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Department of Health
Evaluation of PHN After Hours
Program

Final report
Volume 1: Summary

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Key messages and recommendations

Primary Health Networks (PHNs) are charged with 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 forms the bedrock of the primary care system in Australia, it is complemented by other services offering choice to patients about who they consult and how they do so. These choices vary greatly depending on geography and location, becoming more constrained in regional and remote Australia. This results in a patchwork of provision with some areas well served while others have limited options. Consumers are often confused and unclear about what services are available, how to access them and how much it will cost.

The Primary Health Network (PHN) After Hours Program aims to fill some of the gaps after hours. It provides a mechanism to commission services that are more responsive to local needs and focus on system-wide coordination and planning.

PHNs operate within systems that are complex both financially and from a service point of view. There are wider issues and challenges related to the broader landscape of primary care provision and its future direction.

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 workforce supply issues. It is clear from the analysis of MBS services and ED attendances that there are factors which drive these relationships related to geography, population needs and limited service access in the community. PHNs have to work within the current system and identify which services can work in step with the existing service landscape and tackle the most significant gaps in care. This is not always easy when challenges are deep-rooted and sometimes perceived as intractable or 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 of the program need to be viewed in this context. However, there is some statistical evidence that the Program has had a small but positive effect on low urgency ED attendances.

There is a role for a program such as this that can be used in a flexible way to target the specific and unique needs of local areas. At a local level, collaborative partnerships with local hospital networks, general practice, other key providers of after-hours primary care, ambulance services and consumer groups are needed to maximise the effect of local initiatives.

The challenges of after-hours primary care cannot be readily separated from the delivery of primary care more generally. Underlying trends in technology, service delivery and public expectations will have a strong bearing on how primary care will be delivered in future. These

set the context for considering options for after-hours provision more generally and the PHN After Hours Program in particular.

Workforce challenges have been prominently felt around the globe. Shortages of GPs affect many regions, sometimes reflecting the relative unattractiveness of general practice compared with other medical specialties and exacerbated by the increasing reluctance of the younger workforce to commit to a traditional 24-hour care model and a desire for a work-life balance. Even where there are sufficient numbers of GPs, many countries like Australia have difficulty making sure they are distributed equitably.

Consumers are seeking 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 has been hastened by the COVID-19 pandemic. A further driver is the desire for more integrated and coordinated care, with a more proactive approach to managing chronic illnesses that actively engages patients and families as partners.

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 Primary Health Care 10-year Plan. They will also shape the landscape for the role of PHNs and after-hours provision.

PHNs are delivering a diverse range of activities under the program. The activities are tailored to the communities served by the PHNs. Many of the services funded under the activities are valued, and if they were not there, some groups and communities would be under-served. PHN-commissioned services also make use of additional funding from mainstream sources, which can result in an enhanced provision of services.

This report recommends that the PHN After Hours Program should continue but changes should be made to focus the program on the greatest needs, to flexibly support the PHNs in their wider roles, and to improve how the program functions.

Broad policy issues

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 populations, 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. Although general practice is the bedrock of the primary care system in Australia, it is complemented by other services offering choices to patients. However, the choices vary greatly and become highly limited in regional and remote Australia.

Issues that need to be addressed for an effective system of after-hours primary care are outlined below.

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 few 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 and 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 emergency department (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 for service delivery 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 of the many issues facing the primary health care system. The PHN After Hours Program is small in scale compared with the wider range of services and funding for after-hours care and 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 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.

There are strong cross-sectional relationships between geographic remoteness and the level of low urgency after hours ED 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 more disadvantaged areas.

These patterns reflect a complex interaction of the supply of services and relative need, which are impacted by both socio-economic factors and remoteness. Analysis was conducted at SA3 geography level. Figure 1 shows the observed relationship between the rate of use of MBS-supported after-hours services and low urgency after-hours ED presentations. Within the plots the observed rates for a particular 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. This suggests an overall negative relationship between MBS-supported after-hours services and the ED presentation rates but there is 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.

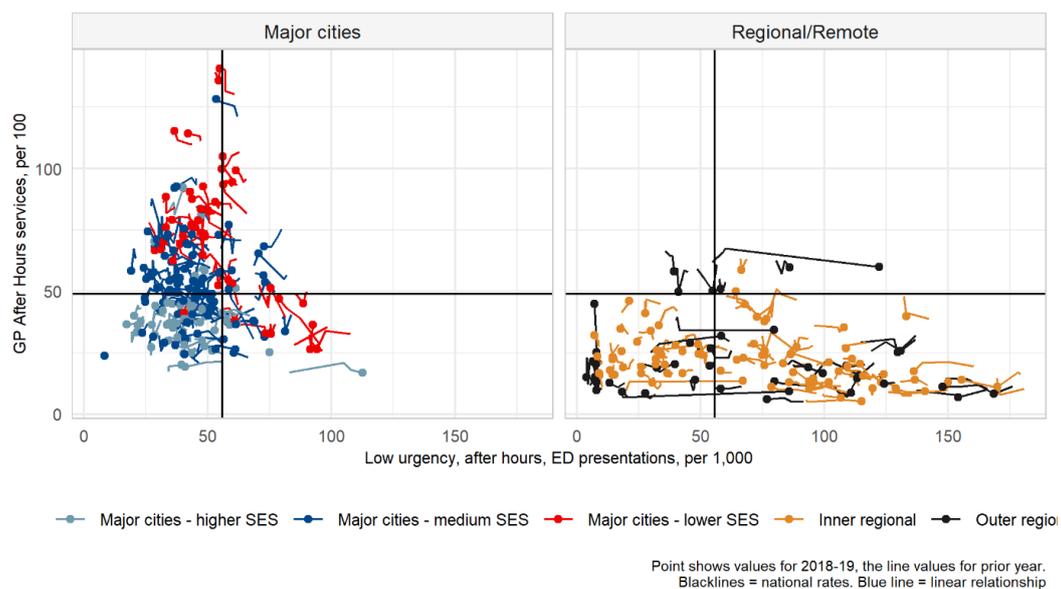


Figure 1 – Relationship between rates of MBS-supported GP after-hours services and low urgent after-hours ED presentations by SA3 level: 2015-16 to 2018-19

These relationships were explored in statistical models. 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. 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 those 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 locally driven program that sits within a national context. 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 afterhours 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. 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 that 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. At times, 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 PHNs include providing a more responsive model of care or an appropriate level of subsidy for the services to be economically viable.

The Department should 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 health districts 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 different plans may be required for several localities within their catchments.

Enable greater flexibility

Recommendation 5: PHNs should 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 made use of 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 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.

Summary of other options

The Department can consider a range of options for the future of the After Hours Program. The aims and objectives of the Program are still relevant and the gaps in services and needs remain evident across the PHNs. Some PHNs are less committed to the future of the program, but this is not because they feel that effective, efficient and accessible after-hours care is in place. Rather, they have concerns about whether the Program should operate as a stand-alone program instead of being integrated into the other programs.

The program could be discontinued if there were other mechanisms in place to meet the gaps in after-hours provision. The evidence presented above suggests that they are unlikely to be met within the context of the current arrangements and no other agencies are charged with working at a system level to address these issues. 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 alongside states/territories and other organisations can make a difference through coordination, joint planning activities and system-wide activities.

1. Evaluation of PHN After Hours Program

Structure of report

The report is organised into four volumes:

- Volume 1 (this document) summarises the key findings of the evaluation.
- Volume 2 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.
- Volume 4 describes the evaluation methods and includes supplementary analysis of data.

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. 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.

The context – after-hours services

The Commonwealth Department of Health defines after-hours primary health care as “*accessible and effective primary health care for people whose health condition cannot wait for treatment until regular primary health care services are next available*” (Department of Health, 2015). In practice, this means services delivered to patients in the time periods specified by the after-hours MBS items of service, typically evenings, overnight and parts of the daytime at weekends. For reimbursement purposes the after-hours period is divided between *sociable hours* and *unsociable hours*.

GPs are increasingly unwilling to provide a fully comprehensive after-hours service. Other services, such as pharmacies, also choose not to open beyond core hours because it is not economically sustainable. Consequently, consumers find it harder to access after-hours care, particularly where primary care services are already more limited in normal hours, such as in rural and remote areas. The limited availability of services after hours can lead to the potentially inappropriate use of EDs and other urgent-care services.

However, from a consumer perspective, public hospital EDs are a visible and trusted destination for seeking urgent after-hours care. They are always open, have imaging and pathology available, and provide care at no additional cost to consumers. A challenge for governments is to increase the provision of after-hours services, encourage use of the most appropriate service for each health issue, ensure equitable access for different areas and for all consumer groups, and ensure these services are provided efficiently. As urgent-care needs range from minor to life-threatening, clear routes of escalation are required throughout the system.

Current after-hours service provision

Table 1 summarises existing after-hours services in Australia and their limitations in meeting after-hours care needs.

Table 1 – After-hours services and their limitations

Service	Nature of provision	Limitations in meeting after-hours care needs
MBS after-hours items	Higher rebates for after hours to improve availability of services	<ul style="list-style-type: none"> • Lower take-up in certain localities: <ul style="list-style-type: none"> ○ Benefits levels may not be sufficient to cover higher costs due to scale ○ Lower supply or absence of primary care workforce available ○ Willingness of GPs to work after hours • Cost to consumers if services are not bulk billed.
MBS telehealth items	Improve availability of services by providing alternative to face-to-face service	<ul style="list-style-type: none"> • Availability of technology and reliance on internet. • Some conditions may not be appropriately dealt with through telehealth and result in an extra step.
Practice Incentive Program (PIP) After Hours Incentive.	Improve availability of services by providing incentives to provide or co-ordinate care	<ul style="list-style-type: none"> • Funding may not be sufficient to incentivise practices to provide after-hours care. • In certain localities, contracted providers for after hours (medical deputising services/GP cooperatives) may not exist • Does not guarantee full after-hours coverage. • Criteria may be too demanding.
GP cooperatives	Improve availability of services by providing an after-hours roster	<ul style="list-style-type: none"> • Limited coverage. • Cost if not bulk billed. • Declining interest/availability of GPs to participate.
Medical deputising services	Improve availability of services providing GP service after hours under MBS	<ul style="list-style-type: none"> • Require sufficient volume to make the service economically viable, so coverage is mainly in metropolitan areas.
Healthdirect	Provides information and advice to callers on their health needs and options for access to after-hours care.	<ul style="list-style-type: none"> • Different arrangements in different states/territories makes consumer awareness more difficult. • Perception among some stakeholders that the service may be risk averse and increase rather than manage demand.
National Directory of Services	Provides information about local services and opening times to increase consumer awareness and help navigate the system	<ul style="list-style-type: none"> • Consumer awareness of directory may be limited. • Reliance on service providers and others to keep the information up-to-date.

Service	Nature of provision	Limitations in meeting after-hours care needs
State and territory initiatives , including urgent-care centres	Provide range of services to improve availability, reduce demand and reduce cost to consumers	<ul style="list-style-type: none"> • Contributes to the diversity of services but leads to greater complexity for consumers.
Private sector providers operating outside of MBS	After hours clinics, telephone advice and telehealth	<ul style="list-style-type: none"> • Contributes to the diversity of services provided, leading to greater complexity for consumers. • Cost to consumers.

International landscape

Australia and other countries are looking to improve after-hours primary care. Most countries seek a balance between the public's expectations about service availability, health care professionals' need for a work/life balance and governments' aims to provide appropriate but efficient services. The main focus for governments relates to strengthening service capacity and developing integrated and collaborative systems to secure appropriate access and triage, and to guide patients' journey and manage demand. Key findings from a rapid review of the literature relating to after-hours arrangements internationally are:

- 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.
- Regional systems of demand management have developed, such as GP collaboratives **providing 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 required to call the regional nurse/GP triage service before accessing services, including EDs.
- **Co-location and 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 **telehealth and virtual care**, 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 GP services.

Challenges with after-hours primary health provision

The current landscape of after-hours primary health provision presents a number of challenges to ensure that services are appropriate and support quality and continuity of care for consumers. These include:

- gaps in provision across the country

- the need for clear information for consumers about where and how to access services
- lack of clarity and transparency about the cost of alternative services
- lack of low- or no-cost provision in some areas
- workforce shortages in rural and remote areas
- difficulties in accessing in-hours care leading to unmet need or potential exacerbation in the after-hours period
- lack of an agreed national after-hours primary care strategy and framework.

The PHN After Hours Program

The Commonwealth Government established the PHN After Hours Program in 2015 following the recommendation of the Jackson review, that:

Primary Health Networks (PHNs) [should] receive funding to work with key local after-hours stakeholders ... 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. (Jackson (2014))

The broad objectives of the 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 priority areas identified for the program include:

- access to after-hours GP services
- residential aged care facilities
- rural and remote locations
- services supported and delivered by pharmacies and allied health services
- disadvantaged groups, including palliative care and house-bound aged patients
- information sharing, health literacy, data collection and electronic health mechanisms.

The principal purpose of the PHN After Hours Program is to address gaps in access and also address system-level improvement, to enhance the capacity, efficiency and effectiveness of services after hours.

Key issues identified during the evaluation

Interviews were conducted with 29 Primary Health Networks and a broad range of stakeholders along with a review of associated documentation. The following key issues and themes emerged.

1. Clarity around objectives of the program
2. Maturation of approaches since 2015
3. Approach to needs assessment
4. Interaction with local health networks, ambulance services and state/territory health planning

5. Effect of GP workforce availability
6. Integration with Healthdirect, other telephone triage services and after-hours home visit services
7. Flexibility and alignment with other PHN funding schedules
8. Access to data and data analytic capabilities
9. Funding cycles, approval timelines and sustainability
10. Balancing support of existing services, commissioning and innovation
11. Health literacy and consumer access to information
12. Evaluation and assessing impact.

These issues are referred to in the findings and recommendations section of this summary report and discussed in more detail in the main report.

How has the program been implemented?

PHNs undertake needs assessment and collaborative processes to determine priorities for the program. The commissioning processes reflect local circumstances and availability of services. Some PHNs are commissioning services inherited from the Medicare Locals.

The contexts within which PHNs are working are highly variable but there are some common themes across PHNs mainly related to the vibrancy of the local primary care market. This is often highly dependent on the level of demand in an area and, on the supply side, the ease with which GPs and others are attracted to work in particular locations. Where the market is not functioning as effectively, the gaps in provision are more marked and the challenges are often less manageable. These circumstances tend to be much more prominent in rural and remote parts of the country.

There are general patterns that emerge in the nature of the services commissioned. Metropolitan areas tend to focus more on services for vulnerable groups and mental health needs. In more rural and remote areas, the focus was more on supporting basic primary care services across the whole population as well as initiatives that were focused on developing capacity and capability of the system. Activities that provided mental health services and those to support aged care were prevalent across all areas, especially inner regional areas. Most PHNs undertake consumer awareness and health literacy activities. Two of the PHNs – Hunter New England and Central Coast, and Primary Health Tasmania – have funded their own telephone triage services, which also provide a link to GP services.

2. Evaluation findings

The program overall

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.
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 could help decision-making across different aspects of the program.
3. There is a lack of awareness of the program among national stakeholders and also among many local stakeholders interviewed.
4. The context within which PHNs are operating is important in understanding the approach PHNs have taken to the program. There are system-wide challenges driven by the pattern of supply and population needs that influence after-hours models.

Program implementation and delivery

This set of findings focuses on how the PHNs identified the gaps and needs for after-hours services, how they designed and implemented these service models, and which models have been implemented well and which have not been implemented well.

5. PHNs make use of 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 in their ability to assess the effects of their activities.
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 priority should be given to system-level interventions.
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.
8. PHNs make use of 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 demand, 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).

9. Many PHNs have integrated the 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.
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.
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.
12. There are systematic differences in the nature of services commissioned by PHNs. These differences are dictated by the nature of the local primary health care market and the different needs of their populations.
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 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.
14. Implementation approaches have been variable. There are often key elements that contribute to greater success in implementation. These include making use of expert provider organisations and having local 'champions' that can support delivery of a service.

Impact and outcomes

This set of findings focuses on the extent to which the expected program outcomes have been achieved, what models have worked relatively well, and in what contexts and why. The findings from the statistical analysis examining the effect of the program on low urgency and potentially preventable hospitalisation are included. The findings also relate to funding issues, including how efficiently the PHNs have used their funding, whether there is a trend or ceiling for each PHN, and whether the program is delivering value for money.

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 their progress using patient outcome measures but most are using process and output measure as part of their contract monitoring processes.
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.

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.
18. PHNs and stakeholders broadly regarded the commissioned activities as successful.
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.
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.

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

Appropriateness

These findings consider to what extent funding allocated to each PHN is proportionate to after-hours needs and whether PHN models are appropriate to consumers and providers.

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.

24. Service providers were generally supportive of the models that PHNs were designing. Where these models integrate or align with existing service provisions, or

can build on an existing provision, they were seen as more successful. Some services were hampered by the lack of consumer awareness which led to low uptake.

Alignment with other programs

These findings consider to what extent the PHN models integrated or aligned with existing service provision and to what extent the PIP after-hours incentive, changes to the MBS after-hours items and changes in the supply of medical deputising services affected access to after-hours services in each PHN.

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, which are funded through 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 integrated with other services. For other PHNs, there is potential to create more effective linkages with Healthdirect.
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').
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.
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.
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.

References

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