Submission to Health 2040: A discussion paper on the future of healthcare in Victoria

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KEY MESSAGES

A PERSON-CENTRED VIEW OF HEALTHCARE

- A person centred view of healthcare includes, but is not limited to, the engagement of individuals about addressing their own health care needs. It also includes engagement with individuals and communities in broader decisions about programs, services and policies.

- Engaging with specific communities ensures that targeted strategies can be developed to facilitate access and respond to their specific health care needs.

Recommendation 1: All health providers adopt a person centred view of healthcare, to improve engagement in decisions about individual health, address access barriers and support improved healthcare experiences and health outcomes.

PREVENTING AND TREATING CHRONIC DISEASE

- Community health responds to the needs of marginalised communities by actively facilitating access, and by providing integrated services. Community health organisations are well positioned to support the response to chronic and complex health conditions amongst marginalised individuals and communities.

- Policy responses and interventions to address chronic and complex health conditions need to be sensitive to the needs of the most disadvantaged populations, where these is the greatest potential for gains in health status and quality of life, and for reduction in avoidable health system costs.

IMPROVING PEOPLE'S HEALTH OUTCOMES AND EXPERIENCES

- Low literacy materials need to be incorporated into service provision planning to support marginalised and disadvantaged people in accessing the health system. These should be co-designed with service users to respond to community needs.

- Community-based primary prevention interventions, which are based on an empowerment model which emphasises the rights of communities rather than the needs of communities, are vital to address the social factors which impact on both health experiences and health outcomes.

- Primary prevention work and service responses should be based on analysis of population health needs, including the social determinants of health as well as the prevalence of behavioural risk factors and health conditions.

IMPROVING THE WAY THE SYSTEM WORKS

- Service providers should enter into partnership agreements to maximise the opportunities to provide comprehensive and integrated responses, particularly for the complex needs of marginalised and disadvantaged individuals and communities.

Recommendation 2: Strategies to improve the interface between the acute and primary health care sector should incentivise collaborative or partnership models.

COHEALTH

cohealth is one of the largest community health organisations in Australia. We provide support services and deliver programs promoting community health and wellbeing to more than 110,000 people per year across a broad range of high-growth communities from 44 sites and 14 local government areas in Melbourne's northern, western and inner suburbs.

We prioritise disadvantaged or marginalised individuals and communities because we know that these groups experience poor health and have high needs. These priority groups[1] include:

- Refugees and asylum seekers
- Aboriginal and Torres Strait Islander peoples
- People at risk of harm associated with alcohol and drug use
- Families and young people at risk
- Disadvantaged and disenfranchised people (for example recent prisoners)
- People with or at risk of chronic disease
- People with or at risk of mental illness or poor mental health
- People with a disability
- Older people with complex needs
- People who are inadequately housed or at risk of being homeless

Central to how we operate is a codesign approach, in which we work in partnership with consumers, clients, carers and the community to create opportunities for active and meaningful participation in decisions about people's own health and health care. Our commitment to codesign is highlighted in our Strategic Plan, in which one of the five key focus areas is "keeping people and communities at our core". This partnership extends beyond empowering people to engage in their own health care, and is also used to inform the design and delivery of cohealth's services, programs and advocacy.

This submission draws on cohealth's experience as a provider of prevention and management programs and services for chronic and complex conditions, as well as a wide range of locally-based health and community support services. It also draws on the organisation's commitment to, and experience of, being a vigorous advocate with and for people whose voice is often absent from community and political debate. Our experience in developing approaches which address access barriers for marginalised individuals and communities positions us to identify emerging barriers and new service delivery systems and opportunities.

BACKGROUND

cohealth recognises and supports the contention in the 'Ministerial foreword' of Health 2040: A Discussion paper on the future of healthcare in Victoria ("Health 2040") that the current model of funding health "will increasingly fail to deliver the care people expect". Against a background of an ageing population, Australia is experiencing an increase in the incidence of chronic and complex health conditions,[2] which includes an estimated 126,800 cancer

[1] cohealth *Service Access and Service Delivery Framework*
[2] Australian Institute of Health and Welfare, 2015, Chronic Diseases. From: http://www.aihw.gov.au/chronic-diseases/ These conditions include: diabetes, asthma and chronic obstructive pulmonary disease (COPD), cardiovascular disease, cancer, and mental health conditions.

diagnoses in 2015.[3] The burden of chronic health conditions is 32 per cent higher for the most disadvantaged Australians (people in the lowest 20 per cent of socio-economic status) than the most advantaged Australians (people in the highest 20 per cent of socio-economic status.[4] Conversely, the most disadvantaged population have the greatest potential for gains in health status and quality of life, and reduction in avoidable health system costs.

Alongside increases in chronic and complex health conditions, awareness of, and treatment options for, mental health are increasing. 1 in 5 Australians aged 16 – 85 experience a mental health condition in a given year with a third of these people accessing health services to seek support for their condition.[5] The episodic nature of mental illness and the side effects of treatment demand a specific response to support the needs of the individual. Mental health service delivery options need to be responsive to these needs and avoid poor health outcomes.

A PERSON-CENTRED VIEW OF HEALTHCARE

Person centred health care is a model to shape future health service and program options. The model places the individual who accesses services at the centre of the decision making process about their health. This approach emphasises holistic and preventative approaches and highlights individual experience as a key indicator of healthcare performance and quality. As a concept this allows for a more collaborative, partnership based approach to health.

A person centred approach to healthcare entails actions at four levels:

Individual - this involves engaging with the individual as partners in person centred, goal directed and integrated treatment and care

Program – ensuring there is engagement to inform the review, design, evaluation and implementation of services and programs

Organisational – the facilitation of engagement and involvement in decisions relating to policy access, care coordination, planning, quality improvement and infrastructure to ensure the lived experience of service use in the delivery of services to improve accessibility and appropriateness of services.

Community – supporting community led responses, participation in community building, health sector development, advocacy and partnerships.

This approach encourages innovation to remove barriers to access and to optimise the experience of the individuals and families who access our services. This process is critical at responding to the healthcare needs of many of the communities that access our services (see footnote 1). Many of these communities experience barriers to access when using mainstream services, and therefore do not receive the necessary support services to prevent chronic condition progression. A codesign influenced, person centred view of healthcare

[3] Australian Institute of Health and Welfare 2014. Cancer in Australia: an overview, 2014. Cancer series no. 78. Cat. no. CAN 75. Canberra: AIHW.
[4] Begg, S., Vos, T., Barker, B., Stevenson, L, and Lopez, A. 2007, The burden of disease and injury in Australia 2003, Cat. No. PHE 82, Canberra: AIHW
[5] Mental Health Council of Australia, Fact Sheet: Statistics on Mental Health. See https://mhaustralia.org/sites/default/files/imported/component/rsfiles/factsheets/statistics_on_mental_health.pdf

facilitates the engagement of individuals and communities with, or at risk of, chronic and complex health conditions and supports responses that address their needs.

As a community health service, we have specific strategies designed to facilitate access to services for specific populations experiencing social disadvantage. For example, we provide services for people who are homeless or at risk of homelessness, through a combination of welcoming, accessible sites; assertive outreach (e.g., our health providers attending housing and welfare services where homeless people spend time); and drop-in sessions where no appointment is needed. We also have priority access for marginalised groups, for example providing priority access to dental services for homeless people.

Recommendation 1: All health providers adopt a person centred view of healthcare, to improve engagement in decisions about individual health, address access barriers and support improved healthcare experiences and health outcomes.

Examples of person centred view of healthcare at cohealth

Healthy Together Health Champions

The Healthy Together Health Champions program was designed using an empowerment framework, to engage communities in the planning and implementation of initiatives. The program supports people to improve their health and influence the health of their families, friends and community in the places where they live, work, learn, and play. People recruited as health champions were trained and resourced to gain the confidence, knowledge and skills to lead local community action and change to support healthy lifestyles. The program saw individuals become empowered to change their own behaviours and then encourage collective action in their communities which empowered behavioural changes and improved health literacy in low socio economic communities.

Living Well

The Living Well program supports people with a chronic health condition (e.g. diabetes, arthritis, asthma, Hepatitis C, heart or lung disease) or people who have risk factors (e.g. smoking, being overweight, lack of healthy eating/physical exercise, high blood pressure/blood sugar) to take charge of their health and achieve their health goals. Living Well is facilitated by a team of health coaches who provide information and support to service users in regards to healthy eating, being physically active, quitting or reducing smoking and effectively managing their condition. Living Well's Health Coaches can assist service users to begin to take action in regards to their health, maintain motivation, overcome perceived barriers to achieve their health goals.

The Living Well Health Coach team is comprised of health professionals with clinical expertise with a variety of backgrounds and experience such as nursing, social work and occupational therapy. This team is highly skilled in Health Coaching and Motivational Interviewing and works collaboratively with the service user, GP and other health professionals to achieve the best possible health outcomes.

PREVENTING AND TREATING CHRONIC DISEASE

Health 2040 notes that the current approach to healthcare in Australia which is focused around "the clinician and the patient", and "episodic engagement with the health system" is not sufficient to respond to Victoria's future health needs. Patients with, or at risk of, chronic

and complex health conditions require the ongoing support of a range of health care professionals. The range of health care required is part of a continuity of care that facilitates transitions through care when the nature of an individual's condition changes.

The health system is composed of a complex web of services, structures and providers all funded from the various tiers of government that constitute Federation. Without one specific tier of government having responsibility, or authority, to ensure a cohesive health system there is a need to consider innovative funding approaches to facilitate coordinated and integrated service delivery to address chronic and complex health conditions.

Location of multi-disciplinary services in community health settings is of particular importance to meeting the needs of marginalised individuals and communities with chronic and complex needs.

Examples of integrated programs at cohealth that have been designed to respond to chronic and complex health conditions include:

Collingwood Integrated Pharmacy

The Collingwood Integrated Pharmacy is a working model of integration and good practice supporting better health outcomes for disadvantaged populations requiring complex service responses. This clinic is run from cohealth Collingwood, and employs pharmacists to work alongside GPs and other health providers within an integrated setting. The pharmacy is the only one of its type in Australia, and has been in operation for over two decades.

The service provides low cost medication, medication review, monitoring and education in collaboration with other health providers to local community members from disadvantaged and marginalised groups. The service dispenses about 30,000 prescriptions annually.

Clients of the service are people in significantly disadvantaged circumstances, often with low levels of health literacy and multiple chronic diseases. Approximately 40% of clients are from non-English speaking and low English proficiency backgrounds. The use of interpreters with both GPs and pharmacists is a key feature of the model. The co-location of GPs and pharmacists means that service users access the pharmacy while interpreters are still present and available during and following the GP appointment – simply by accessing the additional minutes which are paid for as part of a minimum block of time but often go unutilised. The use of qualified interpreters in this setting promotes the right of people with diverse language backgrounds to be fully engaged in their own health care. This program ensures that people actually get their prescribed medication, and understand how to take their medication as prescribed.

HARP Diabetes Clinic

The Hospital Admission Risk Program (HARP) Diabetes Clinic provides service users at risk of hospital admissions with specialist diabetes care from within a community health setting. Follow up and support is provided by diabetes nurse educators, dietitians and podiatrists.

Additional health professionals are linked in as required (i.e. Dental, Health Coaches, Physiotherapists, Occupational Therapists, Exercise Physiologist, Woman's Health Nurse and a myriad of broader services).

Through the implementation of a multidisciplinary framework, service users are commonly seen jointly where possible. Therapeutic goals are person focused and team directed. There is an emphasis on continuity of care, simple language and use of appropriate health literacy tools. Additionally, home visits are provided as required.

Receiving diabetes care within a community health setting provides many benefits for the service user. These include a sense of trust and engagement with a more flexible health care system, easier access and parking, reduced wait times for service users who may be physically frail or emotionally challenged navigating a larger formal setting. Communication is maintained with a service user's family doctor, the hospital system and other specialists as is deemed necessary.

The continuity of care proved by the HARP Diabetes Clinic team promotes safety, decreases the likelihood of hospital admissions, results in improved health and most importantly, through community engagement and a social model of care, connects services users back to their community. After discharge from the HARP Diabetes Team, the service user is subsequently linked back to the community funded diabetes educator and dietician.

In addition, a weekly Diabetes Specialist clinic is offered at the Footscray site, as a satellite of Western Health Endocrinology. This has been running for some 8 years now and is well-subscribed and greatly appreciated by service users.

It is vital to recognise the role of the social determinants of health in producing chronic conditions. Social disadvantage needs to be recognised as a leading modifiable risk factor for poor health outcomes.[6] The most disadvantaged populations have the greatest potential for gains in health status and quality of life, and reduction in avoidable health system costs. Policy responses and interventions need to be sensitive to the needs of these groups.

IMPROVING PEOPLE'S HEALTH OUTCOMES AND EXPERIENCES

Health 2040 recognises "low levels of individual *health literacy* as a contributing factor in poorer health outcomes."

Low health literacy is associated with poorer health outcomes, more hospitalisations and Emergency Department visits, fewer preventative health services, and more medication-related problems.[7] Just as the incidence of chronic disease is unequal across different population groups, lower levels of health literacy are experienced by people living in areas with lower socio-economic status.[8]

To support marginalised and disadvantaged people in accessing the health system, low literacy materials and information need to be incorporated into service provision planning.

[6] Australian Institute of Health and Welfare, 2014, *Understanding Health and Illness.* from http://www.aihw.gov.au/australias-health/2014/understanding-health-illness/
[7] Berkman ND, Sheridan SL, Donahue KE, Halpern DJ, Crotty K. 2011. Low Health Literacy and Health Outcomes: An Updated Systematic Review. Ann Intern Med ;155:97-107. doi:10.7326/0003-4819-155-2-201107190-00005
[8] Australian Bureau of Statistics, 2006, Health Literacy: Australia. http://abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/4233.0Main%20Features22006?opendocument&tabname=Summary&prodno=4233.0&issue=2006&num=&view= Accessed 14 July, 2015

These materials should be co-designed with local communities to ensure they respond to the communities needs.

To address low health literacy in the community of people who use our services cohealth initiated a program called *Connected: A Community Health Literacy Pilot Project*, which aimed to improve participants' health literacy by;

- building their confidence to ask questions,
- supporting participants to understand the social determinants of health
- assisting participants to develop booklets to share with others
- supporting facilitators to communicate in easy to understand ways

The course was co-designed with six members of a targeted community to develop processes and content that would assist learning about health literacy. The course was then trialled with 80 people in six sessions and covered:

- how to ask questions and get ready to see a doctor or health worker
- taking notes during meetings with health services, and taking a person with you
- how to find good health information on the internet
- how to understand what your rights are and using your voice; and
- how to get involved in better health for yourself and your community

The program provided participants with increased confidence in understanding and engaging with the health system.

cohealth's approach to service access and service delivery is based on a human rights approach and the community health principles of the social model of health promotion and prevention. As part of this rights based approach, health literacy is seen as not limited to the individual being provided with information and materials to support their engagement with the system. It is also about the system acknowledging that it is imperfect, and incorporating mechanisms to accommodate the experiences, opinions and needs of people with low literacy.

cohealth worked in collaboration to co-design a number of materials suitable for people with low literacy, including our client rights and responsibilities statement (see Appendix). The *Tooth Out Take Care* card was developed for people who access our oral health services who have had teeth removed. The document provides information about reducing the risk of infection for people who have had teeth removed. The *Misfits* brochure is a harm minimisation initiative about Hepatitis C that was codesigned with the injecting drug community who frequent our services.

In addition, a broader view which recognises the social determinants of health also highlights the importance of community capacity building work, addressing the social and structural factors which contribute to individuals and communities to be at higher risk of poor health outcomes. These include low incomes, poor access to services (for reasons of distance, cost or acceptability), and stigma and discrimination, which may be experienced within health services. cohealth has a specific interest and experience in applying community-based primary prevention interventions. Community-based interventions go beyond just educating community members about health and lifestyle choices. This approach is based on an empowerment model which emphasises the rights of communities rather than the needs of communities.

Primary prevention work and service responses should be based on analysis of population health needs at the broadest level, encompassing the social determinants of health as well as the prevalence of behavioural risk factors and health conditions.

IMPROVING THE WAY THE SYSTEM WORKS

Commonwealth state and territory governments need to pursue the development and testing of new funding models to support people with, or at risk of, developing chronic and complex health conditions. This involves providing hospitals and community health organisations with an opportunity to work together to provide a continuity of care. Given community health's strong history of integrating services into their service planning, community health services should be key participants in the process.

Health 2040 raises the prospect of bundled or pooled funding packages as supporting integrated and innovative service delivery. As complex needs are increasingly seen as not only an individual's health conditions, but also an individual's challenges, experiences, circumstances and history, there is a need to reconfigure service delivery to ensure that these complexities can be met. This involves acknowledging that different service providers have discrete skills and levels of expertise that can complement each other.

To maximise the opportunities to provide comprehensive and integrated responses to the complex needs of marginalised and disadvantaged individuals and communities, service providers should enter into agreements with each other to provide services. In this scenario, the funding remains with existing provider, rather than being directed into a single organisation, or pooled.

The *Travis Review* of Victorian hospitals noted that services previously delivered in a hospital setting could be better delivered in community-based health settings.[9] Providing these services in community settings would increase the range of services available in the one setting and reduce hospital admissions and emergency department visits. There would also be opportunities to increase health monitoring, improve health literacy, reduce errors in care, duplication of screening and treatment and make transitions between different services and providers more seamless.

To support improved user experience cohealth recommends an increased focus on integrated healthcare services between service providers.

An example of an innovative approach to delivering programs includes The *Inner North West Collaborative*.

This Collaborative[10] involves the Melbourne Primary Care Network (now the North Western Melbourne PHN; formerly Inner North West Melbourne Medicare Local), Melbourne Health, cohealth and Merri Community Health Services. A formal Collaborative Framework guides the partnership, which aims to improve patient care, pathways and outcomes in the region. Four flagship projects have been agreed as part of the Collaborative: Diabetes Demonstration, Chronic Kidney Disease, Information and Communications Technology

[9] Travis D. 2015. Travis Review: Increasing the capacity of the Victorian public hospital system for better patient outcomes. Final report. From: http://www.health.vic.gov.au/travis/

[10] See Travis D. 2015. Travis Review: Increasing the capacity of the Victorian public hospital system for better patient outcomes. Final report. From: http://www.health.vic.gov.au/travis/ for an additional review of the Collaborative

interface and eHealth, and the development of a Regional Health Strategic Plan. Each organisation has responsibility for one of the priority projects.

The organisations that constitute the collaborative have developed health care pathways, advance care planning, chronic disease management, integrated mental health services, after-hours access, and information technology improvements. The partners each play a unique role within the healthcare system and have made a commitment to work together to trial and then mainstream different service delivery models to improve the coordination of care for patients.

The partner organisations strive to find the best solutions to strengthen access to primary health care services, reduce avoidable hospitalisations, and keep people well, in ways that they could not be achieved as a single service working alone.

The Collaborative is a highly-regarded example of a partnership approach to improving the interface between the acute sector and the primary health care sector. Partnership approaches are recognised as international best practice in care for high risk cohorts.[11] These approaches recognise that different providers have distinct, and complementary, services to provide. Within this context, community health services have expertise in locally-based, highly accessible services, which are designed specifically to meet the needs of high risk cohorts.

State funding models can be configured to support collaborative or partnership approaches. These may or may not involve pooled funding. For example, strategies to reduce hospital admissions or emergency department presentations for people with chronic and complex conditions could incentivise collaborative or partnership models rather than working solely through acute sector providers.

Recommendation 2: Strategies to improve the interface between the acute and primary health care sector should incentivise collaborative or partnership models.

[11] The Advisory Board Company, 2015. The Population Health Enterprise: Building the High-Performance Care Management Network. From https://www.advisory.com/international

APPENDIX: Examples of low literacy materials

Client rights & responsibilities statement

"Tooth out? Take care" Card page 1

Misfits brochure cover