New South Wales

Special Commission of Inquiry into Healthcare Funding

Submission Number: 20

Name: NSW and ACT Primary Health Networks

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30 October 2023

Mr Richard Beasley SC
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SYDNEY NSW 2000

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Dear Mr Richard Beasley SC,

The NSW and ACT Primary Health Networks (**PHNs**) acknowledge the traditional owners of Country throughout Australia on which we gather, live, work and stand. We acknowledge all traditional custodians, their Elders past and present, and we pay respect to all First Nations people.

This submission is made jointly by all **NSW PHNs** in response to the NSW Government's Special Commission of Inquiry into the funding of the NSW Health system.

Primary Health Networks have been part of our communities, delivering support and education to primary healthcare professionals and working with key partners to progress our region's health systems. PHNs are primarily funded by the Australian Government Department of Health and Aged Care to strengthen primary care, improve patient-centred service integration, and increase the efficiency and effectiveness of primary healthcare services for Australians; particularly those at risk of poor health outcomes.

This submission aims to address all areas of the inquiry's terms of reference, drawing on the joint expertise of NSW PHNs as regional commissioners of primary healthcare including extensive collaboration and co-design with our LHD counterparts.

NSW and ACT PHNs would welcome the opportunity to contribute at a public hearing to further elaborate on our recommendations for how the NSW Health system can deliver improved quality of care, timeliness of care and cost savings.

Yours Sincerely,

Lizz Reay
CEO
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SUBMISSION

EXECUTIVE SUMMARY

The funding model of the NSW Health System primarily and increasingly supports acute, episodic care in hospitals and emergency departments (EDs), as opposed to primary and preventative healthcare in community settings. This trend has resulted in a scenario where inadequate primary and community healthcare, especially after hours, triggers a higher demand for acute care. Subsequently, funding for acute care is increased to meet this demand.

The occurrence of chronic conditions is rising, with many individuals having more than one condition. Multi-morbidity leads to complex, costly health needs, increased emergency department visits, and poorer patient outcomes. The primary and community care system, which is focussed on continuity of care, is best fit for preventing or managing chronic conditions long term, which can improve an individual's health, reduce cost, and reduce pressure on hospitals.

Over the last decade, the demand for hospital care in NSW has risen, with a significant surge observed in EDs. Although triage category 2 – Emergency presentations have seen a notable increase, the majority of ED presentations are of lower urgency, and many could be addressed in a timely and safe manner within primary and community settings.

Evidence indicates that the trend in lower-urgency presentations is often influenced by the limited availability of ED care alternatives beyond standard GP hours. Urgent Care Centres, utilising local General Practice networks during extended hours, present a viable, timely, accessible, and cost-effective solution to this concern. Moreover, expanding integrated care models is a constructive step towards ensuring patients with chronic conditions and multi-morbidity receive the necessary continuity of care, which is instrumental in better managing their conditions while keeping a check on cost escalation and condition deterioration.

The progression of the NSW Health system towards a framework that delivers the right care, at the right time, in the right place, whilst managing the rising healthcare costs, advocates for a harmonised health system approach. This objective may be furthered by nurturing collaboration and integration among the Commonwealth and State, Primary Health Networks and LHDs, GPs, allied health, private providers and non-government organisations. NSW Health should consider a review of the core service offerings between PHNs and LHDs, reallocating community care services budgets to reduce overlap and enhance service efficiency. The collaborative commissioning model, having demonstrated its ability to provide adaptive, effective solutions tailored to the healthcare needs of the local community, suggests that collaborative commissioning arrangements between PHNs and LHDs are worth supporting and expanding upon for an enriched healthcare delivery system.

This submission provides context, background and supporting materials. It makes the following recommendations.

Recommendation 1 – Increase the proportion of funding allocated to community services, prevention, and early intervention, working in partnership with PHNs, primary health care and other community service providers.

Recommendation 2 – Enable PHNs and LHDs to establish and support community services, aligning them with local needs to promote integrated primary, community, and acute service models.

Recommendation 3 – Continue to invest in urgent care services embedded within primary care providers in community through PHNs, working in partnership with LHDs. Support the establishment of infrastructure, including integrated access to outpatient services, LHD/Speciality Health Network community outreach, mobile diagnostics, community messaging and communications and a central intake service to triage and book patients into the most appropriate service in the health system for their need.

Recommendation 4 – Expand and build upon past integrated care programs to further progress shared care models between outpatient clinics, community health centres, general practices and other community-based providers for the prevention and management of chronic conditions and avoidable hospitalisations.

Recommendation 5 – Improve the coordination and linkages between primary and acute care via enhanced governance arrangements between PHNs and LHDs.

Recommendation 6 - That the NSW Government allocate additional funding and prioritise activities aligned with the national health reform agenda, while actively removing barriers hindering their progress.

Recommendation 7 - That The NSW Government recognises the interconnectedness of their roles and actively works together with the Commonwealth, PHNs, and stakeholders including the primary care sector to create a sustainable, cost-effective, and patient-centred healthcare system for the future.

Recommendation 8 - Embed the implementation of the joint statement between NSW Health, NSW PHNs and the Commonwealth Department of Health and Aged Care into the Service Level Agreements between LHDs and the Ministry and within the Core Funding contract between the Commonwealth and NSW PHNs.

Recommendation 9 - Monitor spending on community-based services separately from total LHD Service Level Agreements budgets.

Recommendation 10 – Implement Innovative Funding models, applying flexible funding approaches such as including social impact bonds and equivalent, to foster investment in locally led and centrally supported solutions that are person-centred, sustainable, and outcome-focused.

Section 1: Context & Background

NSW Health system funding largely caters to acute, episodic care instead of primary and preventive care, despite a rising tide of chronic disease.

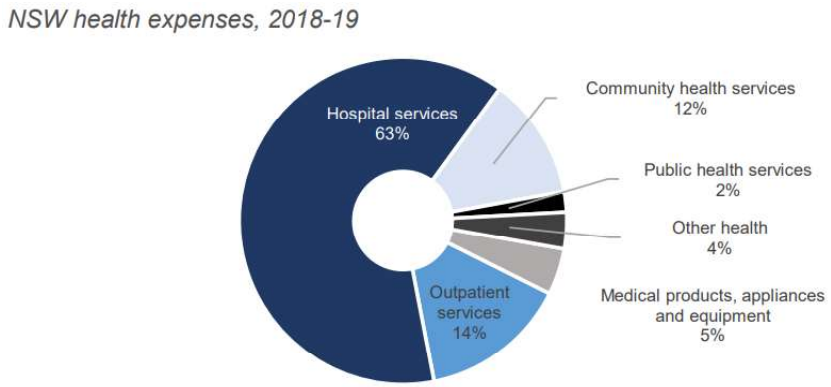


Figure 1. NSW health expenses, 2018-19, Source: ABS, 2020 cited in NSW Treasury 2021

The prevalence of chronic diseases is escalating, amplifying healthcare costs due to an increased lifespan and years spent in ill health [1]. Chronic diseases have burgeoned by 5% over a decade, putting significant pressure on NSW Health services as well as primary and community based services which have been receiving relatively less funding over that same period compared to acute services [2] [1].

Multi-morbidity, the co-occurrence of multiple chronic conditions, further complicates healthcare, demanding complex, coordinated, and expensive treatments, especially among disadvantaged, older, and First Nations people.

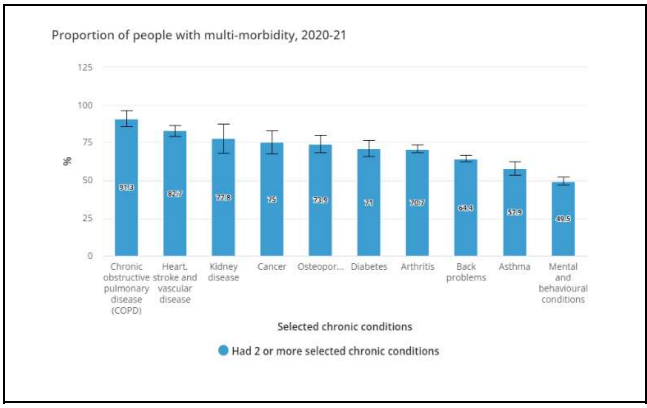


Figure 2: Multi-morbidity of select chronic conditions, ABS, 2022

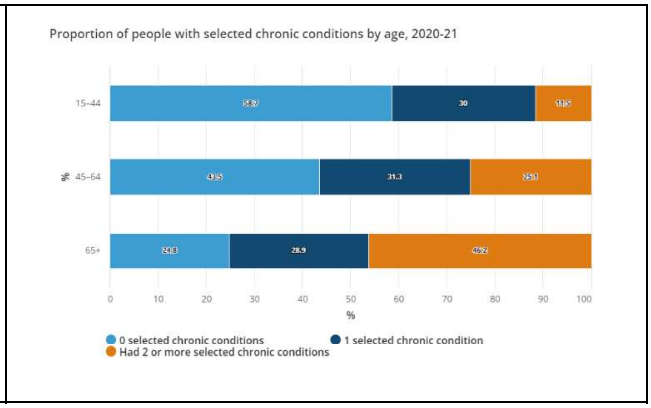


Figure 3: Multi-morbidity by age cohort, ABS, 2022

The RACGP and Australian Institute of Health and Welfare (AIHW) outline evidence that people who have multi-morbidity are found to experience:

- Reduced quality of life
- Higher mortality
- Polypharmacy
- Higher treatment burden
- Greater likelihood of uncoordinated or fragmented care
- Vulnerability to safety issues due to poor health, advanced age, cognitive impairment, limited health literacy and comorbidity of depression or anxiety.
- Greater use of services including higher consultation rates with healthcare professionals and GPs and a higher number of hospital admissions [3].

- Multi-morbidity often requires more complex treatment and ongoing management and coordination of specialised care across multiple parts of the health system [1]. The last decade has seen increasing strain placed on all parts of the state's acute care system. To meet this need the NSW Government's annual hospital spending has grown by $3.2 billion in this time [2]. This funding has enabled hospital care to adapt well with reductions in post-hospitalisation mortality and stable readmission rates [4] [5].

However, for this same period, Emergency Department care has surged even more drastically, with the NSW Bureau of Health Information (BHI) data showing that since 2010:

- There has been a 52% rise in the total number of emergency department presentations [6].
- There has been a 20% increase in patients arriving at EDs by ambulance [6].
- T2: Emergency presentations have risen by 180%, T3: Urgent presentations have risen by 91% and T4: Semi-urgent presentations have risen by 32% with Urgent and Semi-urgent presentations making up 75% of all ED presentations [6].

While Emergency Departments across the state have done a remarkable job at adapting to meet surging ED demand, they are simply not able to keep up with patient demand, which has been exacerbated by under investment in primary and community-based care. In general Emergency Department wait times have been increasing over the last decade according to the Bureau of Health Information.

- The percentage of patients transferred from paramedic to Emergency Department care within 30 minutes has declined by 8.1% since 2013 [6].
- 6.4% fewer ED patients are starting treatment within the clinically recommended time than in 2010 [6].
- The percentage of patients leaving the ED within 4 hours was 56.7% in 2022, 5.8% less than in 2010 [6].

AIHW data shows that NSW has historically spent relatively less on healthcare as compared to other states and territories, and spends the smallest proportion of its tax revenue, the second smallest proportion of its total expenses, and the least per person of any state in Australia [7]. Of this funding, NSW spent 4.6 times more on hospitals ($11.2B) than on primary and community care ($2.4B) in 2020-21 with similar ratios in 2015 and 2010 [2].

Individuals in NSW also spent 10 times more on primary care in 2021 than on hospital care and 3 times more on primary care than the state government [2]. This is symptomatic of the NSW health system's over-reliance on acute care, while a trip to an ED visit is typically free ABS data shows more people delayed or avoided visiting a GP due to cost in 2021-22 than in 2020-21 [8]. The fact that NSW residents are spending so much more on primary care than on hospitals may indicate that cost is a factor in choosing hospital care over primary healthcare. This would appear to align with the evidence as AIHW data indicates that emergency department presentations per capita are 8% higher in NSW than the Australian average, higher than any state or territory except for the Northern Territory [9]. Notably, AIHW data also indicates that ED presentations are lowest in Victoria, where public health spending is highest, and highest in the NT where public health spending is lowest [2] [9].

This evidence highlights the importance of chronic conditions, multimorbidity and cost as the drivers of healthcare demand and need. It stresses the importance of integrated and community-based approaches to health system growth and priority setting. Primary care and prevention are becoming more and more essential for promoting health equity in NSW, given their links to improving outcomes for disadvantaged communities. Further action is essential to ensure the future financial viability of the NSW health system given the additional costs imposed by chronic conditions and multimorbidity alongside Australia's ageing population.

Section 2 - Re-orientation of the health system in NSW to a Primary, Community based preventative system

Studies suggest that bolstering primary and community healthcare can mitigate the burden on emergency departments, reduce avoidable hospitalisations, and yield substantial savings. Investing in primary and community care could translate to cost-savings, better management of chronic diseases, and improved overall health outcomes [10] [11]. Studies by both the RACGP and Victoria University concluded that for every $1 invested in primary and community care the health system can expect to save between $6 and $9 [12] [13].

The Grattan Institute estimated in 2016 that each year there are more than a quarter of a million hospital admissions for health problems that potentially could have been prevented by improved primary and community care for chronic disease [14]. Since this report was published ED presentations in NSW have grown by 23% and NSW Government spending on primary care has been reduced twice, in 2016 and again by 17% in 2019 [2] [6]. Grattan argue that at best, our primary care system only provides half the recommended care it should for chronic conditions, for example, nearly a million Australians have been diagnosed with diabetes, but only a quarter get the care that is recommended each year [14].

A study conducted by Western Sydney Diabetes tested the HbA1c levels of 1267 patients presenting to Blacktown Hospital ED. They found that of these patients, 40% had diabetes, 30% were prediabetic and 30% had normal HbA1c levels (see Figure 4) [15]. This figure is 7.5 times the rate the ABS estimates for all Australians and 3.5 times the rate that NSW HealthStats estimates for Western Sydney [16] [17]. This disparity indicates that there is likely to be a significant proportion of chronic diseases that go undetected, undiagnosed, and untreated, further driving complications and health costs.

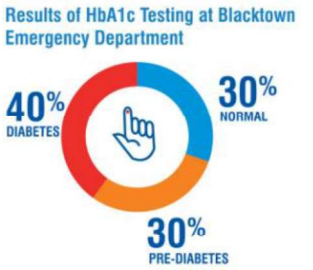


Figure 4: HbA1c testing at Blacktown Hospital ED, Western Sydney Diabetes

Investing disproportionately in primary, community and preventative care over the coming decade will allow NSW Health to rebalance its services portfolio more in line with Australian and OECD averages and progressively reduce the over-reliance on Emergency Department and acute care. Focussing on community need, public health, and integrated, value-based care in partnership with PHNs and community based primary and community care providers will achieve better sustainability, patient/provider experience, outcomes, and a more equitable approach to care.

Key Recommendations:

Recommendation 1 – Increase the proportion of funding allocated to community services, prevention, and early intervention, working in partnership with PHNs, primary health care and other community service providers.

Recommendation 2 – Enable PHNs and LHDs to establish and support community services, aligning them with local needs to promote integrated primary, community, and acute service models.

Section 3 - Urgent Care Clinics: Improving access in community to address increasing Emergency Department demand

Access is crucial for tackling ED overcrowding; primary healthcare providers, typically active during standard business hours, create a gap after 5 PM for those in need of medical assistance. This often directs individuals to their local ED post-business hours.

Four years of Lumos data from South-Western Sydney PHN confirms this, indicating a consistent peak in lower urgency and non-urgent presentations between the hours of 6 and 9 PM, and 8 and 9 AM. Furthermore, a study by Stephens and Broome into patterns of low acuity ED presentations in NSW concluded that lower GP density and non-business hours were associated with increased ED presentations [18].

As outlined above lower acuity ED presentations are a major issue in NSW with Semi-urgent presentations comprising almost 40% of NSW ED presentations and non-urgent admissions a further 8% in 2023, down from 13.7% in 2021 [6]. Examining this, the NSW Agency for Clinical Innovation conducted a rapid evidence check of several primary healthcare interventions to reduce after-hours ED presentations. Studies reviewed by the ACI found significant links between expanding after-hours care and reductions in ED presentations, hospital admissions, length of stay in hospital, fewer presentations and admissions from lower triage groups, and cost savings [18].

Recognising the need to reduce lower urgency ED presentations in NSW, and relieve pressure on our state's emergency departments, the Western Sydney Primary Health Network (WentWest) joined forces with Western Sydney Local Health District (WSLHD) to trial a primary care alternative to after-hours ED presentations, Urgent Care Clinics (UCCs). WSPHN and WSLHD submitted a joint proposal to the Ministry of Health to be an early adopter of the Collaborative Commissioning model. This model is built on the premise that by uniting and engaging partners across the primary health and acute care space, we can transform the way we deliver health care in our community. The objectives were to take a whole-of-system approach to design, deliver system change, and incentivise local autonomy and accountability for delivering patient-centred and outcome-focused care. Under the Collaborative Commissioning model WSPHN and WSLHD co-designed a Value-Based Urgent Care (VBUC) pathway to reduce the number of low acuity conditions requiring 'urgent' treatment presenting to emergency departments.

UCCs are operated by existing General Practices, in partnership with other providers across the Healthcare Neighbourhood. This network approach leverages the resources of the LHD and the capability building and commissioning capacity of the PHN to ensure patients can receive timely care for low-acuity conditions while reducing the burden on emergency departments.

An urgent care line was established to triage and connect patients to the right point of care based on their presenting symptoms. Triaging patients via telehealth also reduces wait times and ensures that patients receive the right care, delivered at the right time. This also facilitates team-based care and alternative care to be provided at UCCs, for example, care provided by mental health and other allied health professionals. These alternative care pathways are communicated to patients via triaging and further reduce burdens on the healthcare system, particularly when community-based alternatives are more suitable for patients.

In the past year:

- 2,144 patients have received treatment in UCS centres, avoiding ED visits.
- 46% of these patients were children.
- The Urgent Care Line has triaged 1,190 calls to the most appropriate point of care.
- Patient experience has improved, with a reported 95% satisfaction rate with the service.

The systems, supports and implementation of this program in Western Sydney closely aligned and linked with the expansion of the urgent care program via NSW Health and Commonwealth urgent care initiatives which followed as a result of this joint PHN and LHD initiative.

Implementation of UCCs in Western Sydney highlighted that the successful implementation of this model relies on:

1. Strong regional governance across LHD and PHN (with equal representation) along with support from the Commonwealth and the Ministry of Health.

2. Consumer and clinician co-design from the start and ongoing co-production to monitor, evaluate and continuously improve the model.
3. A team-based approach for producing effective solutions to patient flow.
4. Acute, primary care and service providers that are aligned and connected via shared care and empowered to deliver more comprehensive and efficient care to their patients.

Key Recommendation:

Recommendation 3 – Continue to invest in urgent care services embedded within primary care providers in community through PHNs, working in partnership with LHDs. Support the establishment of infrastructure, including integrated access to outpatient services, LHD/Speciality Health Network community outreach, mobile diagnostics, community messaging and communications and a central intake service to triage and book patients into the most appropriate service in the health system for their need.

Section 4 – Integrated Care

Integrated care involves prevention and management of complex, chronic conditions through a teams-based approach to shared care but has applications at all points of one's life stages. It necessitates a greater focus on a person's health needs through better communication and connectivity between healthcare providers in primary care, community, and hospital settings; and better access to community-based services close to home [19].

Integrated care is an approach to healthcare that seeks to provide comprehensive and coordinated services to patients, particularly those with complex or chronic conditions [19]. It involves the coordination of various healthcare providers, including doctors, nurses, social workers, and other health professionals, to ensure that patients receive the care they need in a timely and efficient manner [20] [21].

At its core, Integrated Care is about putting the patient at the centre of the healthcare system and ensuring that their needs are met in a holistic way. This means addressing not only their physical health, but also their mental, emotional, and social well-being. Integrated care can take many forms, depending on the specific needs of the patient and the resources available in the healthcare system. Some examples of integrated care models include:

- **Care coordination**: This involves a designated care coordinator who works with the patient and their healthcare providers to ensure that all aspects of their care are well-coordinated and that any gaps or redundancies in care are addressed.
- **Collaborative care**: This involves a team of healthcare providers from different disciplines working together to provide comprehensive care to patients. For example, a patient with diabetes might receive care from a primary care physician, a nurse practitioner, a diabetes educator, and a nutritionist, all working together to manage their condition.
- **Patient-centred medical homes**: This is a model of primary care that emphasizes a comprehensive, coordinated, and team-based approach to care. Patients have a designated primary care provider who serves as the "home base" for their care, but they also have access to a range of other healthcare professionals who work together to support their health and well-being [20].

Overall, integrated care is about breaking down silos in the healthcare system and ensuring that patients receive the right care, at the right time, in the right place, from the right providers. By improving coordination and communication among healthcare providers, integrated care can improve outcomes for patients, reduce healthcare costs, and enhance the overall quality of care [20]. Evidence tells us that integrated care has many benefits for both the patient and the health system including:

- **Improved patient outcomes**: By ensuring that patients receive comprehensive, coordinated care that addresses their healthcare needs.

- **Enhanced patient experience**: Integrated care puts the patient at the centre of the healthcare system, improving patient experience. By providing patient-centred care that is tailored to their individual needs and preferences, patients may feel more engaged in their care and more satisfied with their overall healthcare experience [21].
- **Reduced healthcare costs**: By coordinating care and avoiding unnecessary duplication of services, integrated care can help reduce healthcare costs over time. This can be particularly beneficial for patients with complex or chronic conditions who require frequent healthcare services [19].
- **Improved healthcare efficiency**: Integrated care can help improve the efficiency of the healthcare system by reducing fragmentation and improving communication among healthcare providers. Integrated care can also lead to expanded workforce competencies across sectors and can help ensure that patients receive the right care, at the right time, in the right place, and from the right providers [19].
- **Enhanced healthcare quality**: Integrated care can help improve the overall quality of healthcare by promoting evidence-based care, reducing medical errors, and ensuring that patients receive appropriate care based on their individual needs and circumstances [18].

Recognising integrated care's potential in prevention and management of chronic disease and multimorbidity, and reducing the burden on EDs, WSPHN spearheaded several projects in integrated care over the last decade in partnership with NSW Health.

The Chronic Disease Management Program (CDMP) (2010-2014)

The CDMP was intended to improve the health, wellbeing, and independence of patients with complex chronic disease over 16 who were at risk of multiple unplanned visits to hospital. Once enrolled in the program, the CDMP focused on the patient's individual needs and sought to link together the health services required to care for that patient.

The CDMP provided care coordination and health coaching to help manage patient's chronic conditions. Toward the end of the CDMP, Western Sydney was named as one of three Integrated Care Demonstrator sites across NSW under the ***Integrated Care Program (ICP)*** which was the next generation of the CDMP.

Integrated Care Program (ICP) (2014-2018)

The ICP continues to foster the relationships that had been built under CDMP and allowed further expansion of care coordination, including the funding of the first-generation digital shared care planning tool (LinkedEHR). ICP advanced integrated care in Western Sydney in several ways:

- Improved Integrated Care and Health Care Home practice capacity, efficiency, and ability to provide comprehensive patient care.
- Enhanced shared care planning capability to support Integrated Care & Health Care Home patient cohorts (including investments in chronic disease management nurses)
- Enabled effective data linkage and sharing across WSLHD and WSPHN to support decision making, efficient resource allocation and cost-effective care.
- Improved medication management of patients enrolled in Integrated Care & Health Care Homes via the deployment of clinical pharmacists in general practice.

An analysis of the Western Sydney Integrated Care Program by CSIRO revealed that preliminary findings showed a notable impact for patients who were enrolled or had attended the RASS component of the service, as follows:

- A 34% reduction in the number of hospital admissions from 8341 to 5484.
- A 37% reduction in potentially preventable hospitalisations from 3219 to 2044.
- A 32% reduction in ED presentations from 9978 to 6760.
- In total 15,085 occasions of service were provided by RASS including, 5066 for type 2 diabetes, 5942 for coronary artery disease or congestive cardiac failure, and 4077 for chronic obstructive pulmonary disease [22].

Collaborative Commissioning (2019-Present)

The Western Sydney Care Collective (WSCC) is a partnership between WentWest (WSPHN) and WSLHD. Service gaps are collaboratively commissioned through WentWest's strategic commissioning function and WSLHD's resources are realigned to support the integrated community-based care pathway.

Through integrated governance, delegations, shared culture, information sharing, community engagement and communications, WSCC allows WentWest and the WSLHD to overcome organisational barriers and work together to support the patients, families and carers who need care [23]. The collaborative commissioning model takes a regionalised approach to addressing local healthcare needs.

The models are underpinned by planned realignment of LHD non-admitted patient services and acceleration of the transformation of primary care to take on additional models of care down the track. It incentivises local partnerships and integration of care across the entire care continuum and embeds local accountability for delivering value-driven, outcome-focused, and patient-centred care.

The Western Sydney Care Collective's Collaborative Commissioning encompasses two care models: Value-Based Urgent Care (discussed previously) and the Cardiology in Community model (discussed below).

According to 2020 data, 365,593 individuals in Western Sydney possess risk factors that could be addressed through early cardiology care interventions. Within this population, 130,298 individuals aged 65 and above are at risk of atrial fibrillation [23]. Early intervention is crucial for managing cardiovascular issues and averting chronic illnesses and complications. Such proactive measures have been shown to benefit both patients and the healthcare system by inducing reductions in associated health issues including:

- Strokes that are associated with atrial fibrillation.
- Emergency department (ED) presentations and hospital admissions for patients exhibiting chest pain symptoms.
- Unnecessary referrals for specialised cardiology care.
- Hospital readmission rates for atrial fibrillation and heart failure patients [24].

Following the WSCC principles, Cardiology in Community (CIC) takes a whole-of-system approach to enable the delivery of value-based care in the community, ensuring that health care is outcome-focused and patient-centred, and provided at the right time, in the right place, the first time. CIC achieves this through general practice and the wider healthcare neighbourhood in concert with WSLHD who contribute to the program via their chronic and complex care nurses and rapid access stabilisation nurses (RASS).
CIC was designed to:

- Increase screening for people at risk of CVD.
- Enhance management and treatment for patients with atrial fibrillation.
- Improve access to Rapid access stabilisation services.
- Increase support for general practice and enhance capacity for cardiology management in the community.
- Reduce the volume of avoidable ED presentations.

The Cardiology in Community program has three stages:

1. **Early intervention**: Early intervention through proactive patient screening is a key component of this pathway design. With the aim to reach a larger population of at-risk patients earlier, the design uses a two-pronged approach to screening:
    - Opportunistic screening undertaken by Healthcare Neighbourhoods (HCN) and care providers.
    - Targeted screening carried out by Patient Centred Medical Home (PCMH) practices.

2. **Ongoing management and escalation**: This pathway is designed around the PCMH and its associated HCN and outlines how the PCMH will deliver ongoing management and care to a patient who has been diagnosed with atrial fibrillation, with support from the HCN. This seeks to optimise ongoing management delivered through:
    - Enhanced ongoing monitoring of patients diagnosed with atrial fibrillation, including by providing patients with remote monitoring devices when appropriate.
    - Integrated shared care planning.
    - An improved coordination of care.

In line with standard practice, treatment, and ongoing management, plans for different patient types will continue to be defined in HealthPathways. This design will encourage a dynamic relationship between the PCMH, its associated HCN and specialist services, which will result in coordinated and timely care.

3. **Handover of care from acute services**: This pathway design focuses on the importance of connecting patients back to the general practice care setting, particularly after discharge from hospital services. This is achieved through:
    - Enhanced discharge planning and increased support post-discharge.
    - Transition back to care in a general practice setting.

SNPHN Collaborative Commissioning model

Similar initiatives are progressing across NSW, with Sydney North PHN (SNPHN) devising a collaborative commissioning model in alliance with Sydney North Local Health District (SNLHD), aiming to dissolve health system silos and deliver integrated, timely, and proactive community care to reduce avoidable ED presentations. A pathway, fostering robust collaboration between primary care and hospital sectors, has been developed to ensure care is more coordinated and tailored to individual needs across all settings. The initiative primarily targets frail and elderly individuals aged 75 and over, residing in the community or Residential Aged Care Facilities, who are at a heightened risk of hospitalisation.

The initiative's design was informed through consultations with 74 primary care staff across 31 practices, 11 LHD services, NSW Ambulance, and 10 aged care and commissioned support services. Consumer focus groups, individual interviews, and a large group workshop were conducted alongside a survey involving 253 individuals aged 75 and over, and 92 carers, facilitated by 34 community organisations. The initiative's implementation and monitoring are conducted in close coordination with the NSW Ministry of Health (funders) and a diverse group of clinicians and executives across the partnership, with program outcomes being evaluated and discussed at local committees through joint governance arrangements.

The Pathway provides flexible services tailored to an individual's specific needs taking into consideration their overall health status. They are divided into four sub-components:

1. GP in-reach services which include a GP quality improvement program and care coordination.
2. GP outreach where Geriatricians work collaboratively with GPs to manage their complex patients.
3. Hospital in the home and remote patient monitoring which includes the use of Bluetooth-enabled devices to take measurements of patients' vital signs.
4. Rapid response which is a Geriatric medical outreach team who provide acute assessment and treatment for people in RACFs and the community.

As of May 2023, 51 GPs have signed up and 100 patients have been enrolled into the quality improvement program. There have been more than 3700 referrals made to the Geriatric Rapid Response Service, with 60 per cent of those patients avoiding an ED admission. Rapid Response has also intercepted nearly 800 NSW Ambulance call-out events resulting in 650 ED transports avoided.

Building alliances across state, federal and private organisations requires trust, transparency, and time before it is an embedded way of working. The Northern Sydney partnership has worked closely together to develop a shared vision that fosters system-level design and thinking. Collaborative commissioning, initially focused on a limited scale (frail and older people aged 75 and over), aims to demonstrate proof-of-concept in changing the way health services are commissioned and funded. The pathway is continuously adapted to meet the needs of GPs and their patients as well as responding to opportunities arising from state and federal initiatives.

The focus of Year 2 is to grow pathway services by increasing capacity of the workforce and increasing the number of patients that are treated in the community. This will contribute to the overall goal which is to reduce avoidable ED admissions.

Key Recommendations:

Recommendation 4 – Expand and build upon past integrated care programs to further progress shared care models between outpatient clinics, community health centres, general practices and other community-based providers for the prevention and management of chronic conditions and avoidable hospitalisations.

Recommendation 5 – Improve the coordination and linkages between primary and acute care via enhanced governance arrangements between PHNs and LHDs.

Section 5 – Collaboration among all sectors in Australia's healthcare ecosystem is required to achieve sustainable health savings

Australia's healthcare system is a complex web of public and private providers, encompassing hospitals, general practitioners and other primary care providers, specialists, insurance providers, and various government agencies. There is a growing realisation that social determinants such as housing and education also impact on health.

Attaining healthcare savings and efficiencies requires a well-planned, long-term, and collaborative approach that engages many government jurisdictions and sectors – both within and outside of health. Policy changes in one area have significant flow-on effects in other sectors.

Neither the federal nor the state governments can achieve health system reform by acting alone.

Australia has an overarching policy and governance structure for a joined-up government response to health reform. All Australian governments signed up to the National Health Reform Agreement (NHRA) in 2011, which was updated at regular intervals, including in 2020 where long-term reforms that required inter-government collaboration were outlined in an Addendum. The goals of the NHRA are to deliver safe, high-quality care in the right place at the right time, prioritise prevention, and help people manage their health across their lifetime and to drive best-practice and performance using data and research. Joint planning and funding at a local level are key to implementing the NHRA.

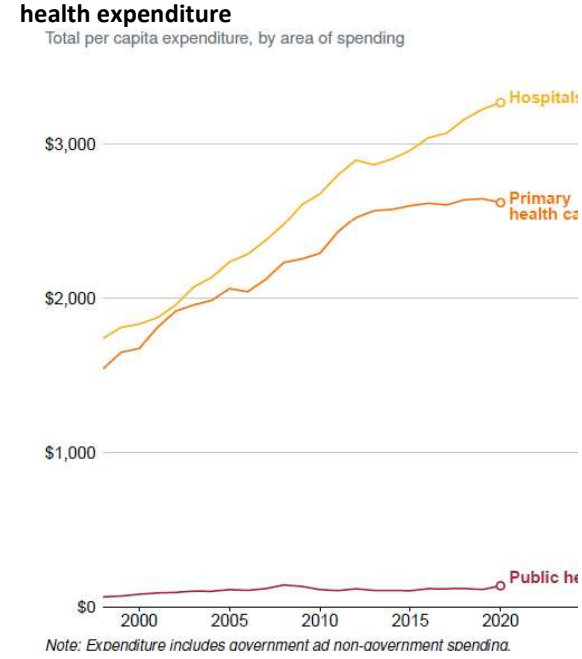
However, the recent *Mid-Term Review of the National Health Reform Addendum 2020-2025* received evidence that the NHRA has not brought about the funding and structural changes needed to ensure our health system is fit for the future [25] [26].

Commonwealth and NSW Government policies have recognised that health investment must shift away from hospitals and towards community-based and primary care, and that new models of integrated multidisciplinary care must be introduced to cope with the rising burden of chronic and long term conditions [27] [28]. Primary health care in particular is widely recognised as a key component of all high-performing health systems [29].

Moving towards this type of health system will deliver improved patient experience and outcomes while at the same time ensuring financial sustainability of the health system, improved workforce productivity and importantly, equity of health outcomes [28] [30].

Contrary to the goals outlined in the NHRA, a report by the Grattan Institute has revealed an opposite trend in Australia. Instead of curbing the rise in hospital spending, growth in hospital funding has exceeded that of primary care and public health (see figure below) [26]. The Building a Stronger Medicare funding initiative announced in the 2023-24 Federal Budget is anticipated to go some way to bridging this funding gap, but state level action is also required [31].

Figure 5: Hospital cost growth has outpaced other health expenditure



Australia must heed the lessons learned from similar international health systems. In the UK, The King's Fund, a prominent think tank, published a report suggesting that the performance of the NHS has been in decline since 2010 and is in a state of crisis. Despite numerous warnings from health economists, hospitals experienced higher activity and spending compared to primary care and community services. Similarly in Australia, funding for primary care and community services even decreased over the ten-year period. These trends persisted despite policy initiatives aimed at shifting care and resources from hospitals to community-based services and supporting the development of innovative integrated care models [32].

The pressure points exerted on the hospital system can be seen at the intersection of federal and state government programs. For example, a lack of funding for aged care and barriers to GP attendance in aged care facilities has resulted in residents increasingly relying on the public hospital system. This is seen in an increase in ED presentations and also extended hospital stays while people wait for admission to an aged care facility. The Illawarra Shoalhaven region has more patients in acute hospital beds waiting for aged care placement than anywhere else in NSW [33]. Funding was announced in the Federal Budget 2023-24 and by the NSW Minister for Health to address both these issues, but additional effort is required at the state level.

In addition, PHNs are involved in co-commissioning mental health services with NSW Health in order to overcome gaps and barriers, under the bilateral agreement between the Commonwealth and NSW under the National Mental Health and Suicide Prevention Agreement [34]. These are designed to overcome serious workforce issues – for example there are rural and regional areas in NSW whose residents have no access to a psychologist or psychiatrist, despite their needs for medium and high intensity mental health care.

In times of financial constraints, there is a risk that innovative health reform initiatives, such as the implementation of the bilateral agreement, may be delayed or scrapped altogether. However, the integration and interoperability of health, primary care, aged care and disability sectors will be required to provide a fit for purpose, efficient health system. Our stakeholders have told us that the LHDs are overstretched, with demand for services exceeding what they can supply.

This makes it understandably difficult to engage in any long-term reform activities as they are dealing with an influx of patients – who could have been treated earlier in more appropriate setting for a lower cost to the health system. There is also growing realisation that social care – including housing, education, and welfare – are also key factors impacting health care needs.

Health savings in Australia are attainable, but they require a concerted effort from all sectors involved in the healthcare and social care ecosystems. By fostering collaboration, breaking down silos, embracing innovation, and implementing effective policies, Australia can not only reduce healthcare costs for the long term but also enhance the overall quality of care provided.

To progress these reform activities need the support of the highest levels of NSW Health.
To achieve savings, NSW Government policymakers must support enhanced efforts to collaborate with the Commonwealth government, PHNs, primary care, healthcare experts and stakeholders to design policies that support and incentivise cost-effective practices, foster innovation, integrated models of multidisciplinary care, and prioritise primary and preventive care. Health reform activities require protected funding as well as the support of management. In the long term these activities will lead to the optimised management of people with multiple, chronic conditions as well as reduce the rates of preventable hospitalisation.

Key Recommendations:
Recommendation 6 - That the NSW Government allocate additional funding and prioritise activities aligned with the national health reform agenda, while actively removing barriers hindering their progress.

Section 6 – Community Care Service Budget

The NSW Health system provides funds to LHDs to deliver community care services, NSW Health commissions services into regional communities and PHNs commission services within their regions. In addition, a range of NSW government departments, such as the Department of Communities and Justice, commission the same service providers on the ground to deliver services (social care services in this example).

Throughout this submission, we have outlined the importance of integrated primary and community healthcare interventions as crucial for improving population health, outcomes from chronic diseases, and reducing avoidable demand on EDs. We have also outlined the successes NSW PHNs have had in spearheading interventions in these areas in collaborative partnership with LHDs and the NSW Government.

To continue to build on this collaborative work and outcomes achieved to date, it would be helpful to clarify the core service offerings of NSW Health/LHDs, recognise the core service offerings of PHNs and the principals to determine which services are best commissioned and provided by community-based providers vs. directly by NSW Health.

This clarity on roles and responsibilities will then enable efficient and effective delivery and integration of services and better enable the equitable distribution of funding, prioritising areas with scarce access to primary and community care. The equitable distribution of funding and development of integrated care solutions could be facilitated by joint needs assessments conducted in partnership between LHDs and PHNs, utilising our joint expertise to capture a whole-of-system assessment of the health needs of our region.

A next step to achieve this, would be the implementation of the joint statement (see *Attachment 1*) and referencing this statement, roles and responsibilities within LHD Service Level Agreements. Monitoring progress across NSW Health with respect to core KPIs around integrated care, patient experience and joint governance will also be important.

To ensure maintenance and increasing of the relative investment in community services over time, as previously discussed, it would also be beneficial to monitor spending on community-based services separately to total LHD Service Level Agreements budgets, as is done by the Commonwealth with respect to PHN program spending.

Social impact and innovative funding models

Given the substantial impact of integrated care programmes and collaborative commissioning models, it would be beneficial to explore innovative funding models that further incentivise such collaborative approaches. Social impact funding, for instance, could be leveraged to drive community-centric healthcare interventions, particularly for chronic disease management and preventative care. By aligning funding with measurable social outcomes, such as reduced ED presentations and hospital admissions, resources can be more effectively channelled to programmes that demonstrate tangible benefits to community health. Furthermore, establishing clear governance frameworks within collaborative models like the Western Sydney Care Collective, can enhance accountability and ensure a patient-centred focus. The integration of early intervention programmes like the Cardiology in Community model, with a funding structure that rewards successful patient outcomes, can potentially foster a sustainable and innovative healthcare ecosystem. Engaging diverse stakeholders, including Local Health Districts, Primary Health Networks, and other community-based providers, in a shared financial risk and reward model, can further encourage the holistic and integrated approach necessary to address the complex health needs of the community.

Key Recommendations:

Recommendation 7 - That The NSW Government recognises the interconnectedness of their roles and actively works together with the Commonwealth, PHNs, and stakeholders including the primary care sector to create a sustainable, cost-effective, and patient-centred healthcare system for the future.

Recommendation 8 - Embed the implementation of the joint statement between NSW Health, NSW PHNs and the Commonwealth Department of Health and Aged Care into the Service Level Agreements between LHDs and the Ministry and within the Core Funding contract between the Commonwealth and NSW PHNs.

Recommendation 9 - Monitor spending on community-based services separately to total LHD Service Level Agreements budgets.

Recommendation 10 – Implement Innovative Funding models, applying flexible funding approaches such as including social impact bonds and equivalent, to foster investment in locally led and centrally supported solutions that are person-centred, sustainable, and outcome-focused.

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