Central and Eastern Sydney Primary Health Network

Population Health Strategy 2026-2031

phn
CENTRAL AND EASTERN SYDNEY

An Australian Government Initiative

ACKNOWLEDGEMENT OF COUNTRY

Central and eastern Sydney PHN acknowledges the Aboriginal and Torres Strait Islander peoples of this nation. We acknowledge the Traditional Custodians and Sovereign People of the land acroos which we work. We recognise their continuing connection to land, water and community and pay respect to Elders past, present and emerging.

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FOREWORD

Central and Eastern Sydney PHN's **vision** is healthy and thriving communities, which are enabled by high quality, accessible health care and underpinned by collaboration, innovation, inclusion and equity[1].

Achieving this requires a population health approach that embeds prevention within primary and integrated care settings, and connects health with broader determinants such as housing, education, employment, justice, and social support. Through this strategy, we aim to improve health outcomes and equity, enhance care and caregiver experiences, and deliver better value for the people who live and work in our region.

Central and Eastern Sydney PHN's prevention approach recognises that health risks accumulate and interact across the life course, and that many chronic conditions share common modifiable determinants. Addressing these shared risks through integrated and coordinated prevention offers the greatest potential for long-term population impact. Equity and integration are cornerstones of population health.

EXECUTIVE SUMMARY

Population health can be broadly described as activities to protect and improve the health and wellbeing of the population. It extends beyond health services, intersecting with the broader determinants of wellbeing. Prevention is central to this goal — by preventing or delaying the onset of disease, detecting conditions earlier, and slowing progression, prevention delivers healthier lives and reduces health care costs. Investments in population health and prevention activities help build healthier, fairer communities and improve long-term sustainability of our health system.

This strategy sets the ambition of Central and Eastern Sydney PHN (CESPHN) to strengthen population health from 2026 to 2031. Our aim is that by 2031, communities across Central and Eastern Sydney will experience better health outcomes, and a primary care system where prevention is embedded.

This strategy builds on existing CESPHN initiatives and aligns with our strategic goals to address community health and wellbeing needs, facilitate connected and quality care, and demonstrate leadership for the Central and Eastern Sydney region[2]. It sets out strategic priorities and actions to guide our investments, partnerships and priorities for the coming years.

CESPHN POPULATION HEALTH STRATEGY

WHY POPULATION HEALTH AND PREVENTION MATTER

Population health aims to improve health outcomes for entire populations, reduce inequities, and optimise resource use. Prevention is critical to improving population health outcomes and reducing long-term care costs because it:

- Reduces risk factors (primary prevention).
- Detects issues early (secondary prevention).
- Slows progression and disability (tertiary prevention)[3].

Population health and prevention are not only a health sector responsibility. Rather, they intersect with housing, education, justice, and social support services, creating opportunities for integrated approaches that address the broader determinants of health. These activities directly improve people's lives and deliver benefits to the wider community.

Many risk factors are common for a range of leading chronic diseases in Australia, reinforcing the need for joined-up prevention across the health system. Modifiable factors such as hypertension, diabetes, obesity, hyperlipidaemia, physical inactivity, smoking, excessive alcohol use, poor diet, sleep disturbance, social isolation, depression, low educational attainment, air pollution, and sensory loss contribute both to cognitive decline and to conditions such as cardiovascular disease, diabetes, and some cancers.

By addressing these risks through integrated, place-based and population-level action, CESPHN and its partners can achieve multiple impacts: reducing the burden of chronic disease while delaying or preventing dementia, improving quality of life, and strengthening system sustainability. These shared determinants underscore CESPHN's leadership role in aligning prevention across primary care and community settings.

THE ROLE OF CESPHN

Central and Eastern Sydney PHN supports primary care and commissions programs for the following key priorities identified by the Australian Government: mental health, Aboriginal and Torres Strait Islander health, population health, health workforce, digital health, aged care, and alcohol and other drugs. To inform the implementation of these activities, the ***CESPHN 2025-2027 Needs Assessment***[4] identifies local health and wellbeing status, health needs, and gaps in service delivery.

The ***National Preventive Health Strategy*** has set a target of 5% of health expenditure by 2030 for prevention[5], but this will require scaled investment and a strong commitment to evidence-based interventions. NSW Health's ***Future Health: Guiding the next decade of health care in NSW 2022-2032***[6] has identified seven key objectives to guide implementation and help keep people healthy, prevent ill health and tackle health inequality. In addition, both Sydney Local Health District and South Eastern Sydney Local Health District have identified immunisation and diabetes as their key focus areas for prevention in the next four years. Central and Eastern Sydney PHN will commission services, harness advanced data and digital capabilities, and leverage trusted relationships with primary care and community providers to deliver integrated, region-wide impact.

Central and Eastern Sydney PHN has a range of strategies and key documents that underpin and intersect with the Population Health Strategy. These include:

- CESPHN 2025-2027 Needs Assessment
- Joint Regional Mental Health and Suicide Prevention Plan 2024-2026
- PHN Multicultural Health Framework 2024
- Innovate Reconciliation Action Plan 2023-2025
- Healthy Ageing Strategy 2023-28
- Practice Nurse Workforce Strategy 2025-28
- Digital Health Strategy 2026-2030
- CESPHN Allied Health Engagement Strategy 2022-2025
- Research Strategy 2024-27
- Climate Change and Population Health Statement 2022

The priorities of our national, state and local partners, combined with CESPHN's own assessments, provide a clear mandate to develop a population health strategy that embeds prevention, and to invest in activities and partnerships that will improve health outcomes, reduce inequities, and contribute to the sustainability of the healthcare system.

THE CESPHN REGION

Central and Eastern Sydney has one of the most diverse populations in the country. The region encompasses the full socioeconomic spectrum, with significant numbers of people experiencing high levels of socioeconomic disadvantage and others with substantial socioeconomic advantage. The region is characterised by a highly mobile population, with frequent inflows and outflows of residents. This turnover creates challenges for continuity of care and increases demand for responsive, accessible services that can adapt quickly to changing community needs. The region has high rates of chronic conditions, significant mental health needs, and service pressures linked to rapid growth. This diversity also creates opportunities for innovation and community-driven solutions[7].

KEY CHALLENGES

Central and Eastern Sydney faces interconnected challenges in advancing population health. Modest investments in prevention limit effective interventions, while rising rates of chronic conditions continue to strain primary care and hospital services. Fragmented service delivery across health sectors contributes to inefficiencies and gaps in care, and persistent health inequities across socioeconomic, cultural, and geographic groups affect equitable access. Current and predicted workforce shortages[8] further impact service capacity, and limited data sharing and integration across systems restrict the ability to monitor outcomes, and to implement and scale targeted, evidence-based strategies. These challenges highlight why a regional strategy is needed — CESPHN is positioned to convene, commission and lead prevention at scale.

OPPORTUNITIES

While challenges exist, there are also significant opportunities to achieve better population health outcomes. The CESPHN Population Health Strategy can harness a skilled primary care workforce and an innovative commissioning approach that drives equity and integration. Upcoming health reforms, robust data and analytics, and the effective use of digital health technologies provide new tools to strengthen service delivery. In addition, targeted use of funding and incentives, stronger cross-sector partnerships, and clear leadership and governance create opportunities to embed prevention at the heart of a more connected and resilient primary health care system.

OUR APPROACH AND GUIDING PRINCIPLES

The CESPHN Population Health Strategy identifies six strategic priorities. Three of these priorities are broadly aligned to the life stages – Healthy beginnings, Living well and Ageing well. The remaining three priorities cut across the entire lifespan and address factors that influence health outcomes for all people in our region – Living well with chronic conditions, Health equity for all and Resilient communities.

These priorities were chosen not only for their clarity and relevance to community experiences, but also because they reflect health challenges across the lifespan where targeted action can have the greatest impact. They provide a practical and inclusive framework for action.

In addition, the following key principles underpin CESPHN's Population Health Strategy. We will:

1. Prioritise prevention across the lifespan, from risk reduction to early detection and disease management.
2. Target complex and high-burden conditions and risk factors prevalent in our region.
3. Embed equity by focusing on priority populations, including Aboriginal peoples[9], multicultural communities, and people experiencing socioeconomic disadvantage.
4. Leverage partnerships with primary care, local health districts, community organisations, and non-health sector organisations to deliver integrated solutions.
5. Harness available data to ensure interventions are evidence-based, scalable, and deliver value for money.
6. Enhance system capability through workforce development, digital innovation, and data driven decisions.

STRATEGIC PRIORITIES

HEALTHY BEGINNINGS

Experiences during the early years of a child's life can have lasting impacts on physical and mental wellbeing, and can influence their social, emotional and intellectual development [10]. Every child in Central and Eastern Sydney deserves the best start in life. This can be achieved by promoting health and wellbeing from preconception through to age five, through integrated and equitable approaches that upskill primary care providers and empower families and communities.

We will:

- Facilitate integrated antenatal care to improve access and choice in healthcare and improve health outcomes for mothers and babies.
- Collaborate with our regional partners to support and develop better referral pathways and services for children experiencing mental health concerns and their families.
- Commission screening and early intervention services to support children achieve their development milestones and be referred to additional support where required.
- Increase vaccinations in pregnancy and work with immunisation providers, public health authorities, and primary care to achieve the highest possible rates of childhood immunisation, aiming for the national goal of 95% coverage.
- Strengthen early identification and support for children with developmental delay, disability or intellectual disability by commissioning early intervention programs and improving shared care pathways between primary care, specialist, and community providers.

- Support access to psychological interventions for individuals and partners during the perinatal period.
- Support primary care providers to complete a range of screenings and checks to improve health outcomes, including for the postnatal period; childhood development; mental health; domestic, family, and sexual violence; and alcohol and other drugs.

By giving every child the best possible start, we will lay the foundations for lifelong health, wellbeing, and opportunity.

Strategic priorities

LIVING WELL

Screening and early intervention are essential components of an integrated health system, enabling the timely identification and management of health issues before they progress into more serious or costly conditions. For CESPHN, this is particularly important given the region's growing and diverse population, high prevalence of chronic disease, and the complex needs of priority groups[11]. Strategic investment in these activities will improve long-term health outcomes. It will also enhance the efficiency of healthcare resources and empower individuals and communities to take an active role in their health.

We will:

- Invest in initiatives with an early intervention and prevention focus, and especially those that meet intersecting health needs, such as chronic disease education for diverse communities, screening activities for those with co-occurring mental health conditions, and domestic, family, and sexual violence training.
- Harness data to identify communities of highest need and partner with local health districts, primary care and community organisations to deliver chronic disease prevention and early detection activities.
- Deliver quality improvement activities for general practice that foster patient-centred care, data driven improvement, and practice viability, with a focus on disease prevention and health protection activities.
- Develop a CESPHN immunisation strategy to inform the organisation's immunisation program delivery and support immunisation providers to deliver the National Immunisation Program in partnership with local health districts and Public Health Units.
- Support general practice and community organisations to increase participation in the national bowel, cervical and breast cancer screening programs and support general practice in the implementation of lung cancer screening.

- Commission mental health services to enable access for people to connect with the right mental health support, such as Medicare Mental Health Centres, and the Medicare Mental Health Phone Service.
- Commission early intervention services such as headspace centres to support young people with emerging health needs including physical health, mental health, substance use, and vocational/ educational needs.

- Partner with local health services and commission services focused on suicide prevention at the individual, family, and community level, with additional services for priority population groups.
- Support primary care providers to manage alcohol and other drug concerns, including patients receiving opioid treatment, through best-practice education and support services.
- Partner with local health districts and community organisations to promote sexual health services, particularly for priority populations, and upskill the primary care workforce on sexual health screening and detection.
- Enhance the Central and Eastern Sydney Health and Community Service Directory, the Mental Health Services Directory and the Headstart mental health navigation tool, to empower individuals and health professionals to connect with local service providers and information specific to their needs.
- Expand continuing professional development and education opportunities for primary care providers, with a focus on prevention, early detection, and integrated care, ensuring the workforce is skilled and supported to respond to community health needs.
- Undertake community education activities with our partners to improve health literacy and boost community awareness such as in palliative care and mental health and wellbeing.

Investing in prevention and early intervention today will help ensure stronger, healthier communities in the years ahead.

LIVING WITH CHRONIC HEALTH CONDITIONS

Many people across the Central and Eastern Sydney region are living with one or more chronic health conditions, which affects their quality of life and places pressure on the health system[12]. In response, CESPHN commissions targeted activities, supports primary care providers, and strengthens integration with other health services to better support individuals managing chronic conditions. Our focus is on promoting best practice and advancing health equity, ensuring that everyone has access to the care they need, regardless of their circumstances.

We will:

- Support general practices to implement Chronic Condition Management Plans, including the optimisation of recalls and practice nurse collaboration, to better manage patients with chronic conditions in community settings.
- Commission multidisciplinary innovation, such as the work to embed pharmacists and social workers in general practice.
- Commission moderate and high intensity mental health services, and suicide postvention services, to support people in our region and their families with tailored and multidisciplinary care to meet their individual needs.
- Partner with leading community organisations and implement quality improvement activities in general practice to screen, immunise, and treat people living with, or at risk of developing a chronic disease such as hepatitis.
- Increase the capacity of the alcohol and other drugs sector and commission flexible treatment services that focus on priority populations and co-occurring health needs.
- Partner with local health districts to develop quality improvement and commissioning activities to better integrate care between primary and acute care services for the target areas of diabetes and immunisation.

- Work in partnership with public health authorities and general practice to target vaccination uptake for people living with chronic disease.
- Embed digital initiatives to increase integration and support primary care practitioners in managing chronic disease, including My Health Record, e-referrals, and the National Cancer Screening Registry.
- Work across the organisation and use available data to implement patient-centred quality improvement activities to improve health outcomes for people with chronic disease and intersecting health and social needs.
- Identify system opportunities to enhance early assessment, coordinated care, and management for people with intellectual or neurodevelopmental conditions, supporting improved participation and quality of life.

Supporting people to live well with chronic or neurodevelopmental conditions helps reduce health inequities and strengthens the entire health system.

Strategic priorities

AGEING WELL

People in the Central and Eastern Sydney region are living longer, and the older population is growing rapidly. It is essential to support older people to live not only longer lives, but healthier ones which minimise the impact of disability and maintain independence for as long as possible. One of the greatest challenges is ensuring a well-equipped primary care and aged care workforce that can meet the diverse and complex needs of older individuals. Central and Eastern Sydney PHN is committed to enabling older people to lead active and meaningful lives, which are supported by inclusive communities and underpinned by integrated, person-centred health and social care services[13].

We will:

- Support primary care to deliver health promotion and best practice prevention and screening throughout the lifespan, and particularly in later life to assist a healthy ageing process, for example through regular health assessments, Chronic Condition Management Plans, and domestic, family, and sexual violence screening.
- Support implementation of the General Practice in Aged Care Incentive and Aged Care Onsite Pharmacist measure, to increase continuous, quality care for older people in residential aged care homes.
- Work in partnership with public health authorities, primary care, and aged care providers to target vaccination uptake for older people in our region.
- Implement community-led models of care, such as Healthy Ageing Hubs, that support GPs and primary care workers through social prescribing and service navigation for older people.
- Deliver the Care finder program through best practice commissioning and support activities, to provide secure housing for prematurely aged and older people in crisis.

- Work in partnership with local Aboriginal groups to support the delivery of priority health programs and promote existing initiatives including the 715 health check.

- Promote emotional mental health and wellbeing for older people, commissioning services to support emotional wellbeing in aged care residents and supporting primary care providers to detect, prevent and manage mental health conditions such as depression, anxiety, and dementia.
- Review and improve aged care and dementia care clinical referral pathways to support GPs and primary care workers to refer and link older people to relevant supports.
- Partner with primary care providers and residential aged care homes to accelerate the adoption of digital health technologies that improve quality and access to care for older people.
- Support GPs and primary care workers to deliver quality palliative care and end of life care for older people in our community.

Helping older people to live longer, healthier and more connected lives benefits families, communities and the wider health system.

HEALTH EQUITY FOR ALL

Central and Eastern Sydney is characterised by densely populated suburbs, communities that span the spectrum from significant wealth to deep disadvantage, and a large non-resident population that accesses local health services daily. The area is home to high numbers of people experiencing or at risk of homelessness, Aboriginal communities, multicultural populations, and a significant LGBTIQA+ population[14]. While these characteristics contribute to a rich and vibrant social fabric, they also present complex challenges in ensuring equitable access to primary health care. Central and Eastern Sydney PHN is committed to fostering thriving communities where every individual, regardless of their background, can access high-quality, culturally safe, and responsive health services.

We will:

- Commission and support culturally appropriate Aboriginal health services in collaboration with Aboriginal people and communities.
- Implement the Multicultural Health Framework Action Plan, embedding cultural responsiveness across CESPHN operations and commissioned service providers.
- Commission services whose workforce reflects the diversity of our community.
- Develop a CESPHN LGBTIQA+ Health Strategy and provide resourcing to support its implementation.
- Develop and implement integrated care models tailored to the needs of priority populations.
- Strengthen the primary care workforce capability to provide inclusive, trauma-informed, and culturally safe care for diverse populations through education and training opportunities.
- Lead the national PHN Homelessness Access Program and continue to support commissioned services for people at risk of or experiencing homelessness.

- Advocate for increased funding and improved models of care to improve access to care for people with complex health needs and diverse social circumstances.
- Strengthen monitoring, data collection and reporting on access, experience, and outcomes for priority populations across commissioned services and partner with providers to make data driven improvements to improve service equity.

Achievement of heath equity is a measure of whether our health system is truly working for everyone.

RESILIENT COMMUNITIES

Central and Eastern Sydney PHN acknowledges that community resilience is essential for achieving population health goals because resilient communities can adapt, recover, and thrive in the face of health, social, and environmental challenges. By building resilience, we create the conditions for equitable access to care, stronger social support networks, and sustainable improvements in health outcomes across the population.

We will:

- Commission targeted mental health and community wellbeing support services to address the impact of psychological harm and community distress on our community.
- Strengthen partnerships with community organisations across our region that reflect the diverse population, to break down barriers, work better together and build up community wellness and resilience.
- Develop an Emergency Response Procedure to coordinate a primary care response during a disaster or critical incident that would include urgent care centres, general practice. private allied health and community pharmacy.
- Deliver the second phase of CESPHN's Climate Change and Population Health Implementation Plan.
- Embed the Primary Care Emergency Response Team model to support preparedness, coordination and response during emergencies and critical incidents.
- Partner with local health districts, councils, and other stakeholders to strengthen regional coordination and planning.
- Advocate for policies and funding that support health system resilience related to environmental and climate threats.

- Support general practices, allied health and commissioned service providers to adopt environmentally sustainable practices, and to develop or update their business continuity and emergency response plans.
- Collaborate with Urgent Care Centres to consider emergency preparedness in their services planning and how these services may be accessed in the event of an emergency.
- Develop evidence-based resources and education that consider the physical and mental health impacts of climate change on healthcare providers and the community.

Building resilience means ensuring our communities and health system can adapt, recover, and thrive in the face of future challenges.

GOVERNANCE, IMPLEMENTATION AND MONITORING

Elements of this Strategy will be reflected in the workplans and priorities of our teams and advisory committees. Program logics will be completed for all major activities to facilitate monitoring and evaluation and where feasible we will differentiate process indicators from impact indicators while acknowledging achievement of intermediate outcomes on areas such as workforce capacity and care integration.

In addition, key components will be incorporated into new strategies, such as for immunisation and LGBTIQA+ health. Successful implementation will rely on active collaboration with our partners in primary care, local health districts, non-government organisations and other PHNs. Progress will be tracked through annual reporting to the CESPHN Board and partners, using measures such as childhood immunisation coverage, cancer screening participation, reductions in preventable hospitalisations, uptake of digital health tools, and improvements in service equity. A mid-term review will ensure priorities remain relevant and effective.

Through this strategy, CESPHN reaffirms prevention, equity, and integration as cornerstones of population health. As the PHN for Central and Eastern Sydney, we are uniquely placed to convene partners, champion prevention, and demonstrate how PHNs can drive system change. By working together, investing in innovation, and keeping communities at the centre, we will sustain impact and build a healthier, fairer future for our region. The Strategy provides the foundation for future investment, collaboration, and measurable improvement in population health across our region.

Strategic Plan 2025-2028

Vision | Healthy and thriving communities

Purpose | Enabling high quality, accessible health care

Values | Collaboration, Innovation, Inclusion and Equity

Strategic goals

Address community health and wellbeing needs

Invest in programs and services that improve health equity

Facilitate connected and quality care

Work together to improve health outcomes and healthcare experiences

Demonstrate leadership for the central and eastern Sydney region

Partner to identify and address regional challenges

Achieve organisational excellence

Ensure a high-functioning organisation that is transparent, accountable and fair

REFERENCE LIST

1 See CESPHN's Strategic Plan – plan on a page – Attachment 1.

2 Central and Eastern Sydney PHN, 2024, Strategic Plan 2025-2027.

3 Australian Government Productivity Commission, 2025, Delivering Quality Care More Efficiently interim report.

4 Central and Eastern Sydney PHN, 2025, 2025-2027 Needs Assessment.

5 Australian Government Department of Health, 2021, National Preventive Health Strategy.

6 NSW Health, 2022, Future Health: Guiding the next decade of care in NSW 2022-2032.

7 CESPHN Needs Assessment 2025-2027.

8 CESPHN Needs Assessment 2025-2027.

9 In this document we have used the terms Aboriginal and Aboriginal people/s when referring to Aboriginal and Torres Strait Islander peoples. We chose Aboriginal because it is inclusive of different language groups and areas within the CESPHN region.

10 CESPHN Needs Assessment 2025-2027.

11 CESPHN Needs Assessment 2025-2027.

12 CESPHN Needs Assessment 2025-2027.

13 Central and Eastern Sydney PHN, 2023, CESPHN Healthy Ageing Strategy 2023-2028.

14 CESPHN Needs Assessment 2025-2027.

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