HPA
HEALTH POLICY ANALYSIS

Commonwealth Department of Health

Evaluation of PHN After Hours Program

Final report

Volume 2: Main report

Revision history

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Disclaimer

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Abbreviations

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
ACSQHC	Australian Commission on Safety and Quality in Health Care
AIHW	Australian Institute of Health and Welfare
CALD	Culturally and linguistically diverse
ED	Emergency department
GP	General practitioner
HNECC	Hunter New England and Central Coast
HPA	Health Policy Analysis
LETSS	Lived Experience Telephone Support Service
MABEL	Medicine in Australia: Balancing Employment and Life
MBS	Medical Benefits Schedule
MMM	Modified Monash Model
PHN	Primary Health Network
PIP	Practice Incentives Program
RACGP	The Royal Australian College of General Practitioners
SES	Socio-economic status
SWPE	Standardised whole patient equivalent

1. Introduction

PHN After Hours Program aims and objectives

The Primary Health Network (PHN) After Hours Program started in 2015–16, the same year that PHNs were established across Australia. The program was the Australian Government's response to a recommendation from a review of after-hours primary care (Jackson, 2014Table 10A.50). The program partly replaced arrangements that had been in place with Medicare Locals, and some earlier arrangements with Divisions of General Practice.

The broad aims and objectives of the PHN After Hours Program are to:

1. Increase the efficiency and effectiveness of after-hours primary health care for patients, particularly those with limited access to health services.
2. Improve access to after-hours primary health care through effective planning, coordination and support for population-based after-hours primary health care.
3. Improve the availability of after-hours GP services through working collaboratively.

The specific objectives are set out in a Standard Funding Agreement Schedule between the Department and PHNs (Department of Health, 2015b) detailed in Chapter 4. In 2019–20, $71 million was allocated to the PHNs through the program. In addition to the program, the Australian government supports primary care after-hours services through:

- Benefits paid for specific after-hours Medical Benefits Schedule (MBS) items.
- Incentives to primary care practices for after-hours arrangements for their populations, through the Practice Incentive Program (PIP).
- Use of non-vocationally registered GPs to provide MBS-eligible services (through the Approved Medical Deputising Service Program).
- Support for Healthdirect, including the After Hours GP Helpline (available for selected regions in Australia) and other services.

Purpose of the evaluation

The Department of Health commissioned Health Policy Analysis (HPA) to evaluate the PHN After Hours Program. Conducted between October 2019 and November 2020, the evaluation aimed to assess how well the program is being delivered and whether it continues to be the right response in the current context. Specifically, the evaluation looked at the extent to which:

- PHNs achieved the objectives of the program
- the program is value for money
- data indicate the successes or lessons learned.

Issues that have been specified as out of scope for this evaluation include:

- the effect of the program on population health

- the clinical appropriateness of after-hours services supported by the program
- the effectiveness of other after-hours programs.

The services within the scope of this evaluation include all services and activities commissioned or undertaken by PHNs as part of the program. The range of services commissioned is broad and includes both physical and mental health services, direct patient care and activities directed at service providers, and those that aim to improve the workings and capacity of the local primary health care system.

Evaluation methods

The evaluation methods were specified in an *Evaluation plan* approved by the Department in December 2019 and detailed in Volume 4. Briefly, they included developing an initial program theory represented from both the perspective of the program (i.e. the program logic) and from the perspective of the patient (i.e. patients' 'journey' when a health issue requires attention after hours). Detailed evaluation questions were specified, and sources of data and a plan for analysing these data developed to answer the questions. The details are set out in Appendix 1, Volume 4.

Figure 1 summarises the evaluation methods and data sources.

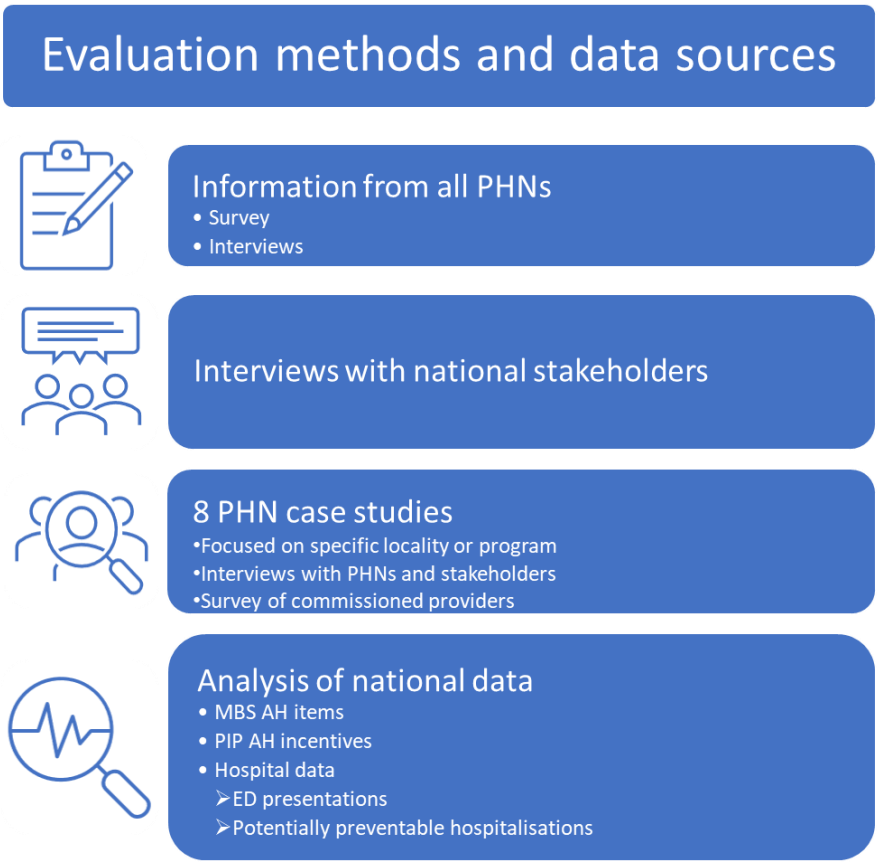


Figure 1 – Evaluation data sources

Table 1 provides further details on the data sources.

Table 1 – Data and sources

Data	Source
National data: Analysed at the Statistical Area 3 (SA3) level or PHN level and, where possible, using monthly time-series.	
MBS services and benefits paid	Services Australia MBS Item Statistics Reports AIHW reports Specific data request approved by the Department of Health Data Request Assessment Panel
Practices receiving PIP After Hours Incentive payments	Department of Health publicly released data and a specific data request approved by the Department of Health Data Request Assessment Panel
Healthdirect statistics	Accessed through Healthmap
Low-urgency ED attendances in after-hours period	AIHW reports Analysis of the Department of Health's holding of the Non-admitted Patient ED data collection
Potentially preventable hospitalisations	AIHW reports Analysis of the Department of Health's holding of the Admitted patient care data collection
Resident population demography and socio-economic characteristics	ABS statistics
Characteristics of commissioned services	
Activity Work Plans and performance reports 2015–16 to 2019–20	Department of Health
PHN survey	Conducted by HPA
Analysis of local needs assessments, plans and evaluations where available	PHNs and online
Perspectives on the program	
Interviews with national stakeholders	Stakeholders advised by Department of Health
Interviews with PHNs	All PHNs approached
Case studies	
Interviews with PHN and range of stakeholders	As advised by PHNs
Survey of commissioned providers	Conducted by HPA

The evaluation also involved a review of local and international literature on models of after-hours service provision. More information is available in Appendix 5, Volume 4 of the report.

Surveys

PHN surveys

The evaluation included the distribution of surveys to all 31 PHNs across Australia. The PHN survey was designed to help answer the program evaluation questions. The information collected through the surveys is set out in Box 1.

Box 1 – Information collected from survey of PHNs conducted February to May 2020

The survey collected the following information from PHN respondents:

- needs assessment process
- stakeholder consultations
- approaches to assessing after-hours needs and priorities
- priorities identified for the program

- designing and specifying services to be commissioned under the program
- the co-design process
- target group(s)and/or localities
- approaches to measuring outputs and outcomes
- how the program affects the demand for after-hours primary care
- perspectives on the success of commissioned services
- factors that have facilitated success
- factors that have hindered success

After initial contact with the PHN chief executive officers and requesting their participation in the evaluation, the survey was sent to them or a designated PHN contact. Since the survey was distributed during the period of the COVID-19 pandemic, the evaluation team and the Department of Health agreed on flexible time scales to accommodate the PHNs. Out of the 31 PHNs that received the survey, 28 PHNs completed the entire survey, two PHNs partially completed the survey and one PHN did not complete the survey.

After-hours provider surveys

In addition to surveying the PHNs, the evaluation team distributed surveys to selected after-hours commissioned providers operating within the eight PHN case study sites. After initial discussions with these PHNs regarding the scope and focus of the case studies, each site compiled a list of commissioned after-hours service providers, and these organisations received a formal request to complete a survey on their experience with the PHN After Hours Program. Box 2 sets out the information collected from the commissioned providers.

Box 2 – Information collected through survey of commissioned after-hours provider organisations within eight case study PHNs, conducted February to May 2020

The survey sought the following information from commissioned service providers:

- the nature of the services or activities provided under the program
- duration of the service(s)
- geographical coverage
- if and/or how the program focus has changed
- target population groups
- how the service has affected after-hours demand
- patient and volume measures
- program objectives
- factors that have facilitated success of service and the program
- factors that have hindered success of service and the program

There were 43 providers contacted and requested to participate. The survey was fully completed by 30 providers and partially completed by 7 providers, a response rate of 70% for full completion and 86% for partial completion.

Further information on the PHN and after-hours provider surveys, including the survey templates, is provided in Appendix 2, Volume 4 of the report.

Case studies

To explore the diverse after-hours landscape across Australia and assess the evaluation questions more thoroughly, eight case studies were conducted. Through these, the

evaluation team explored in greater depth the approach that PHNs have taken and obtained perspectives from local providers and stakeholders. The case studies were selected to reflect diverse contexts, geographies, populations, local after-hours provision and the nature of commissioned services. The case studies generally focused on specific program activities or on a specific locality. The case studies are detailed in Volume 3 with summaries included throughout this volume of the report. Table 2 provides a summary of the case studies.

Table 2 – Case studies overview

#	PHN	Scope	Focus
1	Eastern Melbourne	Service	PHN-commissioned activities within the PHN.
2	Brisbane South	Locality	Jimboomba, a town on the periphery of the Brisbane South PHN.
3	Perth South	Service	50 Lives 50 Homes After Hours Support Service that covers the whole of the PHN catchment.
4	Adelaide	Service	Lived Experience Telephone Support Service (LETSS) supported by the PHN and servicing the entire PHN catchment.
5	Tasmania	Service	GP Assist telephone service, a long-running service covering the whole of Tasmania.
6	Hunter New England and Central Coast	Service	GP Access Program, which services the Lower Hunter region, including Maitland, Cessnock, Newcastle, Port Stephens, Lake Macquarie and surrounding areas.
7	Northern Queensland	Locality	Tablelands and Bowen (Mackay area).
8	Northern Territory	Locality	Alice Springs township.

Impact of COVID-19

The evaluation was conducted during the period of the COVID-19 pandemic. Since March 2020, the pandemic response has markedly increased interaction between PHNs and the Commonwealth, state and territory health departments and local hospital networks. These groups have worked together to:

- provide clinical information to general practices and commissioned service providers
- establish fever clinics
- create COVID-19 health pathways
- distribute personal protective equipment to general practices
- support practices to provide telehealth consultations.

In addition to its profound effects on activities of the PHNs and the wider health system, the pandemic affected the conduct of the evaluation. The original evaluation plan included face-to-face interviews with PHNs and service providers in eight localities across Australia. The approach was adapted so that almost all interviews were conducted by phone or video conference. This meant the contextual detail and appreciation of places and people (the 'thick descriptions' characteristic of qualitative research) that would have been gleaned from in-person visits were not possible. Nevertheless, interviewees were cooperative and descriptive in their accounts of local environments. Coupled with evaluation team members' in-depth experience of the Australian health care system, especially primary care, this situation did not materially compromise the evaluation.

On the positive side, the timing of the evaluation has provided an opportunity to observe and reflect on how policies and services have adapted during the pandemic. Specific changes included the introduction of bulk-billed telehealth items under the MBS, which enabled primary care consultations to continue and fostered a significant switch to telehealth. This expansion of telehealth items led to an emergence of new providers and service models, in both the in-hours and after-hours periods.

These changes revealed various issues, including those relating to clinical governance, continuity of care and cost to government. The Australian Healthcare & Hospitals Association (2020) has responded to the pandemic with a report on telehealth and virtual healthcare. The Association recommends that consideration be given to designing services that are patient-centred, ensuring equity in implementation of virtual healthcare, ensuring there is cross-sector leadership and governance, workforce capability, interoperability of systems, and appropriate funding to support reform.

This fluid environment meant many discussions with PHNs and other stakeholders were prefaced with describing how things were 'in normal times' or 'pre-COVID'. There is uncertainty about whether recent changes will remain in place and how they will interact with provision and access to after-hours care. It is possible the evaluation has been carried out during a 'tipping point' in the evolution of after-hours and primary care more generally.

Report structure

The report is organised into four volumes:

- Volume 1 summarises the key findings and recommendations of the evaluation.
- Volume 2 (this document) is the main evaluation report. It describes the background and context and considers the overall after-hours landscape within which the PHN After Hours Program operates. It presents the evaluation findings backed up by quantitative and qualitative data.
- Volume 3 presents the eight case studies conducted for this review. These are summarised throughout Volume 2 of the report.
- Volume 4 describes the evaluation methods and includes supplementary analysis of data and reports on the detailed modelling work.

Case study: Eastern Melbourne PHN

Case study focus
The case study focused on after-hours services delivered throughout the entire PHN area.

Locality overview
Eastern Melbourne PHN has a population of 1.5 million people, spans 12 local government areas and takes in almost a quarter (24%) of the Victorian population (Eastern Melbourne Primary Health Network, 2018). Much of the PHN region is classified as urban, but the outer northern and eastern areas are classified as inner regional (Australian Government Department of Health, 2018).

PHN approach to after hours and after-hours commissioned activities
Eastern Melbourne PHN has shifted away from funding smaller scale, grant-based projects. The PHN needs assessment identified the following groups as priorities: young people under 15; people living in Banyule, Yarra Ranges, Knox and Manningham East; mental health issues, alcohol and other drugs (AOD) issue; people experiencing homelessness; those living in rural and regional areas and Aboriginal and Torres Strait Islander peoples. The PHN focused on four key areas.

Enhanced and innovative after-hours services:

- Innovative after-hours solutions – My Emergency Doctor telehealth service provides after-hours support to areas with limited access to after-hours services.
- After-hours ED diversion – a partnership between four local hospital networks and participating practices enabling practices to extend their operating hours into the after-hours period.
- After-hours clinic in the Outer East and the Northern Area of the PHN.

After hours vulnerable groups:

- After Hours Palliative Care in the North and East Program – weekend GP support provided to palliative care nurses
- Residential aged care facility (RACF) Redesign Capacity Initiative – workforce training and education to RACF staff, LHNs, GPs, telehealth and residential in reach (RIR) services to better manage RACF residents and limit avoidable ED transfers and hospitalisations.

After hours mental health:

- Extended hours for an Aboriginal mental health liaison officer and ED after-hours AOD worker.
- After-hours Mental Health Nurse and Liaison Service in the Box Hill community for low-acuity support.
- Mental health intervention services to families in the Northern area of the PHN.

After hours community awareness:

- Campaigns to improve awareness of after-hours options within the community, enhance overall health literacy of residents, and share information about current ED wait times after hours.

Key observations from the case study

- Stakeholders noted a **growth in demand** for after-hours services.
- In some instances, there appeared to be **limited trust in after-hours care options** beyond the ED.
- The **12-month program funding cycles** and **general uncertainty about the future of the program** impacted the PHN's ability to plan, co-commission and co-design after-hours activities, and commission larger-scale projects that may have had a broader impact on the PHN population.
- It is difficult for PHNs to **attribute the extent to which after-hours services reduce ED demand**.
- **Recruiting GPs and other health professionals to work after hours was an ongoing challenge** in the region and had become more difficult with changes to both the eligibility for MBS after-hours items and the recruitment of overseas doctors.
- **Collaboration, service integration and information sharing were continuing challenges** for stakeholders, and there are opportunities to improve these across the health system

2. After-hours primary care – an overview

Patient journey through the after-hours system

Figure 2 shows how patients journey through and engage with after-hours services. The Figure provides one way of conceptualising the key steps and decision points in this journey. Seven steps are identified:

A. Onset or exacerbation of a health issue in the after-hours period
B. Identifying the need to seek primary care after-hours care
C1. Awareness of the options
C2. System navigators and triage services
D. Deciding on an after-hours service provider
E. Consulting an after-hours services provider
F. Additional steps to resolve issue
G. Follow-up for after-hours services

At each of these steps, patients and their families may engage with different service providers who may help them navigate the system, provide an after-hours primary care service or contribute in some other way to resolving the patient's issue.

The Australian Bureau of Statistics estimates that 9% of the Australian population aged 15 years and older (1.8 million people) needed to see a GP after hours on at least one occasion in 2018–19 (Australian Bureau of Statistics, 2019)

This patient journey assumes that the onset or exacerbation takes place in the after-hours period. It is possible that patients may seek after-hours care during this period even though the need has not arisen in the after-hours period. This may be because the person cannot access care during the in-hours period and the condition worsens or the patient delays seeking care. This could be because accessible services are not available or the person has difficulty (because of work or other reasons) seeking care during the in-hours period. The patient journey described here does not distinguish between health care needs that arise after hours or at other times. However, access to services in-hours can affect the flows of patients and affect services in the after-hours period.

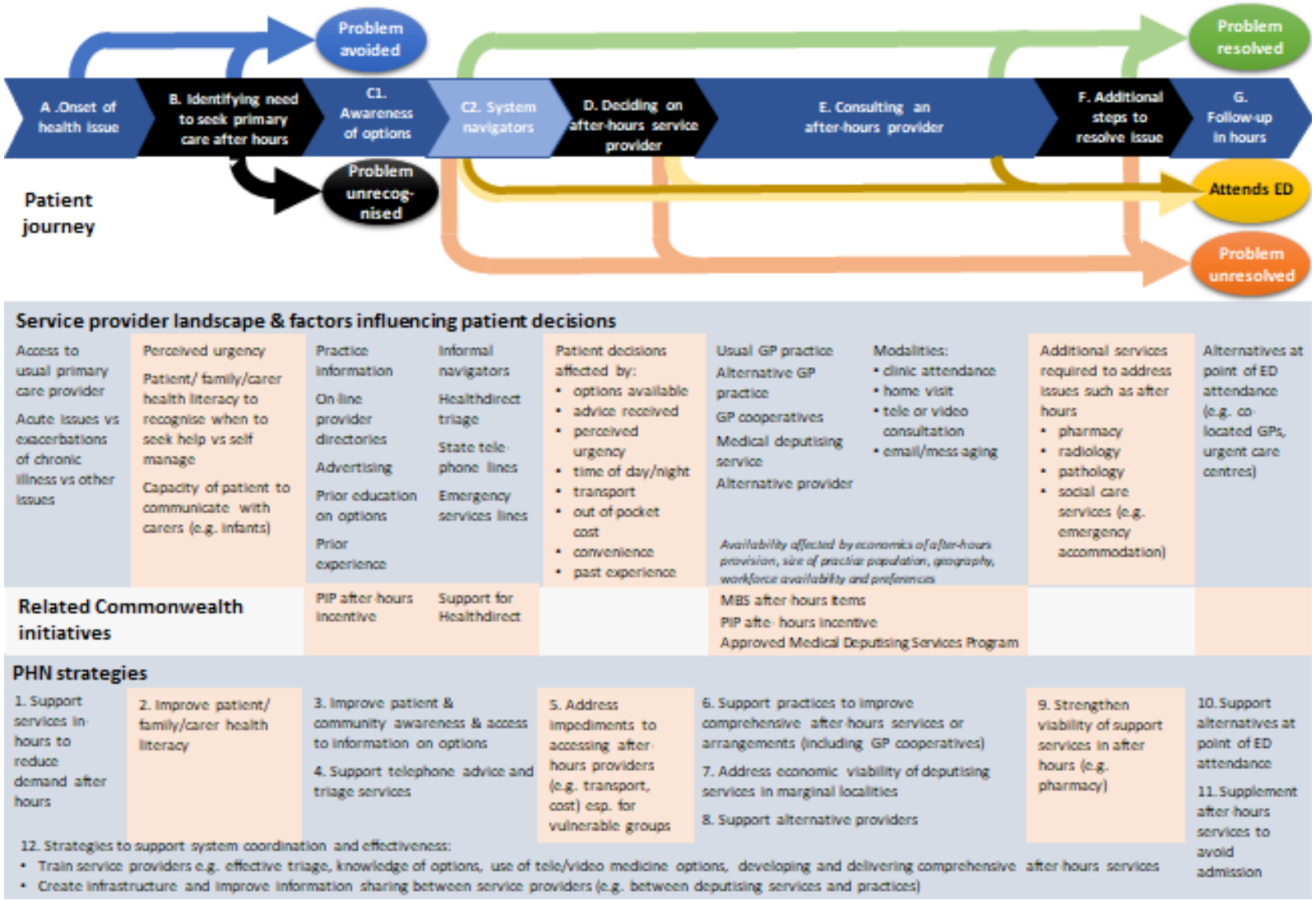


Figure 2 – How patients journey through and engage with after-hours services, and key points where interventions supported by the PHN After Hours Program may affect this journey

A. Onset or exacerbation of a health issue in the after-hours period

The journey starts with the onset or exacerbation of a health issue after hours. The types of health issues requiring access to primary after-hours care can vary greatly (e.g. acute infections, injuries, exacerbations of chronic conditions, problems in managing symptoms for people receiving palliative care, emergence or exacerbation of a mental health issue, running out of a prescription). They may also be affected by the patient's ability to communicate their symptoms (e.g. infants, people with dementia). The issue may arise after hours because patients have not been able to access primary care in-hours (e.g. because of work, lack of available appointments, or other reasons). Patients and their families and carers may recognise the need to seek primary care, but this cannot always be assumed.

B. Identifying the need to seek primary care after-hours care

Patients may feel they are able to deal with the health issue themselves with support from family and others. The extent to which they feel able to do so will depend on the severity of the issue, their level of health literacy and their capacity to **self-care**. Their level of health literacy and their capacity to self-care may in turn be influenced by the level of support patients have had from their practice, other support mechanisms such as patient support groups, and access to reliable information. If they feel unable to manage the condition or symptoms themselves due to their severity or other factors, they will feel the need to access care.

C. Awareness of options and system navigators

Having identified a need for care, decisions will be influenced by **awareness of options available** and through **formal and informal sources of advice**. Consumers navigate the system and its multiple entry points and pathways based on their own knowledge and experience of what is available and what works for them. Where they or their family have little knowledge and experience, they may obtain information from many different sources. The patient's usual primary care practice may provide information about options in a leaflet, through an after-hours telephone message or diverting calls to a deputising service, or through information provided on their website. Consumers may access information through the Healthdirect website, through an alternative provider directory or from other informal sources. They may be aware of a home visiting service through advertising.

> The Australian Bureau of Statistics estimates that 19.7% of people needing to see a GP after hours in 2018–19 were unable to do so. This ranged from 15.6% in major cities, 30.3% in inner-regional areas to 41.3% in outer-regional, remote and very remote areas (Australian Bureau of Statistics, 2019).

As described later in this report, the after-hours system is confusing for many consumers. There is no evidence that the situation has improved greatly from the 2014 Jackson review of after-hours services:

> Consumers generally were seen to have limited awareness of the services available to them in the after-hours period or how to access the most appropriate care (Jackson, 2014, p. 26).

Confusion arises from:

- the number of options available generally
- local variations of these options
- fluctuation in the availability of options across different after-hours periods
- changes in the availability of services.

Overlaying these issues is that consumers or their advisers need to decide which option is appropriate given their understanding of the urgency of their health problem. Improving community awareness of options and the health literacy of consumers in deciding which option to take is a large and complex task.

Consumers may seek advice from a **telephone advice and triage service**, such as the Healthdirect nurse triage service. These services will usually assess the urgency of the problem, and provide reassurance or direct patients towards an appropriate option.

In 2019 there were 825,000 calls to the Healthdirect nurse triage service, 72% in the after-hours period (Healthdirect Australia, 2019).

Patient decisions about which after-hours service to turn to will be influenced by the service providers available in the locality at the time they require care. But other factors will also influence these decisions such as transport, cost and past experiences. Not everyone that needs to see a GP after hours will be able to so. A survey by the Consumers Health Forum of Australia (2020) found that key issues in accessing after-hours care were:

- Mixed experiences of general practices providing **information** about what to do if a person needs to access care after hours.
- A lack of **available services**, especially in rural and remote areas.
- The **flux in service availability** with services coming and going making it difficult for consumers to keep track of what services were available.
- **Transport** to get to a clinic, particularly in rural and remote areas but also in metropolitan areas reliant on public transport.
- Difficulty in **accessing bulk-billed services** – an important factor contributing to patients deciding to attend an ED directly rather than a primary care alternative.
- **Wait times** for both primary care and ED care.

D. Deciding on an after-hours service provider

Patients may be directed to a specific service provider by a telephone triage service or through consulting the health directory or other sources. They will be guided by the options available to them, the advice or information accessed, the perceived urgency, time of day, transport and cost implications, and their past experience of what has or has not worked. Patients may not always follow the advice offered by telephone triage services.

In 2018–19, MBS-supported 12.2 million after-hours services – 1.2 million claimed as urgent.

81.5% of urgent services occurred in sociable hours – mainly evenings from 6 pm to 11 pm weeknights and Saturdays from noon to 11pm.

87.7% of non-urgent services occurred in a primary care clinic, 3.4% in a residential care facility and 8.9% in other settings, mainly patients' homes.

E. Consulting an after-hours care provider

Patients may access after-hours care through different options, including their usual primary care provider, another primary care service, a GP cooperative service or a medical deputising service. Other alternatives (such as urgent-care centres) may also be available. The resulting consultation may be undertaken through a clinic visit, a home visit, or through telemedicine. Consumers may also seek advice at a **pharmacy**.

F. Additional steps to resolve issue

As a result of an assessment by an after-hours GP or other health professionals, the patient may be reassured, provided with advice, prescribed treatment, referred for further diagnostic tests, referred for follow-up in-hours, or referred to an ED. Following the consultation, patients may still require additional services to resolve an issue, for example a

pharmacy to fill a prescription, radiology or pathology to assist diagnosis, or social care services. Lack of availability of these services can mean the issue remains unresolved.

At any of the stages described above, patients may present to an ED. This may be appropriate, reflecting a triage nurse, pharmacist or GP assessment that the issue requires urgent diagnosis or care in a hospital setting. An ED attendance may also reflect a failure of the primary care after-hours system in providing information, guidance or services that are acceptable and accessible. Many patients end up at an ED because it is the only option available or because it is the most visible part of the health system, it is open 24/7 and can be relied on to be available, and results in no additional cost. For some consumers, EDs are their preferred option if their own GP is not available or they do not have a usual GP.

In 2018–19 there were 1.4 million ED presentations for lower urgency conditions in after-hours periods.

G. Follow-up

At the point of attending an ED, a co-located GP service may be available as an option for patients. Where patients are assessed and treated within the ED, in some cases it may be possible to avoid an admission by having relevant support and referral services available within the ED. This may be the case if, for example, there are ways of assessing and dispensing medicines for patients with complex conditions or aiding access to social care services, such as for people who have experienced violence and need alternative emergency accommodation.

Box 3 – Description of potential proximal end points of the patient's journey

- **Health problem is avoided**. The need for care in the after-hours period may reflect issues in accessing primary care within hours and receiving preventive care. For example, good access to comprehensive primary care in managing chronic illnesses or an emerging acute issue, may reduce the likelihood of needing after-hours care. Patients, families and carers may receive education on their health conditions that allows them to either manage an emerging issue themselves through self-care or more accurately recognise when to seek care. Good access can ensure patients have access to preventive and health screening programs.
- **Health problem not recognised**. Patients fail to recognise the need to seek care because of lower levels of health literacy or high levels of stoicism, and as a consequence fail to seek care.
- **Health problem is resolved.** Includes situations in which the patient has a consultation with a primary care medical practitioner and the problem is assessed. As a result of the assessment the patient may be reassured, prescribed treatment (e.g. antibiotics) or referred for follow-up in-hours.
- **ED attendance**. A distinction is drawn between patients who attend an ED directly (not shown in the Figure) and those who are referred to the ED after assessment by a primary care practitioner or following assessment and triage – usually by a nurse – from a service such as Healthdirect. An ED attendance may also lead to a **potentially preventable hospitalisation**.
- **Problem unresolved**. This entails several situations, such as where the patient is discouraged from seeking care because of a lack of awareness of options, the absence of options, and factors such as transport or cost. Also, after being assessed by a primary care practitioner, the patient may be unable to access additional services necessary to resolve the issue, for example, being able to fill an urgently required prescription.

Figure 2 suggests five broad types of 'endpoints' for this journey, which are further described in Box 3. These are 'proximal' in the sense that they represent what happens in the after-hours period. Patient experiences associated with these outcome points are important to consider. Each endpoint may ultimately have implications for a patient's health outcomes, which is important to acknowledge but is beyond the scope of this evaluation. The endpoints are a way to describe the outcomes of the broader after-hours system and components of that system. For some of the endpoints, further information is required to determine whether they

represent a positive or negative outcome. The main example is ED attendance. In many situations this will be appropriate, even for low-urgency patients and even where patients have self-referred without prior assessment. However, for other patients, a more appropriate provider in the primary care system could have adequately resolved the problem.

The model presented in Figure 2 is a simple representation of a complex system. One of its uses is to clarify the type of strategies PHNs may employ to address gaps and improve the functioning of existing service configurations that are supported more directly by MBS, PIP and other initiatives. Twelve strategies are described in the Figure, which are targeted at different stages of the patient journey or more broadly targeted at strengthening the after-hours system itself. These strategies are described further below, along with a quantification of investments from the PHN After Hours Program in these strategies.

After-hours primary care services

The PHN After Hours Program was established to address gaps in after-hours service provision and assist in improving the functioning of existing after-hours primary care services. An understanding of related initiatives supporting after-hours service provision is important in building a picture of how the PHN After Hours Program has evolved.

The Commonwealth Government encourages access to after-hours primary care through several initiatives, which are described below, with further detail in Appendix 4. The effects of these initiatives are not in scope of this evaluation, but it is important for understanding the PHN After Hours Program context.

Figure 3 provides a timeline of after-hours arrangements, funding schemes, organisational and infrastructure changes, and key after-hours evaluations that have taken place over the past three decades. The timeline illustrates how policies, funding streams and programs related to after-hours primary care services have changed and developed over the past several years.

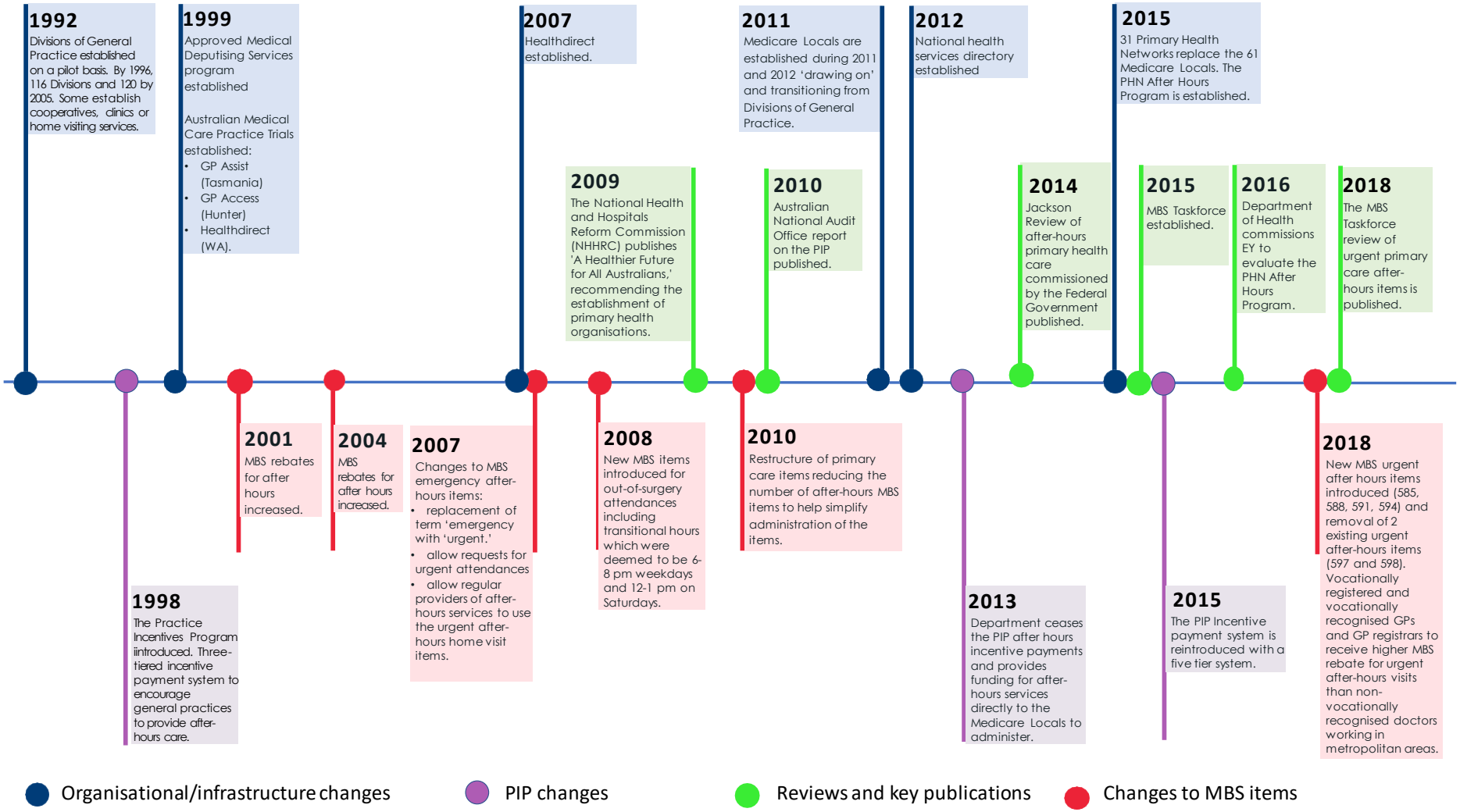


Figure 3 – Timeline of key events in relation to after-hours care arrangements

MBS after-hours items

Primary health care in Australia is largely supported by the Commonwealth Government through MBS and is mostly paid via fee-for-service. Several items within the MBS attract higher levels of benefit when they are claimed for services provided in the after-hours period. Benefits levels are adjusted to reflect differences between **urgent services delivered in sociable hours**, **urgent services in unsociable hours** and **non-urgent services**. Figure 4 shows the days and hours specifying the services for which these items can be claimed. For non-urgent items, different levels of benefits are paid to reflect whether the service provider is a vocationally registered GP, specialist or other medical practitioner, and whether the service was delivered in a clinic/office setting, residential aged care facility or other setting – principally the home. In response to the COVID-19 pandemic, additional items for telephone or video consultations were introduced.

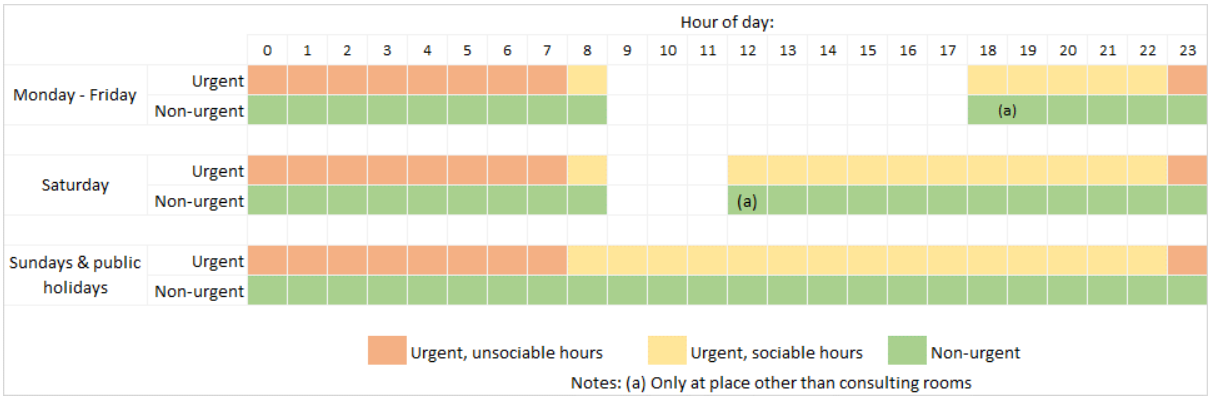


Figure 4 – After-hours periods relating to MBS items

Source: MBS Online (http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&qt=ItemID&q=5020)

MBS items for after-hours services, and rules governing these items, have changed over time (see Figure 3). Changes introduced from 1 March 2018 reflected government decisions on recommendations of the MBS Review Taskforce. The Taskforce found use of urgent after-hours items had increased dramatically in the six years to 2017, without any clear clinical justification (Department of Human Services, 2018). The changes introduced new MBS items and retired two existing urgent after-hours items. A further change was to differentiate rebates for vocationally registered and non-vocationally registered GPs and GP registrars in metropolitan areas.

There were 12.3 million MBS after-hours service claims made in 2018–19 with associated benefits of $749.6 million (see Table 3) and out-of-pocket expenses of $38 million. In 2019–20, MBS-supported services dropped to about 11 million, with $672 million in benefits paid (see Table 3). Figure 5 shows trends in monthly claims for urgent and non-urgent after-hours MBS services, reflecting the impact of policy changes around urgent after-hours items and the effect of COVID-19. The level of MBS-supported after-hours services varies across Australia. Figure 6 provides one view of this variation, showing trends rates of these services per 100 people at the PHN level across six recent financial years. Rates are higher in PHNs based in major cities (60.5 per 100 people in 2018–19) compared with other PHNs (26.9 per 100 people). Rates have increased over time, with some evidence of a decline in non-metropolitan PHNs in 2018–19. The PHNs with the lowest level of GP after-hours services – particularly those supporting inner- and outer-regional populations - have experienced increases since 2013–14 but remain at rates well below metropolitan-based PHNs.

Table 3 – After-hours MBS items: 2018–19 and 2019–20

MBS item categories	Services		Benefits		
	'000	%	$m	%	$ per service
2018–19					
Urgent	1,214.3	9.9	138.1	18.4	114.0
Non-urgent	11,054.3	90.1	611.5	81.6	55.0
Total	***12,268.6***	***100.0***	***749.6***	***100.0***	***61.0***
2019–20					
Urgent	880.7	8.0	103.3	15.4	117.0
Non-urgent	10,173.7	92.0	568.8	84.6	56.0
Total	***11,054.4***	***100.0***	***672.1***	***100.0***	***61.0***

Source: Medicare Australia, Medicare Statistics online reports as of 25 November 2020. See Volume 4, Appendix 6.

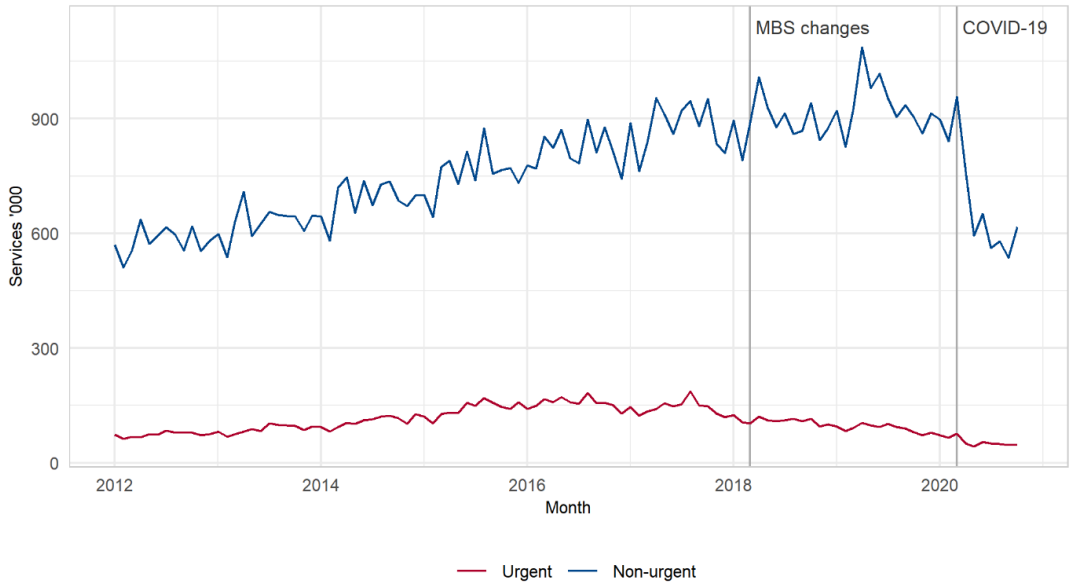


Figure 5 – Number of urgent and non-urgent MBS-supported services January 2012 to June 2020

Source: Medicare Australia, Medicare Statistics online reports as of 25 November 2020.

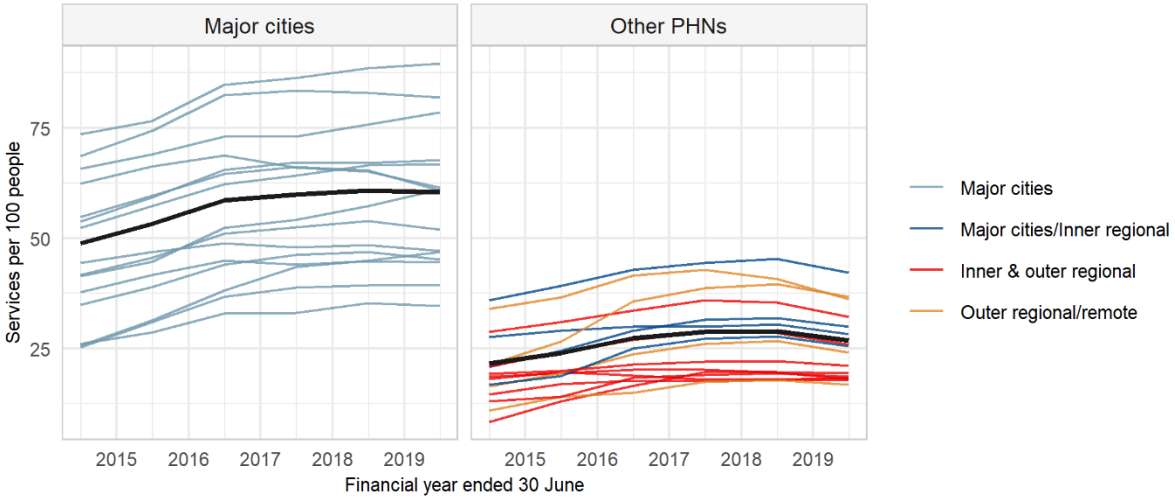


Figure 6 – Trends in general practice MBS after-hours items per 100 people by PHN 2013–14 to 2018–19

Source: Australian Institute of Health and Welfare, 2020c.

MBS-supported services may be provided by several different types of primary care services:

- **General practices**: There were an estimated 8,147 general practices in Australia at June 2019[1] (Steering Committee for the Review of Government Services, 2019 Table 10A.50). These operate under various ownership structures such as solo practices, small privately owned practices, partnerships, GP super clinics and corporate chains. In 2018, approximately 84% of practices were accredited with one of two (now 5) accreditation agencies (Steering Committee for the Review of Government Services, 2019 Table 10A.50). General practices must be accredited to access the PIP scheme, which means that about one in six practices are not eligible for PIP[2].

- **Aboriginal medical services**, including **Aboriginal Community Controlled Health Services**: There were 210 Indigenous-specific primary health care organisations that received funding from the Department of Health in 2018–19 (Australian Institute of Health and Welfare, 2020a), 137 of which were community-controlled organisations and 64 managed by government[3].

- **Medical deputising services** (described below): Twelve medical deputising services are members of one of the two bodies representing these organisations. Some medical deputising services operate outside the two main peak bodies.

- **Other primary care services**[2]: A range of government and non-government services, including community health centres, government-operated clinics in remote areas (not receiving Commonwealth Department of Health funding), services targeting specific populations, services supported by private health insurers and other private sector services, including some providing only tele-medicine consultations.

Practice Incentives Program (PIP) After Hours Incentive

The PIP program was established in 1998 by the Federal Government and provides financial incentives to general practices to help build capacity, foster the delivery of high-quality care and increase access to primary care services. There are currently three overarching payment channels: the capacity stream, the quality stream and the rural support stream. Within these channels, practices can receive payments for eight subcategories: incentives related to after-hours care, eHealth, aged care access, Indigenous health, procedures, quality improvement, rural loading and teaching. To be eligible to receive these payments, general practices must apply to receive the incentives and be accredited against the RACGP standards. Depending on the incentive subcategory, individual payments are calculated based on meeting certain activity thresholds. For example, GPs can receive the Aged Care Access Incentive tier 1 payment of $1,500 annually if they provide a minimum of 60 eligible MBS services in residential care facilities during the financial year. This incentive is increased to $3,500 annually (tier 2 payment) if they provide a minimum of 140 eligible MBS

[1] The evaluation team downloaded more recent data (November 2020) from the National Health Services Directory on general practices, which suggested there were approximately 7,950 general practices across Australia. These data are 2.4% lower than the estimates produced for the Review of Government Services but appear to be the only available source for estimating the number of practices by PHN.
[2] https://www.safetyandquality.gov.au/our-work/primary-health-care/national-general-practice-accreditation-scheme
[3] Most Indigenous-specific primary health care organisations and many of the 'other primary care services' will be included in the estimated total of 8,147 general practices.

services in residential care facilities throughout the financial year (Department of Human Services, 2019b).

Under the PIP scheme, After Hours Incentive Payments are made to eligible practices that directly provide after hours services to their patients and/or have arrangements for their patients to access primary care services after hours. These may be through an after-hours cooperative arrangement or an accredited medical deputising service. Different payments per 'Standardised Whole Patient Equivalent' (SWPE) are made quarterly (from $1 to $11 per SWPE), depending on the nature and extent of coverage (Department of Human Services, 2019), as described in Table 4.

About 5,600 practices received after-hours PIP payments in the November 2019 payment quarter (Table 4). This represents 89% of the 6,277 practices receiving any form of payment. Estimates of the total number of general practices across Australia are available from statistics published by the Review of Government Services (Steering Committee for the Review of Government Services, 2019). The publication used data supplied by the Department of Health and derived from analysis of the National Health Services Directory, MBS and PIP covering the period for 2018–19 to estimate there are 8,147 general practices across Australia[4]. This suggests that 77% of practices receive any form of PIP payment, and about 69% of practices receive a PIP after-hours payment.

In November 2019, we estimate:

- **2,300–2,500 (29–31%) practices did not receive a PIP after-hours payment**.
- **3,004 practices received a Level 1 PIP after-hours payment** (54% of practices participating in PIP after hours, about 37% of all practices). This is the base participation payment for the after-hours incentive. While the actual arrangements in place for these Level 1 practices are not available, it appears these practices generally address after-hours arrangements through an arrangement with a medical deputising service.
- **1,036 practices received a Level 2 or 3 PIP after-hours payment** (17% of practices participating in PIP after hours, around 13% of all practices). These practices have arrangements to cover the entire sociable after-hours period (6-11pm) through a cooperative arrangement with other general practices (Tier 2) or by the practice itself (Tier 3). Care during the unsociable after hours period is typically provided by a medical deputising service.
- **1,550 practices received a Level 4 or 5 PIP after-hours payment** (25% of practices participating in PIP after hours, around 19% of all practices). These practices have

[4] Using data from the two general practice accreditation agencies, it is estimated that 6,825 practices were accredited and 7,136 registered with these agencies for accreditation (Steering Committee for the Review of Government Services, 2019, Table 10A.50). The difference between the total estimated number of practices (8,147) and number of practices registered for accreditation (7,136) will relate to (a) practices that have not registered for accreditation and, potentially, (b) differences in counting methods between data sources. The evaluation team downloaded more recent data (November 2020) from the National Health Services Directory on general practices, which suggested there were approximately 7,950 general practices across Australia. These data are 2.4% lower than the estimates produced for the Review of Government Services but appear to be the only available source for estimating the number of practices by PHN.

specific arrangement in place to cover all after-hours periods, either through the practice itself (Tier 5) or through a GP cooperative (Tier 4).

Table 4 – Practices receiving PIP After Hours Incentive, November 2019

Level and payment rate and requirements	Practices receiving PIP after-hours payment		
	N	%	$ per SWPE
Level 1 Participation *Sociable and unsociable hours:* Formal arrangements in place to ensure practice patients have access to care in the complete after-hours period	3,004	54%	$1
Level 2 Sociable After Hours Cooperative Coverage *Sociable hours:* Participate in a cooperative arrangement with other general practices that provides after-hours care to practice patients *Unsociable hours:* Ensure formal arrangements are in place to cover the unsociable after-hours period	605	11%	$4
Level 3 Sociable After Hours Practice Coverage *Sociable hours:* Provide after-hours care to practice patients directly through the practice. *Unsociable hours:* Ensure formal arrangements are in place	431	8%	$5.50
Level 4 Complete After Hours Cooperative Coverage *Sociable and unsociable hours:* Participate in a cooperative arrangement with other general practices that provides after-hours care to practice patients for the complete after-hours period	342	6%	$5.50
Level 5 Complete After Hours Practice Coverage *Sociable and unsociable hours:* Provide after-hours care to practice patients in the complete after-hours period	1,208	22%	$11.00
Total	**5,600**	**100%**	**NA**

Notes: 1. Represents the percentage of practices receiving any form of PIP payment. There were 6,277 practices receiving any form of PIP payment in November 2019. Some practices do not register for or receive PIP payments. The Department of Health estimates that 85.3% of GP patient care services are provided by practices registered for PIP (Department of Health, 2019b, p. 75).

Source: HPA analysis of data supplied by the Department of Health.

The budget allocation for the PIP overall was $407.2 million in 2019–20 (Department of Health, 2019b, p. 61) (Table 5). Actual expenditure for the PIP After Hours Incentive in 2018–19 was approximately $78 million (communication from the Department of Health). The numbers of practices participating in PIP has been growing since May 2015 (Figure 7). No data is available for the quarters between November 2013 and May 2015, when the scheme was managed by PHNs. Participation in the scheme appears to have dropped during this period. However, from 2016, participation has exceeded 2011 to 2013 levels.

Table 5 – Expenditures on PIP overall and on PIP After Hours Incentive, participating practices, 2015–16 to 2019–20

	2015-16	2016-17	2017-18	2018-19	2019-20
Expenditure					
PIP total[1]	$368.1m	$341.7m	$342.9m	$339.8m	$407.2m
After-hour incentive[2]	58.9m	74.4m	76.6m	78.0m	80.5m
Estimated %	27%	30%	30%	31%	27%
Number of practices					
Participating in PIP[3]	5,423	5,811	5,985	6,133	6,277
Participating in PIP After Hours Incentive[3]	4,680	5,169	5,389	5,555	5,590
Per cent of PIP practices	86%	89%	90%	91%	89%

Sources: [1] Department of Health (2015a, p. 29); Department of Health (2019b, p. 61); Department of Human Services (2019a, p. 75); [2] Correspondence from Department of Health; [3] Department of Human Services (2019a). Expenditures on the PIP After Hours Incentive reflect forward estimates from the 2015–16 Budget Portfolio Statement Data for 2019–20 is estimated by HPA; Data for PIP practices are based on 2015–16: Department of Health PIP PHN Tables - Public Release (August 2018), using data for May 2016; 2016–17 to 2018–19: Department of Human Services (2019a p75); 2019–20: HPA analysis of data provided by Department of Health for this evaluation.

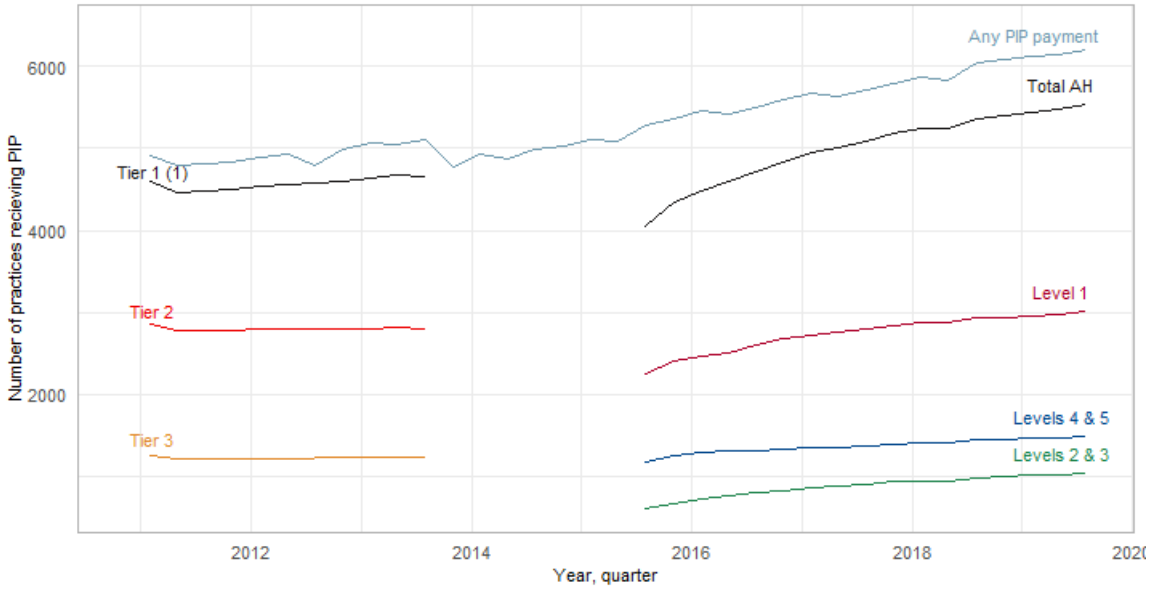


Figure 7 – Trends in general practice participant in Practice Incentive Program (PIP) After Hours Incentive: May 2011 to August 2019

Notes: No data is available for the quarters between November 2013 and May 2015, when the scheme was managed by PHNs. (1) In the earlier after-hours PIP scheme, 'tiers' were not mutually exclusive. Tier 1 is equivalent to the total number of practices receiving a PIP after-hours payment. Due to minor discrepancies in data for November 2019, the time series is to August 2019.

Sources: Data for PIP practices are based on Department of Health PIP PHN Tables - Public Release 2011–2018 (August 2018), and Department of Health data provided for the evaluation for August 2018 to November 2019, analysed by HPA.

Participation in PIP after hours varies across PHNs, as shown in Figure 8. Overall participation tends to be higher among practices in PHNs based around major cities (about 70% of practices), but in these PHNs there is relatively low participation in Levels 4 or 5 (around 11% of practices). Participation is also relatively higher for practices in PHNs that include major cities and inner regional populations (around 75%). In these PHNs, a larger proportion of practices are participating in Levels 4 or 5 (around 25%). These PHNs include Hunter New England and Central Coast, where 30% of practices are participating in Level 4 or 5,

including many in the Lower Hunter Region that participate in the GP Access arrangement (see page 130).

Overall participation is relatively lower in practices in PHNs serving mainly inner-regional, outer-regional and remote populations. However, within these PHNs, participation in Level 4 or 5 is generally higher (37%/30%). One exception is Tasmania, where overall participation in PIP is low, and participation in Levels 4 and 5 is the lowest of all PHNs outside major cities. In Tasmania, the GP Assist arrangement (see page 130), may account for the low level of participation.

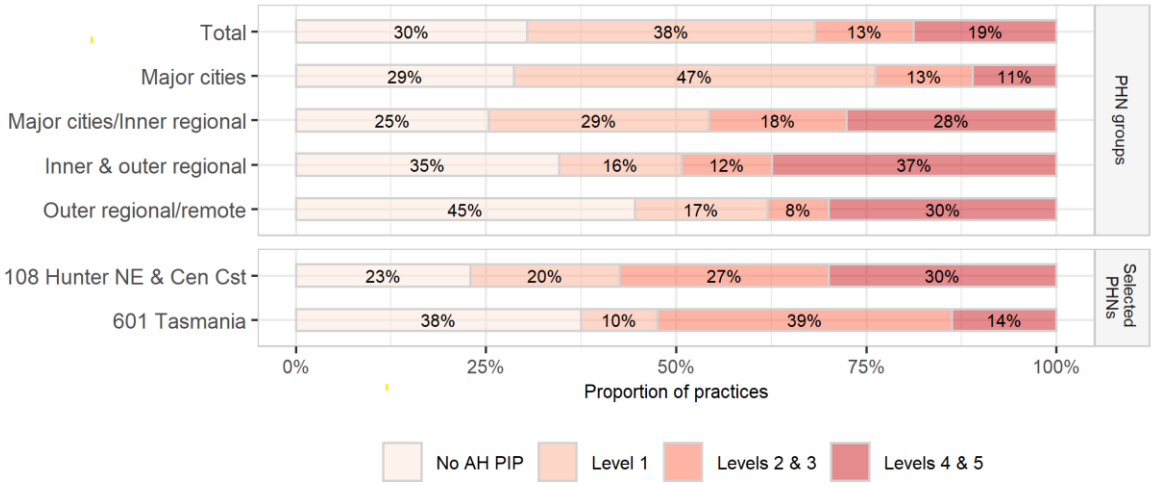


Figure 8 – Estimated proportion of general practices participating in PIP after hours, by PHN groups and selected PHNs: August 2019

Sources: Department of Health data provided for the evaluation for August 2019. Estimated practices by PHN based on data downloaded from the National Health Service Directory, November 2020.

General practices must be accredited to receive PIP payments under any of the three incentive streams. When general practices seek accreditation, they must meet standards related to responsive service provision, including a criterion related to 'Care outside normal hours' (Royal Australian College of General Practitioners, 2020, Criterion GP1.3). This prescribes that patients of the practices are both 'informed about how they can access after-hours care' and 'can access after-hours care'. Among the requirements are that the practice:

> … must inform patients of your normal opening hours and the arrangements for care outside of normal opening hours … using one or more of the following:
>
> - An out-of-hours message on your practice's telephone.
> - Relevant information on your website and in your practice's collateral, including leaflets, newsletters and an information pack for new patients.
> - A clearly visible sign outside of the practice that indicates your normal opening hours and the arrangements for care outside of those hours.

The standards specify that practices can deliver after-hours care directly, either during sociable after-hours or for the full after-hours period, or through participation in a cooperative arrangement with another practice or through another (deputising) service provider. Where the latter applies, *there must be a direct and continuing relationship between* [the] *practice's GPs and the clinicians who perform the after-hours care on their*

behalf reflected in a formal arrangement or agreement, which includes details of sharing of information.

After hours and medical deputising services

As discussed above, one option available for practices in the after-hours period is to contract with a medical deputising service or other after-hours services such as a GP cooperative. There are several different types of after-hours service providers involving various combinations of clinic-based, home visiting and telemedicine options (Royal Australian College of General Practitioners, 2019, p. 7).

A medical deputising service is:

> … an organisation which directly arranges for medical practitioners to provide after-hours medical services to patients of Practice Principals during the absence of, and at the request of, the Practice Principals. (National Association for Medical Deputising Services, 2016, p. 3)

Medical deputising services provide a means through which general practices can "externally contract the after-hours components of both continuous access to care and continuity of care to practice" (National Association for Medical Deputising Services, 2016, p. 3).

Medical deputising services and after-hours services can be accredited against standards developed by the RACGP (Royal Australian College of General Practitioners, 2019). They typically provide a telephone booking service, supplemented with messaging and email options. According to the RACGP accreditation standards, medical deputising services should implement a triage system that should be "performed by suitably qualified staff such as GPs, registered nurses or trained staff using appropriate triage protocols" (Royal Australian College of General Practitioners, 2019, p. 110). In addition:

> … staff who triage calls can determine the patient's needs, document the needs clearly and arrange a consultation according to the urgency of the situation, or refer the patient to the nearest emergency department. If the situation is not urgent, the staff member could refer the patient back to their regular GP (Royal Australian College of General Practitioners, 2019, p. 110).

Staff who perform triage do not necessarily have to be clinicians, but they must be trained and work to appropriate protocols.

After-hours and medical deputising services may offer home visiting services, including to residential care services, as well as telemedicine consultations and, in some instances, a clinic.

Accreditation is a requirement for participating in the Commonwealth Government's Approved Medical Deputising Service Program. This program allows non-vocationally registered GPs to provide services through a medical deputising service and for MBS claims to made for those services. The Approved Medical Deputising Service Program provides the economic base of medical deputising services, as well as a means for non-vocationally registered GPs to obtain clinical experience in the after-hours period. The program was introduced in 1999 as a response to a decrease in the number of after-hours services being provided by fully qualified GPs in the capital cities. An associated program – the After Hours Other Medical Practitioners Program – is being phased out and will cease in 2023.

The RACGP has strongly advocated that after-hours services should not unnecessarily divert patients from daytime GP services. That is, they should not compete with or replace daytime services by directly marketing their services and seeking to build demand.

There are restrictions on advertising by medical deputising services under the guidelines for the Approved Medical Deputising Service Program that go beyond the general restrictions on general practice and other regulated health services, including:

- no direct or database marketing to patients
- no emails, push notifications or pop-up advertisements that advertise the business to patients through any channel
- no payments to an online service or search engine to promote their service, whether by advertising or improved search result ranking.

However, they can:

- provide specified information to practices where deputising agreements are in place
- publish specified information on websites or social media pages.

There are 12 accredited medical deputising services affiliated with the two organisations that represent their interests. These operate in all capital cities except Darwin and many regional centres, including Newcastle, Central Coast, Geelong, Shepparton, Gold Coast, Ipswich, Sunshine Coast, Toowoomba, Townsville, Cairns, Bundaberg, Gladstone, Hervey Bay, Maryborough, Wide Bay, Rockhampton, Mackay and Launceston. Populations not covered largely relate to selected areas of capital cities (particularly outer suburban), some regional centres, smaller rural towns and remote communities.

Some PHNs have commissioned medical deputising services to provide services to areas where there is no coverage and where general practices provide little after-hours care. This is sometimes in the form of a subsidy to make the deputising service economically viable. The Northern Queensland and Brisbane South case studies provide examples of these. Other PHNs, such as Eastern Melbourne, have commissioned My Emergency Doctor to provide after-hours services. These are both in States that do not currently use Healthdirect and therefore do not have access to their after-hours GP telephone service.

Medical deputising services have been a part of the after-hours landscape for several decades but have become more prominent since the mid-2000s. In 2009, it was estimated that 56.8% of Australian GPs worked in a practice that subscribed to a medical deputising service, while 37.8% of GPs worked in a practice that provided their own or cooperative after-hours care (Britt et al., 2016, p. 29).

GP cooperatives

GP cooperatives involve practices entering into an arrangement to jointly provide after-hours services through a rotating roster in which GPs from each practice participate. Patients seen during the after-hours period are subsequently referred back to their usual practice. Cooperatives vary in the number of participating practices and many have been operating for decades.

Other provision: urgent-care centres, walk-in centres, after-hours clinics

In line with international developments, some states, PHNs and the private sector have established 'urgent-care centres' to address the rising demand for non-acute ED presentations. The aim is to divert ED attendances to these centres and enable patients with minor injuries or illnesses to be treated in a timely manner. There is no standard terminology or widely accepted definition of these services and the phrase is sometimes used to refer to a small rural hospital. However, services such as these are seen as alternatives to hospital or to supplement poor access to a GP after hours. They are designed to deal with minor conditions and to perform minor procedures such as suturing and plastering. They vary in their staffing – some involve GPs while others are staffed by nurses but may have medical back-up. Payment arrangements vary but may involve out-of-pocket expenses. There are also walk-in centres such as the nurse-led, after-hours clinics in the Australian Capital Territory. Some of these developments are described further in Appendix 3 in Volume 4 and an example of a recent pilot initiative in Western Australia is provided in Box 4.

Box 4 – Western Australia Urgent-care centres

The WA Department of Health and PHNs are piloting a network of urgent-care centres. The program was launched in September 2019 and it is expected that 125 practices will be involved in the pilot scheme operating across the Perth metropolitan area and the Bunbury region. The centres are general practices that have access to diagnostic services and typically remain open 7 days a week from 8 am to 8 pm. They are not co-located at hospitals and patients are charged MBS fees. Walk-in access to the services is possible, but patients can book online through the National Health Services Directory or be booked by Healthdirect if access to one of the centres is considered suitable for a caller.

Healthdirect

Healthdirect was established in 2007 as part a Council of Australian Governments reform package and offers several services, some of which are targeted to specific needs of regions in Australia. The main Healthdirect service is a 24/7 helpline that connects callers with a registered nurse, who assesses their situation and advises what to do next. In 2019 there were 825,000 calls to the Helpline (nurse triage), of which 72% were in the after-hours period (Healthdirect data accessed via Healthmap) and 74,000 calls from the After Hours GP Helpline (Healthdirect Australia, 2019).

In the after-hours period, the caller may be offered a call back from a doctor 15 minutes to an hour later via telephone or video via the After Hours GP Helpline. The caller can be transferred directly to triple zero in the event of an emergency (Healthdirect Australia, 2019). The After Hours GP Helpline was added as an extension to Healthdirect in 2011. Following the Jackson Review in 2014, the After Hours GP Helpline was scaled back to be available at selected times. Outside of major cities, the service is available during the whole of the after-hours period. In major cities, the service is available mostly in the unsociable hours: 11 pm to 7:30 am Monday to Friday, after 6 pm on Saturday and all day on Sunday and public holidays.

Victoria, Queensland and Tasmania have different arrangements in place. In Queensland, the call centre is different, acting as a main portal of health information for the system, and including health coaching, notifications of food poisoning and health triage. Victoria has a

service called NURSE-ON-CALL, which operates 24/7 as a telephone advice service. The service is run by Ambulance Victoria and can transfer emergencies directly to triple zero. The South Australia ambulance service conducts some telephone triage when callers ring the emergency number. Hunter New England and Central Coast PHN continues to fund a nurse triage call centre called GP Access After Hours, which operates in the Newcastle and surrounding areas. This service operates in the after-hours period and can refer patients to an after-hours clinic if required. Primary Health Tasmania provides a GP telephone service called GP Assist. Two of the case studies in this report focus on telephone triage services and their relationships to Healthdirect and other urgent and emergency care services. The array of different arrangements is set out in Table 6.

Table 6 – Telephone triage service arrangements

Location	Nurse triage service	Related GP system
Queensland	13 HEALTH	May be passed onto Healthdirect After Hours GP Helpline
Victoria	NURSE-ON-CALL	May be passed onto Healthdirect After Hours GP Helpline
Tasmania	Healthdirect initially but may be passed to GP Assist nurse triage	GP Assist
Newcastle and surrounds	GP Access (some calls to Healthdirect diverted)	GP Access can book patients into the after-hours clinic
WA	Healthdirect	Healthdirect can book callers direct to urgent-care centres or pass along to After Hours GP Helpline
All other states and territories	Healthdirect	After Hours GP Helpline

Figure 9 and Figure 10 provide data on quarterly trends for the Nurse Triage Service and the After Hours GP Helpline respectively at the PHN level. Numbers of calls to the Nurse Triage service are much lower in Victoria and Queensland due to the specific arrangements in those states (see above). Volumes for the GP Helpline in Tasmania are also much lower, due to other arrangements including the GP Access service (see above).

Use of the Nurse Triage services varies between PHNs and is generally lower in PHNs with populations in inner-regional, outer-regional and remote areas. In contrast – and consistent with the rules that apply to the service – use of the GP Helpline is generally higher in PHNs with populations in inner-regional, outer-regional and remote areas.

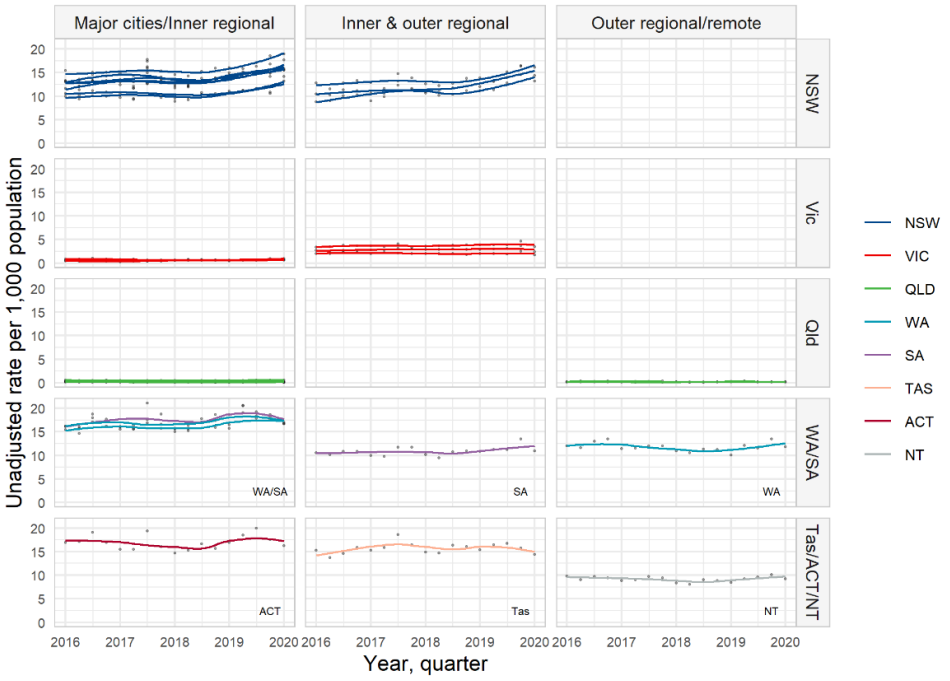


Figure 9 – Trends in quarterly number of calls to Healthdirect Nurse Triage Service: March 2016 to March 2020

Source: HPA analysis of Healthmap data (https://healthmap.com.au/)

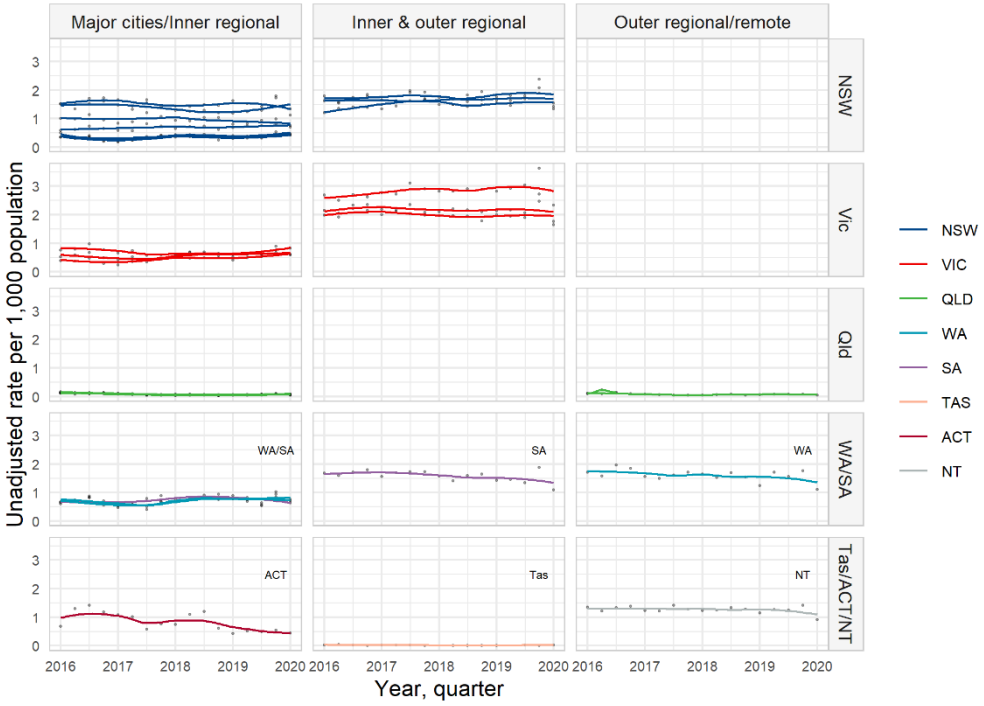


Figure 10 – Trends in quarterly number of calls to Healthdirect After Hours GP Helpline: March 2016 to March 2020

Source: HPA analysis of Healthmap data (https://healthmap.com.au/)

Healthdirect also provides an online symptom checker and numerous specialised helplines (such as the Pregnancy, Birth and Baby Helpline that links callers via video link to a maternal

child health nurse). The organisation has a role in providing support to service providers in offering video calls to patients.

A national standard (Australian Health Contact Centres 5205:2019) has been developed to guide the care consumers can expect to receive from health contact centres and to assist in providing a consistent approach to healthcare delivery across Australia.

Other telephone advice and triage services

Telephone triage offered by medical deputising services, GP cooperatives or practices: All medical deputising services offer a nurse-based triage service after hours. As discussed above, about half of primary care practices have arrangements with a medical deputising service for coverage for some or all after-hours periods. In these instances, a call to the practice will generally be transferred to the deputising service, or a patient calling the practice will hear a message directing them to the service. Medical deputising services may also receive calls directly from patients, who become aware of the service through other means such as past experience or marketing. The call will be taken by a nurse who will assess the urgency and arrange either follow-up by a medical practitioner through a home visit, video consultation or an appointment at an after-hours clinic. Patients requiring urgent care will be advised to attend an ED or be transferred to the emergency services line to request an ambulance.

Practices and GP cooperatives may offer a similar service – nurse triage with options to refer immediately to a GP or arrange appointments. In these cases, the after-hours service is provided by practice staff, who may be able to view the patient's medical record in formulating their advice.

State services: Victoria (NURSE-ON-CALL) and Queensland (13 HEALTH) offer a nurse advice and triage line similar to Healthdirect. In addition, states also support various telephone advice lines related to issues such as mental health, family violence, parenting, poisons information, and aged care nursing advice (for residential care facilities). These lines generally operate 24/7, with advice provided by health professionals.

States and territories and the Royal Flying Doctor Service also play a role in after-hours provision in remote parts of Australia where there is no resident GP. These communities are typically supported through community clinics, which may be operated by Aboriginal Community Controlled Health Services or state/territory services. The case study for Alice Springs describes an example of such an arrangement, where patients or remote area nurses can contact a medical practitioner, usually an emergency care specialist, to help assess the issue and decide on a course of action, which may involve a medical evacuation. In some states, the Royal Flying Doctor Service provides a telehealth service. These services are staffed and run through their main bases.

Private and non-government services: A range of helplines operated by non-government organisations are available for various health issues, in particular for mental health. In recent years, additional private sector operators have emerged. My Emergency Doctor, launched in 2016, offers a 24/7 telehealth consultation with an ED specialist via an app. Unless funded via a third-party organisation, access to the service requires a credit card to pay the fee of $250 (in-hours) or $280 (after hours). My Emergency Doctor claim that a Medicare rebate is

available for patients who live in a telehealth eligible area and where they have been referred by a GP[5].

Booking appointments online

The public can book GP services online through a variety of platforms, with the scope and coverage of these online facilities rapidly evolving. Online platforms such as HotDoc, HealthEngine and DocBook allow anyone with internet access to book a telehealth or face-to-face appointment with a GP from their mobile device or desktop computer. These online booking systems often indicate that additional fees are required but do not always provide details. In addition to direct access, pathways to these engines are hosted by individual GP websites, care networks (e.g. WA Urgent Care Networks) and call centres (e.g. Healthdirect).

Healthdirect manages the National Health Services Directory, which lists Australian general practices, their opening times, billing arrangements (but not necessarily the fees), their hours of operation and after-hours arrangements. The directory also hosts links to the HealthEngine booking system allowing users to select a service and then make an online booking. Healthdirect also has the capacity to make direct bookings for callers at the 125 Urgent Care Centres operating around Perth. The site indicates whether the practice bulk bills but does not provide any details of gap payments that may be required. The directory provides information on other services available within specific localities including pharmacies and EDs. The accuracy of the directory relies on practices and other services updating the information.

While these platforms are facilitating access to after-hours services, when available, the number of online providers and variety of service options (virtual, clinic, home-based) may be confusing to the public and run the risk of creating inefficient and inappropriate service use. In many instances, specific charges and out-of-pocket payments are not specified, hampering patient choice of provider.

Symptom checkers

Online and mobile symptom checkers are becoming more prevalent in health systems, not only to gain insights into diagnosis but also to work out what to do next in terms of possible care options.

Healthdirect provides an online symptom checker that aims to provide information and advice to support people who are unsure about what to do about their symptoms. It is not considered to be a diagnostic tool or intended to replace assessment by a clinician. Users can have their information and advice sent to them via SMS. If a user calls the Healthdirect triage helpline, a unique reference number enables the nurse on the helpline to bring up their information. In February, Healthdirect developed a COVID-19 app that has been accessed over 2.5 million times. The COVID-19 Symptom Checker had been updated more than 30 times to take into account changes in Communicable Diseases Network Australia guidelines and testing and restrictions criteria.

Recent Australian research (Hill et al., 2020) has found that symptom checkers developed here and overseas tend to be risk-averse, often recommending more urgent care than clinically required, with the triage functions providing the appropriate advice in about 50% of cases, including 60% of emergency and urgent cases, but only 30–40% of less serious cases.

[5] https://www.myemergencydr.com/patients/

The study also found the symptom checkers recommended individuals seek urgent or emergency care services in 40% of cases that required only non-urgent or self-care. In 10% of cases where emergency care was required, the symptom checkers recommended non-urgent or self-care.

State and territory initiatives

In addition to operating and supporting services as described in the previous section, states and territories contribute to after-hours coverage through ambulance services, supporting primary care in remote communities and in rural towns. In the after-hours period, rural hospitals often have nurses providing the initial assessment and then calling in a GP or visiting medical officers where required. An increasing number are also supported by a video telehealth connection with larger hospital EDs and services.

In some states, such as Western Australia, the state government and local PHNs have supported the establishment of urgent-care centres and other services (see Other provision: urgent-care centres, walk-in centres, after-hours clinics).

State and territory governments have also implemented initiatives related to after-hours service provision. Examples include:

- websites and directories that provide information on available after-hours primary care, pharmacies and other services
- enhanced on-site ambulance paramedic treatment (including treatment at home and transfer to general practice care)
- GP clinics co-located on hospital grounds.

Further, there are various arrangements in which after-hours support is provided to patients. For example, patients with chronic illnesses may be enrolled in a disease or case management program. These patients have ready access to a 'case manager', usually a specialist nurse familiar with a patient's chronic conditions and potentially an on-call medical specialist. Many hospitals have arrangements post-discharge, providing the patient with guidance and/or with a point of contact where specific issues arise. After-hours services are growing for patients receiving at-home palliative care. Many local hospital networks now provide an aged care specialist nurse telephone advice service for selected residential care facilities.

These initiatives are undertaken in parallel with Commonwealth Government initiatives, including the PHNs, but are not always coordinated. How these services interact with the PHN After Hours Program will be discussed further in Chapter 4.

Overall expenditure on after-hours services

The overall level of expenditure on after-hours primary care includes the costs of:

- MBS after-hours items
- PIP payments for after-hours services
- triage services, including Healthdirect and other similar services
- out-of-pocket expenses for consumers
- state and territory programs
- the PHN After Hours Program

An element of ED lower-urgency attendances could be attributable to after-hours care. However, not all low-urgency ED visits can be appropriately managed in primary care. There are also the costs of ambulance services, a proportion of which could be avoided if patients had accessed appropriate primary care. States and territories also devote some resources to the funding of primary care-type provision.

Table 7 sets out the costs of the various after-hours services. Healthdirect costs related to after hours are estimated to be about $82 million. This includes a proportion of the nurse triage costs as they operate 24 hours (after-hours costs estimated as 72% of the total) and the costs of the GP service, which operates only after hours. The costs of the nurse triage services in other states are not included in this figure, although the costs of the Tasmania and Hunter New England and Central Coast triage services are included in the PHN costs. Out-of-pocket expenditure is difficult to gauge and the figure included here is an estimate based on overall levels of out-of-pocket expenditure for general practice. Medical deputising services have to be bulk billed but private practices operating in the after-hours period may charge higher fees. Other providers may also charge more. It is unclear if the cost burden is relatively higher for after-hours care. Overall, the costs are estimated to be about $1,380 million with the PHN After Hours Program representing about 5% of overall expenditure.

Table 7 – Estimates of overall costs of after-hours provision

Service	Year	Expenditure estimate	Activity estimate '000	Average cost
MBS after hours items: Urgent	2018-19	$138.1m	1,214.3	$114
MBS after hours items: non-Urgent	2018-19	$611.5m	11,054.4	$55
Out-of-pocket costs to consumers	2018-19	$38m	760.7	$50
PIP After Hours Incentive payment	2018-19	$78m	NA	NA
NURSE-ON-CALL: Nurse triage – Vic.	2009-10	$9.9m	350	$28
13HEALTH: Nurse triage – Qld	2011-12	$18.5m[1]	NA	NA
Healthdirect (a): Nurse triage	2019-20	$26.9m	782.1	$34
Healthdirect (a): GP consultations	2019-20	$8.0m	69.9	$115
PHN After Hours Program	2019-20	$71m	430[2]	$85-$176
ED low urgency attendance	2018-19	$307.5m	716	$430

Notes: NA=Not available. [1] Figure includes funding for Chronic Disease & Child Health, Quitline. [2] This figure is a mix of patients, consultations and other based on volume of patient contacts/items of service from items of service and some part-year scaled to an annual figure from the PHN survey. The activity figure covers about half of the overall budget so the range of average costs reflects the range assuming this activity only relates to the associated expenditure (minimum cost) or is the maximum level of activity (maximum cost). This is intended to give a broad estimate of PHN After Hours Program activity. See also Table 28.

Sources: MBS and PIP – see Table 31; ED lower urgency: Australian Institute of Health and Welfare (2020d)and National Hospital Cost Data Collection (Independent Hospital Pricing Authority, 2020) based on an estimate that 'did not wait' represents 7% of low urgency presentations and mean costs of $194 for 'did not wait' and $448 for non-admitted triage categories 4-5; Healthdirect: Correspondence with Department of Health; Out-of-pocket costs: Australian Institute of Health and Welfare (2018). Estimated that average co-payment was $50 applied to 5.8% of after-hours MBS service. Bulk-billing rate estimated at 94.8% – see Table 31. PHN activity estimate: PHN survey; NURSE-ON-CALL: Victorian Auditor-General (2010); 13HEALTH: Queensland Commission of Audit (2013).

Key features of after-hours primary care

The bedrock of the primary care system in Australia is general practice. GPs are private providers operating as small businesses and funded primarily through MBS fee-for-service payments. Significant differences in the availability of after-hours primary care services exist across communities and while provision is good in some areas, in others there are significant

gaps. Despite Commonwealth and state governments' efforts to bolster primary care services, in many communities there remains a reliance on hospital care as the mainstay for urgent care after hours. This is particularly apparent in rural and remote communities.

The Federal Government has supported after-hours care through the MBS, PIP and the PHN After Hours Program. A range of Medicare items have been introduced and modified over time to encourage GPs and other doctors to provide after-hours care. The aim has been to keep a patient's usual GP central to the care provided and maintaining continuity of care. The recent introduction of the new telehealth MBS item number during the COVID-19 crisis has sped up innovation and created opportunities for new service providers but also uncertainly in the market, given the lack of clarity over longer-term policy directions.

Healthdirect provides the infrastructure for 24/7 telephone triage and advice for people seeking urgent primary care. The service is jointly funded by the Commonwealth and states and territories (excluding Victoria and Queensland). These states and territories access the infrastructure and provide links to the services provided. In some states, local solutions have been dovetailed into the Healthdirect systems and in other states, separate state-run systems exist.

Many GP practices provide services during some or all of the after-hours period either directly or through the use of deputising services. Deputising services operate predominately in metropolitan areas where the scale and density of the population renders home visits more feasible, safe and profitable for private practitioners. Other arrangements also exist, including GP cooperative systems, rota systems within practices, nurse triage and state- or PHN-funded urgent-care centres and walk-in clinics.

There is an almost universal acceptance across government that the use of hospitals for less urgent or serious after-hours primary care is inappropriate and inefficient and should be reduced. To this end, there has been significant policy and program activity over the past few decades to reduce demand for hospital-based care and increase availability and uptake of alternative providers, predominantly in the GP community. A variety of alternative and innovative service arrangements has emerged within existing funding and regulatory arrangements, some of which promote a model of care that may be construed as providing a substitute for care provided by local GPs in the market (e.g. urgent-care centres).

From a patient perspective, one of the strongest features of the primary care after-hours landscape is its variation and complexity. Depending where they are, those with after-hours health needs may be presented with either a wide (and potentially confusing) array of options (generally in metropolitan areas) or little to no options (generally, but not exclusively, in remote and rural areas). There is no single, well-understood source of reliable and safe information. The resulting after-hours primary care system is one characterised by variation in needs and services across the country. Finding ways to fill gaps in provision without undermining or cutting across existing services or incentive structures is complex.

Case study: Brisbane South PHN

Case study focus
The Brisbane South PHN case study focused on the delivery of a medical deputising service in Jimboomba.

Locality overview
The Brisbane South PHN comprises four local government authorities: Brisbane City, Logan City, Redland City and Scenic Rim Regional, covering urban, rural and remote regions. Its geographic boundary is aligned with that of the Metro South Hospital and Health Service. The PHN has a population of 1,021,494, which is 23% of the state's population (Australian Bureau of Statistics, 2016).

Under the Modified Monash Model (MMM) the region covers: Major Cities (MM1, representing 96.1% of the PHN's population), Inner Regional (MM2, representing 3.4% of the PHN's population), Outer Regional (MM3, representing 0.3% of the PHN's population) and Remote Australia (MM4, representing 0.2% of the PHN's population) (Brisbane South Primary Health Network, 2019b).

PHN approach
The PHN completed a general needs assessment (published 2018), informed by data, stakeholders, service mapping and research (Brisbane South Primary Health Network, 2018a).

In 2018, to further inform and develop the PHN's after-hours program, the PHN commissioned a review of after-hours GP services. The review had two key findings (Deloitte, 2018):

- There was demand and need (from an equity of access perspective) for after-hours primary care services in Mt Gravatt and Jimboomba given the regions' highest representation (SA3 level) of low-acuity after-hours ED presentations, relatively limited access to after-hours providers considering the size of the population, and high population growth.
- Children aged 0-4 years had the highest demand for after-hours primary care services, representing 17% of after-hours ED presentations (Category 4 and 5) but only 7% of the population and 34% of 13HEALTH calls.

Informed by the Deloitte review and the general needs analysis, the PHN's Activity Work Plan focused on selected vulnerable population groups or place-based responses. The Activity Work Plan for 2019–20 allocated the PHN's $1.7 million in after-hours funding across five primary projects: the CALD Health System Navigation Project, Domestic and Family Violence, Homeless Health, After Hours Response and Emergency Department Avoidance Campaign. This included the funding of an MDS service to support the provision of after-hours GP support in the Jimboomba area.

Key observations

- **There can be after-hours service gaps in metropolitan PHNs even where supply of after-hours GP clinics is appropriate for the majority of the population**. Jimboomba, in the Brisbane South PHN, was not well supported in the after-hours period and distance and travel times were a significant barrier to an MDS being established and sustained.

- The MDS was not able to engage in direct consumer advertising in line with the Department of Health guidance. The MDS can promote the service to GP practices and this formed part of the 13SICK's engagement plan. The restrictions in promoting and increasing awareness appeared to limit the growth and usage of the MDS. Services of this nature, particularly in the establishment phases, **need to be supported by strategies to work closely with general practices, service providers and others** so that consumers are able to access care and the after-hours services are well integrated with general practice.

3. International trends and implications for Australia

International context

Australia is not the only country looking to improve its systemwide provision of after-hours primary health care. As public expectations for expanded service availability continue to grow and the desires of health care professionals to maintain a healthy work and life balance are strengthened, governments across the OECD are facing the growing challenge to efficiently provide appropriate access to after-hours primary care for their communities.

This section of the report provides an overview of the relevant key trends and directions being taken in health systems internationally to improve access to and capacity of their urgent- and emergency-care systems, particularly in relation to the provision of after-hours primary care. Further details of the international findings from the literature scan, and their implications for Australia, are provided in Appendix 3 in Volume 4. These findings are then considered in relation to the PHN After Hours Program.

Key messages for Australia from this review of international trends are summarised in Box 5.

Box 5 – Key messages for Australia from the international review

Service capacity

Mandatory participation and collaborative regional action

- Many OECD countries **require primary care providers to actively participate in after-hours care**. In some countries this is a requirement for professional registration.
- Regional **collaboration of GPs has helped build service capacity**, manage the level of participation by GPs and maintain a degree of continuity of care.
- The majority of OECD countries **do not rely on deputising services** to provide service capacity to the extent that Australia does.

Service access

Integrated regional systems of demand management and service provision

- GP collaboratives **provide integrated regional service systems**, including telephone triage and seamless links to direct the full range of care provision (e.g. telehealth, clinics, home visits).
- **GP gatekeeping to after-hours care** is stronger in some OECD countries, with people seeking after-hours care being required to call the regional Nurse-GP triage service before being able to access services, including the ED.
- Further integration of after-hours primary care is being explored in some countries, including **GP-led triage at ED** and **co-located after-hours GP clinics** and **integrated emergency/urgent-care triage** processes.

- Expansion of **virtual GP services**, where digital technology is being used to integrate e-health (including point of care testing, e-prescribing, electronic health records) and traditional face-to-face services.

Urgent and emergency care systems

The interface between GPs, ambulances and EDs is critical to a well-functioning urgent and emergency care system. While each service is generally characterised by a focus on particular patient groups, GPs, EDs and ambulance services are approached every day by people in the community with a myriad of routine, urgent and emergency care needs. Ultimately, the success of any system lies in:

1. Clearly signalling and effectively guiding and linking people to the most appropriate service and care professionals.
2. Ensuring sufficient capacity exists to meet the expressed needs of people presenting to these services.

Many countries are reviewing and reforming their urgent and emergency care systems to provide enough capacity to meet the growing demands for care from their populations. Increasing demand for ED care is being experienced in these countries, with reports of overcrowding and patients waiting outside in ambulances. In some countries, system performance has been focused on achieving waiting time targets for patients seeking services. Figure 11 shows the change in the number of ED visits per 100 population between 2001 and 2011 (or nearest available dates). Most countries saw increases in ED visit rates. While Australian rates increased over this period it was only a little above the average across the OECD.

In tandem with hospital demand management, policy attention has also been given to ensuring there is sufficient availability and capacity in general practice and other primary care settings (e.g. pharmacy, nurse-led clinics) to manage patient demand. This is particularly pertinent outside normal working hours – in the evening, overnight and on weekends – where it is important that access to primary care services is maintained to meet those urgent health needs of the community that can't wait until care during normal hours.

There is an important interaction between access and capacity of primary care services in-hours and after-hours, where routine and more urgent care may be sought after hours because of the relative inconvenience, waiting times and costs of in-hours care.

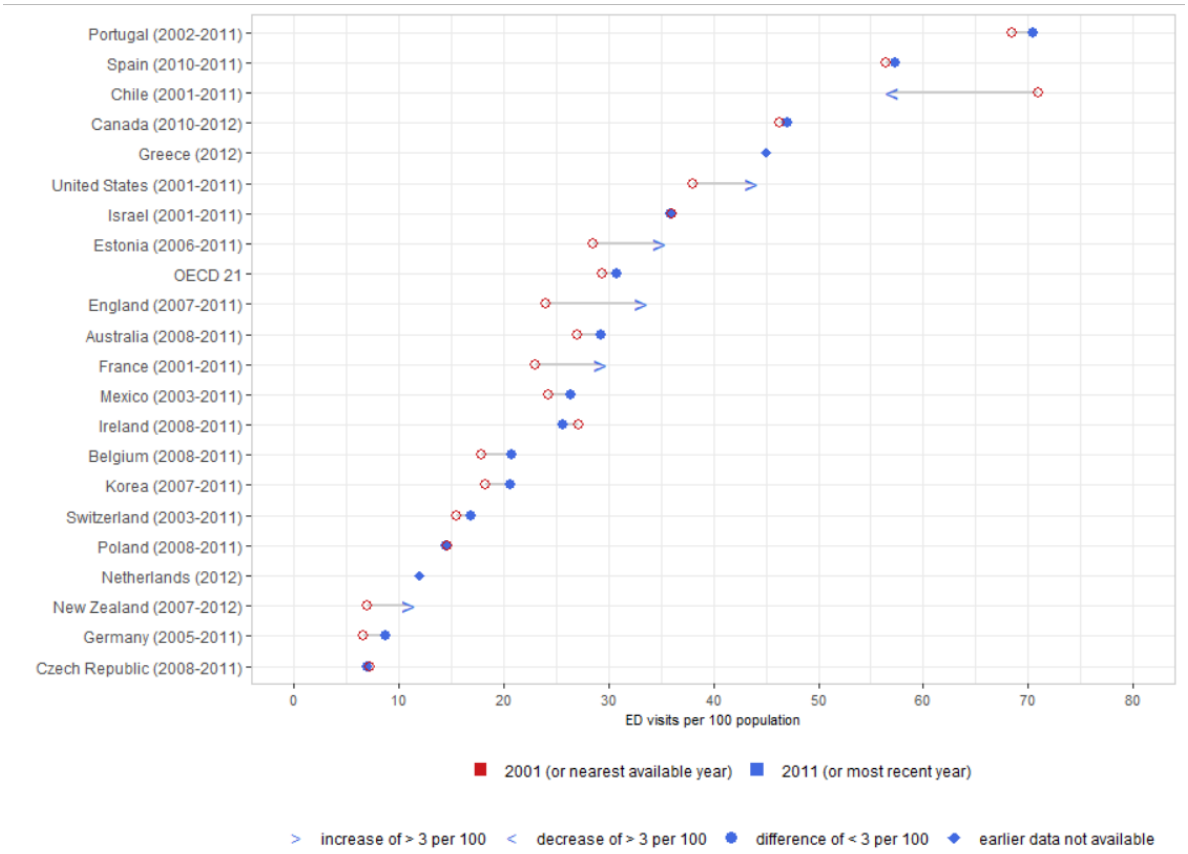


Figure 11 – Change in number of ED visits per 100 population across OECD countries

Note: Due to different definitions and identification of emergency care services, caution is needed when comparing OECD countries. Some countries include both ambulatory and inpatient ED visits (e.g. Australia), while other countries (e.g. Switzerland or Germany) include only inpatient ED visits (ED visits which lead to hospital admissions with a minimum of one stay and/or ED visits from patients already hospitalised).
Source: Berchet (2015)

Approaches to better managing service access

Countries employ a range of policy options to manage demand and access to after-hours primary care, including price signals, consumer awareness and education, and professional triage and advice. The effects can be that service demand is reduced or delayed or transferred to an alternative after-hours service provider. Key policy trends are outlined below.

Telephone, digital and virtual health

Many countries have put in place a national or regional network of telephone-based (in some instances web-based) triage and advice services to help guide and facilitate access to appropriate after-hours care. The scope of these services varies, with some providing advice on appropriate options based on the patient's reported condition, while others provide a more integrated service with the capacity to book ambulances, make appointments at clinics and provide real-time information on ED waiting times. In some instances, telephone triage is part of an integrated service to callers. For example, GP collaboratives are providing virtual, clinic and home-based care with linkage, where indicated, to ED services. In a few countries these services are co-located and further integrated into the ED, with GP-led shared triage processes. In some countries, further

integration with emergency services triage functions aims to streamline public access and make use of existing infrastructure.

In the United Kingdom, Babylon Health is using artificial intelligence to establish a range of virtual solutions for primary care, including online symptom checking and virtual consultations with GPs. In partnership with National Health Service trusts, the organisation has developed Ask A&E, a 24-hour digital service aimed at helping people access the right information about their symptoms. Callers are asked a series of questions via the Ask A&E symptom checker, and based on their information, they are given information to help decide what to do next.

In April 2020, two trusts – University Hospitals Birmingham and Royal Wolverhampton – partnered with Babylon to use its COVID-19 care assistant. The artificial intelligence-powered tool provides an option to speak to clinicians by video for more severe symptoms, as well as detecting red flags when a patient's health is deteriorating, aiming to ease pressure on GPs and NHS 111, England's equivalent to the Healthdirect helpline.

There are a range of other broader digital developments that will affect potential care options in the future, which need to be considered in the context of the wider strategic direction for primary care and the mechanisms by which these developments can be taken up and implemented in an Australian context.

Cost sharing

In some countries, out-of-pocket payments exist for patients accessing after-hours primary care and/or EDs. There is some evidence, mainly from the United States, indicating these price signals reduce or change the pattern of utilisation of services. For example, differential payments for urgent primary care and ED care can provide an incentive to access GP services after hours. However, there can be unintended consequences for access to services for vulnerable patient groups in such approaches.

Awareness and education

Some countries have introduced education interventions, including those focused on educating patients regarding self-management of their conditions or increasing their awareness about their options for appropriate service use. While the evidence of their effect on service demand is conflicting, there are indications that sustained and multi-faceted interventions may be more effective.

Policies to build service capacity

Policies to strengthen after-hours primary care service capacity focus on ways to increase the participation of GPs in the provision of care, more efficient ways of providing GP-led care and alternative ways to provide primary care. The key policy trends are outlined below.

Financial and non-financial incentives

Countries are providing a range of financial and non-financial incentives to encourage GPs and other primary care professionals to be available and provide care after hours. Most countries provide higher reimbursement to the professional and/or their practice, along with various forms of organisational support, including free use of facilities, help with administration and provision of support staff.

Mandatory participation of providers

Many higher-income countries have established mandatory requirements for GPs to participate in the direct provision of after-hours services, for example, as part of their ongoing professional registration or maintenance of accreditation status. It is considered to be an effective way of establishing a sustainable after-hours workforce and may encourage greater GP collaboration in providing care at a regional level. There are indications that the level and sophistication of financial and non-financial incentives is heightened in countries where GPs are not required to participate directly in the provision of after-hours care.

Regional governance and service consolidation

Countries have been moving away from a reliance on individual general practices providing after-hours care and looking to ways to facilitate and establish regional organisations to promote greater consolidation of services and encourage broader population approaches to the provision of after-hours care (see Box 6 for Netherlands example). These organisations vary in their role and function (e.g. GP cooperatives, clinical commissioning bodies, municipalities, or local government and regional primary care governance bodies).

The consolidation of services has the potential to:

a) Help alleviate issues of workforce availability by reducing the burden on participating GPs and other providers.
b) Build sufficient scale to make clinic-based care provision sustainable and the availability of supporting services more viable, including radiology, pathology and pharmacy services.
c) Create the opportunity to market a visible and available alternative to ED care at the regional level and align triage and advice functions.

There are indications that enrolment with a GP can enhance the capacity for planning, monitoring and managing regional provision of after-hours services.

Alternative models of care

In response to the challenges in maintaining adequate workforce availability to provide GP-centred after-hours care, some countries are promoting alternative arrangements where other workforce groups are contributing more to the provision of after-hours care (e.g. community pharmacy and nurse-led urgent-care clinics). Some countries are also exploring less intensive GP-led service models, including clinic-based and virtual primary care rather than home visits.

Box 6 – GP-led regional collaboratives in the Netherlands

The Netherlands has a strong focus on developing regional arrangements for the provision of after-hours primary care. GPs are required to actively participate in collaboratives to provide regionally based telephone triage and GP support services, after-hours clinics and home-based care. Over time, and through public education and awareness programs, the GP collaboratives have become accepted as the gateway to after-hours urgent care. Most people now call the GP collaborative in their area before heading to an ED.

More recently, greater emphasis has been given to strengthening the integration of the GP collaboratives and EDs, with most collaboratives now co-located at hospitals. This is giving rise to opportunities for them to access the diagnostic services available at the hospitals and for shared triage arrangements to be put in place for walk-in patients. Increasingly, the GP collaboratives provide the triage service at the hospital for walk-in patients, with this triage process providing

access to either the ED or the after-hours clinics. This has resulted in significant reductions in presentations to ED.

While cost-effective, the shift from ED to after-hours GP clinics at the hospitals has required additional capacity for GP-led services. GPs point to greater use of co-payments, stricter triage protocols and a stronger role for GP telehealth to reduce overall demand for after-hours care by people with lower urgency needs, and redirecting patients to daytime GP care (Keizer, 2018).

Moves to greater integration of ED and GP collaboratives for urgent care are now being extended to emergency care. Commentators are looking for the evolution of the system to include greater sharing of expertise, care processes and infrastructure across the urgent- and emergency-care systems (Rutten, 2019). This innovation would require collaboration between all emergency-care workers, of which GPs, ambulance services and EDs are central. This could be realised by the reorganisation of emergency care into what is being termed Mutual Medical Emergency Services.

Key features of the Netherlands system are:

- Out-of-hours primary care has been provided by large-scale general practitioner cooperatives since 2000. There are around 120 GP cooperatives in the Netherlands, covering 90% of the population.
- Cooperatives cover a population of 100,000 to 500,000 patients with an average care consumption of 250 contacts per 1,000 population per year.
- GP cooperative clinics are usually situated in or near a hospital's ED. Distance of patients to GP cooperative is 30 km at most.
- Access is via a single regional telephone number, meaning the first contact is mostly with a triage nurse.
- Triage is supervised by doctors who can be consulted in case of doubt, while also checking and authorising all calls. Contacts are divided into telephone advice (38%), centre consult (52%), or GP home visit (9%).
- Patients are classified into urgency categories from high to low urgency (U1: 2%, U2: 15% , U3: 38%, U4: 18%, U5: 27% in 2015).
- GPs undertake different roles within a shift: supervising telephone triage, centre consultations or home visits.
- GP-led triage at hospitals manages access to GP clinics and ED from walk-in patients (only 5–10% walk in without a call in advance).

Source: Keizer (2018)

Implications for Australia

What can we draw from the literature about how the after-hours system works in Australia and the implications for the PHN After Hours Program? Where does Australia fit in relation to this international context? By highlighting areas where after-hours primary care is either more aligned or less aligned with international trends, we can understand where Australia fits in relation to this international context. Three key aspects of after-hours care are outlined below.

Increasing the efficiency and effectiveness of care for patients

In some countries, responsibility for regional planning and funding for hospital and primary care services is located at one level of government, facilitating coordinated reforms to emergency- and urgent-care systems. For example, in Denmark, the regional authorities are

responsible for hospital and primary care. The regions negotiate collective contracts with GPs for services in their geographical area (including after-hours care), with GPs unable to access government benefits for their services without an agreed contract in place.

In Australia, the situation remains fragmented, with the responsibility for planning and funding ambulance services and hospital care (emergency system) lying with the state governments, whereas the responsibility for funding GP services (including after-hours services) lies with the Commonwealth Government.

Medical deputising services are currently one of the main after-hours providers in Australia. These services employ their own GPs and other doctors and have predominantly provided home visits until the recent introduction of MBS items for telehealth. Australia is one of only a few OECD countries that report having established deputising services. Evidence suggests that by focusing on after-hours home visits, overall GP workloads and primary care costs may be increased both because of the use of fee-for-service and the use of home visits, rather than requiring patients to visit a clinic or engage by phone.

Australia has established a range of clinic-based primary care services in or near hospital EDs to increase integration of services but concerns still exist regarding the implications for encouraging access to care after hours that could be provided in-hours by the patient's GP. Denmark and the Netherlands are tackling this issue through the use of telephone-based GP gatekeeping of access to EDs. Models exist in these countries where access to ED services requires patients to first ring the GP-led call centre. This increases the ability to triage patients to self-care, care by their GP the next day or urgent care at a co-located GP clinic, where appropriate, and before presenting to the ED.

Some ambulance services in Australia are looking to establish secondary triage functions, to bring greater integration with other urgent-care triage and service provision systems for callers with non-emergency needs. Only New South Wales and Western Australia currently use Healthdirect for this function, however, in some countries, a single telephone number has been created to deal with both emergency and urgent needs and link with appropriate services. In other instances, shared triage protocols enable GP-led helplines to directly dispatch ambulances.

Improving access to appropriate care

Australia has a national infrastructure for telephone information and advice in Healthdirect. While advice may be given regarding available after-hours primary care services, the helpline does not generally book the caller into the after-hours primary care service, dispatch an ambulance or arrange an ED visit. In some countries, online booking functionality and shared triage functions allow a more integrated approach for callers.

While the after-hours Primary Care Linkages initiative[6] seeks to link Healthdirect to different service arrangements operating locally within the PHNs, establishing and linking Healthdirect to regionally coordinated and scaled primary care services that offer virtual, clinic and home-based services is perhaps a key missing link in many instances across Australia.

With the advent of new bulk billing after-hours primary care providers offering home, clinic and telehealth options, there is the possibility that after-hours primary care capacity will

[6] https://about.healthdirect.gov.au/after-hours-primary-care-linkages-service

continue to grow. However, without any direct links to a triage service and greater integration between hospital EDs and these new services, the available evidence (both here and overseas) indicates that ED demand will not be substantially reduced.

In some countries, the GP gatekeeping role in after-hours care would appear stronger than in Australia, with patients required to access a regional GP-led triage service (except for emergency cases) before being able to attend and access an ED. In other instances, GPs and EDs share triage arrangements where the services are co-located.

Improving the availability of GP services

Australia has a range of financial incentives to encourage GPs to organise and provide after-hours primary care, through PIP and MBS. Additional financial support is also provided to the PHNs to build capacity for population-based after-hours primary care. The After Hours GP Helpline also contributes to primary care capacity.

The OECD considers that the most effective way to improve primary care service availability after hours is to mandate the participation of GPs. A survey by the OECD in 2015 indicated that voluntary GP participation in after-hours care is available only in Australia and a handful of other OECD countries. Most countries require some level of participation, for example, as a requirement for continuing professional registration.

Australia is advancing telemedicine across the health system, particularly in rural and remote communities, and the After Hours GP Helpline provides some basis for substituting face-to-face consultations. The recent introduction of MBS items for telemedicine is now generating significant momentum for broader use. Countries such as the United Kingdom and Sweden have been exploring Digital Primary Care, with younger, mobile-savvy patients and others now accessing over 30,000 digital consultations a month in Sweden (Ekman et al., 2019). This has raised concerns about the potential for 'cream skimming' and challenges the funding mechanisms to ensure that the funding is appropriate to the needs of patients. These developments have been rapidly accelerated due to the COVID-19 pandemic with the longer-term effects not yet clear.

Case study: Perth South PHN

Case study focus
The Perth South PHN case study focused on the 50 Lives 50 Homes After Hours Support Service. 50 Lives 50 Homes is a multi-agency housing first initiative.

Locality overview
The Perth South PHN supports primary care services across the southern part of Perth city, Fremantle and Mandurah, Murray and Waroona region, and includes Rottnest and Christmas islands, which are classified as very remote. The population is just under 1 million (928,842) and is spread across 5,148 square km (Department of Health, 2018b). Perth South makes up 35% of the state's population (WA Primary Health Alliance, 2019). Almost all the population of the PHN (99% or 915,729 people) live within the RA category 1 ASGS major city region. A very small percentage (1.1%) live in an inner region RA2. The three PHNs covering Western Australia were brought together under a single organisation – the WA Primary Health Alliance – which commissions services. A centralised approach is used where there are benefits, and a local approach when required.

PHN approach
The PHN rolled forward contracts from the previous Medicare Local for 12 months, but some activities were decommissioned over time. Only one activity remains from 2015, which is the urgent-care centre in Armadale where there are limited GP services. The PHN commissioned a needs assessment, which identified that the heaviest users of after-hours services were children under five years, people over 65 years, and vulnerable and disadvantaged populations such as people with chronic conditions, mental health diagnoses, homeless people and Aboriginal people.

Some services were commissioned to support other programs to stretch into the after-hours period. The PHN's overall approach has been to focus on high-impact activities. After-hours activities for 2019–20 include: the Armadale after-hours service; after-hours support for disadvantaged, vulnerable and homeless populations; after-hours integrated mental health, suicide prevention, and drug and alcohol treatment services; Advance care planning and My Health Record collaboration; and the urgent-care centres public awareness and education campaign.

Key observations

- **There can be after-hours service gaps in metropolitan PHNs even where supply of after-hours GP clinics is appropriate for the majority of the population.** Like many other major cities, Perth South PHN identified the homeless population as having a high need for primary care services. This is a group that has been identified as being intensive users of ED and hospital services.
- The support service commissioned under the PHN After Hours Program is a small element of a much larger 'housing first' initiative that includes a homeless healthcare service. The service is delivered to the very highest need group of homeless people with significant health issues**. The service represents a significant and disproportionate investment for the PHN to the benefit of a relatively small but high-need group.** The service is highly valued and appears to have delivered significant health and social benefits.
- Mainstream services are not designed to meet the needs of some patient groups and **distinctions between in-hours and after-hours mean very little for some vulnerable groups**. More flexible and responsive approaches are needed.
- The success of the after-hours support service is built on a broader initiative that has brought together agencies from across the charitable, state, health and other sectors. **Strong relationships, collaboration and effective joint work are important prerequisites, as is the need for the PHN to be effective as a commissioner. Using the program to link and extend existing services has been very beneficial.**
- **There are often critical ingredients that come together to deliver change.** As well as the effective multi-agency work, there are key individuals who influenced and championed the needs of this client group as well as a charitable organisation that was willing to take on the 'backbone' role.

4. The PHN After Hours Program

This chapter describes the operation of the PHN After Hours Program, including the commissioning, funding and approval cycles for the program, the method used for allocating funds between PHNs, and other aspects of how the program operates. The chapter describes the strategies adopted by PHNs. These are considered in relation to the patient journey discussed in Chapter 2.

The program was established in the 2015–16 financial year, the same year PHNs commenced operation. The program is implemented through funding agreements between the Department of Health and PHNs.

PHN After Hours Program

The PHN After Hours Program was established in 2015–16 reflecting the Australian Government's response to recommendation 3 of the Jackson Review (Jackson, 2014):

> From 1 July 2015, Primary Health Networks (PHNs) receive funding to work with key local after-hours stakeholders (including Local Hospital Networks (LHNs), Medical Deputising Services (MDSs), consumer groups, Aboriginal and Torres Strait Islander representatives, the private health sector and non-government organisations) to plan, coordinate and support population-based after-hours health services. Their focus should be on **gaps in after-hours service provision, vulnerable groups and service integration** (Department of Health, 2014; Jackson, 2014).

The objectives of the program and associated guidance are set out in the Standard Funding Agreement Schedule (see Box 7). These largely reflect the Jackson review recommendations, placing an emphasis on gaps, vulnerable groups and service integration.

Box 7 – PHN After Hours Program aims, objectives, priorities and implementation guidance, Standard Funding Agreement Schedule

Broad program objectives:

1. Increase the efficiency and effectiveness of after-hours primary health care for patients, particularly those with limited access to health services.
2. Improve access to after-hours primary health care through effective planning, coordination and support for population-based after-hours primary health care.
3. Improve the availability of after-hours GP services through working collaboratively.

Specific program objectives:

1. Develop innovative solutions to address service gaps and improve access to after-hours primary health care, ensuring ongoing consideration for vulnerable populations and those populations who have not been well served by previous after-hours arrangements, such as rural and remote populations.
2. Address the lack of, or inequity of access to, after-hours primary health care through targeted (and collaborative) programs.

3. Improve patient outcomes through working collaboratively with health professionals and services to integrate and facilitate a seamless patient experience.
4. Address fragmentation, increase efficiency and effectiveness, and implement systems to support effective communication and continuity of care across after-hours service providers and a patient's regular GP.
5. Work with key local after-hours stakeholders, including GPs and state and territory governments, to plan, co-design, coordinate, and support population-based after-hours primary health care.
6. Foster local-level solutions and enable a greater focus of specific target groups, particularly where the PIP After Hours Incentive may not reach.
7. Increase consumer awareness of after-hours primary health care available in their community and improve patient health literacy on the appropriate health services to access in the after-hours period.

Priority areas for PHNs to consider:

- Access to after-hours GP services
- Residential aged care facilities
- Rural and remote locations
- Services supported and delivered by pharmacies and allied health
- Disadvantaged groups, including palliative care and house-bound aged patients
- Information sharing, health literacy, data collection and electronic health mechanisms.

PHNs are required to deliver their plans by:

- Commissioning high-quality, innovative, locally relevant and effective after-hours primary health care, based on community need, as identified in the latest needs assessment and considering a system-wide view of after-hours provision in the PHN region.
- Promoting collaboration and partnerships that support the after-hours care system to help meet the needs of the PHN region.
- Considering opportunities for co-design and co-commissioning to enable more sustainable solutions.
- Continuing to address gaps in the provision of after-hours primary health care.
- Build capacity to work with key after-hours stakeholders to foster local-level solutions, particularly where the PIP After Hours Incentive may not reach.
- Implementing systematic monitoring and evaluation of the local after-hours programs.

Source: Department of Health (2015b)

The commissioning cycle

PHNs have operated within a commissioning model, key elements of which were originally laid out in the first set of grant program guidelines (Department of Health, 2016). For each program, the cycle involves:

Strategic planning: Baseline needs assessments were undertaken in 2015–16 and have been updated subsequently. Needs assessments may also involve identifying priorities for the program. Some PHNs have incorporated specific after-hours needs assessment within their wider needs assessments. PHN needs assessments are submitted to the Department of Health for approval.

Activity Work Plans: This involves identifying activities that meet the needs identified within the needs assessment and addressing priorities identified, taking into account the funds available and their duration as advised to the PHN by the Department of Health. These

activities may include work undertaken by the PHN itself. Most activities, especially direct service provision, are typically undertaken by organisations external to the PHN but some are done in house, e.g. consumer awareness programs. Activity Work Plans detailing activities to be supported through the program are submitted by the PHNs to the Department of Health for consideration and approval. PHNs may have already conducted some preliminary market analysis and identified potential providers or engaged in some co-design activities. Approval by the Department involves an assessment of each activity against the PHN After Hours Program guidelines, selected components of which are shown in Box 7. The Activity Work Plans are a key input to the funding agreement between the Department and the PHN.

Service procurement: Following approval of the Activity Work Plan, the PHN is able to proceed to service procurement. This involves determining the commissioning strategy (including approaches to market, direct commissioning, co-design, co-commissioning as appropriate). Following consideration of expression of interest and request for tender responses where relevant, agreements with commissioned providers are finalised, activities implemented, and progressive payments made by the PHN. Depending on the nature of the activity, whether the service is new or continuing, and the commissioning strategy used, there may be a delay with commencement while the contracted organisation recruits staff and other resources required.

Monitoring and review: Ongoing monitoring within the program occurs at three levels:

- *Reporting by commissioned services:* PHNs are required to "ensure appropriate data collection and reporting systems are in place for all Contracted Services" and to "monitor and review/evaluate Contracted Services to determine progress towards achieving expected outcomes in an efficient and cost-effective manner and to identify service issues, gaps, underperformance and areas for improvement" (Department of Health, 2015b). However, there is no further specification or guidance on how this should be undertaken.
- *PHN Performance reports:* PHNs are required to submit annual (previously six-monthly) performance reports. These take the form of a narrative against each activity, which may include discussion of achievements. The reports are reviewed by Department of Health staff.
- *Indicators under the PHN Program Performance and Quality Framework* (Department of Health, 2019a): Indicators from this framework are regularly reported by the AIHW. These are used by PHNs in their planning. The Department uses information from PHN Performance Reports and publicly available data (supplied by AIHW) to assess performance. There are four indicators under this framework that are potentially relevant to the PHN After Hours Program:
    - P6: Rate of general practices receiving payment for after-hours services
    - P7: Rate of GP-style ED presentations
    - P8: Measure of patient experience of access to GP
    - P12: Rate of potentially preventable hospitalisations.

Funding allocations and approval cycles

Funding allocations that have been made under the program are shown in Table 8. The funding cycles for the program have generally involved up to two-year allocations, with each program reviewed periodically. For the program, three rounds of allocations have been made, each for two years. The extension of the program has often occurred quite late in the financial year prior to implementation. PHNs have been advised of the extension of the program one to three months in advance of the funding round.

Table 8 – PHN After Hours Program funding and approval cycles, 2015–16 to 2020–21

	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21
Round	Round 1		Round 2		Round 3	
PHNs advised	June 2015		June 2017		March 2019	
Funding Allocated	$45.1m	$64.4m	$65.7m	$66.6m	$71.0m	$71.0m
Activity Work Plan due	Aug 2015	May 2016	Aug 2017	Feb 2018	Variable[1]	Mar 2020
Activity Work Plan approved	Oct 2015-Feb 2016	May 2016-Dec 2016	Aug 2017-Dec 2017	July 2018-Feb 2019	Aug 2019-Nov 2019	Ongoing[2]

Notes: [1] Four weeks from schedule execution; [2] At 21 July 2020, 11 Activity Work Plans had been approved.

Following advice on the funding allocation, PHNs prepare an Activity Work Plan for each financial year. These should be considered first by PHN boards and then submitted to the Department for approval. The Activity Work Plans set out the activities that PHNs intend to commission.

There was a lack of consistency in the dates that funding was announced and that the Activity Work Plans were due for submission, but in some years the dates have been after the commencement of the financial year. For 2015–16 to 2017–18, Activity Work Plans were assessed by staff within the state/territory offices of the Department of Health. In following years, assessments were made by the PHN Operations Section in collaboration with policy areas. Dates Activity Work Plans were finally approved has varied depending on when the PHNs actually submitted their Activity Work Plan, and the time taken for assessment and approval. In the assessment process, Departmental officers consider whether the proposed activities are consistent with program objectives and criteria and they may raise questions with the PHN and negotiate changes to the plans. The approvals process can take some time because of revisions to the Activity Work Plan or for other reasons. This means approvals were sometimes not finalised until five to six months into the financial year.

In the current financial year, program allocations will be $71.0 million, the same level as for 2019–20. Funding is allocated between PHNs on a weighted population-based formula, which includes adjustments for Indigenous population, age, socio-economic measures and rurality/remoteness using the Modified Monash Model classification system (Table 9). The current allocation model was implemented from 2019–20 with modifications to an earlier model to reflect: new population data, a move to the Modified Monash Model regional classification system, and revised weightings for age, rurality, Indigenous status and socio-economic disadvantage.

Table 9 – HN After Hours Program funding formula: Population characteristics and associated weights

Population weighting factor	Weight
Indigenous status	
Non-Aboriginal or Torres Strait Islander	1.00
Aboriginal or Torres Strait Islander	3.00
Modified Monash Model (MMM)	
MMM 1 and 2	0.70
MMM 3 and 4	1.00
MMM 5	3.00
MMM 6	4.00
MMM 7	5.00

Population weighting factor	Weight
Age group	
Younger	1.00
Older: Non-Indigenous > 65 years Indigenous > 50 years	3.00
SEIFA quintiles	
Quintile 1	1.50
Quintile 2	1.30
Quintiles 3 through to 5	1.00

In addition to the above, reductions compared with previous allocations for any PHN were capped at $31,000 and increases were capped at $400,000.

Hunter New England and Central Coast PHN and Primary Health Tasmania receive additional funding over and above the standard allocation, designed to support pre-existing after-hours programs (GP Access and GP Assist respectively).

Figure 12 shows per capita funding allocations by PHN for the 2019–20 financial year. Across Australia the average allocation is $3.06 per capita. This varies from $1.47 for the ACT PHN to $22.25 for Western Queensland. The funding range for PHNs that primarily serve metropolitan populations was $1.47 and $2.26 per capita, while the funding for PHNs that serve significant rural populations ranged from $3.15 to $22.25 per capita. In terms of total funding, the allocations range from $580,000 (ACT) to $5.5 million (Hunter New England and Central Coast). Fifteen PHNs are allocated less than $2 million, 10 between $2 million and $3 million and 6 more than $3 million per year.

The largest share of the funding (7.7%) is allocated to Hunter, New England and Central Coast PHN. Northern Queensland, Tasmania and Country WA PHNs all receive more than 6% share of the funding (in excess of $4 million). ACT receives the lowest per capita and share of funding.

Since the establishment of PHNs, the PHN After Hours Program has represented around 6.8% of overall funding support under the PHN funding agreement schedules (see Table 10). In 2020–21, PHN core funding represented 26.6% of total funding, 54.8% related to mental health and drug and alcohol programs, and 6.7% to the Indigenous Australians' Health Program. PHNs often seek to coordinate and combine funding from various programs, including the PHN After Hours Program, to address priorities identified for local communities. For example, some PHNs have aligned after-hours mental health care with provision funded under the Primary Mental Health Care Program.

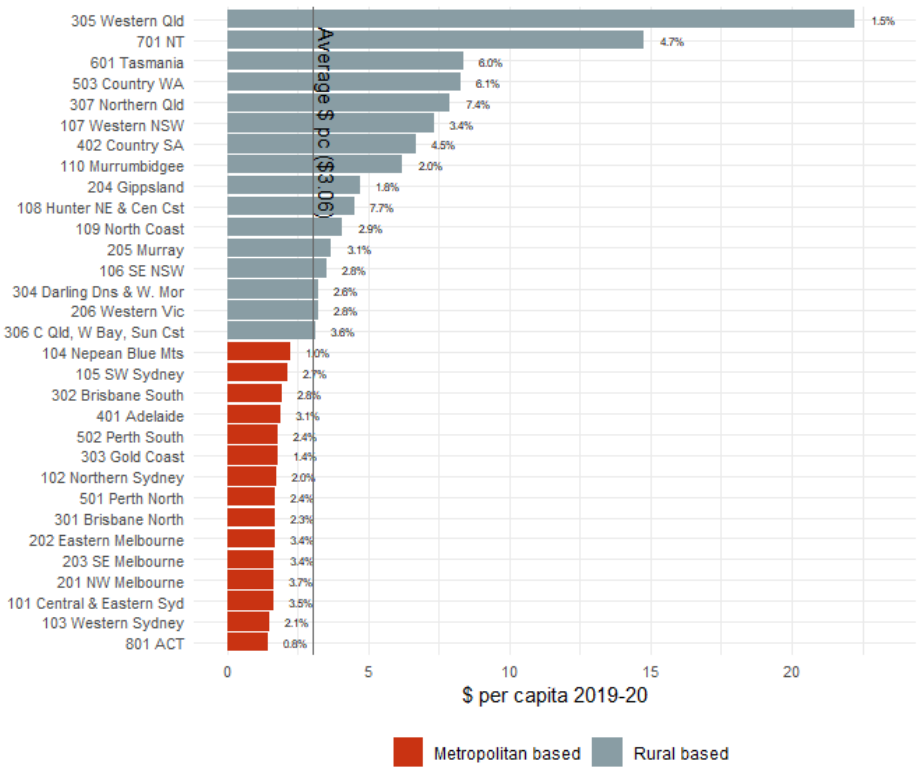


Figure 12 – PHN After Hours Program funding allocations per capita and percentage share of Program funding by PHN, 2019–20

Table 10 – Commonwealth Government funding support for PHNs: Percentage of total allocations under the PHN funding agreement schedules

PHN programs	2016–17	2020–21
PHN core funding	31.2%	26.6%
After Hours	6.7%	6.8%
Primary Mental Health Care	37.7%	48.2%
Drug and Alcohol Treatment Services Program	7.4%	4.3%
Indigenous Australians' Health Program	7.0%	6.7%
National Psychosocial Support	0.0%	2.3%
Partners in Recovery	7.7%	0.0%
Continuity of Support	0.0%	3.5%
Community Health and Hospitals Program	0.0%	1.1%
Other	2.4%	0.5%
Total	100.0%	100.0%

PHN variation and contexts

PHNs have taken different approaches to the program driven by the specific circumstances in their areas. For the purposes of analysis, we have grouped the PHNs into four groups according to the type of area, making use of the Rural, Remote and Metropolitan Area (RRMA) classification. Many PHNs cover a wide diversity of geography and population, so some judgement is required in assigning a PHN to a group. The grouping is based on which

class of RRMA or pair of classes account for most of the population. The four groups that we created are:

- **Major cities**, which includes PHNs in all the major cities with the exception of Darwin and Hobart (as they are included within a wider PHN area).
- **Major cities/inner regional** PHNs were ranked by the proportion of the population within the major cities and inner-regional class.
- **Inner and outer regional** PHNs were ranked by proportion of the population in inner- and outer-regional areas.
- **Outer and remote area** PHNs were ranked by proportion of population in remote areas.

Country South Australia has a substantial proportion of the population covering both major cities and remote areas (22%). For the purposes of ranking PHNs, remoteness was treated as a more important factor. Table 11 provides the resulting grouping, which is used to present analysis of PHN After Hours Program activities and relevant statistics.

The contexts within which PHNs are working are highly variable but there are consistent patterns across PHNs dependent on their geography and population. These differences mainly relate to the vibrancy of the local primary care market, which reflects both the demand side (size and density of population) and the supply side factors (the numbers of GPs, practices and other services such as pharmacy and deputising services in the area). Where the market does not function effectively, the gaps in provision are more marked and the issues that need to be tackled tend to be less tractable.

Some of the factors that influence or give an indication of the after-hours and wider health landscape that face PHNs are set out in Table 12.

In the metropolitan areas, people with health needs in the after-hours period generally have several options available. Their usual practice may offer extended-hours services or a deputising service, or there may be alternative practices offering extended hours or walk-in services operating in some or all of the after-hours period.

The rate of urgent after-hours MBS items in the cities is more than double that for other PHNs. This difference is less marked for in-hours MBS services. After-hours options become increasingly constrained moving from cities and inner-regional to outer-regional and remote areas. This is reflected in the low number of GPs available, which in remote areas is only half the number per 1,000 as in the metropolitan areas. There are also fewer primary care practices and other options available, such as pharmacies. Medical deputising services are available in most, but not all, suburbs of major cities but generally not available in outer-regional and remote Australia. Urgent-care centres and primary care co-located with EDs may also be available in the metropolitan and inner-regional areas.

Table 11 – Grouping PHNs by remoteness

#	Group description	PHN	Population within named remoteness area(s) %
1	**Major cities** (% of population in major cities ≥ 90%)	Adelaide	99%
		Perth South	99%
		Perth North	98%
		Gold Coast	98%
		Brisbane North	95%
		Brisbane South	96%
		Eastern Melbourne	96%
		South Eastern Melbourne	98%
		North Western Melbourne	98%
		South Western Sydney	90%
		Nepean Blue Mountains	90%
		Western Sydney	99%
		Central and Eastern Sydney	100%
		Northern Sydney	100%
		Australian Capital Territory	100%
2	**Major cities/inner regional** (ranked by % population in city/inner-regional, high to low)	Central Queensland, Wide Bay, Sunshine Coast	93%
		Hunter New England and Central Coast	90%
		South Eastern New South Wales	90%
		Darling Downs and West Moreton	85%
3	**Inner and outer regional** (ranked by % population in inner/outer regional, low to high)[1]	North Coast	84%
		Western Victoria	69%
		Gippsland	100%
		Murray	100%
		Tasmania	98%
		Murrumbidgee	99%
		Western New South Wales	91%
		Country South Australia	79%
4	**Outer regional/remote** (ranked by % population in remote areas, low to high)	Northern Queensland	89%
		Country WA	64%
		Northern Territory	100%
		Western Queensland	100%

Notes: [1] Country South Australia has a lower proportion of its population in inner/outer regional areas but has a high proportion of population in remote areas (12%) so is included in this group and ranked as more remote than others in the group.

In remote areas, there are generally few GPs residing in communities, with primary care delivered by Aboriginal Community Controlled Health Services and government-supported health clinics. These are generally staffed by remote area nurses, Aboriginal health practitioners, and GP and allied health services delivered by visiting GPs and allied health practitioners. There are few, if any, dedicated extended-hours services available and after-hours care is provided by local staff being on-call. Rates of MBS services are around 30% lower than for metropolitan areas and 70% lower for after-hours urgent MBS items. There is rarely a local hospital and emergency care is supported by aeromedical services such as the Royal Flying Doctor Service, which provides telephone, radio and video services.

Low-urgency ED use in the after-hours period is much higher outside the major cities (see also Figure 13).

Table 12 – Characteristics of the primary care markets

Characteristic of primary care and health systems	PHNs: Major cities (n=15)	PHNs: Mainly inner-regional populations (n=4)	PHNs: Mainly outer-regional populations (n=8)	PHNs: Mainly remote and very remote populations (n=4)	
	Major cities	Inner regional	Outer regional	Remote	Very remote
Primary care services:					
Workforce: FTE GPs per 100,000[1]	116.4	112.5	98.6	82.1	66.4
Practice types generally available	Independent, corporate, super clinics, Aboriginal Community Controlled Health Services		Independent, Aboriginal Community Controlled Health Services		Aboriginal Community Controlled Health Services, Government clinics
Had to wait longer than 24 hours for an GP appointment for urgent care [2]	25%	34%	36%		Missing data
GP MBS services bulk billed (%) [1]	87.2%	83.1%	84.2%	83.6%	90.5%
GP MBS services (crude rate per 1,000) [3]	6,403	6,569	6,128	5,283	
After-hours urgent MBS services (crude rate per 1,000)[3]	605	307	225	291	
Medical deputising services available	Mainly Yes	Mixed	No	No	No
Practices routinely open in after hours	Mixed		Minimal	Minimal	Minimal
After-hours pharmacies	Yes	Mixed	No	No	No
ED services:					
Availability of local ED	Yes			Mixed	No
ED low-urgency after-hours attendances (age standardised rate per 1,000)[3]	47	83	99	Not reported	
ED services provided by local GP:	No		Yes	Mixed	No

Sources: [1] Steering Committe for the Review of Government Services (2020); [2] Australian Bureau of Statistics (2019); [3] Australian Institute of Health and Welfare (2020d).

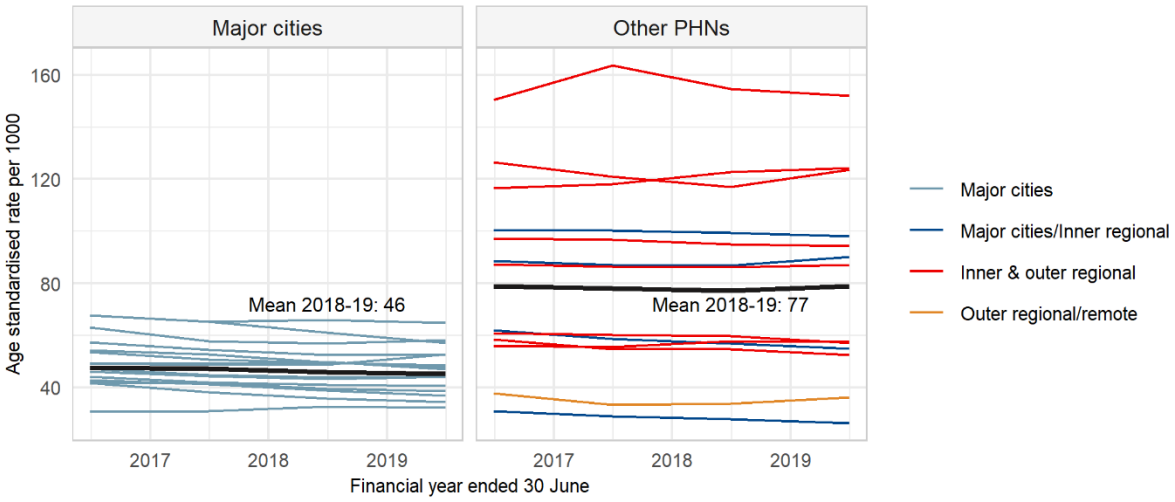


Figure 13 – Low-urgency after-hours ED attendances[7], age standardised rate by PHN, 2018–19
Source: ED – Australian Institute of Health and Welfare (2020e); GP after hours – Australian Institute of Health and Welfare (2020b). The measure is published for only one PHN in the outer regional/remote category

As shown in Table 12, low-urgency ED use in the after-hours period is much higher outside the major cities. Figure 13 shows trends in age standardised rates.

Table 13 compares after-hours GP MBS items of service and ED low-urgency attendances by PHN group. There is generally a negative correlation between low-urgency after-hours ED use and MBS after-hours items. In PHNs based in major cities, rates of MBS-supported GP after-hours services are much higher and low-urgency ED visits are lower on average. In the inner- and outer-regional areas, after-hours ED attendances are higher on average than for the cities but there is a high degree of variation across the inner- and outer-regional PHNs. (Data on ED presentations is more problematic for remote regions due largely to incompleteness of patient-level reporting).

Figure 14 shows the relationship between after-hours GP services and after-hours ED presentations at PHN level, including trends over recent years. In the plot, the points or head are the values for 2018–19 and the line or tail are values for previous years. The plot gives a sense of the direction in which rates are moving for each PHN. The black lines indicate the national average in 2018–19. The blue line shows the linear relationship between the two measures and suggests that although there is variation, on average, as after-hours GP attendance rates go down, ED attendance rates increase.

[7] Low-urgency ED presentations are defined as presentations at formal public hospital EDs where the person:

- Type of visit is 'emergency presentation'.
- Allocated triage category 4 (semi-urgent: within 60 minutes) or 5 (non-urgent: within 120 minutes).
- The status of the patient at the end of the non-admitted patient ED service episode was that the patient did not die, and was not admitted or referred to another hospital for admission.

Table 13 – Comparison of GP after-hours items and low-urgency ED after-hours care by geographic grouping (2018–19)

PHN	Crude rate per 1,000	
	GP after hours	ED low-urgency after hours
Crude rate per 1,000:		
1 Major cities	605	45
2 Major cities/inner regional	307	69
3 Inner and outer regional	225	79
4 Outer regional/remote	291	NA
Australia	490	56
Total services/presentations:		
Australia	12,248,288	1,393,756

Sources: ED – Australian Institute of Health and Welfare (2020e); GP after hours – Australian Institute of Health and Welfare (2020b).

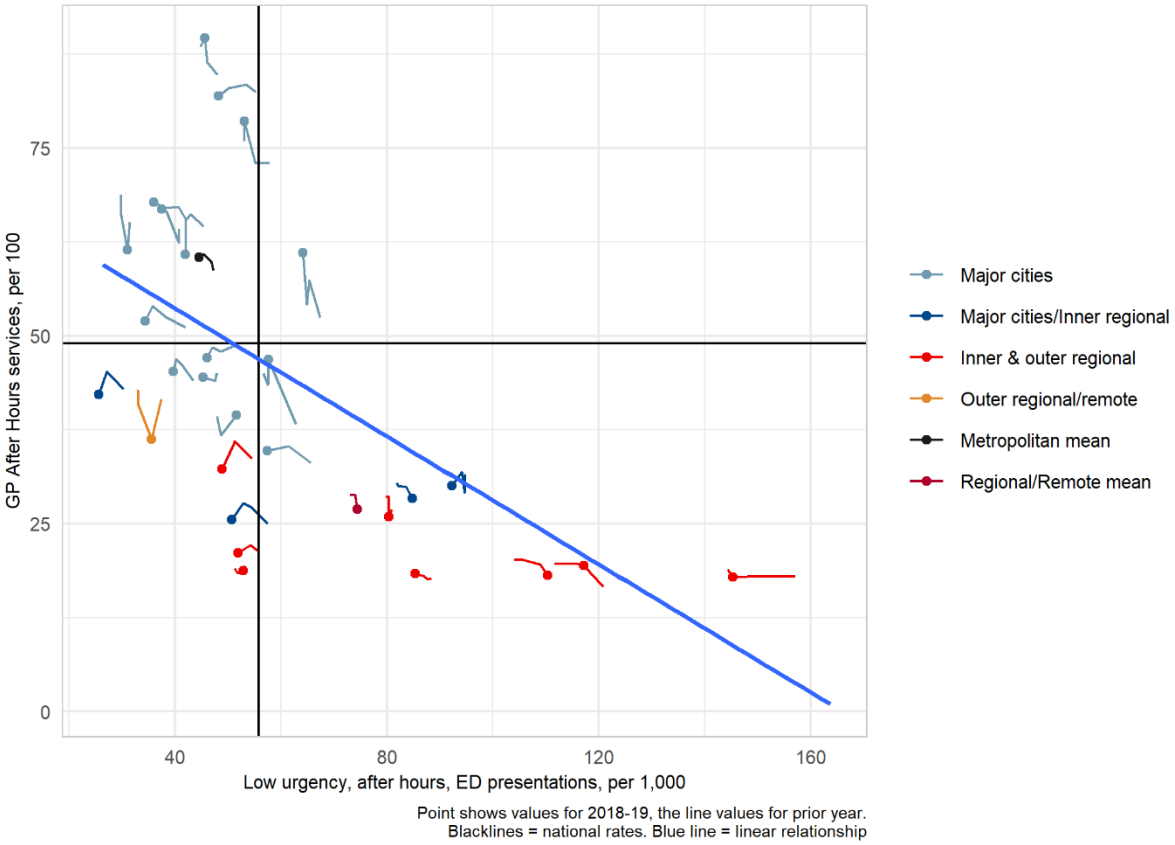


Figure 14 – Rates of GP after-hours attendances plotted against low-urgency After-hours ED presentations by PHN, 2014–15 to 2018–19

Source: ED – Australian Institute of Health and Welfare (2020e); GP after hours – Australian Institute of Health and Welfare (2020b)

Hospital EDs are still the most visible and trusted provision of urgent after-hours primary care in Australia. Many patients end up at an ED either because it is the only option available or because it is the most visible part of the health system and is open 24/7, has imaging and pathology available and, importantly, provides care at no additional cost to patients. For some consumers, EDs are their preferred option if their own GP is not available or they do not have a GP as they have greater trust in the ED doctors and nurses. Cost is commonly cited as

a motivating factor for patient choice and rates of bulk billing tend to be higher in the metropolitan areas.

The needs of patients will also vary. Transport limitations makes access difficult both in rural and remote areas but also in poorly served parts of metropolitan areas where people may have limited access to public transport and longer travel times. Health needs will vary but there may also be concentrations of vulnerable groups whose needs are not easily met from mainstream services. Specific needs relate to people with mental health issues, those living in residential aged care facilities, the homeless and people requiring palliative care in the community. In some regional areas, there appears to be an expectation or broad acceptance that there are few services available and that stoicism is an expected part of living in those areas. But it appears that consumer attitudes are changing and there is little acceptance that it should be more difficult to access care in the evenings or weekends.

The complexities of the system and diversity of provision makes it more difficult for people to understand and navigate and the onus for educating patients about appropriate services does not sit neatly with one organisation or level of government. The PHN After Hours Program's principal purpose is to address these gaps in access and capacity, and to improve the efficiency and effectiveness of services after hours as well as to build services to meet the needs of vulnerable patient communities. The PHNs can adopt a range of strategies for doing so and these are covered in the next section.

PHN after-hours strategies

Figure 15 sets out the broad strategies outlined previously (Figure 2) that PHNs can employ to address the program objectives and target different parts of the patient journey.

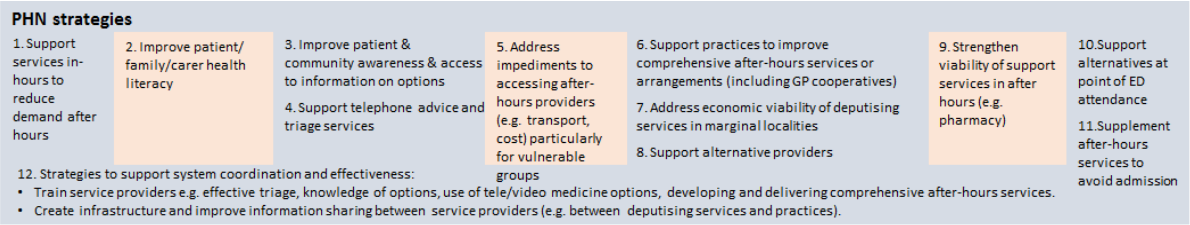


Figure 15 – PHN strategies drawn from Figure 2

These strategies include:

1. **Supporting services in-hours to reduce demand after hours** is not explicitly covered by the program aims and objectives. Some of the services commissioned by PHNs recognise that if access to care is poor during the in-hours period then exacerbations or acute conditions could occur potentially resulting in use of EDs in the after-hours period.

2. Improve **health literacy** to manage health issues and recognise when and what options are available to seek after-hours care.

3. These complement patient and **community awareness** raising strategies that attempt to increase understanding of common health issues and information and guidance to help people navigate the system. Some PHNs have focused on particular population groups such as culturally and linguistically diverse groups or parents of young children.

PHNs also provide information and links to the telephone triage services on their website and promotional material.

4. Directly support **after-hours telephone triage and advice services**. Hunter New England and Central Coast PHN and Primary Health Tasmania have both invested in telephone triage services. Other PHNs have commissioned telephone advice services, often to support people with mental health issues or for residents in residential care.

5. **Address geographic and other barriers** to accessing after-hours care to improve equity of access. There are a range of different approaches that PHNs have taken to overcome these barriers to access. Many PHNs are funding urgent-care centres or after-hours clinics in areas where there is little or no provision. Some services are commissioned to sit alongside ED services to divert patients to a more appropriate service if they arrive at ED. Some PHNs have funded access to telehealth services (prior to the development of MBS-funded telehealth items) PHNs have also sought to increase or improve provision of services tailored for **vulnerable patient groups.** The patient journey recognises that there may be reasons that some vulnerable patient groups need services that are more tailored to their circumstances. This could include services targeted at Indigenous patient groups, homeless people or those at risk of domestic violence.

6. **Support general practices to improve after-hours provision**. This may include supporting general practices to achieve the standards required to participate in PIP or providing other support to enable them to provide a more comprehensive service to residential aged care facilities**.** These strategies may also be concerned with improving patient pathways and streamlining systems to direct patients to appropriate care. Primary care providers are not always aware of the service options available or are not able to recognise when patients have specific needs, e.g. people at risk of family violence. The support that PHNs put in place may be directed at service providers rather than directly to patients.

7. **Improve effectiveness or viability of medical deputising services** and their relationships with practices. For medical deputising services to be able to deliver a sustainable service, they need to be able to achieve a minimum number of visits over a period on call. In areas where travel times are too great, medical deputising services are not economical. Some PHNs have provided subsidies to medical deputising services to make it viable for them to operate in particular areas. For example, the Northern Queensland PHN funds House Call Doctor to increase access to after-hours services in rural and remote locations.

8. **Support alternative providers** such as urgent-care centres or walk-in centres as cost-effective alternative types of provision.

9. **Strengthen viability of support services** (e.g. pharmacies) to expand or improve after-hours services. Pharmacies can provide advice and support to patients in the after-hours period that can mean a patient is able to wait to see a GP in-hours. Some patients may be able to access a GP service but are not able to obtain their prescription, which can create further difficulties. Some PHNs have sought to increase the opening hours of pharmacies. Other PHNs have used pharmacists to support particular patient groups such as those with palliative care needs.

10. **Support alternatives at point of ED attendance.** Some PHNs have commissioned services to manage patients once they arrive at an ED and divert them to or support them with more appropriate care. This could include establishing a co-located urgent-care centre or identifying frequent users of ED services and supporting patients directly.

11. **Supplement after-hours service provision to avoid admission.** This could include referral to more appropriate care such as social services, medication support, or drug and alcohol support services.

12. **Strategies to support system coordination and effectiveness.** In many areas there is a need to work at the system level to improve coordination and planning of services across state/territory, primary care and other providers. PHNs can use their funding and commissioning approaches to aid system-level development and reduce fragmentation of services. This could include activities that support population health management approaches and improving infrastructure and practice for information sharing following a patient accessing an after-hours service (e.g. communicating details back to a patient's regular general practice). A key part of the patient journey is ensuring that whatever service a patient has accessed, the information is conveyed back to their usual GP. This ensures that patient records are up to date and complete and supports effective continuity of care. This might include, for example, using digital technologies to support secure messaging between service providers.

Figure 16 shows how the 12 strategies relate to the objectives of the program. The program objectives strongly emphasise improving access to and the availability of GP after-hours services. This implies increasing service provision and potentially increasing demand through levelling-up of services. The other objective of the program is concerned with improving efficiency and effectiveness, which is likely to focus more on managing demand and ensuring services are appropriate to needs. These strategies are concerned with matching appropriate services to needs and potentially reducing demand for services such as ED presentations. There is no standard accepted and objective measure of what the appropriate level of GP provision is for a given population. Too little provision in after-hours care is likely to lead to unmet need and potential exacerbation of a condition or inappropriate ED care. Readily accessed care after hours may lead to patients receiving care after hours that could be dealt with in-hours resulting in higher cost than necessary. Telephone triage is seen as a way of trying to manage demand. However, the algorithms used for triage currently tend to be on the conservative side compared with a GP assessing a patient.

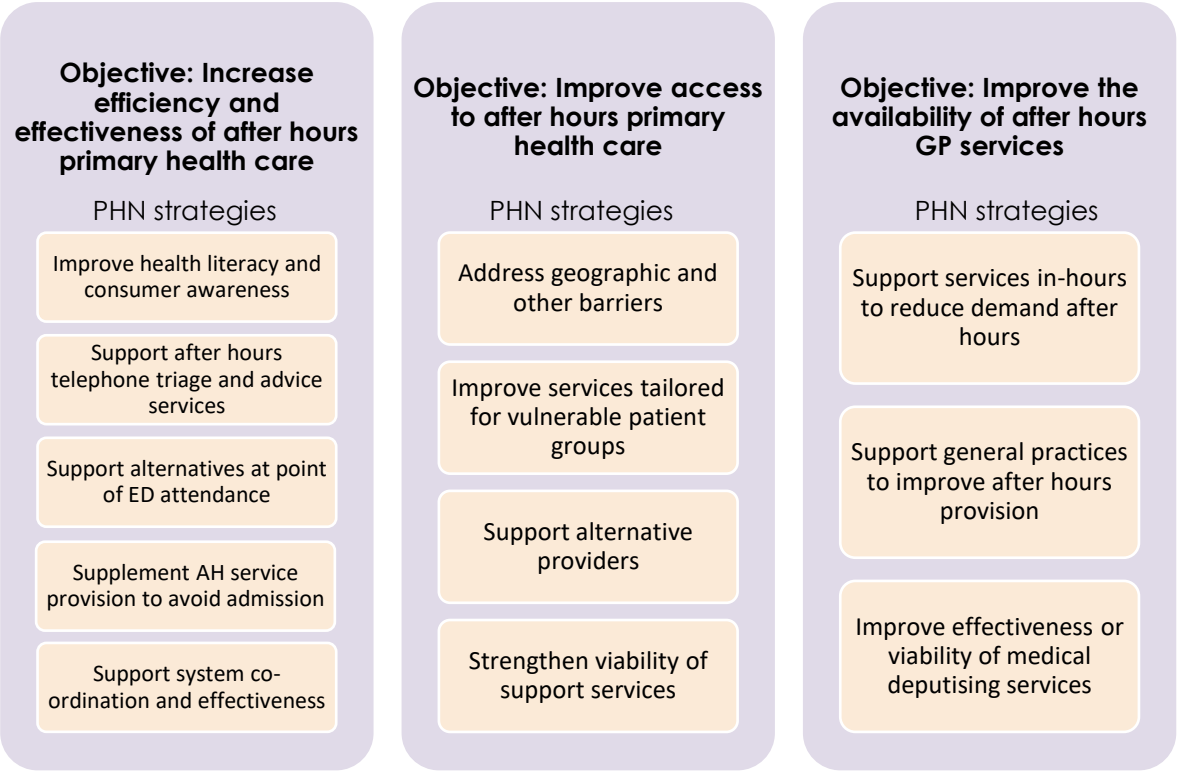


Figure 16 – Linking program objectives to PHN strategies

The PHN survey conducted as part of the evaluation asked PHNs how the services commissioned were intended to affect demand for or provision of care. In the period 2019–20, the 30 PHNs responding to the survey commissioned or planned 144 activities. For each activity, information on the planned expenditure was included in PHNs' Activity Work Plans. Figure 14 presents the intended effect on demand for or provision of after-hours primary care, how it links to the strategies identified above and the associated proportion of planned expenditure on these services. Note that the activities may include more than one strategy and the table includes the main intended impact.

Table 14 – Intended impact on after-hours primary care, activities and proportion of expenditure

Intended impact on demand	Strategy	Number of activities with intended impact on demand	Activity with intended impact on demand (%)	Proportion of planned expenditure on activities with intended impact on demand (%)
Support services in-hours to reduce after hours	1	2	1.4%	0.7%
Improve patient/carer health literacy and community awareness of options	2 & 3	16	11.1%	5.1%
Support after-hours telephone triage and advice services	4	2	1.4%	4.3%
Address geographic/other barriers to accessing after-hours care	5	7	4.9%	8.0%

Intended impact on demand	Strategy	Number of activities with intended impact on demand	Activity with intended impact on demand (%)	Proportion of planned expenditure on activities with intended impact on demand (%)
Improve provision of services tailored for vulnerable patient groups	5	17	11.8%	11.0%
Support general practices to expand their provision of after-hours services	6	19	13.2%	15.7%
Improve effectiveness or viability of medical deputising services	7	4	2.8%	1.2%
Support alternative after-hours services	8	22	15.3%	18.9%
Strengthen viability of after-hours support services (e.g. pharmacies)	9	1	0.7%	0.1%
Support alternatives at point of ED use	10	6	4.2%	3.8%
Supplement after-hours provision to avoid admission	11	0	0%	0%
Strategies to support system coordination and effectiveness	12	27	18.8 %	21.2 %
No service or not yet in place or not a commissioned activity	-	21	14.6%	10.0%
Total	**-**	**144**	**100.0%**	**100.0%**

Sources: [1] PHN survey; [2] PHN Activity Work Plans 2019-20.

Many of the PHN-commissioned activities were aimed at improving access to care and expanding provision of after-hours primary care. Most of the activities commissioned by PHNs were addressing one of five strategies: improving health literacy, addressing barriers (including for vulnerable patient groups), supporting general practices, alternative provision, and strategies aimed at supporting the system. These strategies make up three-quarters of all the activities commissioned and 80% of the planned expenditure. The proportion of funding broadly matched the proportion of activities with the exception of the consumer awareness and health literacy activities where the proportion of activities was higher than the proportion of spend.

Table 15 provides specific program examples of the PHN strategies listed above.

Table 15 – PHN strategy examples

Strategy	PHN	Example
1. Supporting services in-hours to reduce demand after hours	South Eastern New South Wales	Enhanced care over winter. Identifying patients at increased risk of illness and hospitalisation over winter; ensuring their care is proactive and well-coordinated and that they have increased health literacy (e.g. sick day action plans); on the expectation that better care during business hours will result in reduced need for urgent care after hours.
2. Improve health literacy	Northern Sydney	Managing an unwell child in the after-hours period. The service seeks to improve confidence and skills of parents to manage their unwell child at home in the after-hours period.

Strategy	PHN	Example
3. Community awareness	South Western Sydney	The after-hours primary health care consumer awareness and health literacy campaign seeks to educate and inform consumers about available after-hours services beyond the ED.
4. Directly support after-hours telephone triage and advice services	Central Queensland, Wide Bay, Sunshine Coast	After Hours GP Telehealth services. Aims to increase access to efficient and effective after-hours primary health care via an established Australian-based telehealth provider.
5. Supporting general practices	Nepean Blue Mountains	The 'Building capability and capacity in the primary care workforce initiative' focuses on improving local providers' knowledge and skills in managing patient health needs during and after hours. This includes improving clinical handover, medical emergency management, care plans and chronic disease management. In 2018–19, the PHN reported that 52 participants had completed training workshops focused on increasing general practices' capability and capacity to manage complex patients and, therefore, help to reduce demand for after-hours services.
6. Addressing barriers to accessing care	Western Queensland	Support the Royal Flying Doctor Service to provide comprehensive primary health care to very remote communities. The Royal Flying Doctor Service Charleville provides GP services to 14 remote villages in the Far South West and Western Corridor regions. The service is fly in/fly out with booked appointments if patients are sick on the day. This model ensures patients are engaged with improving their health and reduce the need for ad hoc after-hours care and retrievals from remote villages.
7. Improve effectiveness or viability of deputising services	Brisbane South	GP deputising service commissioned to provide service to outlying part of the PHN catchment where after-hours care is limited. PHN provided funding to enable deputising service to operate on an economic basis.
8. Supporting other service providers	Brisbane North	The aim of this activity is to provide services to homeless and vulnerable population groups during the after-hours period. The PHN commissions local agencies to provide after-hours clinical services and care coordination – including connection to mainstream primary care services – to homeless and vulnerable population groups across the region.
9. Support viability of support services	Australian Capital Territory	The After Hours Palliative Care Medications Program provides home delivery of medical supplies and medications to palliative care patients during the after-hours period.
10. Support alternatives at point of	Country Western Australia	The Albany After Hours GP Clinic is co-located outside of the Albany Hospital ED, and works in collaboration with the Albany Hospital Campus and local general practices so there is an alternative for general practice-type presentations to be seen

Strategy	PHN	Example
ED attendance		through the GP clinic as primary care clients and not through the ED.
11. Supplement after-hours service provision to avoid admission	Murrumbidgee	Frequent Flyers Vulnerable Population initiative. The model centres around a 'Care linkage' role that connects patients identified as having a history of frequently presenting to the ED or using ambulance services and linking them with appropriate services in in the community, including general practice. The initiative will support patients to achieve condition stability, self-management and improve use of general practice during weekdays to reduce demand on the after-hours system.
12. Strategies to support system coordination and effectiveness	Northern Sydney	The Access, Navigation and Co-ordination project seeks to improve system capacity across the health system by increasing the use of digital health technology, such as e-health software and secure messaging technology, to improve continuity of care. This includes establishing and increasing the adoption of this technology to allow urgent-care and local providers to share information on patient referrals and care summaries with the aim of reducing potentially avoidable ED presentations in the after-hours period and improving the quality of patient care. As a result of this initiative, the PHN reported that all commissioned services were offered the secure messaging app and have implemented the software. There have been 200 patient handovers completed through the Ambulance New South Wales Secure Messaging software with participating GPs reporting positive user experiences.

The following sections set out the findings from the evaluation. Section 5 covers perspectives on the program as a whole and the remaining sections focus on implementation and delivery (section 6), impact and outcomes (section 7), and appropriateness (section 8). Section 9 deals with the alignment of the PHN After Hours Program with other initiatives.

Case study: Adelaide PHN

Case study focus
The Adelaide PHN focused on the Lived Experience Telephone Support Service (LETSS). Paid staff with lived experience of mental illness provide after-hours mental health telehealth services.

Locality overview
The PHN region encompasses the 17 local government areas that make up the Adelaide Metropolitan area. It extends from Sellicks Hill in the south to Angle Vale in the north, and from the beaches in the west to the foothills in the east. The PHN supports the vast majority of the South Australian population, with an estimated resident population for 2019 of 1,246,737, and a population density of 8.03 persons per hectare (Adelaide Primary Health Network, 2020). Adelaide PHN covers 0.2% of the state geographically and incorporates 70% of South Australia's total population.

PHN approach
The needs assessment undertaken by the PHN led to prioritising services that support general practice. The PHN identified mental health as a priority area, with high rates of psychological distress in the community leading to potentially preventable hospital admissions. Further, a GP roundtable identified that urgent mental health care was difficult to access and that there were often long waiting times for other mental health services.

Adelaide PHN after-hours activities for 2019–20 included the After Hours Consumers Awareness Resources, Extended Primary Care for Residential Aged Care Facilities (Camellia Project), Northern and Southern After Hours Walk-in Clinics, LETSS, Northern and Southern Paediatric Partnership program, After Hours Extended Mental Health Clinical Services and the After Hours Needs Assessment Process – Options and Opportunities initiatives.

LETSS was jointly developed by Adelaide PHN and the Mental Health Coalition of South Australia through co-design with people with lived experience of mental illness. It was designed to address the expressed needs of those experiencing mental health issues and to fit within the overall plan for stepped primary mental health care service delivery across the region. The service is delivered as a one-to-one, non-clinical telephone service optimising the lived experience of a peer support mental health workforce.

Key observations

- While the Adelaide PHN was relatively well served by GPs in the after-hours period, the needs analysis identified **significant gaps in primary care to effectively support people with mental health issues. These gaps existed in both the in-hours and after-hours periods.**
- The LETSS service is addressing a gap in service after hours **and contributing to the development of a stepped model of primary care** for people with mental health needs living in the Adelaide PHN region.
- Critical success factors for the LETSS included:
    a. A trained, paid peer-workforce with lived experience
    b. A focus on non-crisis needs, including service links and informal counselling
    c. strong relationships to escalate to and receive referral from crisis support services
    d. no referral or appointment required, with minimal waiting time
    e. unlimited access, with no time or contact limit.
- LETSS volumes continued to grow and **the service was considered by callers and referrers as being effective in meeting client need.** The service reported that **it had reached full capacity.**
- Many considered **the service hours should be extended to in-hours and additional after-hours periods**. There were also opportunities to extend the service to Country South Australia.
- **Few callers (3%) reported that they would have attended the hospital**, called **an ambulance or visited a GP** if LETSS was not available.
- LETSS was providing an effective model of care that appears to **be meeting an unmet need** that sits between acute care, crisis care, other call centres and more traditional primary health care.

5. Perspectives on the PHN After Hours Program

Through the evaluation, many stakeholders commented that the success of the PHN After Hours Program was constrained in various ways, for example by broader tensions within the market for primary health care services. They also commented that the program lacked visibility and a clarity of purpose. This chapter describes some of these perspectives on the program as a whole and highlights their implications for the future of the program. This is followed by a description of the different contexts within which PHNs are operating and sets out how the PHNs have been grouped together to enable the further analysis of the implementation and delivery of the program.

Wider national context

Finding 1: The PHN After Hours Program is aligned with national policy goals to support accessible and effective primary health care for all Australians and provides a flexible way of tackling local issues. However, the program does not enable PHNs to address some of the underlying issues such as workforce supply and access to primary care services more generally.

The stated intention of the program is to address gaps in access to primary care after-hours services, after the major initiatives supported by the Australian Government are considered. Many of these gaps are 'local' in nature and to address these the program needs to be responsive to local circumstances. While there are ways in which the program can be improved, it remains the principal mechanism through which gaps and shortcomings of mainstream provision can be addressed.

It is often difficult for PHNs to work within existing mechanisms or to more actively provide support to service providers. The mainstay of the system is market-based and so PHNs need to take care not to be undermining the market in the activities they commission. There are examples from the case studies of services that were seen as undermining existing service provision, such as commissioning the services of a deputising service. Where service provision is patchy, PHNs often have to work around, rather than through, the existing mechanisms within the system. The size of the program is also a constraining factor as in many areas it is small in relation to the total expenditure on after-hours primary care and the activities appear limited and piecemeal. The levers and tools available to PHNs are limited. For example, the limitations on advertising of deputising services make it difficult for PHNs to raise awareness of a service they commission and they have limited ability to influence the number of GPs practising in an area. Being able to take a wider view of access beyond after hours could provide additional leverage.

The underlying numbers and distribution of the GP workforce clearly influence the availability of after-hours general practice services. This is not only a rural and remote issue, as many of the metropolitan PHNs advised of issues facing communities in the outer urban localities. PHNs suggested that data on the number of GPs and practices often masked other issues such as practices 'closing their books' for new patients and limited access to bulk billing.

These factors affected availability in-hours, contributing to after-hours demands. The availability of after-hours general practices did not, in itself, ensure good access for communities. Out-of-pocket costs and lack of after-hours public transport were frequently raised as significant barriers for consumers, for example, co-payments of between $50 and $80 were cited.

Both the GP workforce numbers and the willingness of GPs to work after hours were major factors in determining what activities and strategies a PHN might adopt and fund under the PHN After Hours Program. Apart from some longer-standing services run by GP cooperatives, PHNs often encountered difficulties in finding GPs willing to participate in new after-hours services and co-located after-hours GP clinics near hospital EDs. The increase in GPs working part time and work/life balance demands contributed to the reduced availability of GPs available to work after hours.

> "… the combined effect of difficulties around recruiting and newer entrants to general practice not wishing to work after hours is having a very damaging effect on the supply of GPs and the local health system's collective attempt of increasing access to both in-hours and after-hours care. There was a view that no amount of incentive payments can coax certain GPs to provide after-hours care, and many stakeholders are focused on fixing the insufficient amount of GPs and general lack of access to primary care services that exists in-hours." [Northern Queensland Case study]

These views are supported by the mounting evidence that suggests Australian GPs are working fewer hours or that they would like to reduce their current working hours. Furthermore, a study in 2014 using data from the 2010–2011 Medicine in Australia: Balancing Employment and Life (MABEL) national survey revealed that 40% of GPs surveyed wanted to decrease their working hours (Norman & Hall, 2014). Data from MABEL shows a significant downwards trend in average weekly hours from around 40 to 38 over a 9-year period to 2017 (Munir, 2018) and growth in the number of full-time equivalent doctors has been modest, at only 2.4% from 2005 to 2015, but domestically trained doctors are reluctant to practice in rural areas (Scott, 2017).

In 2019, a report produced by Deloitte showed similar findings (Deloitte Access Economics, 2019). The report projected that the demand for GPs will continue to rise from 1.8 GP hours per person annually in 2019 to 2.1 GP hours per person in 2030 due to an ageing population, a rising burden of chronic disease and population growth. However, the supply of GP hours is projected to decrease from 1.8 GP hours per person annually in 2019 to 1.6 GP hours of care per person annually in 2030. Both reports cited a wide variety of factors contributing to the shift in GP supply. These include:

- desire to work fewer hours
- an increase in the number of female GPs who are more likely to work part-time
- the retirement of older GPs who are more likely to work more hours than younger GPs
- and an increased cultural emphasis on work/life balance.

The paper discussed the especially detrimental effect that the decreased GP workforce supply will have on rural and remote areas that are already struggling with health workforce shortages. All of these factors point to an ongoing requirement to find ways to tackle workforce shortages either directly through workforce strategies at the Federal level or through supplementing or finding alternative ways of delivering services.

Program purpose

Finding 2: Many stakeholders, including PHNs, considered there was a lack of clarity about the purpose of the program. Steps to clarify the program's purpose and guidance on implementation would assist in decision-making.

> "What is the objective of the PHN After Hours Program? Is it to reduce hospital admissions or take pressure off the EDs? Because ultimately that's where patients go if there's no other after-hours services." [National stakeholder]

The *Standard funding agreement schedule: Primary health networks core funding* (Department of Health, 2015b) provides guidance about the program. Issues of interpretation about the program's purpose have mostly arisen in instances where Department of Health staff have questioned or not approved activities outlined in PHNs' Activity Work Plans. However, PHNs have also had internal debates about whether specific activities are consistent with the program purpose. Staff turnover within PHNs and the Department have exacerbated the issue. PHNs and their boards have sometimes decided on broader priorities for the local primary care system, which sometimes do not fully align with the program's objectives. For example, in commissioning in-hours services to address after-hours demand. This lack of clarity has shaped some national stakeholders' perception of the program. They questioned the overall objectives of the PHN After Hours Program and its intended aims. The following sections outline a range of issues related to the program's purpose and scope.

Flexibility

An important aim of the program is to **address gaps** in after-hours provision. As these gaps vary widely across the communities supported by PHNs (see next section), **flexibility is required in the types of activities commissioned.** Many PHNs have appreciated this flexibility as it allows them to develop appropriate solutions to local problems. The need for flexibility and innovation varies across PHNs, with more rural and remote regions requiring solutions that need to reflect challenges faced in those communities, such as workforce recruitment difficulties and lack of funding to support general infrastructure requirements and worker safety. Sometimes the need to develop innovative solutions has pushed boundaries and led to differing perspectives on what is in scope for the program. More developed guidance on the types of solutions that might be in scope for different types of localities could help guide decision-making. A consistent approach need not constrain flexibility, but if more latitude is to be granted to PHNs facing more significant challenges, then this can be incorporated explicitly within the guidance with some clear parameters.

Piloting and innovation

One perspective about the program is that it should focus on supporting **piloting innovative solutions** – effectively 'seed funding' – with a view to ultimately transferring these to more sustainable funding models based on other sources. PHNs have supported various pilot solutions. Some PHNs adopted a strategy in the first years of the PHN After Hours Program to focus funding on pilot programs with a view to evaluating and identifying the best options for ongoing support. While pilots and trials have been an important part of the program, many of the services commissioned do not have realistic alternative funding sources in the longer term. There are some examples of commissioned projects being taken up by local hospital networks, but these are relatively few. Some PHNs have argued that using a grants funding

process for service providers to bid for funds is the most effective way of managing a program with no long-term funding commitments. But this suggests the funding model rather than service needs are driving the commissioning approach.

Wider system impacts

Another tension is between the role of the program **in supporting or improving the broader system of after-hours provision** versus direct commissioning of organisations to deliver after-hours services. The impacts of initiatives that support system-wide improvements, such as workforce supply and/or capability, are indirect and cannot be directly or easily assessed in terms of changes in after-hours access. Some initiatives – such as efforts to improve the transfer of information and quality of information from after-hours providers to their main primary care provider – are likely to improve continuity and quality of primary care more generally, but not after-hours service access and quality itself. Again, some of these system-wide issues are easier to target with time-limited funding as they do not risk de-funding of a service but the funding context should not be the key driver of priorities as it risks being piecemeal and ineffective.

Aims of the program

An underlying issue is the different perspectives on whether the scope of services commissioned under the program can be defined by **the types of outcomes** the services aim to achieve, the **type of service supported**, or a combination of these. For example:

- Should the focus be to *reduce* ***demand for after-hours primary care services***? If so, then initiatives that address more effective in-hours service provision could be considered. In the case of services targeting some vulnerable groups – for example, people suffering homelessness – the distinction between 'in-hours' and 'after hours' can be relatively arbitrary.

- An objective of the program is *to reduce* ***inappropriate demand for ED care and potentially preventable hospitalisations*** *in the after-hours period*. There are various hospital or secondary care initiatives that can also contribute to this objective. Examples include: providing an after-hours contact point within the specialised team supporting people with complex chronic conditions (e.g. heart failure, renal failure, chronic obstructive pulmonary disease); providing a means to access specialised medication in the after-hours period; or providing specialised support for people attending EDs as a result of domestic violence. In some localities these types of services are largely or only available through hospital-related services. However, these may not be considered *primary care after hours.*

> "Many persons interviewed … raised access issues in-hours as a contributing factor to after-hours demand (including avoidable attendances at EDs). These issues include limited access to bulk billing general practice, availability of public transport and care coordination and support for people living with chronic or complex conditions." [Tasmania Case study]
>
> "… it is hard to dissuade individuals not to attend the ED during the after-hours period when they know that they will have access to free comprehensive care that includes pathology, radiology and imaging services that many after-hours clinics may not have onsite." [Northern Queensland Case study]

- Should the focus be on ***primary health care after-hours services***, rather than broader after-hours provision and when is it appropriate to decide that providing a primary

care service is not economic and therefore non-primary care alternatives will improve access and outcomes?

Direct support for general practice or deputising services

There are perceptions of mixed messaging relating to whether the program can **directly support general practice services or medical deputising services** to provide or extend their after-hours coverage. In some instances, particularly in metropolitan settings, PHNs have explicitly steered away from commissioning these types of services. Some of those metropolitan areas have commissioned deputising type services, but this is only in specific locations where deputising services do not operate. Both Brisbane South and Eastern Melbourne PHNs cover localities where after-hours services are poor or absent. Some PHNs reported that this type of activity was explicitly excluded under the PHN After Hours Program. However, in rural and more remote localities, there are many instances in which PHNs have directly supported these services. The provision of support to general practices and medical deputising services has raised various concerns, for example that supported services are receiving an unfair advantage within a local market. There have also been tensions when PHNs have commissioned services with a requirement to offer bulk billing when the practice generally does not have a bulk-billing policy.

Urgency or convenience

> "… there was a question of whether individuals were accessing after-hours services out of convenience, not necessity … [was] the PHN … attempting to promote a convenience-type model that increases after-hours access or a demand management model …" [Eastern Melbourne Case study]

An issue that is not addressed in guidance is whether program initiatives should give priority to **urgent after-hours access**, rather than more general after-hours access. This touches a tension between the changes in community attitudes towards an expectation that primary care services should be convenient – including in the after-hours periods – and the requirement that after-hours services should be responding to urgent needs. Many national stakeholders and providers noted these tensions and considered community education as one of the key avenues for modifying these trends (see next point). But other stakeholders raised the issue that convenience is an important aspect of ensuring good access to primary care. One practice in a rural town did not offer traditional after-hours clinics in line with the PIP time periods but was open at 7 am to 'encourage the men' to access services, who would otherwise not attend for routine screening and non-urgent needs as they are unwilling or unable to take time off work to get to the GP. 'Convenience' is sometimes construed as not being a valid consideration for after-hours services but access to routine care can be hampered if services are not convenient. There were many examples of rural and remote areas where access to primary care is heavily constrained, leading to potential exacerbations and greater use of emergency care after hours.

Consumer awareness and health literacy

Awareness raising, information and developing health literacy have emerged as important features of the PHN After Hours Program. Nearly every PHN has funded some health literacy or consumer awareness initiative. It is unrealistic, however, for the program to be able to address this issue alone. A report conducted by the Australian Commission on Safety and Quality in Health Care (Australian Commission on Safety and Quality in Health Care, 2014) reviewed evidence about the costs associated with low health literacy. The report highlights

the difficulties in assessing the cost impact because it is not easy to tease out the effect of health literacy from other factors influencing behaviour. However, the report quotes estimated additional costs of $US143 to $US7,798 per person annually amounting to 3-5% of total healthcare spending. The costs relate to higher utilisation of emergency health services, increased hospitalisations, lower medication adherence and poorer health outcomes. The ACSQHC report reflects that improving consumer health literacy can bring benefits as well as cost savings. The review also reports that a survey conducted by the ABS in 2006 found about 60% of the Australian adult respondents had a low level of health literacy.

The ACSQHC recommends a clear, coordinated approach to promoting health literacy that uses a variety of forms of communication such as online, print and electronic resources and platforms. It also highlights the importance of embedding health literacy into the education system, fostering a collaborative approach with involvement and partnerships with stakeholders, and establishing policies that integrate health literacy into health planning, policies and design.

This suggests that if PHNs are promoting health literacy then there should be consistent messages available to the community through multiple channels, including community-wide advertising campaigns. The reality is that there is a proliferation of websites – practices, medical deputising services, PHNs, local hospital networks, states and territories, help lines (Healthdirect and a range of other providers), and other promotional campaigns undertaken by service providers. The role that PHNs alone can effectively play in community education, campaigns on ED avoidance and promotion of options remains unclear. There appears to be little research to map the effectiveness of PHN initiatives such as websites and apps aiming to guide consumers into the right pathways. PHN approaches to measuring the success of these initiatives appear to be weak. One PHN suggested that raising consumer awareness and providing information could only be effective if undertaken at three levels: national, state-wide and local. The PHN felt they were most effective in campaigns if they can 'come in behind' a state-wide program, otherwise their efforts are likely to have minimal effect. Given the low level of awareness of PHNs themselves, their websites are unlikely to be the first port of call for consumers seeking information or advice.

> "I think some of their strengths can be around dissemination of information through networks, and I think the PHNs can probably do some of that quite well, because they do have that local knowledge. So, that's a useful add-on that I think the PHNs can do." [National stakeholder]

National stakeholders also cited limited consumer awareness of the PHN After Hours Program and associated after-hours services as a barrier to the program's success. Interviewees felt that consumers may be unaware that certain services are available and free to access. Many people do not know how these programs were implemented and what they are entitled to as consumers. Some stakeholders felt that PHNs were in the best position given their local knowledge to effectively promote services and provide additional information to consumers on the availability of after-hours services in their local area.

Awareness and visibility

Finding 3: There is a lack of awareness of the program among national stakeholders and also among many local stakeholders interviewed.

Many national stakeholders said they had limited or no knowledge of the PHN After Hours Program. There also appeared to be limited awareness at the local level. Stakeholders based their observations about the program on experiences with specific initiatives and appeared to have a limited understanding of the program's objectives, what services it supported and what funding was provided. There are examples from the case studies (Northern Queensland and Brisbane South) where advertising restrictions related to deputising services meant awareness of the PHN-commissioned service was low, resulting in low take-up and limited opportunity for the service to demonstrate its viability.

> "I must admit that, prior to [the] request for this interview, I had not been aware that the PHNs were still receiving after-hours funding …" [National stakeholder]
>
> "… it's fair to say that most pharmacists probably wouldn't be aware of the program overall." [National stakeholder]

Program awareness among national and local stakeholders is important because it can result in:

- a stronger understanding of existing after-hours arrangements and the health and socio-economic issues that residents of diverse communities across Australia face
- increased engagement among local providers leading to improved stakeholder and provider collaboration that will help promote co-design approaches and locally targeted after-hours solutions
- better acceptance and visibility of PHN-supported after-hours activities among providers and communities
- additional outlets to promote and raise awareness of after-hours activities supported by the PHNs
- The potential to foster and develop relationships with clinical champions that understand the needs of their communities
- Better alignment with state and other agency activity (including third-sector providers).

Most PHNs include information about the PHN After Hours Program through their website and annual reports and many publish their Activity Work Plans. However, there is no single national source of consolidated information about the program. The information on the Department's website appears to have very limited recent information and there is no evidence of showcasing the work of the PHNs.

PHN contexts

Finding 4: The context within which PHNs are operating is important in understanding the approach they have taken to the program. There are system-wide challenges driven by the pattern of supply and population needs that influence after-hours models.

As described in Chapter 4, it is important to understand the context in which PHNs are operating as regions across Australia have diverse systemic challenges. Variation in the pattern and range of after-hours primary care and other services across the country is very marked. Even within PHNs, the range of services available to meet needs can be highly

variable, particularly those that cover rural and remote areas. Population sparsity and workforce shortages often work against an effective market for after-hours care. There are pressures on the GP workforce caused by reduced working hours and GPs seeking a better work/life balance, which has led to gaps in after-hours provision, especially in rural and remote areas. These trends are continuing, presenting a policy challenge to governments and resulting in the exploration of innovative ways of encouraging workforce availability and the provision of care, while maintaining a degree of care continuity for people who regularly see a particular GP or practice.

> "The [Northern Territory] experiences a high turnover of residents, both seasonally and over longer durations, this affects both service demand, but also workforce supply, particularly in more remote locations." [Northern Territory Case study]

Stakeholders reported, and evidence suggests, that many GPs have less interest in working after hours, despite incentives to do so. There is additional pressure for GPs in rural and remote areas to provide after-hours services due to the limited number of GPs practicing in these regions and the general lack of community access to after-hours services. National stakeholders expressed a need for increased remuneration and incentives for GPs to provide after-hours services in these areas. Other stakeholders advocated for a rural generalist practice model of care with GPs working in the community and hospitals as a longer-term strategy to increase workforce in these areas. Other suggestions included a separate funding model for urban and rural service delivery due to the often-limited viability of rural services. Though the PHN may not have a major role to play in promoting these types of models, they are fundamental issues that affect PHNs' ability to make an impact locally.

Although rural and remote areas face the most significant challenges, it is clear that all of the localities away from the inner cities face varying degrees of difficulties in establishing robust and sustainable services. In many inner cities, the volumes and workforce supply are such that the market can be relied upon to provide a reasonable range of services at low or no out-of-pocket cost to consumers. These services often leave gaps in meeting more specific needs of vulnerable population groups (such as homeless people) or result in a complex set of options that can be difficult for people to navigate, resulting in a need to provide signposting to guide consumers to appropriate levels of care or to meet more niche requirements such as mental health needs.

These factors are evident in PHN needs assessments and have led to priorities and responses that are often geared to supply side factors in outer urban fringe areas and the more rural and remote areas, and meeting the needs of vulnerable population groups or a specific geographical community in the more urban localities.

Case study: Hunter New England and Central Coast PHN

Case study focus

The Hunter New England and Central Coast (HNECC) case study focused on the GP Access After Hours Program, also known as the GP After Hours Program – Hunter.

Locality overview

The HNECC PHN region is the second-largest in New South Wales and covers 23 local government areas and more than 1.2 million people. There are three main areas: Hunter, Central Coast and New England. The PHN has a higher than average population aged 65 years and older and of Aboriginal and Torres Strait Islander peoples. The area has fewer than average residents reporting financial stress but a higher proportion of residents on pensions and single-family homes. Some residents have limited access to the internet and to transport due to its rurality. The region has higher than national average rates of some chronic conditions and of alcohol consumption, smoking, obesity (Hunter New England and Central Coast PHN, 2018a, 2018b).

PHN approach

The PHN has established services in the three main regions. Some projects operate in both the Hunter and New England regions (e.g. the Aged Care Emergency program). The PHN's after-hours needs assessment was incorporated into the PHN's core needs assessment and assessed against other regional health priorities. HNECC PHN after-hours activities for 2019–20 included the Small Town After Hours, Aged Care Emergency Program, GP After Hours Program – Hunter, GP After Hours Program – Central Coast, and the After Hours Primary Health Care Planning initiatives. The Small Town After Hours Program supports the rural and remote towns in the New England region. The service triages category 3-5 patients presenting to small regional hospital EDs when the usual GP is sick or on vacation. The GP After Hours Program – Hunter (GP Access) provides support via a call centre and five clinics that are dispersed throughout the Hunter region. The GP After Hours Program – Central Coast includes two sites.

Key observations

- GP Access enjoys **a high degree of trust and support** from other providers and the broader community, with key stakeholders emphasising strong collaboration and collegiality.
- GP Access has strong **collaboration with GPs and other local providers** with participation from over 200 local GPs in the Lower Hunter region to provide the triage, tele-GP and after-hours clinics.
- GP Access is a **well-integrated** system of services providing local telephone triage and linking to tele-GP advice, co-located after-hours GP clinics, home visits and aged care providers.
- Potential exists to **expand the triage service, tele-GP and provider supports** across the PHN and link these functions to existing after-hours clinics, home-visit services and hospital care in place locally.
- Scope exists for **further integration of GP Access and EDs**. There is potential to explore shared triage models, including greater promotion of GP Access telephone triage and the use of GP-led triage for all walk-in patients before attending ED.
- In discussion with patient and community representatives, there were indications that there is **confusion over the various telephone numbers for services that exist**, particularly around Healthdirect and GP Access (given the change in arrangements), but also with the recent emergence of new call-based service providers.
- The ability to actively promote the use of GP Access to the public is limited, in line with restrictions on all medical deputising services. Support is needed to help PHN **identify opportunities to increase public awareness of GP Access triage functions without fuelling unnecessary after hours care.** This could be done in conjunction with Healthdirect.
- The GP Access service is funded from a variety of sources, namely MBS reimbursement, NSW Health, out-of-pocket payments as well as the PHN After Hours Program. **The PHN receives significant additional funding** through the PHN After Hours Program to support the service contributing over half of the costs.

6. Implementation and delivery

This chapter addresses three of the evaluation's key questions:

PHN After Hours Program evaluation key questions 1-3

1. How well did PHNs identify gaps and needs for after-hours services?
2. How well did PHNs design and implement after-hours models?
3. What PHN after-hours models have been implemented relatively well and less well? Why?

Needs assessment

The approach to needs assessment has changed over the past five years with the Department and PHNs moving to a 3-yearly cycle of major revisions, with annual updates as required. Some PHNs have maintained a separate after-hours needs analysis. Many have moved to incorporating after-hours needs as a component of a broader needs assessment for their area.

Use of data

Finding 5: PHNs use a range of data sources to conduct their needs assessment. The level of disaggregation, timeliness and reliability of much of the standard data hampers the PHNs in their needs assessment and their ability to assess the effects of their activities.

PHNs use of a range of data sources in conducting their needs assessments. Table 16 summarises the findings from the PHN survey. Almost all PHNs reported that they use demographic data, ED presentation data, claims related to after-hours MBS items and other information about practices' after-hours arrangements. Around three-quarters of PHNs use Healthdirect (or equivalent) data. Sixty per cent of PHNs made use of data on PIP uptake and around half made use of data related to medical deputising services. A small proportion (25%) made use of consumer or patient experience and 15% made use of both Healthmap data and other primary care data sources.

"Some providers expressed the need for improved data linkages between other PHN program areas, such as mental health and chronic disease, and increased data sharing amongst stakeholders and commissioned providers. For example, one after-hours general practice expressed the value in data sharing agreements with local hospitals that reveal the common types of low-acuity ED presentations, so that the practice could better understand local health needs and establish stronger working relationships with these hospitals." [Eastern Melbourne Case study]

PHNs reported access to relevant and timely data was an issue specifically related to MBS data, ED data, Healthdirect/state call centre data, ambulance service data and other after-hours primary care utilisation data. PHNs also reported limitations and gaps in data available to them. Two key issues that emerged from the survey and discussions with PHNs are access to information below the SA3 level and linkage of primary and secondary care data. Both sets of data can contribute to being able to assess after-hours needs more accurately.

Other issues included:

- Timeliness of data – the time lags associated with several key data sources are at least 12 months.
- Frequency of data provision – in-year reporting helps quantify service impacts.
- Insufficient disaggregation – SA3 level data, age, sex and Indigenous status.
- Reliability of data – some concerns were raised about the accuracy of practice opening times and service availability within Healthmap.
- Precision of estimates for consumer experience information.
- Inability to analyse data in more detail to get behind important issues, for example, presenting conditions at EDs or age groups of patients.
- Impact of itinerant population such as seasonal visitors and workers, fly-in/fly-out workforces, tourism and mobility of remote populations.

Table 16 – PHN views on limitations of data sources

Data PHNs use in needs assessment	Use by PHNs	Limitations cited by PHNs			
		Insufficiently granular[1]	Incomplete/ inaccurate	Timeliness[2]	Difficult to access/ use
After-hours telephone services	***	*	*	*	*
MBS – after-hours items	***	***	**	*	*
Medical deputising service data	**		***		
Demographic data	***	**	*	*	*
ED attendances	***	***	*	**	***
Other information about practice after-hours coverage	***		***		
PIP After Hours Incentive data	**	***		*	
Healthmap	*		***		
Consumer experience/ community engagement	*		**		

*Notes: Numbers of PHNs *** High ** Medium * Low. [1] At a geographic or population group level; [2] Both frequency and how up to date.*

Some PHNs focused on ED use and identifying services that could substitute, such as GP services. For others, the focus has been on mapping and clarifying the availability of after-hours general practices and medical deputising services. The involvement of local hospital networks in the after-hours needs analysis was varied and depended on the relationship between the PHN and the local hospital network(s).

Some PHNs undertook what they referred to as 'deep dives', looking at specific issues such as mental health after hours, parents with young children, Aboriginal community needs, homeless populations, refugees, and culturally and linguistically diverse communities. Due to internal resource and time constraints, PHNs that engaged consultants for this purpose generally found the outcomes more useful. Northwestern Melbourne PHN developed an index of need representing local government sub-regions and used this to identify priority needs.

While some PHNs analysed demand for non-GP primary care services after hours – pharmacy, allied health and community nursing – overall the focus tended to be on access to GP services and ED avoidance. Most of the PHNs have created datasets that describe the supply of after-hours services across the PHN, for example, after-hours arrangements for each general practice, Aboriginal Community Controlled Health Service, pharmacy and other primary care services.

Consultation

Finding 6: PHNs say engagement and consultation are important steps in needs assessment and prioritisation, but there are still 'legacy' issues to overcome, which means engagement with stakeholders is often challenging. There are systematic differences between PHNs based on their perceptions of how much system-level interventions should be given priority.

PHNs made systematic efforts to engage with their local communities and stakeholders. There is a mixed picture of the success of these efforts, with greater success in areas with more challenging primary care supply. Generally, local stakeholders have not signed-off on a plan and set of priorities for after-hours services, except as members of a PHN board or clinical council.

Nearly all PHNs report that they have conducted workshops, consultations or roundtables with stakeholders. About half reported engaging with the community. Sometimes this was done with specific groups, for example vulnerable population groups or those with specific needs such as culturally and linguistically diverse groups. Some PHNs made use of more formal consultation processes or advisory groups.

Some stakeholders reported that their PHNs were doing a very good job of identifying needs and existing gaps in after-hours services and supporting providers to deliver these services. However other stakeholders raised concerns about the PHNs' role and the extent to which they are operating as commissioning organisations and have been able to transition successfully from a Medicare Local.

Local stakeholders in case study areas also reported relatively low levels of engagement with the PHN needs assessment processes. Even in an area where an external consultant had recently conducted a needs assessment, none of the stakeholders interviewed (including local GPs, the local area health network, local ED) appeared to be aware of any engagement activities or opportunities to contribute. A few local service providers reported being 'fatigued' and somewhat disillusioned about engagement activities, particularly where underlying issues identified in these efforts remained unchanged ("listening but not hearing").

"I actually think that there's probably little engagement with the … needs assessment being done. I get the feeling it happens at a desktop level …" [National stakeholder]

"Look, no one ever talked about that, to be honest. No one ever mentioned that a PHN had come to talk to them …"[National stakeholder]

"I would suggest that it is during the needs assessment that you include the community to help to identify their priorities, and I think that relationship would be a lot smoother." [National stakeholder]

"We have seen some of the needs assessment … We did some sort of scoping and scanning across. It's based on a local area, but a lot of these are GP-focused … A lot of … what we've seen is the pharmacies are overlooked." [National stakeholder]

Several national stakeholders considered that there has been little engagement from PHNs in identifying after-hours needs.

The success of engagement efforts appears to be enhanced by the visibility and wider role of PHNs in the local health economy. PHNs facing more challenging primary care supply issues appear to have better engagement with local stakeholders, especially GPs. This may reflect the relative size and importance of the PHN After Hours Program and funding within those PHNs.

As well as engaging with stakeholders and the wider community to assess needs, there is also variation in the extent of engagement for planning, priority setting and commissioning of services. It was reported that the timescales associated with developing Activity Work Plans and the funding cycles made it difficult for PHNs to adequately engage, consult and co-design. PHN clinical and community councils provided varying input to planning and priority setting, but they are not a substitute for structured community consultations. Many PHNs undertook community surveys and workshops, but some stakeholders felt that more could be done.

> "My experience … is that most of the relationships that have been developed with PHNs has been more through the formal tender commissioning type process, rather than them coming to us as individuals and saying, here's an issue that we've identified, what can you do to solve the problem?" [National stakeholder]

Some stakeholders considered PHN activities to be very GP-focused and that the after-hours services they have funded largely do not support other health professionals and models that might incorporate different types of after-hours service provision, such as allied health or pharmacy services.

Engagement of GPs has been challenging for some PHNs. The transition from Medicare Locals to PHNs was disruptive, and re-establishing trust and engagement took time for some PHNs. In some areas, it is reported that there remains a level of scepticism and suspicion of PHNs among GPs, which has affected the level and quality of their engagement. Some PHNs have taken a pragmatic view. For example, Country WA PHN described taking an approach that involved a 'coalition of the willing' initially and had built on it subsequently to good effect, resulting in strong engagement and participation from local GPs.

Although PHNs generally report engagement activities, there has been limited evidence of the success of engagement with stakeholders. This may reflect the relatively low profile of PHNs in local health systems and may also relate to residual issues from the change from Medicare Locals to PHNs.

Overall quality of needs assessments

Finding 7: Needs assessments have generally been conducted well. They could be more effective if they were set in the context of a system-wide plan for after-hours services.

In most areas, it appears that the needs analysis did not lead to an overall after-hours primary care plan for the PHN region or localities 'signed off' by the key players – general practices, local hospital networks, ambulance services, medical deputising services, other providers and consumer groups. While the needs assessments were available to PHN Boards (and in many cases formally approved by the Boards), they were not routinely provided to and/or discussed by clinical or community councils. The timelines for submission to the Department also affected the ability to engage councils and other groups in discussion and finalisation of the needs assessments.

Needs assessments conducted by PHNs have generally been conducted well and in a structured way. Most have conducted these in-house, but others have commissioned consultants or university centres to undertake or support the process. There is some variation between PHNs on emphasis and approach. PHNs have made good use of available data but identified deficiencies that affect the capacity to quantify needs for specific localities and monitor outcomes.

Some PHNs have moved towards an integrated approach where the after-hours needs assessment is incorporated within an overall needs assessment for the PHN. Given that many of the key primary care issues are closely inter-connected, it makes sense for after-hours needs assessments to be conducted as part of the system-wide needs assessment. Once developed needs assessments could be subject to a 2-3 year rolling refresh.

Priority setting

Finding 8: PHNs use a variety of sources to determine priorities and target a wide range of health care needs, including in-hours services. This may be reflective of widely cast objectives for the program, including whether the objective was to manage demand or meet unmet need and the imperative to fund legacy activities. PHNs have generally moved away from grant-based or multiple projects to a smaller number of more strategic focused priorities (e.g. covering workforce development and strategies to improve integration).

As a result of this variation and the multitude of approaches that could be used to address after-hours service issues and demand, it is not surprising that the gaps and needs identified by PHNs and services prioritised also vary. Some of this arises from systematic impacts of geography, demography, socio-economic circumstances and the economics of service provision. In many instances, PHNs have made the best use of opportunities available in resource-constrained environments. They have also had to work with the legacy of some services inherited from Medicare Locals, which has sometimes constrained their ability to start afresh.

Stakeholders thought some of the challenges facing communities with sparse after-hours provision may not be alleviated or resolved by allocating funding to supporting after-hours services, but that the funding may be better spent focusing on in-hours care in certain areas and working to support or educate certain patient groups.

"… if [the PHN] actually had a little bit of seed funding where they could address or build on the work that some people might have already done, I think probably that would be as effective as anything else." [National stakeholder]

"The PHN was formed from the amalgamation of three Medicare Locals that were operating in the region. Since the dissolution of the Medicare Locals and the establishment of the PHN, the organisation has sought to shift away from funding smaller scale, grant-based projects and taken a more innovative approach to commissioning services on a larger scale." [Eastern Melbourne Case study]

Other national stakeholders thought the money should be used to support and bolster existing after-hours services or community-generated services instead of funding new alternative arrangements that have little engagement with or involvement from local providers or services.

The PHNs describe using a variety of approaches to determining priorities. These are set out in Figure 17. More than half of the PHNs used the needs assessment and a third consulted with stakeholders. A small number of PHNs used formal priority setting frameworks such as the Hanlon method and North Western Melbourne developed an index of need to steer their priorities.

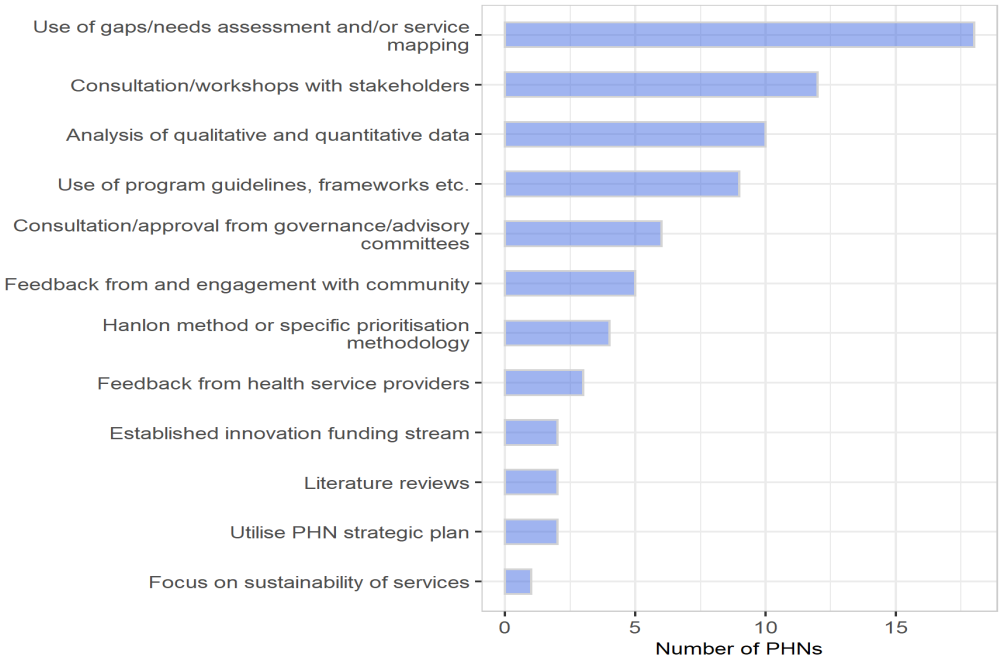


Figure 17 – Process for deciding priorities

The priorities identified by PHNs through their needs assessment varied. Table 17 sets out the priority areas identified by the PHNs by PHN group. The needs of specific patient groups or conditions was the most common priority area. This was the case across all groups of PHNs. Reducing demand for after-hours services (including ED) and improving and/or maintaining access to after-hours services (including services such as pharmacy) were the next most common priorities. The former was particularly highlighted by major city PHNs. The focus here was often on the use of ED services rather than seeking to reduce demand on GP or other services. Health literacy and consumer awareness was identified by about half of the PHNs, especially the major city PHNs. There was a strong emphasis on prioritising service integration and workforce development. This was particularly a feature for the outer regional/remote PHNs where all four PHNs and half of the inner- and outer-regional group noted this as a priority.

Table 17 – Program priority areas identified, by type of PHN

Priority[1]	Number of PHNs				
	Major cities (n=14)	Major cities/Inner regional (n=4)	Inner and outer regional (n=7)	Outer regional/ Remote (n=4)	Total (n=29)
Target specific health needs	18	9	10	7	44
Reduce demand for after-hours services incl ED	13	1	3	5	22
Improve/maintain after-hours services access	9	2	7	2	20
Health literacy and consumer awareness	10	1	2	3	16
Improve service integration and coordination, quality of care, capacity building	8	3	2	3	16
Workforce development, support & recruitment	3	2	4	4	13
Implement innovative and locally tailored after-hours solutions and models	2	1	3	3	9
Vulnerable populations	6	1	2	0	9

Priority[1]	Number of PHNs				
	Major cities (n=14)	Major cities/Inner regional (n=4)	Inner and outer regional (n=7)	Outer regional/ Remote (n=4)	Total (n=29)
Increase after-hours access to rural & remote areas	3	1	1	2	7
Aboriginal health	2	0	2	2	6
Improve after-hours access to other services	1	0	1	3	5
Improve data collection process/data sharing	1	1	0	0	2
Support medical deputising services	1	0	0	1	2

Notes: [1] Each PHN could list up to six priority areas.

Finding 9: Many PHNs have integrated PHN After Hours Program processes with other programs. Some PHNs have sought to align the program with priorities they have set more broadly for primary health care, seeking synergies between these programs.

Many PHNs have an integrated process across programs, for example needs assessment, community consultation, commissioning and administration of contracts. Due to their geographic size and diversity, Some PHNs have created units within their broader structure responsible for particular localities/regions. There are clearly benefits of adopting a locality-based approach in relation to needs assessment and understanding the local circumstances and market. There is inevitably a tension between a locality-based approach and one that takes a wider strategic approach to specific service areas such as after-hours provision, particularly where these are systemic issues rather than, for example, local demand or population issues.

> "So, it ends up being you get one person in charge of one set of money, and another in charge [of a different set of money]. And while there's this idea of crossover, there's not really. I think if … the [chief executive officer] of those organisations can use those funds more flexibly, I think that would be better." [National stakeholder]
>
> "… we would very much like to see a whole-of-system focus rather than focusing on after hours, because the issues that you see after hours are not a pure after-hours issue. They are just a symptom of a broader system malaise …" [National stakeholder]

Several local and national stakeholders considered that multiple funding streams or 'buckets' were problematic. It was argued that these tend to work against a more integrated approach to commissioning that is responsive to the needs of local communities. They also stressed the importance of flexibility and the ability to apply funding based on individual populations and their associated needs. There are different oversight arrangements and different buckets of funding and these have limited crossover, therefore, stakeholders felt increased flexibility would promote better outcomes.

Some PHNs appear to have addressed these issues through integrating the program more fully into the PHN's overall strategy development processes and looking for opportunities to leverage funding from several programs and other sources. Several PHNs described strategies that integrate with mental health and drug and alcohol services. Other PHNs are taking a population health-based approach to assessing needs and commissioning services.

PHNs raised the need for greater flexibility in the use of the program funding. Several PHNs proposed that the program be rolled into the PHN flexible funding to achieve this. A few stakeholders wished to pool resources across PHN, local hospital networks and other national

and state organisations to help co-design and co-commissioning to provide more comprehensive solutions to issues faced in specific localities.

Commissioning

Finding 10: PHNs vary in the maturity of their commissioning approach and strategies. Some PHNs may be constrained where the service provider market is thin and where service providers are not acquainted or experienced with formal tendering processes.

The diversity in Activity Work Plans, both across PHNs and across time, reflects the different PHN communities and regions, general practice workforce availability and sustainability, approaches to needs analysis, the maturity of the PHN After Hours Program, the nature of relationships with local hospital networks, and the extent of co-design activities undertaken by PHNs.

The transition from Medicare Local-funded after-hours programs was disruptive for some PHNs. In some instances, there were established services funded by former Medicare Locals and cessation of funding or retendering risked disruption to the services and loss of GP engagement. Establishing new services required careful risk assessment of the impact of the new service on the viability of existing GP services.

> "So, the difference between a Medicare Local and a PHN is around the fact that the Medicare Locals feed off … service delivery. Whereas the PHN is around being a commissioning organisation who commissions other services to do the work. There are people that work in PHNs, and this is very much a personal view, who have not understood that transition. They don't really understand what commissioning really means." [National stakeholder]

In some instances, there was staff continuity between the Medicare Local and the PHN but re-establishing engagement and trust with general practices and former funded service providers took time.

PHNs did not start with a 'clean sheet' and needed to work from what was already in place and move more gradually to establish their direction of travel. The program was commenced late in the 2015–16 cycle and there was little time to conduct a full needs assessment and set up commissioning processes. Having some Medicare Local legacy projects enabled PHNs to more quickly use the resources allocated. However, some PHNs reported it was difficult to disinvest from legacy activities from Medicare Locals, and that there were 'political' constraints around their decisions.

In the first years of the program, many of the activities commissioned were based on little 'needs analysis' and reflected a combination of:

- continuing to fund what was already in place
- brainstorming and 'shoulder tapping' relevant services that could assist
- a 'commissioning-lite' approach often incorporating a grant-based program that sought bids from providers
- 'seed funding' or longer-term funding support of a smaller number of core service models
- piloting and trialling options.

Overall, PHNs took differing approaches to their plans. For some the focus was supporting after-hours general practice, while others focused on ED diversion projects, specific geographic sub-regional needs, or the needs of vulnerable population groups. A small

number of PHNs entered into funding contracts with My Emergency Doctor and similar services to provide an emergency medicine specialist telehealth service to specified geographic areas or particular care providers (e.g. residential aged care). Where a PHN had determined that the funding was solely to support access to after-hours GP services and/or services to divert GP-substitutable attendances from EDs, the PHN handled the PHN After Hours Program as a stand-alone program.

Other PHNs adopted a broader primary care scope and sought to address the contributing factors leading to unmet needs in after hours. The types of issues these commissioned services addressed included:

- System development activities such as Eastern Melbourne training residential aged care staff to help them deal with issues arising in the after-hours period.
- Addressing in-hours issues leading to unmet need in the after-hours period.
- Demand for after-hours access to mental health, alcohol and other drug services, pharmacy and allied health services.
- Consumer health literacy and knowledge of available pathways and options (including website updates and after-hours apps).
- Interaction with PHN and other externally funded programs supporting and strengthening Aboriginal and Torres Strait Islander health improvement and Aboriginal Community Controlled Health Services.
- Needs of specific population subgroups, including persons who were homeless or at risk of homelessness, young parents, culturally and linguistically diverse groups, and refugees.
- Coordination and case management of persons with chronic and/or complex conditions.
- Expansion of, and extending the hours of, existing primary care services in specific geographic locations, including pharmacy and nurse-led services.

Some PHNs have established cross program project management systems and structures to better integrate and align their activities across their funding schedules. The major interactions were with mental health activities and in-hours activities for population subgroups. These PHNs are seeking to move away from what they see as 'siloed' funding arrangements towards more integrated commissioning.

Some PHNs have recognised the risks around allowing 'a thousand flowers to bloom' and have taken a strategic decision to aim for a low number of high-impact projects. Other PHNs have dispersed funding across multiple activities or are maintaining a small grants/innovation component. For PHNs that are largely well served by after-hours general practice and medical deputising services, their focus has moved over time to identifying and addressing gaps, the needs of particular subgroups, and working on strengthening in-hours service availability to reduce after-hours demand. With commissioning of services for particular populations or needs groups, expanding the reach and hours of existing providers was often a more cost- and time-effective strategy. With some more 'niche' service needs, there was only one suitable provider and direct commissioning was appropriate. With services co-designed or developed in conjunction with local hospital networks, an expression of interest or request for quote was not appropriate. Addressing a complex population subgroup's needs or identifying service options in specific geographic sub-regions can require significant investment of time and resources in consultation, co-design and exploring potential service provider availability and capability.

For some PHNs, continuing activities formed a major part of their funding and activities (e.g. GP Assist in Tasmania and GP Access in Hunter New England and Central Coast PHN in New South Wales). Over time, the development of agreed projects with local hospital networks and/or state health departments were reflected in a number of Activity Work Plans (e.g. Western Australian metropolitan urgent-care centres).

Commissioning activities can be affected by changes in personnel but also structural and organisational approaches. Some PHNs have moved from having a specific after-hours program manager to embedding the program in a larger portfolio. Some PHNs have had problems with access to data, with differing resources and capabilities across PHNs, and uneven relationships with the local hospital network and GP workforce issues. All of these factors influence the approach and success of commissioning activities.

> "The PHN inherited a number of activities from the Medicare Local and had to move quickly to get things in place when the PHNs were established. The PHN rolled forward contracts for 12 months but some of these activities have been decommissioned over time. Only one activity still remains from 2015." [Perth South Case study]

Since March 2020, the COVID-19 pandemic response has also had a mixed effect on PHN after-hours planning and Activity Work Plan implementation. While it has resulted in increasing interaction with general practice and local hospital networks, the pandemic has deferred community and general practice consultations and co-design on after-hours services and deferred commissioning of new services.

Finding 11: PHNs recognise the importance of consultation and co-design in their commissioning processes. There is variation in the extent to which co-design principles are adopted across the whole of the commissioning cycle.

All but one of the 29 PHNs responding to the PHN survey reported the use of co-design in relation to funded services, with around 60% of the PHNs indicating they engaged a variety of stakeholders through a range of targeted activities and consultations. Co-design is reported as part of different stages in the commissioning cycle, although it is often unclear how far these activities involve co-design compared with consultation. The number of PHNs that reported using co-design as part of the process is set out in Table 18.

Table 18 – Co-design activities of PHNs

Stage of commissioning cycle	Number of PHNs (N=29)
Needs assessment	8
Service response/priority setting	14
Service design and specification	17
Procurement process	8
Review and evaluation	5
Non-specific co-design processes	7
No co-design	1

Some PHNs made it clear that co-design was an element for some but not all activities. There appears to be a heavier emphasis on co-design as part of the service development part of the commissioning cycle with less emphasis on the input of stakeholders in the procurement process or review and evaluation.

Nonetheless there are examples of co-design in the procurement process, such as South Western Sydney PHN which sought nominations from various stakeholder groups to assist in finalising a tender document. Northern Sydney PHN involved stakeholders and consumers on the evaluation panel for shortlisted providers and Murray PHN invited general practices to

present and share experiences of their service models to support future development of after-hours activities.

The groups most often identified to be involved in co-design were consumers or services users, general practices, residential aged care facility providers, peak bodies and providers. Four PHNs reported the specific involvement of providers. More than half of the PHNs referred to multiple stakeholder groups being involved in co-design of commissioned services.

About half of the PHNs worked with local hospital networks in designing services. Adelaide PHN seconded a worker from the Local Hospital Network to work with other Local Hospital Networks and peak bodies to design after-hours services. Western Sydney co-designed two projects with the Local Health District, including a hospital in the home service and a youth mental health service.

Nearly half of the commissioned providers reported being involved in a co-design process. The commissioned providers reported being involved in one of the following aspects of the co-design processes:

- initial meetings prior to a project commencing
- discussions to identify issues and gaps, existing arrangements, and intended program outcomes
- development and collaboration in the design of service delivery models.

This suggests that provider perspectives on co-design may be a little more limited than the PHN perspective. However, it is important to bear in mind that the sample of providers is drawn from a small number of PHNs and is not representative.

Overview of services commissioned

Finding 12: There are systematic differences between PHNs in the nature of services they commission. These differences are dictated by the nature of the local primary health care market and the different needs of their populations.

Information about the services being commissioned by PHNs has been obtained through analysing the Activity Work Plans submitted by PHNs for approval with the Department of Health. These activities were verified with the PHNs through the survey with additional information requested.

The activities listed by PHNs vary in the degree of detail provided. Some PHNs group together a range of activities and commissioned services into one 'activity' while others are very specifically defined. This means that it can sometimes be difficult to categorise the activities by target group as they may include a service designed to be used by its residents across the entire PHN area but combine this with a highly targeted service in a specific area. This makes classification challenging, particularly where there are multiple objectives, client groups and geographies. There may also be some non-patient-facing activities, such as training, included in the activity. Some of the activities were internal PHN activities, such as conducting more detailed evaluations or needs assessments. It is was not always clear why these activities would be approved under the terms of the program requirements. Other activities were delayed in commissioning or were still at a development stage and so precise details were not available. Given this, the analysis below needs to be caveated with the

understanding that precise groupings are not always possible and they should be interpreted as broadly indicative rather than precisely correct.

The analysis of planned expenditure against activities is based on that set out in the Activity Work Plans. The overall figure obtained from the Activity Work Plans ($69 million) is lower than that allocated by the Department ($71 million). There are two PHNs that did not complete the PHN survey (South East Melbourne and North Coast PHNs) and consequently are not included in the analysis of the PHN activities. They account for $4.4 million. There is also some variation at a PHN level between funding allocated and committed within the Activity Work Plan. There may be many reasons for this, including the use of carry forward funding (although this is generally identified separately) or use of other funding sources or expenditure for internal activities or administration. We have not attempted a full reconciliation of the figures but for this reason, it is important to bear in mind that the funding levels are indicative rather than actuals.

Table 19 profiles activities supported through the program in 2019–20. There were 144 activities identified by the 29 PHNs that responded to the PHN survey – an average of 5 per PHN. The size and monetary value of activities is highly variable (ranging from $20,000 to $3 million). Almost a quarter (22.9%) of the activities were inherited from Medicare Locals and in operation prior to 2015. Many of these activities will have been modified in subsequent years. However, only one of the PHNs serving outer regional/remote areas had two pre-2015 activities. A much higher proportion of major city PHNs had legacy activities operating in 2019–20.

The overall national per capita budget was $3.30 per head of population but ranged, on average, from $1.80 for the major cities to $12.40 for PHNs serving outer regional and remote areas. More detail on the allocation method is included in Chapter 7.

Table 19 – Overall profile of PHN After Hours Program activities by PHN group, 2019-20

Measure:	Inner & outer regional	Major cities	Major cities/Inner regional	Outer regional/remote	Total
PHNs (n)	7	14	4	4	29
Activities: 2019/20 (n)	35	68	19	22	144
Activities per PHN	5.0	4.9	4.8	5.5	5.0
Activities operating in 2015 % (n)	25.7% (9)	25.0% (17)	26.3% (5)	9.1% (2)	22.9% (33)
PHNs with activities operating in 2015 (n)	85.7% (6)	71.4% (10)	50.0% (2)	25.0% (1)	65.5% (19)
Budget: all activities ($m)	$16.2m	$24.3m	$10.7m	$18.1m	$69.3m
Resident population ('m)	3.0m	13.6m	3.2m	1.5m	21.3m
Budget: per capita ($)	$5.3	$1.8	$3.4	$12.4	$3.3

Source: HPA analysis of survey of PHNs undertaken for the evaluation. Responses were received from 29 of 31 PHNs.

Table 20 provides further details of commissioned activities. More than 60% of the activities and more than 80% of funding across all PHNs focused on providing 'direct patient services' rather than indirect activities, such as workforce capacity building or quality improvement activities. For outer regional/remote PHNs, the proportion of funding directed at supporting

direct patient services was slightly lower, reflecting a greater emphasis on other initiatives intended to bolster more fragile local systems and address workforce development issues. The more urban the PHN, the more activities were devoted to specific target population groups. The major cities group of PHNs planned over 75% of activities and funding to be targeted at specific population groups.

Table 20 – Description of PHN After Hours Program activities by type of PHN

Measure:	Major cities	Major cities/Inner regional	Inner and outer regional	Outer regional/remote	All
PHNs (n)	14	4	7	4	29
Activities: 2019–20 (n)	68	19	35	22	144
Direct vs Indirect:					
Activity supports direct patient services: % (n)	67.6% (46)	84.2% (16)	65.7% (23)	63.6% (14)	68.8% (99)
Indirect support activities: % (n)	32.4% (22)	15.8% (3)	34.3% (12)	36.4% (8)	31.2% (45)
Planned expenditure: activities for direct patient services (expenditure)	81.1% ($19.7m)	96.5% ($10.3m)	77.0% ($12.5m)	77.7% ($14.1m)	81.6% ($56.6m)
Target groups (of direct activities):					
Activity relates to general population: % (n)	21.7% (10)	25.0% (4)	43.5% (10)	50.0% (7)	31.3% (31)
Activity targets specific group(s) % (n)	78.3% (36)	75.0% (12)	56.5% (13)	50.0% (7)	68.7% (68)
Planned expenditure: activity targets specific groups % (expenditure)	78.9% ($15.5m)	45.0% ($4.6m)	24.4% ($3.0m)	61.7% ($8.7m)	56.4% ($31.9m)

Source: HPA analysis of survey of PHNs undertaken for the evaluation. Responses were received from 29 of 31 PHNs.

A further breakdown of the 68 activities reported by PHNs were grouped into the following categories:

- Those targeting specific health conditions or needs such as mental health or palliative care.
- Those targeting specific population groups (e.g. homeless people or Aboriginal and Torres Strait Islander peoples).

Many activities focus on multiple target groups such as mental health for Aboriginal and Torres Strait Islander people, awareness campaigns that target people from culturally and linguistically diverse backgrounds, activities that provide additional after-hours support for 'vulnerable groups', and programs for frequent ED users. This means there is a high degree of cross over between the categories. Table 21 breaks down the activities and planned expenditure based on these groupings and the PHN groups.

The largest groups from the targeted activities covered mental health, aged care and palliative care services. These three target groups covered about 20% of funding and activities. Many of the activities targeting specific population groups also targeted specific health conditions so there is clear overlap between these two broad categories. About 5% of funding has been targeted at homelessness in metropolitan areas. Further detail of the types of services commissioned are set out below.

Table 21 – PHN After Hours planned expenditure by target groups, 2019-20

Target Group	Activities: 2019–20 (n)	Planned expend-iture	% of expenditure				
			Major cities	Major cities/ Inner regional	Inner and outer regional	Outer regional/ remote	Total
Specific health conditions/needs							
Mental health only	12	$4.4m	16.2%	0.0%	2.9%	0.0%	8.3%
Aged care	10	$3.9m	7.4%	10.5%	5.7%	4.5%	6.9%
Palliative/aged care	8	$4.7m	4.4%	15.8%	2.9%	4.5%	5.6%
Other specific health needs	13	$4.7m	5.9%	21.1%	11.4%	4.5%	9.0%
Specific population/vulnerable groups							
Aboriginal and Torres Strait Islander peoples	1	$0.7m	0.0%	0.0%	0.0%	4.5%	0.7%
Aboriginal and Torres Strait Islanders and specific health conditions/needs	7	$6.0m	1.5%	5.3%	5.7%	13.6%	4.9%
Homeless people	7	$4.2m	5.9%	5.3%	5.7%	0.0%	4.9%
Vulnerable groups and specific health conditions/needs	7	$2.6m	7.4%	5.3%	2.9%	0.0%	4.9%
Other vulnerable population groups	1	$0.0m	1.5%	0.0%	0.0%	0.0%	0.7%
Other/multiple groups							
Multiple target groups	2	$0.7m	2.9%	0.0%	0.0%	0.0%	1.4%
Total targeted activities							
Activity targeted at general population	31	$24.7m	14.7%	21.1%	28.6%	31.8%	21.5%
Activity does not involve direct patient services	45	$12.8m	32.4%	15.8%	34.3%	36.4%	31.2%
Total	**144**	**$69.3m**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: HPA analysis of survey of PHNs undertaken for the evaluation and Activity Work Plans provided.

Figure 18 provides a similar breakdown but related to proportions of activities rather than expenditure. About a quarter of these targeted activities relate to aged care or palliative care although this accounted for only half of that in relation to expenditure (12.5%). PHNs across all regions have supported activities focused on aged care and palliative care. The major cities/inner regional group of PHNs devoted more activities and expenditure to this group of residents. This group of PHNs also devoted a lower proportion of spend and activities to mental health needs (although some of the mental health activity may be devoted to specific target populations or vulnerable groups). Most other PHNs have supported activities focused on mental health. Activities that have Aboriginal and Torres Strait Islander people as a specific target group are almost all located outside the major cities and make up close to a half of activities for PHNs with large remote populations (although as noted above, these PHNs also have relatively high level of activities related to the general population).

PHNs in major cities have a relatively high proportion of activities related to other target groups. Activities related to homeless people or those at risk of homelessness account for up to almost half of expenditures on specifically targeted activities in these PHNs.

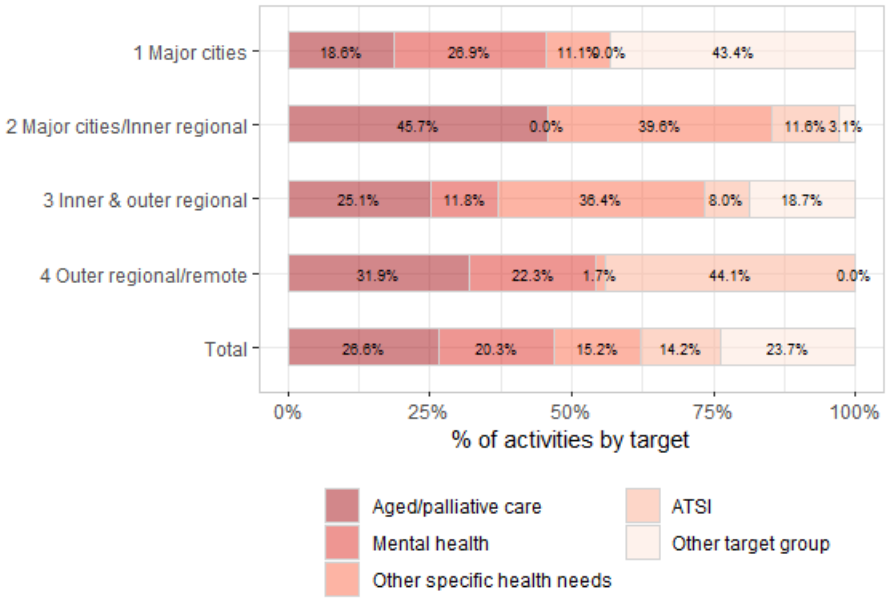


Figure 18 – Proportion of PHN After Hours activities (by number) by target groups, 2019–20

Source: HPA analysis of survey of PHNs undertaken for the evaluation. Responses were received from 29 of 31 PHNs.

The pattern of service provision is a reflection of the needs assessment process undertaken by PHNs. However, some of the commissioning may be driven by other factors such as:

- Legacy activities – it can be difficult to decommission services, especially in areas where alternative provision is lacking and there are no viable alternative sources of funding.
- Opportunity – outside the main cities, it can be more difficult to identify organisations with the capacity to develop new or innovative after-hours provision.
- Responsiveness – commissioning may be driven by other supply side factors, such as which providers respond to PHN initiatives and their ability and capacity to respond.

Types of services commissioned

This section sets out in more detail some of the main types of services commissioned by PHNs. The main target groups or health needs are described in the previous section. We have identified seven groups of services that have predominated across PHNs. These services have benefited from significant investment and represent a significant element of PHN activities and expenditures. The service areas are set out in Table 22.

Table 22 – Summary of main types of services commissioned

Type of service commissioned[1]	Number of PHNs commissioning this type of service	Approximate funding associated with type of service[2]
Consumer awareness and health literacy	27	$2.2m
Mental health services	14	$13m
Residential aged care facilities	15	$4m
Services for those at risk of or who are homeless	7	$4m
Telehealth services	12	$8m
Face-to-face after-hours provision (intended for the general population)	18	$10m
Workforce and capacity building	29	$21m

Notes: 1 These categories are not mutually exclusive. Activities may count toward multiple groupings; 2 These figures include any service that fits these categories. They are not mutually exclusive and therefore not additive. The earlier table contains mutually exclusive categories.

Consumer awareness and health literacy

Consumer awareness and health literacy initiatives that seek to raise awareness of after-hours primary care services were funded by 27 PHNs. In addition to patient education, the aim of these initiatives is generally to reduce unnecessary ED attendances during the after-hours period and direct people to more appropriate services.

Many PHNs have sought to raise awareness of available after-hours options through various communication channels, including establishing digital marketing campaigns, engaging in web-based advertising, distributing flyers, brochures and magnets, working with local providers to showcase and distribute campaign materials, and organising speakers and community events. PHN marketing campaigns often use Google ads and promote services via social media platforms and websites. Some PHNs allocated funding to the development, maintenance and/or expansion of certain web portals or websites. For example, the Gold Coast PHN established HealthyGC, a web-based resource that provides primary care information, referral guidelines, templates, literary sources, patient resources, and links to community services. The PHN funded the maintenance and expansion of their web-based portal to ensure that accurate and reliable information on available after-hours primary care services was listed on the portal.

While multiple PHNs funded a general consumer awareness or health literacy campaign, others took a more targeted approach that focused on specific patient cohorts. Some PHNs identified high ED users and targeted these cohorts through marketing campaigns and educational initiatives. For example, the North Western Melbourne PHN targeted parents and caregivers of young children aged 0–4. The initiative supported local providers to develop and provide education and training for parents and caregivers to help them more confidently manage their sick child during the after-hours period. In Central and Eastern Sydney, direct engagement with patients and providers has been undertaken to promote the uptake of My Health Record by after-hours providers. Culturally and linguistically diverse groups have often been identified as groups with health literacy needs and help with navigating the system. Health literacy campaigns that promoted various forms of self-care for certain population cohorts was an emerging trend (i.e. younger patients in ACT). In

certain instances, this included funding to support advance care planning, specifically for patients with chronic disease or palliative care needs.

Behavioural change has been sought as part of a broader service development in some PHNs. For example, in WA, both Perth North and South PHNs have partnered with the State Government to establish a network of urgent-care centres and create online pathways to the services. As part of this development, an extensive public awareness and education campaign has been undertaken in recognition that the success of the Urgent Care Network will depend on people's awareness and acceptance of such services.

"LETSS [Lived Experience Telephone Support Service] collaborated actively with local hospital networks across metropolitan Adelaide (including EDs and the mental health triage service), police services and other social and community service providers (e.g. across mental health, drug and alcohol, disability, youth, domestic violence, CALD, Aboriginal and Torres Strait Islanders, local government) in the region. Discussions with representatives of selected organisations indicated that LETSS is well respected and trusted by staff, with either formalised referral pathways established or promotion of the service to patients and clients.

For example, a formalised escalation and de-escalation pathway between LETSS and the State-funded Mental Health Triage service exists, including a 'warm' handover facility. This represents around 20% of referrals." [Adelaide Case study]

Mental health services

Almost half of the PHNs (14) supported around 22 activities that relate to increasing access to mental health services during the after-hours period. While some PHNs supported increasing access to face-to-face community mental health services, other PHNs funded mental telehealth services. For example, Adelaide PHN funded the Lived Experience Telephone Support Service, which helps fund one-on-one telephone services delivered through peer support workers. Other PHNs focused on increasing access to community mental health services such as Headspace. For example, the Country South Australia PHN funded the Headspace and psychological therapies extended access initiative that aimed to increase young people's access to mental health services during the after-hours period.

Beyond young people and the general population, the PHNs focused on increasing access to mental health services for certain priority groups, such as women, individuals experiencing domestic violence, Aboriginal and Torres Strait Islanders, residents living in specific underserviced areas, individuals struggling with alcohol and drug abuse, homeless people, older adults, children, and families. PHN-supported services often included activities such as free to low-cost screening, counselling sessions, follow-up and/or AOD counselling services. Certain services focused on early intervention, enhancing referral pathways and mental health planning. For example, the Gold Coast PHN supported the Mental Health After Hours – Safe Space initiative, which aimed to provide young people with a 'safe space' to access mental health support, assessments, patient navigation, advice and care planning services. The service allowed individuals to 'drop in' and hosted extended hours until late in the evening, weekends and public holidays.

Face-to-face after-hours services

Services commissioned include dedicated after-hours clinics, extended hours at GP clinics and mainstream medical deputising services commissioned to cover specific localities, often outside of major urban areas. Examples of medical deputising services include: Jimboomba (Brisbane south); Eastern Melbourne (east and north area); Nepean (Hawkesbury, Penrith and Lithgow); Hunter New England and Central Coast (Central coast localities); Perth South

(Armadale); Albany (Western Australia), Dubbo (Western New South Wales) and Wagga Wagga (Murrumbidgee).

These services often use local GPs or are nurse-led with GP back up. Some provide tailored support for residential care facilities. Many services are co-located with hospitals. Western Queensland commissioned a service to operate at Mount Isa Hospital, aiming to divert appropriate patients from the ED to primary care. Patients are not turned away but are triaged, provided with medication or treatment if required immediately and referred back to their GP (sometimes an appointment is booked). Like the service in Mount Isa, some of the PHNs have commissioned services in conjunction with the local hospital. In the Northern Territory, hospital in-reach services have been commissioned. The PHN has made clear that these services must not duplicate hospital provision.

Many of the services commissioned target specific localities where service coverage is poor or, in the case of regional and remote areas, towns or population centres (e.g. in the Northern Territory, services have been commissioned in Katherine, Alice Springs and Palmerston). Gippsland set up a service in an area where the hospital services were withdrawn.

> "While the medical deputising service previously covered this geographic region, it was in a secondary capacity, and the distances (and time, 40 minutes each way) to conduct visits were a significant barrier to the service's employed workforce accepting referrals into the region. By eliminating the service fee paid by doctors to the medical deputising service, the PHN After Hours Program effectively provided an economic lever for the medical deputising service workforce to engage and provide support to patients in Jimboomba." [Brisbane South Case study]

Some PHNs have commissioned medical deputising services to provide home visiting. This is the case in the Northern Territory, Wagga Wagga, Murray, Nepean Blue Mountains and Brisbane South (Jimboomba).

Some services are 24 hours but more typically they run into the evenings and daytime on weekends, with some covering evenings at weekends. Some services charge privately, such as the Wagga after-hours clinic, the clinic in Central and Eastern Sydney and the Central Coast GP after-hours service. Most others appear to offer bulk billing. Most of the services operating as bespoke after-hours services are walk-in services, while some require pre-booking.

The services are a mix of GP and nurse-led services. Nurse-led services are a feature in: Albany (Western Australia); Lakes Boulevard (Eastern Melbourne); Murray and Bathurst and Dubbo in Western New South Wales. The nurse-led services often have GP back-up either remotely or on site. The services in the Central Coast, Healesville (Eastern Melbourne) and Armadale (Perth South) are GP-led. Some of the services that have been set up are bespoke services and facilities. Others, such as the Central Coast and Dubbo services, use existing practices or local GPs. The Western Australian pilot of an urgent-care network is using existing general practices to establish networks and sought bids from general practices that met specific criteria.

Some alternative providers were commissioned to extend their hours. These are mainly focused on pharmacy services, but Eastern Melbourne has added a psychological service to sit alongside the after-hours provision in the east of the PHN. Alternative provision includes:

- Murray – pharmacy and allied health providers
- Northern Territory – extended pharmacy hours and social work provision
- Eastern Melbourne – psychological services attached to the Healesville service

- Nepean Blue Mountains – a 24-hour opening of pharmacy to support services at after-hours clinic and provide health advice

Telehealth activities

The PHNs funded around 12 after-hours activities in 2019–20 supporting the provision of after-hours telehealth services. These services were often supported in PHNs with more rural and remote areas such as Northern Territory, Country Western Australia, Murray, Northern Queensland, Murrumbidgee and Nepean Blue Mountains. These services often seek to increase after-hours coverage and provide consumers with additional resources during the after-hours period. For example, Gippsland funded an activity that provided residents with 24/7 virtual access to medical services via an app-based videoconferencing service. Western New South Wales funded an after-hours phone service provided by local GPs in Bathurst, Dubbo and surrounding regions. The service uses a phone system that allows doctors to effectively triage an individual to the ED or provide medical advice over the phone. Residential care facility staff and residents can use the service, and they offer visits to residential care during the after-hours period. Many PHNs sought to fund telehealth services that specifically support and target residential care. An example was a pilot in the Nepean Blue Mountains PHN.

In some instances, PHNs with more urban demographics supported telehealth services, such as My Emergency Doctor, to provide additional after-hours coverage to specific areas of their catchment. Other PHNs, such as Murray, were considering telehealth to strengthen seasonal capacity. While an equivalent service is available through Healthdirect, Victoria has its own telephone triage service which does not include a GP advice option. Northern Queensland wanted a telehealth service provider that had some familiarity with the area. They also partnered with pharmacies to provide iPads for people who have difficulty accessing the internet.

The telehealth services supported through the PHN After Hours program were commissioned prior to the introduction of temporary MBS-funded telehealth items in response to the COVID-19 pandemic. Should access to MBS-funded telehealth items be made permanent, there is an opportunity for PHNs to reconsider how after hours telehealth services are best supported in their region.

Homelessness services

Programs have been funded in metropolitan areas of most states that provide outreach and other services to homeless and vulnerably housed people. These services are typically provided in tandem with community support workers and either provide direct primary care (through mobile clinics or clinics in community settings) or help engage homeless people with primary care services. For example, the Central Queensland, Wide Bay and Sunshine Coast PHN provides funding to the Sunny Street service, which supports nursing and volunteer coordination, consumables and travel for essential outreach primary care services across the nine primary care clinics in the Sunshine Coast and Gympie. This funding also allows the service to deliver after-hours primary care services to homeless and vulnerable populations in the area. The Perth North and South PHNs support the 50 Lives 50 Homes Program, which provides housing and support to homeless individuals in the area and helps the service provide a nursing service to support those with chronic conditions (see also the Perth South case study).

Support for residential aged care facilities

Many PHNs are tackling residential aged care support in the after hours. This appears to be an area where improving in-hours provision can have significant benefits for the after-hours period. Some of the PHNs have identified niche activities, such as targeting palliative care patients or specific pharmacy requirements. Others are focussed on education and training initiatives to help RACF staff identify and manage patients to avoid unnecessary ED visits.

PHNs across all the mainland states had activities under the program targeted at residential aged care facilities. Some of the services, such as the telehealth services, had specific arrangements to handle residential care facilities. The aim of these services is often to support residential care providers in the after-hours period and avoid ambulance transfers and ED attendances. Many of the service responses include upskilling residential aged care staff and establishing agreed care pathways and service protocols to reduce the escalation of service responses in the after-hours period.

In some PHNs, the initiatives are being led by the aged care providers (e.g. Adelaide) and in other PHNs outreach services are being provided by hospitals in the local hospital network (e.g. Central and Eastern Sydney). Care support to nursing homes and other aged care facilities is being provided by GPs, Nurse Practitioners (e.g. Country WA, Gold Coast) and hospital clinical staff. Some PHNs are providing telehealth access to doctors (e.g. Eastern Melbourne, Nepean Blue Mountains) and nurses (Hunter New England Central Coast). Some of the support is aiming to increase the uptake and use of My Health Record (e.g. Darling Downs and West Moreton) by residents, including promotion of advance care planning (e.g. Country WA PHN).

Workforce and capacity building activities

There were 57 after-hours activities in 2019–20 that aim to build capacity and support the primary care workforce to provide increased access to high-quality after-hours care. These initiatives supported a wide range of activities, from training and helping paramedics treat patients with non-life-threatening injuries at the scene (ACT) to educating general practice staff to better identify and support individuals experiencing domestic violence (ACT, Brisbane South).

PHNs predominantly supported capacity building and primary care workforce development by: establishing and/or enhancing multidisciplinary care models during the after-hours period (Brisbane South); developing stronger partnerships between local hospital network, providers and hospitals (Murray); improving patient referral pathways and navigation (Gippsland); the promotion of advance care planning services (Country WA); needs assessment activities and service mapping and developing quality improvement guidelines in various settings (Murrumbidgee).

Intended impact on after-hours primary care

Finding 13: PHNs adopted a range of strategies in delivering the program. In general, PHNs covering more rural/remote PHNs adopted strategies that were focused on tackling barriers to accessing services and supporting practices to extend their provision. Metropolitan PHNs' strategies were more concerned with vulnerable groups and providing alternatives to mainstream after-hours services. There is wide support for a greater emphasis on in-hours

services as a way of reducing demand for after-hours services and improving health outcomes especially in areas where access to primary care is poor.

Table 23 sets out the number of activities against the intended impact on after-hours primary care and links these intended impacts with the broad strategies to deliver the program objectives and target different parts of the patient journey outlined previously in Chapters 1 and 4. These are set out again for reference in Figure 19.

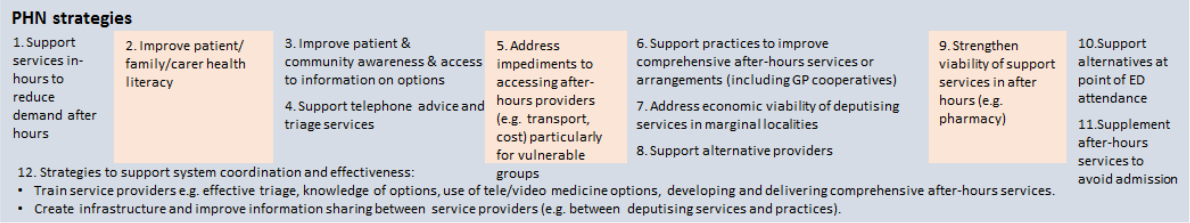


Figure 19 – PHN strategies drawn from Figure 2

There were some differences between PHNs in the intended impact of their activities. A higher proportion of outer regional/remote PHN activities are aimed at addressing geographic and other barriers to after-hours care, improving integration and coordination, and directing patients to appropriate pathways with much less focus on consumer awareness and improving services for vulnerable groups.

A fifth of the planned expenditure for this group of PHNs was focused on supporting GPs to increase or improve provision, twice as much as those in the cities.

In the major cities and inner-regional group almost half of the planned expenditure was intended to improve availability of alternative services in the after-hours period. For the major cities there was a much higher proportion of planned expenditure focused on targeting services for vulnerable people. Both PHNs and commissioned providers were asked to reflect on the effect the services and activities they commissioned had on demand for and provision of after-hours services. While the responses from both groups were largely aligned, only providers gave greater emphasis to the importance of improving in-hours services to avoid the need for services during the after-hours period.

Figure 20 shows the distribution of planned expenditure for each group of PHNs. This chart excludes the proportion of planned expenditure that had not yet been committed as the service was not in place. This was of the order of 10% across all PHNs but was higher (17%) for the outer regional/remote PHNs.

Table 23 – Intended impact on after hours primary care, activities and proportion of expenditure

Intended impact on demand	Strategy	Number and % of activities, % (n)	Planned % planned expenditure	% of activities			
				Major cities	Major cities/Inner regional	Inner and outer regional	Outer regional/remote
Support services in-hours to reduce after hours	1	1.4% (2)	0.7%	0.0%	2.9%	0.9%	0.0%
Improve patient/carer health literacy and community awareness of options	2 & 3	11.1% (16)	5.1%	8.7%	4.3%	0.9%	4.4%
Provide alternatives through after-hours telephone triage and advice services	4	1.4% (2)	4.3%	0.0%	0.0%	18.6%	0.0%
Address geographic/other barriers to accessing after-hours care	5	4.9% (7)	8.0%	0.0%	0.5%	12.2%	19.2%
Support general practices to expand their provision of after-hours services	6	13.2% (19)	15.7%	10.7%	8.2%	16.3%	26.3%
Improve availability and effectiveness of medical deputising services and their relationships with practices	7	2.8% (4)	1.2%	3.4%	0.0%	0.0%	0.0%
Increase or improve provision of services tailored for vulnerable patient groups	8	11.8% (17)	11.0%	28.2%	1.8%	3.5%	0.0%
Provide alternative after-hours services		15.3% (22)	18.9%	21.3%	53.3%	14.1%	0.0%
Expand/improve after-hours support services (e.g. pharmacies)	9	0.7% (1)	0.1%	0.3%	0.0%	0.0%	0.0%
Support alternatives at point of ED use	10	4.2% (6)	3.8%	4.0%	0.0%	2.1%	7.5%
Workforce support	12	0.7% (1)	1.4%	0.0%	0.0%	6.2%	0.0%
Improve knowledge and capacity of service providers to direct patient to appropriate pathways or to facilitate access to services or to manage patients appropriately		12.5% (18)	15.5%	13.4%	23.1%	9.8%	18.8%
Improve infrastructure and practice for information sharing following a patient accessing an after-hours service (e.g. communicating details back to a patient's regular general practice)		1.4% (2)	0.4%	0.4%	0.0%	0.0%	0.8%
Improved coordination/integration of care		4.2% (6)	3.9%	3.4%	5.6%	1.2%	6.1%
No service or not yet in place or not a commissioned activity	NA	14.6% (21)	10.0%	6.3%	0.6%	14.3%	16.9%

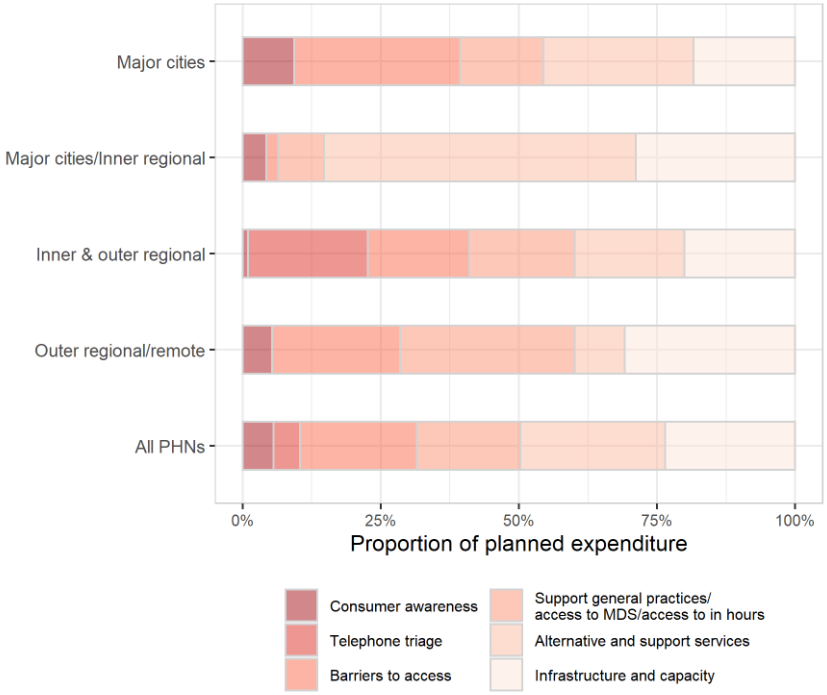


Figure 20 – Intended impact on demand or provision for commissioned activities, by PHN group (excluding funding not yet committed)

Note: The categories in the chart group the strategies as follows: Consumer awareness (strategies 2 & 3)- includes health literacy; telephone triage and advice (strategy 4); Barriers to access (strategy 5)- geographic barriers and improving services for vulnerable groups; Support general practices includes MDS support and improving in hours access (strategies 1, 6 and 7); Alternative and support services includes expanding support services and alternatives at point of ED use (strategies 8, 9 and 10); Infrastructure and capacity includes workforce, service provider support, information sharing infrastructure and improved coordination(strategy 12).

There are many factors that influence how quickly the funding has been spent. One is the extent to which PHNs are rolling over existing activities or commissioning new services. The commissioning of a new service is likely to take longer than rolling over an existing contract. The COVID-19 pandemic has also had some impact on the ability of PHNs to progress commissioning activities. Clearly delays in commissioning services and deploying funding delays the potential impact of the program.

The approach taken by PHNs to commissioning activities has been strongly influenced by the specific issues they face. PHNs in areas with active after-hours coverage predominantly identified gaps that were typically related to vulnerable groups or those in pockets of deprivation or geographical pockets with more limited services. In city areas this may be outlying towns such as Jimboomba in Brisbane South or Armadale in Perth South. Many PHNs appear to be concerned with health literacy and consumer awareness of what to do if they need after-hours care. There was much lower expenditure on this issue from PHNs covering rural and remote areas.

In certain areas that have a high after-hours coverage, national stakeholders felt some PHNs have implemented after-hours activities that have undermined existing services and had a negative effect. There has been an emphasis among some PHNs to fund innovative after-hours service models, but these may only be appropriate in areas that have limited access to after-hours services. Some national stakeholders felt that funding these types of models in

metropolitan areas that have good coverage of after-hours services may cause service duplication.

Where GP clinics have been encouraged to open in the after-hours period there was anecdotal evidence that they are often providing appointments of convenience (i.e. to people who cannot attend in-hours without missing work), and only a small proportion of the extended capacity is supporting care of a more urgent nature that would go the ED. This may be an entirely legitimate way of broadening access to primary care but PHNs and providers need to be aware that this is often the consequence of extending opening hours. Where there are shortages of GPs, which means people struggle to access primary care in-hours, then there is a risk that this results in either a health care need not being met in a timely way or an acute exacerbation necessitating after-hours care. On this basis, many PHNs have argued that there is a need to focus on meeting in-hours needs.

> "There was an emergence of after-hours bulk-billed services that provided non-urgent care that should be treated in the daytime. GP Access felt that these services, coupled with certain [Local Health District] objectives, promoted increased use of the ED and encourage people to seek treatment during after hours out of convenience, not necessity. This is an ongoing tension that exists across Australia, especially in urban areas." [HNECC Case study]

> "But the problem is that [PHNs are] also acquiring these innovative-type solutions in metropolitan areas where there well may be already good coverage of after hours." [National stakeholder]

A focus on workforce issues is generally confined to those areas with severe shortages of GPs and other staff such as those in outer regional and remote areas. There is a stronger focus on supply side factors in those areas given the fragile and thin market for health professional and service providers. Initiatives to bolster the system and develop stronger capabilities are evident in these areas. The inner regional areas have also tended to focus on the supply side by improving the availability of services by supporting GPs and practices or by supporting other service provision.

Program delivery

Finding 14: Implementation approaches have been variable. There are often key elements that contribute to greater success in implementation. These include making use of existing expert provider organisations, having local 'champions' that can support delivery of a service and bringing existing local providers along.

National stakeholders stated that the success of implementing PHN after-hours services has largely been mixed. For example, there have been instances where there was a perceived need and the PHN put a service in place that was not effectively integrated with local community GPs:

> "I think at times there's a perceived need and the PHNs have put a model in place, but it hasn't actually been integrated with the GPs in that community … It's well intended, but it misses the mark." [National stakeholder]

Commissioned services aimed at providing access to care for homeless people feature heavily in the PHN After Hours Program activities. Perth, Brisbane, Adelaide, Cairns, Melbourne and Hobart all have projects focusing on this group. In most cases they have successfully partnered with existing specialist service providers (e.g. MICAH in Brisbane and Ruah Community Services in Perth). The Perth project added an after-hours component to a homeless health care project that is seen by stakeholders as highly effective in supporting

newly housed people and preventing housing breakdown (with a consequent impact on health and wellbeing). The project seems to have a range of ingredients that have contributed to its apparent success: passionate and committed health care professionals (an ED consultant and a GP), an effective NGO with strong links to partner organisations, and capacity to act as a 'backbone organisation' and a supportive and philanthropic funder.

In a similar way, some PHNs have looked to integrate after-hours elements with mental health primary care services. For example, a peer worker after-hours mental health call centre in Adelaide provides a basis for navigation, reassurance and follow-up in a practical way, and allowing for escalation to the main mental health triage service.

Approaches to implementation have been variable. Some activities have been rolled over from one year to the next, sometimes with some modifications. Other activities have been subject to tendering processes with variable success. Adopting a tendering approach tends to result in a lengthier commissioning process and some of the organisations or professionals that are potential service providers have little training or experience of tendering (e.g. pharmacists and general practices). Approaches to implementation that tap into existing specialist NGOs or other organisations appear to be more successful. The commissioning processes need to align with the maturity and strength of the local market. PHNs operating in rural and remote areas heavily rely on a smaller number of providers and often with limited staff available to provide a service in a particular locality. A service can fold altogether because a single member of staff leaves. Therefore, strengthening the local market and developing workforce capacity and capability are particularly important.

> "The GP Access model may not be appropriate for all regions. The service did try to advocate for expansion of GP Access to Nelsons Bay, but local GPs did not support or trust the service given their existing market dynamics. In rural areas, there are potential issues around the GP Access model reducing GP incomes due to the high [visiting medical officer] rates; therefore, the PHN and other stakeholders need to explore different options for different regions." [HNECC PHN Case study]

PHNs and stakeholders highlighted some of the commissioning issues that are apparent in the after-hours market. While some service providers have knowledge of and experience in submitting tenders, this is not the case for pharmacists, most GPs and other service providers. They will generally be disadvantaged in bidding for contracts because of this. They associated overhead costs may also be a barrier.

In rural and remote areas, there are other factors that dictate the success of services from patients' perspectives. Some PHNs said their residents don't want to use a telephone service that involves speaking to someone in a call centre in Brisbane or Melbourne. Instead they want to talk to someone who understands their local circumstances. For many PHNs, commissioning services from a known provider operating successfully within the local area is often seen as a more reliable route to securing appropriate and acceptable services.

Case study: Tasmania

Case study focus

The Primary Health Tasmania (PHT) case study focused on three programs: the state-wide GP Assist service; a specialised service supporting homeless people or those at risk of homelessness in central Hobart; and a community development project in Brighton (outer northern Hobart). These three programs account for about 85% of the PHT after-hours program budget.

Locality overview

PHT covers the whole of Tasmania. While the population has been growing about 1% per year, 15 of the 29 Tasmanian local government areas are projected to decline over the next 20 years. Most of the population lives in Hobart and Launceston but there are many small rural towns and villages and remote communities (such as Flinders and King Islands in Bass Strait).

PHN approach

PHT's strategic plan sets out goals for health outcomes, person-centred care, provider capability and engagement, integrated primary health system, and value, effectiveness and efficiency. The PHT after-hours activities for 2019–20 include GP Assist, an evaluation of GP Assist, After Hours Community Awareness and Education, the Paramedic and Community Nurse Project, Mobile Health Clinic Hobart, a needs assessment to determine requirement for extension of the mobile health clients to other vulnerable client groups, and the After Hours system reform initiative. GP Assist started in 1987 and has evolved into a state-wide nurse (funded by the Tasmanian Department of Health) and GP (funded by PHT) telephone triage and advice service via a call centre linked with Healthdirect. The Mobile Health Clinic Hobart aims to improve after-hours access for vulnerable clients of community services. It operates in the evenings on weeknights on a roster-basis at NGOs across various locations. It is free for certain groups. The clinic also responds to urgent calls from NGOs. The PHT Community Awareness and Education Campaign was a state-wide initiative that focused on increasing consumer awareness of available after-hours primary care services in the region. The Paramedic and Community Nurse Project sought to create and trial a model to support frequent users of ambulance services after hours.

Key observations

- There is **no coordinated after-hours primary care plan for** Tasmania. PHT would welcome working with the Tasmanian Department of Health, Ambulance Tasmania and others to develop one.
- GP Assist clearly meets a need and the **service is strongly supported** by GP organisations, the Rural Health Workforce Agency, rural GPs and the Tasmanian Department of Health. PHT regards GP Assist as fundamental, supporting and stabilising rural general practice in Tasmania.
- Opportunity exists to **explore greater integration** of telephone triage and telehealth services provided by Healthdirect, the GP Assist service, after-hours GP clinic services, other telehealth services, Ambulance Tasmania secondary triage and ED triage. There are concerns the current arrangements are overly complex, costly and may be generating additional risks for patients.
- Based on available information, preliminary calculations indicate the average cost per call to the PHT and Tasmanian Department of Health of GP Assist is about $211, excluding Healthdirect initial call costs. There would be value in the Tasmanian Department of Health engaging with PHT for a more comprehensive **cost-effectiveness evaluation** of GP Assist.
- Subject to the outcome of the Commonwealth Department of Health's review of the PHN After Hours Program, and confirmation of longer-term funding, it would be opportune for PHT to undertake a **review of the service** in conjunction with the Tasmanian Department of Health.
- Stakeholders raised **access issues "in hours"** as a contributing factor to after-hours demand, including limited access to bulk-billing general practice, availability of public transport and care coordination and support for people with chronic or complex conditions.
- The **PHN receives a larger share of the After Hours Program funding** than the amount that would be allocated through the weighted population-based formula. This additional funding reflects historic support of the GP Assist service. As a result, the PHN has the 3rd highest per capita funding under the PHN After Hours Program.

7. Impact and outcomes

This chapter describes what the evaluation has learnt about how PHNs have approached implementation and addresses five of the evaluation's questions:

PHN After Hours Program evaluation key questions 4-8

4. To what extent have the expected program outcomes been achieved?
5. What models have worked relatively well and less well, in what contexts and why?
6. How well (efficiently) have PHNs used their after-hours funding?
7. Is there a program spending trend/ceiling for each PHN?
8. To what extent is the program value for money?

How have impacts been measured?

Finding 15: The outcomes PHNs expected to achieve were mainly improved consumer satisfaction and access to care, and reduced hospital and ED use. PHNs are keen to track progress using patient outcome measures but most are using process or output measures as part of their contract monitoring processes.

In the survey, PHNs were asked what outcomes they expected the PHN After Hours Program to achieve. Table 24 shows that a very high proportion of PHNs (23 of 29) expected improved patient/consumer satisfaction or wellbeing. Reducing hospital or ED use was identified by an equally high number of PHNs (22). About half of the PHNs saw the ability of consumers (particularly vulnerable groups) to access care appropriate to their needs as a key outcome. Health literacy was identified by 12 PHNs. Only five PHNs identified supporting general practices to expand their provision of after-hours services. Some PHNs were concerned more with outcomes related to workforce or system-level issues.

Table 24 – Program outcomes expected by the PHNs

Outcome Measure	Number of PHNs	% of PHNs
Patient and consumer satisfaction/wellbeing	23	79%
Reduce hospital/ED use	22	76%
Consumers able to access care appropriate to needs	14	48%
Improve patient/family/carer efficacy/health literacy to manage health issues and recognise when and what options are available to seek after-hours care or improve patient and community awareness of options for after-hours primary care	12	41%
Increase or improve provision of services tailored for vulnerable patient groups	11	38%
Address geographic/other barriers to accessing after-hours care	7	24%
Improved coordination/integration of care	7	24%
Directly support after-hours telephone triage and advice services	5	17%

Outcome Measure	Number of PHNs	% of PHNs
Support general practices to expand their provision of after-hours services/uptake of PIP	5	17%
Improve knowledge and capacity of service providers across the PHN to direct patients to appropriate pathways or to access services	4	14%
Uptake of program	3	10%
Workforce support	3	10%
Improve infrastructure and practice for information sharing following a patient accessing an after-hours service (e.g. communicating details back to a patient's regular general practice)	1	3%
Other	5	17%

Most PHNs were using contract monitoring processes to track progress on meeting outputs (and outcomes in the case of some PHNs) of the program. Some are also using published data to track progress. We know from elsewhere in the survey that PHNs find this is often not sufficiently timely to enable them to use the published data in an effective way.

Some PHNs have included patient outcome measures as part of their commissioning process. They use a variety of measures, including patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs). Output measures such as service use and contacts were often included. PHNs were asked to provide the latest output and outcome measures and there were few measures included in the survey against specific activities.

Figure 21 sets out how well the PHNs judged that the program is achieving the expected outcomes with very few responses indicating that the program was unsuccessful. There were some responses indicating limited success, particularly relating to reducing hospital ED use and improving consumer awareness and health literacy. Twenty of the 29 PHNs responding to the survey thought the program was very or moderately successful in improving consumer satisfaction or wellbeing. About half thought the program had been very or moderately successful in reducing ED or hospital use.

"Stakeholders were universally positive about the program and the after-hours component. It is clear that one of the contributory factors in the overall success of the program has been the multi-agency approach … The ED consultant from one of the Perth hospitals has been a key player in changing the way that homeless people are treated at the hospital but also recognising what heavy users this group were. Tackling homelessness was seen as an important way of reducing pressure on ED services and improving health and life outcomes for this group. The homeless health care service was a key element of the overall provision … This service included GPs who are specialist in this group." [Perth South Case study]

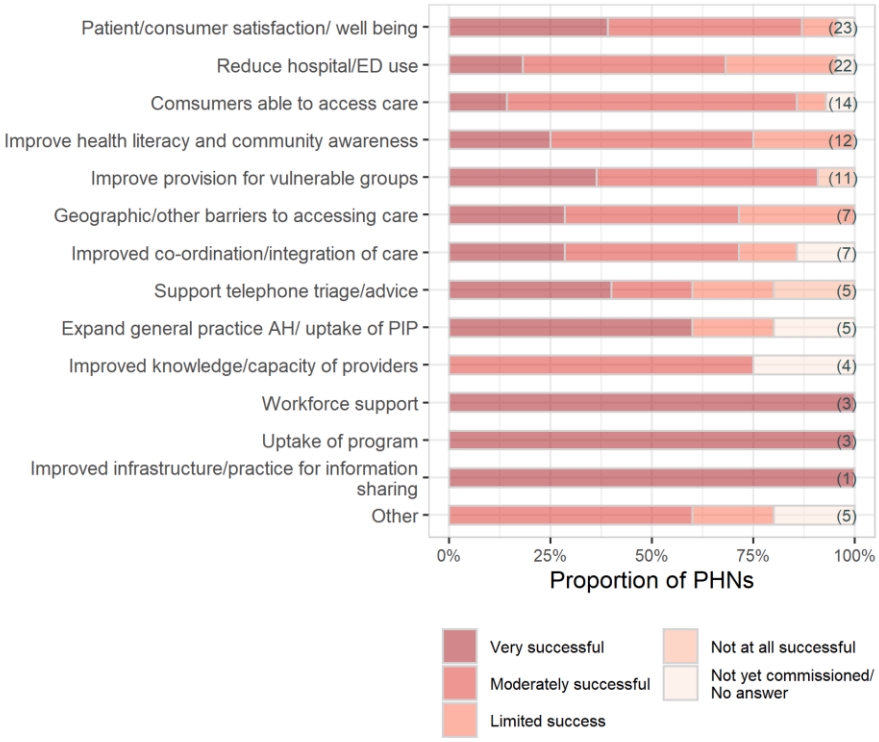


Figure 21 – PHN self-reported views on success of the program in relation to different outcomes

Note: Number of PHNs reporting against each outcome is shown alongside each bar. Percentage shown is of those PHNs

Program success factors

Finding 16: Strong relationships and multi-agency working are key ingredients to the success of the program along with good commissioning processes, appropriate service models and consumer awareness of service offerings. PHNs and commissioned providers identified continuity of staffing and the way in which the program has operated (funding cycles and approval processes) as key challenges.

The surveys sought views from PHNs and commissioned providers about the factors that facilitated success and those that had an adverse impact. The key success factors reported by both PHNs and commissioned providers are shown in Figure 22. These mainly related to the development of strong relationships and partnerships between PHNs, commissioned providers and other stakeholders, effective commissioning processes, and well-targeted solutions and commissioned services. These three factors accounted for about 60% of PHN and provider responses. Issues relating to the quality of providers was identified as a key success factor by almost a third of the PHNs.

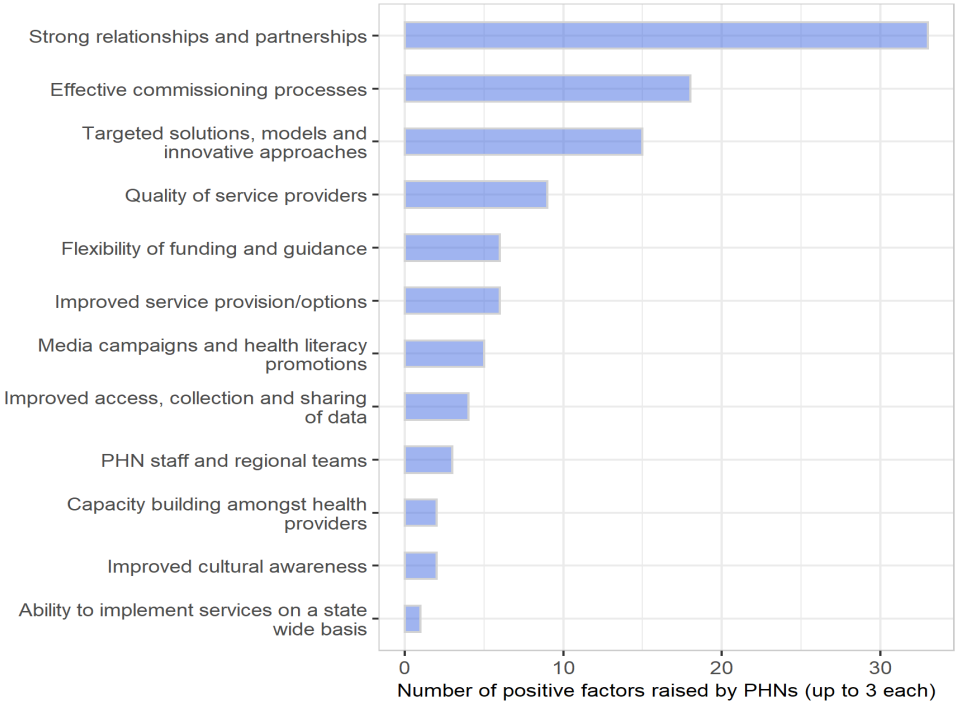


Figure 22 – Program success factors

The key factors limiting success, reported by both PHNs and commissioned providers, related to funding and staffing, with abound 20% of PHNs pointing to issues with short funding cycles and difficulties with recruitment and retention of staff. Abound one in five commissioned providers also identified a lack of awareness of the service, pointing to issues of marketing.

Adverse factors reported by PHNs are shown in Figure 23. Some national stakeholders thought the short-term nature of the PHN After Hours Program funding has hindered PHNs' ability to design and commission long-term services and affected commissioned providers' capacity to deliver sustainable, consistent and well-organised after-hours services. They point to the fact that it takes time to build consumer awareness of services. The 'stop-start' nature of these services is an issue that has been identified by the Consumers Health Forum of Australia (2020) as one that difficulties for patients. Some stakeholders say services need time to bed in and be recognised and used optimally by patients. Longer-term funding is important to allow this.

"The PHN reflected on the difficulty of achieving certain needs assessment objectives, evaluating after-hours services, co-designing and co-commissioning after-hours activities and making more strategic program changes and investments due to the short-term program funding cycles and general uncertainty around the future of the program. Due to these existing arrangements, the PHN has been more conservative in co-designing and co-commissioning services, but they would like to take a more collaborative approach in the future. Specifically, they expressed interest in co-commissioning … [Eastern Melbourne PHN Case study]

> I think my anecdotal experience of that program is that there is growth over time. It does take a long time for people to realise that this service is available and then to have the space to change their routines because they know it's going to be around for a while. [National stakeholder]

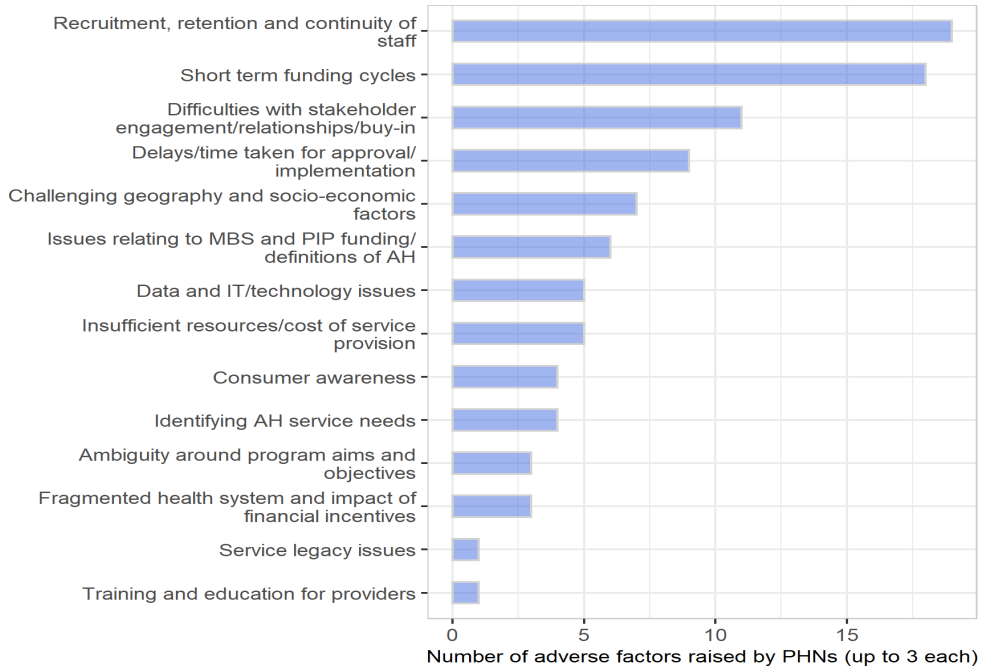


Figure 23 – Program adverse factors

Service provider perspectives on the program

Commissioned providers consider the PHNs have been successful in achieving key objectives in strengthening the availability, accessibility, effectiveness and efficiency of after-hours primary care. Providers were asked to assess how effective the activity they provide had been against four domains: effectiveness, efficiency, improving access and improving availability. For the first three of these domains, the majority of providers judged the activities to be either very or moderately effective. About 50% of providers thought that the activities had been very or moderately effective in improving availability of services (Figure 24).

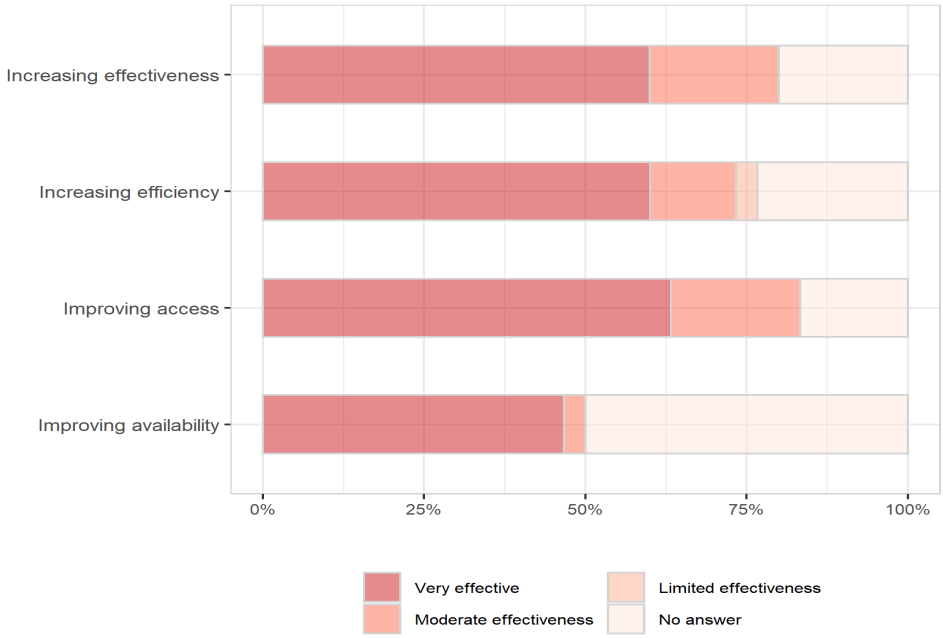


Figure 24 – Commissioned providers' assessment of PHN After Hours Program effectiveness

Commissioned services were asked what improvements could be made to the PHN After Hours Program, with providers suggesting a range of options (see Table 25), including increased and longer-term funding, greater integration, collaboration and relationship building, enabling service expansion, and strengthening advertising and community awareness of services.

Table 25 – Improvements to PHN After Hours Program suggested by commissioned services

improvement that could be made to the PHN After Hours Program in this PHN	Responses
Increased and longer-term funding	11
Allow for additional service integration, collaboration and relationship building activities	10
Enable service expansion and target broader population groups	8
Increase ability to advertise or raise community awareness of services	7
Help with recruitment and sourcing, ease recruitment restrictions on hiring after-hours GPs	3
Increase flexibility to change service models, targets and/or outcomes	3
Increase capacity to help improve IT and/or deliver telehealth services	3
Design services that recognise and meet community need and provide holistic solutions	3
Clearly identify purpose of program and what constitutes after hours	2
Improved ability to provide feedback to PHN and the Department of Health	2
Better manage patient safety and risk	1
Improved linkage with other areas within PHN	1
Continued support for after-hours pharmacy services	1
Increase access to ED services	1

The issue of advertising was also raised in the context of two of the case studies in relation to commissioning a medical deputising service (in one case a standard medical deputising service, in the other case a telehealth service provided by a medical deputising service). In both cases it was felt that consumer awareness inhibited the success of the service. There are clearly complex issues regarding advertising of these services and further consideration should be given to how to reconcile the protection of service providers with ensuring that consumers can access reliable and important service information.

Outcomes of commissioned activities

Finding 17: PHNs are measuring outputs, not outcomes, and the impact is often unknown. PHNs are hampered in analytics capability, data, lack of national standardisation and sharing of best practice.

PHNs are aware of the imperative to evaluate outcomes of commissioned services. Some have specifically contracted evaluations or reviews. For example, the Perth South PHN 50 Lives 50 Homes After Hours Support Service has been assessed as part of an evaluation of the wider program. Some PHNs are developing more sophisticated approaches to reporting, monitoring and commissioning. There are constraints in PHNs assessing outcomes given the lack of data and the ability to link after-hours access to other outcomes. Through their contracts with commissioned services, all PHNs have financial and activity reporting. Activity reporting focuses on counts of patients/consumers assisted and other characteristics. Some PHNs have trialled outcome measures – including consumer-reported outcome measures – but they are generally in their infancy.

> "… high-quality evaluation was not the norm and … it's not really publicised and shared around the health community and around the care centres … I don't think we actually know how useful the funding investment has been … a lot of the people aren't using data they have access to. I think we don't have a strong culture of sharing the outcomes of each PHN program amongst the entire PHN cohort or publishing the outcomes of programs." [National stakeholder]

Figure 25 shows the types of output measures being used by PHNs. In their responses, PHNs could list up to three output measures for each of the 144 activities. Activities that had not yet been commissioned were excluded, as were those activities without a specific service element.

The most frequently listed output measures relate to service contacts or patient presentations. Some PHNs had measures of website use that relate to consumer awareness and patient information initiatives, while others were focused on workforce-related activities and counted participation in programs or activities to measure outputs.

Although PHNs listed outcome measures for commissioned activities as shown in Figure 26, very few of the PHNs included any specific measures, although some were clearly actively pursuing outcome measurement. Patient experience measures were commonly listed as outcome measures to be used to assess commissioned activities. Reduced hospital and ED use was the second most commonly referenced outcome measure. Interestingly, workforce or service provider perspectives were included for a small number of activities.

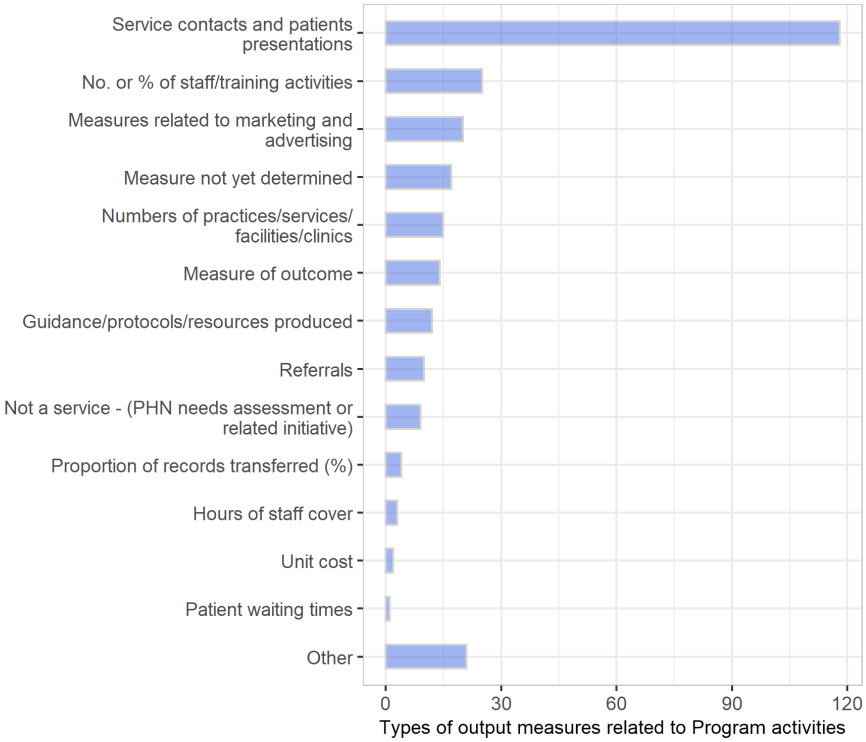


Figure 25 – Output measures being used by PHNs for commissioned activities

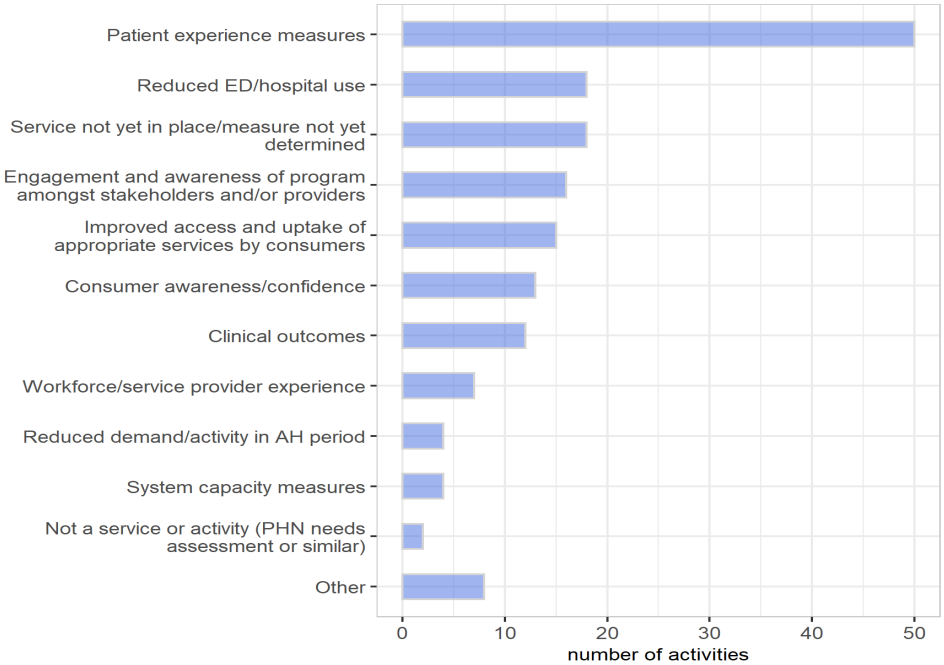


Figure 26 – Outcome measures being used by PHNs for commissioned activities

Qualitative measures are being used by many PHNs. These include monitoring GP satisfaction with after-hours programs, periodic surveys of consumers asking where they would have gone had the service not been available (particularly if to an ED) and one-off evaluations of ED diversion programs undertaken in conjunction with local hospital networks (e.g. avoiding ED attendances for residents of aged care facilities).

Finding 18: PHNs and stakeholders broadly regard the commissioned activities as successful.

Success factors

PHNs were asked to rate the success of the services they commissioned. There is a strong overlap with the issues identified in relation to the program as a whole, which were raised in the interviews with PHNs. Of the responses provided, about one-quarter indicated the service was too new to judge whether it was a success or not. Of the services that were rated, more than 60% were either rated very successful (13%) or moderately successful (51%) by the PHNs (see Table 26). Note that in the case of 35 activities no answer was provided. There were no observable differences between the PHN groups. Where an answer was provided for a service, only 4 activities (of 74) were identified as of limited or no success. The activities with limited to no success described issues with the mode of program care delivery, objectives and engaging local stakeholders.

"Several stakeholders stated that collegiality is an integral part of the GP Access model. Due to the medical workforce shortage in the region, there is limited competition amongst GPs and they are often overstretched; therefore, GPs were able to work together to fill the gap that existed in after-hours care. Another important component of the program is the local knowledge and presence of the GP Access team. All of the GPs and nurses that work for GP Access also work in community EDs, health organisations and general practices throughout the Hunter region. They understood residents' way of life and have knowledge of existing services that were accessible to these patients." [HNECC Case study]

The commissioned service providers were also asked to rate the success of the services, in terms of improving availability, improving access, increasing efficiency and increasing effectiveness. The commissioned services rated the success of the services highly, with almost all responses rating the services they provide as moderately (20%) or highly effective (80%) across all objectives.

Table 26 – PHN assessment of success of activities, by PHN group

Grouping	New Service	Very successful	Moderately successful	Limited success	Not successful	No answer	Total
Major cities	16	3	27	1	1	20	68
Major cities/Inner regional	5	4	7	0	0	3	19
Inner and outer regional	10	7	8	0	2	8	35
Outer regional/remote	4	0	14	0	0	4	22
Total	35	14	56	1	3	35	144
%	24%	10%	39%	1%	2%	24%	100%
% where service commissioned		13%	51%	1%	3%	32%	100%

PHNs were asked to rate the success of their activities in relation to the outcome measures they listed for the commissioned activities. These are shown in Figure 27. Most of the activities were deemed to be moderately successful in relation to the outcome measures identified. Where clinical outcomes were used, a higher proportion of PHNs judged these to be very successful. Activities with an intended outcome that involved developing system capacity were judged to be less successful as were those related to consumer awareness/confidence.

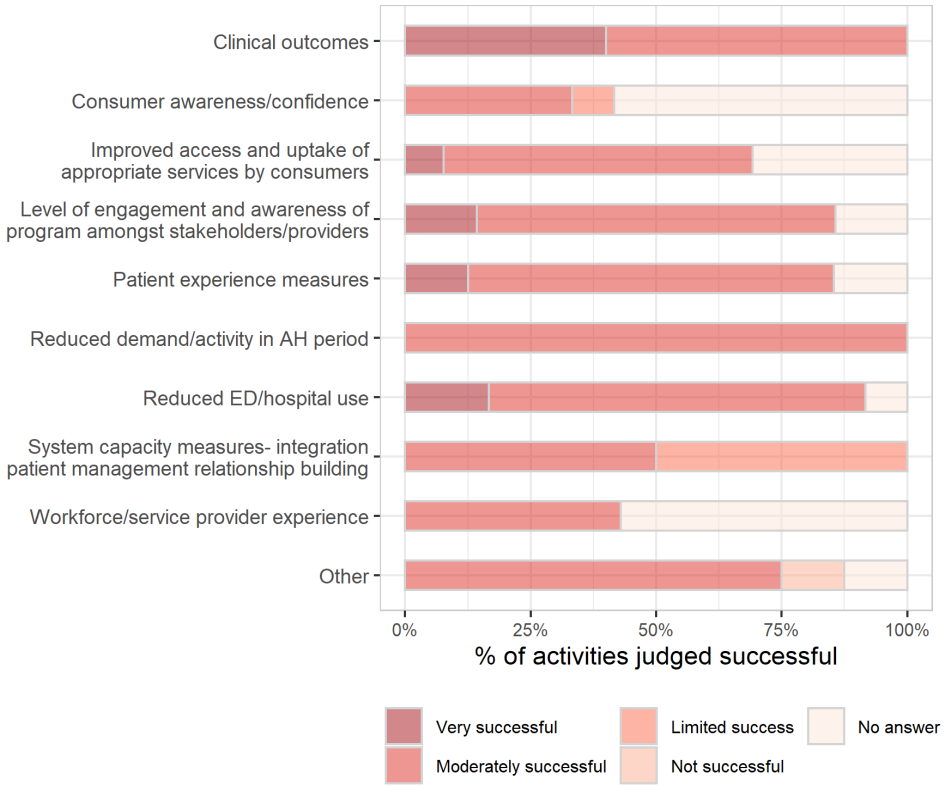


Figure 27 – PHN view of success of activities in relation to outcome measures

Adverse factors

When asked about factors that adversely affected success, the responses amplified answers to the questions on the program as a whole, citing issues with funding, staffing, marketing and engaging with stakeholders. PHNs were asked to list the factors that contributed to the success of the activities commissioned and those that had an adverse impact on the success of the commissioned activities. The success factors are shown in Figure 28 and the adverse factors in Figure 29. The factor mentioned most frequently was effective education, professional development and training, followed by strong relationships and partnerships.

The key factors adversely impacting on success (Figure 29) reported by both PHNs and commissioned providers related to funding and staffing, with around 20% of PHNs pointing to issues with short funding cycles and difficulties with recruitment and retention of staff. One in five of the commissioned provider responses also identified a lack of awareness of the service, pointing to issues of promotion, marketing and advertising. It is noteworthy that there were significantly fewer factors mentioned as adverse factors than as success factors.

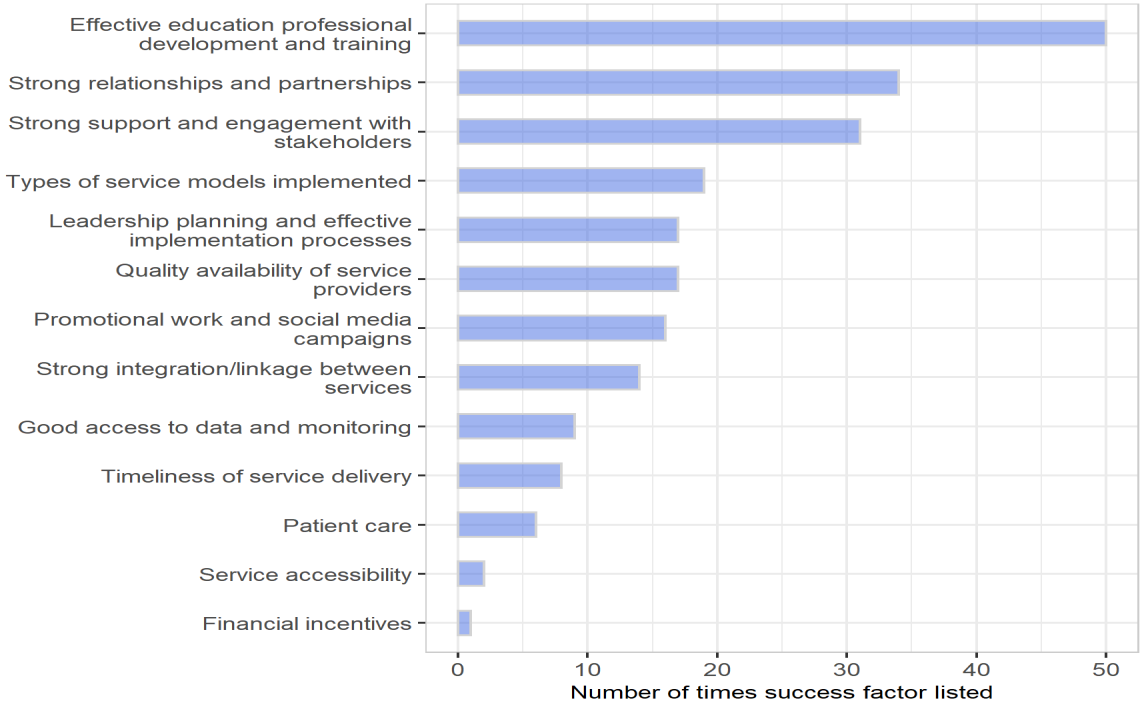


Figure 28 – PHN views of factors that contributed to success of commissioned activities

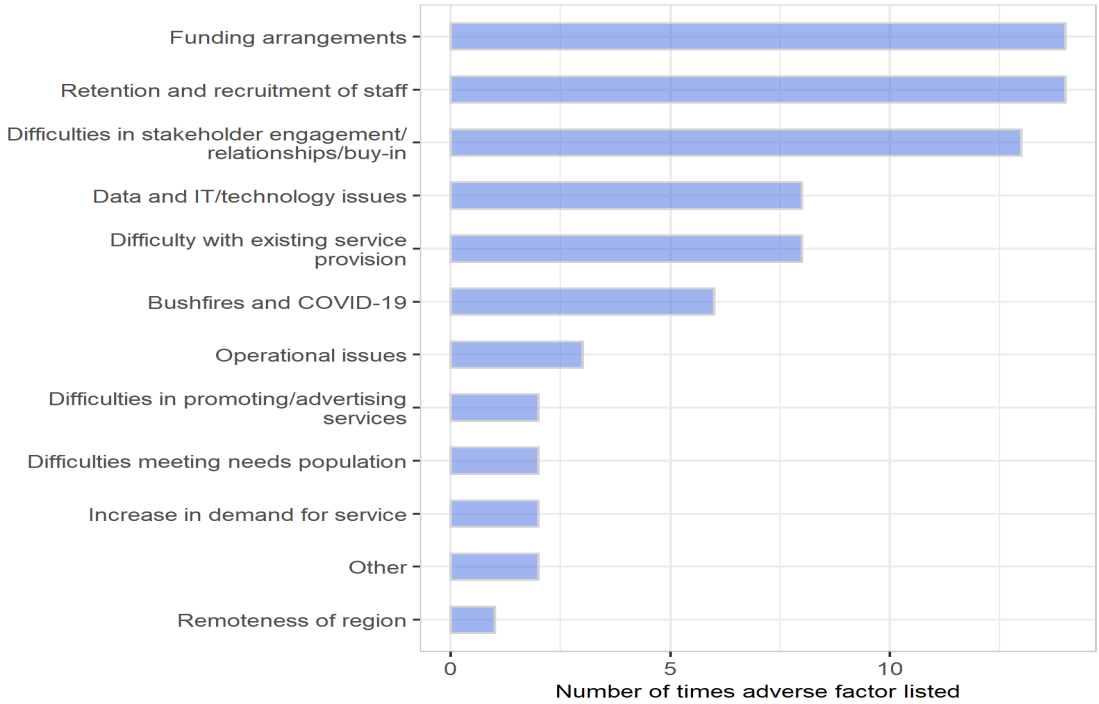


Figure 29 – PHN views of factors that adversely contributed to success of commissioned activities

Other adverse issues identified by the PHNs included bushfires, the COVID-19 pandemic and other operational issues.

Finding 19: PHNs need access to timely and disaggregated data to assess the effects of the program. Some standardised measures of output and outcome would allow a better assessment of relative performance of PHNs and of the whole program.

All PHNs raised the difficulties in having access to relevant and timely data on after-hours demand, services availability, utilisation, outcomes and consumer out-of-pocket costs. In addition to access to general practice data and ED data, PHNs raised the need to have access to telephone triage and telehealth services and MBS item number utilisation at sub-regional levels (SA2) and ambulance data. The need for linkage of these data sources to obtain an accurate picture of program effects was also raised.

Some PHNs argued for the need to create a minimum data set of patients/consumers assisted by commissioned services, similar to that developed for the PHN mental health programs.

The capacity of PHNs internally to analyse available data varied significantly. This was not just an issue for smaller PHNs. Resourcing requires a complex set of analytical, statistical and reporting skills and supporting software. The development of the National Data Storage and Analytics Solution for PHNs to be hosted by the WA Primary Health Alliance will be a major step forward.

> "I also think that there's an opportunity for PHNs to possibly share their after-hours discussions with each other a little bit more effectively … PHNs tend to operate very much in silos." [National stakeholder]

One issue that stands out is the relative lack of sharing lessons learned and resources across the Australian PHN network. National stakeholders reflected that there is also a general lack of clarity on the outcomes being delivered through the PHN After Hours Program. While there are many ongoing external issues that have affected the after-hours landscape, such as workforce issues, some stakeholders feel there is not enough sharing of outcomes. There is limited transparency among these bodies, which has made it difficult to measure the overall success of the PHN After Hours Program. Many PHNs said they would welcome more opportunities to share experience and best practice. Central assistance to facilitate this would be an effective way to support those opportunities.

Impact on ED presentations and hospitalisations

Finding 20: MBS-supported after-hours services led to a moderate reduction in rates of low urgency after-hours ED presentations. These effects are moderated by the level of rurality and socio-economic characteristics of a region.

The introduction of new activities under the PHN After Hours Program was associated with a small decrease in the level of low urgency after-hours ED presentations. However, there is little evidence of an effect on potentially preventable hospitalisations.

An objective of the PHN After Hours program and after-hours primary care more generally is to reduce unnecessary ED presentations and hospitalisations. This section summarises the results of the analysis presented in Volume 4, Appendix 8, which examines the relationship between services supported under the program and measures of ED use and hospitalisation. The three measures examined are:

- low urgency after-hours ED presentations
- acute potentially preventable hospitalisations
- chronic potentially preventable hospitalisations.

These measures are part of indicators P7 and P12 of the PHN Program Performance and Quality Framework (Department of Health, 2019a) and are also used as broader health system performance measures.

There are strong cross-sectional relationships between geographic remoteness and the level of low urgency after hours ED (see Figure 13 and Volume 4: Figure 16) presentation and potentially preventable hospitalisations. In most instances, rates are highest for populations living in outer regional and remote areas of Australia. They are lower for inner regional areas and lowest in major cities. Within major cities, gradients can be observed related to socio-economic status (SES) variation, with highest rates generally in more disadvantaged areas.

In contrast, the supply of MBS-supported after-hours services tends to be highest in major cities and declines with remoteness. However, within major cities, rates for MBS-supported after-hours services tends to be higher in areas in more disadvantaged areas (see Figure 13 and Volume 4: Figure 10, Figure 11, Figure 17).

These patterns reflect a complex interaction of the supply of services (generally MBS-supported after-hours services are less available in regional and remote Australia as is MBS-supported primary care) and relative need, which are impacted by both socio-economic factors and remoteness. The following charts describe the observed relationship between the rate of use of MBS-supported after-hours services and low urgency after-hours ED presentations, first at the PHN level (Figure 30), then at the SA3 level (Figure 31). Within the plots the observed rates for a particular PHN/SA3 for each financial year between 2015-16 and 2018-19 are linked into a line, with 2018-19 represented as a point, which provides a sense of the direction in which rates are moving over time. Figure 30 suggests an overall negative relationship between MBS-supported after-hours services and the ED presentation rates at the PHN level, which is also supported by the analysis at the SA3 level. Analysis at the SA3 level is more complex (Figure 30), but broadly aligns with the overall relationship at the PHN level. However, the plots suggests considerable variation between SA3s within major cities, which is associated with SES groupings. SA3 assigned to the lower SES groups tend to have higher rates for both measures. There is also considerable variation between SA3 located outside major cities. Rates of MBS-supported after-hours services are mostly lower, however there is a wide range in the ED presentation rates, potentially impacted by missing data for some rural localities. Also note that data at the SA3 level on the ED measures was not reported by the AIHW for many remote localities.

These relationships were explored in statistical models, with key results presented in Table 27. The key results are:

- There is a negative relationship between the two rates suggesting that higher rates of MBS-supported after-hours services generally lead to a reduction in rates of low urgency after-hours ED presentations. However, this effect is moderate.
- There are additional contributions to the levels of rates of low urgency after-hours ED presentations related to rurality and socio-economic characteristics of SA3. Because of limitations in available data, effects for outer regional SA3 are likely to be under-estimated and estimates for remote SA3 were not possible. Otherwise, compared with SA3s in major cities assigned to the higher SES group, SA3s assigned to the inner

regional group have rates that are around 50% higher, SA3s assigned to the major cities/lower SES group have rates that are 40% higher and SA3 assigned to the major cities/median SES group have rates that are 10% higher.

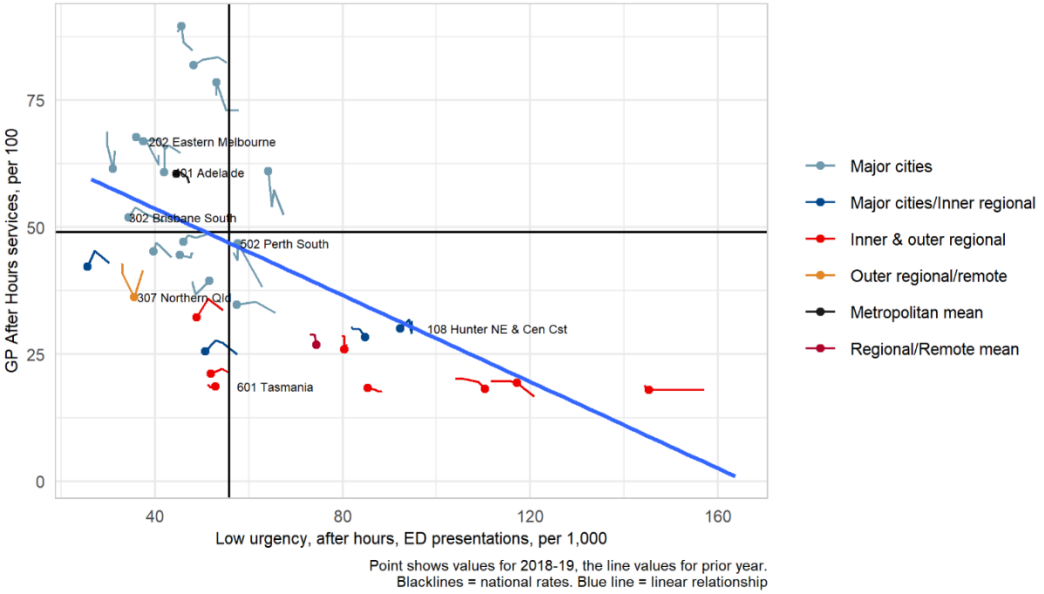


Figure 30 – Relationship between rates of MBS-supported GP after-hours services and low urgent after-hours ED presentations, by PHN: 2015-16 to 2018-19

Source: Australian Institute of Health and Welfare, 2020b; Australian Institute of Health and Welfare, 2020e; PHNs assigned to groups as described in Volume 4, Table 18.

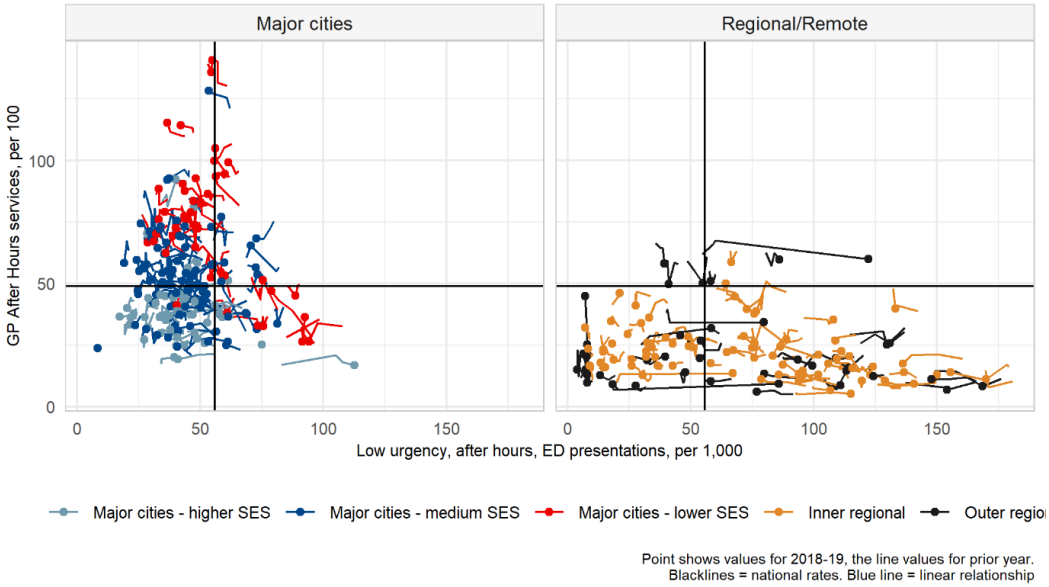


Figure 31 – Relationship between rates of MBS-supported GP after-hours services and low urgent after-hours ED presentations by SA3 level: 2015-16 to 2018-19

Table 27 – Key results of statistical models of relationship at SA3 level between rates of MBS-supported GP after-hours services and low urgent after-hours ED presentations: 2015-16 to 2018-19

Parameter	Coefficient estimate (LCL,UCL)		Relativity	
	Linear model	Random effects linear model	Linear model	Random effects linear model
Intercept	54.37	50.68		
MBS services (per 100 people)	-0.30 (-0.40,-0.20)	-0.17 (-0.28,-0.07)		
Major cities – higher SES	Referent		1.00	1.00
Major cities – medium SES	7.14 (1.66,12.63)	4.61 (-5.90,15.12)	1.13	1.09
Major cities – lower SES	23.66 (16.69,30.62)	18.82 (6.35,31.28)	1.44	1.37
Inner regional	22.98 (17.26,28.71)	24.09 (13.25,34.93)	1.42	1.48
Outer regional	13.72 (7.22,20.22)	14.84 (2.39,27.29)	1.25	1.29

Source: See Volume 4 Appendix 8.

Models were also estimated to examine the impact of introducing new activities under the program. The results of these analyses suggested that:

- There is some evidence that introduction of new activities under the program was associated with a small decrease in the level of low urgency after-hours ED presentations. The evidence is strongest for activities commencing in 2016-17, which were associated with a 4.5% decline in the ED rate in subsequent periods. Initiatives introduced in later financial years were not associated with a decline in the ED rate.
- Overall, the evidence on the effect of introduction of activities under the program and rates for acute and chronic potentially preventable hospitalisations is inconsistent, suggesting there is little evidence of a relationship between the program and potentially preventable hospitalisations.

Efficiency and cost

Finding 21: Estimates of the costs of services funded under the program are highly variable. The costs are difficult to compare given the wide variety of activities and the absence of standardisation or clear measures of outputs. However, the estimates of costs and output suggest they are broadly consistent with other mainstream services operating after hours.

Overall costs of after-hours provision

One of the questions for the evaluation is how well PHNs have used the program funding and whether the program is delivering value for money. Assessing value for money and efficiency involves an examination of the value of the outputs and outcomes of the program. It also requires comparison with alternative ways of delivering after-hours care. We have some limited evidence of the outcomes of some of the activities commissioned as part of the program. Other evidence will come from assessing the impact of the program through statistical analysis of MBS and hospital data, which will be included in the final report.

One important consideration in assessing efficiency and value for money is that the PHN After Hours Program is primarily concerned with filling gaps in existing provision. These gaps or market failures occur for a range of reasons:

- It is **uneconomic for service providers to deliver services** to particular groups or in particular locations. This means that the cost of delivering these services is higher than the level of remuneration available.
- The market may respond to deliver care, but the consequence is that out-of-pocket costs are such that **consumers are unable or unwilling** to pay the price required.
- There are some services that are difficult to leave to the market because they are **public goods,** such as information and activities that are designed to raise levels of health literacy. Coordination and system-level activities would also fit into this category where they generally need to be provided by public sector bodies.

The cost of providing services where they do not currently exist may not be comparable with the current costs of existing services for the reasons outlined above. It is likely to be more costly to deliver an after-hours home visit to a patient in a small regional town if there is insufficient volume of call outs to justify lengthy travel costs.

Unit costs of after-hours provision

Comparisons of unit costs of provision are complex, especially after-hours provision where the nature of the service and what is included is variable. Rather than unit costs for different services delivered, it is more meaningful to look at the cost of after-hours pathways so they can be compared on a like-for-like basis. An ED visit may appear relatively high cost, but the costs will likely include pharmacy and diagnostics and there will be no out-of-pocket expenses for patients. An after-hours GP visit is likely to result in a prescription and some follow-up diagnostic investigations before an issue is resolved or treated. A patient who begins the pathway with a call to Healthdirect may incur higher costs overall once any subsequent costs are considered. Different pathways will have different costs and will be appropriate for different presenting conditions and situations. Pathways are built up from these different services, so they are not alternatives but additive elements of a pathway. To determine the most cost-effective pathways requires a detailed analysis including assessing whether there were alternatives at different decision points. Pathways are dictated by clinical decisions, but also by how patients respond and react to the advice given. Patient choice is a key component of the Australian health care system and patients will exercise that choice in different ways. These will have implications for the costs imposed on the system.

A report conducted for the National Association of Medical Deputising Services compared the costs of different patient pathways (Deloitte, 2016). The report suggests that the lowest-cost pathways are those that use extended and after-hours only clinics ($93). After-hours home and residential aged care visits are also relatively low cost compared to ED ($128), Healthdirect ($256) or an ambulance and ED pathway ($1,351). The cost of Healthdirect is shown as high cost due to the likelihood of most patients requiring further services following a triage call. The cost of the call on its own was estimated at $45 for the nurse triage service.

This analysis is helpful in exploring pathway costs. In comparing the costs of the PHN Program, it would be important to build in consideration of how these interventions influence the probability of patients accessing a further service and the point at which their health care issue is resolved. Table 7 in Chapter 2 presents average costs for various elements of after-hours care provision. The following costs should be viewed in this context.

Program costs

As noted earlier in the report, the nature of the activities funded under the PHN After Hours Program are diverse. They include services that deliver care directly to patients, but they also include activities that are focused on supporting health care providers to deliver services differently or to support their capacity and capability. Comparison is difficult when looking across the range of services, which include, for example, face-to-face support and health care interventions for homeless people, or one that delivers medicines to patients with palliative care needs, or a telephone helpline for teenagers and young people with mental health needs.

For some of the services the amount of funding from the PHN is expected to cover the overall costs of the service. For other services, the funding may effectively be a subsidy, which levers in additional funding from mainstream after-hours sources (such as MBS or PIP funding). The cost of the service to the PHN may appear to be low compared with Commonwealth Government-funded services.

The PHN survey included information about the outputs from the service which, in theory, could allow some estimate of unit cost. In practice, these output measures are highly variable and not readily amenable to comparison because of the differences in measure and the differences in the nature of the services being delivered.

Rather than trying to compare across the program, it may be possible to compare within groups of services where the service model is more similar. Comparison is still inherently complex given the caveats noted above (mainly that the services may be very different in whether they are funding the entirety of a service or just one element). The costs of services may not always be clear if there is a variety of services included within one activity.

The costs shown below are for a sub-set of activities where there were output measures included in the survey that could be used to translate into a unit cost.

Cost of PHN-commissioned services

The overall funding for the PHN After Hours Program is $71 million. This funded 144 activities in 2019–20. As described above, the activities commissioned under the program are varied, combining a mix of direct care services and activities that focus on development work across the health system, such as information infrastructure or workforce capability initiatives. The proportions of expenditure on these activities is presented above. However, this gives little indication about the cost of the activities and any measure of the services being delivered. Given the diversity of activities, it is not easy to compare in a meaningful way. However, we have used information provided from the PHN survey and information about expenditure from the Activity Work Plans to gauge an indication of the activities and their costs.

Not all the PHNs provided information about the outputs of the activities. Of the 144 activities, 35 had not yet been commissioned or did not have associated output measures at the time the PHN was responding to the survey. Of the remaining activities, there were 54 that were direct patient services with output measures that included one of the following:

- numbers of users
- numbers of contacts

- referrals
- number of clinics
- number of episodes
- number of calls

Of these, further analysis was conducted on 54 activities where the survey response included measures of users, contacts or calls (Table 28 summarises). These activities cover almost $36 million of budgeted expenditure on the program. For measures of activity, the survey requested data on the most recent period. An annual figure was used if provided. Where that was not the case, the figures were scaled to provide an annual figure. Where case study sites provided activity data, this information was used rather than that provided in the survey.

These services were grouped to identify the type of service model with a view to being able to compare and group activities that were more similar in nature or were being targeted at a specific client group. The service models identified were:

- face-face GP or urgent-care services
- telehealth
- telephone triage services (not GP service, which is included in telehealth category)
- services designed to support residential aged care facilities
- services designed to support homeless
- services for people with mental health needs
- other services, including services supporting frequent ED users, those with chronic conditions or other vulnerable groups.

Some program activities include a bundle of interventions or services but with a single figure that represents the budgeted expenditure. In these cases assumptions were made to break down the budget between activities. This, combined with the various ways of capturing activity and the time period they cover, means that the figures presented are indicative only, as a detailed costing exercise would be necessary to validate the figures. Other issues are:

- Some services are multi-stage, and may include an initial call and then follow-up. The detail to apportion costs to each stage was not always available.

- The costs of many services (especially services that are supporting mainstream GP or deputising services) are subsidising but not covering the entire cost of the service event. The PHN may be paying for an element that facilitates delivery of a mainstream MBS service. This explains why some unit costs look low.

Some services have improbably large average costs. It is likely that these services are funding other activities not reflected in the outputs. Examples are the North Western Melbourne and Western Sydney PHNs services for aged care. One of these activities has a quality improvement aspect, which may be more focused on capability and capacity building in this sector. The Western Sydney activity appears to be part of a wider multi-agency program.

Services that seem to be supporting more mainstream GP services tend to have a lower unit cost than the others. It is highly likely that some of these services are covering only the partial costs of the service and the activities are likely to be leveraging additional MBS and other funding steams. The face-to-face contacts will include a mix of GPs and nurse-led services. The telehealth services may include some other follow-up care where the issue is not resolved over the phone or by video. These costs also do not reflect the entire patient pathway.

Patients may require subsequent follow-up with a medical deputising service, a GP after-hours contact, Healthdirect or ED attendance. The costs therefore need to be viewed as indicative rather than definitive.

Table 28 – Summary of estimates of units of output and unit costs for selected activities

Outputs	Number of services	Estimated annual volume*	Estimated average cost	Estimated total cost
Face-to-face service contacts	17	208,860	$59	$12,334,355
Telehealth	8	78,197	$75	$5,842,812
Telephone triage	1	74,069	$38	$2,289,016
Residential care facilities	7	16,831	$209	$3,517,856
Homeless services	6	21,812	$176	$3,837,385
Mental health	11	19,280	$367	$7,070,835
Other services	4	10,024	$92	$925,867
Overall	**54**	**429,073**	**$85**	**$36,318,126**

*Notes: * It is important to note that these activities mix patients, contacts, occasions of service. The volume can be thought of as a unit of service delivered.*

The estimated average cost for mental health services looks implausibly large. This group of services is very diverse with a wide range of unit costs ($34 to $4,262). The activity figures for some of the services appear to be quite low, which results in a high average cost. Given this, these figures should be interpreted with caution.

As is noted in the Table, the volumes mix measures of output that are not necessarily equivalent. The volume of activity shown gives an indication of the number of units of activity delivered by the program. They include patients, contacts, calls, and consultations. The variation in unit costs reflects these differences in cost. However, within the groupings there is a greater degree of homogeneity in the ways in which services are measured and so are more comparable within groups than across groups.

While these volumes and costs are indicative only, they provide plausible estimates of the costs of services and the volumes of interactions and units of service that are being delivered within the PHN After Hours Program (with the possible exception of the mental health services). The overall number of units of output of just under 430,000 compares favourably with other after-hours services. It would not be reasonable to scale up this activity to the full cost of the program as the other activities being funded are less amenable to being assessed in this way. For example, activities that relate to consumer awareness or health literacy are being assessed in relation to visibility and exposure to consumers. It is difficult to assess the effectiveness of these in bringing about behaviour changes or health outcomes.

This analysis cannot give us a definitive view of whether the PHN After Hours Program is delivering value for money without being able to assess the outcomes of the activities. However, the broad indication of the level of service delivery and relative costs suggest that the program is delivering what might reasonably be expected given the groups that are being targeted and the nature of the services being delivered.

Sufficiency of funding

As indicated above, the amount of funding within the PHN After Hours Program is relatively small against the overall level of provision. Opinions diverge on whether the level of program funding is sufficient to meet needs. Some PHNs said constraints on what the funding can be

used for, the limited duration of funding and the late notification means they had difficulty spending the money. Other PHNs thought that they could fund other worthwhile projects if they had additional resources.

There is a relatively high level of underspend apparent from the 12-month performance reports. In the 2018-19 financial year, 21% of expenditure was reported as unspent and carried forward to the following year. PHNs were asked to report the reason for any underspends. Of the 26 PHNs with underspends, eight did not explain the reason for the underspend. Of those that gave a reason, the most common was delays associated with approvals (Departmental, internal processes and governance or stakeholder management issues). Four of the PHNs reported that the delays were related to low service uptake and the service being decommissioned. Two of the PHNs covering remote areas commented that workforce issues were a challenge and had delayed the roll out of activities because of staffing issues. This may also reflect one of the other issues raised by PHNs, which is that it takes time to design and commission a new service, especially if it involves a procurement process rather than going to an existing provider. A service intended to be in place for a specific year may not come to fruition until mid-way through the financial year or later.

PHNs more likely to have underspends appeared to be those in the major cities and outer regional/remote areas. There was no consistent pattern reflecting the reason for the delays other than PHNs in outer regional and remote areas reporting workforce or recruitment issues.

For some PHNs, the relatively small amount of funding relative to their overall budget represents a disproportionate burden in planning, commissioning and monitoring. There are overheads associated with these activities that likely do not diminish significantly with smaller amounts of funding. This may explain why some PHNs felt the program was of limited value.

It may also explain why some PHNs carried over some of the programs and activities from the Medicare Locals, at least for the first year or two. Where a PHN was formed out of the consolidation of more than one Medicare Local, the transitional process was more disruptive, and time was required to establish relationships and a whole-of-PHN approach. From our consultations and our review of the Activity Work Plans, it is evident that some PHNs commenced funding small-scale local projects and programs and are now looking to establish fewer but larger, PHN-wide programs. These changes may have positive implications for service efficiency and costs. Implementing these changes takes time and forward planning for services to be ready to implement when the funding comes on stream.

Sustainability

Finding 22: PHNs are concerned about the long-term sustainability of activities because of the impacts on local service providers and on vital local services.

Some PHNs said if the PHN After Hours Program were to cease they would need to find other ways to support specific services. Some of these services have become intrinsic and vital parts of local service delivery.

PHNs covering rural and remote Australia point to the fragility of some of the services and their dependence often on individuals to run a service. There are examples of services ceasing when an individual leaves. Planning services in this context is a risk.

Country WA PHN, which is part of the WA Primary Health Alliance, along with the Perth North and South PHNs, discussed workforce and recruitment challenges the catchment has faced and expressed concerns about sustainability of after-hours activities. In certain instances, the PHN has had to decommission services due to the inability to retain clinical workforce. For example, the PHN commissioned an after-hours activity that targeted domestic violence and included Aboriginal medical services and pharmacy services, but the activity lasted only 12 months as the funding required was too great for the program to achieve long-term sustainability, and the service could not replace the key staff members. The PHN stated that if the after-hours funding ceased, they would continue to fund some after-hours activities, but it would be 'to the detriment of other services'.

> "Some persons interviewed felt that PHN was 'GP-centric' and primarily focused on GP Assist and existing after-hours general practice providers, making it difficult for alternative service providers to access the market." [Tasmania Case study]

The Perth South PHN echoed this sentiment and noted wide variation in the availability of GPs and the healthcare workforce in certain areas. A key difference that existed when commissioning after-hours services between the metro and country areas was that the metro areas did not have a 'thin market' with limited GP after-hours services. Due to these concerns around service sustainability, short-term funding cycles and general uncertainty of prolonged PHN After Hours Program funding, the WA Primary Health Alliance has tested services in certain instances and worked to enhance initiatives in other programs or stretch their capacity to provide after-hours care. After piloting certain activities, they have been able to move certain models across into other funding programs. In other instances, when the Perth South PHN has chosen to implement larger projects and a higher degree of after-hours funding towards a service, such as the 50 Homes 50 Lives Program, a consortium approach has provided additional funding security.

Some rural and remote PHNs said it is sometimes difficult to identify service providers who are capable of delivering appropriate services. In many non-metropolitan areas, GPs have no interest in extending their hours and finding alternatives is challenging. When options are limited it can be difficult to commission effectively. The PHNs operating in the more remote areas are clearly working towards building capability. Western Queensland PHN discussed the fragility of the existing market and that service linkage is integral to the successful development of new services in the region. Therefore, the PHN has is focusing on establishing a comprehensive model that encompasses after-hours care.

Case study: Northern Queensland PHN

Case study focus

The Northern Queensland (NQ) PHN case study was geographically based, focussing on the Tablelands and Bowen.

Locality overview

NQ is one of the larger PHNs covering about half a million square km and a population of 668,147. About 70% of the population is concentrated in the regional centres of Cairns, Townsville and Mackay. Atherton and Mareeba are located 30 km apart on the plateau of the Atherton Tablelands, which forms the Great Dividing Range about 100 km inland of Cairns. Atherton has a population of 10,708 but serves a wider population of around 40,000. Mareeba is at the northern end of the Tablelands and has a population of 11,079. Bowen is a seaside town, north of Mackay and close to the Whitsunday islands. The area surrounding Bowen is agricultural. It has a population of 9,105.

The needs assessment highlighted the relatively poor access to after-hours primary care across the entire PHN. There was no access to after-hours services in 11 of the 35 population health areas within the PHN area and only 4 had general practices that were open seven days a week after hours.

PHN approach

NQ PHN would like to move to a more integrated approach to funding. The PHN reported that the siloed nature of the after-hours funding has made longer-term integrated investment in local health services more difficult. In 2018–19, the PHN decided that the funded after-hours services were not well targeted and decided to 'pause' funding and conduct a review. The PHN said they been working towards increased stakeholder collaboration and engagement across the board, and reflected that, though they have strong partnerships with some Hospitals and Health Services (HHSs) in the region, developing and maintaining relationships with the four diverse HHSs across the catchment has been a challenge.

The PHN funded two activities that operate within the Tablelands and Bowen regions. The Telehealth Doctor NQ activity, which was operated by House Call Doctor, sought to increase access to after-hours services throughout the entire PHN catchment with a specific focus on patients that live in rural, regional and remote areas, such as Mareeba and Tablelands. They also focus on regions that have GP workforce shortages. The PHN also supports the Mulungu Service Corporation, an Aboriginal community-controlled organisation located in Mareeba. The PHN funding helped support increased access to health services for Aboriginal and Torres Strait Islander people, primary care workforce training, enhanced coordination of GP and allied health services, and community awareness of these services to prevent potentially avoidable ED attendances.

Key observations

- There is **complexity in filling gaps in after-hours access, especially when these exist at a micro level.** Where some limited mainstream after-hours services are available in a locality, it can be difficult to commission a service that works around existing provision and is effectively targeted.
- Stakeholders queried whether it made more sense to **rely on the ED** when patient volume and demand for after-hours services were low.
- **Systemic workforce and recruitment issues** exist throughout the region, especially in rural and remote areas. This, coupled with a reluctance of local GPs and other health professionals to work after hours, makes it difficult to improve after-hours access.
- Stakeholders asked for increased engagement and collaboration from the PHN, especially regarding the design of services that consider and acknowledge **existing arrangements**.
- **Access problems are not limited to after hours, patients also face significant barriers to in-hours care**. Many practices were no longer accepting new patients, which results in limited or no access to a regular GP in certain areas. There is also a lack of bulk-billing services in the PHN.
- **The complexities of the MBS system, and the financial incentives that a fee-for-service reimbursement model creates, make it difficult for the NQ PHN to subsidise and promote deputising or other services** without running the risk of being seen to undermine competition or the livelihood of other providers.

8. Appropriateness

This chapter describes what the evaluation has found about how PHNs have approached implementation and provides an assessment of the following evaluation key questions:

PHN After Hours Program evaluation key questions 9 and 11

9. To what extent is the funding allocated to each PHN proportionate to their after-hours primary health care needs?

11. To what extent were PHN models appropriate to consumers and service providers?

Funding allocations

Finding 23: PHNs in most need are allocated proportionately greater funding. Selected components of the formula used by the Department to allocate funding could be recalibrated, specifically related to age and MMM categories.

The Department should consider a threshold level of funding below which program funding and associated processes are managed under PHN Core Funding. PHNs to which arrangement apply would retain their responsibilities within the after-hour sphere but have greater flexibility in the use of funds.

Two PHNs receive additional allocations related to specific after-hours services that have a long history of support. We suggest that over five years, the Department transition allocations for these PHNs to the level indicated by the funding formula. The transition period should provide sufficient time for the PHNs to plan for change and determine the priority these services have within their allocations, and time for the services to secure alternative sources of support.

Funding and approval cycles and whether the current allocations represent a fair allocation depends on considering several factors, such as:

(a) For each locality across Australia, what is the difference in the level of after-hours services supported in MBS (and potentially PIP, Healthdirect, and payments to visiting medical officers by rural and regional health services), compared with a 'benchmark' level of provision, for example reflecting potentially the levels that are observed in inner-metropolitan areas?
(b) Are there other population characteristics that affect the potential demand for after-hours services that should be considered?
(c) How does the cost of delivering after-hours services vary by geography?
(d) Given a set of resources available, what allocation across PHNs would yield a similar level of capacity to deliver an equivalent level of services?

The current allocation formula includes relative weights for four characteristics of the populations of PHNs as shown previously in Table 9. The formula was implemented from 2019-20 but modified to include a limit on the funding reduction (a maximum reduction of $31,000) and a limit of the level of increase any one PHN would receive (a maximum increase of $400,000). Two PHNs receive funding over and above the amounts implied by the formula:

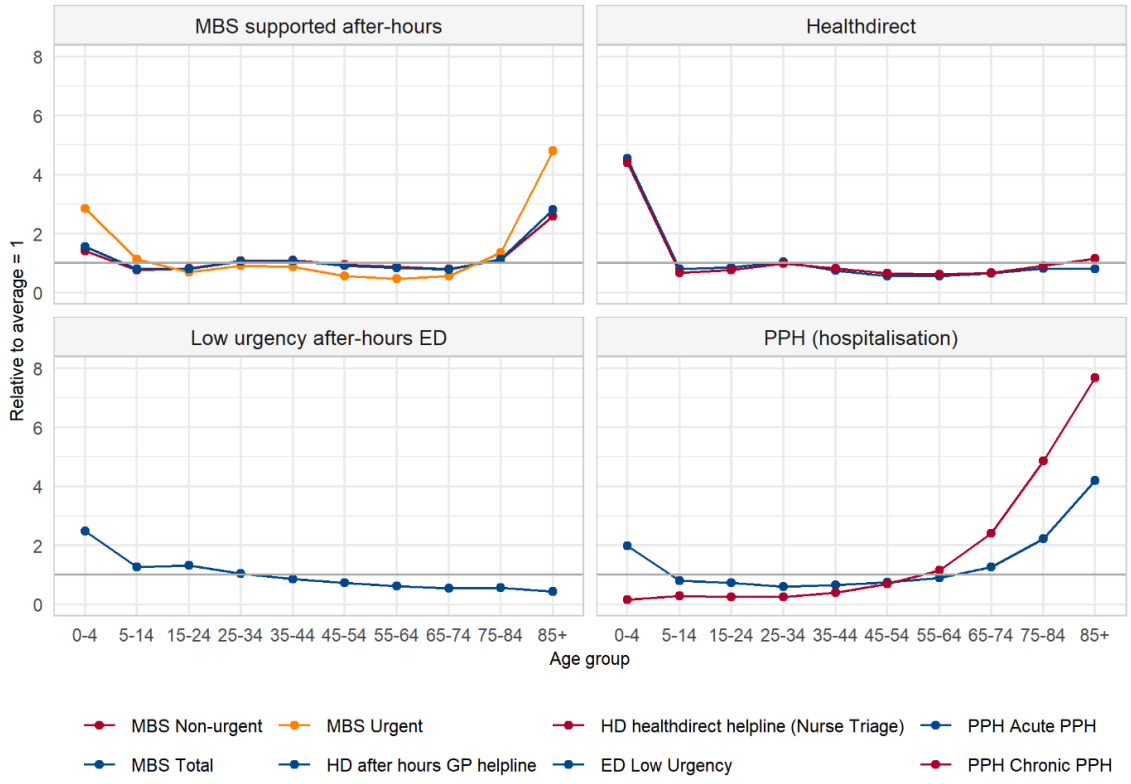
Hunter New England and Central Coast PHN (for GP Access), and Primary Health Tasmania (for GP Assist).

The overall effect of the funding allocation was previously shown in Figure 12. It results in a range of allocations from around $2 per person (ACT) to $22 per person (Western Queensland).

Observations that can be drawn about the weighting used in the funding formula are outlined below.

Age weights

The formula's age weights were compared with various measures of utilisation related to after-hours demand. The results are shown in Figure 32 and Table 29. Table 29 also allows comparison with the weights used for the PHN After Hours Program (normalised to the Australian population). The general conclusion is that the program's weights may be too heavily weighted to populations aged 65 years and over. Other than relative rates for potentially preventable hospitalisations (which have a more tenuous relationship with after-hours demand), other sources suggest that there is only a moderate effect of age. The relative weights derived from urgent MBS- supported after-hours services could be a more appropriate, that is, 0.933 for people aged under 65 and 1.352 for people aged 65 years and older. When rebased to have the under 65 year groups assigned a weight of 1.000, this yields a weight for the over 65 years group of 1.449.



Note: For each service, the age specific age rate was calculated for Australia, then expressed as a ratio of the Australian rate for all age groups. A value above 1 indicated a relative use of service above the Australian rate for all age groups.

Figure 32 – Relative utilisation of selected services relevant to after-hours service delivery

Table 29 – Relative utilisation of selected services relevant to after-hours service delivery: people aged 65 years and under vs people aged 65 and over

Service	Under 65 years	65 years and over	Total
PHN After hours program	0.758	2.275	1.000
MBS supported after-hours services			
Urgent	0.933	1.352	1.000
Non-urgent	0.975	1.131	1.000
Total	0.971	1.153	1.000
Healthdirect			
Helpline (nurse triage)	1.036	0.810	1.000
GP helpline	1.051	0.730	1.000
Emergency department presentations			
Low urgency after-hours	1.087	0.539	1.000
Potentially preventable hospitalisations			
Acute	0.823	1.935	1.000
Chromic	0.463	3.835	1.000

Socio-economic status weights

Table 27 includes key results from modelling factors contributing to the rates of low urgency after-hours ED presentations, including a socio-economic dimension. In this analysis SA3s in major cities were split (by the AIHW) into three groups reflecting low, median and high SES, whereas the weights using in the program's funding formula are based on quintiles. However, there is a reasonable alignment between these. Our conclusion is that the formula's socio-economic weights are broadly appropriate.

Weights for Modified Monash Model categories

Because of the nature of available data, the modelling undertaken for this evaluation has generally been based on the AGSC remoteness categories, rather that MMM categories. Table 27 also includes key results related to remoteness categories. However, estimates for outer regional SA3s are affected by missing data, and there was only limited data available for remote and very remote areas. These results suggest that relative to SA3s in major cities assigned to the high SES category, the relative utilisation of low urgency after-hors ED in inner regional SA3s is around 40% higher.

It is worth noting that there is an interaction between SES factors and rurality, that has not been fully explored in the analysis conducted for this report outside major cities. The current formula gives very high relative weights to MMM categories 6 and 7. Through the evaluation it was observed that PHNs had commissioned some services for very remote communities, but for a variety of reasons there tended to focus on the (relatively) larger towns in these regions rather than smaller, more remote communities. While there are undoubted gaps in after-hours services and primary care more generally in these communities, effectives solutions need broad strategies focussed on strengthening primary care more generally. Data are not available to support specific recommendations, but our tentative conclusion is that the current MMM weightings are potentially too high for the MMM categories of 6 and 7,

but too low for the MMM categories 3, 4 and 5. However, we have not made a specific recommendation on weights by locality.

Weights for Indigenous status

The evaluation was not able to draw specific conclusions about the appropriateness of the formula's weights for Aboriginal and Torres Strait Islander people. However, we believe these appear in line with the general understanding of their relative needs.

Current allocations are strongly skewed in per capita terms towards rural and remote PHNs. This overall pattern appears to be appropriate but could be fine-tuned. Specifically, we conclude that age weights should be updated to reflect the analysis described above. We also conclude that adjustment to weights for MMM categories 3-7 could be considered, reducing slightly the weights for categories 6 and 7 and increasing the weights slightly for categories 3, 4 and 5.

Other issues to consider in funding allocations in future include:

- Allocations for some PHNs may be too small to justify the effort associated with managing the program, including needs assessment, separate approval processes, and specific program-level activities. A threshold of funding could be considered, below which funding available under the program is be rolled into and managed through the PHN Core Funding, rather than the After Hours Program.
- Hunter New England and Central Coast PHN and Primary Health Tasmania receive additional allocations for GP Access and GP Assist. These services were established many years before the program commenced. We would propose that allocations to these PHNs be gradually brought towards the funding formula recommendation over a transitional period of five years, allowing sufficient time for the PHNs to plan for change and determine priority these services have within their allocations, and time for the services to secure alternative sources of support.

Appropriateness of models to consumers and service providers

Finding 24: Service providers were generally supportive of the models that PHNs were designing. Where these models integrate or align with existing service provision, or can build on existing provision, they were seen as more successful. Some services were hampered by the lack of consumer awareness which led to low uptake.

There was strong support from service providers and other stakeholders for service models that facilitated an after-hours component to an existing service. Some of the service models were well designed to support patients with particular health needs, especially when co-designed with organisations that were already delivering services to specific target groups. The after-hours support service funded by Perth South PHN to add an after-hours service to the Housing First initiative is an example of where a small additional element can add considerably to the overall effectiveness of the service. Service models such as GP Access in Hunter New England and Central Coast have developed effective linkage mechanisms with other services, with scope to develop these further.

Commissioned providers surveyed were generally supportive that PHNs had been effective in achieving the aims of the program. Where there were localised gaps and some services providing after-hours care, it can be difficult to design a service model that will work for some areas without undermining others (e.g. supporting the medical deputising service when there are practices operating a cooperative system).

There were some general frustrations from GPs and other service providers, for example in awareness raising and advertising of services where it resulted in lower uptake than needed for a sustainable service. This meant that the service model was less successful because it did not reach a critical sustainable volume. For example, in the Hunter Valley, the medical deputising service GP Access has a long history of providing a telephone triage service (integrated with 5 after-hours GP clinics in the region) to manage demand in the after-hours period and more recently Brisbane South has commissioned the medical deputising service 13SICK to provide services in Jimboomba, where after-hours services were previously very limited.

Some commissioned providers wanted to see opportunities to expand their service provision and develop their service models to target broader population groups. Some also wanted increased flexibility to revise service model targets and outcomes.

PHNs and other stakeholders felt there was a role for service models that supported access to care in-hours and not just after hours. This was particularly the case for certain vulnerable patient groups and for areas with poor access to after-hours care. There is a need for greater flexibility in being able to design services that can have more flexible operating times as a more pragmatic response to the needs in the PHN communities.

Case study: Northern Territory PHN

Case study focus
This was a geographically based case study of Alice Springs.

Locality overview
The Northern Territory PHN supports primary care across the entire Northern Territory. Although the resident population is relatively small – estimated at 245,600 – it is spread across a wide area (1.3 million square km equivalent to five times the geographic area of the United Kingdom) (Northern Territory Primary Health Network, 2019b). The majority of the Northern Territory falls within categories 6 and 7 of the Modified Monash Model (MMM) classification. However, the majority of the population (57%, over 130,000 people) live within the category 2 region covering Darwin and surrounds. Alice Springs, Katherine and surrounding areas fall within category 6 (18.4%, over 41,000 people), and there is a small area of category 5 surrounding the greater Darwin region, which covers 3% of the population. The most remote category 7 covers the bulk of the geographical area of the Northern Territory and includes over 47,000 people (21% of the population).

PHN approach
An initial after-hours needs assessment was completed in 2015 in consultations involving 50 organisations and 111 individuals, including GPs and pharmacists, residential aged care, Hospital and Health Service Districts, and Aboriginal Community Controlled Health Services, among others. The consultations identified gaps as well as local solutions. The assessment was also supported by a comprehensive service review, which identified all primary health care services and opening hours across the region.

In 2019, the Northern Territory PHN completed a selective review and update of its needs assessments. New population health topics were included and most statistics were reviewed where new information was available, and the associated priorities and options reviewed and adjusted accordingly. The alcohol and other drugs, psychosocial and after-hours needs assessments were comprehensively reviewed as part of the 2019 review, which incorporated consultation and learnings from the development and commissioning of services and changes identified in the service environment. The key findings and priority areas, however, remained relatively unchanged, as remoteness, socio-economic disadvantage, poor population health and limited service provider options had not changed significantly. Northern Territory PHN after-hours activities for 2019–20 included after hours in regional hubs, after hours in remote communities, after hours hospital into primary health care pathway, Health Pathways expansion to improve safety and quality of after-hours care, Supporting Health Care Home Model Implementation Strategy, and the Health Care System Digital and Innovation Readiness initiative.

Key observations

- **Prior to 2015 there were no after-hours primary care services available in Alice Springs.** A combination of the impact of the Northern Territory PHN After Hours Program and the development of expanded clinic hours has resulted in a significant improvement in the availability of services.
- Despite this, there continues to be a **lack of bulk-billing general practices** in Alice Springs, presenting a significant barrier to access, even if practices provide after-hours services. This is a key factor for patients attending the ED at Alice Springs Hospital.
- There are opportunities to **develop more collaborative and strategic partnerships** between the acute and primary health care sectors. Stakeholders considered that there were opportunities for the PHN to be more proactive in facilitating strategic planning of after-hours responses. Establishing a partnership of this nature may provide improved coordination, planning and more effective service delivery, and in time, provide opportunities to co-design and co-fund activities.
- The PHN After Hours Program **funding cycle and agreements need to be longer than one year.** This would assist in planning and recruitment, and in addressing industrial relations challenges.

9. Alignment with other initiatives

This chapter describes what has been learnt about how the PHN After Hours Program aligns with other national initiatives, addressing the final four evaluation questions:

PHN After Hours Program evaluation key questions 10, 12-14

10. To what extent did PHN models integrate/align with existing after-hours services?
12. To what extent has the PIP After Hours Incentive affected the availability and access to after-hours services in each PHN?
13. To what extent have changes to the MBS urgent after-hours items affected the availability and access to after-hours services in each PHN?
14. How have PHNs responded to any changes to these MBS items and changes in the supply of Medical Deputising Services?

Healthdirect

Finding 25: The telephone triage landscape has become complex and there is scepticism among some stakeholders about the effectiveness of Healthdirect to direct patients appropriately. GP Access and GP Assist – funded through the Hunter New England and Central Coast PHN and Primary Health Tasmania respectively – are strongly supported by other service providers and their broader communities. GP Access is strongly integrated with other services. For other PHNs, there is potential to create more effective linkage with Healthdirect.

All PHNs included information on the nurse telephone triage service Healthdirect (and in Victoria, Nurse-On-Call and in Queensland, 13 Health) on their websites and, where available, their apps. However, apart from the Tasmanian PHN, PHNs generally had little direct interaction with Healthdirect or the Victorian and Queensland health department telephone triage services.

A few PHNs reported there is a perception among some GPs that the nurse telephone triage service offered by Healthdirect is 'risk averse', leading to too many callers being advised to go to an ED or that they needed to see a GP within 6–12 hours. PHNs also commented that information in the National Health Services Directory is not always accurate or complete and lacks location-specific information about after-hours services, sometimes leading to inappropriate recommendations by the triage service. Healthdirect asserts that the perception that their service is 'risk averse' is largely misguided. They also consider that services are not adequately incentivised to update the National Health Services Directory, and that transmission of local knowledge to this national resource could be significantly improved.

Few PHNs appear to have explored the role of integrating telehealth triage and advice into their after-hours needs analysis and Activity Work Plans. With growing interest in shaping and supporting the role of telehealth in Australian health care, especially post COVID-19, this is an area that could be a focus for the program in future years

GP Access and GP Assist

Two of the case studies in this report focus on PHN investment in local telephone triage services and their relationship to Healthdirect and after-hours GP services, namely GP Assist funded by the Primary Health Tasmania and GP Access funded by the Hunter New England and Central Coast PHN and the Local Health District (see Volume 3).

GP Assist receives only calls that have been assigned a disposition of ED by Healthdirect, whereas GP Access receives all calls to Healthdirect, rendering a direct comparison of the two services difficult in terms of impact:

- In 2017–18 GP Access handled 69,000 calls, with 28,000 callers (40%) supported with advice for self-care and 52,000 patients attending the GP Access after-hours clinics co-located at hospitals. The clinics received 11,000 direct referrals from EDs.
- In 2016–17 GP Assist received 3,230 calls from Healthdirect with an ED disposition, with 664 callers (20%) supported with advice for self-care and 522 managed by GPs working after hours in a clinic or on-call in a rural area.

These services receive significant funding through the PHN After Hours Program. Hunter New England and Central Coast PHN spends about $2.8 million of its allocation with additional funding from the Local Health District. Tasmania planned expenditure of $3 million in 2019–20. Comparing the costs and outcomes is difficult because additional funding is leveraged into the services through MBS and state funding. In addition, Tasmania uses Healthdirect – which is funded by the Commonwealth Government – as an entry point to the system. How these services fit within the program needs to be considered alongside the wider questions relating to telephone triage services across Australia.

A comparison of various aspects of the programs is provided in Table 30.

Table 30 – Comparison of GP Access (Hunter New England and Central Coast PHN PHN) and GP Assist (Primary Health Tasmania)

Feature	GP Access	GP Assist
Ownership	Hunter Primary Care, a company limited by guarantee	Privately owned entity
Linkage with Healthdirect	No formal arrangement exists.	Calls triaged with ED disposition or see GP within 12 hours are diverted to GP Assist call centre
Funding of call centre	PHN funds nurse and GP on call for GP Access call centre	PHN funds GP on call and majority of the operating costs for the GP Assist call centre and in addition to this the Tasmanian Department of Health funds a nurse to receive the ED warm transfers.
Ambulance triage of calls	GP Access does not provide secondary triage service for NSW Ambulance. Healthdirect provides this service for NSW.	GP Assist does not provide secondary triage service for Ambulance Tasmania

Feature	GP Access	GP Assist
Geographical coverage	Only the Lower Hunter sub-region of the PHN, albeit the most populous	Whole of PHN
Use of service by rural GPs	Rural GPs in other sub-regions rely on GP visiting medical officer arrangements and regional hospital support	Strong GP Assist focus on supporting rural GPs by providing telephone-based deputising service for participating rural GPs.
Residential aged care facilities support	Focus on supporting residential aged care facilities via integrated program of training and protocols under the Local Health District ACE program	Support is provided to residential aged care facilities by GP Assist.
Staffing	Cooperative roster of local GPs run 5 integrated and co-located after-hours clinics	Relies on privately owned after-hours clinics in urban centres – Hobart and Launceston
Bulk-billing GP clinics?	Yes	Privately owned after-hours clinics – not 100% bulk billing
Appointment booking?	GP Access directly books with clinics for direct and ambulance calls	GP Assist refers callers to available clinics to make their own appointments
Linkage with ED	Well-integrated system of referral between public ED and GP Access clinics.	EDs are not integrated with GP Assist nor with local after-hours GP clinics.
Support to other health professionals	GP Access provides support to residential aged care facilities but not to other services	GP Assist provides separate telephone advice to other health professionals and services (about 25% of calls)

These services vary in the way they integrate with emergency services, EDs and local GP services but both provide a nurse/GP-based triage service that is linked to Healthdirect. For example, GP Access provides an integrated service where callers can be triaged and booked into one of the five GP Access after-hours clinics without the caller making another call. NSW Ambulance also refers to GP Access, providing a more integrated response to people calling the national emergency number with less-urgent health conditions. The collocation of four of the GP Access after-hours clinics also allows for greater integration of hospital ED and GP after-hours clinics, with potential scope for further integration of triage functions for the future.

GP Assist provides substantial support to rural and remote GPs after hours and stakeholders indicate this has been a key driver for recruitment and retention of the GP workforce in Tasmania. Key stakeholders reported that this has been achieved through the development and maintenance of relationships of trust in the provision of an integrated and locally based telephone triage and medical advice service.

Healthdirect has a primary care linkages program that has established arrangements for referring callers of Healthdirect to local triage services. Hunter New England and Central Coast PHN (GP Access) and Primary Health Tasmania (GP Assist) are two areas where this occurs. Healthdirect is looking to increasingly work with PHNs and local hospital networks to establish links to local arrangements that leverage the national infrastructure they have available and has recently sought government support for expansion of infrastructure in the after-hours space and enhancement of the National Health Services Directory to expand capacity to link to local after-hours services.

Stakeholders in both New South Wales and Tasmania pointed towards the benefits of having locally managed regional helplines and triage functions, both in terms of the more intimate

knowledge of the local capacity and access to services and the ability to assist and support providers in the after-hours periods, including in small rural towns and staff in residential aged care facilities.

A national standard (Australian Health Contact Centres 5205:2019) has been developed to guide the care consumers can expect to receive from health contact centres and to assist in providing a consistent approach to healthcare delivery across Australia. More attention to adherence to these standards may be warranted given the range and diversity of arrangements in place in Australia.

Currently there is an array of triage arrangements across Australia, often involving multiple triage processes and handover of patients between services, including emergency services (both primary and secondary triage functions), health triage (including Healthdirect, Nurse on Call and 13 Health), local triage (including GP Assist and GP Access) and hospital ED triage.

This heightens the risk of:

- patient confusion over appropriate service access points in the system and
- service duplication, inconsistency and inefficiency.

Stronger promotion of national standards for triage services, supported by a network of locally integrated triage systems, could help work towards alleviating these risks.

"In contrast to other medical deputising service, a stakeholder stated that the GP Access program is less focused on managing rather than creating demand. This is due to the block funding arrangement, which means that the service is not solely reliant on MBS funding or heavily incentivised to provide costly home visits, and the fact that the participating GPs also work during the day and are not competing with daytime GPs. They understand what should be treated during the day versus what requires medical attention after hours, and they triage accordingly." [HNECC Case study]

The overall aim is to resolve the patient's needs in the least intrusive manner, starting with digital resources (symptoms tracker, nurse triage, online GP consults) and then moving to face-to-face GP consults (clinic, home-based) and finally hospital care (ED attendance). For this to work well there needs to be trust between the providers, with sharing of information and joint triage arrangements. For example, in New Zealand and the United Kingdom it is understood that triage services like Healthdirect can directly dispatch ambulances, where in Australia a separate and additional triage process is required.

With the advent of new bulk-billing after-hours primary care providers, offering home, clinic and telehealth options, there is the possibility that after-hours primary care capacity will continue to grow. However, without any direct links with a triage service and greater integration between hospital EDs and these new services, the available evidence (both here and overseas) indicates that ED demand will not be substantially reduced.

Relationships with local hospital networks and state/territory services

Some PHNs reported they had strong relationships between the PHN and their local hospital networks, which facilitated exploration of co-funding and co-design for some activities. In several cases, the successful projects were taken up and expanded by the local hospital network. The main motivation for local hospital network involvement was ED demand management and provision of alternative services, such as urgent-care centres co-located or near to GP services, telephone support to residential aged care services, and community information campaigns.

Largely due to the closer relationships between local GPs and smaller rural and remote hospitals, rural-based PHNs appear to have had a greater level of interaction with their local hospital networks on after-hours services. However, even where this is the case, some PHNs are looking for a system-level alignment to support service development.

PHNs raised the issue of poor care coordination and case management services for persons with chronic and/or complex conditions contributing to after-hours demand. Addressing this issue requires effective relationships, service planning and co-design between the primary care sector, hospitals, specialist services, the aged care sector and, in some cases, state initiatives. The alignment of PHNs within local hospital networks appears to have been important. PHNs with a one-to-one alignment with local hospital networks appear to have better relationships compared with those with one-to-many relationships.

> "In Mareeba, there appeared to be a view that the local hospital was providing an effective service, including good feedback to general practices, so there was a sense that there was no need for any additional services as this met the needs of the community. The good relationships and lines of communication did not appear to be replicated in Atherton or Bowen where the link back to practices was reported as being less effective. 'They're too busy' was one respondent's view … There was a perception among interviewees that the level of after-hours need was not significant, especially after 10 pm. Due to the low level of patient demand, stakeholders felt that it was unclear whether a reliance on the ED is really such a bad option for consumers, especially when operating an after-hours service may not be sustainable." [Northern Queensland PHN Case study]

There were few examples of PHNs developing or pursuing relationships with ambulance services to explore options for after-hours provision.

Practice Incentive Program (PIP) After Hours Incentive

Finding 26: PHNs had low visibility of PIP uptake. Many PHNs thought the PIP criteria were too rigid and did not encourage smaller and more marginal improvements to after-hours availability. There was anecdotal evidence of some poor practice (after-hours services available 'on paper but not in practice').

As noted in Chapter 2, it is estimated that in November 2019, 68% of all practices received some form of PIP after hours incentive payment. The majority (37% of all practices) receive Tier 1 which, is the base payment level, with 13% of practices at levels 2/3 and 19% at levels 4/5.

In consultations, some PHNs argued that the PIP After Hours Incentive is too rigid around the hours that need to be covered to claim PIP payments. These PHNs would like to see greater flexibility in how the after-hours period is viewed. There is a commonly held view among PHNs and other stakeholders that the critical time periods are evenings and weekends. Demand for overnight access is generally minimal. Some PHNs would like to see greater flexibility in how the PIP operates so incremental additional hours are incentivised rather than the 'all or nothing approach'. For example, one PHN said they thought some of their local GPs may be prepared to offer services for two to three hours in the evening for some days, but this would not meet the eligibility criteria to receive PIP funding. One PHN wanted the ability to provide incentives for practices to stay open a little later in the evenings but not necessarily until 11 pm. A general practice in Northern Queensland focusing on providing services for Indigenous people opened at 7 am on some weekdays to encourage men to attend for health screening and to access care more generally ("otherwise they just don't come…").

There also appear to be issues regarding PIP-accredited practices appearing not to meet the spirit of the requirements even if they met them on a technical level. This was described by one PHN as 'providing after hours on paper but not in practice'. National stakeholders stated that there have been reports of certain practices claiming the PIP After Hours Incentive payment when providing no more than a telephone number after hours, which goes unanswered, or implementing a costly service that requires patients to expend considerable amounts of money to reach a health professional after hours. This has had the effect of squeezing those providers delivering better services. These reports were anecdotal but came from a variety of sources. Some stakeholders expressed a view that there should be additional market regulation of PIP After Hours Incentive funding to help reduce the potential for abuse.

> I just think putting [in] an answering service or redirecting your phone isn't providing an after-hours service. [National stakeholder]

Despite these reflections, some stakeholders stated that the PIP After Hours Incentive is vital to the viability of delivering after-hours services, especially in rural and remote areas.

> There's absolutely no doubt that in rural and remote areas those incentives and loadings are probably the only way or one of the main ways in which rural and remote practices actually keep those services open. And if it weren't for the Practice Incentive Program, I would say that a lot of the private practices wouldn't be able to afford after-hours services at all. [National stakeholder]

MBS after-hours items

Finding 27: Changes to MBS urgent after-hours items came into effect in March 2018. Since then, claims related to the unsociable hours have declined slightly, while claims in the sociable hours have declined more substantially, to levels similar to those observed in 2013. This was an intention of the changes. Stakeholders consulted through this evaluation have not reported significant adverse effects of these changes.

The evaluation team was asked to report on the impact of changes to the MBS urgent after-hours items implemented from March 2018 in terms of the availability and access to after-hours services in each PHN. Table 31 provides an overview of after-hours services supported under MBS. In 2018–19 there were 12.3 million services provided related to $729.6 million in benefits. 94.8% of claims were bulk-billed (97.1% for urgent and 94.6% for non-urgent).

Table 31 – After hours MBS items, 2018–19

MBS items:	Services			Benefits			
	'000	% of after-hours activity	Annual increase[1]	$m	% of after-hours activity	Annual increase[1]	$ per service
Urgent after hours							
Unsociable hours							
GPs	202.3	1.6	6.4%	30.9	4.1	6.7%	152.7
Other practitioner	22.2	0.2		2.6	0.3		117.1
Sociable hours							
GPs	372.8	3.0	-5.0%	48.3	6.4	-4.2%	129.6
Other practitioner[2]	496.3	4.0	37.9%	51.2	6.8	38.9%	103.2
Mix of practitioners	120.7	1.0		5.1	0.7		42.2
Non-urgent after hours							
Consulting room							
GPs	9,585.6	78.1	7.2%	513.6	68.5	8.5%	53.6
Other practitioner	297.9	2.4	1.8%	12.5	1.7	2.6%	42.0
Residential aged care							
GPs	754.3	6.2	14.7%	53.8	7.2	15.7%	71.3
Other practitioner	18.8	0.1	14.0%	1.1	0.1	17.6%	58.5
Home visit							
GPs	367.9	3.0	9.7%	28.8	3.8	11.1%	78.3
Other practitioner	29.8	0.2	19.0%	1.7	0.2	24.2%	57.0
Subtotal urgent	**1,214.3**	**9.9**	**6.5%**	**138.1**	**18.4**	**5.2%**	**113.7**
Subtotal non-urgent	**11,054.4**	**90.1**	**7.5%**	**611.5**	**81.6**	**9.0%**	**55.3**
Total after-hours items	**12,268.7**	**100.0**	**7.4%**	**749.6**	**100.0**	**8.2%**	**61.1**

Notes: 1 Average annual growth 2010–11 to 2018–19; 2 A separate item was introduced for other medical practitioners in 2018. Average annual growth of urgent after-hours in unsociable hours is for GP and other practitioners.

Source: HPA analysis of data from Medicare Australia, Medicare Statistics online item reports as at 27 July 2020.

For urgent after hours there were 1.2 million services provided in 2018–19 and $138.1 million in benefits paid. These grew by an annual average rate of 6.5% and 5.2% respectively over the previous nine years. However, as Table 32 and Figure 34 show, this trend pivoted significantly with the introduction of changes to MBS in March 2018. Prior to March 2018, the average annual growth rate in urgent/sociable items had been 13.4%. In the following two years, these items fell by an annual average of 24.9%. Annual growth in urgent/unsociable items had been 8.3% prior to March 2018, but dropped 7.3% in the subsequent two years. Table 32 also suggests that growth in non-urgent after-hours items services moderated significantly following March 2018.

Table 32 – After hours MBS items – growth prior to and since March 2018

MBS items:	Services: Annual average increase		Benefits: Annual average increase	
	Mar 2010-Feb 2018	Mar 2018-Feb 2019	Mar 2010-Feb 2018	Mar 2018-Feb 2019
Urgent, unsociable	8.3%	-7.3%	9.2%	-7.2%
Urgent, sociable	13.4%	-24.9%	14.9%	-30.4%
Non-urgent	8.4%	2.9%	10.4%	3.0%

Source: HPA analysis of MBS data summaries prepared by Department of Health.

Since March 2020, responses to COVID-19 have had further impacts on service levels, although interpretation of the impact requires some caution. The total of urgent after-hours

items has declined since March 2020, with some limited evidence of an uptick in claims in June 2020. For urgent after-hours services in the unsociable hours, new telehealth items were introduced. In June 2020, these items accounted for 35.1% of urgent/unsociable hour services.

No specific telehealth items were introduced for urgent after hours in sociable periods, but other telehealth items can be claimed in these periods. It is clear that these other telehealth items are being used as a substitute for the urgent services in sociable periods. Similarly, substitution will be occurring with non-urgent after-hours services.

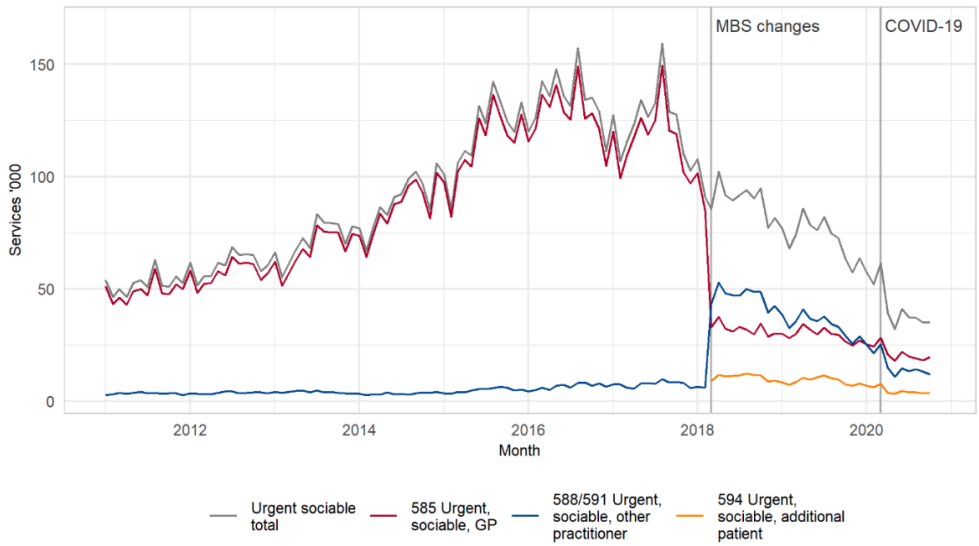


Figure 33 – MBS services for urgent after-hours items claimed in the <u>sociable hours</u> period, July 2011 to June 2020

Source: HPA analysis of Medicare Australia, Medicare Statistics online item reports as at 19-7-2020. Prior to March 2018 item 585 included both GP and other practitioners. MBS Items 597 and 598 were retired in March 2018 and are included in 585/591 respectively.

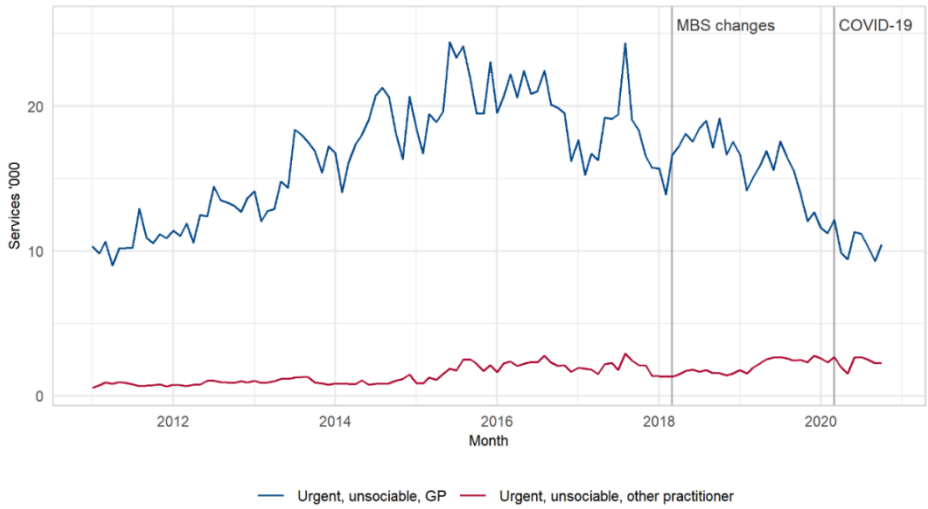


Figure 34 – MBS services for urgent after-hours items claimed in the unsociable hours period, January 2010 to June 2020

Source: HPA analysis of Medicare Australia, Medicare Statistics online item reports as at 19 July 2020. Prior to March 2018, item 599 included both GP and other practitioners. MBS Items 92210, 92211, 92216, 92217 are the new telemedicine items.

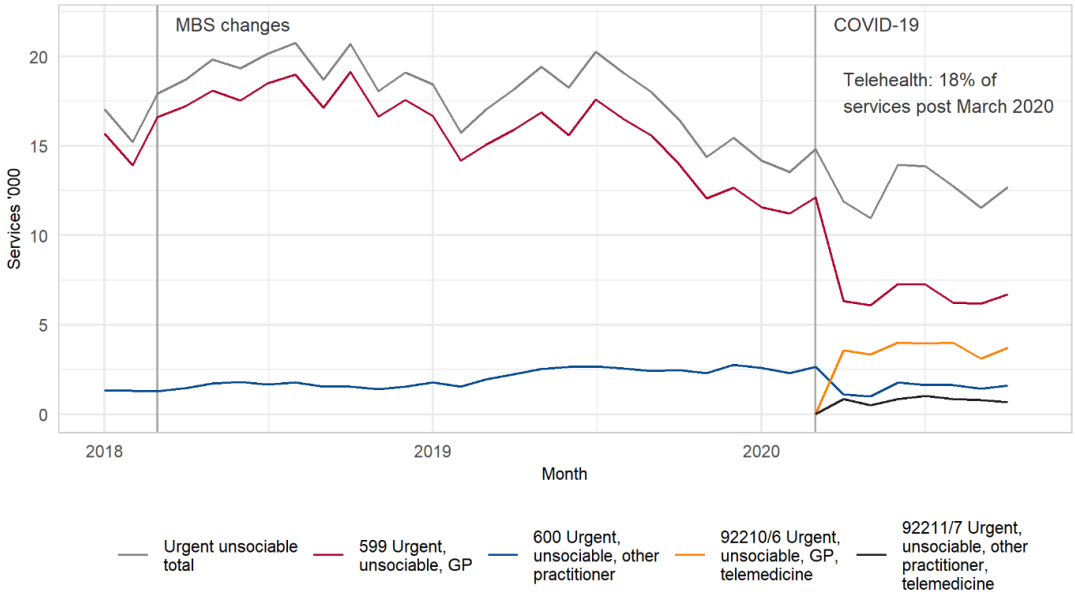


Figure 35 – MBS services for urgent after-hours items claimed in the <u>unsociable hours</u> period, January 2018 to June 2020

Source: HPA analysis of Medicare Australia, Medicare Statistics online item reports as at 19 July 2020. Prior to March 2018, item 599 included both GP and other practitioners. MBS Items 92210, 92211, 92216, 92217 are the new telemedicine items.

Analysis at the PHN level up to December 2019 suggested that for urgent after-hours items, reductions in claims were more pronounced in more urbanised PHNs, with larger effects for those with relatively high rates of claims per 1,000 population. However, there was considerable variation across PHNs. For non-urgent after-hours items, there were increases in per capita services in PHNs based in major cities, with relatively constant rates for other regions. (More detailed analysis is provided in Volume 4.)

Medical deputising services

Finding 28: Very few PHNs noted any specific issues as a consequence of the changes in supply of medical deputising services. There was much greater focus and general support from PHNs for a continuation of the COVID-19 temporary telehealth items

Several PHNs have subsidised medical deputising services to expand into specific localities. These initiatives were generally welcomed by GP organisations and rural workforce agencies as they reduced the after-hours burden for GPs, especially in rural areas. This contributed to the ability to recruit and retain GPs in these regions. Examples of such services include GP Access in the Hunter region and GP Assist in Tasmania. However, there was also significant anxiety in areas where there is some level of after-hours provision being offered. Some GPs were concerned if the PHN commissioned services of this sort without giving the opportunity to local practices.

Some PHNs and commissioned providers indicated that the awareness and take-up of medical deputising services was restricted by adverting limitations on these services. For example, Brisbane South PHN attributed the inability to directly market services to patients as the cause of the limited uptake of the medical deputising service at Jimboomba. Similarly, stakeholders in the Hunter Valley claimed that restrictions on advertising were holding back community awareness of the GP Access telephone triage medical deputising service. There

are indications that greater clarity and further guidance on the scope to promote medical deputising services commissioned by PHNs to fill service gaps would be beneficial.

Very few PHNs identified significant change resulting from the changes made to the MBS items in 2018. There was much more comment on the impact of the additional telephone and telehealth items introduced as a result of the COVID-19 pandemic response (see below).

Telehealth

Finding 29: There is a strong appetite for the temporary changes in MBS items to be consolidated into a longer-term approach to reimbursing telephone and telehealth services. Caution was advised to ensure that these modalities are used appropriately while maintaining face-to-face services where these are more appropriate.

The COVID-19 pandemic response has markedly increased interaction between PHNs and the Commonwealth, state and territory health departments and local hospital networks. This interaction has centred around provision of clinical information to general practices and commissioned service providers, establishment of fever clinics, creation of COVID-19 health pathways and distribution of personal protective equipment to general practices.

The expansion of bulk-billed Medicare telehealth items has led to an emergence of new providers and service models, both in the in-hours and after-hours periods. These services and models have raised a range of clinical governance, continuity of care and cost to government issues.

There were fewer general practice consultations during the quarter to June 2020 (Australian Bureau of Statistics, 2020). A recent report highlights the effect the pandemic has had on GPs and non-GPs working in primary care (Scott, 2020). The report used information collected from the MABEL COVID-19 survey, which was distributed between 14–24 May 2020 and received responses from 2,235 clinicians (869 GPs and 1,366 non-GP specialists) working in the Australian private primary care setting.

A key point from the report is that the adoption of the MBS telehealth items during COVID-19 has accelerated the use of telehealth in private practice among both GPs and non-GP specialists. Nearly all GP respondents reported using the telehealth item numbers, while just over three-quarters of non-specialist GP respondents reported using them (Figure 36). This has resulted in a sharp increase in telehealth consultations, from 1.3% prior to COVID-19 to 36% during the pandemic.

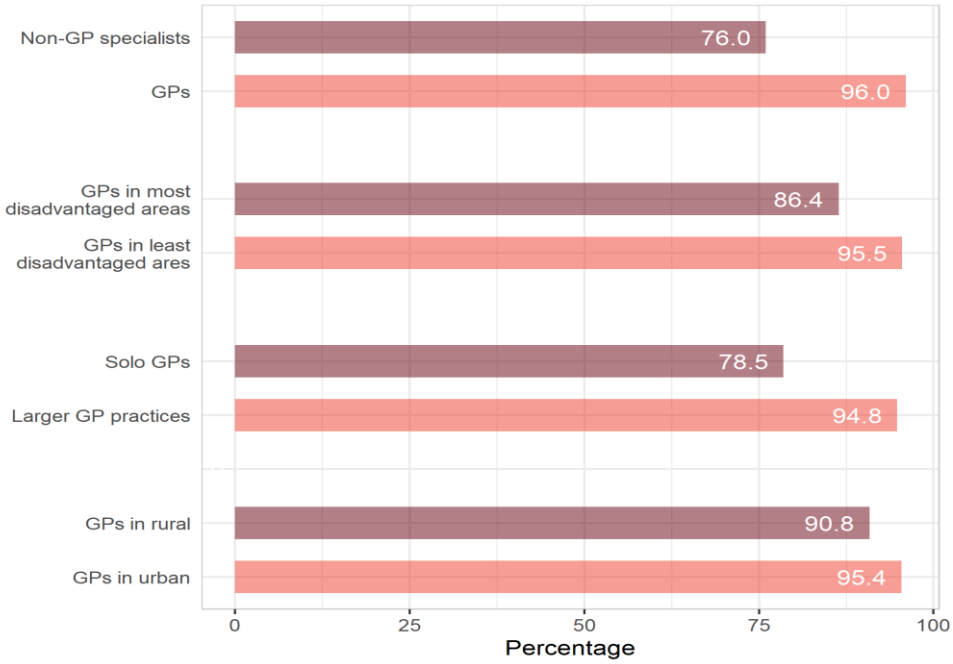


Figure 36 – Percentage of doctors using telehealth by type of doctor
Source: Scott (2020)

During April 2020, the number of telehealth items of service (4.7 million) surpassed the reported decrease in face-to-face consults (2.7 million). In May 2020, the number of telehealth services fell, while the number of face-to-face consults increased, resulting in an overall reduction in patient consultations. Figure 37 shows the pattern of services for GPs and non-GP specialists.

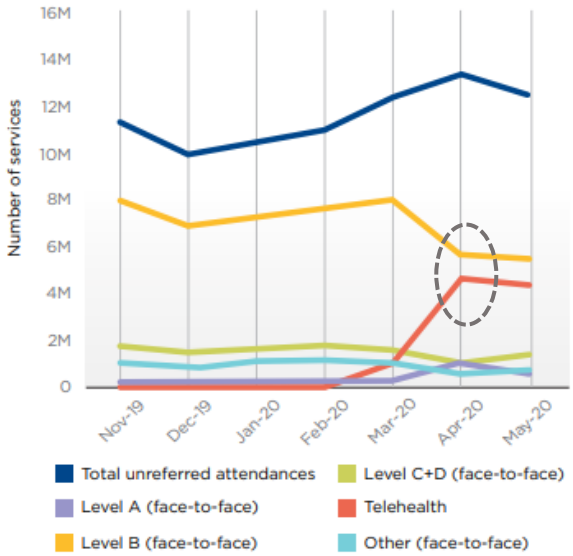


Figure 37 – Change in the number of Medicare items claimed by GPs, November 2019 to May 2020
Source: Scott (2020)

GPs in metropolitan and higher socio-economic areas were more likely to report a decrease in patient volume and working hours.

There is currently much greater use of phone consultations compared with video consultations, with 96% of GPs stating that they consulted with patients by phone. Only about 5% of doctors reported they had introduced home monitoring technology for patients as a result of the pandemic.

To soften the potential fallout of the pandemic, some practices reported decreasing the number of practice staff, changing staff mix and/or changing staff hours. Non-GP specialists were more likely to implement these types of changes.

Both GPs and non-GP specialists reported an increase in bulk billing for face-to-face consultations, perhaps in response to the overall economic impact on consumers of COVID-19 and the downturn in service demand. The new telehealth consultations were initially restricted to bulk billing.

Most respondents (84%) thought telehealth should be permanently funded by Medicare.

There have been some major impacts on commissioned services as a result of these changes. Some telehealth services that had been commissioned by PHNs had to adapt to the fact that these were now generally available and would affect existing GP services. GPs' workloads declined during the period and so they felt their incomes were at risk unless they were able to undertake telehealth consultations. They often viewed other telehealth providers as a threat to their livelihoods. One advantage for GPs was the fact they felt that some of the services conducted on an 'unpaid basis' are now being reimbursed. Examples included telephone advice to residential aged care facilities and phone calls with patients (even where no formal after-hours service is provided by the practice).

PHNs saw the new MBS items as very significant in shaping future services should they be retained. Most PHNs were positive about the move to provide options for video and telephone consultation while making sure that face-to-face consultations are still an option. One PHN commented that 15 years of seeking change was accomplished in 5 days. Many PHNs see this as a significant step forward. However, some stakeholders are concerned about how these new services may play out and the impact they may have on existing service providers. Concerns were also raised about protecting quality and continuity of care.

Many national stakeholders welcomed the introduction of the telehealth numbers and hoped that these items stay in place permanently. They see the overall value of telehealth and the potential for better patient access. Though many stakeholders and providers hope that these item numbers are retained, they want to ensure that they are used appropriately as there may be some potential for abuse and over-use of these MBS items.

10. Recommendations

Broad policy context

Recommendation 1: **The Department of Health and Primary Health Reform Steering Group consider issues identified in this report in developing a broader strategy for Australian primary care and setting directions for PHNs and the PHN After Hours Program. Key issues include:**

- **Creating highly visible entry points for clients seeking after-hours care.**
- **The need for a communication strategy that promotes wide community understanding of how to seek after-hours primary care that is appropriate and supports quality and continuity of care.**
- **Mechanisms for triaging patients to the most appropriate after-hours options.**
- **Determining the continuing role of telehealth options in after-hours care.**
- **Ensuring after-hours services consistently provide high-quality communication back to patients' usual primary care provider.**
- **Establishing a common set of outcome measures that assess efficiency, effectiveness and accessibility of primary care.**
- **Addressing gaps in primary care, particularly with a focus on outer regional and remote Australia.**
- **Addressing the primary health care needs for vulnerable population, such as homeless people, people living in residential aged care and people with disabilities.**

PHNs have been given the task of increasing the efficiency and effectiveness of primary care services for patients and improving coordination of care. They operate within the context of a primary care system that has general practice and Medicare at its heart. Although general practice is the bedrock of the primary care system in Australia, it is complemented by other services offering choices to patients about how they access care. However, the choices on offer vary greatly and become highly limited in regional and remote Australia.

The challenges of accessing after-hours primary care cannot be readily separated from the delivery of primary care more generally. There are changes taking place in how primary care and general practice will be delivered in future, hastened by the changes brought on by the COVID-19 pandemic. These underlying changes set the context for options for after-hours provision more generally and the PHN After Hours Program in particular.

There are workforce challenges within Australia and around the globe with shortages of GPs evident. General practice is sometimes seen as relatively unattractive compared with other medical specialties. Lifestyle changes and expectations about work/life balance mean there is an increasing reluctance of the younger workforce to commit to a traditional 24-hour care model.

Consumers are seeking greater convenience in accessing care matching what is available in other parts of their lives. The market is responding to these trends by offering new and innovative ways of delivering care, some of which can be disruptive to traditional modes of service delivery. A move towards virtual delivery of health care had already begun and this shift was hastened by the COVID-19 pandemic. There are policy drivers for more integrated

and coordinated care and a proactive approach to managing chronic illnesses that actively engages patients and families as partners in achieving good care.

These drivers will shape the future of primary care and general practice. They will be issues the Primary Health Reform Steering Group will undoubtedly consider in advising the Federal Government on the proposed 10-year plan for primary health care. These factors will also shape the landscape for the role of PHNs and after-hours provision.

Chapter 2 described the current system and highlighted the issues that need to be addressed for an effective system of after-hours primary care. These include:

Multiple and confusing entry points
Individuals face a confusing array of entry points to primary care after hours that are not evident during usual business hours of general practice. There are no well understood, visible, accessible, consistent and trusted entry points to primary care that are widely understood within the community. Internationally, some health systems mandate or incentivise the use of a single access point for after-hours care guiding patients to the most appropriate options, which contributes to a system that is easily understood by consumers. While a single point of entry is easy to understand diversity of provision to meet different needs has advantages. If multiple entry points continue to be a feature of the system then there is a need to simplify and support PHNs, GPs and other service providers (such as pharmacists) to communicate clearly how services are accessed and how much they cost.

Access to primary care services generally
Pressures on after-hours systems are often related to the accessibility of services within working hours. The after-hours system cannot compensate effectively for shortcomings in access to primary care more generally.

Stepped model of urgent after-hours care
Individuals seeking access to after-hours primary care have a wide range of needs. A stepped model of urgent after-hours care is one that can help individuals identify and access the most appropriate level of available service for their needs, whether this be an online symptom checker, virtual GP consultation, after-hours GP clinic or home visit, or attendance at a hospital ED. In many cases, confidence in self-care and/or a subsequent check-up with a person's usual GP is all that is required. The availability and use of stepped service options is variable across PHNs currently, particularly in non-metropolitan areas.

Financial incentives
General practice and the Medicare system are the bedrock of primary care in Australia. GPs mostly work in private practices that require a sound business model to sustain service capabilities and livelihoods. The payment system creates financial incentives that do not always work effectively to direct patients to the most appropriate pathway. Patients are highly sensitive to co-payments and during this evaluation, this was regularly raised as one of the key drivers behind patients choosing ED care.

The PHN After Hours Program sits within this context, aiming to increase the efficiency and effectiveness of after-hours primary care. Broader policy settings are part of the context within which PHNs pursue these tasks, and they have a significant effect on promoting or impeding PHN efforts. Among the issues that are likely to require resolution over the coming years are:

- the role of triage services and how they link with the wider system
- the role of urgent-care centres and similar types of services
- integration and streamlining of services at the interface of primary care and services provided by states/territories
- integration of digital health solutions within a funding system largely based on face-to-face care.

PHNs are not in a position to solve all the issues that arise from the complexity of the primary health care system, interactions with state/territory health care systems and the adequacy of workforce supply issues. PHNs have to work within the current system and identify which services can work alongside the existing service landscape but also how they can do so most effectively. This is not always easy when challenges are deep-rooted and sometimes perceived as intractable or at least requiring system-level reform. The PHN After Hours Program is relatively small scale compared to the wider range of services and funding for after-hours care. Expectations for the program need to be viewed in this context.

Despite the complexities of the system, there is a role for a program such as the PHN After Hours Program that can support more locally tailored initiatives and promote coordination between, and functioning of, local providers. The strength of the Program is its flexibility to respond to the diversity of local needs in ways that other national programs cannot match.

The recommendations below need to be considered in the context of these system-wide issues and be viewed alongside the other changes that may be required to make the overall after-hours system more efficient, effective and accessible.

Continue the program

***Recommendation 2:* Continue the PHN After Hours Program but implement changes to sharpen its focus, improve accountability and support sustainability of services.**

The evaluation team's assessment is that the general objectives of the PHN After Hours Program are still relevant – gaps in services and needs are still evident across the PHNs and a role for coordination and systems support at a local level remains. The team's assessment is that a program addressing these issues through locally tailored initiatives is required. As gaps and systems of primary care vary across the country, any such initiative will result in diversity in local responses. This should be accepted. However, changes in the way the program operates are required. Further, national direction on the future of primary care is vital, together with additional national initiatives to address key system-wide challenges. A program that focuses on local solutions is not the vehicle through which broader challenges for the health system can be addressed. For example, the program is not the means through which community awareness can be generally addressed and it does not have the resources to address broader imbalances in workforce supply.

An objective of the PHN After Hours program and after-hours primary care more generally is to reduce unnecessary ED presentations and hospitalisations. The evaluation included statistical analysis to assess whether there was evidence of any effect on these two variables and to examine the relationship between MBS after-hours services and ED low urgency presentations.

The key results are:

- There is a negative relationship between the rates of MBS supported after-hours services and low urgency ED presentation rates. This suggests that higher rates of MBS-supported after-hours services generally lead to a reduction in rates of low urgency after-hours ED presentations. However, this effect is moderate.
- There are additional contributions to the levels of rates of low urgency after-hours ED presentations related to rurality and socio-economic characteristics of SA3. Rurality and lower socio-economic status both increase rates of presentations.

Models were also estimated to examine the impact of introducing new activities under the PHN After Hours Program. The results of these analyses suggested that:

- There is some evidence that introduction of new activities under the program was associated with a small decrease in the level of low urgency after-hours ED presentations. The evidence is strongest for activities commencing in 2016-17, which were associated with a 4.5% decline in the ED rate in subsequent periods. Initiatives introduced in later financial years were not associated with a decline in the ED rate.
- Overall, the evidence on the effect of introduction of activities under the program and rates for acute and chronic potentially preventable hospitalisations is inconsistent, suggesting there is little evidence of a relationship between the program and potentially preventable hospitalisations.

In consultations, some PHNs were ambivalent about the continuation of the program and would prefer that the funding was rolled into a broader program that provided greater latitude for investment. Others were enthusiastic and considered the program one of their most effective initiatives.

Given the gaps in after-hours provision, the program could be discontinued if there were other mechanisms in place to meet these needs. The evidence presented in this report suggests that these needs are unlikely to be met in the absence of the PHN After Hours Program. Some of the most acute service gaps are in the remote and outer regional areas where there are systemic issues that need to be tackled. PHNs working with states/territories and other organisations can make a difference through joint planning and coordinating activities.

The Department of Health could consider undertaking a national-level initiative that does not operate through the PHNs. However, one of the key findings from the evaluation is that there is no 'one size fits all' solution and that the contexts and challenges vary considerably across the country, and this is replicated within PHNs. The solutions need to be locally driven and locally derived. An alternative would be to roll the funding into the overall PHN budget rather than running this as a separate program. If this course of action were adopted, the focus of the program may be lost with other priorities crowding out the focus on after-hours services.

Overall, our view is that there is a role for a local, flexible program that sits alongside mainstream service provision. Although similar types of issues arise in different PHN areas, these need to be understood at a local level – indeed many of them are highly localised requiring highly targeted interventions. The flexibility allowed within the program means PHNs can and do respond differently to the needs of their communities in ways that may not be feasible for other parts of the system to deliver.

However, aspects of the program should change to increase the ability of PHNs to meet their objectives. These changes are set out in the recommendations below.

Review and refine the focus of the program

***Recommendation 3:* The PHN After Hours Program should be flexible but more actively directed towards four main areas:**

- **Supporting services in parts of the country where there are limited or no after-hours services available in the local community.**
- **Identifying and supporting sustainable solutions to ensuring people living in residential aged care have appropriate access to after-hours primary care.**
- **Services for vulnerable groups where it is demonstrated that there are physical, geographic or other barriers to accessing after-hours primary care services.**
- **Promoting coordination between services at a local level and supporting local services providers in having the skills and systems to provide effective after-hours care that integrates with a patient's usual primary care provider.**

Priority be given to addressing gaps in urgent after-hours care, recognising that economic sustainability of some models requires a mix of urgent and non-urgent care. Program guidance for PHNs should place additional emphasis on the need to assess unit costs, likely volumes, potential alternative models, the impact on the viability of existing after hours services and the broader impact of commissioned services.

The gaps in after-hours services vary for different parts of the country. Away from the metropolitan areas, there are significant gaps in the basic provision of after-hours primary care and in remote areas, there is virtually no provision. In these areas, the Program can help fill the gaps in basic provision.

This does not mean the metropolitan areas are without needs. Issues identified in the metropolitan areas relate to groups for whom mainstream services do not work effectively because they are not geared to their needs. In some cases mainstream services are not sufficiently responsive or the cost of delivering care to these groups is high relative to the reimbursement available. Approaches taken by PHN include providing a more responsive model of care or an appropriate level of subsidy for the services to be economically viable.

Given the multitude of health literacy and community awareness programs, it would be beneficial for the Department to consider working with the Australian Commission on Safety and Quality in Health Care on guidance for health literacy activities. The Department should also consider wider strategic approaches to consumer awareness and literacy beyond the PHN After Hours Program and across all levels of government. This would ensure that the local approaches taken by PHNs could fit into a wider program of communications and education and ensure greater impact and value for money for the PHN efforts.

Key considerations that could be included in guidance for PHNs in commissioning after-hours services are:

- Assessing the relevant after-hours periods to cover. Many PHNs have geared services around the peak after-hours periods rather than aiming for a 24/7 approach, which is reasonable given the volumes.
- Careful consideration of volumes and cost and assessing the volume thresholds necessary to be economically viable.

- Availability of alternative provision. Where the volumes are low and workforce scarce, then reliance on EDs may be the most cost-effective and appropriate way of meeting needs.
- Assessing how to integrate PHN-funded services with existing health care services.

PHNs have a remit to improve the working of the system and, while limited, this is an important role that can provide effective linkage between the primary and secondary care systems.

Co-develop regional after-hours plans

***Recommendation 4:* PHNs co-develop an after-hours primary care plan with local primary care and hospital service providers. This should include effective engagement with local GPs and primary care providers, local hospital networks and consumers. The plan should address the broader system of after-hours care and access to primary care more generally, identifying priorities for existing and planned services.**

The needs assessment and co-design processes were mixed across the PHNs. In some areas there was very effective joint work with the local hospital networks and with GPs, while in others this was less effective.

There are challenges in planning given the diverse range of stakeholders and localities and, in some cases, lack of geographical alignment between the PHN and local hospital networks. However, we have found that the PHN After Hours Program works best when it is built on strong local relationships that include all relevant government and non-government sectors and health care consumers. Success factors appear to be:

- Relevant stakeholders are actively engaged in developing and 'signing-off' on the plan.
- The plan addresses the broader system of after-hours care, not just the primary care aspects of after-hours care.
- The plan is local – some PHNs cover a diverse range of localities and plans may be required for several localities within their catchments.

Enable greater flexibility

***Recommendation 5:* PHNs be encouraged to explore opportunities for program funds to be pooled with other funding sources where there is evidence that pooled funding represents an effective way to achieve program objectives. Increased flexibility in commissioning and tendering processes should be explored to enable greater diversity in provider involvement, especially in areas where the provider market is relatively weak. Methods for reporting on outputs and outcomes for initiatives involving pooled funding should be developed.**

Some of the most successful program initiatives were those that leveraged mainstream or other funding and alternative sources of funds. Several initiatives supported through the program were sufficiently successful that local hospital networks took over funding.

Challenges in providing adequate after-hours primary care in non-metropolitan communities require creative and innovative service solutions, particularly in remote communities. The service provider landscape is often 'thin', and options limited, and hence the best use needs to be made of the available workforce and resources.

In these circumstances, the program should be sufficiently flexible to allow funds to be pooled across programs and other funding sources, without the creation of burdensome accountability mechanisms. Accountability remains important for these types of initiatives, but the focus should be on outputs delivered and outcomes achieved, reflecting how the initiative contributed to after-hours access.

Target funding to those areas with poor after hours provision

***Recommendation 6:* Selected components of the formula used by the Department to allocate program funding to PHNs be recalibrated, specifically related to age and MMM categories.**

The Department consider a threshold level of funding below which program funding and associated processes are managed under PHN Core Funding. PHNs to which arrangement apply would retain their responsibilities within the after-hour sphere but have greater flexibility in the use of funds.

Over five years the Department transition allocations for Hunter New England and Central Coast PHN and Primary Health Tasmania to the level indicated by the Program funding formula.

Allocations to PHNs from the after-hours primary health care program funding reflect the size of the population and account for differences in population needs. The current formula included weights for age, rurality and socio-economic status. Components of this formula could be refined as described in this report. Across the program, there is a case for a greater degree of targeting, especially to better account for socio-economic disadvantage and the presence of vulnerable population groups.

There is evidence that some PHNs struggle to identify suitable funding opportunities and this was coupled with an aspiration to use funding more flexibly. PHNs in areas of greatest need generally felt they could effectively use additional funding. Under a more targeted formula, allocations for some PHNs may be too small to justify the effort associated with managing the program, including needs assessment, separate approval processes, and specific program-level activities. A threshold of funding could be introduced, below which funding available under the program is be rolled into and managed through the PHN Core Funding, rather than the PHN After Hours Program.

Stabilise funding, create longer approval cycles

***Recommendation 7*: In relation to the funding cycles and approval processes, the Department of Health should:**

- **Establish a 3-year rolling funding cycle for the After Hours Program.**
- **Allow approval of activities within an Activity Work Plan for up to three years.**
- **Implement a cycle for submission and approval of Activity Work Plans prior to the commencement of a financial year.**
- **Require after hours needs assessments to be conducted as part of the wider PHN needs assessment process and refreshed on a rolling 2 to 3 year basis.**

New services usually take time to be approved and established. It can also take time for the service to be embedded into the local service context and for consumers to become aware

of options. Services often require funding stability to attract quality providers and ensure sustainability.

Since 2015–16, the PHN After Hours Program has been managed through 2-year budget allocations to PHNs, with annually approval cycles for Activity Work Plans. Timeframes have often meant approval of budgets for commissioned services occur well into the financial year. Late approvals and short funding cycles seriously compromise the potential effectiveness of commissioned services.

The program would operate more effectively with:

- Program-level budget allocations to PHNs communicated on a 3-year rolling cycle.
- Capacity to approve some activities identified within an Activity Work Plans for up to 3 years within this cycle – 3-year approvals may not be desirable or appropriate for all activities.
- Submission of Activity Work Plans several months before the commencement of the financial year with approval prior to the commencement of the financial year.
- Needs assessment for after-hours services brought together with wider needs assessment and as part of a broader primary care planning process.

Appropriate promotion of commissioned services

***Recommendation 8:* The Department of Health provide guidance for PHNs on implementing appropriate strategies to raise awareness of and promote after hours options including commissioned services.**

The MBS Review found advertising by medical deputising services resulted in increased demand for services based on patient convenience rather than urgent need. The review resulted in restrictions governing advertising by medical deputising services, general practices and other regulated health services. There is evidence from the evaluation that the perceived or actual restrictions on such advertising are limiting public awareness of services commissioned by the PHN to meet gaps in after-hours care. The case studies also identified concerns that medical deputising and other services may be inappropriately increasing demand for after-hours services. There is clearly a tension between raising awareness of services for people in need of urgent care and encouraging uptake of inappropriate or unnecessary care. Lack of awareness can lead to unmet need but ready access to services may lead to overuse of these services with consequent implications for the public purse. While this evaluation does not recommend changes to the advertising restrictions on regulated health services, the Department could provide further support to PHNs to ensure they have a good understanding of what they are able to do to promote and raise awareness of after-hours services.

Improve planning and accountability through better data

***Recommendation 9*: Review the accountability arrangements and develop a process for ensuring that PHNs have robust monitoring and performance reporting in place for the commissioned activities. The Department of Health should establish an after-hours minimum data set that captures occasions of service for all funded services.**

***Recommendation 10:* To assist PHNs in conducting their needs assessments, the Department of Health should work with AIHW and states and territories to review the arrangements for**

access to data. This should include exploring ways to establish consistent and robust ways of ensuring PHNs have access to timely, accurate and geographically disaggregated data relating to MBS (including after-hours items), PIP, ED and potentially preventable hospitalisations.

Accountability

The current reporting requirements primarily concern financial commitments and expenditure. There are few requirements to demonstrate delivery of planned and agreed activities. The diversity of activities makes a standard reporting format more complicated to achieve, but it is important that PHNs can demonstrate that effective reporting and monitoring arrangements are in place.

Establishing a minimum dataset would provide an opportunity to standardise output and outcome measures. There are several ways in which improved information flows could be created within the program to aid planning and evaluation and promote accountability. Creating a common vocabulary and guidance for describing activities supported under the program is one way. For example, PHNs have adopted many ways of defining activities, some of which bundle a diverse set of activities. Guidance could be provided to determine appropriate ways to define an activity for the Activity Work Plans and for reporting purposes.

Data for monitoring and needs assessment

High-quality and timely data are critical for needs assessment, monitoring, and evaluating effectiveness and outcomes. PHNs report that the data available to them is often insufficiently timely, or granular, especially at a geographical level but also in relation to patient characteristics.

Key data include MBS items covering both in and after hours, PIP data coverage and levels, and ED and potentially preventable hospitalisation data.

Additional strategies to improve planning for after-hours services include:

- Identifying with the AIHW opportunities to better use existing data sources to provide a better understanding of how local after-hours services are functioning. This includes expanding on analyses of data at the SA3 level and potentially smaller geographical levels and exploring opportunities for reporting on data that links MBS and ED care.
- Exploring with the AIHW, states and territories, and other stakeholders the opportunity to regularly survey a sample of low-urgency patients attending EDs to obtain information on the pathways they followed prior to arriving at the ED, the reasons for attendance, and knowledge and acceptability of alternative services.

Share and learn

***Recommendation 11*: PHN chief executive officers and the Department of Health should consider mechanisms to facilitate greater sharing and learning between PHNs about after hours. This needs to operate at a level below senior management and should allow contract managers and other staff to be able to engage with each other.**

PHNs have established informal processes for sharing information about their strategies and initiatives between each other but these are ad hoc. PHN staff were often unaware of projects and initiatives in other PHNs. Where PHNs have successfully commissioned effective

models of care, there should be greater opportunities for these approaches to be shared. Similarly, sharing experiences of activities that were less successful can be effective and lead to greater spread of knowledge and best practice.

Promote the program

***Recommendation 12*: The Department of Health should consider methods of providing information about the program and promoting or showcasing the PHN After Hours Program activities.**

There is limited awareness of the PHN After Hours Program both among national bodies and stakeholders and also locally. Very little information can be found on the Department of Health website about the program. PHNs generally have good websites and provide information about the program but there is little national-level information about the program. The benefits of promoting the program are three-fold:

1. Improves national stakeholder awareness of the program and provides a fuller picture of the extent of central support for after-hours services
2. This in turn helps to leverage local stakeholder awareness, engagement and buy-in.
3. Supports wider government requirements relating to transparency and accountability.

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