PCP Program; and options for the future of the PCP Program.

The Review was informed by the following data sources:

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- An online survey of PCP partners / stakeholders.
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- Consultations with key stakeholders, identified in consultation with DHHS.
- More in-depth analysis of four PCPs from across Victoria (case study sites).
- A rapid review of the current primary care and integration landscape in Victoria, and good practice examples of partnership platforms and approaches to integration.

More information on the review methodology, limitations, data collection tools and a write up of the case studies is provided in Appendices B, C, D, E and F.

# 2 Relevant contextual factors

This chapter describes the current primary care landscape in Victoria, with a focus on the key features that characterise the sector, emerging and evolving sector and health trends, and areas of identified overlap between the PCPs and existing structures and functions. Additional discussion of contextual factors is provided in Appendix G.

## 2.1 Current primary care landscape

The PCP Program was designed and implemented 20 years ago, and the Program has not been substantially reviewed or revised since that time, despite major changes in the operating environment.

In that time major sector reforms have, and will continue to, shape Victoria's primary health care sector. Significant transformations associated with disability, family violence, aged care and mental health sector reforms are changing the role of primary care in the health and social system, and driving increasing pressure for integration and more person-centred responses.[3, 4]

Consistent with national health system trends, Victoria is also experiencing pressures associated with an ageing population, workforce shortages (particularly in regional and rural general practice), and health inequity for certain population groups, including Aboriginal people.[5]

Victorian's primary care landscape is unique in many ways, and is characterised by the following features:

- A mandated role in health and wellbeing for local government through the Public Health and Wellbeing Act 2008, which requires that local councils develop Municipal Health and Wellbeing Plans in four-year cycles which align with the Victorian Health and Wellbeing Plan.[6]
- Over 300 hospitals and health services, including many small Health Services.
- A well established and embedded community health sector, which provides state-funded primary health care, often including a comprehensives suite of health and social services, and targeting vulnerable Victorians.
- The establishment of the Victorian Health Promotion Foundation (VicHealth) to facilitate state-wide promotion initiatives and support the prevention of chronic disease in Victoria.
- A well established and generally high functioning Aboriginal Community Controlled health sector, mainly operating under a consortium model, meaning that most organisations are relatively large and provide a comprehensive range of health and social services.
- The existence of PCPs.

In order to respond to the emerging health system challenges, and rising and evolving demand, it is essential that Victoria's primary care sector reduces complexity, is agile and can mobilise impactful collaborations around clearly define aims and objectives. Clear roles and responsibilities around progressing and responding to reforms, as well as localised capacity and capability to create placed-based responses to population health needs are all critical.

[3] Report of the Family Violence Reform Implementation Monitor - As at 1 November 2018. (2019).
[4] Australian Government, Department of Social Services. (2010). National Disability Strategy 2010-2020.
[5] National Medical Workforce Strategy. (2019). Retrieved 11 December 2019, from https://www1.health.gov.au/internet/main/publishing.nsf/
[6] Municipal public health and wellbeing planning. (2019). Retrieved 11 December 2019, from https://www2.health.vic.gov.au/public-health/

## 2.2 Duplication with the PCP Program

The review has identified some areas of duplication between the PCP Program and other existing structures and mechanisms in Victoria's primary care landscape. These include (but are not limited to):

- The Integrated Health Promotion program which funds local health promotion initiatives, primarily through Community Health Services.
- VicHealth's role in driving state-wide health promotion initiatives and prevention of chronic disease.
- PHNs, particularly in relation to population health planning, system integration and primary care capacity building at a local level.
- Local government's role in place-based health and wellbeing planning and initiatives, with a strong focus on primary prevention and health promotion.
- Metropolitan and Regional Partnerships as a partnership platform designed to support Government decision-making and planning at a local-level.
- The role of The Orange Door initiative in delivering specialised, integrated care for Victorians experiencing family violence and supporting place-based primary prevention initiatives in family violence.
- The role of Respect Victoria in the primary prevention of all forms of family violence.
- DHHS's role in fostering effective partnerships and supporting system integration through the facilitation of collaborative forums, place-based partnerships, and cross-sector capability uplift opportunities.

The duplication between the PCPs and other existing structures contributes to the complexity of the Victorian primary care landscape.

# 3 Current state of the PCP Program

This chapter describes the current state of the PCP Program, including the strategic priorities and types of activities that PCPs are currently engaged in, as well as how they have evolved over time.

## 3.1 Strategic priorities and areas of focus

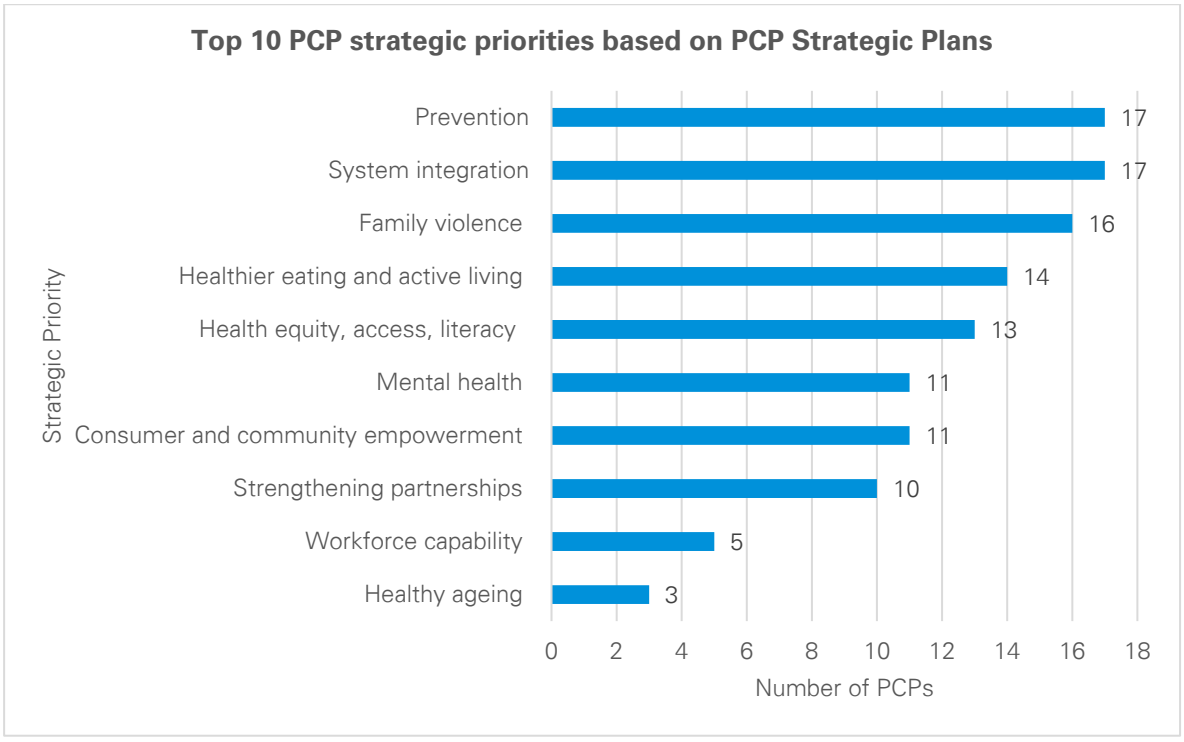
**Key finding: PCP strategic priorities have evolved over time, with a clear trend towards primary prevention and in line with major policy reforms, including in family violence and mental health.**

### 3.1.1 Current strategic priorities

PCPs were first established in 2000 to support the development of a more responsive, integrated and prevention focused primary health care system, with stated aims to maximise health and wellbeing outcomes, promote health equity and avoid unnecessary hospital presentations and admissions. However, the strategic priorities of individual PCPs have changed over time.

Analysis of PCP strategic documents (Figure 2) indicates that current priorities and projects are focused on prevention (generally), system integration and family violence in particular. [7] When general prevention, prevention of family violence and violence against women and health eating and active living are combined, it is clear that primary prevention is the leading current priority according to formal documentation.

*Figure 2: Top 10 PCP strategic priorities based on formal strategic documentation*




*Source: KPMG document review*

[7] Based on PCP Strategic Plans developed since 2017

These findings are supported by the PCP staff survey results, in which PCP staff reported the following as the top five current strategic priorities:

- Primary prevention (general) (n=76)
- Family violence and prevention of violence against women (n=76)
- Healthy eating and active living (n=75)
- Strengthening partnerships (n=67)
- Mental health and social inclusion (n=67).

Notably, although 'system integration' features strongly in formal strategic plans, staff survey responses and the case studies indicate that this is not the case in practice.

The current priorities somewhat align with the Program aims to maximise health and wellbeing outcomes and promote health equity, noting that these two aims are very broad. There is very little alignment with the third aim (avoiding unnecessary hospitalisations).

### 3.1.2 Changing priorities and areas of focus

It is clear that PCP priorities and areas of focus have shifted over time:

- Feedback from stakeholders and PCP staff during face to face consultations and site visits indicates that there has been a shift away from traditional system integration, hospital avoidance, and chronic disease management, towards primary prevention, supporting vulnerable population groups and the provision of backbone / project management support.
- Staff survey responses indicate that there has been either some change (n=86), or significant change (n=39) in the PCP's priorities over the past five years.

PCPs attribute these changes to evolving policy directions, a lack of updated guidance from DHHS, and changing local needs. Somewhat limited guidance from DHHS in recent years (for example, the program logic has not been updated since it lapsed in 2017) means that PCPs have had the flexibility to respond to emerging local needs, and in some cases, have migrated towards their preferred area of interest or specific skill set. It is also to be expected that a platform which represents and is guided by local partners would evolve over time and reflect changing local needs and priorities.

The establishment of PHNs, with a strong focus on commissioning to improve health outcomes and system integration, was also specifically identified in three of the four case study sites as a key reason for the shift away from chronic disease management and system integration towards primary prevention, to avoid duplication of effort with PHNs.

## 3.2 PCP activities

**Key finding: PCPs are engaged in a broad range of activities, many of which deliver tangible benefits. Some activities, such as development of plans and strategy documents, meeting schedules and advocacy efforts, are focused on sustaining the PCP platform itself.**

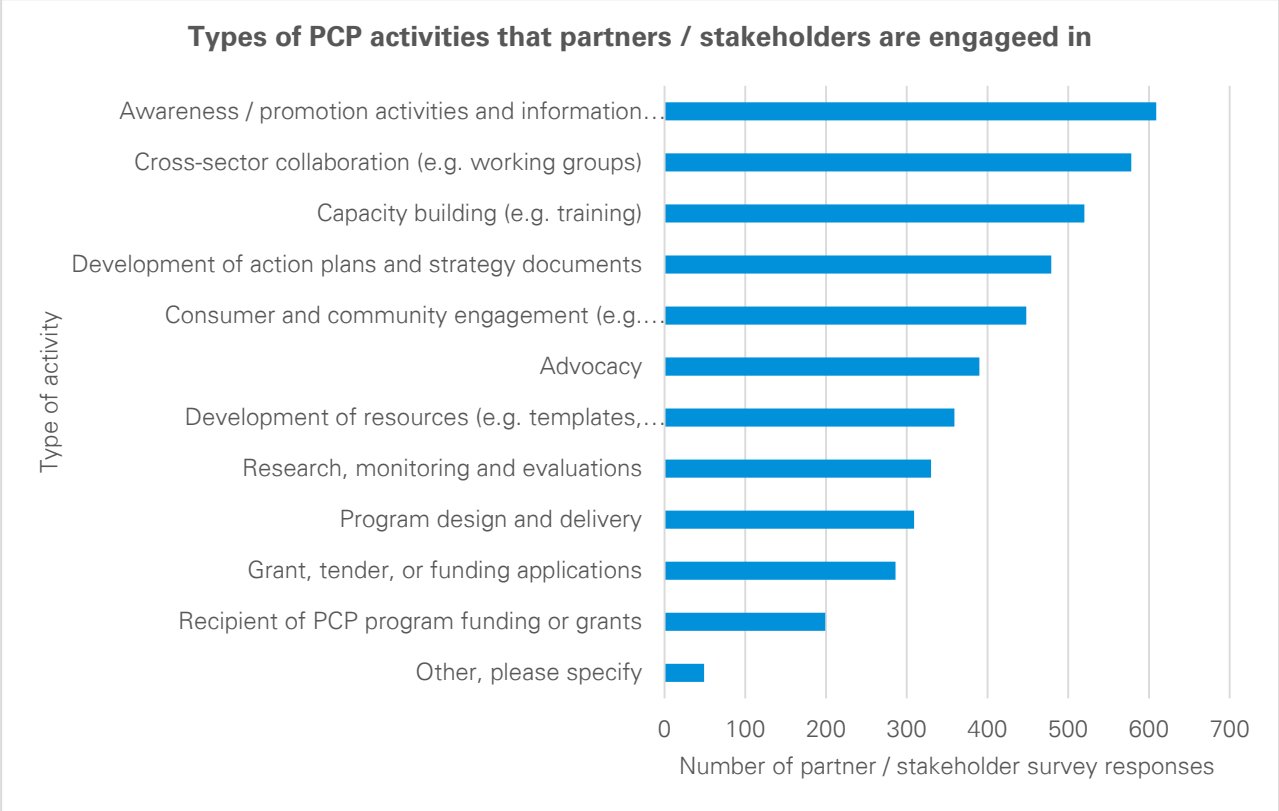
### 3.2.1 Current PCP activities

Across both surveys (stakeholder/partners and PCP staff) the following were identified as the top five types of activities or initiatives that PCPs are currently engaged in:

- Awareness / promotion activities and information sharing (stakeholders/partners n=609, PCP staff n=121)
- Cross-sector collaboration (e.g. working groups) (stakeholders/partners n=578, PCP staff n=120)
- Capacity building (e.g. training) (stakeholders/partners n=520, PCP staff n=113)
- Consumer and community engagement (stakeholders/partners n=488, PCP staff n=112)
- Development of action plans and strategy documents (stakeholders/partners n=479, PCP staff n=106).

Figure 3 illustrates in more detail the types of PCP-associated activities that partners and stakeholders are currently engaged in as per the PCP partner / stakeholder survey results.

*Figure 3: PCP activities that stakeholders are engaged in based on partner / stakeholder survey responses*




*Source: PCP partner / stakeholder survey*

These findings reflect those of the document review in which the following were consistently reported as current PCP activities and initiatives (as based on PCP Strategic Plans and Prevention Reports 2017-18):

- Cross-sector collaboration (n=24, 86 per cent).
- Awareness and promotion activities and information sharing (n=23, 82 per cent).
- Capacity building (e.g. training) (n=16, 57 per cent).
- Development of resources for partners (n=16, 57 per cent).
- Consumer and community engagement (n=15, 53 per cent).

Key activities noted by staff at all four PCP case study sites included:

- Social marketing and health promotion campaigns.
- Backbone / project management support.
- The development and publication of resources to support local primary prevention, service coordination, and health promotion initiatives.
- The facilitation of governance groups and project working groups, as well as communities of practice and networking opportunities.
- Service mapping and development of collaborative plans.
- The delivery of training programs to support local capability uplift, particularly within primary prevention and health promotion.

The provision of project management and support, the delivery of training, and health promotion initiatives were generally considered by partners to be particularly useful, most notably in regional and rural Victoria.

Based on consultations with PCP staff and partners, PCPs tend to assume an enabling or supporting role in local initiatives or activities, unless temporary leadership is required. There is some evidence

that PCPs in regional and rural Victoria are more likely to flex into leadership roles due to variable capability and capacity in their local communities. This highlights the fragility of regional systems and the advantages associated with having an agile and skilled team available to provide backbone / project management or other forms of support as required.

The review of activities does indicate that significant effort is required to sustain the PCP platform and to support the governance structures. Some partners and stakeholders reported that significant effort, by both PCP staff and partner organisation staff, is directed towards activities which sustain the PCP platform rather than providing genuine additional value to the system. These activities include meetings, strategic planning and priority setting for the PCP, and advocacy for PCP initiatives.

## 3.3 PCP funding and financial analysis

Total revenue for the 28 PCPs from 2015-6 to 2017-18 was $44,206,238. Across this time period, PCP Program core funding from DHHS made up 72 per cent of the reported revenue of PCPs, while other DHHS funding contributed 15 per cent, and 13 per cent came from other revenue sources.

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In 2017-18 the 28 PCPs reported spending $13,435,580 (89.4 per cent of total spending) on Salaries and Wages and General Expenses combined, and $1,596,883 (10.6 per cent of total spending) on Project Expenses. This indicates that a significant proportion of PCP expenditure is allocated to workforce and general costs, and that a relatively small proportion is allocated to directly to projects under the current model. It is, however, unclear whether the allocation of spending to the categories is consist across all PCPs.

Salaries and wages cover administrative salaries, work cover, annual and long service leave, superannuation and recruitment. General expenses include costs such as computer software, stationary, administration, asset purchases and rent. Project expenses include consultancy spend and other project-specific costs.

Detailed financial analysis is provided in **Appendix H.**

# 4 PCP Program impacts

This chapter explores the impacts of the PCP Program in the context of the Program aims and strategic domains.

## 4.1 Impacts against the Program aims

**Key findings:**

- **There is limited evidence that the PCP Program has had a measurable impact in line with the stated Program aims. PCPs have demonstrated some *progress* against the Program aims to improve health and wellbeing outcomes and promote health equity. The PCP Program has not had a measurable impact on reducing unnecessary hospital admissions.**
- **The PCP Program aims are extremely broad, and in some cases overlap significantly with the aims of other programs or organisations.**
- **The PCPs lack the authorising environment to effect meaningful change against the Program aims, particularly the avoidance of unnecessary hospital admissions.**

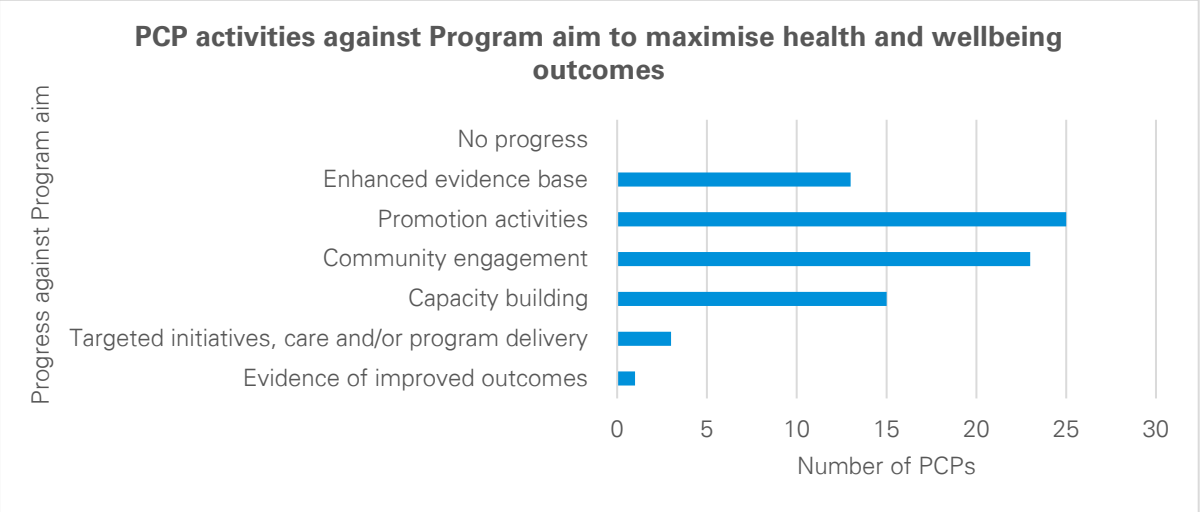
### 4.1.1 Evidence of progress against the Program aims

The three aims of the PCP Program are to:

- Maximise health and wellbeing outcomes
- Promote health equity
- Avoid unnecessary hospital presentations and admissions.

The review PCP documentation (i.e. plans and reports) shows that all PCPs have undertaken some form of activity aligned with the aim to *maximise health and wellbeing outcomes*, particularly in the form of health promotion activities, community engagement, and capacity building (see Figure 4). There is limited evidence within formal documentation of actual impacts or improvements in outcomes.

*Figure 4: PCP activities against Program aim to maximise health and wellbeing outcomes*




*Source: KPMG document review*

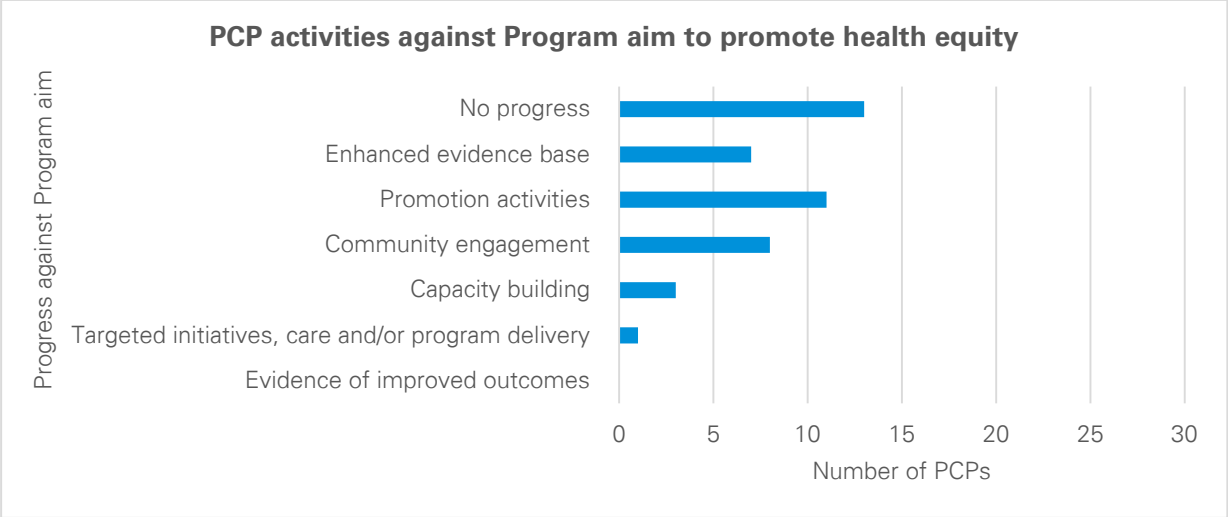
As shown in Figure 5, some but not all PCPs report having undertaken activities aligned with the aim to *promote health equity*, with 46 per cent of PCPs reporting no progress towards that aim. Some PCPs have engaged in promotion activities (39 per cent), community engagement (29 per cent) and

evidence building (25 per cent) activities with a focus on promoting health equity. Health equity related activities were presented as flagship initiatives by the four case study sites, including:

- Collaboration with local schools in disadvantaged areas to develop community gardens and improve access to healthy food in schools.
- Working with young people from refugee or asylum seeker backgrounds to co-design mental health and local youth support services and programs.
- Development of health literacy resources to improve access to local health and social services, and promote health equity.

Within the documentation viewed there was no evidence of improved outcomes associated with promoting health equity.

*Figure 5: PCP activities against Program aim to promote health equity*

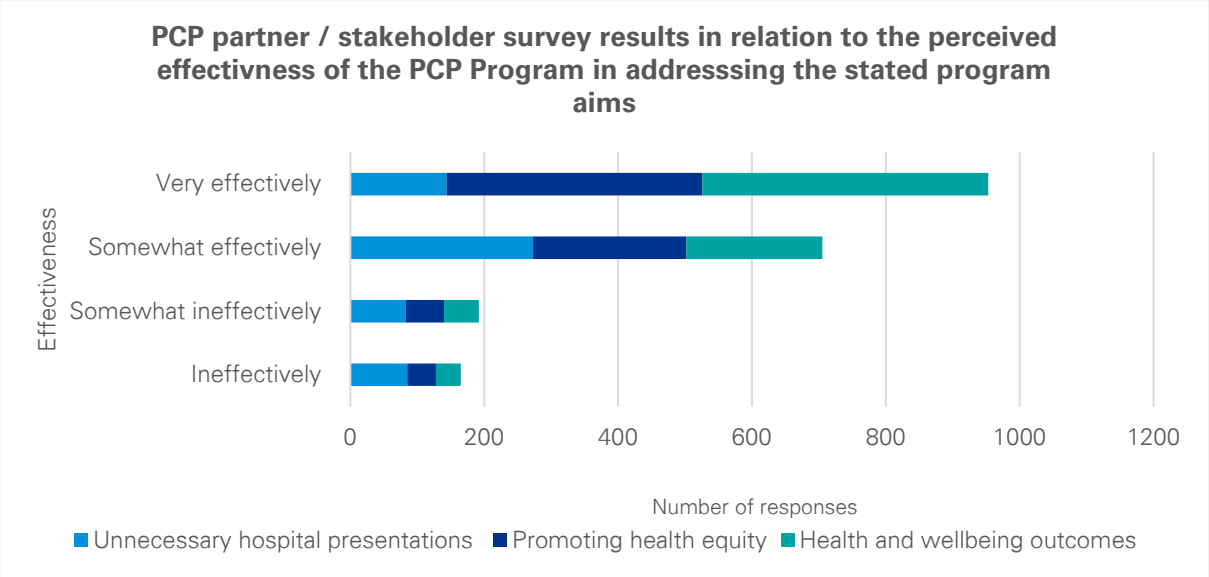



*Source: KPMG document review*

No PCPs are currently engaged in activities specifically designed to address the stated Program aim to *reduce the rate of unnecessary hospital admissions*. This aligns with the message strongly communicated by PCPs and partners that PCPs are not equipped to address this aim, and consider it to be no longer relevant for the PCP Program in its current form. Several partners and PCP staff, noted that PCPs do not have the authority or levers to effect change in hospital admissions or the acute sector more broadly.

The stakeholder/partner survey results indicate that many stakeholders hold a positive view of the effectiveness of the program in achieving the stated aims, and are more likely to perceive the PCPs to be more effective in maximise health and wellbeing outcomes and promoting health equity than reducing unnecessary hospitalisations (as shown in Figure 6).

*Figure 6: PCP partner / stakeholder survey results relating to effectiveness of the Program against program aims*




*Source: PCP partner / stakeholder survey*

### 4.1.2 Relevance and appropriateness of Program aims

The majority of stakeholders, partners and staff report that the first two Program aims continue to be relevant and appropriate. Specifically:

- A total of 72 per cent (n=126) per cent of PCP staff survey respondents and 80 per cent (n=680) of partner / stakeholder survey respondents reported that the first Program aim to maximise health and wellbeing outcomes is still relevant and appropriate.
- Similarly, 71 per cent of PCP staff survey (n=125) respondents and 80 per cent (n=642) of partners / stakeholder survey respondents felt that the second stated Program aim to promote health equity is still relevant and appropriate.

The review notes that both these are very broad and open to interpretation, and that other very substantial agencies and programs are also working to progress these aims, including PHNs, community health, health services, local government, VicHealth, the Aboriginal community controlled health sector.

Considerably less PCP staff and partners / stakeholders reported that the third Program aim to reduce unnecessary hospital admissions is still relevant and appropriate. Specifically, less than half of both staff survey respondents (n=67, 38 per cent) and partner / stakeholder survey respondents (n=400, 49 per cent) reported that this Program aim was still relevant and appropriate.

As discussed previously, PCP staff and stakeholders acknowledge that PCPs lack the authorising environment to drive meaningful change in hospital admissions. Although potentially avoidable hospitals admissions have reduced slightly in Victoria from 173,770 annual separations in 2006-2007 to 159,902 annual presentations in 2016-17, it is difficult to attribute this to any specific intervention, let alone PCPs.[8, 9]

[8] Australian Institute of Health and Welfare. (2018). *Potentially preventable hospitalisations by Primary Health Network (PHN) area*. Australian Institute of Health and Welfare.
[9] Australian Institute of Health and Welfare. *Separation statistics for selected potentially preventable hospitalisations, by state or territory, all hospitals*. (2007). Australian Institute of Health and Welfare.

## 4.2 Other Program impacts

**Key finding:**

- **System integration is consistently identified as strategic domain of the PCP Program in formal program documentation (i.e. plans and reports), but this is not demonstrated in practice.**
- **While many stakeholders and partners reported that individual PCPs are often effective in brokering and sustaining local partnerships, the scale and impact of the partnerships is highly variable and often very limited in terms of driving significant system level change.**
- **The diversity and small scale of PCP initiatives, and often limited capacity for substantial evaluation, makes it very challenging to measure Program level outcomes.**

### 4.2.1 System integration

System integration is identified within the partnership goal in the Program Logic 2013-2017 and recognised as a strategic domain. However, while system integration frequently features in strategic plans, staff survey responses and consultations indicate that this is not the case in practice. System integration was not identified in the top five health or social priorities by PCP staff through the survey (as shown in Section 1.2.2). This finding is reinforced by the projects explored at case study sites which did not reflect a significant focus on integration, beyond what is achieved through partnership building.

PCP staff and stakeholders generally reported that PCPs are not well placed to drive system level integration, although there are examples of projects which include integration as a local or micro-level objective.

Stakeholders and partners also reported that, while system integration may not necessarily be a stated aim of all projects, PCP-led projects are often helping to establish and sustain strong partnerships built on trust and mutual understanding, and this is a critical foundation for integration.

New South Wales' (NSW) integrated care journey is an example of how to approach system integration at scale. What this example demonstrates is that integration requires significant and sustained investment, and strong engagement from active system participants. It also highlights the relative simplicity of the NSW health system, whereby a partnership between an LHD/s and a PHN (sometimes a one to one or one to two match) can be sufficient to progress significant integration between the primary and acute health sectors.

*Figure 7: NSW Integrated Care Journey Case Study*

## The NSW integrated Care Journey – Approaching system integration at scale

The New South Wales Ministry of Health (NSW Health) identified integrated care as a strategic priority as part of the NSW State Health Plan: Towards 2021. Published in 2014, the NSW State Health Plan outlines NSW Health's commitment to trialling innovative, and locally-led models of integrated care across the state.[10, 11]

To progress integration NSW Health committed more than $120 million to drive several reform initiatives, including: the launch of Demonstrator Sites as well as Innovator Site; the introduction of new purchasing and funding models to incentivise greater transparency, cost-effective service delivery, and outcomes-focused care in both primary and secondary settings; and investment in e-Health platforms and resources and programs designed to empower patients to actively engage in their care.[12, 13]

Since 2014 significant progress has been made around integration, and some good outcomes have been achieved, including patients being more involved in their own care, better integration in the community and primary care settings and more effective partnerships between primary care providers and other areas of the health system.[14]

Building on the work of the Integrated Care Strategy, the NSW Health Strategic Framework for Integrating Care was launched in 2018.[15] Focusing on the quadruple aim and value based care as core concepts, the Framework aims to embed a consistent understanding and approach to integrating care across the health system and its interface with social care in NSW.

Central to taking the reforms forward will be the collaborative commissioning agenda currently being developed and tested. This will involve the establishment of regional co-commissioning structures to address local priority needs through formalised arrangements between PHNs and Local Health Districts (LHDs) aimed at redesigning care pathways to achieve greater integration and deliver greater value.

The collaborative commissioning agenda will be supported by state-wide structures, governance and funding, and more local arrangement centred on the establishment of Patient Centred Co-commissioning Groups (PCCGs) which will bring together regional co-commissioning, governance, and funding functions. Initial seed funding will be provided, but the vision is that collaborative commissioning will become self-sustaining over time.

**Key learnings from NSW:**

- The initiative signals the importance of taking a whole-of-sector approach to system integration to effect meaningful system-level change.
- The NSW approach to integration demonstrates that strong leadership and significant investment from all levels of Government is key, providing the authorising environment for change and driving a consistent state-wide agenda.
- While there is much work still to be done, the NSW approach to integration has created forward momentum, and the state is positioning strongly to embed collaborative co-commissioning between PHNs and LHDs as an enduring and sustainable approach to driving integration.

[10] NSW Ministry of Health. (2014). NSW State Health Plan: Towards 2021. Sydney: NSW Ministry of Health.
[11] NSW integrated care journey - Integrated Care. (2019). Retrieved 19 November 2019, from https://www.health.nsw.gov.au/integratedcare/Pages/Our-Plan.aspx
[12] NSW Ministry of Health. (2014). NSW State Health Plan: Towards 2021. Sydney: NSW Ministry of Health.
[13] NSW Health. (2019). Strategic Framework for Integrating Care. NSW Health.
[14] NSW Ministry of Health. (2015). NSW State Health Plan Progress Report 2015 (p. NSW Ministry of Health). Sydney.
[15] NSW Health. (2019). Strategic Framework for Integrating Care. NSW Health.

### 4.2.2 Effective partnerships

Qualitative data suggests that PCPs individually are considered by many to be effective at driving sustainable and meaningful partnerships. Approximately 80 per cent of partners / stakeholders (n=646) reported that the PCP Program is either very or somewhat effective at driving effective partnerships.

PCP stakeholders, partners and staff report that PCPs are creating and sustaining effective partnerships for the following reasons:

- They are seen as 'neutral' in a competitive funding environment (described more section 4.2.3)
- Their continued presence since 2000 has enabled the development of long-standing relationships and trust, which is critical for effective partnerships.
- Particularly in regional and rural Victoria, they hold significant local knowledge and strong local relationships which can be effectively leveraged.

Consistent investment by participants in any partnership, of time and other resources, is a critical success factor. The review has found that engagement in the PCP is waning, including from local government, PHNs and other service providers. This indicates a decline in the efficacy of the PCP Program to develop and sustain effective partnerships, which seems likely to continue. Reported factors contributing to partner disengagement in some areas is discussed further in section 6.2.2.

Other critical success factors are around adding value and demonstrating outcomes. Given the highly specific and localised nature of PCP activities and initiatives, it is difficult to measure significant or scalable impacts generated by the partnerships.

The overall effectiveness of PCPs partnerships is somewhat limited by these factors.

### 4.2.3 Additional valued features of the PCP Program

The evolution of the PCP Program has generated additional value, including the real or perceived value of the PCP as a neutral partnership broker, the value of agile capability and capacity support in regional and rural locations, and the provision of support to local councils to develop local Health and Wellbeing Plans. These features, or functions, are not necessarily consistent with the Program aims or the intentions of DHHS in funding the program.

- **Neutral partnership broker:** The review has heard that some stakeholders value the perceived neutrality of PCPs in a current environment of competitive funding and contestability. PCPs are neither funders nor competitors for funding, and are thus viewed by many as suitable to facilitate collaboration. From the perspective of some partners and PCP staff, this would not be possible through other platforms such as DHHS, PHNs or local government as commissioners or 'decision-makers'.

- **Agility of PCPs to provide backbone / project management support:** In some ways the lack of clear Program guidance has enabled PCPs to provide ad-hoc support to local organisations as needs arise. This is particularly valued in regional and rural Victoria where resources are much stretched. The ability of PCPs to fill capability and capacity gaps and provide ad-hoc project management support has been reported by some as a key sustaining factor for Victoria's regional primary care sector over recent years.

- **Support to develop local Municipal Health and Wellbeing Plans:** It was reported by several stakeholders from local regional councils, DHHS and PCPs that PCPs have played an integral role in the development of Municipal Health and Wellbeing Plans. This has been attributed to the lack of capability and capacity of some local councils to develop these plans. Stakeholders report that PCP staff bring expertise in consultation and population health planning to support the development of these plans, as well as additional capacity.

  *…rural councils, with smaller and less diverse staff profiles, have limited capacity to facilitate multi-agency and inter-sectoral planning... PCPs have done this either with their own staff, or in*

*some cases by providing resources to councils to enable them to better perform their legislated function.*[16]

It is important to note that PCPs are not funded by DHHS to develop local Municipal Health and Wellbeing Plans.

[16] PCP stakeholder.

# 5 Alignment with the collective impact framework

**Key finding:**

- **Many PCPs are working in alignment with the collective impact framework, and are often perceived as effective backbone organisations. However, there is evidence to suggest that commitment to the platform is waning, and is likely to continue to do so. Meaningful commitment to a shared agenda is a critical foundation of collective impact.**

Collective impact is a framework or approach to working which provides a structured way for people and organisations to work together to achieve shared objectives, generally in the sphere of social change. Many PCPs and partners identify that the collective impact framework underpins their approach to working, although other models and approaches to collaboration and partnership also inform the work of PCPs.[17] The review also notes that collective impact is not universally considered to be best practice or comprehensive, including with regard to community and consumer engagement and addressing equity.[18]

The five pillars, or conditions of success, of collective impact are:

- Alignment around a common agenda and shared outcomes.
- Establishment of shared measurement systems.
- Establishment of mutually reinforcing activities.
- Establishment and maintenance of continuous and impactful communication between partners.
- Establishment or identification of a 'backbone' support organisation – an organisation to 'keep things moving' and 'make things happen'.

This section explores the findings of the review in relation to the effectiveness of PCPs against the collective impact framework.

### 5.1.1 Findings in relation to collective impact

A key activity for PCPs is joint planning and alignment of priorities and objectives amongst their partners to establish a **shared agenda**. PCPs generally use collaborative mechanisms (in addition to mapping documented priorities and objectives) to bring organisations together to identify and prioritise activities which then form the basis for the PCP work plan.

There is no one single approach used by all PCPs to identify a common agenda and translate that into a work plan; the case studies demonstrated that variation may exist around the extent to which PCPs:

- Use population health data to inform prioritisation.
- Are influenced by the interests and expertise of their individual staff.
- Are influenced by the likelihood of being able to attract additional resources and funding to progress work.
- Actively incorporate community and consumer input, and the voice of people with lived experience, into planning processes.

[17] For example, Community Coalition Action Theory and public health practice.
[18] Australian Institute of Family Studies (2017). Collective impact: evidence and implications for practice CFCA PAPER NO. 45. Available at https://aifs.gov.au/cfca/sites/default/files/publication-documents/45_collective_impact_in_australia.pdf

The review has identified examples of PCPs establishing **shared measurement mechanisms**, including for general population health measurement and around specific topics. A specific example is the Social Inclusion Measurement Project led by a metropolitan PCP. A key output has been the publication of a summary report which includes the social inclusion framework and agreed priority indicators and measurement tools.[19]

Establishing shared measurement can be difficult, and is probably particularly challenging for PCPs given their status as a partnership platform rather than a service system participant or provider in their own right. PCPs cannot set a precedent or create reciprocity themselves to drive change in this area; they are reliant on generating agreement and goodwill between partners. Shared measurement is also often made more difficult due to the complexity of the Victorian primary care landscape, meaning that there is often a need to align multiple parties around shared measurement to realise meaningful benefit.

The concept of **mutually reinforcing activities** within a collective impact framework refers to creating a situation where the relevant players are each contributing to a shared objective according to their own strengths and remit. While the review has found that PCPs can generally demonstrate that their work plans around a specific project or topic reflect coordinated action by the project participants, it is less clear that the relevant and necessary partners are always participating in the project.

Feedback from partners and stakeholders was that PCPs are generally good at **communicating**, including around specific projects as well as around local sector updates. The main communication channels identified were meetings, and to some extent newsletters and emails updates. The use of newsletters and email updates appears to be more variable between PCPs. It was noted that the inconsistent nature of PCP communication approaches created some challenges for partners who are engaged with multiple PCPs, and that sustaining engagement with the number of meetings is also challenging for some organisations with limited resources and/or relationships with multiple PCPs.

Acting as an effective backbone organisation was identified by PCP staff survey respondents as one of the top three achievements of the PCP Program. 217 of the 801 respondents to the partner / stakeholder survey selected 'acting as an effective backbone organisation' as one of the top five achievements of the PCP Program, and this was the fourth most common response. Driving effective partnerships and aliment of priorities, both relevant to collective impact, were also very commonly identified as key achievements of PCPs.

### 5.1.2 Conclusions in relation to collective impact

The review has found evidence that many PCPs are working in alignment with collective impact framework, and are often effective as backbone organisations. Here as elsewhere in this report, the review notes that there is variation in the effectiveness and impact of individual PCPs.

Central to successful collective impact is the commitment of partner organisations to the platform and the shared agenda. Senior and visible leadership is also very important. The strong response to the partner / stakeholder survey demonstrates that many PCP partners are highly engaged in and committed to the PCP platform and the work that is bring progressed through PCPs. However, it was also reported to the review by PCP staff, partners and stakeholders that participation is decreasing in some locations, and that this is likely to continue across some partner types including local government and PHNs. Specifically is was noted that:

- Some, but not all, local governments are experiencing structural changes associated with divestment of aged care and disability service delivery, meaning that their human resources focused on those social services will be much more limited in the future.
- That PHNs are challenged to sustain engagement with PCPs where they have multiple PCPs in their regions, each of which is progressing multiple projects and priorities, all requiring

[19] Inner North West PCP (2019). Social Inclusion Measurement Project Summary Report. Available at http://inwpcp.org.au/wp-content/uploads/2018/05/Social-Inclusion-Summary-Report-FINAL.pdf

participation in working groups and other structures. In this example, the *number* of PCPs contributes to the difficulty sustaining engagement.

*In the future, councils won't have the people to send to PCP meetings.*[20]

*We have multiple PCPs, it's very difficult to send people to all the meetings for all the projects – we just can't resource it.*[21]

Based on the case studies and consultations, ongoing commitment and participation appears to be somewhat stronger in regional and rural Victoria compared to metropolitan Melbourne (although there are exceptions to this), and the current lack of certainty surrounding the future of PCPs may be contributing to the waning engagement.

[20] PCP stakeholder.
[21] PCP stakeholder.

# 6 Other key findings

This chapter reports on other key review findings including limitations and barriers and partner satisfaction, and discusses observed geographical differences.

## 6.1 Limiting factors and program barriers

**Key finding:**

- **A range of limiting factors and barriers have been identified, some of which reflect inherent limitations of the PCP program in its current form, and others which are more recent and operational in nature.**

### 6.1.1 Strategic and enduring limitations

**Lack of authorising environment and meaningful levers to influence partners and system level change**

PCPs are, by design, reliant on their partnership for endorsement and authorisation. However, this was frequently identified as a key strategic and operational barrier by stakeholder, partners and staff. Stakeholders, partners and staff often attributed this to limited budgets (a key lever) and a perceived lack of engagement from DHHS. However, the review observes that as a partnership platform PCPs should gain their authorisation from the partnership itself, and the fact that this is consistently being identified as a limiting factor demonstrates the limitations of the platform in its current form. See the G21 case study below (Figure 8) below for a case study exploring establishing local authorising environments in more detail.

**Lack of awareness and understanding of the PCP Program**

The lack of awareness and understanding of the PCP Program was identified as a key strategic barrier by stakeholders, partners and staff across case study sites and the surveys. The review has noted that the PCP as a partnership platform is not well understood by some stakeholders. PCPs report that lack of awareness and understanding is limiting community and partner engagement in PCP activities and initiatives and in turn limiting the impacts of the PCP Program. It is concerning that awareness and understanding of the platform is so variable given the longevity of the Program funding and the state-wide coverage of PCPs.

**Size and scalability**

The size and scalability of the PCP Program was identified as a significant barrier to achieving the stated Program aims. Each PCP has a relatively lean workforce, with an average of approximately four staff members. Several PCP staff members reported that workforce sizes have depleted over recent years due to the lack of funding certainty and job security, with one PCP reducing from 13 staff to four over the past few years. The small size of PCPs and their limited access to project or brokerage funds means that projects and initiatives tend to be small scale and highly localised. The limited size and scalability of the PCP Program has in turn been identified as a key barrier by some, particularly in relation to the scale of impacts that can be achieved. The benefits of having a more substantial structure is discussed in the G21 case study at Figure 8.

### 6.1.2 Recent and operational limitations

**The following factors have also been identified as barriers:**

- **Current environment of uncertainty -** The current environment of uncertainty about the future of the Program was consistently identified as a frustration and critical barrier for the PCP Program in achieving the stated Program aims and objectives, and a contributing factor to some partners

disengaging from the platform more recently. This has also contributed to recent challenges sustaining the PCP workforce.

- **A lack of strategic direction from DHHS -** A lack of strategic direction from DHHS was consistently reported as a critical barrier for the PCP Program. One of key concerns is that PCP Program logic is outdated, having been developed in 2012 and expired in 2017. Stakeholders, partners and staff report that this, along with a lack of guidance from DHHS, has resulted in further diversification of the PCP Program across the state, which has limited the collective impact of the platform and its ability to drive change at scale.

*Figure 8: G21 Case Study*

**G21 – The effect of strong local leadership and a clear authorising environment**

G21 is a formal alliance of independent organisations (including government, business and community) working together to progress a shared vision for Geelong and the surrounding region. G21 is the auspice organisation for the Barwon PCP. G21organised into eight pillars, and the Health and Wellbeing pillar is funded under the PCP Program. Examples of key Health and Well-being pillar projects include:

- The GROW initiative (G21 Region Opportunities for Work).
- Growing Up in G21 Report.
- Addressing disadvantage in relation to homelessness and social housing.
- Healthy Eating and Active Living (HEAL) with 14 partner organisations.
- Prevention of Violence Against Women – a regional approach.
- Active Geelong.

The G21 platform as a model to progress the aims of the PCP Program has the following strengths:

- Health and wellbeing is part of a substantial and multidisciplinary structure, with formalised partnerships and strong leadership.
- G21 has senior leadership and buy-in from across the allied organisations.
- G21 has significant influence and goodwill within the region.
- G21 holds a coordinated and sophisticated approach to regional planning.
- Health and wellbeing projects can be easily connected to and coordinated with mutually reinforcing work across other pillars including (but not limited to) Sport and Recreation, Transport, Education and Training, and Planning and Services.
- Financial analysis undertaken as part of this review indicates that G21 is particularly successful in attracting additional funding sources, including non-DHHS funding.

**Key learnings from G21:**

- Having senior leadership and buy-in, a clear agenda, and the right partners around the table is crucial to effect meaningful change.
- Embedding the PCP as part of a substantial structure provides stability, sustainability and leadership, as well as opportunities for scale and integration with related agendas of work.

## 6.2 Stakeholder and partner satisfaction

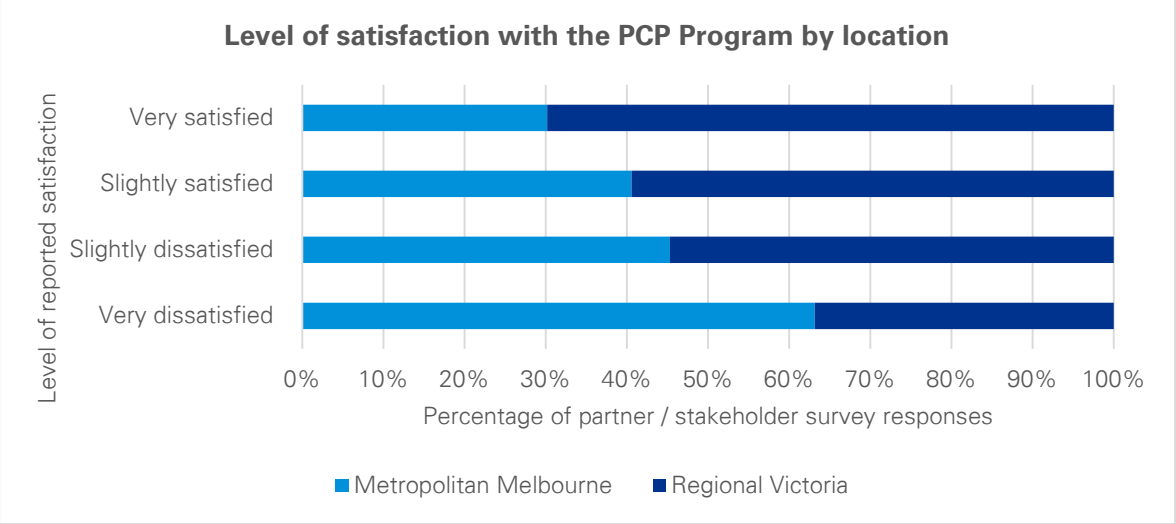
**Key finding:**

- **The overall satisfaction of stakeholders and partners with the PCP Program is variable, and is considerably higher in regional Victoria.**
- **Reasons for satisfaction largely relate to the Program's current focus on primary prevention, effective facilitation of partnerships, and ability to 'fill capability gaps' as required.**
- **Reasons for dissatisfaction are associated with duplication, the unclear role of PCPs, and a perceived inability of PCPs to produce meaningful outcomes.**

Partner / stakeholder satisfaction with the PCP Program is mixed, as demonstrated both by survey responses and consultation findings. Overall, the partner / stakeholder survey results indicate that the majority of partners and stakeholders are very (54 per cent, n=391) or slightly (29 per cent, n=207) satisfied with the Program, and 17 per cent are slightly or very dissatisfied (n=121).

Figure 10 illustrates that stakeholder satisfaction seems to be linked to geography, and is higher in regional and rural Victoria.

*Figure 9: Partner / stakeholder level of satisfaction with the PCP Program by location.*




*Source: KPMG*

### 6.2.1 Reasons for satisfaction

In many consultations, partners and stakeholders articulated that PCPs are filling gaps in the local capability and capacity of other agencies. For example, there is evidence that PCPs have:

- Assisted local councils to complete their Municipal Health and Wellbeing Plan.
- Supported PHNs to 'reach into' rural communities and leverage established partnership networks.
- Led project management and stakeholder consultations on behalf of local DHHS offices.

Additional reasons for partner satisfaction with the current PCP Program model were identified in the partner / stakeholder survey. Based on 419 free text responses received, the following features of PCPs were noted as the top five reasons for stakeholder satisfaction:

- Effective facilitation of sector, and cross-sector, collaboration.
- Provision of support, particularly for small organisations with limited resources.
- Current focus on primary prevention.
- Deep local sector knowledge.
- Central information-sharing platform.

### 6.2.2 Reasons for dissatisfaction

The sources of dissatisfaction include a view that the Program aims can be better achieved through other existing structures which have the scale and capacity to progress work in a more structured way.

It was also suggested that the investment of time required to participate is not commensurate with the value being generated. This is particularly prominent for stakeholders that have multiple PCPs operating within their area or catchment. Some stakeholders strongly articulated a view that rigorous meeting schedules associated with governance, PCP planning and projects was unsustainable for their organisation to continue to engage with, and that the value and benefit of meetings was highly variable and actually creating additional complexity in terms of progressing work. This is contributing

to a degree of partner disengagement in some locations, including from local government, PHNs and some service provider partners.

It is important to note however that there is unanimous agreement that these are features of the PCP Program model, not PCP staff themselves, who are generally held in very high regard.

The following factors were reported as the top five reasons for partner and stakeholder dissatisfaction in the PCP partner / stakeholder survey:

- Ineffective at producing meaningful outcomes
- Unclear role or purpose
- Lack of consistent funding impairs efficacy of the model
- Inadequate skillset / low capacity to achieve outcomes
- Duplication of work with other organisations such as PHNs.

## 6.3 Observed geographical differences

**Key finding: PCPs play a particularly critical and highly valued role in regional and rural Victoria.**

There is clear evidence to suggest that the PCP Program plays a different role in regional and rural Victoria compared to metropolitan Melbourne, and that satisfaction with the Program is high (see Figure 10). In rural Victoria, local systems are struggling with multiple challenges associated with:

- Current workforce shortages, including GPs.
- Fragile and failing markets in NDIS and aged care.
- Health service pressures associated with unsustainable finances and workforce recruitment issues.
- Localised pressures associated with extreme weather events, agricultural failure and suicide clusters.
- Limited capacity of small local governments to drive meaningful health and wellbeing initiatives.

PCPs and stakeholders have communicated a compelling narrative that, while PCPs cannot solve the problems described above, the PCP staff are an integral part of sustaining local system resilience. Specifically, in regional and rural Victoria PCPs are:

- Filling real gaps in local capability and capacity across other agencies.
- Supporting and enabling government responses to crises.
- Contributing important local insights to local strategic planning.
- Attracting additional funding and resources to under-resourced areas.

## 6.4 The role of PCPs in meeting future system challenges

**Key finding: In their current form PCPs are not well positioned to meet future system demands.**

Many stakeholders, partners and staff reported via the survey that PCPs are well positioned to address the emerging health needs and system challenges. Specifically, 68 per cent of staff survey respondents (n=120) and 73 per cent of partner / stakeholder survey respondents (n=590) conveyed this view. Suggested reasons include established local relationships, partnership brokerage skills and a highly skilled workforce.

However, a more nuanced analysis of findings across all data sources indicates that PCPs are well positioned to address some challenges but not others, specifically:

- It is evident that PCPs are not well equipped to address system integrations issues facing the acute health sector, including unnecessary hospital presentations, demand on emergency departments, and access and flow issues. PCPs do not currently have the authority to influence

change to improve primary care access. See the Case Study below on the Clinical Commissioning Groups used in the UK as a mechanism to drive health system reform.

- PCPs are better positioned to address health challenges facing the prevention space, where highly localised and place-based initiatives can be effective.
- PCPs can also be well placed to support the implementation of system reforms at a local level, particularly during the early phases of implementation, and particularly in regional and rural locations where resources might otherwise be very limited.

Other stakeholders have expressed different views that the current PCP platform is unsustainable and contributing unhelpful complexity in the Victorian primary care landscape. These views are consistent with broader insights from the Australian and international case studies which are described throughout this report.

It was acknowledged by several stakeholders that key features of the PCP program (and indeed many PCP staff), such as the ability of PCPs to respond quickly to emerging health needs given their agility, skill-set, local knowledge, and established networks would be highly valuable in the future if embedded in existing structures.

**Clinical Commissioning Groups (CCGs) – The catalyst for primary health integrated care reform**

In 2013, National Health Service (NHS) England established Clinical Commissioning Groups (CCGs) to drive health care reforms to improve the quality of primary care services. There are currently 191 CCGs, which are clinically-led statutory bodies that are responsible for planning and commissioning local health care services. Specifically, CCGs are legally obligated to commission community and secondary health services and improve the quality of primary care services.[22]

Commissioning in the context of CCGs refers to the identification of local population health needs and purchasing the appropriate services required to meet these needs. Unique to CCGs is the responsibility of clinicians to make these commissioning decisions.

In England, it is mandatory for all general practices to be a member of a CCG. As a CCG member, GPs are actively engaged in local service planning and commissioning. By actively involving GPs in these decision-making processes, CCGs are designed to encourage GPs to engage in more integrated and outcomes-focused care.

CCGs also have access to other incentives such as financial incentives, comparative data and the ability to expel members from the CCG, to encourage quality improvement in general practices.

Emerging evidence suggests that CCGs are positively impacting the primary care landscape in the UK. Specifically, the CCGs are strengthening partnerships between local providers, driving new innovative models of care, and positively impacting GP prescription and referral patterns.

The CCG operating model highlights the following critical success factors for driving reform:

- Active engagement of general practitioners in strategic and commissioning decisions
- Financial incentives and the use of comparative data can be used to drive new models of care
- Good leadership, governance and communication is important to drive engagement in primary care reforms. [23]

[22] Naylor, C., Curry, N., Holder, H., Ross, S., Marshall, L., & Tait, E. (2013). Clinical commissioning groups Supporting improvement in general practice?. The King's Fund.
[23] Naylor, C., Curry, N., Holder, H., Ross, S., Marshall, L., & Tait, E. (2013). Clinical commissioning groups Supporting improvement in general practice?. The King's Fund.

# 7 Future investment opportunities

This chapter identifies critical considerations relevant to the future of the PCP Program, and the future of investment in PCP functions. A range of options are presented and discussed, including identification of risks, considerations and potential benefits.

## 7.1 Considerations for future investment

### 7.1.1 Enhanced strategic direction and leadership from DHHS

Throughout the consultations with PCP staff, partners and stakeholders it has consistently been identified that the Department has not provided strong support, direction or oversight for the Program in recent years, and there is a perception that this has undermined the effectiveness and impact of the PCPs and contributed to partners disengaging from the platform. Responses from both the PCP staff and partner / stakeholder survey identified clearer direction from DHHS, updating the name of the Program and refreshing the program logic as key suggestions for the future.

Regardless of the approach to the investment going forward, these messages should not be lost. Specifically, continued funding of the PCP Program, or current PCPs functions, should be supported by:

- Greater clarity from DHHS on the high level objectives and aims of the investment.
- Stronger and more visible leadership.
- Stronger accountability and outcome measurement.

Key actions/investments in the PCP platform and/or functions may need to include:

- Changing the name of the Program (relevant to Options 1, 2 and 3, as described on page 31).
- Refreshing the program / function aims and objectives.
- Updating the program logic (relevant to Options 1, 2 and 3 only).
- A review and formalisation of the management and oversight of the program between central and division DHHS staff.
- A review of the reporting requirements.

The Healthy Families NZ initiative, as described in Figure 11 below, highlights the importance of having structured and tailored governance and leadership to drive effective, systems-level change, particularly in prevention and health promotion.

*Figure 10: Healthy Families NZ Case Study*

**Healthy Families NZ – The importance of central government leadership**

First implemented in 2014, Healthy Families NZ is a large-scale prevention initiative that takes a system-level approach to prevention of chronic disease and broad health promotion. The initiative was implemented by the New Zealand (NZ) Ministry of Health in a shift away from small-scale and time-limited projects towards a more long-term, system-wide approach to change.

Healthy Families NZ operates across 10 locations in urban and rural NZ, in communities identified as having higher rates of risk factors for chronic disease and socio-economic disadvantage. The initiative aims to prevent chronic disease through the creation of more health promoting environments and improved health equity.

The initiative is governed and actioned by three levels of leadership:

- A dedicated Healthy Families NZ team within the Ministry of health has overarching responsibility for the implementation of the initiative.

- A locally based Lead Provider in each location is responsible for implementing the initiative at a local level.
- A local Strategic Leadership Group supports the local implementation of the initiative and seeks to amplify its impacts as a group of cross-sectoral leaders, including local government, health services, sports and recreation and private businesses.

Since 2014, there is evidence that the Healthy Families NZ initiative has driven system-level change in the context of improved prevention awareness and action. There is evidence to suggest that the initiative has had a critical role in the following action areas:

- The introduction of smoke-free outdoor policies.
- The removal of sugar sweetened beverages from council facilities, including schools.
- The introduction of workplace incentives to drive new workplace wellbeing initiatives.[24]

**Key learnings from Healthy Families NZ**

- The involvement of leadership at a central government level is key, enabling action at both a systems-level and local level through the creation of an authorising environment and meaningful levers for local-based prevention teams to enact change.
- The initiative demonstrates the importance of taking a whole-of-community approach to health prevention and promotion that engages multiple levels of governance and leadership, but is also sufficiently agile and adaptable to respond to local needs.

### 7.1.2 High value functions

The review has identified that some functions of PCPs are providing particular benefit in their local communities through the provision of 'backbone' support for:

- Place-based health prevention.
- Ad hoc responses and project management.
- Capability building and training.

The enduring value of these functions is supported by feedback from the four case study site visits, the detailed analysis of the PCP reports and documents, and the survey responses.

The case for an ongoing function around backbone support for place-based prevention activities was particularly strong and consistent. Reponses to both the partner / stakeholder and PCP staff survey identified a continued focus on primary prevention as the number one suggestion for the future of the investment. This is in the context that investment in prevention is particularly low in Australia, at 1.3 per cent of total health funding.[25] Maintaining a place-based focus was also a leading theme in feedback to the review around the future of the investment.

Stakeholders and PCPs have consistently described a critical function of PCPs as driving or enabling local projects or initiatives, sometimes in a time-limited and sometimes in an ongoing way. Examples include (but are not limited to) responses to extreme weather events and agricultural failure.

This function reflects the existing role of PCPs, as well as the capabilities of many PCP staff around stakeholder engagement, community consultation, partnership brokerage, project management, population health planning and monitoring and evaluation. These are not necessarily capabilities which are prioritised or fostered within direct service delivery organisations or local government. Stakeholders have described how these capbilities, along with the additional flex capacity that PCPs can provide, is often the critical success factor in 'getting a project off the ground'. This function was

[24] School of Health Sciences, Massey University. (2018). *Healthy Families NZ*. Ministry of Health.

[25] Fetherston H, Calder R and Harris B (2019). Australia's Health Tracker 2019, Mitchell Institute, Victoria University. Melbourne.

highly valued in regional and rural settings where partners are particularly stretched, but there are also many examples in metropolitan areas.

The PCP role in building capability in other organisations has also been identified as a priority function. In many locations PCP play a critical role in identifying and addressing local training needs. Again, this function was particularly valued in regional and rural settings, where access to local training opportunities is often limited and can be prohibitively expensive for small organisations purchasing in isolation.

### 7.1.3 Organisational neutrality in a commissioning and contestability environment

Through consultations PCP partners and staff consistently raised the real or perceived neutrality of PCPs as a core benefit and strength of the platform. Many partners and PCP staff pointed out that in a changing funding environment, with a strong focus on commissioning and contestability in most sectors, PCPs are valued as neutral participants – neither potential funding sources, nor competitors for funding. PCP staff and partners suggest that this 'neutrality' fosters and sustains a sense of trust and willingness of partners and stakeholders to 'come to the table' when PCPs are leading projects or collaborative activities. This feature was often contrasted with the role of PHNs as commissioners and DHHS as funders.

Evidence from international health systems suggests that as organisations transition to a commissioning model it takes time for both the commissioners and the market to mature and adapt to the paradigm. In the UK, the NHS experience was that commissioning organisations experienced a significant lift in maturity and sophistication in terms of their approaches and ways of engaging with the market after three to four years of stability.

International evidence suggests that as commissioners mature, this manifests itself in the following ways:

- They become more nuanced and adept at identifying and achieving commissioning objectives.
- A clearer understanding that 'procurement' and 'competition' are only one of a number of approaches that can be taken to achieve objectives.
- A growing recognition that influencing partners to work together to achieve a common aim is often more effective than the comparatively blunt instrument of procurement and competition.

In Victoria PHNs are in their fifth year of commissioning, and DHHS is only now starting to transition to a true commissioning model. The evidence suggests that as commissioning matures in Victoria it is unlikely that the market will continue to see a need for 'neutral' partnership brokers.

### 7.1.4 The needs in regional and rural Victoria

As described throughout this report the review has found that the additional value provided by PCPs in regional and rural Victoria is greater than what is being realised in metropolitan areas. This is no way diminishes the high quality work metropolitan PCP staff are producing, it instead reflects the relative capacity and capability within local services systems. The review also recognises the significant challenges faced in the major growth corridors of Melbourne which do, and will continue to, experience unprecedented population growth and highly constrained local service systems.

## 7.2 Options for future investment

Five potential options have been identified:

1 Continue funding the 28 existing PCPs through the Program, and refocus the Program objectives and key design elements.

2 Continue funding the PCP Program, but consolidate and reduce the number of PCPs, and also and refocus the Program objectives and key design elements.

3 Reduce the number of PCPs in regional and rural Victoria, and refocus the Program objectives and key design elements. In metropolitan Melbourne, re-commission high value functions through alternative arrangements.

4 Discontinue funding the PCP Program, and fund priority PCP functions which are demonstrating continued value through alternative arrangements.

5 Cease funding the PCP Program and all existing PCP functions.

The Review findings do not support the continuation of the Program in its current form, but given that the review has also identified valuable aspects of the Program, the findings do not support complete divestment of all functions. The findings indicate that the best opportunities to maximise the impact of the investment can be realised through either:

- Reducing the number of PCPs across the state, and refocusing the Program objectives and key design elements (Option 2);
- Reducing the number of PCPs in regional and rural Victoria, and refocusing the Program objectives and key design elements, while re-commissioning high value functions in metropolitan Melbourne (Option 3 – a hybrid of Options 2 and 4); OR
- Identifying the high value functions and capabilities, and re-commissioning these within the system through alternative arrangements (Option 4).

Option 3 has considerable merit given that the review has found that the PCPs and PCP staff play a particularly valued and important role in regional and rural Victoria; helping to (for example) support and enable government responses to crises, and attract additional funding and resources to disadvantaged areas.

Stakeholder satisfaction is clearly higher in regional and rural Victoria, where 70 per cent of stakeholders / partners reported that they are highly satisfied with the current PCP Program and model, than in metropolitan Melbourne, where only 30 per cent of stakeholders / partners reported the same. The review finds that there is a compelling case to consider a different future path for PCPs depending on their location.

The review finds that any continued investment, whether in PCPs or through alternative arrangements, should be guided by clear strategic direction and a contemporary program logic, and subject to ongoing monitoring and evaluation.

It should also be noted that defunding the PCP Program in part or total may cause some auspice organisations financial issues, and potentially impact on the sustainability of a smaller auspice organisations. Figure 13 below expands on the five options, including key decision points, and the high level benefits, considerations and risk associated with each. Options 2 and 4 are also discussed in more detail in sections 7.2.1 and 7.2.2 below, and these reflections are also relevant for Option 3 given it represents a hybrid of options 2 and 4.

*Figure 11: Options for future investment*


*Source: KPMG*

### 7.2.1 The case for consolidation (options 2 and 3)

The case for consolidation of PCPs is based on the following findings:

- Several stakeholders have reported that one of the factors driving their disengagement from PCPs is the number in their catchment/region, meaning that they must dedicated significant human resources to attend many governance, planning and project meetings. For example, one PHN has eight PCPs in their region.
- Increasing the catchment size of PCPs would provide opportunities for efficiency in terms of administration, management and reporting, and potentially provide the PCPs with enhanced workforce stability and sustainability, as well as greater opportunities to scale good practice across their regions and interface efficiently with each other and their stakeholders.
- Improvements in transport and travel, communications and remote working arrangements mean that people don't all need to work in one location to be part of an effective team, or to interact with local stakeholders. Larger PCPs covering larger geographical regions should be able to maintain a place-based focus through leveraging tools like video conference, and potentially by maintaining staff in their local communities.

Critical considerations for consolidation are:

- Several stakeholders suggested that better alignment of PCPs with either DHHS or PHN boundaries would be beneficial, and if consolidation was progressed then this should be considered. Alignment should be informed by the revised Program aims. For example, if the Program was refocused on traditionally state-funded objectives, then alignment with DHHS regions would be of value. However, if the Program was more focused on integration, then alignment with PHN boundaries may be more beneficial.
- As described in section 7.1 above, there is a compelling case to consider a different future path for PCPs depending on their location.

### 7.2.2 The case for re-commissioning to retain high value functions (options 3 and 4)

The case for retaining core PCP functions and investing in alternative arrangements is based on the finding that, as described above in section 7.1.2, some of the backbone functions of PCPs have been consistently identified as particularly valuable, especially in rural and regional Victoria. These are around: place-based health prevention, ad hoc responses and projects; and capability building and training. That is not to say that other PCP driven projects are not valuable, only that these three functions are more universally considered to be valuable.

Options for retaining high value **place-based health prevention** backbone support include redesign and consolidation of the PCP Program or reinvesting via other platforms such as VicHealth, PHNs, local government, Health Services and community health.

There is also a strong case for alignment with, or directly investing in the existing Integrated Health Promotion (IHP) program funded and administered by DHHS, primarily through the community health sector. This would consolidate the Department's prevention investment and provide an opportunity to refresh that program to include a focus on collaborative partnership approaches, and to consider using additional funds to ensure equitable IHP funding across the state.

Options for retaining high value backbone support for **ad hoc responses and projects,** as well as capability building and training**,** include redesign and consolidation of the PCP Program or reinvesting via other structures such as PHNs, Health Service and Community Health Services.

There is good alignment between the backbone / project management function and the role of PHNs as commissioners, and the growing skills and expertise of the PHNs around stakeholder engagement, co-design, project and program design and project management. PHNs also have an existing remit and considerable experience in training and capability building within the primary care sector. State-

based investment in PHNs would align with the co-commissioning agenda[26] and provide DHHS with mechanisms to address ad hoc local issues and drive more strategic approaches to primary care integration across the state.

It is apparent that there is strong case to retain high value PCP functions in regional and rural areas where other partners have limited resources. High value functions in a rural and regional context can make a major contribution with relatively modest resources, as evidenced by Case Studies 3 and 4 (see Appendix F). This case is less persuasive for PCPs in a metro setting where local resources are generally more available. Consideration should be given to the following possible approaches:

- A collaborative process of mapping the core functions against the existing roles and responsibilities, strategic functions and preferences of all the potential fund holders.
- A commissioning approach which provides an opportunity for different arrangements to be pursued in different locations and according to the strengths and preferences of local agencies or consortia. If well managed, this process could enhance and formalise local partnerships around clear objectives.

It is envisaged that significant corporate knowledge, skills and expertise vested in the PCP workforce would be somewhat maintained through new employment opportunities under the new arrangements.

## 7.3 Conclusions

The review has clearly identified a case for change in terms of the way the PCP Program is currently being both governed and delivered. While many strengths and challenges of the Program and PCPs as a platform have been identified through the review, the critical considerations in determining the future of the program should be:

- The questionable sustainability of the platform over time and apparently waning engagement from partners and stakeholders, which seems likely to continue to undermine the effectiveness of PCPs into the future.
- The lack of alignment between the way the PCP Program functions and identified features which are likely to support the Victorian primary health sector to meet current and future challenges, such as reduced complexity, agility and a focus on impactful collaboration around clear objectives.

[26] Memorandum of Understanding between DHHS and the Victorian PHNs through Victorian and Tasmanian PHN Alliance (VTPHNA)

# Appendix A: Background and context

## A.1 Additional PCP Program information

PCP Program activity is guided by aims, domains and strategic priorities set by DHHS, and as outlined in the PCP Program Logic 2013-17. The aim of the PCP Program is to strengthen collaboration and integration across sectors to:

- Maximise health and wellbeing outcomes.
- Promote health equity.
- Avoid unnecessary hospital presentations and admissions.

The PCP Program Logic 2013-17 is structured against three strategic domains:

- Early intervention and integrated care (included integrated chronic disease management)
- Consumer and community empowerment
- Prevention (including integrated health promotion).

Within these domains, the PCP Program Logic 2013-2017 requires PCPs to focus on one or two locally identified early intervention and integrated care priorities, and one or two prevention priorities. The PCP Program Logic 2013-17 requires these priorities to align with those identified in the Victorian public health and wellbeing plan 2011-2015, including healthy eating, chronic disease, mental health promotion and oral health.

Although the PCP Program Logic has not been updated since 2013, some PCPs have continued to update their strategic priorities against the more recent iterations of the Victorian Health and Wellbeing Plan.

## A.2 Location and distribution of Victoria's PCPs

Victoria's PCPs are distributed across metropolitan Melbourne (n=7), inner regional Victoria (n=16), outer regional Victoria (n=5). Figure 14 below illustrates the geographic locations of Victoria's PCPs across the state. The majority of PCPs are voluntary partnership alliances supported by auspice organisations. The PCP program also part funds two incorporated organisations, Enliven and G21 – the Geelong Region Alliance.

*Figure 12: PCP Locations*


*Source: KPMG*

## A.3 PCP partners and governance structures

A core component of the PCP Program is to strengthen local partnerships to support sector integration. Collectively, Victoria's PCPs have engaged with over 850 organisations either formally (for example, under a Partnership Agreement), or less formally. These include organisations such as hospitals, Community Health Services, local government, and PHNs.

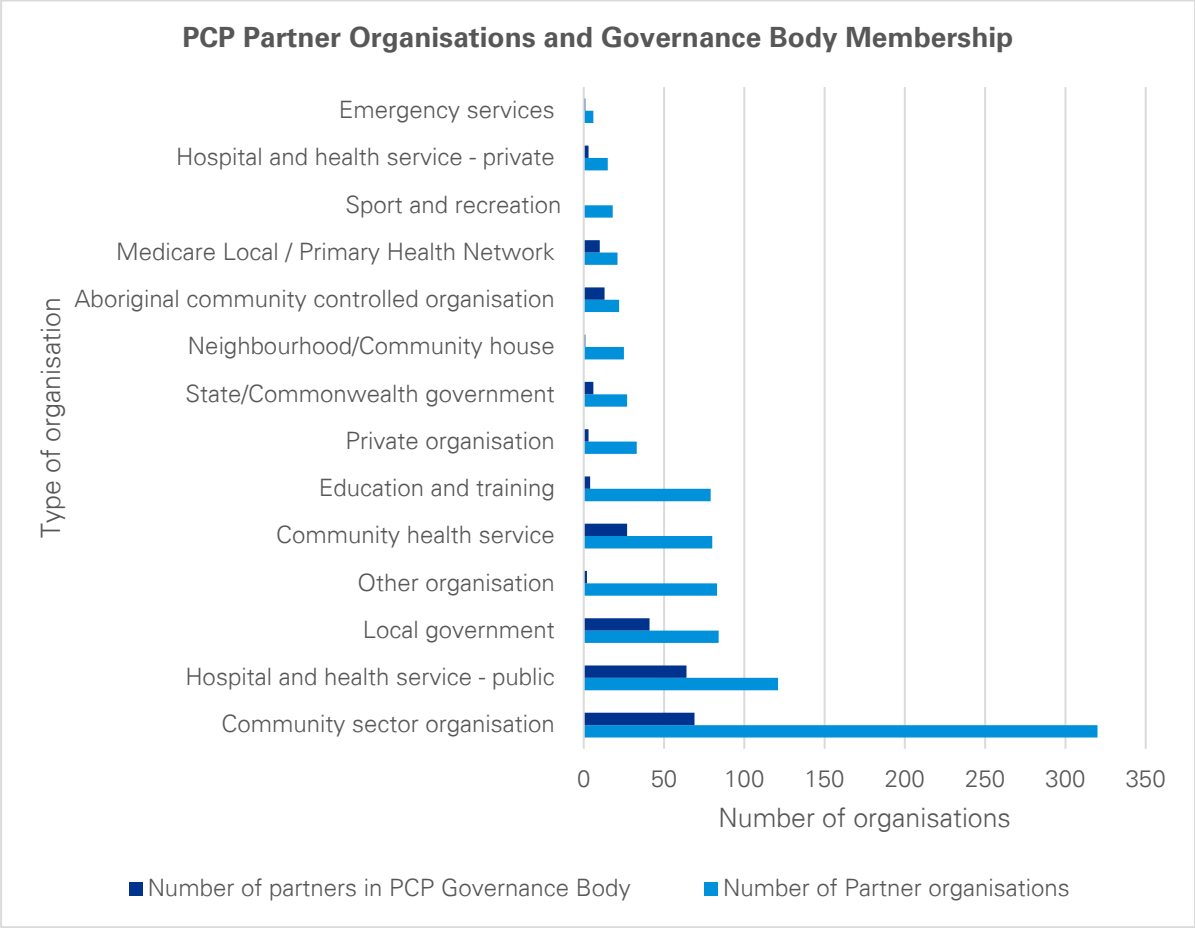
The majority of PCPs are voluntary partnership alliances supported by auspice organisations; with two PCPs auspiced by incorporated organisations (Enliven and G21)

PCPs are managed by an Executive Officer (or equivalent) and supported by a small team of staff. Each PCP has a governance body which generally comprises representatives from the PCP and a sub-section of the formal partner organisations.

PCPs are governed and operated by a governance body, such as an executive team or management group, which are comprised of representatives from the PCP and formal partner organisations.

Figure 14 below illustrates the type of organisations formally partnered with a PCP, and type that hold positions as members of a PCP governance group.

*Figure 13: PCP Partner Organisations and Governance Body Membership*




Source*: PCP Partnership Reports from 2016-17*

In 2015, the Victorian PCP (VicPCP) was established as a central, state-wide governing body of the PCP Program. VicPCP is comprised of representatives from all 28 PCPs and exists to support strategic planning at a state level. The VicPCP is funded by modest contributions from all PCPs.

## A.4 Reporting requirements

PCPs are subject to formal routine reporting requirements to support departmental oversight. This involves the submission of strategic plans, prevention reports, financial information and e-referral reports on an annual basis.[27]

Prevention reports outline the PCP's progress against the selected prevention priorities, and the e-referral reports outlines the number and type of e-referrals made in the local catchment. The introduction of My Aged Care and the NDIS have impacted the value of e-referral reporting.

[27] Department of Health and Human Services. (2018). *Primary Care Partnerships 2018-19 reporting requirements*.

# Appendix B: Methodology

## B.1 Overview

DHHS engaged KPMG to review the PCP Program over a three-month period from October to December 2019. The purpose of the project was to:

- Establish a detailed and evidence based understanding of the current and historical implementation and impact of the PCP Program.
- Explore how the PCP Program operates within the current Victorian primary care landscape.
- Understand the extent to which the PCP Program is designed and equipped to address contemporary trends and challenges in the Victorian primary care landscape.
- Identify opportunities for DHHS to maximise the impact of the PCP Program investment, in order to improve health and wellbeing outcomes for Victorians, promote health equality and reduce unnecessary hospitalisations.

## B.2 Data sources

A mixed method approach was used to inform the review where possible, with a focus on leveraging the available secondary data sources and targeted collection of qualitative primary data.

The secondary data used was predominantly based on the plans and reports submitted to DHHS by PCPs as part of accountability requirements. The targeted qualitative primary data was collected through surveys, case studies, and stakeholder consultations.

Quantitative data has been used where available to demonstrate the reach and impact of the PCP Program. Qualitative data has been used to gain a more comprehensive understanding of the current state and operations of the PCP Program by exploring people's perceptions and experiences of PCPs.

Some stakeholders also elected to provide written submissions, which were accommodated into the review.

Table 1 provides an overview of the data collection activities and their purpose in the review process.

*Table 1: Data sources and purpose*

| Source | Review purpose | Description of source |
|---|---|---|
| Rapid review of the primary care landscape | To understand the current primary care and integration landscape in Victoria. | The rapid review involved analysis of publically available reports and data relevant to Victoria's primary care sector, including national and state-specific features and initiatives. |
| Surveys | To collect input from PCP staff and partner organisations on the impact, operational barriers, and lessons learned from the PCP Program. | Two online survey links were distributed to PCP staff and PCP partners / stakeholders.<br>Responses were received from **176 PCP staff** and **840 PCP partners / stakeholders**. 39 responses were excluded from the analysis due to significantly incomplete responses. |
| Financial data analysis | To understand the relative costs of the PCP program. | The financial analysis examined financial data relevant to PCP Program funding and expenditure, using the annual financial statements submitted to the Department from 2015-16 to 2017-18. |
| Case studies | To obtain a more in-depth understanding of the current state and impacts of the PCP Program in different parts of the state. | Four case studies were developed to examine metropolitan, peri-urban/growth corridor, regional and rural PCP Programs in more detail. This involved site visits, and more comprehensive consultations with PCP staff and partner organisations. See Appendix F. |
| Targeted review of good practice models | To identify and understand the key features and drivers of success for primary care integration. | The good practice models identified and explored were drawn from Victoria, New South Wales, New Zealand, and United Kingdom. |
| Document review | To identify and assess documentation associated with the PCP Program since 2016. | The documents reviewed provided records of information collected and developed to support the PCP Program. The documents obtained were reviewed objectively and included strategic plans, annual prevention reports, partnership reports and governance group Terms of Reference. |
| Targeted stakeholder consultations | To obtain a more in-depth understanding of the current state and impacts of the PCP Program. | Targeted stakeholder consultations were conducted with senior internal (DHHS) and external stakeholder groups, including PHN Chief Executive Officers (CEOs), Victorian Healthcare Association (VHA) and the Municipal Association of Victoria (MAV). More detail is provided in D. |
| Health data analysis | To identify and understand the current and emerging health trends in Victoria relevant to the PCP Program. | A high level analysis of publically available health data relevant to the PCP Program objectives, including rates of potentially avoidable hospitalisations in Victoria since the inception of the PCP Program. |

Source*: KPMG*

## B.3 Review limitations

It is important to note the following limitations of the review methodology, specifically:

- Both surveys were primarily distributed by PCP staff and there is therefore a risk of positive bias, particularly in the partner / stakeholder survey.
- The stakeholders consulted to inform the development of the case studies were nominated by PCPs, and therefore there is also a risk of positive bias.
- The document review was somewhat constrained by inconsistencies in the way PCPs report, particularly around how priorities and projects were described and categorised.
- The views of community members and consumers are not reflected in this report as they were not directly engaged in the review.

# Appendix C: Survey questions

## C.1 Survey distribution

Two surveys were developed to inform the PCP Program Review; a PCP staff Survey and a PCP partner / stakeholder survey.

The PCP staff survey was intended for individuals currently employed by a PCP**.** The PCP partner / stakeholder survey was intended for individuals and representatives of organisations that work with PCPs either formally (for example, under a Partnership Agreement) or less formally.

DHHS distributed the surveys to all PCP Executive Officers on 14 November. The PCP Executive Officers were given clear instructions to complete and distribute the PCP staff survey to all employees at their PCP. The PCP Executive Officers were also encouraged to distribute the PCP partner / stakeholder survey to their respective partner organisations and relevant stakeholder groups. It was specified that PCP employees were not to complete the PCP partner / stakeholder survey.

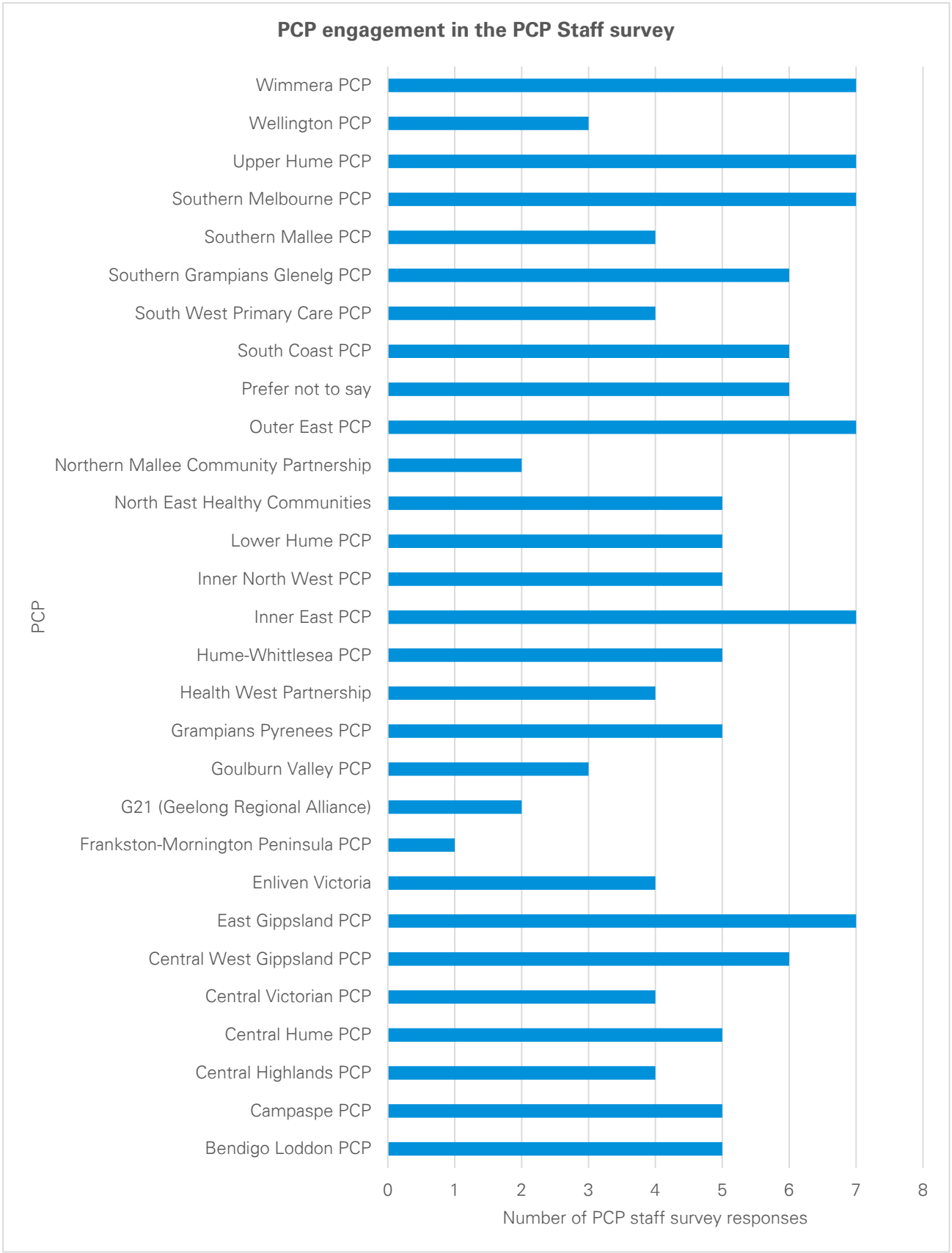
## C.2 Survey response

**PCP staff survey response**

The PCP staff survey received a total of 176 responses. Responses were received from representatives from **all PCPs** (as shown in Figure 18) across all staff levels, including executive officers, project coordinators, and administration staff.

A total of 46 responses were received from PCPs located in metropolitan Melbourne and 92 responses were received from PCPs located in regional Victoria. A majority of survey respondents had worked in their role for more than three years (n=69), compared to those that had been in their role for one to three years (n=40) or less than one year (n=29).

*Figure 14: PCP engagement in the PCP staff survey*



*Source: PCP Staff survey*

**PCP partner / stakeholder survey response**

The PCP partner / stakeholder survey received a total of 840 responses. Of the 840 responses received, a total of 39 responses were excluded from the analysis due to significantly incomplete responses.

Survey respondents represented a breadth of organisations, including community health (n=141), community sector organisations (n=92), public hospitals or health services (n=148) and local government (n=136).

A majority of responses were received by partners / stakeholder organisations located in regional Victoria (n=486) relative to metropolitan Melbourne (n=292). Responses were received from Board members, executives, managers / team leaders, service providers, and administration staff. A majority of respondents had also been in their current role for more than three years (n=444), compared to those that had been in their role for one to three years (n=230) or less than one year (n=104).

## C.3 PCP staff survey questions

**Which PCP do you currently work for? You can select 'prefer not to say'.**

- ☐ Bendigo Loddon PCP
- ☐ Campaspe PCP
- ☐ Central Highlands PCP
- ☐ Central Hume PCP
- ☐ Central Victorian PCP
- ☐ Central West Gippsland PCP
- ☐ East Gippsland PCP
- ☐ Enliven Victoria
- ☐ Frankston-Mornington Peninsula PCP
- ☐ G21 (Geelong Regional Alliance)
- ☐ Goulburn Valley PCP
- ☐ Grampians Pyrenees PCP
- ☐ Health West Partnership
- ☐ Hume-Whittlesea PCP
- ☐ Inner East PCP
- ☐ Inner North West PCP
- ☐ Lower Hume PCP
- ☐ North East Healthy Communities
- ☐ Northern Mallee Community Partnership
- ☐ Outer East PCP
- ☐ South Coast PCP
- ☐ South West Primary Care PCP
- ☐ Southern Grampians Glenelg PCP

- [ ] Southern Mallee PCP
- [ ] Southern Melbourne PCP
- [ ] Upper Hume PCP
- [ ] Wellington PCP
- [ ] Wimmera PCP
- [ ] Prefer not to say

**Where is your PCP located?**

- [ ] Metropolitan Melbourne
- [ ] Regional Victoria

**Which of the following best describes your current role in the PCP? You can select 'prefer not to say'.**

- [ ] Executive Officer
- [ ] Project Coordinator
- [ ] Policy Officer
- [ ] Administration/Communication
- [ ] Prefer not to say
- [ ] Other _____

**How long have you been in your current role?**

- [ ] Less than one year
- [ ] One to three years
- [ ] More than three years

**The following questions relate to the PCP that you work for**

**What are the main *health or social priorities* your PCP is currently focusing on? (*Please select the top five)***

- [ ] Climate change
- [ ] Consumer and community engagement
- [ ] Cultural responsiveness
- [ ] Family violence and prevention of violence against women
- [ ] Health equity and access
- [ ] Health literacy
- [ ] Healthy ageing
- [ ] Healthy eating and active living
- [ ] Mental health and social inclusion
- [ ] Primary prevention
- [ ] Preventing unnecessary hospital admissions and presentations
- [ ] Strengthening partnerships

- ☐ System integration
- ☐ Workforce capacity building
- ☐ Not sure
- ☐ Other, please specify _____

**What types of *activities* is your PCP currently engaged in? *Please select all that apply.***

- ☐ Advocacy
- ☐ Awareness / promotion activities and information sharing
- ☐ Capacity building (e.g. training)
- ☐ Consumer and community engagement (e.g. community events, focus groups)
- ☐ Cross-sector collaboration (e.g. working groups)
- ☐ Development of action plans and strategy documents
- ☐ Development of resources (e.g. templates, guidelines etc.)
- ☐ Grant, tender, or funding applications
- ☐ Program design and delivery
- ☐ Program funding and grant provision
- ☐ Project management
- ☐ Research, monitoring and evaluations
- ☐ Not sure
- ☐ Other, please specify _____

**To what extent, if at all, have your PCP's priorities changed over the past five years?**

- ☐ There has been significant change
- ☐ There has been some change
- ☐ There has been very little change
- ☐ There has been no change at all

**What have been the key changes, and what have been the drivers of these changes?**

_____

**The following questions relate to the PCP that you work for, as well as the PCP Program more broadly.**

The stated PCP Program Aims are:

- Maximising health and wellbeing outcomes
- Promoting health equity
- Avoiding unnecessary hospital admissions

**Do you think that the Program aims are still relevant and appropriate?**

| | Yes | No | Not sure |
|---|---|---|---|
| Maximising health and wellbeing outcomes | ☐ | ☐ | ☐ |
| Promoting health equity | ☐ | ☐ | ☐ |
| Avoiding unnecessary hospital admissions | ☐ | ☐ | ☐ |

**How effective do you believe your PCP is at addressing the following aims or areas of focus?**

| | Ineffective | Somewhat ineffective | Somewhat effective | Very effective | Not applicable |
|---|---|---|---|---|---|
| Health and wellbeing outcomes | ☐ | ☐ | ☐ | ☐ | ☐ |
| Health equity | ☐ | ☐ | ☐ | ☐ | ☐ |
| Unnecessary hospital presentations | ☐ | ☐ | ☐ | ☐ | ☐ |
| Early intervention and integrated care | ☐ | ☐ | ☐ | ☐ | ☐ |
| Consumer and community empowerment | ☐ | ☐ | ☐ | ☐ | ☐ |
| Primary prevention | ☐ | ☐ | ☐ | ☐ | ☐ |
| Effective partnerships | ☐ | ☐ | ☐ | ☐ | ☐ |
| System level change | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sharing best practice models | ☐ | ☐ | ☐ | ☐ | ☐ |

**How effective do you believe the PCP Program is at addressing the following aims or areas of focus?**

| | Ineffective | Somewhat ineffective | Somewhat effective | Very effective | Not applicable |
|---|---|---|---|---|---|
| Health and wellbeing outcomes | ☐ | ☐ | ☐ | ☐ | ☐ |
| Health equity | ☐ | ☐ | ☐ | ☐ | ☐ |
| Unnecessary hospital presentations | ☐ | ☐ | ☐ | ☐ | ☐ |
| Early intervention and integrated care | ☐ | ☐ | ☐ | ☐ | ☐ |
| Consumer and community empowerment | ☐ | ☐ | ☐ | ☐ | ☐ |
| Primary prevention | ☐ | ☐ | ☐ | ☐ | ☐ |
| Effective partnerships | ☐ | ☐ | ☐ | ☐ | ☐ |
| System level change | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sharing best practice models | ☐ | ☐ | ☐ | ☐ | ☐ |

**What do you consider to be the key achievements of the PCP Program? *(Please select the top three)***

- ☐ Acting as an effective backbone organisation
- ☐ Alignment of partners' health and wellbeing priorities
- ☐ Avoiding unnecessary hospital presentations and admissions
- ☐ Catchment planning
- ☐ Development of new models of care
- ☐ Driving early intervention and integrated care
- ☐ Driving effective partnerships
- ☐ Promoting health equity
- ☐ Maximising health and wellbeing outcomes
- ☐ Support consumer and community empowerment
- ☐ Supporting primary prevention initiatives
- ☐ System level change
- ☐ Other, please specify _____
- ☐ Not sure

**What, if any, have been the unintended benefits of the PCP Program?**

_____

_____

**What, if anything, has inhibited your PCP strategically (i.e. achievement of strategic objectives etc.)? (Please select the top three)**

- ☐ Awareness and understanding of the PCP Program
- ☐ Communication
- ☐ Community engagement
- ☐ Funding
- ☐ Governance
- ☐ Leadership
- ☐ Partner organisation engagement
- ☐ Other, please specify _____

**You may provide some additional information about your responses to the previous question *(What, if anything, has inhibited your PCP strategically?)***

_____

_____

**What, if anything, has inhibited your PCP operationally (i.e. day-to-day activities)? For example, workforce recruitment issues etc.**

_____

_____

**The following questions relate to the PCP that you work for, as well as the PCP Program more broadly.**

**How well positioned are PCPs to address emerging health needs and system challenges now and in the future?**

- ☐ Very well positioned
- ☐ Somewhat well positioned
- ☐ Somewhat poorly positioned
- ☐ Very poorly positioned

**Please provide an explanation for your answer to the previous question** (To what extent do you believe PCPs are well positioned to address emerging health needs and system challenges now and in the future?)

_____

_____

**What are your suggestions or ideas for the future of the PCP Program?**

_____

_____

## C.4 PCP partner / stakeholder survey questions

**What type of organisation do you work for?**

- ☐ Aboriginal community controlled organisation
- ☐ Aged care service
- ☐ Community health service
- ☐ Community sector organisation
- ☐ Education and training
- ☐ Emergency services
- ☐ Hospital or health service - private
- ☐ Hospital or health service - public
- ☐ Housing support service
- ☐ Local government
- ☐ Primary Health Network
- ☐ Neighbourhood / Community House
- ☐ Private organisation
- ☐ Sport and recreation
- ☐ State / Commonwealth government
- ☐ Other, please specify _____

**Where is your organisation located?**

- ☐ Metropolitan Melbourne
- ☐ Regional Victoria

**Which best describes your role in your organisation?**

- ☐ Board member
- ☐ Executive
- ☐ Manager, team leader, coordinator
- ☐ Service provider
- ☐ Administration
- ☐ Other, please specify _____

**How long have you been in your current role?**

- ☐ Less than one year
- ☐ One to three years
- ☐ More than three years

**Which PCP does your organisation usually work and/or interact with? *(Please select all that apply)***

- ☐ Bendigo Loddon PCP
- ☐ Campaspe PCP
- ☐ Central Highlands PCP
- ☐ Central Hume PCP
- ☐ Central Victorian PCP
- ☐ Central West Gippsland PCP
- ☐ East Gippsland PCP
- ☐ Enliven Victoria
- ☐ Frankston-Mornington Peninsula PCP
- ☐ G21 (Geelong Regional Alliance)
- ☐ Goulburn Valley PCP
- ☐ Grampians Pyrenees PCP
- ☐ Health West Partnership
- ☐ Hume-Whittlesea PCP
- ☐ Inner East PCP
- ☐ Inner North West PCP
- ☐ Lower Hume PCP
- ☐ North East Healthy Communities
- ☐ Northern Mallee Community Partnership
- ☐ Outer East PCP
- ☐ South Coast PCP
- ☐ South West Primary Care PCP
- ☐ Southern Grampians Glenelg PCP
- ☐ Southern Mallee PCP
- ☐ Southern Melbourne PCP
- ☐ Upper Hume PCP
- ☐ Wellington PCP
- ☐ Wimmera PCP
- ☐ Prefer not to say

**How long has your organisation working with PCPs?**

- ☐ Less than one year
- ☐ One to three years
- ☐ More than three years

**The following questions relate to the PCP/s that your organisation works and/or interacts with**

**What type of activities is / has your organisation been engaged with your PCP/s on? *(Please select all that apply)***

- ☐ Advocacy
- ☐ Awareness / promotion activities and information sharing
- ☐ Capacity building (e.g. training)
- ☐ Consumer and community engagement (e.g. community events, focus groups)
- ☐ Cross-sector collaboration (e.g. working groups)
- ☐ Development of action plans and strategy documents
- ☐ Development of resources (e.g. templates, guidelines etc.)
- ☐ Grant, tender, or funding applications
- ☐ Program design and delivery
- ☐ Recipient of PCP program funding or grants
- ☐ Research, monitoring and evaluations
- ☐ Other, please specify _____
- ☐ Not sure

The stated PCP Program aims are:

- Maximising health and wellbeing outcomes
- Promoting health equity
- Avoiding unnecessary hospital admissions

**Do you think that the Program aims are still relevant and appropriate?**

| | Yes | No | Not sure |
|---|---|---|---|
| Maximising health and wellbeing outcomes | ☐ | ☐ | ☐ |
| Promoting health equity | ☐ | ☐ | ☐ |
| Avoiding unnecessary hospital admissions | ☐ | ☐ | ☐ |

**To what extent do you believe the PCP Program is effectively addressing the following aims or areas of focus?**

| | Ineffectively | Somewhat ineffectively | Somewhat effectively | Very effectively | Not applicable |
|---|---|---|---|---|---|
| Health and wellbeing outcomes | ☐ | ☐ | ☐ | ☐ | ☐ |
| Health equity | ☐ | ☐ | ☐ | ☐ | ☐ |
| Unnecessary hospital presentations | ☐ | ☐ | ☐ | ☐ | ☐ |
| Early intervention and integrated care | ☐ | ☐ | ☐ | ☐ | ☐ |
| Consumer and community empowerment | ☐ | ☐ | ☐ | ☐ | ☐ |
| Primary prevention | ☐ | ☐ | ☐ | ☐ | ☐ |
| Developing effective partnerships | ☐ | ☐ | ☐ | ☐ | ☐ |
| System level change | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sharing best practice models | ☐ | ☐ | ☐ | ☐ | ☐ |

**What, if anything, do you think is limiting the PCPs from achieving the stated Program aims and other local objectives? You can select up to three options.**

The stated Program Aims are:

- Maximising health and wellbeing outcomes
- Promoting health equity
- Avoiding unnecessary hospital admissions

☐ Awareness and understanding of the PCP Program
☐ Communication
☐ Community engagement
☐ Funding
☐ Governance
☐ Leadership
☐ Partner organisation engagement
☐ Other, please specify _____

**What do you consider to be the key achievements of the PCP Program? *(Please select the top three)***

☐ Acting as an effective backbone organisation
☐ Alignment of partners' health and wellbeing priorities
☐ Avoiding unnecessary hospital presentations and admissions
☐ Catchment planning
☐ Development of new models of care
☐ Driving early intervention and integrated care
☐ Driving effective partnerships
☐ Promoting health equity
☐ Maximising health and wellbeing outcomes
☐ Supporting consumer and community empowerment
☐ Supporting primary prevention initiatives
☐ System level change
☐ Not sure
☐ Other, please specify _____

**How well positioned are PCPs to address emerging health needs and system challenges now and in the future?**

☐ Very well positioned
☐ Somewhat well positioned

- [ ] Somewhat poorly positioned
- [ ] Very poorly positioned

**Overall, to what extent are you satisfied with the current PCP Program and model?**

- [ ] Very satisfied
- [ ] Slightly satisfied
- [ ] Slightly dissatisfied
- [ ] Very dissatisfied

**Please provide an explanation for your answer to the previous question (to what extent are you satisfied with the current PCP program and model?)**

_____

_____

**What are your suggestions or ideas for the future of the PCP Program?**

_____

_____

# Appendix D: Review participants

To inform the PCP Program Review, a series of targeted stakeholder consultations and site visits were completed. Table 2 outlines the key stakeholder groups engaged in the targeted consultation process.

Two additional sites, G21 and the Wimmera region PCPs, were consulted to inform the analysis of best practice primary care integration models.

*Table 2: Review participants*

| Stakeholder/s | Date scheduled |
|---|---|
| DHHS Operations Division | 2 December 2019 |
| DHHS Area Population Health | 28 November 2019 |
| DHHS Population Health South Division | Written submission |
| DHHS Regulation, Health Protection and Emergency Management Division | 16 December 2019 |
| DHHS Diversity and Community Participation Division | 16 December 2019 |
| PHN CEOs | 25 November 2019 (and written submission) |
| Victorian Healthcare Association (VHA) | 28 November 2019 |
| Municipal Association of Victoria (MAV) | 3 December 2019 |
| Victorian Primary Care Partnerships (VicPCP) | 29 October 2019 |

# Appendix E: Documents and data

*Table 3: Documents and data received*

| Description | Received from |
|---|---|
| Annual Strategic Plans | DHHS |
| Annual Partnership Reports | DHHS |
| Annual E-referral Reports | DHHS |
| Annual Prevention Reports | DHHS |
| Annual Integrated Chronic Care Reports | DHHS |
| PCP Program Logic | DHHS |
| End of Financial Year Reports | DHHS |
| Workforce and governance | |
| Current PCP Governing Board and Memberships | DHHS/PCPs |
| Terms of Reference for Governing Board and Membership | PCPs |
| Good practice vignettes | |
| Good practice vignettes | PCPs |
| Other | |
| Contributing to better health and wellbeing outcomes for our communities Report, 2019 | Victorian PCPs |
| A departmental guide for place-based approaches | DHHS |

# Appendix F: Case studies

To obtain a more in-depth understanding of the current state and impacts of the PCP Program, four case studies were developed. The case studies examined PCPs in four distinct geographical locations in Victoria: inner-metropolitan Melbourne, peri-urban/growth corridor, regional centre and rural township. The development of each case study involved site visits, document review and more comprehensive consultations with PCP staff and partner organisations.

## F.1 Overarching case study findings

The development of the four case studies demonstrated the high calibre of PCP staff, and some examples of high quality and innovative work being done. Partners identified by PCPs to be consulted to inform the case studies were overwhelmingly positive in their assessment of the value PCPs bring.

The case studies also demonstrated that PCPs have a strong understanding of their local communities and service systems, and are very responsive to the needs of their communities, meaning that the PCPs all operate in different ways.

Through the descriptions of activity by PCP staff and partners, it is clear that significant time and resources are dedicated to maintaining the governance of the PCP, planning and reporting (both to DHHS and to partners).

Across all four case study sites, staff and partners consistently reported the value of PCPs as a 'neutral' entity: as neither a commissioner/funder nor potential competitor for funding. This characteristic of PCPs was portrayed as particularly important within an increasingly competitive funding environment.

The case studies identified some evidence of work which does not appear to align with the purpose of the Program and potentially exists in other forms, including PCP staff providing intensive support around monitoring and evaluation to other organisations, and the development of Aboriginal cultural safety resources and training.

In the absence of updated objectives or outcome measures, PCPs have engaged in a multitude of different activities and initiatives driven by local need, their partnerships, and unique areas of interest. The lack of consistency and the small scale of PCP initiatives makes it very challenging to measure Program level outcomes. This was demonstrated through the case studies, where the nature of projects was highly specific and localised, and measurement of impact was not always apparent.

The review did note through the case studies efforts to share resources and learnings across PCPs and networks, and some limited examples of work being scaled across other locations. It is also important to note that PCPs have engaged external consultants and Universities to evaluate initiatives, but that is sometimes constrained by tight project budgets.

## F.2 Case Study A: Metropolitan PCP

### Background

Case Study A examines a PCP operating in metropolitan Melbourne. The PCP catchment covers four LGAs with a population of more than half a million. As a metropolitan-based PCP, the catchment region is facing health issues associated with an ageing population, as well as local policy and service changes from various sector reforms, including in family violence and mental health.

### Priorities and activities

The PCP activities and initiatives have been guided by three key priority areas – prevention, effective partnerships and family violence. PCP staff reported a shift away from system integration and chronic disease management towards more primary prevention and health promotion following the recent establishment of PHNs. Informed by the partners, the PCP has pursued initiatives in family violence, social inclusion and Aboriginal cultural safety with a focus on capability uplift, evaluation, and shared measurement tools. Key initiatives have included:

- Development of an online tool for measurement of the impact of prevention of family violence.
- The Social Inclusion Measurement Project.
- Delivery of Aboriginal cultural safety training, resources and capability uplift.
- Evaluation support and advice to local organisations, including local health and social service providers and academic partners.
- Facilitation of working groups and communities of practice to strengthen local partnerships and support cross-sector collaboration.

The PCP has also supported local initiatives in a time-limited, project support role. For example, providing additional capacity to a local project in the context of project management, facilitation of stakeholder consultations, and report writing.

## Achievements and outcomes

The PCP demonstrated an ability to bring together local providers, add value to local initiatives and develop resources for local use. Specifically, evidence of the PCP's impact includes:

- Uptake of the online measurement tool for prevention of family violence and the outcomes framework for social isolation in local organisations across different sectors.
- Consistent and active participation of member organisations in forums, working groups and community of practice meetings.
- Positive feedback from partners, particularly in regards to on-the-ground evaluation support and ability to support local collaboration.

The PCP is supported by high calibre staff, evidenced through the quality of resources developed, and feedback from partners.

## Reported challenges

PCP staff reported several challenges limiting the PCP both strategically and operationally:

- Lack of authorising environment and meaningful levers to influence partners and drive local change.
- Lack of strategic direction or leadership from DHHS has limited the PCP network's collective impact and consistency of work.
- The current environment of uncertainty which has led to workforce concerns and inability to commence new work or apply for grants.

## Key messages from partners / stakeholders

The consistent message from partner and stakeholders is that the PCP is very competent and highly functional.

There is a consistent view that by actively engaging partners and stakeholders in collaborative planning processes, the PCP is able to establish strong relationships with, and between partners. This has a positive impact on sector collaboration and the establishment of shared objectives.

With regards to duplication of efforts, stakeholders expressed mixed views. Some report that the PCP is helping to reduce duplication by exposing partners to the work being done by others in the region. Others reported that PCP is providing skills and expertise which exist within other organisations, and the key value is the additional capacity being provided.

## F.3 Case Study B: Growth Corridor PCP

### Background

Case study B is based on a PCP that is located within a major growth corridor in metropolitan Melbourne. The PCP's catchment covers five LGAs and has one of the fastest growing populations in Australia.

The catchment area is very culturally diverse and has experienced long-term social disadvantage, with specific issues including limited public housing and poor public transport infrastructure. As a major growth corridor, the catchment is facing new health-related challenges associated with many young families, a high birth rate, as well as disadvantage and an aging population cohort. This has given rise to a population with complex needs that requires complex health solutions. The areas has had traditionally poor access to health services.

### Priorities and activities

As reported by PCP staff, the PCP has shifted its focus away from traditional service coordination towards primary prevention. Driven by the needs of a complex population group and the objectives of local partner organisations, the PCP has identified the following as key areas of focus:

- Driving effective partnerships.
- Prevention of family violence.
- Health literacy.
- Economic inclusion in health.

The PCP takes a systems-level approach to change, and operates as a broker and advocate on behalf of the partnership. Key initiatives undertaken by the PCP include:

- The development of an online health literacy resource to support organisations improve the accessibility of their information and services for consumers.
- The development of a workforce mutuality resource to support local organisations develop and retain a workforce that is reflective of local population demographics.
- The facilitation of working groups and workshops designed to foster relationships and innovative thinking, as well as the inclusion of vulnerable population groups in sector planning.

Centred on outcomes for vulnerable and diverse population groups, these initiatives highlight the PCP's nuanced approach to addressing the local needs of a socially disadvantaged and diverse catchment population.

### Achievements and outcomes

The PCP has demonstrated the following:

- Strong leadership in times of uncertainty, as reported by staff and external stakeholders.
- Ability to drive positive change in the policies and procedures of external organisations, as evidenced by the adoption of principles outlined in the workforce mutuality and health literacy resources.
- Contribution to the evidence-base in primary prevention, including evaluations and research conducted in partnership with Universities.
- Attraction of additional funding for the local region, accumulating more than twice the Program's core funding through external grants.

### Reported challenges

PCP staff identified several barriers inhibiting the PCP from operating at its full potential, including:

- The current environment of uncertainty, which is leading to high levels of staff turnover and an inability to progress work or future planning.

- Lack of leadership and strategic direction from DHHS, which has contributed to a sense of uncertainty about the role and function of the PCP for both PCP staff and external stakeholders.
- Lack of authorising environment required to drive system-level change.
- Lack of communication and feedback from DHHS which is perceived as disempowering for both PCP staff and partners engaged in PCP initiatives.

### Key messages from partners / stakeholders

The PCP is widely recognised as a highly functional and highly capable team that is committed to driving improved outcomes for the local population.

Partners and stakeholders respected the PCP's ability to set its own course of action, identifying critical issues in the region and taking an innovative solutions-driven approach to address them.

Some partner organisations also shared positive impacts that the PCP has had on their own organisation's operations, including changes to their communications in line with the PCP's health literacy principles, and recruitment strategies in line with the workforce mutuality standards.

Others noted that sustaining participation in PCP mechanisms has become more difficult in recent times, in part due to increasing time and resource pressures within organisations, and in part because of the lack of certainty around the future of the platform.

## F.4 Case Study C: Regional PCP

### Background

Case study C examines a PCP located in regional Victoria with a catchment that covers two distinctly different LGAs, an established regional town and a shire with entrenched socio-economic disadvantage. Experiencing poorer health outcomes, rates of chronic disease, and limited health service capacity, the more disadvantaged area requires a more hands-on approach from the PCP. This PCP highlights the nuanced approach taken by PCPs to meet the unique needs of each LGA.

### Priorities and activities

The PCP's strategic priorities have evolved over time, shifting away from chronic disease management towards primary prevention and health promotion. PCP staff identified the emergence of four primary areas of focus in response to local community need:

- Prevention of family violence.
- Healthy eating and active living.
- Mental health.
- Smoking prevention.

It is clear that the PCP staff are committed to partnership development and operating in the best interests of the local community. Driven by an outcomes-focused and health promotion lens, key initiatives undertaken by the PCP have included:

- The facilitation of working groups, forums and community of practice to facilitate opportunities for relationship building, peer reflection and shared learning.
- The delivery of training to support local capacity building, with a particular focus on health literacy.
- Resource development to support the delivery of high quality health care for vulnerable families and children.
- The completion of health needs analyses and development of multi-agency action plans.
- Mapping local programs and health services to support system navigation.

### Achievements and outcomes

Through its work, the PCP has demonstrated the following impacts:

- The establishment of a very active and committed partnership.
- Attraction of additional funding and resources to the region, which is particularly evident in the more disadvantaged and under-resourced LGA.
- Community uptake of resources developed by the PCP and evidence of changed practices in local health services.
- Strong engagement in capability uplift initiatives and training programs.
- Cross-sector use of local-level data generated by the PCP to catchment planning processes.

### Reported challenges

Several challenges were identified by PCP staff in their day-to-day work:

- The environment of uncertainty impairs their ability to engage in future planning or long-term work, and contributes to job insecurity for PCP staff which is particularly challenging for regional areas that already face workforce recruitment challenges.
- In some cases, the lack of DHHS engagement in PCP initiatives and activities has undermined the credibility of the PCP from the perspective of prospective partners.
- The size of the PCP's workforce limits the scalability and impact of PCP initiatives.

### Key messages from partners / stakeholders

It is clear that this regional PCP is highly valued and has a strong reputation as a credible, skilled and dedicated workforce within the catchment area.

There was a strong sentiment from partners and stakeholders that the PCP acts as a neutral partnership broker for the region, which supports effective collaboration, communication, and action.

The PCP also supports system sustainability by filling capability and capacity gaps as required. This is particularly important in physically isolated and disadvantaged areas that are already under-resourced.

Some stakeholders also reported that the PCP provides a platform to focus on prevention and population health planning which often falls outside of the remit of traditional health service delivery roles.

## F.5 Case Study D: Rural PCP

### Background

Case Study D explores the operations and impacts of a PCP located in rural Victoria. The PCP's catchment covers two LGAs across a large geographical area that is experiencing rapid population growth and relatively high socio-economic disadvantage. The catchment area has high rates of low income households, unemployment and years lost to disease relative to Victorian averages. Recent weather events have also exacerbated the region's vulnerability.

### Priorities and activities

Driven by observed community need and partner organisations, the PCP's program of work is guided by three core strategic pillars – prevention, system integration and family violence. Within these pillars, the PCP has a particular focus on food security, promoting gender equity, and the quality of services for vulnerable children and families.

Key PCP initiatives have included:

- The delivery of training programs and forums to support local capability uplift, particularly in the context of primary prevention and health promotion.
- The facilitation of catchment-wide planning to support sector collaboration and system-level change.
- Development of a resource to support service coordination
- Development of resources to support the development of more health literate organisations.
- Large scale health promotion and public awareness campaigns.
- Facilitation of working groups, networking opportunities, and community of practice meetings to foster relationship building and opportunities for shared learning.

Given the size of the region in which the PCP operates, the PCP works closely with other PCPs also located within the area to improve the collective impact of the platform. PCP staff reported benefits associated with this collaborative partnership, including the scalability of initiatives, the impact of pooled resources, and shared learnings.

## Achievements and outcomes

Key outcomes evident in the PCP's program of work are as follows:

- Evidence of improved food security in the catchment area, defined as greater access to healthy and affordable food.
- Strong partnership as evidenced by active engagement in regular strategic meetings and working groups.
- Attraction of additional funding to the region through external grants.
- Evidence of uptake of key resources developed and published by the PCP.

## Reported challenges

PCP staff identified several factors limiting the impacts of their efforts both strategically and operationally:

- Lack of communication between central and regional DHHS, which is adding to an already uncertain environment and limiting DHHS's ability to provide clear direction to the PCPs. The lack of communication from central DHHS is also hindering the PCP's ability to engage in productive conversations with senior leadership.
- There is an over-saturation of initiatives and platforms in the region all working towards improving health outcomes within the disadvantaged community. This has been challenging for both PCP staff and external partners to identify the role of the PCP in this market without clear direction from DHHS.
- Poor departmental engagement in the activities of the PCP is considered to be undermining, and exacerbates the weak authorising environment that the PCPs operates in.

## Key messages from partners / stakeholders

Stakeholders view the PCP as a positive constant in an ever-changing health sector landscape. The PCP is perceived to support system sustainability by filling gaps as required and driving collaborative planning processes.

The PCP is viewed as a neutral partnership broker, with good credibility in the sector and strong leadership skills. Without the PCP, some stakeholders believe that important primary prevention and health promotion initiatives in the region would cease, as priority is given to service delivery.

Several stakeholders also reported that the PCP is a critical resource for smaller rural organisations in particular with limited resources and capacity.

It is clear that the PCP has a strong reputation amongst its partnership, particularly in relation to staff skill sets, ability to establish strong networks, and leverage local knowledge to drive change.

# Appendix G: Relevant contextual factors

## G.1 Changing landscape

Consistent with national health system trends, Victoria is experiencing pressures associated with an ageing population, workforce shortages (particularly in regional and rural general practice), and health equity issues for certain population groups, including Aboriginal people.[28] Ongoing challenges associated with the responsibility divide between the Commonwealth and Victorian government, contributes to a fragmented primary care system.[29]

Major sector reforms have, and will continue to, shape Victoria's primary health care sector. Significant transformations associated with disability, family violence, aged care and mental health sector reforms are changing the role of primary care in the health and social system, and driving increasing pressure for integration and more person-centred responses.[30, 31] One example is the introduction of My Aged Care which requires that GPs to use the centralised platform to access any age-related supports for patients.[32] At a state level, the introduction of the Orange Door model, and the predicted changes associated with the Royal Commission into Victoria's Mental Health System will continue to drive change.

The Commonwealth Government has led a series of initiatives over the past 20 years to achieve this, including coordinated care trials, the introduction of the Practice Incentives Program (PIP), the establishment of PHNs, and Health Care Homes. [33, 34, 35] It is anticipated that Victoria's primary care landscape will continue to shift towards more integrated and value based models of care, as evidenced by recent government initiatives including the introduction of the PIP Quality Improvement (QI) Incentive. [36]

Other relevant sector trends include:

- Increasing consolidation and corporatisation of general practice, and challenges around the sustainability of the traditional general practice business model, particularly in region and rural areas.
- Rapidly emerging technologies which are starting to fundamentally change the way services can be provided and how consumers engage with these services. Specifically, the introduction of smart phones, digital platforms and wearable technology for example, has driven increased consumer engagement and connectivity.[37] This is driving greater consumer demands for more immediate and personalised care, which will continue to shape the delivery of primary care services in Victoria. [38]
- Evolving Victorian Government initiatives and priority areas which are changing Victoria's primary care sector. Specifically, the Victorian government has become increasingly focused on prevention, particularly within family violence, obesity, mental health and resilience to climate

[28] National Medical Workforce Strategy. (2019). Retrieved 11 December 2019, from https://www1.health.gov.au/internet/main/publishing.nsf/
[29] IBISWorld. (2018). General Practice Medical Services in Australia.
[30] Report of the Family Violence Reform Implementation Monitor - As at 1 November 2018. (2019).
[31] Australian Government, Department of Social Services. (2010). National Disability Strategy 2010-2020.
[32] Services for health professionals. (2019). Retrieved, from https://www.myagedcare.gov.au/health-professionals
[33] Department of Health | Health Care Homes. (2019).
[34] IBISWorld. (2018). General Practice Medical Services in Australia.
[35] Primary health networks (PHNs). (2019). Retrieved 19 November 2019, from https://www.healthdirect.gov.au/
[36] Practice Incentives Program - Australian Government Department of Human Services. (2019).
[37] KPMG. (2018). Healthcare reimagined.
[38] Australian Government Productivity Commission. (2015). Efficiency in health: Productivity Commission Research Paper.

change. This has led to the implementation of new platforms, programs, and models of care designed to support more place-based, integrated and coordinated care. [39]

- Workforce shortages have emerged as a key threat to the sustainability of Victoria's primary care sector. Specifically, the shortage of general practitioners in regional and rural Victoria has become an increasing concern the Victorian Government. [40] It is anticipated that these workforce shortages will worsen as the demand for primary care services increases in line with a rapidly growing and ageing population.[41, 42]

## G.2 Population health trends

Changing population demographics and health trends have also shaped, and continue to shape, the current state of Victoria's primary care landscape. Specifically:

- **Australia's rapidly growing and ageing population,** which is particularly prominent in Victoria.[43] Victoria's population is expected to double to 10.1 million by 2051, in parallel with the proportion of people aged 65 which is expected to double by 2055. [44] These trends are anticipated to place additional pressures on Victoria's health, aged care and social services sectors.

- **Increased prevalence of chronic and non-communicable diseases** associated with both an ageing population and with increased risk factors such as obesity.[45] The increased prevalence of chronic disease has driven the need for the delivery of more individualised, long-term and holistic care. It is predicted that this trend will continue to impact Victoria's primary care landscape which is best placed to provide care the type of care that people require for chronic and complex conditions associated with ageing. [46]

- **Changing consumer demands, expectations and behaviours,** as healthcare becomes more specialised and complex, and people demand more choice and control in the care that they receive, and transparency from providers. These trend is anticipated to continue, placing greater pressure on Victorian primary care providers to deliver this type of quality care. [47]

- **Health disparities** for certain population groups. Specifically, the health-related vulnerabilities of members of the Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ) community, people experiencing family violence, and children in out-of-home care.[48, 49] As a critical access point to Victoria's broader health and social care system, it is likely that primary care providers will continue to be funded or incentivised to target these vulnerable population groups and promote health equity. [50]

[39] What we do. (2019). Retrieved 19 November 2019, from https://www.vichealth.vic.gov.au/about/what-we-do
[40] Harrison, C., & Britt, H. (2011). General practice: Workforce gaps now and in 2020. AFP, 40(1), Pages 12-15.
[41] GML Media Release: Task group formed to address GP shortages and workforce issues across East Gippsland. (2019).
[42] General Practice: Workforce gaps now and in 2020. (2011). Australian Family Physician, 40(1), 12-15.
[43] 3101.0 - Australian Demographic Statistics, Mar 2019. (2019).
[44] Victoria in Future (population and households projections to 2051) - Invest Victoria. (2019).
[45] World Health Organisation. (2010). Status Report on Noncommunicable Diseases
[46] Chronic disease Overview. (2019). Australian Institute of Health and Welfare.
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[48] Chang, Q., Yip, P., & Chen, Y. (2019). Gender inequality and suicide gender ratios in the world. Journal Of Affective Disorders, 243, 297-304.
[49] Koh, H., Piotrowski, J., Kumanyika, S., & Fielding, J. (2011). Healthy People: A 2020 Vision for the Social Determinants Approach. Health Education & Behavior, 38(6), 551-557.
[50] Commonwealth, and State and the Northern Territory governments. (2011). The National Strategic Framework for Rural and Remote Health. Rural Health Standing Committee.

# Appendix H: Financial analysis

Analysis of financial income and expense summaries submitted by PCPs to the Department has been undertaken. The summaries included funding data provided by DHHS that identified: actual PCP Program funding; other DHHS funding; estimates of other revenue sources; and spending on Salaries and Wages, General Expenses and Project Spending. This appendix includes the following sections:

- H.1: An overview of PCP revenue and spending.
- H.2: Detailed analysis of PCP revenue, which includes PCP Program funding, other DHHS funding and other non-DHHS funding.
- H.3: Detailed analysis of PCP spending.
- H.4: An overview of the approach to analysis, the data sources and the limitations.

The analysis provides the Department with an understanding of the composition of PCP revenue, and how that composition has changed over time, as well as analysis of how PCPs are spending their funding, including the composition of spending, and how that has changed over time.

In considering the financial analysis, it should be recognised that KPMG has relied on the amounts that have been reported to the Department by the PCPs, and KPMG did not seek to understand the drivers of the financial information, but rather to highlight the high level trends and characteristics of PCPs.

KPMG did not verify or valid of the financial information submitted to the Department. No audit or independent review was performed and accordingly, no assurance has been expressed.

## H.1 Overview of PCP revenue and spending

Table 4 provides an overview of PCP revenue and spending from 2015-16 to 2017-18. It shows that:

- Total revenue for the 28 PCPs from 2015-6 to 2017-18 was $44,206,238. Across this time period, **PCP Program core funding from DHHS made up 72 per cent of the reported revenue of PCPs**, while other DHHS funding contributed 15 per cent and 13 per cent came from other revenue sources.
- Total DHHS core funding to the PCP Program in 2017-18 was **$10,666,927**. In 2017-18 PCPs reported an additional $2,419,632 from other DHHS sources (i.e. non-PCP Program funds), and reported an additional $1,815,857 in other revenue.
- From 2015-16 to 2017-18 spending by PCPs was made up of:
  - **63 per cent for Salaries and Wages**.
  - **25 per cent for General Expenses**.
  - **12 per cent for Project Expenses**.

- In 2017-18 the 28 PCPs reported spending $13,435,580 (**89.4 per cent of total spending**) on **Salaries and Wages and General Expenses** combined, and $1,596,883 (**10.6 per cent** of total spending) on **Project Expenses**.

*Table 4: Summary of PCP revenue and spending from 2015-16 to 2017-18.*

| Category | Item | 2015-16 | 2016-17 | 2017-18 | Subtotal | Total | Portion of Total Revenue |
|---|---|---|---|---|---|---|---|
| **Revenue** | PCP Funding | $10,433,497 | $10,594,162 | $10,666,268 | $31,693,927 | $44,206,238 | 72% |
| | Other DHHS Funding | $2,656,581 | $1,440,616 | $2,419,632 | $6,516,830 | | 15% |
| | Other Revenue | $2,674,252 | $1,505,372 | $1,815,857 | $5,995,481 | | 13% |
| **Spending** | Salaries and wages | $9,786,914 | $8,638,321 | $9,971,724 | $28,396,959 | $44,631,981 | 63% |
| | General Expenses | $3,790,964 | $3,516,012 | $3,463,856 | $10,770,832 | | 25% |
| | Project Expenses | $2,310,348 | $1,556,959 | $1,596,883 | $5,464,190 | | 12% |

Table 5 and Table 6 below provide a breakdown of revenue and spending by PCP from 2015-16 to 2017-18.

Table 5 highlights that all PCPs received PCP Program funding over the three years, however the total amount ranged from $800k to $1.8m. Not all PCPs reported other DHHS funding over the three years, and the amounts ranged from over $1m to as little as $15,000. Not all PCPs are reporting revenue from other sources, however some report amounts up to over $600k.

The varying amounts and combinations of revenue sources results in varying levels of total income across the PCPs during the time period, however most are within the $1m to $2m range.

*Table 5: Revenue reported by PCP from 2015-16 to 2017-18.*

| PCP | PCP Program | Other DHHS | Other | Total |
|---|---|---|---|---|
| **Bendigo Loddon PCP** | $1,143,310 | $155,000 | $107,556 | **$1,405,866** |
| **Campaspe PCP** | $819,374 | $148,086 | $648,056 | **$1,615,516** |
| **Central Highlands PCP** | $1,250,820 | $52,529 | $16,407 | **$1,319,756** |
| **Central Hume PCP** | $991,439 | $581,963 | $266,861 | **$1,840,263** |
| **Central Victorian PCP** | $1,036,344 | $265,900 | $196,297 | **$1,498,541** |
| **Central West Gippsland PCP** | $1,119,378 | $16,521 | $95,695 | **$1,231,594** |
| **East Gippsland PCP** | $942,551 | $- | $210,261 | **$1,152,812** |

| PCP | PCP Program | Other DHHS | Other | Total |
|---|---|---|---|---|
| **Enliven Victoria (The South East PCP)** | $1,124,412 | $235,155 | $532,417 | **$1,891,984** |
| **Frankston-Mornington Peninsula PCP** | $1,032,553 | $434,089 | $317,800 | **$1,784,442** |
| **G21**[51] | $1,198,534 | $85,000 | $567,368 | **$1,850,902** |
| **Goulburn Valley PCP** | $1,061,277 | $29,998 | $42,808 | **$1,134,083** |
| **Grampians Pyrenees PCP** | $1,169,391 | $- | $- | **$1,169,391** |
| **HealthWest PCP** | $1,733,049 | $304,017 | $173,555 | **$2,210,621** |
| **Hume-Whittlesea PCP** | $1,160,508 | $1,097,953 | $578,189 | **$2,836,649** |
| **Inner East PCP** | $1,583,210 | $130,299 | $18,139 | **$1,731,648** |
| **Inner North West PCP** | $1,372,648 | $289,225 | $56,720 | **$1,718,593** |
| **Lower Hume PCP** | $825,105 | $15,000 | $227,401 | **$1,067,506** |
| **North East PCP** | $1,123,878 | $590,730 | $8,162 | **$1,722,770** |
| **Northern Mallee Community Partnership** | $1,009,810 | $40,000 | $164,552 | **$1,214,362** |
| **Outer East Health and Community Support Alliance** | $1,346,335 | $557,781 | $141,928 | **$2,046,044** |
| **South Coast PCP** | $919,925 | $- | $13,655 | **$933,579** |
| **South West Primary Care PCP** | $1,089,779 | $324,403 | $83,056 | **$1,497,238** |
| **Southern Grampians Glenelg PCP** | $983,799 | $170,998 | $573,421 | **$1,728,218** |
| **Southern Mallee PCP** | $961,132 | $245,000 | $128,740 | **$1,334,872** |
| **Southern Melbourne Primary Care Partnership** | $1,829,609 | $- | $93,473 | **$1,923,083** |
| **Upper Hume PCP** | $866,051 | $253,519 | $219,256 | **$1,338,826** |
| **Wellington PCP** | $1,016,597 | $4,266 | $16,183 | **$1,037,046** |
| **Wimmera PCP** | $983,108 | $489,399 | $497,526 | **$1,970,032** |
| **Total** | **$31,693,927** | **$6,516,830** | **$5,995,481** | **$44,206,238** |

Table 6 highlights that, unsurprisingly, all PCPs reported spending on salaries and wages over the three years, however the levels ranged from just over $400k to over $2m. As would be expected, all PCPs reported spending on general expenses over the three years, and the levels varied from over

[51] It should be noted that, throughout this report, revenue reported by G21 for other DHHS and other non-DHHS may relate to the broader Health and Wellbeing platform which PCP Program funding supports within the G21 structure.

$1.2m to as little as $160k. Not all PCPs are reporting spending on project expenses, and of those that did there are large differences in the amounts reported in this category across the PCPs.

It is unclear whether the variations in spending relate to the actual operations of PCPs, or to inconsistencies in reporting on spending.

*Table 6: Spending reported by PCP from 2015-16 to 2017-18.*

| PCP | Salaries and Wages | General Expenses | Project Expenses | Total |
|---|---|---|---|---|
| **Bendigo Loddon PCP** | $906,702 | $232,538 | $158,883 | **$1,298,123** |
| **Campaspe PCP** | $1,045,411 | $275,861 | $170,882 | **$1,492,154** |
| **Central Highlands PCP** | $775,705 | $327,546 | $25,000 | **$1,128,251** |
| **Central Hume PCP** | $955,501 | $494,396 | $700,978 | **$2,150,875** |
| **Central Victorian PCP** | $718,476 | $183,369 | $227,152 | **$1,128,997** |
| **Central West Gippsland PCP** | $720,378 | $251,193 | $107,165 | **$1,078,736** |
| **East Gippsland PCP** | $627,529 | $204,585 | $49,116 | **$881,229** |
| **Enliven Victoria (The South East PCP)** | $1,087,995 | $552,427 | $- | **$1,640,422** |
| **Frankston-Mornington Peninsula PCP** | $1,113,590 | $378,954 | $149,399 | **$1,641,943** |
| **G21** | $1,542,101 | $962,479 | $43,403 | **$2,547,983** |
| **Goulburn Valley PCP** | $948,969 | $272,114 | $93,814 | **$1,314,897** |
| **Grampians Pyrenees PCP** | $983,932 | $628,443 | $20,259 | **$1,632,634** |
| **HealthWest PCP** | $2,135,978 | $620,812 | $605,331 | **$3,362,121** |
| **Hume-Whittlesea PCP** | $1,982,853 | $440,744 | $334,154 | **$2,757,751** |
| **Inner East PCP** | $1,298,260 | $278,536 | $399,282 | **$1,976,078** |
| **Inner North West PCP** | $1,193,314 | $217,486 | $255,342 | **$1,666,142** |
| **Lower Hume PCP** | $771,410 | $254,180 | $51,642 | **$1,077,232** |
| **North East PCP** | $745,900 | $677,506 | $- | **$1,423,406** |
| **Northern Mallee Community Partnership** | $839,402 | $317,079 | $110,914 | **$1,267,395** |
| **Outer East Health and Community Support Alliance** | $887,345 | $327,784 | $573,691 | **$1,788,820** |
| **South Coast PCP** | $418,964 | $163,060 | $46,053 | **$628,078** |
| **South West Primary Care PCP** | $904,721 | $312,041 | $231,625 | **$1,448,387** |

| PCP | Salaries and Wages | General Expenses | Project Expenses | Total |
|---|---|---|---|---|
| **Southern Grampians Glenelg PCP** | $1,072,677 | $317,389 | $289,571 | **$1,679,637** |
| **Southern Mallee PCP** | $769,739 | $279,554 | $66,519 | **$1,115,812** |
| **Southern Melbourne Primary Care Partnership** | $1,453,735 | $367,763 | $241,693 | **$2,063,190** |
| **Upper Hume PCP** | $460,672 | $313,098 | $442,656 | **$1,216,426** |
| **Wellington PCP** | $777,117 | $211,456 | $69,666 | **$1,058,239** |
| **Wimmera PCP** | $1,258,581 | $908,441 | $- | **$2,167,022** |
| **TOTAL** | **$28,396,959** | **$10,770,832** | **$5,464,190** | **$44,631,981** |

## H.2 Detailed analysis of total PCP revenue

This section provides a detailed breakdown of PCP reported revenue by year and by type. PCP revenue is reported in three streams: PCP Program funding, other DHHS funding and other non-DHHS funding.

### H.2.1 Revenue by year

Table 7 reports on total revenue by PCP from 2015-16 to 2017-18. PCPs receive an average of around $550k each year in revenue, and this has fluctuated over the period analysed. Total revenue each year for the PCPs has ranged from $300,000 to over $1m.

The variability in revenue between PCPs is important in the context of other findings around the variability of PCPs in terms of perceived effectiveness, satisfaction and even stakeholder awareness of the Program.

*Table 7: Total revenue by PCP from 2015-16 to 2017-18.*

| PCP | 2015-16 | 2016-17 | 2017-18 | Total |
|---|---|---|---|---|
| **Bendigo Loddon PCP** | $488,029 | $430,675 | $487,162 | **$1,405,866** |
| **Campaspe PCP** | $542,142 | $563,099 | $510,275 | **$1,615,516** |
| **Central Highlands PCP** | $417,630 | $478,348 | $423,778 | **$1,319,756** |
| **Central Hume PCP** | $709,029 | $543,954 | $587,281 | **$1,840,263** |
| **Central Victorian PCP** | $381,508 | $479,471 | $637,562 | **$1,498,541** |
| **Central West Gippsland PCP** | $391,081 | $363,675 | $476,838 | **$1,231,594** |
| **East Gippsland PCP** | $318,106 | $477,295 | $357,411 | **$1,152,812** |
| **Enliven Victoria (The South East PCP)** | $694,276 | $642,488 | $555,220 | **$1,891,984** |

| PCP | 2015-16 | 2016-17 | 2017-18 | Total |
|---|---|---|---|---|
| **Frankston-Mornington Peninsula PCP** | $835,788 | $384,160 | $564,494 | **$1,784,442** |
| **G21** | $467,146 | $403,041 | $980,715 | **$1,850,902** |
| **Goulburn Valley PCP** | $376,121 | $384,535 | $373,427 | **$1,134,083** |
| **Grampians Pyrenees PCP** | $404,157 | $379,769 | $385,465 | **$1,169,391** |
| **HealthWest PCP** | $1,009,676 | $601,640 | $599,305 | **$2,210,621** |
| **Hume-Whittlesea PCP** | $931,240 | $909,203 | $996,206 | **$2,836,649** |
| **Inner East PCP** | $572,602 | $602,926 | $556,120 | **$1,731,648** |
| **Inner North West PCP** | $725,268 | $540,100 | $453,226 | **$1,718,593** |
| **Lower Hume PCP** | $385,504 | $329,380 | $352,622 | **$1,067,506** |
| **North East PCP** | $967,955 | $374,598 | $380,217 | **$1,722,770** |
| **Northern Mallee Community Partnership** | $440,738 | $378,644 | $394,980 | **$1,214,362** |
| **Outer East Health and Community Support Alliance** | $751,971 | $548,746 | $745,327 | **$2,046,044** |
| **South Coast PCP** | $297,483 | $310,103 | $325,994 | **$933,579** |
| **South West Primary Care PCP** | $362,654 | $487,584 | $647,000 | **$1,497,238** |
| **Southern Grampians Glenelg PCP** | $740,201 | $479,155 | $508,863 | **$1,728,218** |
| **Southern Mallee PCP** | $451,760 | $352,515 | $530,597 | **$1,334,872** |
| **Southern Melbourne Primary Care Partnership** | $630,059 | $665,910 | $627,114 | **$1,923,083** |
| **Upper Hume PCP** | $410,509 | $375,098 | $553,219 | **$1,338,826** |
| **Wellington PCP** | $348,061 | $340,796 | $348,189 | **$1,037,046** |
| **Wimmera PCP** | $713,637 | $713,244 | $543,151 | **$1,970,032** |
| **TOTAL** | **$15,764,331** | **$13,540,150** | **$14,901,757** | **$44,206,238** |

Table 8 below illustrates that all PCPs received PCP Program funding in 2015-16. The amounts ranged from over $250,000 to over $600,000, and made up over 60 per cent of total revenue. Not all PCPs reported other DHHS funding during the year, and the amounts varied from over $500,000 to as little as $16,000. Not all PCPs reported revenue from other sources, however some reported amounts over $400,000.

*Table 8: Revenue by source and PCP in 2015-16.*

| PCP | PCP Program | Other DHHS | Other Revenue | Total |
|---|---|---|---|---|
| **Bendigo Loddon PCP** | $371,011 | $100,000 | $17,018 | **$488,029** |
| **Campaspe PCP** | $269,069 | $60,000 | $213,074 | **$542,142** |
| **Central Highlands PCP** | $410,748 | $- | $6,882 | **$417,630** |
| **Central Hume PCP** | $325,572 | $169,086 | $214,371 | **$709,029** |
| **Central Victorian PCP** | $350,392 | $6,000 | $25,116 | **$381,508** |
| **Central West Gippsland PCP** | $344,598 | $- | $46,483 | **$391,081** |
| **East Gippsland PCP** | $305,519 | $- | $12,587 | **$318,106** |
| **Enliven Victoria (The South East PCP)** | $359,386 | $68,500 | $266,390 | **$694,276** |
| **Frankston-Mornington Peninsula PCP** | $329,221 | $188,767 | $317,800 | **$835,788** |
| **G21** | $393,578 | $- | $73,568 | **$467,146** |
| **Goulburn Valley PCP** | $348,505 | $- | $27,616 | **$376,121** |
| **Grampians Pyrenees PCP** | $404,157 | $- | $- | **$404,157** |
| **HealthWest PCP** | $569,104 | $304,017 | $136,555 | **$1,009,676** |
| **Hume-Whittlesea PCP** | $381,091 | $408,201 | $141,948 | **$931,240** |
| **Inner East PCP** | $554,824 | $12,056 | $5,722 | **$572,602** |
| **Inner North West PCP** | $418,901 | $289,225 | $17,142 | **$725,268** |
| **Lower Hume PCP** | $270,950 | $- | $114,554 | **$385,504** |
| **North East PCP** | $369,063 | $590,730 | $8,162 | **$967,955** |
| **Northern Mallee Community Partnership** | $331,604 | $25,000 | $84,134 | **$440,738** |
| **Outer East Health and Community Support Alliance** | $432,262 | $237,781 | $81,928 | **$751,971** |
| **South Coast PCP** | $295,068 | $- | $2,415 | **$297,483** |
| **South West Primary Care PCP** | $357,865 | $- | $4,789 | **$362,654** |
| **Southern Grampians Glenelg PCP** | $323,063 | $- | $417,138 | **$740,201** |
| **Southern Mallee PCP** | $335,768 | $55,000 | $60,992 | **$451,760** |

| PCP | PCP Program | Other DHHS | Other Revenue | Total |
|---|---|---|---|---|
| **Southern Melbourne Primary Care Partnership** | $600,813 | $- | $29,246 | **$630,059** |
| **Upper Hume PCP** | $284,400 | $125,518 | $591 | **$410,509** |
| **Wellington PCP** | $333,833 | $- | $14,228 | **$348,061** |
| **Wimmera PCP** | $363,133 | $16,700 | $333,804 | **$713,637** |
| **TOTAL** | **$10,433,497** | **$2,656,581** | **$2,674,252** | **$15,764,331** |

Table 9 below illustrates that all PCPs received PCP Program funding in 2016-17. The amounts ranged from $250,000 to over $600,000, and made up over 70 per cent of total revenue. Again, not all PCPs reported other DHHS funding during the year, and the amounts ranged from over $200,000 to as little as $15,000. Not all reported revenue from other sources, however some reported amounts over $200,000.

*Table 9: Revenue by source and PCP in 2016-17.*

| PCP | PCP Program | Other DHHS | Other Revenue | Total |
|---|---|---|---|---|
| **Bendigo Loddon PCP** | $361,351 | $15,000 | $54,324 | **$430,675** |
| **Campaspe PCP** | $273,105 | $68,086 | $221,908 | **$563,099** |
| **Central Highlands PCP** | $416,909 | $52,529 | $8,910 | **$478,348** |
| **Central Hume PCP** | $330,455 | $195,583 | $17,916 | **$543,954** |
| **Central Victorian PCP** | $340,423 | $92,160 | $46,888 | **$479,471** |
| **Central West Gippsland PCP** | $349,767 | $- | $13,908 | **$363,675** |
| **East Gippsland PCP** | $321,695 | $- | $155,600 | **$477,295** |
| **Enliven Victoria (The South East PCP)** | $394,777 | $- | $247,711 | **$642,488** |
| **Frankston-Mornington Peninsula PCP** | $364,160 | $20,000 | $- | **$384,160** |
| **G21** | $399,482 | $- | $3,559 | **$403,041** |
| **Goulburn Valley PCP** | $353,733 | $20,816 | $9,986 | **$384,535** |
| **Grampians Pyrenees PCP** | $379,769 | $- | $- | **$379,769** |
| **HealthWest PCP** | $577,640 | $- | $24,000 | **$601,640** |
| **Hume-Whittlesea PCP** | $386,807 | $509,464 | $12,932 | **$909,203** |
| **Inner East PCP** | $510,366 | $87,149 | $5,411 | **$602,926** |
| **Inner North West PCP** | $522,185 | $- | $17,915 | **$540,100** |
| **Lower Hume PCP** | $275,015 | $- | $54,365 | **$329,380** |

| PCP | PCP Program | Other DHHS | Other Revenue | Total |
|---|---|---|---|---|
| **North East PCP** | $374,598 | $- | $- | **$374,598** |
| **Northern Mallee Community Partnership** | $336,579 | $15,000 | $27,065 | **$378,644** |
| **Outer East Health and Community Support Alliance** | $468,746 | $30,000 | $50,000 | **$548,746** |
| **South Coast PCP** | $310,103 | $- | $- | **$310,103** |
| **South West Primary Care PCP** | $363,233 | $85,000 | $39,351 | **$487,584** |
| **Southern Grampians Glenelg PCP** | $327,909 | $- | $151,246 | **$479,155** |
| **Southern Mallee PCP** | $310,355 | $- | $42,161 | **$352,515** |
| **Southern Melbourne Primary Care Partnership** | $609,825 | $- | $56,085 | **$665,910** |
| **Upper Hume PCP** | $288,656 | $- | $86,442 | **$375,098** |
| **Wellington PCP** | $338,841 | $- | $1,955 | **$340,796** |
| **Wimmera PCP** | $307,680 | $249,829 | $155,735 | **$713,244** |
| **TOTAL** | **$10,594,162** | **$1,440,616** | **$1,505,372** | **$13,540,150** |

Table 10 below illustrates that all PCPs reported PCP Program funding in 2017-18. The amounts ranged from over $250,000 to over $600,000. Again, not all PCPs reported other DHHS funding during the year, and the amounts reported ranged from nearly $300,000 to as little as $4,000. Similar to the previous two years, not all PCPs are reported revenue from other sources, however some reported increased amounts close to $500,000. G21 reported $490,241 in other funding, which may indicate that the model of embedding the PCP Program within more substantial structures assist in attracting additional funding sources.

*Table 10: Revenue by source and PCP in 2017-18.*

| PCP | PCP Program | Other DHHS | Other Revenue | Total |
|---|---|---|---|---|
| **Bendigo Loddon PCP** | $410,948 | $40,000 | $36,214 | **$487,162** |
| **Campaspe PCP** | $277,201 | $20,000 | $213,074 | **$510,275** |
| **Central Highlands PCP** | $423,163 | $- | $615 | **$423,778** |
| **Central Hume PCP** | $335,412 | $217,294 | $34,574 | **$587,281** |
| **Central Victorian PCP** | $345,529 | $167,740 | $124,293 | **$637,562** |
| **Central West Gippsland PCP** | $425,013 | $16,521 | $35,304 | **$476,838** |
| **East Gippsland PCP** | $315,337 | $- | $42,074 | **$357,411** |

| PCP | PCP Program | Other DHHS | Other Revenue | Total |
|---|---|---|---|---|
| **Enliven Victoria (The South East PCP)** | $370,249 | $166,655 | $18,316 | **$555,220** |
| **Frankston-Mornington Peninsula PCP** | $339,172 | $225,322 | $- | **$564,494** |
| **G21** | $405,474 | $85,000 | $490,241 | **$980,715** |
| **Goulburn Valley PCP** | $359,039 | $9,182 | $5,206 | **$373,427** |
| **Grampians Pyrenees PCP** | $385,465 | $- | $- | **$385,465** |
| **HealthWest PCP** | $586,305 | $- | $13,000 | **$599,305** |
| **Hume-Whittlesea PCP** | $392,609 | $180,288 | $423,309 | **$996,206** |
| **Inner East PCP** | $518,021 | $31,093 | $7,006 | **$556,120** |
| **Inner North West PCP** | $431,562 | $- | $21,663 | **$453,226** |
| **Lower Hume PCP** | $279,140 | $15,000 | $58,482 | **$352,622** |
| **North East PCP** | $380,217 | $- | $- | **$380,217** |
| **Northern Mallee Community Partnership** | $341,627 | $- | $53,353 | **$394,980** |
| **Outer East Health and Community Support Alliance** | $445,327 | $290,000 | $10,000 | **$745,327** |
| **South Coast PCP** | $314,754 | $- | $11,240 | **$325,994** |
| **South West Primary Care PCP** | $368,681 | $239,403 | $38,916 | **$647,000** |
| **Southern Grampians Glenelg PCP** | $332,828 | $170,998 | $5,038 | **$508,863** |
| **Southern Mallee PCP** | $315,010 | $190,000 | $25,587 | **$530,597** |
| **Southern Melbourne Primary Care Partnership** | $618,972 | $- | $8,142 | **$627,114** |
| **Upper Hume PCP** | $292,995 | $128,001 | $132,223 | **$553,219** |
| **Wellington PCP** | $343,923 | $4,266 | $- | **$348,189** |
| **Wimmera PCP** | $312,295 | $222,870 | $7,987 | **$543,151** |
| **TOTAL** | **$10,666,268** | **$2,419,632** | **$1,815,857** | **$14,901,757** |

### H.2.2 Revenue by type

Table 11 reports on PCP Program funding by PCP from 2015-16 to 2017-18. PCPs receive an average of around $400,000 each year in PCP Program funding, and that has steadily increased over the time period.

Total PCP Program funding each year for individual PCPs has ranged from $270,000 to over $600,000.

*Table 11: PCP Program funding by PCP from 2015-16 to 2017-18.*

| PCP | 2015-16 | 2016-17 | 2017-18 | Total |
|---|---|---|---|---|
| **Bendigo Loddon PCP** | $371,011 | $361,351 | $410,948 | **$1,143,310** |
| **Campaspe PCP** | $269,069 | $273,105 | $277,201 | **$819,374** |
| **Central Highlands PCP** | $410,748 | $416,909 | $423,163 | **$1,250,820** |
| **Central Hume PCP** | $325,572 | $330,455 | $335,412 | **$991,439** |
| **Central Victorian PCP** | $350,392 | $340,423 | $345,529 | **$1,036,344** |
| **Central West Gippsland PCP** | $344,598 | $349,767 | $425,013 | **$1,119,378** |
| **East Gippsland PCP** | $305,519 | $321,695 | $315,337 | **$942,551** |
| **Enliven Victoria (The South East PCP)** | $359,386 | $394,777 | $370,249 | **$1,124,412** |
| **Frankston-Mornington Peninsula PCP** | $329,221 | $364,160 | $339,172 | **$1,032,553** |
| **G21** | $393,578 | $399,482 | $405,474 | **$1,198,534** |
| **Goulburn Valley PCP** | $348,505 | $353,733 | $359,039 | **$1,061,277** |
| **Grampians Pyrenees PCP** | $404,157 | $379,769 | $385,465 | **$1,169,391** |
| **HealthWest PCP** | $569,104 | $577,640 | $586,305 | **$1,733,049** |
| **Hume-Whittlesea PCP** | $381,091 | $386,807 | $392,609 | **$1,160,508** |
| **Inner East PCP** | $554,824 | $510,366 | $518,021 | **$1,583,210** |
| **Inner North West PCP** | $418,901 | $522,185 | $431,562 | **$1,372,648** |
| **Lower Hume PCP** | $270,950 | $275,015 | $279,140 | **$825,105** |
| **North East PCP** | $369,063 | $374,598 | $380,217 | **$1,123,878** |
| **Northern Mallee Community Partnership** | $331,604 | $336,579 | $341,627 | **$1,009,810** |
| **Outer East Health and Community Support Alliance** | $432,262 | $468,746 | $445,327 | **$1,346,335** |
| **South Coast PCP** | $295,068 | $310,103 | $314,754 | **$919,925** |
| **South West Primary Care PCP** | $357,865 | $363,233 | $368,681 | **$1,089,779** |
| **Southern Grampians Glenelg PCP** | $323,063 | $327,909 | $332,828 | **$983,799** |

| PCP | 2015-16 | 2016-17 | 2017-18 | Total |
|---|---|---|---|---|
| **Southern Mallee PCP** | $335,768 | $310,355 | $315,010 | **$961,132** |
| **Southern Melbourne Primary Care Partnership** | $600,813 | $609,825 | $618,972 | **$1,829,609** |
| **Upper Hume PCP** | $284,400 | $288,656 | $292,995 | **$866,051** |
| **Wellington PCP** | $333,833 | $338,841 | $343,923 | **$1,016,597** |
| **Wimmera PCP** | $363,133 | $307,680 | $312,295 | **$983,108** |
| **TOTAL** | **$10,433,497** | **$10,594,162** | **$10,666,268** | **$31,693,927** |

Table 12 below reports on other DHHS funding by PCP from 2015-16 to 2017-18. PCPs report an average of around $80,000 each year in other DHHS funding, however not all PCPs report having received other DHHS funding. Other DHHS funding each year for individual PCPs has ranged from under $5,000 to over $500,000.

*Table 12: Other DHHS funding by PCP from 2015-16 to 2017-18.*

| PCP | 2015-16 | 2016-17 | 2017-18 | Total |
|---|---|---|---|---|
| **Bendigo Loddon PCP** | $100,000 | $15,000 | $40,000 | **$155,000** |
| **Campaspe PCP** | $60,000 | $68,086 | $20,000 | **$148,086** |
| **Central Highlands PCP** | $- | $52,529 | $- | **$52,529** |
| **Central Hume PCP** | $169,086 | $195,583 | $217,294 | **$581,963** |
| **Central Victorian PCP** | $6,000 | $92,160 | $167,740 | **$265,900** |
| **Central West Gippsland PCP** | $- | $- | $16,521 | **$16,521** |
| **East Gippsland PCP** | $- | $- | $- | **$-** |
| **Enliven Victoria (The South East PCP)** | $68,500 | $- | $166,655 | **$235,155** |
| **Frankston-Mornington Peninsula PCP** | $188,767 | $20,000 | $225,322 | **$434,089** |
| **G21** | $- | $- | $85,000 | **$85,000** |
| **Goulburn Valley PCP** | $- | $20,816 | $9,182 | **$29,998** |
| **Grampians Pyrenees PCP** | $- | $- | $- | **$-** |
| **HealthWest PCP** | $304,017 | $- | $- | **$304,017** |
| **Hume-Whittlesea PCP** | $408,201 | $509,464 | $180,288 | **$1,097,953** |
| **Inner East PCP** | $12,056 | $87,149 | $31,093 | **$130,299** |
| **Inner North West PCP** | $289,225 | $- | $- | **$289,225** |

| PCP | 2015-16 | 2016-17 | 2017-18 | Total |
|---|---|---|---|---|
| **Lower Hume PCP** | $- | $- | $15,000 | **$15,000** |
| **North East PCP** | $590,730 | $- | $- | **$590,730** |
| **Northern Mallee Community Partnership** | $25,000 | $15,000 | $- | **$40,000** |
| **Outer East Health and Community Support Alliance** | $237,781 | $30,000 | $290,000 | **$557,781** |
| **South Coast PCP** | $- | $- | $- | **$-** |
| **South West Primary Care PCP** | $- | $85,000 | $239,403 | **$324,403** |
| **Southern Grampians Glenelg PCP** | $- | $- | $170,998 | **$170,998** |
| **Southern Mallee PCP** | $55,000 | $- | $190,000 | **$245,000** |
| **Southern Melbourne Primary Care Partnership** | $- | $- | $- | **$-** |
| **Upper Hume PCP** | $125,518 | $- | $128,001 | **$253,519** |
| **Wellington PCP** | $- | $- | $4,266 | **$4,266** |
| **Wimmera PCP** | $16,700 | $249,829 | $222,870 | **$489,399** |
| **TOTAL** | **$2,656,581** | **$1,440,616** | **$2,419,632** | **$6,516,830** |

Table 13 below reports on other revenue reported by PCP from 2015-16 to 2017-18. PCPs report an average of around $70,000 each year in other revenue, however not all PCPs are reporting other revenue sources. Other revenuer reported each year for individual PCPs has ranged from under $1,000 to close to $500,000.

*Table 13: Other revenue reported by PCP from 2015-16 to 2017-18.*

| PCP | 2015-16 | 2016-17 | 2017-18 | Total |
|---|---|---|---|---|
| **Bendigo Loddon PCP** | $17,018 | $54,324 | $36,214 | **$107,556** |
| **Campaspe PCP** | $213,074 | $221,908 | $213,074 | **$648,056** |
| **Central Highlands PCP** | $6,882 | $8,910 | $615 | **$16,407** |
| **Central Hume PCP** | $214,371 | $17,916 | $34,574 | **$266,861** |
| **Central Victorian PCP** | $25,116 | $46,888 | $124,293 | **$196,297** |
| **Central West Gippsland PCP** | $46,483 | $13,908 | $35,304 | **$95,695** |
| **East Gippsland PCP** | $12,587 | $155,600 | $42,074 | **$210,261** |

| PCP | 2015-16 | 2016-17 | 2017-18 | Total |
|---|---|---|---|---|
| **Enliven Victoria (The South East PCP)** | $266,390 | $247,711 | $18,316 | **$532,417** |
| **Frankston-Mornington Peninsula PCP** | $317,800 | $- | $- | **$317,800** |
| **G21** | $73,568 | $3,559 | $490,241 | **$567,368** |
| **Goulburn Valley PCP** | $27,616 | $9,986 | $5,206 | **$42,808** |
| **Grampians Pyrenees PCP** | $- | $- | $- | **$-** |
| **HealthWest PCP** | $136,555 | $24,000 | $13,000 | **$173,555** |
| **Hume-Whittlesea PCP** | $141,948 | $12,932 | $423,309 | **$578,189** |
| **Inner East PCP** | $5,722 | $5,411 | $7,006 | **$18,139** |
| **Inner North West PCP** | $17,142 | $17,915 | $21,663 | **$56,720** |
| **Lower Hume PCP** | $114,554 | $54,365 | $58,482 | **$227,401** |
| **North East PCP** | $8,162 | $- | $- | **$8,162** |
| **Northern Mallee Community Partnership** | $84,134 | $27,065 | $53,353 | **$164,552** |
| **Outer East Health and Community Support Alliance** | $81,928 | $50,000 | $10,000 | **$141,928** |
| **South Coast PCP** | $2,415 | $- | $11,240 | **$13,655** |
| **South West Primary Care PCP** | $4,789 | $39,351 | $38,916 | **$83,056** |
| **Southern Grampians Glenelg PCP** | $417,138 | $151,246 | $5,038 | **$573,421** |
| **Southern Mallee PCP** | $60,992 | $42,161 | $25,587 | **$128,740** |
| **Southern Melbourne Primary Care Partnership** | $29,246 | $56,085 | $8,142 | **$93,473** |
| **Upper Hume PCP** | $591 | $86,442 | $132,223 | **$219,256** |
| **Wellington PCP** | $14,228 | $1,955 | $- | **$16,183** |
| **Wimmera PCP** | $333,804 | $155,735 | $7,987 | **$497,526** |
| **TOTAL** | **$2,674,252** | **$1,505,372** | **$1,815,857** | **$5,995,481** |

## H.3 Detailed analysis of PCP spending

This section provides a detailed breakdown of PCP spending by year and by type.

## H.3.1 Spending by year

Table 14 illustrates that PCPs reported an average spend of between just under $500,000 and just over $550,000 each year. Total spending each year for individual PCPs has ranged from just under $300,000 to over $1m.

*Table 14: Total spending by PCP from 2015-16 to 2017-18.*

| PCP | 2015-16 | 2016-17 | 2017-18 | Total |
|---|---|---|---|---|
| **Bendigo Loddon PCP** | $412,011 | $491,216 | $394,896 | **$1,298,123** |
| **Campaspe PCP** | $460,035 | $530,131 | $501,988 | **$1,492,154** |
| **Central Highlands PCP** | $394,930 | $351,887 | $381,434 | **$1,128,251** |
| **Central Hume PCP** | $728,689 | $863,911 | $558,275 | **$2,150,875** |
| **Central Victorian PCP** | $305,375 | $394,250 | $429,372 | **$1,128,997** |
| **Central West Gippsland PCP** | $369,924 | $350,712 | $358,100 | **$1,078,736** |
| **East Gippsland PCP** | $292,606 | $279,297 | $309,327 | **$881,229** |
| **Enliven Victoria (The South East PCP)** | $421,169 | $559,775 | $659,478 | **$1,640,422** |
| **Frankston-Mornington Peninsula PCP** | $820,502 | $- | $821,441 | **$1,641,943** |
| **G21** | $1,085,739 | $359,623 | $1,102,621 | **$2,547,983** |
| **Goulburn Valley PCP** | $376,858 | $447,511 | $490,528 | **$1,314,897** |
| **Grampians Pyrenees PCP** | $514,470 | $693,970 | $424,194 | **$1,632,634** |
| **HealthWest PCP** | $1,166,121 | $1,272,000 | $924,000 | **$3,362,121** |
| **Hume-Whittlesea PCP** | $852,342 | $909,203 | $996,206 | **$2,757,751** |
| **Inner East PCP** | $858,873 | $576,236 | $540,968 | **$1,976,078** |
| **Inner North West PCP** | $677,864 | $465,193 | $523,085 | **$1,666,142** |
| **Lower Hume PCP** | $370,277 | $365,217 | $341,738 | **$1,077,232** |
| **North East PCP** | $970,980 | $- | $452,426 | **$1,423,406** |
| **Northern Mallee Community Partnership** | $401,089 | $439,681 | $426,625 | **$1,267,395** |
| **Outer East Health and Community Support Alliance** | $613,780 | $607,159 | $567,881 | **$1,788,820** |
| **South Coast PCP** | $332,661 | $68,000 | $227,417 | **$628,078** |
| **South West Primary Care PCP** | $442,094 | $518,557 | $487,737 | **$1,448,387** |

| PCP | 2015-16 | 2016-17 | 2017-18 | Total |
|---|---|---|---|---|
| **Southern Grampians Glenelg PCP** | $747,318 | $469,793 | $462,526 | **$1,679,637** |
| **Southern Mallee PCP** | $311,350 | $376,498 | $427,964 | **$1,115,812** |
| **Southern Melbourne Primary Care Partnership** | $651,099 | $729,362 | $682,730 | **$2,063,190** |
| **Upper Hume PCP** | $286,644 | $369,112 | $560,670 | **$1,216,426** |
| **Wellington PCP** | $394,317 | $331,601 | $332,321 | **$1,058,239** |
| **Wimmera PCP** | $629,109 | $891,397 | $646,516 | **$2,167,022** |
| **TOTAL** | **$15,888,226** | **$13,711,292** | **$15,032,463** | **$44,631,981** |

Table 15 illustrates that in 2015-16 all PCPs reported spending on salaries and wages, and amounts ranged from $75,000 to over $650,000. Salaries and Wages represented an average of 60 per cent of spending for the year.

In addition to salaries and wages, all PCPs reported spending on general expenses, and the amounts varied from over $50,000 to $500,000. Not all PCPs reported spending on project expenses, but some reported amounts over $300,000.

*Table 15: Spending reported type and by PCP for 2015-16.*

| PCP | Salaries and Wages | General Expenses | Project Expenses | Total |
|---|---|---|---|---|
| **Bendigo Loddon PCP** | $301,874 | $106,217 | $3,920 | **$412,011** |
| **Campaspe PCP** | $321,264 | $83,715 | $55,056 | **$460,035** |
| **Central Highlands PCP** | $261,769 | $133,161 | $- | **$394,930** |
| **Central Hume PCP** | $261,068 | $174,625 | $292,996 | **$728,689** |
| **Central Victorian PCP** | $244,001 | $55,624 | $5,750 | **$305,375** |
| **Central West Gippsland PCP** | $266,920 | $75,698 | $27,306 | **$369,924** |
| **East Gippsland PCP** | $207,859 | $63,931 | $20,816 | **$292,606** |
| **Enliven Victoria (The South East PCP)** | $219,894 | $201,275 | $- | **$421,169** |
| **Frankston-Mornington Peninsula PCP** | $603,958 | $126,359 | $90,185 | **$820,502** |
| **G21** | $666,314 | $419,425 | $- | **$1,085,739** |
| **Goulburn Valley PCP** | $278,819 | $67,364 | $30,675 | **$376,858** |
| **Grampians Pyrenees PCP** | $335,965 | $158,246 | $20,259 | **$514,470** |
| **HealthWest PCP** | $680,978 | $169,812 | $315,331 | **$1,166,121** |

| PCP | Salaries and Wages | General Expenses | Project Expenses | Total |
|---|---|---|---|---|
| **Hume-Whittlesea PCP** | $593,663 | $156,279 | $102,400 | **$852,342** |
| **Inner East PCP** | $490,825 | $122,704 | $245,344 | **$858,873** |
| **Inner North West PCP** | $487,449 | $57,415 | $133,000 | **$677,864** |
| **Lower Hume PCP** | $265,928 | $99,460 | $4,889 | **$370,277** |
| **North East PCP** | $468,455 | $502,525 | $- | **$970,980** |
| **Northern Mallee Community Partnership** | $232,082 | $158,723 | $10,284 | **$401,089** |
| **Outer East Health and Community Support Alliance** | $229,092 | $103,624 | $281,064 | **$613,780** |
| **South Coast PCP** | $231,543 | $80,678 | $20,440 | **$332,661** |
| **South West Primary Care PCP** | $232,857 | $100,024 | $109,213 | **$442,094** |
| **Southern Grampians Glenelg PCP** | $444,079 | $13,668 | $289,571 | **$747,318** |
| **Southern Mallee PCP** | $243,232 | $68,118 | $- | **$311,350** |
| **Southern Melbourne Primary Care Partnership** | $429,026 | $120,914 | $101,159 | **$651,099** |
| **Upper Hume PCP** | $74,507 | $72,332 | $139,805 | **$286,644** |
| **Wellington PCP** | $285,659 | $97,774 | $10,884 | **$394,317** |
| **Wimmera PCP** | $427,835 | $201,274 | $- | **$629,109** |
| **TOTAL** | **$9,786,914** | **$3,790,964** | **$2,310,348** | **$15,888,226** |

Table 16 illustrates that in 2016-17 all PCPs reported spending on salaries and wages, and amounts ranged from under $70,000 to over $800,000. Salaries and Wages was over 60 per cent of spending for the year.

In addition to salaries and wages, all PCPs reported spending on general expenses, and the amounts varied from over $50,000 to $480,000. Not all PCPs reported spending on project expenses, but some reported amounts over $300,000.

*Table 16: Spending reported type and by PCP for 2016-17.*

| PCP | Salaries and wages | General Expenses | Project Expenses | Total |
|---|---|---|---|---|
| **Bendigo Loddon PCP** | $319,912 | $59,158 | $112,146 | **$491,216** |
| **Campaspe PCP** | $360,931 | $108,431 | $60,769 | **$530,131** |
| **Central Highlands PCP** | $247,531 | $104,356 | $- | **$351,887** |
| **Central Hume PCP** | $367,703 | $185,960 | $310,248 | **$863,911** |

| PCP | Salaries and wages | General Expenses | Project Expenses | Total |
|---|---|---|---|---|
| **Central Victorian PCP** | $296,069 | $58,001 | $40,180 | **$394,250** |
| **Central West Gippsland PCP** | $229,761 | $71,572 | $49,379 | **$350,712** |
| **East Gippsland PCP** | $198,025 | $81,272 | $- | **$279,297** |
| **Enliven Victoria (The South East PCP)** | $405,800 | $153,975 | $- | **$559,775** |
| **Frankston-Mornington Peninsula PCP** | $- | $- | $- | **$-** |
| **G21** | $225,297 | $90,923 | $43,403 | **$359,623** |
| **Goulburn Valley PCP** | $299,987 | $84,385 | $63,139 | **$447,511** |
| **Grampians Pyrenees PCP** | $343,189 | $350,781 | $- | **$693,970** |
| **HealthWest PCP** | $821,000 | $451,000 | $- | **$1,272,000** |
| **Hume-Whittlesea PCP** | $647,964 | $138,370 | $122,869 | **$909,203** |
| **Inner East PCP** | $421,756 | $78,296 | $76,184 | **$576,236** |
| **Inner North West PCP** | $314,461 | $76,778 | $73,955 | **$465,193** |
| **Lower Hume PCP** | $267,040 | $86,154 | $12,023 | **$365,217** |
| **North East PCP** | $- | $- | $- | **$-** |
| **Northern Mallee Community Partnership** | $273,231 | $94,235 | $72,215 | **$439,681** |
| **Outer East Health and Community Support Alliance** | $309,686 | $119,935 | $177,538 | **$607,159** |
| **South Coast PCP** | $68,000 | $- | $- | **$68,000** |
| **South West Primary Care PCP** | $327,042 | $98,926 | $92,589 | **$518,557** |
| **Southern Grampians Glenelg PCP** | $323,656 | $146,136 | $- | **$469,793** |
| **Southern Mallee PCP** | $217,577 | $132,271 | $26,651 | **$376,498** |
| **Southern Melbourne Primary Care Partnership** | $540,338 | $125,587 | $63,437 | **$729,362** |
| **Upper Hume PCP** | $175,441 | $80,744 | $112,927 | **$369,112** |
| **Wellington PCP** | $229,054 | $55,239 | $47,308 | **$331,601** |
| **Wimmera PCP** | $407,869 | $483,528 | $- | **$891,397** |
| **TOTAL** | **$8,638,321** | **$3,516,012** | **$1,556,959** | **$13,711,292** |

Table 17 below illustrates that in 2017-18 all PCPs reported spending on salaries and wages, and amounts increased from the previous years, ranging from close to $120,000 to close to $750,000. Salaries and Wages remained at just over 60 per cent of spending for the year.

In addition to salaries and wages, all PCPs reported spending on general expenses, and the amounts again ranged from over $50,000 to $450,000. Not all PCPs reported spending on project expenses, but some again reported amounts close to $300,000.

*Table 17: Spending reported type and by PCP for 2017-18.*

| PCP | Salaries and Wages | General Expenses | Project Expenses | Total |
|---|---|---|---|---|
| **Bendigo Loddon PCP** | $284,916 | $67,163 | $42,817 | **$394,896** |
| **Campaspe PCP** | $363,216 | $83,715 | $55,057 | **$501,988** |
| **Central Highlands PCP** | $266,405 | $90,029 | $25,000 | **$381,434** |
| **Central Hume PCP** | $326,730 | $133,811 | $97,734 | **$558,275** |
| **Central Victorian PCP** | $178,406 | $69,744 | $181,222 | **$429,372** |
| **Central West Gippsland PCP** | $223,697 | $103,923 | $30,480 | **$358,100** |
| **East Gippsland PCP** | $221,645 | $59,382 | $28,300 | **$309,327** |
| **Enliven Victoria (The South East PCP)** | $462,301 | $197,177 | $- | **$659,478** |
| **Frankston-Mornington Peninsula PCP** | $509,632 | $252,595 | $59,214 | **$821,441** |
| **G21** | $650,490 | $452,131 | $- | **$1,102,621** |
| **Goulburn Valley PCP** | $370,163 | $120,365 | $- | **$490,528** |
| **Grampians Pyrenees PCP** | $304,778 | $119,416 | $- | **$424,194** |
| **HealthWest PCP** | $634,000 | $- | $290,000 | **$924,000** |
| **Hume-Whittlesea PCP** | $741,226 | $146,095 | $108,884 | **$996,206** |
| **Inner East PCP** | $385,679 | $77,536 | $77,753 | **$540,968** |
| **Inner North West PCP** | $391,405 | $83,293 | $48,387 | **$523,085** |
| **Lower Hume PCP** | $238,442 | $68,566 | $34,730 | **$341,738** |
| **North East PCP** | $277,445 | $174,981 | $- | **$452,426** |
| **Northern Mallee Community Partnership** | $334,089 | $64,121 | $28,415 | **$426,625** |
| **Outer East Health and Community Support Alliance** | $348,567 | $104,225 | $115,089 | **$567,881** |
| **South Coast PCP** | $119,421 | $82,382 | $25,613 | **$227,417** |
| **South West Primary Care PCP** | $344,822 | $113,091 | $29,823 | **$487,737** |
| **Southern Grampians Glenelg PCP** | $304,941 | $157,585 | $- | **$462,526** |
| **Southern Mallee PCP** | $308,931 | $79,164 | $39,869 | **$427,964** |

| PCP | Salaries and Wages | General Expenses | Project Expenses | Total |
|---|---|---|---|---|
| **Southern Melbourne Primary Care Partnership** | $484,371 | $121,262 | $77,097 | **$682,730** |
| **Upper Hume PCP** | $210,724 | $160,022 | $189,924 | **$560,670** |
| **Wellington PCP** | $262,404 | $58,443 | $11,474 | **$332,321** |
| **Wimmera PCP** | $422,877 | $223,639 | $- | **$646,516** |
| **TOTAL** | **$9,971,724** | **$3,463,856** | **$1,596,883** | **$15,032,463** |

## H.4 Spending by Type

Table 18 below reports on PCP spending on Salaries and Wages from 2015-16 to 2017-18. PCPs spend an average of around $330,000 each year on Salaries and Wages, and amounts ranged from just over $70,000 to over $800,000. There was an average of around $9m on Salaries and Wages spent across all PCPs each year.

*Table 18: Spending on Salaries and Wages by PCP from 2015-16 to 2017-18.*

| PCP | 2015-16 | 2016-17 | 2017-18 | Total |
|---|---|---|---|---|
| **Bendigo Loddon PCP** | $301,874 | $319,912 | $284,916 | **$906,702** |
| **Campaspe PCP** | $321,264 | $360,931 | $363,216 | **$1,045,411** |
| **Central Highlands PCP** | $261,769 | $247,531 | $266,405 | **$775,705** |
| **Central Hume PCP** | $261,068 | $367,703 | $326,730 | **$955,501** |
| **Central Victorian PCP** | $244,001 | $296,069 | $178,406 | **$718,476** |
| **Central West Gippsland PCP** | $266,920 | $229,761 | $223,697 | **$720,378** |
| **East Gippsland PCP** | $207,859 | $198,025 | $221,645 | **$627,529** |
| **Enliven Victoria (The South East PCP)** | $219,894 | $405,800 | $462,301 | **$1,087,995** |
| **Frankston-Mornington Peninsula PCP** | $603,958 | $- | $509,632 | **$1,113,590** |
| **G21** | $666,314 | $225,297 | $650,490 | **$1,542,101** |
| **Goulburn Valley PCP** | $278,819 | $299,987 | $370,163 | **$948,969** |
| **Grampians Pyrenees PCP** | $335,965 | $343,189 | $304,778 | **$983,932** |
| **HealthWest PCP** | $680,978 | $821,000 | $634,000 | **$2,135,978** |
| **Hume-Whittlesea PCP** | $593,663 | $647,964 | $741,226 | **$1,982,853** |
| **Inner East PCP** | $490,825 | $421,756 | $385,679 | **$1,298,260** |

| PCP | 2015-16 | 2016-17 | 2017-18 | Total |
|---|---|---|---|---|
| **Inner North West PCP** | $487,449 | $314,461 | $391,405 | **$1,193,314** |
| **Lower Hume PCP** | $265,928 | $267,040 | $238,442 | **$771,410** |
| **North East PCP** | $468,455 | $- | $277,445 | **$745,900** |
| **Northern Mallee Community Partnership** | $232,082 | $273,231 | $334,089 | **$839,402** |
| **Outer East Health and Community Support Alliance** | $229,092 | $309,686 | $348,567 | **$887,345** |
| **South Coast PCP** | $231,543 | $68,000 | $119,421 | **$418,964** |
| **South West Primary Care PCP** | $232,857 | $327,042 | $344,822 | **$904,721** |
| **Southern Grampians Glenelg PCP** | $444,079 | $323,656 | $304,941 | **$1,072,677** |
| **Southern Mallee PCP** | $243,232 | $217,577 | $308,931 | **$769,739** |
| **Southern Melbourne Primary Care Partnership** | $429,026 | $540,338 | $484,371 | **$1,453,735** |
| **Upper Hume PCP** | $74,507 | $175,441 | $210,724 | **$460,672** |
| **Wellington PCP** | $285,659 | $229,054 | $262,404 | **$777,117** |
| **Wimmera PCP** | $427,835 | $407,869 | $422,877 | **$1,258,581** |
| **TOTAL** | **$9,786,914** | **$8,638,321** | **$9,971,724** | **$28,396,959** |

Table 19 below reports on PCP spending on General Expenses from 2015-16 to 2017-18. PCPs spend an average of just over $120,000 each year on General Expenses, and amounts ranged from just over $50,000 to just over $500,000. There was an average of around $3.5m on general expenses spent across all PCPs each year.

*Table 19: Spending on General Expenses by PCP from 2015-16 to 2017-18.*

| PCP | 2015-16 | 2016-17 | 2017-18 | Total |
|---|---|---|---|---|
| **Bendigo Loddon PCP** | $106,217 | $59,158 | $67,163 | **$232,538** |
| **Campaspe PCP** | $83,715 | $108,431 | $83,715 | **$275,861** |
| **Central Highlands PCP** | $133,161 | $104,356 | $90,029 | **$327,546** |
| **Central Hume PCP** | $174,625 | $185,960 | $133,811 | **$494,396** |
| **Central Victorian PCP** | $55,624 | $58,001 | $69,744 | **$183,369** |
| **Central West Gippsland PCP** | $75,698 | $71,572 | $103,923 | **$251,193** |
| **East Gippsland PCP** | $63,931 | $81,272 | $59,382 | **$204,585** |

| PCP | 2015-16 | 2016-17 | 2017-18 | Total |
|---|---|---|---|---|
| **Enliven Victoria (The South East PCP)** | $201,275 | $153,975 | $197,177 | **$552,427** |
| **Frankston-Mornington Peninsula PCP** | $126,359 | $- | $252,595 | **$378,954** |
| **G21** | $419,425 | $90,923 | $452,131 | **$962,479** |
| **Goulburn Valley PCP** | $67,364 | $84,385 | $120,365 | **$272,114** |
| **Grampians Pyrenees PCP** | $158,246 | $350,781 | $119,416 | **$628,443** |
| **HealthWest PCP** | $169,812 | $451,000 | $- | **$620,812** |
| **Hume-Whittlesea PCP** | $156,279 | $138,370 | $146,095 | **$440,744** |
| **Inner East PCP** | $122,704 | $78,296 | $77,536 | **$278,536** |
| **Inner North West PCP** | $57,415 | $76,778 | $83,293 | **$217,486** |
| **Lower Hume PCP** | $99,460 | $86,154 | $68,566 | **$254,180** |
| **North East PCP** | $502,525 | $- | $174,981 | **$677,506** |
| **Northern Mallee Community Partnership** | $158,723 | $94,235 | $64,121 | **$317,079** |
| **Outer East Health and Community Support Alliance** | $103,624 | $119,935 | $104,225 | **$327,784** |
| **South Coast PCP** | $80,678 | $- | $82,382 | **$163,060** |
| **South West Primary Care PCP** | $100,024 | $98,926 | $113,091 | **$312,041** |
| **Southern Grampians Glenelg PCP** | $13,668 | $146,136 | $157,585 | **$317,389** |
| **Southern Mallee PCP** | $68,118 | $132,271 | $79,164 | **$279,554** |
| **Southern Melbourne Primary Care Partnership** | $120,914 | $125,587 | $121,262 | **$367,763** |
| **Upper Hume PCP** | $72,332 | $80,744 | $160,022 | **$313,098** |
| **Wellington PCP** | $97,774 | $55,239 | $58,443 | **$211,456** |
| **Wimmera PCP** | $201,274 | $483,528 | $223,639 | **$908,441** |
| **TOTAL** | **$3,790,964** | **$3,516,012** | **$3,463,856** | **$10,770,832** |

Table 20 below reports on PCP spending on Project Expenses from 2015-16 to 2017-18. Unlike Salary and Wages and General Expenses, not all PCPs have reported spending on projects in all years. PCPs reported spending an average of around $60,000 each year on Project Expenses and amounts ranged from as little as just under $4,000 to over $300,000. There was an average of $1.8m spent on project expenses across all PCPs each year.

*Table 20: Spending on Project Expenses by PCP from 2015-16 to 2017-18.*

| PCP | 2015-16 | 2016-17 | 2017-18 | Total |
|---|---|---|---|---|
| **Bendigo Loddon PCP** | $3,920 | $112,146 | $42,817 | **$158,883** |
| **Campaspe PCP** | $55,056 | $60,769 | $55,057 | **$170,882** |
| **Central Highlands PCP** | $- | $- | $25,000 | **$25,000** |
| **Central Hume PCP** | $292,996 | $310,248 | $97,734 | **$700,978** |
| **Central Victorian PCP** | $5,750 | $40,180 | $181,222 | **$227,152** |
| **Central West Gippsland PCP** | $27,306 | $49,379 | $30,480 | **$107,165** |
| **East Gippsland PCP** | $20,816 | $- | $28,300 | **$49,116** |
| **Enliven Victoria (The South East PCP)** | $- | $- | $- | **$-** |
| **Frankston-Mornington Peninsula PCP** | $90,185 | $- | $59,214 | **$149,399** |
| **G21** | $- | $43,403 | $- | **$43,403** |
| **Goulburn Valley PCP** | $30,675 | $63,139 | $- | **$93,814** |
| **Grampians Pyrenees PCP** | $20,259 | $- | $- | **$20,259** |
| **HealthWest PCP** | $315,331 | $- | $290,000 | **$605,331** |
| **Hume-Whittlesea PCP** | $102,400 | $122,869 | $108,884 | **$334,154** |
| **Inner East PCP** | $245,344 | $76,184 | $77,753 | **$399,282** |
| **Inner North West PCP** | $133,000 | $73,955 | $48,387 | **$255,342** |
| **Lower Hume PCP** | $4,889 | $12,023 | $34,730 | **$51,642** |
| **North East PCP** | $- | $- | $- | **$-** |
| **Northern Mallee Community Partnership** | $10,284 | $72,215 | $28,415 | **$110,914** |
| **Outer East Health and Community Support Alliance** | $281,064 | $177,538 | $115,089 | **$573,691** |
| **South Coast PCP** | $20,440 | $- | $25,613 | **$46,053** |
| **South West Primary Care PCP** | $109,213 | $92,589 | $29,823 | **$231,625** |
| **Southern Grampians Glenelg PCP** | $289,571 | $- | $- | **$289,571** |
| **Southern Mallee PCP** | $- | $26,651 | $39,869 | **$66,519** |

| PCP | 2015-16 | 2016-17 | 2017-18 | Total |
|---|---|---|---|---|
| **Southern Melbourne Primary Care Partnership** | $101,159 | $63,437 | $77,097 | **$241,693** |
| **Upper Hume PCP** | $139,805 | $112,927 | $189,924 | **$442,656** |
| **Wellington PCP** | $10,884 | $47,308 | $11,474 | **$69,666** |
| **Wimmera PCP** | $- | $- | $- | **$-** |
| **TOTAL** | **$2,310,348** | **$1,556,959** | **$1,596,883** | **$5,464,190** |

Table 21 provides the composition of total spending reported from 2015-16 to 2017-18 by PCP. The table highlights that Salaries and Wages is the largest category for all PCPs, although there is variation, with some PCPs spending as little as 38 per cent on Salaries and Wages, and others spending over 70 per cent.

It is difficult to draw any conclusions about the variation in spending across the PCPs because little is known about how consistently PCPs are allocating expenditure to these broad categories, and how much of the variation reflects inconsistent reporting practices rather than actual operational variation.

*Table 21: Composition of total spending reported from 2015-16 to 2017-18 by PCP.*

| PCP | Salaries and Wages | General Expenses | Project Expenses |
|---|---|---|---|
| **Bendigo Loddon PCP** | 70% | 18% | 12% |
| **Campaspe PCP** | 70% | 18% | 12% |
| **Central Highlands PCP** | 69% | 29% | 2% |
| **Central Hume PCP** | 44% | 23% | 33% |
| **Central Victorian PCP** | 64% | 16% | 20% |
| **Central West Gippsland PCP** | 67% | 23% | 10% |
| **East Gippsland PCP** | 71% | 23% | 6% |
| **Enliven Victoria (The South East PCP)** | 66% | 34% | 0% |
| **Frankston-Mornington Peninsula PCP** | 68% | 23% | 9% |
| **G21** | 61% | 38% | 2% |
| **Goulburn Valley PCP** | 72% | 21% | 7% |
| **Grampians Pyrenees PCP** | 60% | 38% | 1% |
| **HealthWest PCP** | 64% | 18% | 18% |
| **Hume-Whittlesea PCP** | 72% | 16% | 12% |
| **Inner East PCP** | 66% | 14% | 20% |
| **Inner North West PCP** | 72% | 13% | 15% |
| **Lower Hume PCP** | 72% | 24% | 5% |

| PCP | Salaries and Wages | General Expenses | Project Expenses |
|---|---|---|---|
| **North East PCP** | 52% | 48% | 0% |
| **Northern Mallee Community Partnership** | 66% | 25% | 9% |
| **Outer East Health and Community Support Alliance** | 50% | 18% | 32% |
| **South Coast PCP** | 67% | 26% | 7% |
| **South West Primary Care PCP** | 62% | 22% | 16% |
| **Southern Grampians Glenelg PCP** | 64% | 19% | 17% |
| **Southern Mallee PCP** | 69% | 25% | 6% |
| **Southern Melbourne Primary Care Partnership** | 70% | 18% | 12% |
| **Upper Hume PCP** | 38% | 26% | 36% |
| **Wellington PCP** | 73% | 20% | 7% |
| **Wimmera PCP** | 58% | 42% | 0% |

## H.5 An overview of the data sources

Analysis in this Appendix has been informed by PCP Program acquittals including program information provided by the Department, general purpose financial reports, and internal management reports of 28 PCPs that were submitted to the Department for the financial years 2015-16; 2016-17; and 2017-18. See Table 23 below for the list of PCPs and the financial information that was utilised for this analysis.

The financial information that was utilised included details of revenue/income and spending of each PCP for each of the years. The revenues were categorised using the categories in the DHHS PCP Program acquittals into DHHS PCP Funding; Other DHHS Funding; and Other Revenue. The spending was categorised into Salaries and Wages (Including on-costs); General Expenses; and Project Expenses. It should be noted that where financial information could not be easily allocated to the above categories, revenues were categorised into *Other Revenue*, and spending was categorised into *General Expenses.* See Table 24 for more information about the spending categories.

*Table 22: Summary of Financial Information Provided*

| Region | PCP | 2015-16 | 2016-17 | 2017-18 |
|---|---|---|---|---|
| **Barwon South Western** | South West Primary Care PCP | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal |

| Region | PCP | 2015-16 | 2016-17 | 2017-18 |
|---|---|---|---|---|
| | Southern Grampians Glenelg PCP | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding Report<br>2 Internal Management Reporting |
| | G21 (Geelong Regional Alliance) | 1 DHHS PCP SAMS Funding Report<br>2 General Purpose Financial Report | 1 DHHS SAMS Funding report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding Report<br>2 General Purpose Financial Report |
| **Eastern Metropolitan** | Outer East Health and Community Support Alliance | 1 DHHS SAMS Funding report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal |
| | Inner East PCP | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding Report<br>2 General Purpose Financial Report |
| **Gippsland Region** | South Coast PCP | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal | 1. DHHS SAMS Funding Report<br>2. Salary & Wages Expenditure Report | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal |
| | Central West Gippsland PCP | 1 DHHS SAMS Funding report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding report<br>2 Internal Management Reporting |

| Region | PCP | 2015-16 | 2016-17 | 2017-18 |
|---|---|---|---|---|
| | Wellington PCP | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal |
| | East Gippsland PCP | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding report<br>2 Internal Management Report | 1 DHHS SAMS Funding report<br>2 DHHS PCP Acquittal |
| **Grampians Region** | Central Highlands PCP | 1 DHHS SAMS Funding Report<br>2 Internal Management Report | 1 DHHS SAMS Funding report<br>2 Internal Management Reporting | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal |
| | Grampians Pyrenees PCP | 1 DHHS SAMS Funding Report<br>2 General Purpose Financial Statements | 1 DHHS SAMS Funding Report<br>2 Internal Management Reporting | 1 DHHS SAMS Funding Report<br>2 Internal Management Reporting |
| | Wimmera PCP | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal | 1. DHHS SAMS Funding Report<br>2. Internal Management Report | 1 DHHS SAMS Funding report<br>2 Internal Management Reporting |
| | Central Hume PCP | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding report<br>2 DHHS PCP Acquittal |
| | Goulbourn Valley PCP | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding report<br>2 DHHS PCP Acquittal |

| Region | PCP | 2015-16 | 2016-17 | 2017-18 |
|---|---|---|---|---|
| | Lower Hume PCP | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal |
| | Upper Hume PCP | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal |
| **Loddon Mallee Region** | Bendigo Loddon PCP | 1. DHHS SAMS Funding Report<br>2. Internal Management Reporting | 1 DHHS SAMS Funding report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding report<br>2 DHHS PCP Acquittal |
| | Campaspe PCP | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding report<br>2 DHHS PCP Acquittal | 1. DHHS SAMS Funding Report<br>2. DHHS PCP Acquittal |
| | Central Victorian PCP | 1 DHHS SAMS Funding report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS funding report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal |
| | Northern Mallee Community Partnership | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal |
| | Southern Mallee PCP | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal |

| Region | PCP | 2015-16 | 2016-17 | 2017-18 |
|---|---|---|---|---|
| North and West Metropolitan Region | HealthWest PCP | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding Report<br>2 Internal Management Reporting | 1 DHHS SAMS Funding Report<br>2 Internal Management Reporting |
| | Hume-Whittlesea PCP | 1 DHHS SAMS Funding report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal |
| | Inner North West PCP | 1 DHHS SAMS Funding report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal |
| | North East PCP | 1 DHHS SAMS Funding report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding Report | 1 DHHS SAMS Funding report<br>2 DHHS Acquittal |
| Southern Metropolitan Region | Enliven Victoria (The South East PCP) | 1 DHHS SAMS Funding Report<br>2 General Purpose Financial Report | 1 DHHS SAMS Funding report<br>2 General Purpose Financial Report | 1 DHHS SAMS Funding Report<br>2 General Purpose Financial Report |
| | Frankston-Mornington Peninsula PCP | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding Report<br>2 DHHS Grant Funding Details | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal |
| | Southern Melbourne Primary Care Partnership | 1 DHHS SAMS Funding report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal | 1 DHHS SAMS Funding Report<br>2 DHHS PCP Acquittal |

The spending categories include a number of expenses which are listed in the table below.

*Table 23: Spending Categories*

| Category | Expense |
|---|---|
| **Salaries and Wages** | *Administrative Salaries* |
| | *Work cover* |
| | *Leave (Annual and Long Service)* |
| | *Superannuation* |
| | *Recruitment* |
| **General Expenses** | *Computer Software* |
| | *Printing & Stationary* |
| | *Administration (General)* |
| | *Repairs and Maintenance* |
| | *Asset Purchases* |
| | *Motor Vehicles and Travel* |
| | *Corporate/Management charge by host agency* |
| | *Rent* |
| | *Staff Training and Education* |
| | *Conferences and Travel* |
| **Project Expenses** | *Consultancy* |
| | *Other* |

A detailed explanation of the methodology and associated limitations is provided below, followed by the outcomes of the financial analysis.

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