phn COOPERATIVE

An Australian Government Initiative

SUPPORTING HEALTHY AGEING THE ROLE OF PHNs

WHITE PAPER

PHN

Acknowledgement

All 31 PHNs support the directions and views expressed in this White Paper and have contributed through comments, case studies and revisions. Brisbane North PHN was the lead PHN with key input from Central Queensland, Wide Bay, Sunshine Coast PHN, North West Melbourne PHN, Nepean Blue Mountains PHN, Brisbane South PHN, Central and Eastern Sydney PHN and other members of the CEO Cooperative Healthy Ageing Working Group.

We acknowledge the traditional custodians of country throughout Australia and recognise their continuing connection to land, waters and community. We pay our respects to them and their cultures; and to Elders both past and present.

Contents

Summary and recommendations

This paper identifies the current and potential roles of Primary Health Networks (PHNs) in supporting healthy ageing and creates the blueprint for the PHN Cooperative to lead and engage with the Healthy Ageing agenda. It calls for government to use the existing national infrastructure and expertise of the 31 PHNs by investing appropriately in their capacity to realise the vision of enhancing the health and wellbeing of older people through the adoption of well-connected, place-based and person-centred strategies and approaches.

PHNs have implemented a broad range of programs and activities that seek to improve the health of older people within their regions.

- PHNs are embedded within their local communities to act as planners, commissioners, innovators and integrators for services in their region.
- PHNs have built a body of evidence that demonstrates their capacity for understanding, analysing and prioritising local needs, and collaboratively developing localised responses to meeting those needs.
- PHNs have a particular focus on vulnerable populations – the people most likely to miss out on the opportunity to access and engage with health and aged care services.

This places PHNs in a strong position to contribute to improving consumer journeys into, within, and between the health and aged care systems.

In responding to the Royal Commission into Aged Care Quality and Safety, the Government has committed $17.7 billion to an aged care reform package in the 2021-22 Federal Budget. The package includes specific funding for Primary Health Networks (PHNs). The report of the Royal Commission, and other recent national reports, clearly articulate the need for reform that supports older people having the same rights to quality health care as other Australians. They also highlight the essential role of person-centred approaches that support older people to manage their health and wellbeing and to engage effectively with the health and aged care sectors when required.

This context provides a significant opportunity for PHNs to deliver coordinated responses to enhance integration of health and aged care services within their regions and to contribute to improvements in the health and wellbeing of older people.

It is recommended that PHNs:

- use the roadmap outlined in this paper to guide plans for building on their existing capabilities
- consider and integrate approaches within all relevant PHN funding streams to address the specific needs of older people (horizontal integration).

It is recommended that the Federal Government:

- leverage the existing national infrastructure and expertise of the 31 PHNs to drive relevant aged care and primary health reform and improvement initiatives
- support PHNs through funding to take on additional activities and resource increased capability development.

It is recommended that Government and other key stakeholders in the health of older people:

- recognise the national PHN network as a willing and capable partner.

Background

Purpose of this document

This paper identifies the current and potential roles of PHNs in supporting healthy ageing and creates the blueprint for the PHN Cooperative to lead and engage with the Healthy Ageing agenda. It calls for government to use the existing national infrastructure and expertise of the 31 PHNs – as regional commissioners, stewards of the primary health care system and providers of general practice support – by investing appropriately in their capacity to realise the vision of enhancing the health and wellbeing of older people through the adoption of well-connected, place-based and person-centred approaches.

In late 2020, the 31 PHNs (the PHN Cooperative), undertook a project to describe a proposed future for the Primary Health Network Program over the next five years. The outcome of this project was the release of the *PHNs of the Future White Paper*[1] which outlined PHN roles and responsibilities in the context of the broader health system and made recommendations on the change required to deliver on PHN Program ambitions.

This paper follows the structure of the *PHNs of the Future White Paper*, with a specific focus on the current and potential roles of PHNs in supporting healthy ageing. The paper highlights the capabilities of the national PHN network and provides examples of PHNs' specific expertise and experience in developing regional and place-based approaches to enhance the health of older people and improve the coordination and integration of primary health care, acute and aged care services. It also discusses future roles and opportunities for PHNs and outlines a roadmap for progressive implementation.

National context

Our ageing population

Australia's older generations – those aged 65 years and over – continue to grow in number and as an increasing proportion of our total population. In 2018, 3.9 million Australians were aged 65 or over. This represented 16 per cent of the total population and is expected to increase to approximately 23 per cent of the population by 2060-61.[2,3] Similarly, the number of Australians aged 85 years and over will more than triple from 515,700 in 2018-19 to more than 1.9 million by 2006-61.[4,5]

Ageing and health

Ageing affects people throughout their lifespan differently. Ageing is normal and not necessarily an indication of frailty.[6]

People's ability to remain healthy as they age is affected by a range of factors including behavioural risk factors, mental and social wellbeing, and biomedical risk factors. Many of these factors are affected by social determinants of health such as socioeconomic status, employment, housing, living environment and social engagement.[7,8] Due to disparities in health status and life expectancy, access to aged care services in Australia is made available from age 50 for the Indigenous population and age 65 years and over among the non-Indigenous population.[9]

Improvements in life expectancy have increased the number of years lived free of impairment but have also increased the risk of years of life lived with chronic disease, frailty, memory and mobility disorders with the resulting need for more complex social and health care.[10,11]

1 PHN Cooperative, 2020
2 Australian Institute of Health and Welfare, 2020
3 Commonwealth of Australia, 2021
4 Royal Commission into Aged Care Quality and Safety, 2021
5 Commonwealth of Australia, 2021
6 Royal Commission into Aged Care Quality and Safety, 2021
7 Australian Institute of Health and Welfare, 2018
8 Australian Institute of Health and Welfare, 2020
9 Australian Institute of Health and Welfare, 2019
10 Australian Institute of Health and Welfare, 2020
11 Australian Medical Association, 2021

Changing demand and preferences

These changing demographics, alongside increasing health and care needs and changing expectations of older people and society, affect demand for, and types of care required. Changes being observed include greater demand for a variety of care choices, and the desire of older people to remain in their homes and communities for as long as possible.[12]

Royal Commission into Aged Care Quality and Safety

In October 2018 the Royal Commission into Aged Care Quality and Safety was established to inquire into the quality of aged care services and the extent to which services meet the needs of people accessing them.[13]

Within the broad reaching findings, the Commission found that people receiving aged care, particularly those in residential aged care, do not consistently receive the health care they need. This includes doctor visits, mental health services, oral and dental health care, and preventative and holistic care.

It found there is poor clarity about the responsibilities of aged care providers and health care providers to deliver health care for people in aged care, and inadequate communication between them. The report also highlighted gaps that occur when older people transition between multiple health and social care systems. These are intensified by individual circumstances such as where people live, their physical or mental health needs, financial capacity, culturally and linguistically diverse needs, and technology access and literacy.[14]

The interface between the aged care, health and disability systems

A report was commissioned by the Department of Health in response to issues identified by the Royal Commission about transitions between the aged care, health and disability systems. The analysis of needs and stocktake of programs being delivered, identified the need for more programs that provide:

- support for people accessing information and navigating the aged and health care systems
- services that are culturally safe for Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, refugees, and LGBTIQ+ communities
- increased access to preventative care and early intervention
- rehabilitative care and support services
- support for people to travel to appointments
- support for information sharing to facilitate clinical handover between aged care and health care providers.[15]

Productivity Commission recent findings

The importance of enabling people to play an active role in their health care was emphasised by the Productivity Commission in their report about Innovations in Care for Chronic Health Conditions.[16] They found that better health outcomes are achieved when health care providers consider people's circumstances and preferences, and people are supported to self-manage their health. This requires delivery of advice and support in formats that are accessible and relevant to the consumer.

Similarly, the Productivity Commission's Inquiry into Mental Health articulated a vision for a person-centred mental health system that supports people to live well in their communities and manage their own mental health where possible. A focus on prevention and early intervention, the need for services that are accessible and culturally relevant, and a system that supports seamless transitions of care over a person's lifespan were identified as key features for delivering on their vision.[17]

12 Royal Commission into Aged Care Quality and Safety, 2021
13 Royal Commission into Aged Care Quality and Safety, 2021
14 Royal Commission into Aged Care Quality and Safety, 2021
15 Nous Group, 2020
16 Productivity Commission, 2021
17 Productivity Commission, 2021

System implications

Taken together, these recent national reports clearly articulate the need for reform that supports older people having the same rights to quality health care as other Australians. Demand being placed on the health and aged care systems due to the ageing population increases the importance of those systems complementing and working better together for the benefit of older people.[18] They also highlight the essential role of person-centred approaches that support older people to manage their health and wellbeing and to engage effectively with the health and aged care sectors when required.

Primary Health Networks (PHNs)

Across Australia, PHNs have implemented a broad range of programs and activities that seek to improve the health of older people within their regions. PHNs are embedded within their local communities to act as planners, commissioners, and integrators for services in their region. They have built a body of evidence that demonstrates their capacity for understanding, analysing and prioritising local needs, and collaboratively developing localised responses to meeting those needs. PHNs have a particular focus on vulnerable populations – the people most likely to miss out on the opportunity to access and engage with health and aged care services. This places PHNs in a strong position to contribute to improving consumer journeys into, within, and between the health and aged care systems.[19]

In responding to the Royal Commission into Aged Care Quality and Safety, the Government has committed $17.7 billion to an aged care reform package in the 2021-22 Federal Budget. The package includes specific funding for Primary Health Networks (PHNs). It provides a significant opportunity for PHNs to deliver coordinated responses to address many of the issues identified above, and to enhance integration of health and aged care services within their regions thereby contributing to improvements in the health and wellbeing of older people.

The Australian aged care program

Australia has a government funded and/or subsidised aged care system that provides support to older people in their own home or in a residential aged care facility. This care is usually delivered in residential facilities or through care visits to the home. Government-funded programs offer three types of mainstream aged care:

- residential aged care, which offers long-term stays in an aged care facility on either a permanent or respite care basis
- home care (Home Care Packages Program), which provides different levels of aged care services for people in their own homes. It is considered to be community-based aged care.
- home support (Commonwealth Home Support Programme), which provides entry-level support at home. It is also considered to be community-based aged care.[20]

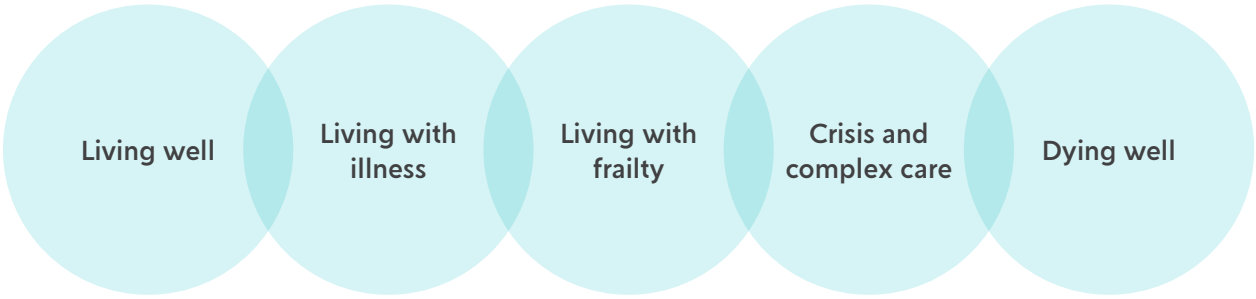
Much of aged care is about social functioning – supporting people to cope when physical and mental decline impairs their capacity to perform everyday activities such as eating, bathing, dressing, shopping, and managing money. The Commonwealth Home Support Programme requires service providers to use a wellness, reablement or restorative care approach. This means providers should build on what people can do; move from 'doing for' a person to 'doing with' them; and help people to regain confidence and independence to reduce their ongoing reliance on services. The focus of the aged care system has principally been about managing and compensating for functional impairments rather than managing disease processes.[21]

Importance of the interface between the aged care and health care systems

To ensure older people receiving aged care services have the same rights to quality health care as other Australians, aged care services need to connect and integrate with primary and acute care services to provide a continuum of services that assist older people to maintain their health, functional capacity, dignity and control, regardless of the setting in which people live. The continuum should include access to health and aged care services across the five domains of care from preventive care through to palliative care as described in Figure 1.

18 Australian Medical Association, 2021
19 Australian Health and Hospitals Association, 2015
20 Australian Institute of Health and Welfare, 2020
21 Royal Commission into Aged Care Quality and Safety, 2021

Figure 1. Five domains of care



PHN program of the future

PHN program purpose

Currently the PHN program purpose is defined by the Department of Health as:

- to improve the efficiency and effectiveness of medical services for patients, in particular those at risk of poor health outcomes
- to improve the coordination of care to ensure patients received the right care, in the right place, at the right time.

Six years on from their establishment in 2015, evaluations and reviews of PHN activities have revealed the true breadth of PHN contributions and an evolution well beyond the objectives set in 2015. PHNs are providing leadership within their communities to foster the development and performance of the primary health care sector and working strategically towards true integration across health sectors. The recent Addendum to the National Health Reform Agreement (2020-2025) provides the latest iteration of these objectives:

Addendum to National Health Reform Agreement 2020-2025 – Strategic Objectives of Primary Health Networks:

a. Identifying the health needs fo their local areas and develoment of relevant focused and responsive services
b. Commissioning health services to meet health needs in their region
c. Improving the patient journey through developing integrated and coordinated services
d. Providing support to clinicians and service providers to improve patient care
e. Facilitation the implementation fo primary health care initiatives and programs
f. Being efficient and accountable with strong governance and effective management

The draft purpose was articulated in the *PHNs of the Future White Paper* as:

The PHN Program furthers an integrated, coordinated primary health care system that delivers high quality, patient centred care.

PHNs are the experts on the primary health needs of their region and the central drivers for reform, integration and equitable access across its health and social care system. As regional commissioners, they reduce fragmentation and address unmet needs working with Local Health Networks, Local Health Districts and other partners through innovative and consistent service delivery. PHNs support the health care workforce to build capacity and capability and are positioned to support coordinated primary health care responses to emergency and natural disasters.[22]

22 PHN Cooperative, 2020

PHN roles

The five core roles (below) proposed for PHNs in the *PHNs of the Future White Paper*, reflect both the current and emerging activity of Australia's PHNs and best practice examples from the global literature.

1. **System coordination and integration:** reduce fragmentation and enhance coordinated, integrated care by working collaboratively across services and sectors.
2. **Regional commissioning:** bridge the jurisdictional, hospital-community-primary and cross-sector divides through collaborative commissioning with a focus on the primary health care system.
3. **Primary care system stewardship and management:** progressively improve system quality, access and equity.
4. **Primary healthcare education, training and workforce development:** build the general practice/primary care workforce of the future.
5. **Health system transformation and reform:** progress against agreed system reform objectives.[23]

This White Paper discusses these PHN roles through the lens of their potential to contribute to improvement in the health of older people.

Current PHN aged care priority

The Commonwealth Department of Health has nominated seven priority areas for the PHN Program. They are:

- mental health
- Aboriginal and Torres Strait Islander health
- population health
- workforce
- digital health
- aged care
- alcohol and other drugs[24]

Whilst 'aged care' is the term used to identify the priority area, the outcome indicators in the PHN Program Performance and Quality Framework suggest a broader scope than that of the support provided within the aged care system (refer to The Australian aged care program section on page six).

For the aged care priority area, the following outcomes relating to access and quality of care, have been identified in the PHN Program Performance and Quality Framework:

- older people in PHN regions are supported to access primary health care services that meet their needs including self-care in the home
- older people in PHN regions are supported to enjoy a greater quality of life
- fewer preventable hospitalisations in PHN regions for older people
- local health and other care providers are supported to deliver coordinated, effective and appropriate care to older people in PHN regions
- local health care systems provide coordinated, quality care to older people.[25]

Whilst aged care is one of seven priority areas for PHNs, limited funding has been allocated to PHNs to directly respond to this priority. Generally, PHNs have addressed identified needs relating to older populations through flexible or health/system improvement funding sources, which constitute a relatively small proportion of the total funding PHNs receive to address the range of local needs across the seven priority areas. PHNs have made different decisions about the amount of focus they can provide within their

23 PHN Cooperative, 2020
24 Australian Government Department of Health, 2018
25 Australian Government Department of Health, 2018

portfolio of activities based on their local needs assessments.

More recently, PHNs have successfully implemented activities specifically relating to aged care/older peoples' needs using new funds provided by the Department of Health. Examples include the *Greater Choice for At Home Palliative Care* measure provided to some PHNs; funds to support PHNs to participate in the rollout of the COVID-19 response and vaccinations in residential aged care facilities; and psychological therapy services in residential aged care facilities – and for older people in their communities – as a response to the pandemic.

In addition, some PHNs have successfully sought opportunities to source funding targeting older people's health including:

- Brisbane North PHN – operates both a Commonwealth Home Support Program service and a Regional Assessment Service through consortium models in their region
- Brisbane South PHN – is a trial site for the national Aged Care Navigator Trials testing different services and activities to help people learn more about the Australian Government-funded aged care services and how to access them
- Northern Sydney PHN – collaboratively commissions rapid care for frail and older people in partnership with NSW Health.

Some of the specific funding allocations to PHNs, together with additional funding streams successfully secured by PHNs, has resulted in variability in access to resources and therefore the amount of focus on addressing the needs of older people that has been possible for PHNs across the country.

Greater equity and a national approach, implemented locally through the PHNs to meet the needs and expectations of older people in their communities, is required.

Healthy ageing– future role for PHNs

Changing demographics resulting in rising needs for high quality health and aged care services, community expectations, and the reforms arising from the recommendations of the Royal Commission and 2021 Federal Budget, mean the potential for PHNs to extend their role in relation to the health of older people is significant. Using the roles outlined in the *PHNs of the Future White Paper*, opportunities for PHNs to build on current work and capabilities to address health and service system challenges are identified below.

Figure 2. The future PHN Program

National PHN Network Purpose Statement (Preliminary)

The PHN Program furthers an integrated, coordinated primary health care system that delivers high quality, patient centred care.

PHNs are the experts on the primary health needs of their region and the central drivers for reform, integration and equitable access across its health and social care system. As regional commissioners, they reduce fragmentation and address unmet needs working with Local Health Networks, Local health Districts and other partners through innovative and consistent service delivery. PHNs support the health care workforce to build capacity and capability and are positioned to support coordinated primary health care responses to emergency and natural disasters.*

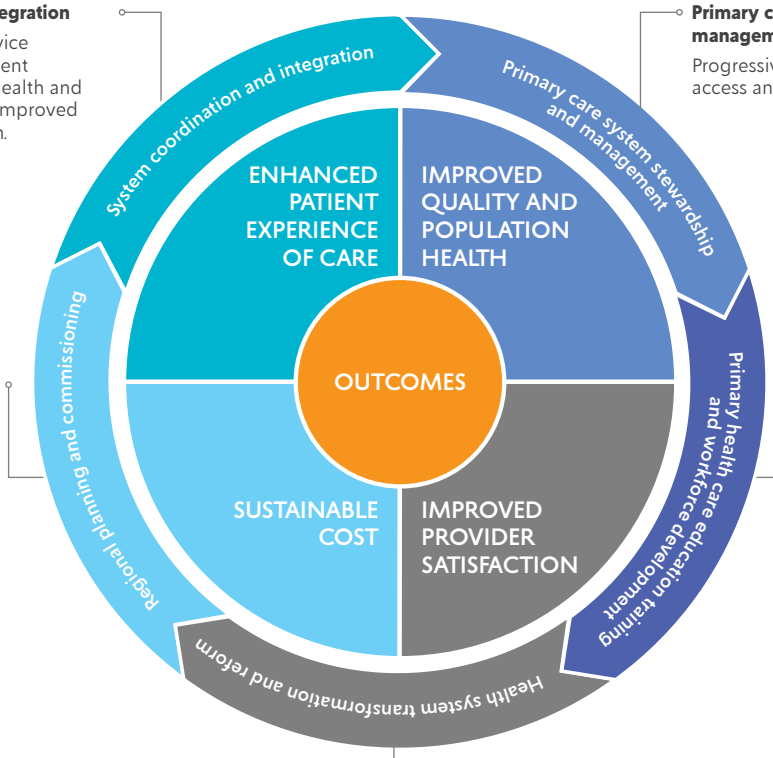
OUR ROLES

System coordination and integration

Enhance access through service navigation and improve patient journeys within and across health and aged care services through improved coordination and integration.

Primary care system stewardship and management

Progressively improve system quality, access and equity for older people.



Regional planning and commissioning

Foster collaborative regional planning and commissioning – with a focus on the primary health care system – that meets the needs of local communities and integrates well with the local health, aged and community service system.

Primary health care education training and workforce development

Build the primary health care workforce of the future and support the aged care workforce in seeking health care support when needed.

Health system transformation and reform

Drive, monitor and support progress against agreed system reform objectives.

OUR ENABLERS

Governance	Relationships and Alliances	Health and System Intelligence	Investment and Financing	Freedom to Innovate
Effective and inclusive governance that facilitates a coordinated approach from planning to evaluation.	Enduring relationships within and across sectors, and all levels of government	Embedded data to support commissioning drive continuing quality improvement and demonstrate outcomes	Adequate investment that leverages existing funding and reflects the integrated nature of care	Autonomy to adapt system elements to meet regional need, reduce barriers and eliminate perverse incentives

* Department of Health

Scope

In considering the potential scope of work for PHNs in relation to the aged care priority as currently defined by the Department of Health, PHNs have determined their focus should be on the health of older people, rather than the care of older people (e.g. services provided through the Australian Aged Care Program).

This proposed scope for activity is consistent with the Strategic Objectives for PHNs as set out in the National Health Reform Agreement, and the proposed purpose of PHNs as outlined above.

The scope implies that PHNs will focus on a broad range of activities that contribute to healthy ageing across the five domains of care (see Figure 1).

These include but are not limited to:

- health promotion and disease prevention
- increasing access to and quality of primary health care services for older people
- improving integration and coordination across the aged care and health care sectors
- workforce education
- supporting comprehensive, coordinated, evidence-based interdisciplinary health care, and
- working with communities to ensure that health and aged care services reach and are accessible and appropriate to the needs of older persons in our regions.

While the focus of PHNs is on the health of older people, an understanding and appreciation of the context and impact of the care of older people on their health and wellbeing will underpin all PHN responses.

PHN roles

System coordination and integration

Despite the best endeavours of both the Commonwealth and States/Territories, the health system that confronts older Australians is complex and fragmented. Available services are difficult to access, confusing for service users and their advocates, and in most cases, lacking in the information that older people need to make well informed decisions about their health needs.

Aged care services interface with both the primary health care and acute health care sectors, and yet are not part of the health system. Disconnection between the health system and aged care services compound the difficulties associated with ensuring high quality health care for older people who are reliant on the aged care system to meet their care and support needs.

Silos and blocks between primary health care, aged care and the acute health care sectors lead to unnecessary hospital presentations, fragmentation of care, and communication breakdowns. Lack of access to specialist clinical expertise (including palliative care) also contributes to unnecessary transfers from the aged care system into the acute health system.

PHN capabilities

PHNs build relationships with key regional stakeholders across the health, social care and aged care sectors to improve service coordination and integration. These include aged care providers, multi-cultural communities, Aboriginal and Torres Strait Islander health services and communities, peak bodies, carer organisations, general practice, local public health networks and private practitioners, acute (tertiary) care, peer support/consumer groups, supporting services (e.g. ambulance, police, local government, etc.) and researchers.

PHNs collaborate with health practitioners, aged care providers, researchers, state and federal government agencies to identify, pilot and implement high quality evidence-based responses to identified and prioritised local needs and service gaps for older people.

PHNs facilitate resource sharing and capacity building within and between health and social care sectors to identify and maximise synergies and the capacity to deliver services closer to home.

PHNs work with diverse stakeholders across the community to identify and co-design local service responses for older people that add to and leverage local resources and knowledge.

PHNs use local networks and local knowledge to troubleshoot and find solutions.

PHNs support improved communication, coordination and referral between aged care and primary health care providers.

PHNs work across local, state and federal government agencies, hospitals, local health networks, primary health care and aged care to co-ordinate and adapt local responses to emergency management situations, such as the COVID-19 pandemic in aged care.

PHNs have built capacity to respond to emergency management situations that impact the health of older people (and others) in the community.

Examples

- PHNs have coordinated regional rollouts of flu vaccines for residents and staff in residential aged care facilities during 2020 and COVID-19 vaccines for residents in 2021. Sydney North PHN (SNHN) worked collaboratively with Northern Sydney LHD during the initial COVID-19 outbreaks in Northern Sydney in 2020 to accelerate RACF connections to the NSW Health telehealth system, so that they could contact the Rapid Response Teams remotely. SNHN was able to successfully connect 98/119 facilities over a 3-4 month period.
- HealthPathways, originally developed in New Zealand, has been implemented in all but one of the PHN organisations. Developed in Australia as a collaboration between local primacy care clinicians and local health/hospital services with a clear focus on improving care pathways for patients, reducing waiting times and improving referrals for a large range of medical conditions.
- PHNs were instrumental in the adoption of My Health Record across primary health care, specialist, pharmacies and RACFs and continue to work with primary health care practitioners to ensure effective use of electronic medical records and My Health Record.

- Other examples are included in the System coordination and integration section of the associated Case Studies document.

Opportunities

PHNs can continue to identify innovation and improve communication, coordination and integration of services within the health system and at the interface of the health and aged care systems within their regions.

PHNs can continue to consider how access and appropriateness of existing primary health care services may be improved for older people.

In addition, specific opportunities were identified in the 2021 Federal Budget, which recognised the significant coordination and integration role that PHNs will lead utilising funds allocated for:

- development of local dementia care pathways which support general practitioners to refer patients to the support they need. This will enable PHNs to enhance their HealthPathways work to focus on dementia and other conditions that affect the health of older Australians.
- enhanced support and face-to-face services to assist senior Australians accessing and navigating the aged care system. This will include a network of community care finders who will provide assistance to access and navigate aged care services and other supports at the local community level.
- PHNs to use their significant commissioning expertise to procure and manage these services in their communities. This commissioning will benefit from PHN's significant knowledge of local service networks, characteristics of their populations – particularly those vulnerable populations, and PHN's experience in service navigation and pathways development and implementation. Additionally, the data and intelligence gathered from the Community Care Finder and navigation process will continue to inform the further development and refinement of the PHNs' commissioning activities to ensure that both older people's expectations and experience are central to the design and redesign of commissioned services.
- streamlining the current assessment process for aged care.
- PHNs have the potential as part of their system coordination and co-design functions, to monitor the impact of changes to the assessment process over time to identify gaps in system accessibility, and opportunities for improved coordination, integration and reform across the aged care and health systems.
- PHNs can work collaboratively with local Commonwealth Department of Health teams being established in eight PHN regions to demonstrate the value of PHN's regional presence to improve rural and regional stewardship of aged care in the initial rollout stage.

Regional planning and commissioning

As people age, their frequency of engagement with the primary health system increases, with 98.3 per cent of older Australians seeing a GP in the last year. In fact, more than 90 per cent of people aged over 65 years have a regular general practitioner and people aged over 85 years were almost five times more likely to see a GP on 12 or more occasions than those aged between 15 and 24 years.[26] Primary health care is extremely important in caring for and managing the health concerns of older people.

The Royal Commission into Aged Care Quality and Safety identified that one of the key causes of substandard care in aged care is that people are not consistently receiving the health care they need.[27]

Equitable health and aged care systems require service availability for all eligible people on the basis of need. A regional planning approach is essential to ensuring that funded services and activities meet the needs and priority of each local community – including the needs of older people from marginalised groups. PHNs have evidenced that regionally designed, delivered, and evaluated models of service tend to have maximum impact and integrate well with other parts of the local health and community service system.[28]

PHN capabilities

PHNs, together with key stakeholders, undertake regional needs assessments and planning to address unmet needs, reduce system fragmentation and minimise duplication across services and organisations.

PHNs lead market development activities to build local capacity to respond to commissioning opportunities and to inform the development of new service models for older people.

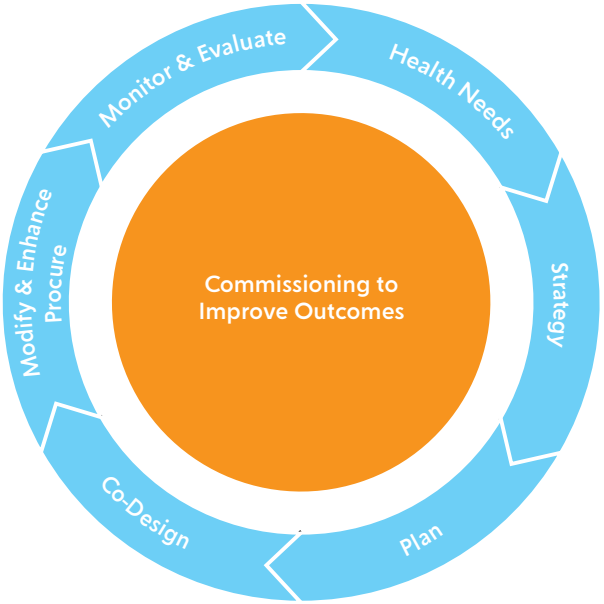
PHNs commission services in response to identified primary health care service gaps across the health, aged and/or social care continuums.

PHNs are skilled at influencing and shaping the supply of local services.

PHNs manage contracts to ensure the optimal delivery of commissioned services tailored to address local community needs and service gaps.

PHNs evaluate provider performance and consumer-related outcomes to ensure value for money, to monitor service quality, and to inform our intelligence and future commissioning activities.

Figure 3: PHN Commissioning Cycle



Driving sustainable change in our health systems to improve people's outcomes and lives

26 The Royal Australian College of General Practitioners, 2017
27 Royal Commission into Aged Care Quality and Safety, 2021
28 National PHN Cooperative, 2021

Examples

- development of Australia's most comprehensive health-based commissioning training
- joint regional plans have been developed by Brisbane South PHN and Brisbane North PHN with their partner Hospital and Health Services – Brisbane South Older People's Health and Wellness Strategy 2019-2024 ; Five-year health care plan for older people who live in Brisbane North 2017-2022
- collaborative Commissioning partnerships between LHDs and NSW PHNs supported by the NSW Health Collaborative Commissioning Initiative. An example includes the North Sydney PHN collaborative commissioning focus on rapid care for frail and older people – https://sydneynorthhealthnetwork.org.au/programs/frailty/
- other examples are included in the 'Regional planning and commissioning' section of the associated Case Studies document.

Opportunities

The 2021 Federal Budget included an announcement that "Primary Health Networks will ... utilise their regional expertise and on the ground capabilities to support the health of senior Australians" through:

- telehealth care for aged care residents
- enhanced out of hours support for residential aged care
- early monitoring and identification of health needs to support people to live at home for longer.

The specific allocation of funds to PHNs for these purposes will enable all PHNs to generate more specific data and intelligence which leads to the commissioning of appropriate services to enhance the availability of, and equitable access to, appropriate health services designed with the expectations and experiences of older people inbuilt.

PHNs will also continue to integrate and commission services to meet the needs and expectations of older people within existing priority areas such as alcohol and other drugs, mental health, and chronic conditions.

PHNs have a role in commissioning early intervention and prevention services to address risk factors early with a view to deferring the need for older people to access aged care services for as long as possible.

Primary health care system stewardship and management (quality)

Older people accessing Commonwealth funded aged care services have complex co-morbidities, are frailer, and generally experience poorer health than peers of a similar age who are living in the community without services. People receiving aged care services, particularly in residential aged care, have inadequate access to pharmacists and medication review, despite being higher users of medicines. There is limited access to services from allied health professionals and mental health services tend to focus on acute, severe or complex mental health issues at the expense of prevention, early intervention or treating milder forms of mental illness and/or social isolation. [29]

The quality of health care, and its coordination for older people is critically important. Quality care includes ensuring accessibility to relevant information – such as through the My Health Record and Advance Care Directives – as people transition between health and aged care systems. Improving the quality of care through supporting innovation, adding to the evidence-base, and translating research into practice can have a significant impact on older people's health journey and outcomes.

PHN capabilities

PHNs have a remit from the Commonwealth to address the health care needs of older people and to improve the delivery of health services to older people in residential aged care facilities, including at the end of life.

PHNs engage with primary health care practitioners to drive ongoing improvements in health care systems and service delivery for older people.

PHNs seek guidance and advice from researchers, clinicians, experts, and consumers, to identify opportunities to improve system performance and outcomes, including better coordination of service responses across the health and aged care interface.

PHNs use evidence to identify and respond to the needs of under-serviced groups in the community, such as older people from culturally and linguistically diverse backgrounds.

PHNs seek to ensure equity of access to services for all in the community, including ensuring that services are available and accessible to those least able to access mainstream services.

PHNs maintain governance structures to ensure ongoing accountability and transparency regarding funding decisions and sector reform.

Examples

- PHNs work closely with general practitioners and other health professionals to build health workforce capacity and design and support quality care initiatives
- the Practice Incentives Program Quality Improvement (PIP QI) initiative is heavily underpinned by PHN support activities to build capacity and capability in the primary health care workforce and to drive ongoing improvements in health care at a primary health care level. PHNs operate in partnerships with researchers, service providers, local communities, general practice and allied health practitioners to identify local needs and priorities, including working with expert advisory groups, health practitioners and others to address capability/knowledge gaps in the local workforce.
- PHNs have collaborated to create a single storage and analysis solution (Primary Health Insights) as a foundation of a more informed and better evidenced system to inform program and policy decisions about Australian primary healthcare delivery
- Sydney North PHN has established a Dementia Quality Improvement Program (DQIP) which provides the tools for General Practices to identify and support individuals living with dementia
- other examples are included in the 'Primary health care system stewardship and management (quality)' section of the associated Case Studies document.

Opportunities

The use of data to inform quality improvement activities for specific population groups and health conditions is an important role of the partnership between PHNs and general practice. This includes the management of chronic conditions in primary health care for older people. Significant opportunities remain for PHNs to continue this work.

Potential primary health reforms such as voluntary patient registration and an increased

29 Royal Commission into Aged Care Quality and Safety, 2021

focus on prevention across the lifecycle will provide an opportunity for PHNs to apply knowledge gained through involvement in the Health Care Homes pilot and other patient centred medical home models to assist general practices to deliver enhanced person-centred, value-driven approaches to the health care of older people.

With the focus from the Royal Commission, and in the Government's response, on digital health (introduction of electronic medication charts in RACFs, increasing adoption of the My Health Record), there are opportunities for PHNs to continue to support health and aged care providers in the use of digital technologies to improve integration and transitions of care. The use of digital technologies are also relevant to the sharing of Advance Care Directives and care plans – including plans for end-of-life care – between relevant health and aged care providers.

Furthermore, planned increases in investment such as the Medical Research Future Fund – Dementia, Ageing and Aged Care Mission, provide ongoing opportunities for PHNs to translate research findings into practice across the five domains of care (refer to Figure 1 on page 8).

Primary health care education, training and workforce development

The ageing of the population creates an ongoing need for the health and aged care workforces to possess and/or develop relevant skills related to increases in the complexity of health care for older Australians. These include skills in relation to (but not limited to) dementia care, palliative care, mental health, medication management, caring for diverse populations and wound management.[30]

Workforce shortages – particularly in rural, regional and remote Australia – escalate the need to ensure the available workforce has access to relevant opportunities for education, training and ongoing workforce development.

It is not the role of PHNs to address the full range of workforce education and training required by workers in the aged care sector, however arguably PHNs have an important role to play in building capability within their region to understand the primary health needs of older people, and to develop and provide education on local clinical and service pathways. Capability building of this nature enables the workforce involved in the care of older people to provide an appropriate primary response within their relevant scope of practice and to know how to refer or seek additional health care support (e.g. specialist services) when required.

PHNs are uniquely positioned to understand and respond to the needs of the communities in which they operate, to identify education and workforce development needs, and to facilitate cross-sectoral collaboration between researchers and practitioners across the primary health care, acute care and aged care interface.

PHN Capability

PHNs build primary health care workforce capacity and capability to understand and address the diverse health needs of older people.

PHNs lead ongoing professional development activities for general practices and interested allied health practitioners

PHNs work with and support general practices to implement continuous improvement activities (PIP-QI) to drive ongoing improvements in primary health care.

PHNs work in partnership with LHNs and primary health care practitioners to design and support quality care initiatives which lead to better health outcomes for older people.

PHNs work in collaboration with Rural Workforce Agencies to identify workforce needs, plan and deliver workforce solutions.

PHNs operate in partnerships with researchers, service providers, community, general practice, allied health practitioners to facilitate the sharing of knowledge and to support the translation of research evidence into practice to improve quality and coordinated care for older people.

Examples

- Primary health networks already lead ongoing professional development activities for general practices, allied health practitioners and other primary health care staff.
- SNHN Project ECHO for Palliative Care – https://sydneynorthhealthnetwork.org.au/wp-content/uploads/2021/02/Care-at-the-end-of-life-in-an-aged-care-setting-Project-Echo-flyer-1.pdf
- Other examples are included in the 'Primary health care education, training and workforce development' section of the associated Case Studies document.

Opportunities

PHNs can continue and/or enhance the delivery of ongoing professional development activities for general practices, allied health practitioners and other primary health care staff.

Needs assessments, as part of PHN commissioning cycles, provide an opportunity to identify capability gaps and training needs.

The 2021 Federal Budget allocation of funding for the development of dementia care pathways will provide an opportunity for educating the local primary health care workforces in their use.

As new technologies emerge – e.g. Project ECHO, decision support tools – PHNs can play an important role in educating the workforce about their availability and use.

PHNs can also use their local partnerships to continue to foster knowledge sharing, support networks and collaboratives, and related activities that build the capability of the local workforce in relation to improving the health of older persons.

30 Royal Commission into Aged Care Quality and Safety, 2021

Health system transformation and reform

The Royal Commission into Aged Care Quality and Safety has highlighted many gaps and challenges in system navigation, delivery of coordinated care, and provision of high-quality clinical care to older people in the aged care system. The recommendations of the Royal Commission and the work underway by the Primary Health Reform Steering Group in relation to the development of the Australian Government's Primary Health Care 10 Year Plan identify the need for health system reform in the face of the growing number of Australians with chronic conditions, mental health needs and frailty.[31] There is agreement across numerous reports that our health and aged care systems need reform to re-orient them towards promoting wellbeing, preventing illness, undertaking early detection and responding with early and coordinated intervention in a timely way to alter disease trajectories and ongoing care needs.

PHNs are well placed to play a significant role in these health system transformation and reform agendas and therefore to improve the health outcomes and care journeys of older people in their regions.

PHN capabilities

PHNs develop close working relationships with the communities in which each PHN operates

PHNs have commissioning expertise, with knowledge of local needs and priorities underpinning commissioning activities locally

PHNs' have the capacity to co-design and pilot new solutions/service models within local communities

PHNs have existing relationships across sectors (primary, acute, sub-acute, palliative care, aged care, etc.)

PHN evaluation capabilities (both internal and commissioned evaluation activities)

PHNs advocate for local community/knowledge of local community needs (especially under-represented, under-serviced groups)

Experience in local primary health care/sector capacity building within PHN regions

PHNs have established partnerships to increase translation of research findings into practice.

Examples

- 11 PHNs – *Greater Choices in Palliative Care* initiative. The 2021 Federal Budget included funding for this initiative to be expanded to all PHNs.
- Western NSW PHN – Shared Health and Advance care Record for End of life choices (SHARE)
- Other examples are included in the 'Health system transformation and reform' section of the associated Case Studies document.

Opportunities

There are a range of opportunities for PHNs to continue, extend and add to existing capabilities that will support their role in health system transformation and reform.

Working at a system level to improve transitions of care, increase choice and control by providing support to consumers, the community, and health and community service professionals to access aged and health care services. This includes:

- provision of care finding services
- health pathways
- supporting providers and consumers in the use of communication tools such as telehealth and the My Health Record across primary, acute and aged care sectors.

Developing and implementing innovative solutions to monitoring and identifying health needs.

Commissioning a single assessment workforce.

Supporting workforce education and change.

Supporting general practices to enhance person-centred, integrated models of chronic disease management for older persons.

Provide ongoing strategic and policy advice to commonwealth and state governments to influence decisions and reform directions at the interface of health and aged care.

Underpin PHN and government reform-related decisions with advanced data analytics capacity at local, regional, state and national level.

31 Primary Health Reform Steering Group

System enablers

The *PHNs of the Future White Paper* reported that Australian PHN activities and best practice examples from global literature consistently identified five key enablers for success which are clearly recognised in, and generalisable to, the Australian context.[32] As part of the development of this paper, these enablers have been reviewed and are considered equally relevant in the delivery of PHN work to support the health of older people.

1. **Governance** – Effective and inclusive governance that facilitates a coordinated approach from planning to evaluation
2. **Relationships and alliances** – Ensuring relationships within and across sectors, and all levels of government, business and community
3. **Health and system intelligence** – Embedded data to support commissioning, drive continuing quality improvement and demonstrate consumer experience and outcomes
4. **Investment and financing** – Adequate investment that leverages existing funding and reflects the integrated nature of care
5. **Freedom to innovate** – Autonomy to adapt system elements to meet regional need, consumer expectation, reduce barriers and eliminate perverse incentives

Roadmap for the future

This roadmap identifies outcomes that PHNs aspire to achieve to support healthy ageing in their regions. It provides a plan for building existing capabilities across the PHN network and taking up specific opportunities that have been identified in the Royal Commission and 2021 Federal Budget aged care reform initiatives. We would welcome the opportunity to take up additional funding and partnership opportunities along the way.

The roadmap is expressed in terms of three broad horizons for activities. Different PHNs may spend longer in some horizons than others depending on the starting point for their journey. The third horizon identifies capacities and actions to consolidate, enhance, evaluate and mature service and system responses to improve the quality of life experienced by older people in our regions.

32 PHN Cooperative, 2020

ROADMAP FOR THE FUTURE

System Coordination and Integration

Outcomes:

Better information for consumers and carers to inform choice and decision making

Easier access to services across the continuum of care

Improved journeys for older Australians across health and aged care services

Improved communication among, and interaction between, service providers to support high quality health and aged care

- Build relationships to improve regional service coordination and integration
- Identify and prioritise local needs and service gaps with/for older people
- Identify and co-design local service responses with/for older people
- Use local networks and knowledge to troubleshoot and find solutions
- Consider how access and appropriateness of existing primary healthcare services may be improved for older people
- Support improved communication, coordination and referral between aged care and primary health care providers (e.g.development of local dementia care pathways)
- Build capacity, coordinate and adopt local responses to emergency management situations that impact the health of older people (and others) in the community

- Commission Community Care Finders – 2023 to enhance service navigation supports
- Collaborate closely with and/or commission single assessment workforce from 2023 to monitor local impact of changes and opportunities for system integration and collaboration
- Work with the ADHA to support adoption of digital technologies for transitions between aged care and health care services

- Strengthen and expand service navigation roles
- Enhance use of data and intelligence from care finding roles to place older people's needs, expectations and experience at the centre of system design and service commissioning.
- Increase the system focus on prevention, screening and early intervention to support healthy ageing
- Use knowledge and relationships to continue to enhance system coordination and integration across health and aged care services

Regional Planning and Commissioning

Outcomes:

Older people have equitable access to primary health care.

Health and aged care services are available for older people on the basis of need.

The mix of health and aged care services is appropriate for the population and services are well integrated.

- Undertake regional needs assessment and planning
- Lead market development activities to build local capacity to respond to commissioning opportunities
- Commission services in response to identified primary health care service gaps
- Influence and shape the supply of local services
- Manage contracts to ensure the optimal delivery of commissioned services to address community needs and service gaps
- Evaluate provider performance and consumer-related outcomes
- Support the use of telehealth care for aged care residents
- Enhance out of hours support for residential aged care
- Commission innovative models for monitoring and identifying health needs to support people to live at home for longer
- Integrate and commission services within existing priority areas such as alcohol and other drugs, mental health and chronic conditions

- Increased commissioning of early intervention and prevention services to address risk factors to delay the need for aged care services
- Enhance data intelligence and analysis capabilities to monitor health and service needs, and evaluate commissioning outcomes

- Enhance collaborative commissioning models that foster integration between the health, aged care and community service systems.

Primary health care system stewardship and management (quality)

Outcomes:

Older people have equitable access to high quality primary health care.

The quality of services are monitored and continuous quality improvement drives improvements in system performance and outcomes.

Providers are supported in the use of new technologies (e.g. digital health, new funding models).

Evidence from research is translated into practice in a timely way.

- Improve the delivery of health services to older people in residential aged care facilities
- Drive ongoing improvements in health care systems and service delivery
- Identify opportunities to improve system performance and outcomes
- Identify and respond to the needs of under-serviced groups in the community
- Ensure equity of access to services for all older people
- Support health and aged care services in the use of digital technologies to share Advance Care Directives and care plans

- Enhance the collective capability of PHNs to use data to improve the quality of care provided by general practices to older people
- Support increased use of screening tools to aid early identification of issues that adversely impact health and the need for increased use of aged care services
- Assist general practices to implement reforms such as voluntary patient registration to deliver enhanced preventative and person-centred care

- Increase translation of research findings into practice
- Continue to innovate, develop and implement strategies to support primary health care quality improvements.

HORIZON 1 | HORIZON 2 | HORIZON 3

Primary health care education, training and workforce development

Outcomes:

The primary health care workforce has access to education and training relevant to the specific needs of older people.

The local aged care workforce know how to refer or seek health care support when required.

Workforce education and development needs are understood and communicated

Cross-sectoral collaborations between research and practitioners foster knowledge sharing and translation of research into practice.

- Build primary health care workforce capacity and capability to address the health needs of older people
- Identify workforce education and training needs and lead ongoing professional development activities
- Provide education in the use of HealthPathways
- Support general practices to implement continuous improvement activities (PIP-QI)
- Collaborate with rural workforce agencies to identify workforce needs and plan and deliver workforce solutions
- Facilitate the sharing of knowledge and support the translation of research evidence into practice

- Educate the workforce in the use of new technologies as they emerge – e.g. decision support tools, assistive technologies
- Adopt emerging technologies/models for meeting relevant primary health care education and training consistent with changing workforce preferences and needs

- Enhance cross-sectoral partnerships and collaborations to foster knowledge sharing, research and translation

Health system transformation and reform

Outcomes:

PHNs play a key role in driving and supporting health system transformation and reform in their regions.

Older people experience improvements in choice and in their quality of life.

- Foster close working relationships within communities and across health and aged care sectors
- Use commissioning expertise and knowledge to address local needs and priorities
- Co-design and pilot new solutions/service models
- Provide strategic advice to Commonwealth and State/Territory governments to influence decisions and reform directions at the interface of health and aged care

- Build PHN evaluation capabilities
- Provision of Community Care Finder services – from 2023
- Commissioning a single assessment workforce – from 2023
- Support workforce education and change
- Support general practices to enhance person-centred, integrated models of chronic disease management for older people (esp. as primary health reforms such as voluntary patient registration are introduced)
- Underpin PHN and government reform-related decisions with advanced data analytics capacity.

- Increase engagement and partnerships with research institutions
- Enhance monitoring and analysis of the local impacts of system reform initiatives.

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