

COSS Network submission to Inquiry into chronic disease prevention and management in primary health care

**House of Representatives Standing Committee
on Health**

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About the national, state and territory Councils of Social Service

The Victorian Council of Social Service (VCOSS) has prepared this submission on behalf of the national, state and territory Councils of Social Service across Australia.

The Australian Council of Social Service (ACOSS) and the state and territory Councils of Social Service (COSS) are the peak bodies of their community services and welfare sectors, and are voices for the needs of people affected by poverty and inequality. Their visions are for a fair, inclusive and sustainable Australia where all individuals and communities can participate in and benefit from social and economic life.

COSS have long called for a health system that promotes positive health outcomes for all people in Australia, regardless of their social or economic situation. We advocate against systemic barriers in the health system that lead to people having poorer health; and we work towards equitable access to income, education, secure housing and employment as some of the social factors that correlate so strongly with health outcomes. The COSS have developed a [joint statement on health priorities](#).

As the peak body for non-government social and community organisations in states, territories and nationally, we are also informed by a membership that is engaged in the full spectrum of the health system: from providing primary health services, to focusing on the social determinants of health, to voicing the experience and needs of consumers.

COSS welcome this inquiry into the prevention and management of chronic disease in primary health. In a time of significant change for the primary health and broader community sector, the importance of preventative work and collaboration across health and community sectors is central.

Recommendations

Key recommendations of this submission are:

- Tackle health inequities by recognising the higher prevalence of chronic disease and greater exposure to risk factors among disadvantaged populations and work to improve health outcomes for disadvantaged Australians by addressing the social determinants of health.
- Adopt a broad social determinants of health approach to effective prevention and management of chronic disease, and strengthen and consolidate guarantees for universal access to essential health services including affordable primary health care, to provide a basis for good health and wellbeing over the life cycle.
- Sustain and increase investment in chronic disease prevention, including reversing foreshadowed reductions in funding to Health Flexible Funds that will reduce the capacity of community organisations to support vulnerable and disadvantaged communities.
- Introduce measurable preventative health targets and regular reporting on population health expenditure.
- Ensure Primary Health Networks operate as open and transparent organisations that work in partnership with all stakeholders, including consumer organisations and community service providers.
- Ensure Primary Health Networks are supported and resourced to actively engage consumers in the design and delivery of services
- Address the barriers that prevent equitable access to timely and affordable primary health care services, discourage early intervention to keep people well.

Chronic disease

Chronic disease in Australia

Chronic diseases in Australia are significant contributors to illness, disability and premature death. Chronic disease causes nine out of ten Australian deaths.¹ Heart disease, cancer, lung disease and diabetes account for three quarters of all of these deaths.²

In 2007-08 one in 50 people reported having four or more chronic health conditions. This proportion increased with age, with eight per cent of people aged 65 or older reporting four or more chronic health conditions.³

It is anticipated that the rate of chronic disease in the community will continue to grow, and the health system will struggle to cope. The World Health Organization has called chronic conditions ‘the health care challenge of this century’.⁴

Chronic diseases are often long term. As a result, they pose significant challenges for the health care system. People with chronic disease use health services including hospitals, primary and community health, regularly and often over a long period of time. For example, heart disease was the main cause in about one in every 16 hospital admissions and played a secondary role in one in ten admissions.⁵ Kidney disease and the need for dialysis in particular, accounted for between one in seven to eight hospital admissions.⁶

Chronic disease and disadvantage

Health and wellbeing are influenced by social determinants – the conditions in which people are born, grow, live, work and age. In Australia, the higher your income and education level, the better your health will tend to be, resulting in health inequality. People on low incomes, people in rural and remote areas and Aboriginal people, on average, have poorer health, die earlier and receive less healthcare than other Australians.

The foundations of adult good health are laid before birth and in early childhood. Social and environmental stressors in prenatal and early childhood can become deeply embedded in children’s neurobiology, and have been associated with increased risk of chronic disease, poor emotional health and mental ill-health later in life.

¹ AIHW, *Australia’s Health 2014*, 2014, pp. 94.

² AIHW, *Australia’s Health 2014*, 2014, pp. 94.

³ Mitchell Institute, *Chronic disease in Australia: the case for changing course*, 2014, pp 7.

⁴ World Health Organisation, *Innovative care for chronic conditions: Building blocks for action*, Geneva, 2002.

⁵ AIHW, *Cardiovascular disease: Australian Facts 2011*, Cat No. CVD 53.

⁶ Mitchell Institute, *Chronic disease in Australia: the case for changing course*, 2014, pp 7.

The burden of chronic disease falls particularly on communities that are already facing disadvantage, including people on lower incomes and people in rural and remote Australia. Disadvantaged populations have higher levels of chronic disease and greater exposure to risk factors.

Australians aged 25-44 in the lowest socioeconomic group are nearly five times more likely to have a chronic health condition as those in the highest.⁷

Chronic conditions have significant financial impacts that extend beyond direct medical costs that can force households on low incomes into cycles of poverty and ill health. They are also a barrier to independence, participation in the workforce and in society.

Aboriginal and Torres Strait Islander people are at particular risk of chronic disease. About 80 per cent of the mortality gap for Aboriginal Australians aged 35 to 74 is due to chronic disease.⁸ The gap is caused by higher rates of chronic disease at younger ages as well as increased death rates associated with chronic disease. For example, Aboriginal people experienced end-stage kidney disease at seven times the rate of non-Aboriginal people in 2007-2010.⁹ They had more than three times the rate of diabetes/high sugar levels and three times the hospitalisations for respiratory conditions.¹⁰

In the Northern Territory, Aboriginal people in remote areas make up 26 per cent of the total Aboriginal population, but contribute 50 per cent of the health gap attributable to alcohol, 34 per cent attributable to tobacco and 38 per cent attributable to high body mass.¹¹

People experiencing or at risk of homelessness are also at higher risk of chronic disease. Data from a Queensland Council of Social Service project, which surveyed almost two and half thousand people who were homeless or at risk of homelessness across Queensland, found that survey respondents had an incidence of diabetes, asthma, kidney disease and hepatitis C that was three times that of the general population.¹²

There is evidence of a social gradient in the prevalence of diabetes, heart disease and smoking rates, as shown by the diagrams below.

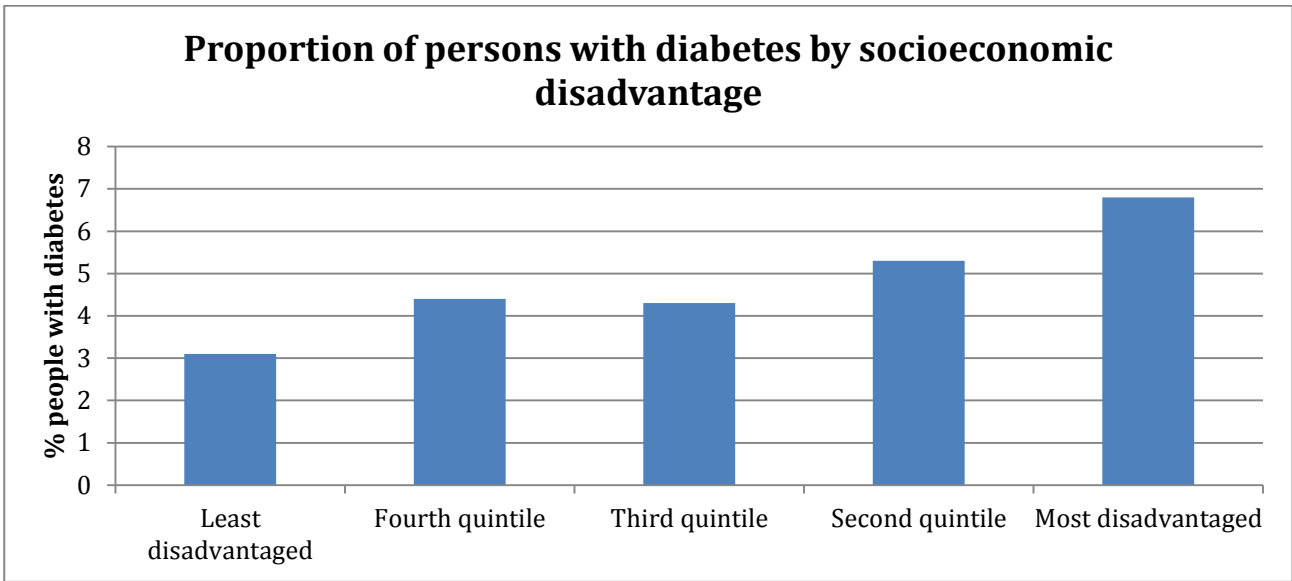
⁷ NATSEM, *Health lies in wealth: Health inequalities in Australians of working age*, Report No 1/10, September 2010, p. x.

⁸ AIHW, *Contribution of chronic disease to the gap in adult mortality between Aboriginal and Torres Strait Islander and other Australians*, Cat. No IHW 48, 2011.

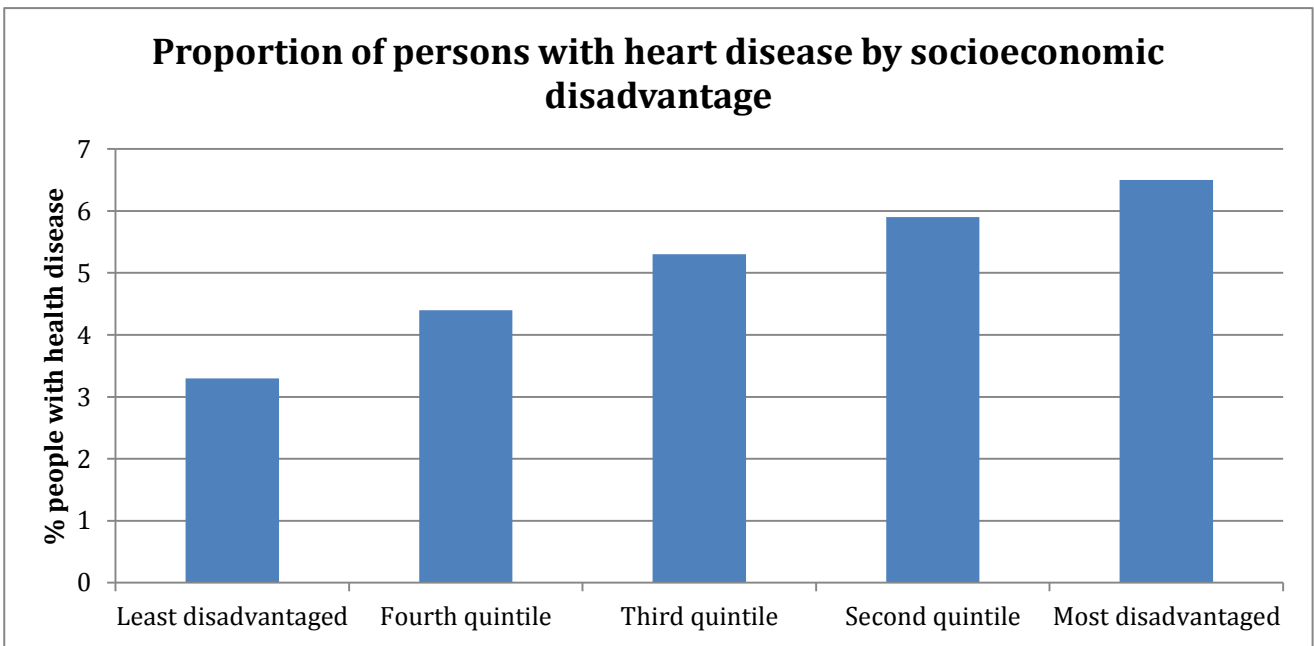
⁹ AIHW, *Australia's Health 2014 In Brief: Not faring so well*, accessed at <http://www.aihw.gov.au/australias-health/2014/not-faring-so-well/>

¹⁰ AIHW, *Australia's Health 2014 In Brief: Not faring so well*, accessed at <http://www.aihw.gov.au/australias-health/2014/not-faring-so-well/>

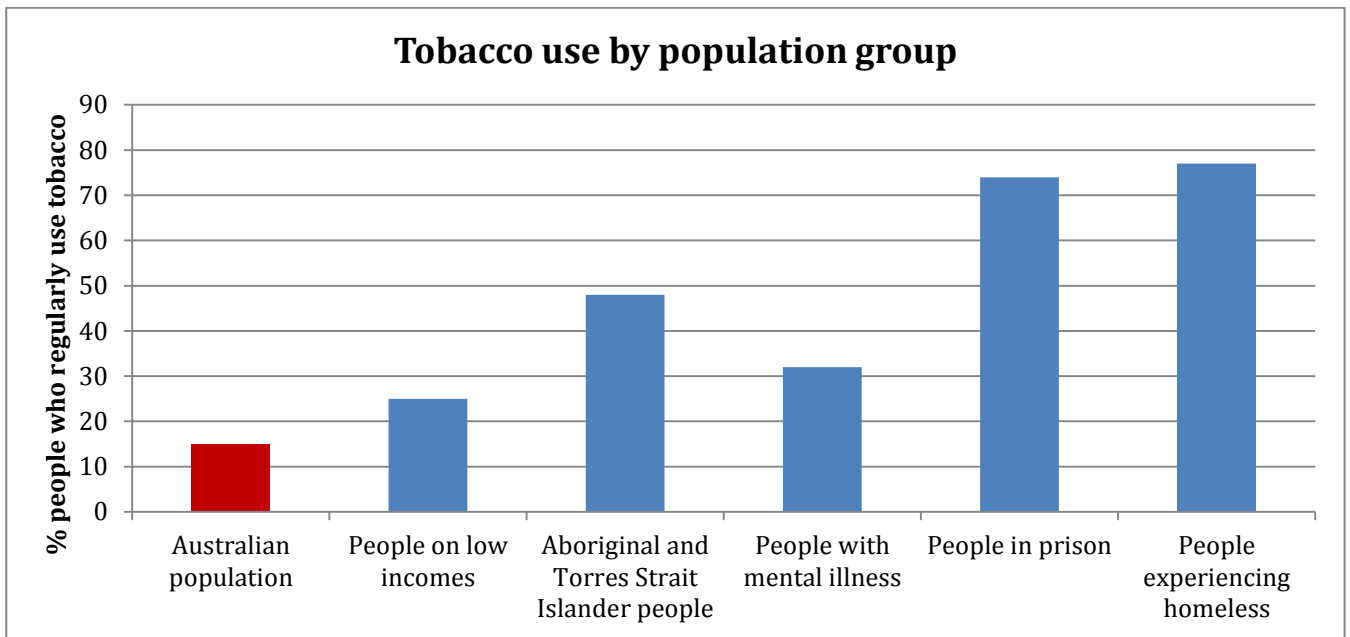
¹¹ QCOSS, *Characteristics of people who experience poverty*, 2015, unpublished.



Source: Australian Bureau of Statistics, *Australian Health Survey: First Results 2011-12*, Cat No. 4364.0, October 2012, Table 2.3.



Source: Australian Bureau of Statistics, *Australian Health Survey: First Results 2011-12*, Cat No. 4364.0, October 2012, Table 2.3.



Source: Quit Victoria and VCOSS, *Supporting disadvantaged people to quit smoking*, 2012.

The role of governments in chronic disease prevention

Risk factors for chronic disease

The WHO's *Global Action Plan*¹³ for the prevention and control of non-communicable diseases identified tobacco use, unhealthy diet, physical inactivity and the harmful use of alcohol as shared risk factors for chronic disease. Much of the work to prevent and tackle chronic disease focuses on these common 'lifestyle' risk factors. However, lifestyle choices are made within the social, cultural and economic contexts in which people live, work, and play.

For example, obesity is often considered a result of individual behaviours. But food choices depend on a balance of factors including access to affordable and nutritious food, trends in portion sizes, marketing and advertising of unhealthy foods, understanding of food labeling and increases in access to fast-food and highly-processed foods.¹⁴

The causes of chronic diseases are multifactorial and extend beyond individual lifestyle behaviours to include many external factors, such as social, environmental and socioeconomic characteristics of the communities people live in. Many of the risk factors that contribute to chronic illness occur well before the first symptoms of ill-health appear, sometimes even in childhood.

“Childhood health and the uterine environment have a lasting impact on health and socioeconomic status throughout life. Many adult health conditions, including major public health problems such as obesity, heart disease, diabetes and mental health problems, have their origins in childhood health conditions.”¹⁵

A broad social determinants of health approach is required to prevent chronic disease, that moves beyond the behaviour of individuals to identify how to reduce exposure to risk factors at different stages of life and in different settings.

“A life-course perspective is essential for the prevention and control of non-communicable diseases. This approach starts with maternal health and prenatal nutrition, pregnancy outcomes, exclusive breastfeeding for six months, and child and adolescent health; reaches children at schools, adults at worksites and other settings, and the elderly; and encourages a healthy diet and regular physical activity from youth into old age.”¹⁶

¹³ World Health Organisation, *Global Action Plan for the prevention and control of non-communicable diseases 2013-2020*. 2013.

¹⁴ Mitchell Institute, *Chronic disease in Australia: the case for changing course*, 2014, pp 12.

¹⁵ National Health and Hospital Reform Commission, 2008.

¹⁶ World Health Organization. *Global strategy on diet, physical activity and health*. Fifty-Seventh World Health Assembly. 2004.

Prevention of chronic disease

Health promotion and chronic disease prevention efforts are essential to sustainable change. Taking a population-based approach to prevention provides scope for multi-sectoral action, involving many groups, including government, industry, community organisations and health professionals, and in many settings, including workplaces, communities, sporting clubs, schools and health services.¹⁷

The World Health Organisation (WHO) has estimated that at least 80 per cent of all heart disease, stroke and diabetes are preventable, as are 40 per cent of all cancers.¹⁸ With rates of chronic disease rising, preventative health is crucial and should be the responsibility of all levels of government.

Investment in promotion and prevention is also highly cost-effective and can create real and lasting improvements benefiting the health of all Australians. A study commissioned by the Department of Health and Ageing in 2003 shows impressive long-term returns on investment and cost savings from prevention. For example, the report estimated that the 30 per cent decline in smoking between 1975 and 1995 had prevented over 400,000 premature deaths, and saved costs of over \$8.4 billion – more than 50 times greater than the amount spent on anti-smoking campaigns over that period.¹⁹

Prevention for a Healthier America, shows that for every US\$1 invested in proven community-based disease prevention programs (increasing physical activity, improving nutrition and reducing smoking levels), the return on investment over and above the cost of the program would be US\$5.60 within five years.²⁰

The Assessing cost-effectiveness in prevention study (ACE-Study) in 2010²¹ found that implementing an alcohol volumetric tax that does not discriminate between beverage types would have a large impact on population health, preventing in excess of 100,000 disability-adjusted life years (number of years lost due to disability, ill-health or early death) and net savings of \$700million. This has also been a recommendation of a number of reviews including the 2010 report on *Australia's Future Tax System*.

However prevention has and continues to be an area of significant under-investment. In recent years Australia has invested a lower proportion of its health expenditure in prevention than most other OECD countries, with just 1.7 per cent of 2010–11 health spending on public health, or less

¹⁷ Mitchell Institute, *Chronic disease in Australia: the case for changing course*, 2014, pp 17.

¹⁸ World Health Organisation, *Prevention chronic disease: a vital investment*, 2005.

¹⁹ National Preventative Health Taskforce, *Australia the healthiest country by 2020: National Preventative Health Strategy*, 2009, pp. 10.

²⁰ National Preventative Health Taskforce, *Australia the healthiest country by 2020: National Preventative Health Strategy*, 2009, pp. 10.

²¹ Vos et al, *Assessing cost-effectiveness in prevention Final Report*, University of Queensland and Deakin University, 2010, p. Table 0.1.

than 0.2 per cent of GDP.²² In comparison, New Zealand invested seven per cent of total health expenditure in prevention.²³

The AIHW no longer provides detailed reporting on public health expenditure. The decline in funding for population-based health, as well as the declining capacity for analysis of where funds are currently spent, is part of the problem we face in establishing the true nature and effectiveness of funding in primary health broadly.

The recent termination of the National Partnership Agreement on Preventative Health (NPAPH), four years before its extended expiration date of June 2018, is a disappointing example of the lack of priority given to preventative health. The NPAPH provided more than \$870 million in funding over eight years for programs to reduce risk factors and prevent chronic diseases in schools, workplaces and the community. As well as a large investment in preventative health programs, the NPAPH included measurable targets for reducing risk factors for chronic diseases.

As a result of the termination of the NPAPH many successful programs will be forced to end, including those funded through the Health Together Victoria program.

Healthy Together Victoria – Wyndham

Healthy Together Victoria is a comprehensive preventive health initiative, funded through the National Partnership Agreement on Preventative Health, and designed to improve people's health and wellbeing. Under the initiative a number of "healthy together communities" have been established across Victoria, including in Wyndham, west of Melbourne.

Only five per cent of adults living in Wyndham eat enough vegetables and about 53 per cent are overweight or obese. 25 per cent of women in Wyndham smoke, well above the national average. In the two-and-a-half years that Healthy Together Wyndham has operated, the program has reached about 54,500 residents. Two-thirds of Wyndham schools, kindergartens and childcare centres are involved in the program, along with 39 businesses.

To address increasing obesity rates and chronic disease, the team has been:

- working where people live, work and play – in workplaces, schools, kindergartens, child-care centres and sports clubs
- helping create the conditions for good health by ensuring all residents have access to healthy food, recreation opportunities, employment, housing, community services, education and transport; by reducing social exclusion; and by limiting the availability of alcohol
- helping to deliver statewide health campaigns and programs (such as Jamie's Ministry of Food)
- delivering healthy eating and exercise programs
- increasing access to community wellbeing services.

²² AIHW, *Health Expenditure 2010-11*, September 2012.

²³ AIHW, *Australia's Health 2014; Chapter 8 Preventing and treating ill-health*, <http://www.aihw.gov.au/australias-health/2014/preventing-ill-health/>, accessed 4 August 2015.

The Australian Government has foreshadowed \$596 million in cuts to Health Flexible Funds over the next four financial years. This comes on top of a nearly \$200 million cut in last year's budget. While there is not yet clarity about how these savings will be achieved, there is likely to be significant impact on funds that support services working in chronic disease prevention, substance use treatment and essential services in rural, regional and remote Australia.

It had been our understanding that services funded through the Flexible Funds would have current funding arrangements extended. However we are aware of at least one example of funding for a proven chronic disease prevention initiative not being extended.

CO-OPS Obesity Prevention Network

The Collaboration of Community-based Obesity Prevention Sites (CO-OPS Collaboration) is an initiative currently funded by the Australian Government Department of Health under the Chronic Disease Prevention and Service Improvement Fund.

The purpose of CO-OPS is:

- To identify and analyse the lessons learnt from a range of community-based obesity prevention initiatives aimed at tackling obesity.
- To identify the elements that make community-based obesity prevention initiatives successful and share the knowledge gained with other communities.

CO-OPS is recognised nationally as essential in providing central coordination for collaboration, information-exchange and best practice implementation by professionals across health and non-health agencies, all levels of government and non-government organisations in the prevention of obesity and related chronic diseases, reaching at least 1.4 million Australians each year.

The type of initiatives or programs that the CO-OPS Collaboration focuses on are those that consider the socio-cultural and environmental determinants of obesity within a setting or population group, rather than those with a focus solely on individual behaviour change or weight loss (treatment).

Opportunities for Primary Health Networks

What is primary health care?²⁴

Primary health care usually involves the first (primary) layer of services encountered in health care and requires teams of health professionals working together to provide comprehensive, continuous and person-centred care.

Primary health care is the frontline of Australia's health care system. It can be provided in the home or in community-based settings such as in general practices, other private practices, community health, local government, and non-government service settings for example, Aboriginal Community Controlled Health Services.

The types of services delivered under primary health care are broad ranging and include: health promotion, prevention and screening, early intervention, treatment and management.

Services may be targeted to specific population groups such as: older persons, maternity and child health, youth health, people living in rural and remote areas, Aboriginal and Torres Strait Islander people, refugees, and people from culturally and linguistically diverse or low socioeconomic backgrounds.

Primary health care services may also target specific health and lifestyle conditions, for example:

- sexual health
- drug and alcohol services
- oral health
- cardiovascular disease
- asthma
- diabetes
- mental health
- obesity
- cancer

Appropriate and effective management in the primary and community health sector can delay the progression of many chronic diseases as well as prevent or minimise the severity of

²⁴ Source: Commonwealth of Australia Standing Council on Health, *National Primary Health Care Strategic Framework*, April 2013.

complications.²⁵ Individuals benefit from improved health and wellbeing, and the capacity for greater economic and social participation. Reduced demand for treatment in the acute health sector can reduce the burden on the broader health system.

General practitioners (GPs) are not the only providers of primary health services. Community health and organisations, Aboriginal community controlled organisation and local government are all providers or important access points to primary health services.

Primary health networks (PHNs)

In April 2015, the Health Minister Sussan Ley announced the establishment of 31 new Primary Health Networks (PHNs) to “reshape the delivery of primary health care across the nation.” Announcing the PHNs, former Health Minister Peter Dutton said they would be “more locally relevant, accountable and responsive” than the previous Medicare Locals.

Sussan Ley set the Primary Health Networks six priority areas for targeted work in

- mental health
- Aboriginal and Torres Strait Islander health
- population health
- health workforce
- eHealth
- aged care.

The PHN governance arrangements include the establishment of GP-led Clinical Councils and Community Advisory Committees to provide the PHN boards with community perspectives and experiences.

The COSS are particularly interested in the role of PHNs in addressing health inequity and population health, and the development of strong collaborative relationships between PHNs and the community sector.

Population health is focused on understanding health and disease in community, and on improving health and well-being through priority health approaches addressing the disparities in health status between social groups.²⁶ Population health planning requires the PHN to have a clear understanding of the needs of the local community, the experiences of different population groups within the community, the gaps and barriers to accessing services and opportunities for better targeting. PHNs will only be able to effectively undertake population health planning with strong relationships and engagement with consumers and community organisations.

²⁵ AIHW, 2008

²⁶ AIHW, Population Health, <http://www.aihw.gov.au/population-health/>

Engagement with consumers

The growing evidence from around the world is that health services that empower consumers tend to produce better outcomes for people and organisations. Active consumer engagement is necessary at all stages of the development, implementation and evaluation of health policy, programs and strategies. Living with the effects of a chronic condition gives people and their families and carers expert knowledge of their needs.

However, there is concern in the community sector that the Australian Government's approach to PHNs appears to place less emphasis on giving consumers a say in the governance and priorities for PHNs than clinicians. Stephen Duckett said in a recent journal article:

“What is important for consumers (and communities) is that they seek to have the same level of engagement as clinicians. It could be very easy for PHNs to slip into ‘provider capture,’ assuming that providers, such as GPs, speak for and in the interests of consumers and communities.”²⁷

Effective engagement with consumers requires PHNs to work with communities to identify needs and aspirations; work with the public to plan and transform services; work with patients and carers to improve quality and safety; and work with the patients and the public to procure and monitor services. The meaningful engagement of diverse communities and consumers will require PHNs to resource and support it, including through the development of shared understanding across organisations of the importance of consumer participation.

Engagement with the community sector

The success of PHNs will depend on their ability to engage and collaborate with others.²⁸

Many of the factors influencing health and wellbeing and that contribute to the risk of chronic disease are outside the control of PHNs and primary care providers. Housing, education, employment support and transport service providers all play an important role. Addressing chronic disease requires collaboration within and across these sectors and the development of strong partnerships between PHNs, primary health care providers and the broader community sector. Community sector organisations can work together and with the health system to provide the range of services required to address the many co-occurring factors that can contribute to disadvantage and ill-health.

Australians experiencing the highest and most complex levels of disadvantage and ill-health may also be the most marginalised and disengaged from society. They may be reluctant to engage with new systems and face many barriers to getting help. Community organisations often hold positions of trust and legitimacy in the community and have established long-term relationships with the communities and individuals they work with, which are essential to supporting engagement with

²⁷ Stephen Duckett, ‘Consumer and community engagement in Primary Health Networks.’ *Health Voices*, Consumers Health Forum of Australia, Issues 16, April 2015, pp 10.

²⁸ Australian Healthcare and Hospitals Association, *Primary health network critical success factors*, 2014.

services and to understanding the systemic issues facing marginalised communities. The wealth of knowledge and understanding the community sector holds in relation to local needs and complex problems experienced by disadvantaged communities can be of great benefit in identifying solutions and designing policy responses.

The Peninsula Model is one example of a strong and supported collaboration between primary health services, consumers and community organisations.

The Peninsula model

The Peninsula Model for Primary Health Planning (the Peninsula Model) is a catchment-based partnership between a range of health and community service organisations, key stakeholders, consumers, carers and communities. Working collaboratively, the partnership identifies the health needs of Frankston and Mornington Peninsula communities and develops effective service responses to meet those needs.

Based on a population health approach, the model wraps the collective effort of providers around agreed health priorities to address service gaps for the catchment. This collective effort maximises impact and makes efficient use of resources through integrated planning, reduced duplication of effort, and shared ownership of processes and outcomes.

An evaluation conducted in late 2014 of the Peninsula Model showed that critical success factors include:

- robust core structures, processes and common agenda;
- backbone resourcing particularly for the necessary breadth and depth of engagement;
- commitment from partners despite impact of external reforms;
- continuous communication of the vision and 'wins' more broadly;
- investment in resources and skills (direct and in-kind).

The extent of engagement between Medicare Local and the community sector varied significantly. The PHNs provide an opportunity to build on successful examples, such as the Peninsula Model.

An NCOSS survey in 2013 found NSW community sector organisations had mixed experiences engaging with Medicare Locals. The main challenges were a lack of understanding between Medicare Locals and community organisations about their respective roles, a lack of time and resources to support engagement, infrequent or poor communication from Medicare Locals and Medicare Locals' focus on clinical health priorities over community or population health. Survey respondents recommended engagement could be improved by providing more information about Medicare Locals, including their role, services provided and how to engage with them. Specific performance measures reporting on community sector engagement were also supported.

The PHNs are also expected to have a significant role in commissioning services: purchasing services from existing providers, rather than delivering services themselves. When developing commissioning systems and strategies, the PHNs should engage with the community sector and

build on the experiences and the lessons learnt in previous commissioning and procurement processes. The Western Australian Council of Social Service, for example, with WA Health, has produced good practice guidelines in commissioning services that would be valuable tools for PHNs.

Partnering in Procurement

A good practice guideline to engagement in community service procurement, and developing and measuring outcomes.

WA Health and WACOSS have worked together with the Health Partnership Council and WA Health procurement professionals to co-design *Partnering in Procurement: A Guide to Outcomes Based Contracting*

The document is designed to be used by both community service organisations and WA Health procurement staff to be consistently applied across all aspects of community services procurement in health. The focus of the Guideline is on good practice engagement to co-design and procure services and basics of how to define and measure outcomes.

Aboriginal peak organisations, in partnership with the Australian Council of Social Service, have also developed *Principles for a Partnership-centred Approach*, designed to guide the development of a partnership-centred approach between Aboriginal and Torres Strait Islander and mainstream non-government organisations in tendering for program funds and engaging in the delivery of services or development initiatives in Aboriginal and Torres Strait Islander Communities. PHNs can foster the development of partnerships between Aboriginal and non-Aboriginal services by developing commissioning processes that support them.

Principles for a partnership-centred approach

Aboriginal and Torres Strait Islander and mainstream NGOs commit to the following national Principles for a partnership-centred approach when working with Aboriginal and Torres Strait Islander organisations and communities in Australia, on the basis of practical community development and the relationship with and knowledge of local community and organisations.

Before considering a tender, mainstream NGOs shall thoroughly research existing Aboriginal and Torres Strait Islander service providers and development agencies before applying in order to recognise the capacity of such organisations to deliver further services/programs and to build upon existing relationships with partnership potential.

NGOs shall objectively assess their own capacity (either in service delivery or development practice) to deliver effective and sustainable outcomes in Aboriginal and Torres Strait Islander communities and only tender for such services when it is determined that such capacity is of a level that warrants it making such an application.

Where Aboriginal and Torres Strait Islander NGO's are willing and able to provide a service or development activity, mainstream NGOs shall not directly compete for tender, but will seek, where appropriate, to develop a partnership in accord with these principles. National peak Aboriginal and Torres Strait Islander organisations will agree to provide advice if required regarding Aboriginal and Torres Strait Islander organisations tendering under the IAS procurement process.

Where participating in a tender Aboriginal and Torres Strait Islander and mainstream NGOs shall include Key Performance Indicators (KPI) and outcomes that demonstrate implementation of these principles including:

- participating in and supporting development of community level capacity, governance and decision making;
- developing a robust accountability framework and evaluation process together with partnering organisations and communities;
- where the desired outcome is for local Aboriginal and Torres Strait Islander organisations to deliver services or provide a development role, mainstream NGOs will develop a mutually agreed, transparent exit strategy in consultation with their partners. Contracts with government should incorporate a succession plan and long term planning for local Aboriginal and Torres Strait Islander organisations to deliver services, with appropriate resourcing included.

Aboriginal and Torres Strait Islander organisations and mainstream NGOs will seek to work together to share learnings and establish effective development practice and cultural competency standards for development projects and service delivery initiatives to enhance the cultural relevance and quality of services to Aboriginal and Torres Strait Islander peoples, recognising there may be a need to resource this work specifically.

Access to primary health

Primary health presents an important opportunity to address some of the risk factors that can contribute to chronic disease, and to intervene early for people at risk. Equitable, affordable and timely access to primary health care is essential to reducing health inequities and effective early intervention and management of chronic disease. Universal healthcare is the most effective, efficient and equitable way to ensure the delivery of our commitment to the Australian public of adequate health care. Primary and community health services are often the first point of contact for people needing care. GPs, for example, have significant reach, with about 85 per cent of people visiting their GP at least once per year.²⁹

However there are a range of structural barriers that inhibit equal access to primary health care, particularly for disadvantaged consumers. These include costs of care and fees or copayments, low health literacy, poor access to health service information by consumers and unavailability of timely, quality services in parts of the country.

One in 20 people deferred visiting a GP in the last twelve months because of cost.³⁰ One in twelve people also deferred or delayed purchasing prescribed medication in the last twelve months due to cost.

In some regions it is difficult to access bulk-billing GPs. The ACT, Western Australia and Tasmania in particular have comparatively low rates of bulk-billing.³¹

A significant number of people also do not have the level of health literacy needed to navigate the health care system and manage their health. There are links between low health literacy and poor health outcomes. People most at risk are older people, people from non-English speaking backgrounds, people on low socioeconomic backgrounds, people with disability and people with low levels of education. Simpler and more engaging written materials, illustrative aids, culturally and language specific information and materials and more health education in schools are all ways to improve community health literacy.

We need to address the barriers people face to accessing primary health care, if we are to improve the prevention and management of chronic disease among disadvantaged Australians.

²⁹ Family Medicine Research Centre, *General Practice Activity in Australia 2013-14: BEACH*, University of Sydney, November 2014, pp 7.

³⁰ Productivity Commission, *Review on Government Services*, 2015, Table 10A.37

³¹ The Department of Health, *Quarterly Medicare Statistics, July – March 2014-15*, 2015.

Cohealth Community Pharmacy

cohealth (Collingwood) operates a community pharmacy that employs pharmacists to work alongside GPs and other health providers within an integrated setting. The pharmacy is the only one of its type in the country.

The service provides medication services to clients of cohealth GPs, some of whom are eligible for a prepayment contribution scheme. Clients of the service are people in significantly disadvantaged circumstances, including people who are Aboriginal and Torres Strait Islander, refugees and asylums seekers, people with mental health and alcohol and other drug issues, experiencing homelessness or at risk of homelessness, family violence, and other life challenges. 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.

People that require frequent scripts to be filled, such as those with chronic or complex conditions, are offered a prepaid pharmacy contribution for 6 or 12 months. This scheme allows voluntary participants to pay up front or via instalments until an amount equivalent to the PBS safety net is reached. They are then able to get their prescriptions filled for the period with no further charge.

The pharmacy is funded by the Department of Health through the Alternate Arrangement Transfer to PBS Program for NYCH. For the period 2014-15 year to date April, the pharmacy dispensed approximately 24,660 prescriptions.

In the 2015-16 Federal budget, the Government announced its intention to cease the Alternative Arrangement Transfer To Pharmaceutical Benefits Program which funds cohealth to provide the service. The funding is proposed to cease on the 31 December 2015.

Transport barriers continue to have a detrimental impact on timely access to appropriate health and social care services. During 2014, the Council of Social Service of NSW undertook a collaborative study of access to community transport for people with chronic illness, including cancer and chronic kidney disease. It found that 77 per cent of respondents in dialysis units, and 81 per cent of respondents in cancer centres reported that their patients experienced some level of difficulty accessing transport to and from treatment. The greatest burden of unmet non-emergency transport needs was borne by older people, people on low incomes, people living in rural and regional areas, people with a disability, Aboriginal and Torres Strait Islander people and people from culturally diverse backgrounds.

State based patient transport assistance schemes for people living in rural and regional areas have inconsistent eligibility and payment rates across the country, and often do not meet the actual costs of travel and accommodation people face.

Aboriginal people

Aboriginal people continue to experience barriers to accessing primary healthcare. One in eight Aboriginal people deferred visiting a GP because of cost³² and one in three delayed purchasing prescribed medication.³³ Similarly, only 21 per cent of Aboriginal people had a Medicare funded annual Indigenous Health Check in 2013-14, with rates ranging from more than 25 per cent in the Northern Territory and Queensland to as low as six per cent in Tasmania and 13 per cent in Victoria.³⁴

Preventative and early intervention programs that are most effective in supporting Aboriginal people address the underlying issues associated with histories of loss and trauma. The Peak Aboriginal Organisations in the Northern Territory has said:

“There is a growing evidence base in relation to working with individuals and communities with issues relating to trauma and loss... has identified that effective programs rely on genuine community engagement, principles of empowerment and long term work.”

Aboriginal community controlled health services take a holistic and culturally safe approach to consumer care and tend to utilise a greater number of allied health professionals, including Aboriginal health workers, in the care of consumers.

Primary healthcare is a key strategy for improving the health of Aboriginal Australians. The primary healthcare model offered through ACCHS in particular, has played a significant role in early intervention in chronic disease and reducing the incidence of costly hospital admissions. For example, in recent years, ACCHS have successfully implemented programs that have led to an increase in the level of clients with valid MBS health checks, GP Management Plans and Team Care Arrangements. All of these processes are critical in the prevention, early detection and management of chronic illnesses. The role, training and career pathways of Aboriginal health workers can be further developed to include more involvement in chronic disease prevention, early identification and management.

In the context of a rapidly growing Aboriginal population, ACCHS continue to receive funding that is not proportionate to the demand they face. Additional investment is urgently needed.

Culturally and linguistically diverse people

Increased funding for specialist health interpreters is needed to meet the growing numbers of people from CALD backgrounds. Anecdotal evidence indicates many consumers and service providers experience difficulties accessing interpreter services. In some areas, interpreters are not always immediately available due to high demand for services and a lack of interpreters in emerging community languages. Regional variation between interpreter services, particularly different fee policies and availability of translation services, creates further access barriers.

³² Productivity Commission, Review on Government Services, 2015, Table 10A.38

³³ Productivity Commission, Review on Government Services, 2015, Table 10A.43

³⁴ AIHW, Indigenous Health Check (MBS 715) data tool, <http://www.aihw.gov.au/indigenous-australians/indigenous-health-check-data-tool/>, accessed 9 July 2015.

The Nepean Blue Mountains Primary Health Network has taken steps to overcome language barriers by producing a Multi-lingual GP directory. This initiative could be replicated in other areas, incorporating a range of health services to facilitate better access for CALD communities.

Children

The early years of a child's life are an important developmental period. Growth and development during this period has consequences for the remainder of the child's life and wellbeing throughout their life.

Universal child and family health services are uniquely placed to support families, enhance parenting and monitor health and developmental progress during the critical early childhood period.

However maternal and early childhood outcomes are often poorer for women and children from disadvantaged backgrounds. In Victoria, participation rates in maternal child health services among Aboriginal people dropped away at a greater rate than for the rest of the population, from birth to 3.5 years of age. Approximately 80 per cent of culturally and linguistically diverse mothers received their first home visit, but only 35 per cent made the 3.5 year visit.

There is a need to ensure more consistent and equitable access to universal maternal and child health services, and to expand programs that target vulnerable and disadvantaged families.

LGBTI communities

Lesbian, gay, bisexual, transgender and intersex (LGBTI) people can face complex health needs multiple morbidities. This can include, for example, experiencing mental health issues associated with exposure to discrimination, violence and other forms of trauma, as well as living with a chronic condition, such as HIV. In addressing this burden of ill-health, coordinated, population-based interventions that improve access to timely care are required, including through primary care settings.

Addressing barriers to healthcare access, including at the primary care level, is also critical. A recent survey by the Australian Human Rights Commission found that 55 per cent of participants felt uncomfortable disclosing their sexual orientation in a clinical setting.³⁵ Initiatives to address these barriers could include greater integration of training for medical graduates, through medical program curricula, and practicing GPs, through professional development modules, in terms of how they engage with these heterogeneous population groups.

³⁵ Australian Human Rights Commission, *Resilient Individuals: Sexual Orientation, Gender Identify and Intersex Rights, National Consultation Report, 2015.*

Conclusion

Health and wellbeing is influenced by the social determinants. As a result, the burden of chronic disease is particularly borne by disadvantaged communities and individuals. They experience higher rates of chronic disease and greater exposure to associated risk factors.

Yet chronic diseases are often preventable. Inadequate investment and attention is paid to preventative health in Australia. We need greater commitment to funding chronic disease prevention programs and regular reporting on progress in population health.

A broad social determinants of health approach to prevention and management of chronic disease in Australia is required that guarantees universal access to affordable and timely health care. The barriers that prevent people from accessing primary and community health in a timely way must be addressed, including affordability, access to information, transport barriers and cultural responsiveness.

The COSS look forward to working with the community services, health and welfare sectors to build a health system that promotes positive health outcomes for all Australians and reduces the burden of chronic disease on our community

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