cohealth
care for all

Response to:

Discussion paper and draft recommendations from the Primary Health Reform Steering Group

July 2021

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Introduction

cohealth welcomes the opportunity to respond to the Primary Health Reform Steering Group draft recommendations for the Australian Government's Primary Health Care 10 Year Plan.

cohealth supports the direction of reforms articulated in the draft recommendations discussion paper. Australia's primary health care system has many strengths, providing high quality health care for many Australians. However, there are also significant weaknesses in its structure and funding. These hamper effective integration, and ability to provide comprehensive care, across the primary health care sector, as well as with the acute health sector and services outside the health system that are vital to people's health and wellbeing. These barriers have the biggest impact on those who have the greatest health needs.

Barriers include: insufficient primary care investment, particularly to support collaboration and coordination functions; the Commonwealth/State funding divide; technological differences that limit providers ability to easily and quickly communicate with other health providers; and provider attitudes.

cohealth is pleased that the Draft Recommendations addresses these, and other, barriers. We particularly support the focus of the Draft Recommendations on needing to:

- Reorient the system to promote wellbeing, prevent illness and respond with early intervention to emerging illness, and away from our current sickness focus that provides care and treatment only once a person is unwell.
- The need to increase investment in primary care, including ensuring that funding models provide appropriate provision to overcome the barriers to health care access faced by many Australians.
- Improve equitable access to, and experience of, health care for people who face barriers to accessing effective health care, including Aboriginal and Torres Strait Islander peoples, people of low socio-economic status, refugees and people seeking asylum, those of culturally and linguistically diverse backgrounds, people who experience homelessness, or those who experience mental ill health.

  The populations most in need of health services are the least likely to receive them.
- Address limitations of the current primary health care funding system that was designed to respond to one-off episodes of care, rather than ongoing care for chronic conditions. The funding system also does not work well for people with complex health and social circumstances, nor does it promote a focus on population health and preventative care.

The COVID-19 pandemic has exposed many of the deficiencies in our health system identified in the discussion paper and highlighted the urgent need for reform. It is cohealth's view that the community health model, outlined below, and similar to the ACCHO model, addresses many of these challenges and provides a clear foundation for primary health care reform.

About cohealth

cohealth is one of Australia's largest not-for-profit community health services, with almost 1,000 staff working at 30 sites across nine local government areas in Melbourne's CBD, northern and western suburbs. In response to COVID-19 we have also established additional sites to provide testing, vaccinations and care.

cohealth's mission is to improve health and wellbeing for all, and to tackle inequality and inequity in partnership with people and their communities. As a primary health service, cohealth provides integrated medical (general practice, nursing), dental, allied health, mental health and community support services. cohealth also delivers programs promoting community health and wellbeing and involves communities in identifying needs and developing responses.

cohealth prioritises people who experience social disadvantage and are consequently marginalised from mainstream health and other services - such as people who have multiple health conditions, have a disability or mental illness, experience homelessness and unstable housing, Aboriginal and Torres Strait Islanders, people from refugee and asylum seeker backgrounds, people who use alcohol and other drugs, recently released prisoners, LGBTIQ+ communities and children in out-of-home care

cohealth, and our predecessor community health services, has nearly 50 years' experience providing the type of comprehensive, integrated primary health care to local communities that is envisioned in the discussion paper. Our feedback to this consultation is based on our observations of the changes needed to ensure comprehensive primary care is available to all, particularly those who face barriers to accessing health care.

About community health services

Community health services are responsive to (and many managed by), their local community. They share many common features with Aboriginal Community Controlled Health Organisations (ACCHOs). Based in local communities, community health services provide primary care and social support services that respond to the needs of their communities. Working from a social model of health, they recognise the critical influence of the social determinants of health on the health and wellbeing of individuals, families and communities and seek to address these.

Community health services have a deliberate focus on key groups of people: those who are socially or economically disadvantaged, experience poorer health outcomes and have complex health needs or limited access to appropriate health care.

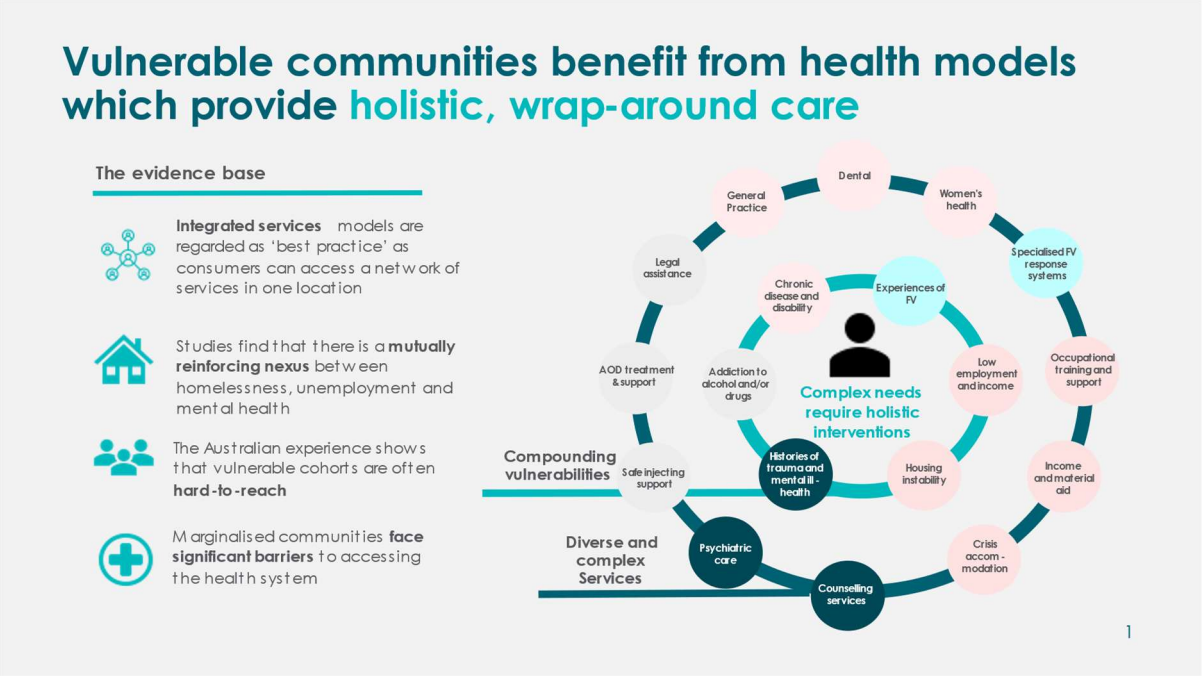

Figure 1. cohealth's model of care for clients with complex needs.

Community health is a coherent, internationally recognised and evidence-based framework for providing integrated primary health care, health promotion and community engagement. The International Federation of Community Health Centres (IFCHCs) describes community health centres (CHCs) as community-oriented primary care organisations that deliver health and social services through interprofessional teams, addressing the specific health and social needs of individuals, families and local communities. CHCs involve members of the community in planning and programming, and they employ a multi-sector approach to address social determinants of health.

The IFCHC's definition of community health centres includes five core attributes[1]:

- interprofessional, team-based primary care

[1] De Maeseneer, et al (2019) Community Health Centres: Operationalizing the Declaration of Astana on Primary Health Care, International Federation of Community Health Centres

- integration of primary care with other health services, health promotion, and social/community services
- action on social determinants of health through inter-sectoral services and cooperation
- ongoing engagement of community members in health and planning of health and social services
- having responsibility for a defined local population, either geographical or by population group(s).

Victoria's network of 28 independently managed registered community health community health organisations deliver a range of primary health, human services and community-based support to meet local community needs.

Community health services provide universal access to services as well as targeted services for vulnerable population groups. They sit alongside general practice and privately funded services to make up the primary health sector in Victoria.

The range of primary health and social services provided by Victoria's community health services are funded by all levels of government, along with consumer directed payments (out of pocket, MBS or NDIS). As such, community health has extensive experience as 'platform providers' of both health and social services - they currently deliver up to 30 different programs through more than a hundred different funding streams. Community health services thus facilitate a broad range of both state and Commonwealth initiatives that holistically address their clients' needs.[2] However, despite the Federal government having responsibility for primary health care, no Federal funding supports the community health service model. Rather, they are predominantly supported through State and Territory governments.

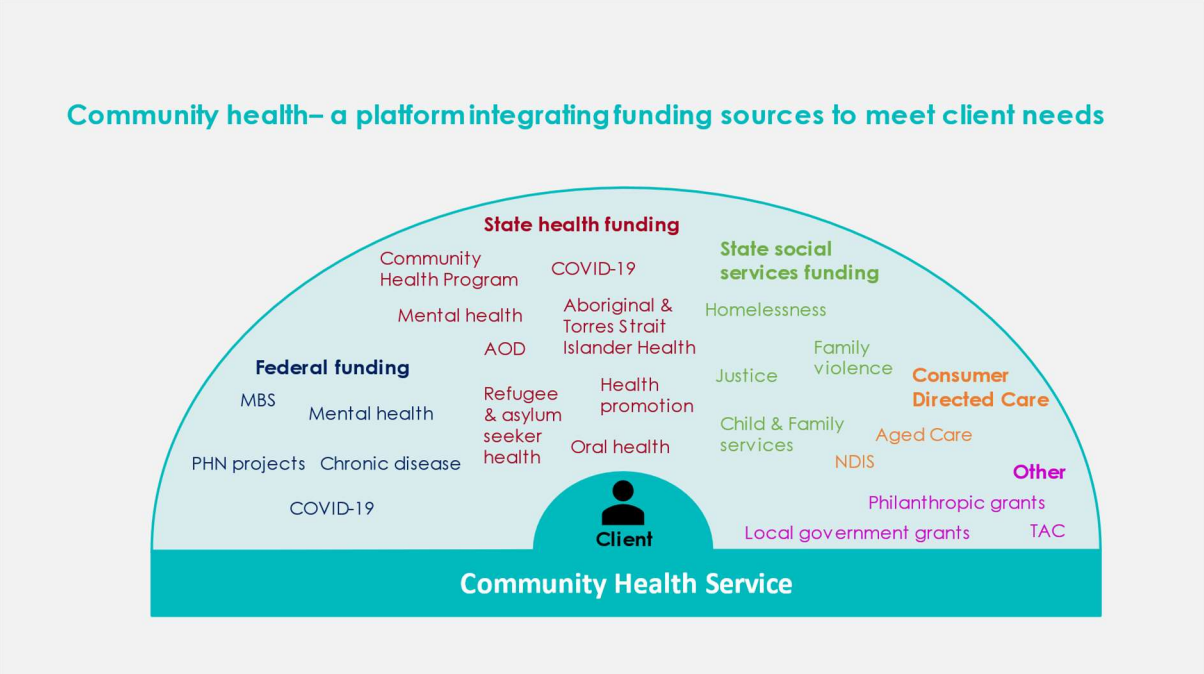

Figure 2. cohealth's unique value is integrating a range of funding streams to provide seamless, wrap around care for clients.

[2] Victorian Auditor General's Office (2018) Community Health Program, report to the Victorian Government

The existing Community Health model already addresses many of the challenges identified in the discussion paper. Community health centres are team based, multidisciplinary settings that integrate primary care with other health and social services. The model is based on the social determinants of health, and services are place-based with each centre having responsibility for defined population groups. Community health services engage with community members in planning their health and social services, they are accessible to all, including the most vulnerable and marginalised people, and they play a critical role in filling gaps left by other parts of the health system.

The sector has significant experience that will be invaluable to primary health care reform, and cohealth urges that the knowledge and contribution of the sector be included in the future planning of the primary health system in Australia and the final recommendations of the Steering Group.

cohealth recommendation 1

That the Steering Group consider the contribution and experience of Victoria's community health sector in its deliberations about reform of the primary health sector and include reference to the community health sector in the final recommendations.

The central role of the social determinants of health

cohealth is pleased to see that the discussion paper refers to the social determinants of health, and that changes in Commonwealth/State governance arrangements 'should more systematically address the social determinants of health, which were so illuminated by the pandemic' (p2).

The circumstances in which people grow, live, work and age and the structural conditions in society which lead to unequal living conditions and affect the chances of a healthy life - the social determinants of health - are a major contributor to health inequities. According to the World Health Organisation (WHO), the social conditions in which people are born, live and work are the single most important determinant of good health or ill health.[3] They include factors such as income, Aboriginal and Torres Strait Islander status, identity, gender, housing, food security, employment conditions, where you live, the urban environment and experiences of stigma, discrimination and marginalisation. Ecological and commercial determinants also have a significant impact on health and wellbeing.

Given the significant contribution the social determinants of health have on health outcomes, cohealth urges the Steering Group to include a recommendation that primary health care can only be most effectively provided if they are addressed, particularly:

- Racism and discrimination

  There is substantial evidence that racism has many harmful health impacts.[4]

  Mental health impacts of racism include conditions such as psychological distress, depression, anxiety, post-traumatic stress disorder and psychosis, while physical health effects include cardiovascular disease, hypertension, adult-onset asthma, cancer and accelerated biological ageing. Racially motivated assaults have both physical and mental health consequences. There is now also evidence that maternal exposure to racism has harmful effects on a foetus that impact child development.

  More broadly, systemic racism serves to maintain or exacerbate the unequal distribution of opportunity across ethnic groups through the way our systems and services are structured and delivered. As a result, people may not seek the support and services they need and are entitled to. Racism reduces access to employment, housing and education, resulting in low socio-economic status, and as socio-economic status declines, so does mental and physical health.

- Climate change

  Climate change is the greatest health emergency facing our planet, with the WHO describing it as the defining issue for public health in the 21st century.[5] Climate change affects health in many ways: directly by the increased intensity and frequency of extreme weather events, such as prolonged heatwaves, floods and

[3] https://www.aihw.gov.au/reports/australias-health/australias-health-2016/contents/determinants
[4] https://www2.health.vic.gov.au/public-health/population-health-systems/health-status-of-victorians/survey-data-and-reports/racism-in-victoria
[5] https://www2.health.vic.gov.au/about/health-strategies/public-health-wellbeing-plan/tackling-climate-change

bushfires; and indirectly through worsening air quality, changes in the spread of infectious and vector-borne diseases, risks to food safety and drinking water quality, and effects on mental health.

These impacts are disproportionately greater for marginalised and vulnerable communities.[6]

The extreme weather events of the summer of 2019/20 – bushfires and lengthy drought – followed by the COVID-19 pandemic will exact a huge toll on physical and mental health and should serve as a warning that urgent action is required to reduce the threats posed by climate change and to adapt to these threats.

- Poverty and income inequality

The relationship between health and income is well established, and generally, the higher a person's socioeconomic position, the better their health.[7] People who are the most socio-economically disadvantaged are twice as likely to have a long-term health condition as the most affluent Australians. Those who are poor are also twice as likely to suffer from chronic illnesses and will die on average three years earlier than the wealthiest.[8]

Low socio-economic status is a key underlying factor common to almost all people experiencing health disadvantage and lies at the heart of health inequality. The impacts of low income are exacerbated by expensive, insecure and poor-quality housing, insecure employment, unemployment and underemployment; and location that is removed from services, jobs and health services. Poverty can be both a determinant and a consequence of poor physical and mental health.

With more than one in eight Australian adults and more than one in six children living in poverty[9], and significant inequality[10], it is essential to address this underlying driver of poor health if we are to improve the health of the nation.

cohealth recommendation 2

That the Steering Group include a recommendation that the Commonwealth, State and Territory governments act on the social determinants of health as a key means to improving the health of individuals, families and communities. Such action will also reduce pressure on primary health care and the overall health system.

[6] Hayes, K, Blashki, G, Wiseman, J, Burke, S & Reifels, L (2018) Climate Change and mental health: risks, impacts and priority actions. International Journal of Mental Health Systems 12:28 https://ijmhs.biomedcentral.com/articles/10.1186/s13033-018-0210-6
[7] https://www.aihw.gov.au/reports/australias-health/australias-health-2018-in-brief/contents/all-is-not-equal
[8] 'The Cost of Inaction on the Social Determinants of Health, CHA-NATSEM Second Report on Health Inequalities http://www.natsem.canberra.edu.au/storage/CHA-NATSEM%20Cost%20of%20Inaction.pdf
[9] http://povertyandinequality.acoss.org.au/poverty/#poverty-australia
[10] http://povertyandinequality.acoss.org.au/inequality/

Person-centred health and care journey, focussing on one integrated system (recommendations 1 – 5)

cohealth supports the focus of reshaping Australia's health care system to enable an integrated system, including reorientation of the secondary and tertiary systems to support primary health care to keep people well and out of hospital. To fully support people's health and wellbeing such a system must also be integrated with the broader health sector, such as aged care, disability and mental health, along with the social support sector (as per Action 1.3.3). Such an integrated, place-based approach is central to the community health service model, and the sector is well placed to achieve this objective.

We offer the following reflections on selected actions:

Action 1.3.4 – Build an evidence base to enable staged implementation, through funding and evaluating 10-15 vanguard regionalised initiatives featuring joint governance, planning, funds sharing and/or pooling and collaborative commissioning by PHNs, ACCHOs and LHNs to accelerate and demonstrate how implementation can occur.

As described above, community health services are already working in this manner and could provide valuable experience and contribution to these initiatives.

cohealth recommendation 3

That a community health service be involved in at least one vanguard project.

Recommendation 3 - **funding reform**, recognises the need to reform funding to support providers to tailor care to meet the needs of their patients, including delivering alternative funding sources for primary health care service providers in addition to fee-for-service MBS.

Action 3.2 recommends creating funding models to support best practice primary/integrated health care to help move the system from volume to value, including using flexible funding for individual service providers, including block and blended payment models, and bundled payment approaches. cohealth supports funding reform that supports greater longitudinal, multidisciplinary and intersectoral team care.

While the discussion paper recognises the need to move away from fee-for-service payments, and towards value-based care it could be strengthened with more detail about how this transition can be made. Pooled funding models should be developed that encourage joint governance and planning between the community health sector, Primary Health Networks and Local Hospital Networks.

Funding reform also needs to recognise, and provide for, the additional requirements of providing comprehensive primary health services to populations with the greatest needs. This can include: employing bi-cultural workers; interpreting and translating; outreach to people unable to attend centre-based appointments; longer appointment times; specific skills/training in working with groups with complex needs, including in trauma informed

approaches; and assisting patients with costs of accessing primary health care, such transport and childcare.

cohealth recommendation 4:

That funding reform includes provision for the additional requirements of providing comprehensive primary health services to particular population groups.

Funding reforms – whether blended, block, fee for service, or other approaches – must ensure that the needs of those with the greatest health needs are prioritised. It will be important to ensure that no unintended incentives are created for practitioners to 'cherry pick' patients with lower needs.

Community health services have lengthy experience delivering a comprehensive range of integrated health and social support services. In our experience the benefits to clients and communities are clear. However, providing health care in this way comes with a number of costs to the organisation, such as the multitude of accountability requirements (reporting, accreditation, quality) from drawing together many funding sources. These are not funded and place significant administrative demands on services and practitioners. Streamlining and resourcing these functions will be critical in a system encouraging greater integration.

Recommendation 5 – Local approaches to deliver coordinated care

Engaging closely with local communities to identify needs and develop appropriate responses is work that community health services – along with Aboriginal Controlled Community Health Organisations - have been doing for decades. Community control and management of these services enables self-determination and local accountability. cohealth commends the recommendation to extend this model to create Rural Area Community Controlled Health Organisations (RACCHOs), broadly modelled on the ACCHO model, and point out that many organisations already exist in regional and rural Victoria. We also urge that this approach is not limited only to rural areas as community-controlled services have potential to play an important role in meeting the primary health care needs of communities in all parts of Australia, including in metropolitan areas.

Indeed, **action 7.7 - locally designed approaches** supports 'locally designed approaches to prevention and addressing the social, emotional, financial and other determinants of health'. The following case study indicates the importance of community led approaches.

The COVID-19 experience has demonstrated the consequences of local communities not being involved in health planning, despite having a sound understanding of the needs of their members, and of the best mechanisms for engaging them in planning and approaches. The critical insights they provide are not utilised until conventional approaches have not had the expected outcome.

For example, in Melbourne the hard lock-down of nine high rise housing towers in July 2020 failed to include community leaders from the beginning. As a result, residents experienced the lock down as traumatic, with many unable to acquire their basic food, medications or

health care. Some of these worst impacts may have been avoided or mitigated with community leaders had been more involved in the planning.

Learnings from this experience have informed the development of a pro-active model of place-based integrated primary health care and engagement that has subsequently been rolled out to other high-rise housing estates across Melbourne. Developed in partnership with local communities and leaders, cohealth and other community health services to respond to communities' needs, key features of this model include:

- Health education in place – community leaders are recruited and trained as health concierges to provide COVID-19 education on site in relevant languages, along with masks and hand sanitiser.
- Early intervention in place – on site COVID-19 testing service, including door-to-door testing, by clinical staff in partnership with concierges.
- Health care in place - provision of primary health care services for all residents and monitoring for all COVID-19 positive patients.
- Case management and referral - telehealth needs assessments are undertaken with residents who have tested positive to COVID-19. Those who have high medical risk are referred to hospital while those with lower health care needs are referred to a GP. Isolation plans and referrals to support services are developed with residents who need to isolate to ensure there are no barriers to them being able to do so.

As a result of adopting this integrated approach that actively engages local communities, COVID-19 outbreaks at other high-rise towers have been prevented.

The involvement of community health services has been central to this success, through their knowledge of local communities, integrated health and social support services and a deliberate focus on key groups of people: those who are socially or economically disadvantaged, experience poorer health outcomes and have complex health needs or limited access to appropriate health care.

Employing bi-cultural workers is another key to the success of the high-rise response model, and builds on the cohealth has been undertaking in this area for a number of years. Bi-cultural workers are employed to use their cultural knowledge, language skills, lived experience and community connections; and to work with both people whom they share a lived experience and mainstream organisations. They elevate community voices, advocate for their needs, co-design and deliver programs, share information and facilitate cultural safety. As such, they provide a vital cultural bridge between mainstream services and their communities, ensuring both greater engagement with communities, and improved delivery of services to diverse communities.

In response to COVID-19, many of the bicultural workers have produced videos that deliver translated public health advice in culturally specific ways to communities that might otherwise miss out on the information. These resources have been a vital complement to government health messaging and support broader efforts to eliminate community infection.

Adding building blocks for future primary health care – better outcomes and care experienced by all (recommendations 6 – 8)

Recommendation 8 - Improved access for people with poor access or at risk of poorer health outcomes.

This is an area that is critical to address as a matter of urgency. It is well established that populations with the greatest health needs too often face barriers to receiving the health care they need. cohealth welcomes the commitment in this recommendation to improving equity and access to person centred, safe and quality health care, including mental health care, treatment and support.

Recommendation 8 includes a lengthy list of groups that face inequitable access to health care. While it can be assumed it was not intended to be an exhaustive list, cohealth encourages the Steering Group to include a number of other groups of people who experience significant health disadvantage: people who experience homelessness (including insecure housing); people of refugee and asylum seeker background; people who have been in out of home care; people who have been involved in the justice system; and people living in special residential services.

People living with disadvantage and particular population groups face numerous and varied barriers to accessing the health care they need. This can include (but is not limited to): the cost of health care appointments, medications, allied health, specialist care, of taking time off work and transport to appointments; not feeling welcome in services; lack of services and resources in appropriate languages; lack of services in the local area; opening hours that do not fit with work and other commitments; lack of childcare; short appointment times; and inadequate knowledge by health care providers of the impact of their circumstances on health.

Ensuring that barriers to access to health care are addressed is critical, and the actions identified for this recommendation, such as co-designing solutions to address barriers to care; providing universal access to interpreter services; and providing additional coordination/navigation supports will help achieve this.

Addressing the out-of-pocket costs that prevent people on low incomes from accessing essential primary health care must also be a critical priority. As the Grattan Institute noted in 2019 'Nearly a fifth – 18.9 per cent – of health spending in Australia comes directly from patients' pockets…Relying heavily on patients to fund their own health care can create financial barriers to care, particularly for low-income people. This causes some people to avoid care, which in turn affects their health and can create future costs.'[11]

[11] https://grattan.edu.au/wp-content/uploads/2019/04/916-Commonwealth-Orange-Book-2019.pdf

Despite our universal Medicare system, many people are unable to access bulk billing health care, and if they do it may be at high volume clinics that may not provide the time for comprehensive consultations. Low-income Australians are more likely to skip or delay care due to the cost than high-income Australians, with around 5 per cent of low-income people skipping or delaying seeing a GP due to cost; and approximately 14 per cent unable to fill a prescription due to cost. More than a quarter of people on the lowest incomes are unable to access dental care due to cost.[12] Similarly, the costs of allied health services can be prohibitive for people on low incomes. Health conditions deteriorate while people wait for publicly funded services, impacting on their health and wellbeing, and resulting in greater use of acute health services including hospitalisation.

cohealth recommendation 5

That the Steering Group expand Recommendation 8 – Improved access for people with poor access or at risk of poorer health outcomes – with a requirement to reduce or remove out of pocket costs for essential primary care for people experiencing disadvantage.

Primary care workforce development and innovation (recommendations 10 – 14)

The actions proposed in **Recommendation 10 – Building workforce capability and sustainability** to ensure that education and training supports the development of skills that support person-centred, holistic, safe and trauma informed care are welcome.

cohealth proposes that the aim that the workforce receive education in cultural competency be set higher – at cultural safety, which also places expectations on services to review their policies and procedures. Cultural safety is both a way of working in health and an outcome of good care. It focuses on the culture of the health professional and of the organisation, asking whether these serve the needs of consumers, families and communities.

The actions in this recommendation should be extended to all workforce groups in the health care system, not only the 'traditional' ones, including newer workforces, such as the peer workforce (in mental health, alcohol and other drugs, homelessness and other groups), bi-cultural workers, service/care navigators, and social prescribing link workers. Workforces engaged in preventative health work, such as health promotion, health literacy and community engagement should also be considered as part of the primary health care workforce. Including these workforces is a strength of community health services, improving the accessibility of services and improving health outcomes for communities.

Funding models need to ensure there is adequate provision for training and education, particularly for workforces working with groups that experience disadvantage and barriers to accessing health care.

[12] https://grattan.edu.au/wp-content/uploads/2019/04/916-Commonwealth-Orange-Book-2019.pdf

Emergency preparedness (recommendation 19)

Community health services play critical roles responding to emergencies such as COVID-19 and during natural disasters. The Victorian Healthcare Association has recently documented the many service adaptations and innovations implemented by community health services in response to the pandemic. These occurred as community health services supported and serviced their existing client groups, while expanding support to new population groups who were vulnerable to COVID-19 infection, social isolation, economic hardship and health risks.[13]

Likewise, during natural disasters such as bushfires and floods community health services play a critical role supporting their local communities.

Community health services must be included in all frameworks, partnerships and plans designed to develop local integrated emergency preparedness solutions.

Climate change is a significant driver of extreme weather events, natural disasters and disease outbreaks, as described earlier in this submission. As such it should be explicitly recognised in this recommendation.

cohealth recommendation 6

That Recommendation 19 recognise the urgent need to address climate change to reduce the frequency and impact of extreme weather events, natural disasters and disease outbreaks.

[13] https://vha.org.au/news/learning-from-the-success-of-victorias-community-health-response-to-covid-19/

Final observation - oral health care

Traditionally missing from any conversation about primary care, and similarly from this discussion paper, is the place of oral health care. Despite the established linkages between oral health and general medical health the two systems often work in isolation from each other and have separate training, funding, regulatory and administrative systems. This adds to system complexity and can be detrimental to people's health.

cohealth operates three public dental clinics as a key part of our service offering. The advantages are clear – oral health practitioners regularly refer patients to cohealth primary care providers such as GPs, mental health services and allied health practitioners, and collaborate about their care (and vice versa) ensuring even more comprehensive health care than is envisaged in the discussion paper.

cohealth urges the Steering Group to recommend that the Government looks at ways to improve the health of individuals and communities by looking at ways to overcome the divide between primary health care and oral health care and endeavouring to integrate the two sectors.

Community health services have significant experience to offer the Steering Group in providing and managing comprehensive, integrated primary health care, particularly to groups who face barriers to accessing health care.

cohealth would welcome the opportunity to discuss this submission with the Steering Group, particularly the role of not-for-profit community health services in the primary health care sector. Please contact:

Kim Webber, Executive Lead – Strategy and Partnerships on kim.webber@cohealth.org.au, or
Jane Stanley, Advocacy and Policy Manager on jane.stanley@cohealth.org.au