Australian Government
Department of Health, Disability and Ageing

PHN Program Performance Measurement and Reporting Framework

Part A: Background – August 2025

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Introduction

1. The Primary Health Network Program

The Primary Health Network Program (PHN Program) commenced in 2015 with the establishment of 31 Primary Health Networks (PHNs). Each PHN is responsible for identifying and addressing the primary health needs in their region through strategic planning, commissioning services, supporting the primary care workforce and strengthening the integration of local health care services.

PHNs also play a crucial role in supporting health reform by driving local innovation and delivering national programs using a 'place-based' approach - tailoring initiatives to meet their local population's health needs. The PHN Program has two objectives and eleven areas of scope (Table 1).

Table 1. PHN Program objectives and areas of scope

PHN Program Objectives	Areas of Scope
• Increase the efficiency and effectiveness of primary health care services for patients, particularly those at risk of poor health outcomes. • Improve coordination of health care to ensure patients receive the right care, in the right place, at the right time.	• Population health • Practice support • Digital health • Emergency preparedness • Mental health and suicide prevention • Alcohol and other drugs • Health services in aged care • First Nations health • Workforce • Emergency response (e.g., COVID-19, bushfires and floods) • Medicare Urgent Care Clinics

The PHN Program has grown in size and breadth in terms of the funding and activities delivered through PHNs. As of June 2025, the program has a total annual expenditure of approximately $2 billion and has a coverage of 43 policy areas, delivered through 82 funding streams.

1.1 Core Functions

To meet the objectives of the PHN Program, PHNs undertake activities under three core functions: coordinate, commission, and capacity-build. Delivery of these functions is aimed to support and strengthen the local health system, to address identified needs and continually strive towards achieving the Quintuple Aim for healthcare reform. These functions generally correlate to activities that PHNs are funded to undertake. In most cases:

- **Core funding** is usually used to deliver coordination and capacity-building activities, and
- **Program funding** is usually used to deliver commissioned services.

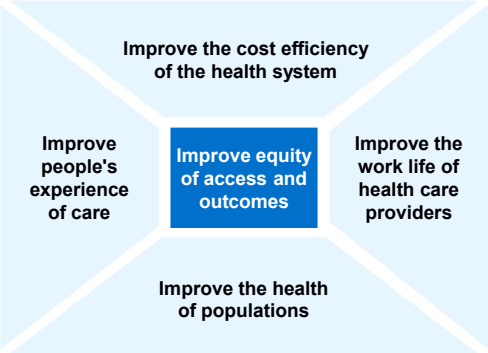


Figure 1. Quintuple aim of health system reform

Table 2. PHN core functions and their descriptions

Function	Description
Coordinate	Coordination activities integrate and build better connections between services across primary, secondary and tertiary levels of healthcare, as well as between public and private sectors. Objectives of these activities are generally aimed at improving processes that contribute to patient access, and the continuity and quality of care. The desired outcome of coordination activities is to address gaps or barriers in a patient's journey for receiving integrated care. Outcomes also seek to reduce duplication of services and (identify and where possible implement ways to) improve efficiency. Coordination activities are directly delivered by PHNs in partnership with LHNs, ACCHOs, or other stakeholders. These partnerships are characterised by agreed objectives that are supported through joint investment.
Commission	Commissioning is a continual and iterative cycle involving the development and implementation of services based on needs assessment, planning, co-design, procurement, monitoring and evaluation. Commissioning encompasses these full range of activities, to deliver targeted interventions that address population health needs and/or gaps in services. Targeted interventions are inclusive of activities beyond procured services and could include other activities (e.g. care coordination and capacity-building) to secure the desired outcome.

Function	Description
Capacity Build	Capacity building activities delivered under this function aim to improve the capability of health care providers to deliver improved quality care. Capacity building activities are directly delivered or facilitated by PHNs and are inclusive of education or development in business practices, continuous quality improvement (CQI), (innovative) models of care, workforce wellbeing, data and digital systems, and scope of clinical practice.

2. Purpose of the Performance Measurement and Reporting Framework

The Performance Measurement and Reporting Framework (PMRF) has been developed to reflect the growth and maturity of the PHN Program since it commenced. It incorporates a new conceptual model and an updated PHN Program Logic, ensuring there is closer alignment between the Program's objectives and activities and how performance is measured.

Its overall aim is to determine how effectively individual PHNs and the PHN Program as a whole are achieving program objectives.

The PMRF measures performance at both an individual PHN and program-level, with a forward focus on the Quintuple Aim. It aims to provide a transparent and accurate representation of PHN performance, in direct relation to activities delivered, particularly across the three core functions of PHNs.

The Framework is designed to:

- identify areas of strength and areas of improvement to support continuous improvement in achieving program objectives,
- support a culture of shared learning and collaboration across the network of PHNs;
- reflect the perspectives of key stakeholders for a comprehensive view of performance.
- be adaptable and have the flexibility to accommodate new activities.
- curb reporting burden resulting from growth of the Program.

2.1 Framework Principles

Principles have been developed to help guide and underpin decision-making and inform the design of the PMRF. The principles will help to support the implementation of the Framework, consistent with the PHN Program Logic. These principles are described below and in Table 3.

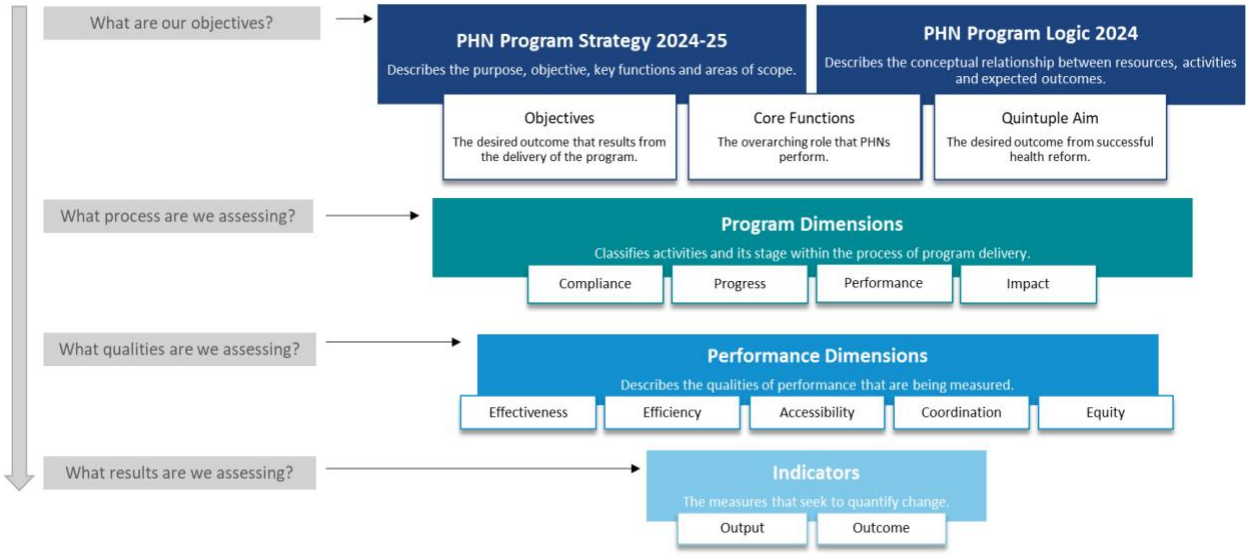
- **Balanced**: The Framework uses an appropriate range of indicators and data sources to support a balanced view of performance for individual programs, individual PHNs, and the PHN program.

- **Proportionate**: The nature and extent of reporting is proportionate to the priority, value, scale, and risk profile of the program being reported on.
- **Adaptable**: The Framework is adaptable to all programs, and all stages of the program life cycle. It allows for measurement of performance across individual programs, individual PHNs, and the PHN program.
- **Transparent**: The Framework explains what information is being collected and why it is collected. It also conveys how the information being collected links to the Department's objectives and outcomes. The Framework is clear on when data collection will occur, how it will be reported and with whom the reporting will be shared.

3. Conceptual Model

The purpose of the Conceptual Model is to provide a systematic approach to measuring and reporting on individual and whole of PHN Program performance. The Model builds on the PHN Program Strategy 2023-24 and PHN Program Logic 2025 and seeks to reflect the relationships that support the program's Theory of Change[1] using a structured cascading methodology. The structure consists of key dimensions that describe the unique roles that PHNs perform, their diversity and the variability in program delivery. These dimensions define what is being measured and how the Framework assesses performance to provide a holistic and multi-faceted perspective. The Framework offers a standardised but flexible approach that is applicable to all PHN activities, including existing and future core and program funded activities.

Figure 2: Key conceptual dimensions of the Performance Measurement and Reporting Framework.



[1] PHN Program Theory of Change: "*PHNs understand the health needs and local health system of their respective regions. PHNs use this knowledge to implement effective commissioning, capacity-building and coordination of health care in their region. PHNs are therefore best placed to deliver targeted and tailored approaches that improve the health outcomes of their community*."

3.1 Program Dimensions

For the PHN Program to meet its objectives, the performance of PHNs across the continuum of program delivery must be measured. The continuum encompasses the inputs or organisational activities that contribute to the operations of a PHN, through to the outputs and outcomes of functions or services delivered. This continuum is reflective of the stages in which PHNs engage or contribute to and has been divided into four dimensions.

Table 3. Program dimensions and their definitions.

Dimension	Definition
Compliance	Measures the extent to which PHNs are meeting their core contractual and organisational obligations.
Progress	Measures how PHNs are implementing their core functions of capacity-building, commissioning and coordination.
Performance	Measures the extent to which PHN activities are achieving the intended outcomes of delivering quality care.
Impact	Measures the extent to which PHNs are working towards achieving the long-term goal of the program. It therefore focuses on system-centric activities.

3.2 Performance Dimensions

Performance dimensions refer to the qualities of performance that are being assessed. In literature and in the context of healthcare, quality healthcare is accepted as consisting of a range of attributes that are considered important in achieving desired outcomes (AIHW 2017).

The selection of performance dimensions for this Framework reflects the attributes explicitly listed or implied in the Program objectives as outlined in the PHN Program Logic 2024. They are also aligned with health system domains developed as part of the AIHW Australian Health Performance Framework (AIHW 2017). These dimensions are described below.

Table 4. Performance dimensions and their definitions.

Dimension	Definition
Accessible	The ability of people to obtain care in the right place and at the right time.
Coordinated	The ability to provide uninterrupted, coordinated care across programs, practitioners, organisations and levels over time.
Effective	Care, intervention or action achieves the desired outcome.
Efficient	Achieving desired results with the most cost-effective use of resources.
Equitable	The minimisation of avoidable differences between groups or individuals.

Source: The Australian Health Performance Framework (2017)

Note that these performance dimensions are intended to compliment and support achievement of the Quintuple Aim. The five performance dimensions provide a basis to drive improvement in the context of the PHN Program in the short to medium term. Over time, improving these qualities will in theory contribute to achieving the Quintuple Aim through the elements of the health system with which PHNs interact.

The Framework consists of indicators grouped against the program dimensions. This ensures there is broad coverage in measuring PHN performance and activity.

3.3 Indicators

Indicators are the metrics for how performance is quantified or evidenced against objectives. Within this Framework, indicators have been developed against each performance and program dimension. Indicators can be defined as a measure of 'output' or 'outcome.' The distinction between the two is described below.

Table 5. Indicator types and their definitions.

Type	Definition
Output	The tangible products or deliverables of program activities. E.g., the number of referral resources published for clinicians.
Outcome	The actual results achieved by a program. This may include knowledge transferred or behaviours changed. Outcomes are the differences or benefits made by the outputs. e.g., an increased number of clinicians using the referral resources.

Source: Busse et al. (2019)

3.4 Agents and Targets of Change

Agents and targets of change help identify who contributes to, and who are the beneficiaries of, intended change.

- **Agents of Change:** those who influence or contribute to (resolving) the issue or problem.
- **Targets of Change:** people or cohorts who are at-risk of or are experiencing an issue or problem.

Generally, the three core functions delivered by PHNs also have distinct agents and targets of change. Examples of these are outlined in Table 7 although this is not an exhaustive list. Identifying these participants informs how progress or performance is assessed. This is because output and outcome measures are dependent on participants and their role. As a result, each core function has a set of progress and performance indicators which align to actions undertaken by the agent or target of change.

Table 6. Identified agents and targets of change, by PHN function.

Core Function	Agent of Change	Targets of Change
Coordinate	PHNs; LHNs; peak bodies	Healthcare practitioners; service providers; consumers; families; carers.
Commission	PHNs; Commissioned service providers	Consumers; families; carers.
Capacity Build	PHNs	Healthcare practitioners and service providers

3.5 Core Functions and Program Dimensions

To develop meaningful indicators, the relationship between core functions and program dimensions must be understood. Tables 8 and 9 build on the definitions of core functions and program dimensions as well as the targets or agents of change provided earlier in this document. They articulate the translation of PMRF concepts to the development of indicators.

Table 7. Relationship between core functions and compliance and impact indicators.

	Compliance Indicators	Impact Indicators
Core Functions	Compliance indicators measure whether PHNs are meeting their core contractual and organisational obligations. They therefore specifically target PHNs and how they have met regulatory standards.	Measure the extent to which PHNs are working towards achieving the long-term goals of the program. These indicators therefore focus on broader population and/or health system outcomes as the Targets of Change.
All	Across all core PHN functions, these indicators assess whether PHNs are meeting minimum requirements in delivering the PHN Program. These requirements are articulated as part of their funding agreements and against the Commonwealth Grant Rules and Principles (2024).	These indicators span all core PHN functions. These indicators assess whether PHNs have made positive advancements towards achieving the Program's goals and healthcare reform against the Quintuple Aim. While assessment of these indicators cannot be directly attributable to PHN activity, PHNs are considered to contribute to these outcomes. This is due to the long-term cumulative effect of the overall PHN Program.

Table 8. Relationship between core functions and progress and performance indicators.

	Progress Indicators	Performance Indicators
Core Functions	Progress indicators measure how PHNs are implementing their core functions. These indicators therefore focus on the Agents of Change and seek to measure the capability of these agents. Capability reflects the progress made towards the early delivery or implementation of an activity.	Performance indicators measure what PHNs have achieved as an outcome of their core functions. These indicators therefore focus on the Targets of Change and seek to measure their benefits gained. They seek to measure the differences made and determine whether program objectives have been achieved.
Coordinate	These indicators assess how PHNs are partnering with stakeholders to deliver joint objectives. They also seek to identify the resources that PHNs leverage in progressing and enabling the delivery of coordination activities.	These indicators assess the extent to which integration or coordination of services has been achieved. It seeks to determine the difference that the PHN efforts have made in developing resources and relationships that strengthen the local health care system.
Commission	These indicators assess how PHNs are performing as commissioners of services to address health needs and/or gaps. The purpose of this assessment is to determine the quality of commissioning undertaken by PHNs through all stages of the commissioning cycle.	These indicators assess the extent to which commissioned services are achieving intended outcomes It seeks to determine the difference that the commissioned providers have made for the Targets of Change.
Capacity Build	These indicators assess the capability of PHNs to deliver capacity-building opportunities to their local workforce. The purpose of this is to determine how PHNs are engaging the local workforce to provide meaningful capacity-building activities.	These indicators assess the level of support provided to the health workforce by the PHNs. Measures therefore seek to quantify changes or improvements in workforce capacity, capability or quality of care as the Targets of Change.

4. Framework Application

4.1 Interpreting Indicators

Each indicator in this Framework has a specification (see Part B) which details the description, rationale, definitions, performance criteria, reporting frequency, data sources and calculations used to assess individual PHN and program performance. The indicator specification standardises and ensures consistency and comparability between PHNs, as well as supporting data quality and accuracy.

PHNs and stakeholders should refer to these indicator specifications to understand what is being measured and how, including the identified limitations of the indicator.

In addition, it is expected that the indicators provide an elementary view of PHN performance, and that nuance and local context may influence their interpretation.

4.2 Indicator Summary

The Framework contains 27 indicators in total. Across these indicators PHNs will be required to provide information against most indicators, with others being sourced and reported by the Department directly. Refer to Data Source within the indicator specifications in Part B for details.

Table 9. Number of indicators by Program Dimensions

Program Dimension	Number of Indicators
Compliance	8 indicators
Progress[2]	6 indicators
Performance	12 indicators
Impact	3 indicators

Table 10. Number of indicators by Core Function

Core Function	Number of Indicators
Coordinate	3 indicators
Commission	7 Indicators
Capacity build	6 indicators

[2] Note that two indicators (CO-02, CB-06) are considered both Progress and Performance indicators and therefore conflate the total number of indicators in Table 10.

Table 11. Framework components and the corresponding indicators

Framework Component	Indicator ID and Title
Coordinate Indicators	• CO-01: Partnerships for system coordination or integration • CO-02: Referral pathways • CO-03. Partnership experience measure
Capacity-Build Indicators	• CB-01. Significant interactions with primary health care providers • CB-02. Proportion of general practice demonstrating improvements following continuous quality improvement activities • CB-03. My Health Record: Rate of uploads by general practices • CB-04. My Health Record: General practice cross views • CB-05. Primary healthcare provider-reported experience • CB-06. Case study: demonstrate change or improvements in practice
Commission Indicators	• CM-01. Evidence that commissioned activities address identified health needs or gaps • CM-02. Program episodes or service contacts • CM-03. Commissioned service clients and positive outcomes • CM-04. Cost per health improvement • CM-05. Proportion of commissioned services delivered to target population • CM-06. Patient-reported experience and outcome measure • CM-07. Commissioned provider experience measure
Compliance Indicators	• CP-01 - Financial reporting obligations • CP-02 - ACNC Reporting • CP-03 - Board composition and contribution • CP-04 - Culturally safe practices • CP-05 – Procurement methods • CP-06 - Value for money in commissioning • CP-07 - Conflicts of interest and related party transactions • CP-08 - Information security management
Impact Indicators	• IM-01: Potentially preventable hospitalisations • IM-02: Lower urgency care presentations • IM-03: Patient coordination of care

Table 12. Matrix of indicators by Program Dimension and Indicator Type

	Progress *Measures how PHNs are implementing their core functions of capacity-building, commissioning and coordination.*			**Performance** *Measures the extent to which PHN activities are achieving the intended outcomes of delivering quality care.*		
Output *The tangible products or deliverables of program activities.*	CO-01 CO-02*	CB-01	CM-01 CM-02	CO-02*	CB-03 CB-04	CM-05
Outcome *Outcomes are the differences or benefits made by the outputs.*	CO-03	CB-05 CB-06*	CM-07		CB-02 CB-06*	CM-03 CM-04 CM-06

* *Note that two indicators (CO-02, CB-06) are considered both Progress and Performance indicators.*

4.3 Commissioning Indicators

The purpose of Commissioning Indicators is to define a standardised set that PHNs can expect to regularly report against in the commissioning of program area activities. It is intended to offer a consistent set of indicator specifications that can be adapted to a range of current and future programs. They are designed to be reported at an activity level. PHNs can therefore expect that of the national or bespoke programs they deliver, these indicators provide a basis for data that is collected and reported.

While Commissioning Indicators are constituents of this Framework and therefore reported on an annual basis, Program Areas are the decision-makers in setting specific definitions and performance criteria relevant to their activity. In most cases, these indicators are intended to apply to across the broad range of programs, providing a common foundation of performance monitoring. However, it is acknowledged that Program Areas may require more tailored indicators to reflect the unique objectives and outcomes of specific programs.

The Department recognises the importance of creating greater cohesion in reporting requirements and views this Framework as a foundational step towards streamlining reporting for PHNs. As such, while indicators have been outlined here, further guidance and refinement will be provided to support consistent and meaningful data collection.

Importantly, Commissioning Indicators are also intended to support aggregation across activities and, where appropriate, across the program. This approach enables the Department to demonstrate the broader impact of the PHN Program over time and across areas of scope.

4.4 Deliverables

This Framework is especially relevant to the delivery of Twelve Month Performance Reporting (12MPR) by PHNs for each financial year. This is the formal annual reporting process used to determine PHN progress of delivering activities contracted by the Department, as stated in executed funding agreements. It subsequently contributes to each PHNs Individual Performance Assessment (IPAs) and the PHN Program's Annual Performance Report.

While this Framework relies on information collected as part of 12MPR, it also leverages information from other program deliverables, such as Health Needs Assessments and Activity Work Plans.

5. Assessment and Reporting

5.1 Implementation

Of indicators included in this Framework, some will require ongoing development to ensure data is meaningfully and consistently collected. It is therefore recognised that implementation of this Framework will take a staggered approach. This approach seeks to collect readily available data in the first instance, while more complex or survey-based indicators – such as Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs) – will require additional time and close collaboration between the Department and PHNs to successfully implement.

Given the development of this Framework, the Department acknowledges that areas such as Performance Criteria will need to be reviewed and refined following receipt of baseline data to inform future assessments. To support this process, an Implementation Plan will be developed to provide PHNs with clarity on reporting requirements, expectations and timeframes.

5.2 Peer Groups

To make meaningful analysis of performance data, PHN peer groups may be used to understand trends and make comparisons. Due to the variability that exists among PHNs, peer groupings will allow for comparisons based on similar characteristics.

Peer groups may include the following:

- Remoteness: a classification developed by the AIHW where a PHN area is classified as a metropolitan PHN area if at least 85% of the population resided in Major cities. All other PHN areas were categorised as regional PHN areas.
- Socio-Economic Indexes for Areas (SEIFA): products developed by the Australian Bureau of Statistics that ranks areas in Australia according to relative socio-economic advantage and disadvantage. The indexes are based on information from the five-yearly Census (ABS 2023). The Index of Relative Socio-economic Disadvantage (IRSD) is the preferred index for use in this Framework.

- State and territory: PHN state group categories are based on PHNs' state and territory locations[3].

Other peer groups may be considered for inclusion as the Framework is implemented and matures.

5.3 Framework Review

A formal review of this Framework will be undertaken every four years. This is for the purpose of:

- Adapting the framework to changes in the landscape and healthcare environment.
- Ensuring performance criteria remain appropriate and relevant
- Refining indicators and specifications to improve clarity, consistency and usability
- Aligning with national data standards, external data sources and policy directions

Informal revisions may be undertaken between formal reviews to address minor corrections or updates.

[3] While most PHNs are solely within state and territory boundaries, Murray PHN is classified as Victorian but includes the New South Wales town of Albury.

Appendix

Acronyms and Abbreviations

12MPR	Twelve Month Performing Reporting
ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
AIHW	Australian Institute of Health and Welfare
CB	Capacity build indicator
CM	Commission indicator
CO	Coordinate indicator
CP	Compliance indicator
CQI	Continuous Quality Improvement
IM	Impact indicator
IPAs	Individual Performance Assessments
IRSD	Index of Relative Socio-economic Disadvantage
LHN	Local Health Networks
LHN	Local Health Network
PHN	Primary Health Network
PHNP	Primary Health Networks and Partnerships (Branch)
PIP	Practice Incentives Program
PMRF	Performance Measurement and Reporting Framework
PREM	Patient Reported Experience Measure
PROM	Patient Reported Outcome Measure
SEIFA	Socio-Economic Indexes for Areas

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Version History

Version	Description of change	Author	Effective date
1.0	Initial release version	Department of Health, Disability and Ageing	August 2025

Primary Health Network (PHN) Program Logic

The PHN Program Logic is available at:

https://www.health.gov.au/resources/publications/primary-health-networks-phn-program-logic?language=en

Health.gov.au

All information in this publication is correct as at August 2025