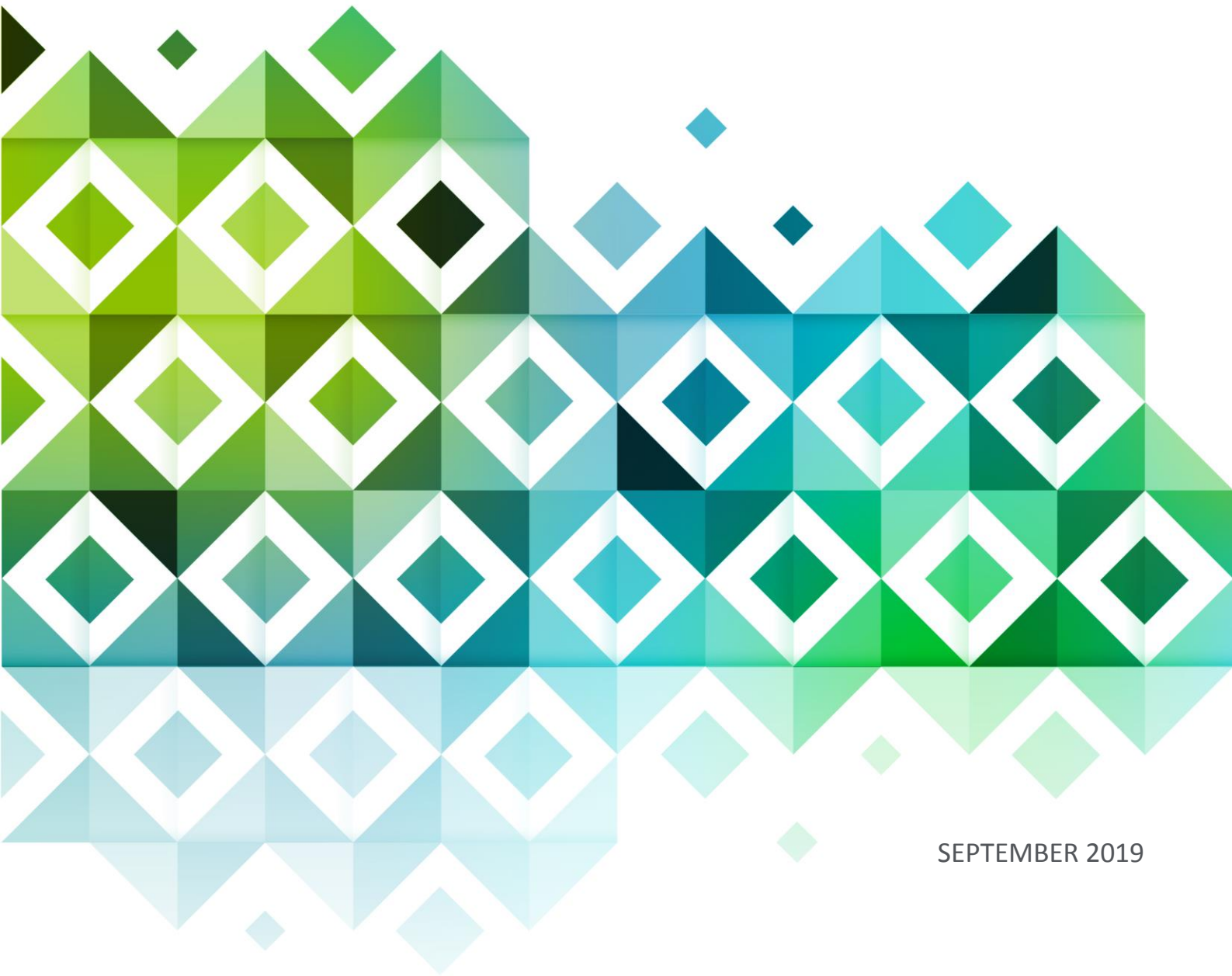


COMMUNITY HEALTH TASKFORCE

REPORT TO GOVERNMENT



SEPTEMBER 2019

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MEMBERSHIP OF THE COMMUNITY HEALTH TASKFORCE

Name	Position
Phillip Bain	(Chair, Community Health Taskforce)
Kerryn Anderson	Executive Director, Primary and Community Services, South West Healthcare
Leanne Beagley	Chair, Victorian Primary Health Network Alliance
Carlo Carli	Chair, Merri Health
Dale Fraser	Chief Executive Officer, Ballarat Health Service
Ian Hamm	Chief Executive Officer, Victorian Aboriginal Community Controlled Health Organisation
Suzanne Miller	Chief Executive Officer, Nexus Primary Health
Lyn Morgain	Chief Executive Officer, cohealth
Patricia O'Hara OAM	Professional Officer, Australian Nursing and Midwifery Federation
Tom Symondson	Chief Executive Officer, Victorian Healthcare Association
Danny Vadasz	Chief Executive Officer, Health Issues Centre

MESSAGE FROM THE CHAIR

On behalf of the Community Health Taskforce (the Taskforce), it is my pleasure to present the Community Health Taskforce report to the Minister for Health and Ambulance Services. Over the past 12 months, the Taskforce has led a review and consultation process with services in the sector and other key stakeholders to inform this advice to government.

The report highlights opportunities for government to provide greater direction for community health services. It also seeks to embed community health in the broader health system as a key partner. This will drive improved health outcomes and integrated models of care.

Community health is uniquely placed to play a more significant role in the health system and address current and future government priorities. This report presents the Taskforce's findings on the role for community health services in the broader health system. It identifies opportunities to strengthen the community health sector's capacity to better meet the needs of Victorians who use these services. It also includes a number of suggested actions for government to ensure the ongoing sustainability of community health and to enhance the sector's capabilities.

When the community health model was established more than 40 years ago, it aimed to offer an integrated and responsive approach to addressing the needs of disadvantaged communities. While the sector has since evolved and expanded, the core values have remained.

The community health sector has faced challenges over the years. Changing client demographics, changing government priorities at state and Commonwealth levels, and limited government investment in community health services, have affected the future sustainability of services.

There is an opportunity for government to better leverage the community health platform to address the needs of an increasing number of vulnerable Victorians. However, if the sector is not empowered and enabled to deliver more targeted services to address government priorities now, reform and change will be increasingly difficult to implement.

Over the next few years, community health services will need to work together as a sector, and in partnership with government. This work will ensure the viability of community health in Victoria, and it will embed community-based care as a fundamental part of the broader health system.

On behalf of the Community Health Taskforce, I would like to thank the Minister for Health and the Andrews Labor Government for their interest in strengthening the Victorian community health sector, and for their ongoing commitment to the health and wellbeing of Victorians. I would also like to acknowledge the significant contributions of more than 100 stakeholders who took part in the consultation.

As Chair, I would like to thank all members of the Community Health Taskforce for their commitment, including giving their time and knowledge, which was critical to the development of this report.

Phillip Bain

Chair

Community Health Taskforce

EXECUTIVE SUMMARY

Victoria's healthcare system faces several significant challenges. These include rising demand due to increased rates of chronic disease and disability, an ageing and growing population and increasing pressure on hospital services.

These challenges require new and innovative ways to deliver health care. This includes integrated care for people with chronic disease, shifting more care into community-based settings, investing in prevention and early intervention, and doing more to address the underlying social drivers of illness.

This will require a reorientation of the whole system, and community health providers are well placed to play a unique role to achieve this.

Prevention and early intervention initiatives are cost effective and generally result in better long-term health outcomes. Despite this, much of Victoria's health spending continues to be directed towards acute care and emergency services.

This historical focus on acute health, and the relatively limited investment in community-based prevention and early intervention services, has led to unsustainable health expenditure. These challenges are taking place at the same time as major health and human services reforms, such as aged care reforms and the implementation of the National Disability Insurance Scheme (NDIS). During these significant and disruptive changes, some health services have struggled to remain financially sustainable and agile.

The Victorian community health sector is in a unique position to deliver targeted, integrated and person-centred services for vulnerable and disadvantaged Victorians. In doing so, the sector has the potential to address systemic challenges and contribute to the delivery of sustainable healthcare in Victoria.


Victorian community health services are embedded in their local communities. They are experts in implementing innovative and collaborative service responses to meet the needs of at-risk populations. They offer an ideal platform to:

- drive local initiatives
- deliver integrated models of care
- support people to manage chronic conditions in the community.

However, the sector faces challenges and limitations that affect its capacity to realise its potential and respond to the changing health needs of Victorians.

Community health services play an integral role in Victoria's health and social care services. They partner with hospitals, Primary Health Networks and other organisations to provide the care Victorians need. However, their role within the broader health system is not clearly articulated. This affects the ability of services to drive innovative reforms, attract new investment and grow the sustainability of their organisations.

For example, health services currently have limited capacity to invest in digital capability and infrastructure. Addressing this will allow health services to better respond to broader health system challenges and deliver more flexible and innovative supports. Similarly, inflexible funding models and performance measures limit services' ability to respond to the changing needs of their local communities and deliver integrated and outcomes-focused supports.



The advice in this report aims to position community health to lead an integrated approach to care within the health sector.

Action to sustain and enhance the community health sector is vital.

This report provides a plan to build on current and future areas of investment in high-quality person-centred health and social services to vulnerable and disadvantaged Victorians. It also seeks to embed financial sustainability within the broader healthcare system.

Achieving reform will require the government to work in collaboration with the community health sector. Harnessing and building on the strengths and opportunities in the sector will ensure community health plays a meaningful ongoing role in health system reform in Victoria.

Table 1: Advice to government – summary

Advice	Actions
<p>1. Clarity from government regarding the role of community health in the broader health system</p>	<ul style="list-style-type: none"> • Articulate the integral role of community health in the broader health system. • Identify community health services as the preferred delivery partner in system innovation, reform and planning. • Formalise the role for community health as part of the community hospital implementation.
<p>2. Support a sustainable sector to enable services to integrate with the broader system</p>	<ul style="list-style-type: none"> • Support community health to source funding to update ageing infrastructure, including exploring innovative finance options such as zero or low-interest loan schemes and shared equity models. • Facilitate sourcing innovative financing options for community health service delivery such as social impact bonds. • Build data capability to enable greater integration. • Ensure community health is a fundamental part of Victoria's health workforce planning. • Develop sector capability to maximise use of Medicare Benefits Scheme (MBS) items and other funding sources. • Support development of a business model that facilitates service delivery in thin markets, particularly the delivery of general practitioners, allied health and mental health workers.
<p>3. Creating a system and policy environment that drives quality and outcomes</p>	<ul style="list-style-type: none"> • Develop a community health outcomes framework. • Develop a performance management framework and sector capability framework. • Provide flexible and outcomes-based funding that is adjusted for social complexity. • Enable community health services to deliver and design models for greater active care coordination, and referral pathways for complex clients. • Leverage community health services to reduce avoidable hospital demand by providing incentives for collaboration and integrating acute interfaces with primary and community health. • Develop innovative models of care for target groups such as children in out of home care and people with complex chronic conditions. • Test digitally enabled models to support the delivery of high-quality care for Victorians, including exploring the expansion of telehealth capabilities to facilitate greater care coordination.

TASKFORCE PURPOSE AND PROCESS

In June 2018, the Victorian Auditor-General's Office (VAGO) released a report into the management of the Department of Health and Human Services' Community Health Program. The report focused on strategic directions, access, management of demand and performance monitoring.

It identified several areas for improvement both for the Community Health Program¹ and community health services more broadly. In particular, it noted the department has limited insight into the effectiveness, efficiency and quality of services delivered by community health services.

The Taskforce was established in August 2018 to provide advice to government on opportunities to strengthen the community health sector, including to:

- oversee a review and consultation process to identify a vision for the role and priorities of community health services, now and into the future
- identify how to better meet the needs of Victoria's disadvantaged and priority populations.

The Taskforce also contributed to several pieces of work identified in the VAGO report.

The Taskforce comprised leaders from across Victoria's health sector, including representatives from registered and integrated community health services, the Primary Health Network alliance, the hospital sector, and peak bodies representing services, consumers and health professionals.

In undertaking an extensive review and consultation process, the Taskforce undertook:

- a comprehensive consultation process facilitated by the Victorian Healthcare Association (VHA)
- targeted workshops to explore key elements of a new strategic framework for community health, including funding models, integrated service models and outcomes
- a review of international examples of best practice.

CONSULTATION

The Taskforce engaged a broad range of stakeholders in the consultation, including integrated and registered community health organisations, key population groups, peak bodies, consumers, union and local government representatives. It held six workshops across the state, including at Shepparton, Traralgon, Melbourne CBD and Ballarat. Two workshops brought together health service CEOs to discuss key focus areas.

These workshops allowed the Taskforce to hear challenges and opportunities for reform identified by the sector and stakeholders.

The Taskforce also developed and circulated an online survey between October and November 2018, which included users of community health services. In addition, the Taskforce held targeted interviews with several stakeholders to explore key issues.

The consultation found that:

- There is a diverse range of views about the role of community health.
- Current funding arrangements do not support innovation, cross-sector collaboration, or the core operations of community health services.
- Clinical governance structures for community health vary between services, and they are perceived to be less rigorous than those that apply to hospitals.
- Community health is well placed to meet local community needs, but it faces barriers to outreach, innovation and collaboration.
- Community health is struggling to gather evidence and articulate its impact, with limited capacity to meet burdensome reporting and accreditation requirements.
- There are significant benefits of outcome-based funding models, and the government should develop models of integrated health and social care that respond more flexibly to people's needs.
- The government can leverage existing innovative and integrated models of care delivered by community health services in their communities and expand and scale them where appropriate.



1. VICTORIA'S HEALTH SYSTEM FACES MAJOR CHALLENGES

Victoria's health needs are changing, and acute care is struggling with the increased demand

Victoria is experiencing a period of rapid population growth, extended life expectancy and increasing prevalence of chronic conditions. These all drive upward demand for health and social services. Approximately half of all Victorians now have three or more long-term illnesses. Despite efforts to improve life expectancy and health outcomes, a significant number of Victorians manage chronic illness.

Victoria's expenditure on hospital-based services is rising due to a growing and ageing population, the increasing burden of chronic conditions, and the higher cost of providing health care in acute settings. This pressure on Victoria's health budget will continue to grow.

The large and increasing volume of hospital presentations is driving these increased costs. Access to effective primary and community-based health care could prevent a large percentage of these presentations.

By 2031, a quarter of Victorians will be aged 60 years or older. The Commonwealth Government has predicted that national health expenditure for older Australians will double over the next 40 years. This level of growth in the acute hospital sector is unsustainable and will require a new approach from the Victorian government.



Victoria's annual **GROWTH IN HEALTH EXPENDITURE** is 4.6 per cent, which is nearly double that of economic growth (2.4 per cent)²



More than a quarter of **PATIENTS REPORTED THAT THEY DELAYED OR AVOIDED SEEING A GP** when needed because of cost, being too busy, long wait times or GP unavailability.³



The **POOR MANAGEMENT OF CHRONIC DISEASE** and other primary care issues costs Victoria tens of millions a year in avoidable hospital admissions.



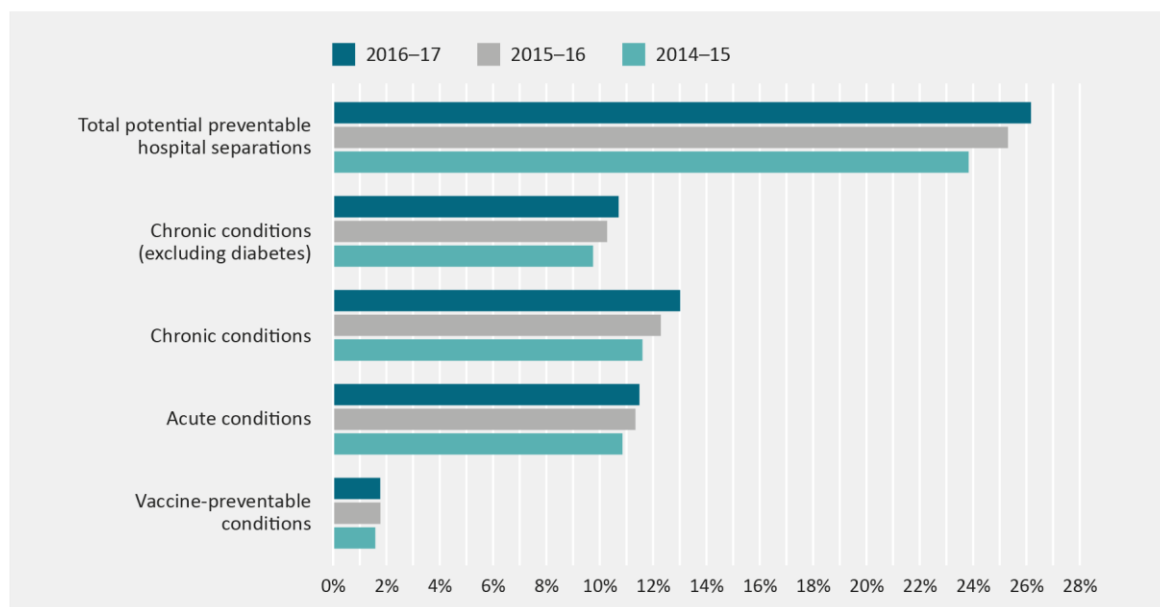
Approximately 40 per cent of **PREVENTABLE HOSPITALISATIONS** are for chronic conditions associated with alcohol, tobacco or obesity.⁴



More than 20 per cent of hospitalisations for Victorians aged over 65 are preventable with **APPROPRIATE CARE IN PRIMARY AND COMMUNITY SETTINGS**.⁵

Many countries around the world have already refocused their investment from acute services to the primary and community health sector to moderate the growth of hospital spending and improve patient outcomes.

Figure 1: Potentially preventable hospitalisations from 2014–15 to 2016–17, Victoria



There is not enough integrated care in the community to respond to changing health needs

Overall, the health and social care system in Victoria is fragmented. The current structure of Victoria’s health system does not adequately support integrated and person-centred care. This is particularly the case for people with chronic and complex conditions and circumstances.

Funding for the current service system is based on episodic, fee-for-service health care. This makes it harder for health professionals to consider people’s holistic care needs or address the social determinants of health.

Many Victorians struggle to access consistent and integrated healthcare. This is compounded by the divide that exists between acute and primary health settings, which creates a barrier to coordinated care. Victorians who are unable to coordinate their own care need to be supported and empowered by community-based services that deliver a holistic response.

Integrated care improves prevention and early intervention, reduces the likelihood of unplanned hospital admissions and improves patient outcomes.

In 2016, the Commonwealth established Health Care Homes. This initiative used a bundled payment model to give general practitioners an incentive to deliver coordinated and outcomes-focused care to patients with chronic and complex conditions. While the model faces challenges due to its implementation, it provides a starting point for health services to deliver integrated, person-centred care, supported by multidisciplinary teams.

Models of integrated care are beginning to be rolled out in Victoria, including the HealthLinks funding model. Similar local and international⁶ models demonstrate that integrating and coordinating healthcare enables services to work more flexibly, at lower cost and with improved outcomes for people.

A shift towards more integrated models of care across acute and community settings will ensure a more efficient and effective health system in which people receive the right care, at the right time, in the right place and by the right person.

Health inequities are unacceptably large and persistent

Health inequity is becoming more entrenched, and it is exacerbated because some people experience barriers to access and the availability of appropriate care. This puts an increasing burden on acute services. It also results in poorer outcomes for people who are already marginalised and disadvantaged. People who are more likely to experience health inequities include those in unstable housing, refugees and newly arrived migrants, children in out-of-home care, rural and regional Victorians, people with a mental illness, people who identify as LGBTIQ, and Aboriginal and Torres Strait Islander peoples. This reinforces the case for an integrated service response.

One of the causes of health inequity is lack of access to primary care services, including not being able to afford private services and lack of services in some communities.

Social determinants are critical to health outcomes. They account for 80 per cent of health outcomes. Vulnerable Victorians are more likely to experience risk factors that limit their access to care and affect their health outcomes. For example, low income earners in Victoria are 50 per cent more likely to go to hospital for potentially preventable conditions, and disadvantaged Victorians are five times more likely to face transport difficulties when accessing services. Social context and vulnerability also exacerbate health inequities. For example, social isolation and loneliness have adverse impacts on mental health, coronary heart disease, cardiovascular conditions and infection disease.⁷

Health inequities are heightened in rural and regional Victoria, with many people experiencing poorer health outcomes. These include a higher prevalence of chronic conditions and associated mortality. For example, people living in Gippsland and Grampians have worse five-year cancer survival outcomes than people living in all other areas of Victoria.⁸ Poor health outcomes in regional and rural areas are compounded by severe health workforce shortages. These shortages limit people's opportunities to access other critical services that rely on meaningful general practitioner engagement and referral.⁹

Particular population groups also experience discrimination and stigma when accessing health and social services. This further contributes to inequitable health outcomes. It also affects people's willingness to access timely health care in the community.¹⁰ Similarly, discrimination and racism can lead to negative health outcomes and poor mental health and wellbeing.¹¹ For example, Victorians who identify as LGBTIQ experience lower levels of wellbeing and social resilience.¹²

Inequitable health outcomes are also linked to economic disadvantage, poor education and limited access to health services, including primary care. Bulk-billing rates are lower in some regional areas, and access to other forms of affordable care can be limited. This means people have to travel to metropolitan areas or forego treatment, and it is a leading cause of hospital presentations for potentially preventable conditions.

Primary care is not currently set up to solve these problems

Primary care is often the first point of contact people have with the health system. This includes the treatment of non-admitted patients in the community by general practitioners, allied health professionals, practice nurses and pharmacists. However, the primary care system as whole struggles to respond to changing health needs, placing strain on the overall sustainability of the health system.

The national and Victorian primary care sectors are constrained by a series of structural and functional challenges. Primary care services have a limited capacity to deliver integrated models of care. They are hindered by scale, funding models, limited organisational support and inadequate systems development.¹³ There has been little change to the funding model since Medicare was established, despite the changing demographic and health needs of Australians. The out-of-pocket costs associated with the current Medicare Benefits Scheme are a significant barrier for people accessing primary care services. A quarter of patients reporting they delay or do not receive the required care due to cost.¹⁴

With more patients having multiple conditions and complex needs, a standard consultation¹⁵ is often not adequate to manage all of a person's needs. In addition, more specialised care responses to address complex needs cannot be remunerated in the current fee-for-service payment model.¹⁶ The current funding models do not provide incentives for general practitioners to use other medically skilled workforces, such as nurses, in place of a general practitioner.¹⁷ This limits services' ability to implement integrated care models.

Similarly, many general practitioner services cannot achieve a scale large enough to deliver flexible and multidisciplinary models of care. Most practices employ five to nine practitioners.¹⁸ As a result, small private practices cannot address patients' urgent care needs or offer after-hours support.¹⁹

Primary care services are also inhibited by a lack of clear governance and accountability arrangements. Services are primarily funded by the Commonwealth, while the state government is responsible for acute care through the management and funding of public hospitals, ambulance and emergency services.²⁰ There is no clear systems manager for primary care.²¹

Primary Health Networks (PHNs) are important, emerging players in shaping the delivery of primary health care in Victoria. More could be done to leverage their scope and influence.

State governments have limited authority to influence the model of care delivered by private primary care providers. However, through the community health sector, the Victorian Government could trial small-scale reforms to primary care to improve health outcomes for all Victorians, particularly people with complex and chronic health needs.

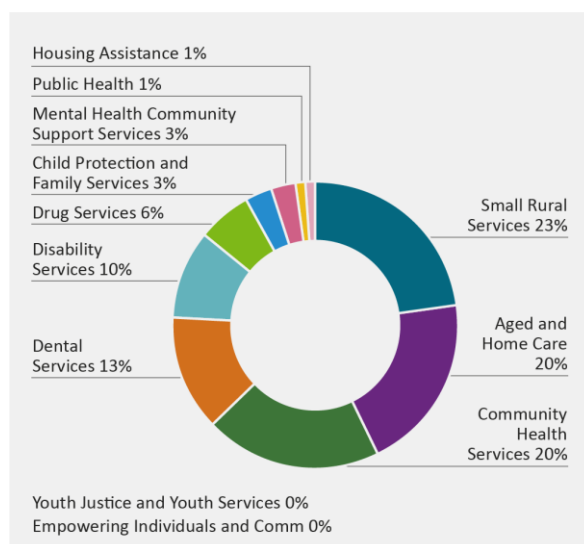
2. COMMUNITY HEALTH SERVICES CAN CONTRIBUTE TO ADDRESSING THESE CHALLENGES

Community health sector profile

Community health services provide a range of services, including both State and Commonwealth funded primary health and social support. They have a strong focus on people who experience barriers to accessing mainstream care, and play a key role in early intervention, treatment and management of people with chronic and complex conditions.

Community health services have been part of the Victorian health system for more than 40 years, delivering local and innovative service responses. There are 84 community health services operating from approximately 240 sites across the state.

Figure 2: Community health service delivery by program, 2016–17



Victoria's community health services bridge the gap between primary, acute and social care services, ensuring people receive the care and treatment they need.

They do this by:

- Providing priority access to particular populations and people experiencing social and economic disadvantage
- Providing services at low or no cost for those unable to pay
- Providing local, place based services which are embedded in local communities
- Delivering integrated health and social care for people with complex needs
- Offering high quality primary care services, including providing access to a GP
- Providing opportunities for early intervention and preventive care
- Leveraging multiple funding streams and services to meet the needs of clients and communities

Victorian community health services operate under two distinct legal and governance arrangements:

- **Integrated community health services** operate as part of Victorian public hospitals. They are subject to the hospital's accountability framework. These services are embedded within health service organisational structures and operate as an integral pillar of the overarching organisation. Currently there are 55 integrated community health services in Victoria.
- **Registered community health services** operate as independent companies limited by guarantee. They are registered under the *Health Services Act 1988* to receive community health funding from the Department of Health and Human Services. Currently there are 29 registered community health services in Victoria.

A vibrant and highly diverse workforce underpins Victoria's community health sector. Professionals include physiotherapists, public dentists, speech pathologists, general practitioners, mental health workers, nurses, refugee support workers, alcohol and other drug counsellors and disability support workers. The array of health and social care professionals working out of community health services shows the breadth of this sector. This also demonstrates the sector's commitment to achieving the very best outcomes for Victorians in need.

Community health services are well placed to support the government to address systemic health issues and respond to the changing needs of Victorians. For example, they are ideal platforms to pilot innovative service responses targeted to high-risk population groups.

The government can leverage the expertise and experience of community health services to:

- drive integrated and community-based care models
- reduce population reliance on acute care services
- improve the sustainability of the health system.

The benefits of community care

International research demonstrates that community-based health care has significant clinical benefits, better caregiver outcomes and a reduction in healthcare costs.²² Community-based services achieve improved health outcomes, better access to health services, and better care by providing secondary prevention and enabling some low-acuity care to be moved into community settings.

Oxford Health (UK) implemented a community-based emergency medical unit (EMU) service to meet the urgent assessment and treatment of patients with multiple, often complex problems, many of whom were frail and elderly. The initiative shifted critical supports into the community and increased the capability and technology available. As a result, non-elective admissions fell by 10 per cent in the first year. In addition, the EMU found that 65 per cent of patients assessed by the unit were able to stay in their own home and only 17 per cent needed acute hospital care.²³

Similarly, an Australian review of community-centred care found that community-based care is a more cost-efficient and cost-effective alternative to hospital-centred care. This is particularly so for long-term chronic conditions, and for patients recovering from coronary care, strokes, renal dialysis, oncology, obstetrics, surgery and technical procedures of many types.²⁴

Community health services deliver a wide range of services

Community health services deliver targeted supports to people in the community. They often bridge the gap between different service types to deliver a holistic care response. In doing so, community health services play a central role in improving access to primary and social care services in Victoria.

Community health services are an optimal platform to deliver integrated models of care embedded in the community. This is because they often deliver several service types in the same location, which enables greater care coordination for individuals.

Case study: Integrated and coordinated care delivered by cohealth

At its Kensington site, cohealth provides primary care, allied health, health promotion and social supports. Client service officers support clients at the Kensington site by identifying client needs and informing them of other health services available.

For example, if a dental client presents with joint pain, a client service officer may ask them if they know about the physiotherapy service. Similarly, all clients who present with complex and multiple health issues are offered care plans, which map out a complete care program that clients and clinicians develop together.

Other services delivered at this site include visiting clinics, refugee health nurse, community development for Vietnamese and Chinese communities, family and reproductive rights education program and a lawyer specialising in elder abuse.²⁵

Community health services have a wealth of experience and expertise in partnering with other health and social care providers to deliver services to people with chronic and complex needs. This includes partnering with hospitals to deliver lower-acuity care in the community to improve people's experience of care and reduce the burden on acute services. They are also a key partner with primary health networks in the delivery of innovative primary health solutions to meet the health needs of local communities.

There is an opportunity for government to use community health to:

- strengthen the links between health and social services
- provide more holistic service responses to people with complex needs.

For example, the government could target priority populations, such as people experiencing mental illness or children in out-of-home care. Community health services could then test alternative models of care.

Case study: Achieving positive health outcomes by integrating care

South West Healthcare has co-located all services providing chronic illness care. A combination of community health program funding and acute hospital funding sits under a single management structure.

This has created a team where all health professionals know and trust the capabilities of others. Services can then wrap around clients in a coordinated way when required.

This works particularly well for clients immediately after a hospital admission. Clinicians visit the client while they are still in hospital to establish goals upon discharge. For example, a client may be admitted with respiratory disease. A care coordinator will visit the client prior to discharge to plan services upon discharge, inclusive of community health program services such as diabetes education, smoking cessation, allied health and community respiratory services.

A similar approach is also taken with clients who present to the community health service and are identified as being at risk of future hospital admission.

This model of care achieves positive and lasting results. It demonstrates the benefits of the acute and community health sector working together.

Community health services respond to local needs

Community health operates a social model of health care. Services are designed in collaboration with local populations and delivered to respond to those who need it most in the community. Community health services have a deep understanding of their community. They work in partnership with other local providers to facilitate collaborative models of care, enabling seamless access to other services. In many communities, they are recognised as a core health and social care provider. For some communities, they may be the only affordable primary care service in the area.

‘[We] improve health and wellbeing for all and tackle inequality, in partnership with people and the communities they live in.’

– cohealth mission statement

Community health services have led the development of innovative, local area-based health interventions. They have done this in collaboration with a wide range of health and social care providers, including working with councils to drive local public health and wellbeing plans. Many of these initiatives have a strong focus on prevention and health promotion activities tailored to target local health issues.

Community health services are unique in their ability to adjust their offerings to responding to local demographics and broader health and social needs. Community health services’ local presence and knowledge enables them to develop strong partnerships and pathways to support integrated care.

Government can leverage this local expertise to address area-specific health issues and barriers to access to achieve greater health equity across Victoria.

Case study: Community health services respond to the needs of local communities

The Connecting2Community program is a partnership between the Western Victorian Primary Health Network, Grampians Community Health and Ballarat Community Health. It responds to the high prevalence of mental health issues in western Victoria, and targets people with psychosocial conditions who have missed out on receiving support through the NDIS.

The program links people experiencing mental illness with peer workers and local services to assist them to achieve individualised goals through support, encouragement and advice.

This program is in its early stages of commencement and achieving early outcomes in supporting Victorians in underserved regional communities.

Community health services focus on addressing disadvantage and vulnerability

Community health services offer universal access to all Victorians, but they prioritise the care needs of people experiencing vulnerability or social disadvantage. These hard-to-reach cohorts tend to be marginalised from mainstream health and other services.

On average, community health clients live in areas that experience greater levels of socioeconomic disadvantage. These communities rely on community health services for health care.

‘We provide services to the most vulnerable [and] pick up the people falling through the gaps.’

– Community health service, stakeholder consultation

Case study: Focusing on Aboriginal and Torres Strait Islander communities

Since 1999, Star Health has worked in partnership with local Aboriginal communities and organisations. This is part of a long-term commitment to reduce the health inequity experienced by Australia’s First Peoples.

Their work to date includes:

- a series of camps for young people in regional Victoria, as well as a school holiday program, to strengthen Aboriginal culture and connection to country
- Gathering Place programs such as the Wominjeka BBQ and Our Rainbow Place, which provide a point of engagement for community and services in a safe cultural space
- a monthly Elders lunch, where people can connect and have conversations about issues that are affecting their health. They also discuss what is happening in the community and work together to problem-solve. The Elders lunch is often combined with sessions covering specific topics, including falls prevention, Alzheimer’s disease, and the effects of smoking.

These initiatives have succeeded in strengthening community connection and linkages with health care and other services.

Source: Star Health 2018, Annual and quality account report 2017–18

Community health services aim to deliver culturally appropriate support to marginalised communities. They also provide important links to the community, working in close collaboration with social care services and local communities. Community health services address the social determinants of health and reduce health gaps for people experiencing vulnerability and disadvantage.

This includes, but is not limited to, services for:

- public housing tenants
- children involved in the child protection system
- refugee and asylum seeker communities
- Aboriginal and Torres Strait Islander communities
- people experiencing homelessness, family violence, mental health issues and alcohol and other drug issues.

Community health services are in an ideal position to address disadvantage and access barriers experienced by these population groups. They are embedded in local communities and have a long history of engaging hard-to-reach cohorts and families.

The government can optimise the health outcomes of Victoria's priority populations by leveraging existing relationships between community health providers and disadvantaged communities.

Case study: Refugee Health Program – Monash Health

The City of Greater Dandenong in the South-Eastern Region of Melbourne has the largest asylum seeker and refugee settlement in the state. Monash Health Refugee Health and Wellbeing (MH RHW) was established in response to the large numbers of refugees living in the region. It aims to address the barriers refugees face in accessing health care.

The program recognises that refugee and asylum seekers require complex health and social support. It provides a holistic model of care, linking primary health, specialist services, capacity building and secondary services, and community development.

MH RHW is underpinned by a commitment to the social determinants of health and, as such, community development activity, with a focus on improving social inclusion and employment.

The integrated service is resourced by a multidisciplinary team comprising: general practitioners, refugee health nurses, infectious disease physicians, paediatricians, bicultural workers, community development workers, psychiatrists, counsellors, physiotherapists, pharmacists and administration staff.

A refugee health nurse provides triage services every day to support local agencies who need refugee health information and to assist with referrals.

Client feedback shows there are high levels of satisfaction with the service. People feel treated with respect and that services are delivered in a culturally appropriate way. Additionally, 83 per cent of clients strongly agreed that their health concerns had been addressed by MH RHW.

Source: McBride J, Block A, Russo A 2017, 'An integrated healthcare service for asylum seekers and refugees in the South-Eastern Region of Melbourne: Monash Health Refugee Health and Wellbeing', *Australian Journal of Primary Care*, CSIRO Publishing.

3. A NEW PARTNERSHIP WITH STATE GOVERNMENT

Community health services are well positioned to deliver **affordable, accessible and equitable** care for disadvantaged Victorians and people with chronic conditions. They can act as a platform for the Victorian Government to build a more sustainable and effective health and social care system. However, the sector is facing **challenges** and **limitations**.

The community health sector are ready to respond to these challenges and improve outcomes for Victorians. The sector seeks an ambitious new partnership with the Victorian Government. This would position community health services to play a more meaningful role in Victoria's health system.

For this to happen, the capacity and capability of the community health sector needs to be enhanced in three ways:

Cohesive community health sector

A fundamental issue for the sector is the lack of a clearly defined role for community health services within the broader health system. This was a key finding of the 2018 VAGO audit and the recent Community Consultation Report undertaken by the Victorian Healthcare Association.

These reports found that the lack of a consistent, overarching narrative for the community health sector has led to a lack of unity and collaboration. Without a consistent narrative and role, the sector is becoming increasingly diverse and fragmented, as each community health service pursues its own disparate strategic objectives and service offerings.

Enhanced system stewardship

Community health services deliver up to 30 different programs through 60 different funding streams. This creates a significant administrative challenge for services.

In addition, two distinct legal and regulatory arrangements govern integrated and registered community health services. This has given rise to two different business models that are driving further inconsistencies across the sector.

In addition, governance varies across the sector. This has been exacerbated by a prolonged lack of investment in governance and capacity building in community health.

Long-term plan for infrastructure investment

There is no long-term plan for investment in capital and digital infrastructure for community health services. This impairs the sector's understanding of how to deliver joined up, appropriate care to vulnerable Victorians.

Services lack the digital capabilities to identify and target population needs. They are limited in their ability to share data and understand patient and client profiles. Some services have created their own work-arounds to meet the needs of disadvantaged populations.

However, the varying data capabilities of individual services entrench the diversification and fragmentation of the sector. For example, integrated community health services in many instances can leverage more sophisticated hospital ICT and data systems. These are not readily available to registered community health services.

ACTIONS FOR GOVERNMENT

- Articulate the integral role of community health in the broader health system.
- Identify community health services as the preferred delivery partner in system innovation, reform and planning.
- Formalise the role for community health as part of the community hospital implementation.

A. CLEAR GOALS AND ROLES

Community health services need role clarity

Clarity from government regarding the future role of community health will provide a platform for community health services to formally engage with other health and social services to deliver better health outcomes for Victorians.

Acknowledgement by government of the unique role community health services play in the Victorian health system is essential, with reference to the following three principles:

- 1 Community health services provide integrated health and social care to vulnerable cohorts.**
 - Community health services bring together a range of care and support services to meet the needs of vulnerable Victorians.
 - Community health provides support to people with chronic conditions and complex health and social needs to navigate various health and social services.
- 2 Community health services develop partnerships across primary, acute and social sectors in local communities.**
 - Providers develop strong partnerships between health and social care services to support enhanced integrated care and contribute to prevention and early intervention.
 - Community health drives service integration to address the social determinants of health, tailoring service design and delivery to meet the specific needs of local communities.
- 3 Community health services deliver health services to people experiencing systemic access barriers.**
 - Community health services provide accessible care for people situated in rural and regional areas and those with chronic conditions or experiencing stigma and discrimination, and social disadvantage.
 - Community health providers have greater flexibility to implement innovative responses to unique issues, accessing funding from multiple streams and delivering holistic service responses.

Community health should be a key partner in system reforms

Broader health and community system reforms need to address access challenges and integration between health and social care. Community health can play a key role in this process.

Community health services deliver flexible and proactive care in the community. Many are co-located with other health and community services, such as maternal and child health services. Many operate out of buildings that are health centres, making them ideally situated to integrate health and social services that have a strong local presence. They can act as expert partner organisations to address the social determinants of health. They can also reduce access gaps, particularly for people who are frequent users of multiple state-funded services.

Case study: Social prescribing

The social prescribing program is a collaboration between IPC Health, North Western Melbourne Primary Health Networks, Australian Health Policy Collaboration at Victoria University and Brimbank City Council.

It was co-designed with staff, clients and community partners. It provides an integrated model of care that innovatively links clinical care and community services.

It complements traditional forms of medical and health care to support people with social and wellbeing needs that cannot be met by the health system. This could include things like not eating well, finding it hard to exercise, wanting to quit a bad habit, struggling with parenting or childcare, housing and legal issues.

Clients are given social prescriptions, in addition to their clinical prescriptions, as a means of providing a more holistic response to an individual's health and wellbeing needs.

Case study: Addressing social determinants of health and delivering holistic service responses

Maria²⁶ was 15 years old and pregnant when she engaged with a regional refugee health program delivered by a local community health service. She was an orphan when she came to Australia as a refugee. She first met her paternal uncle in Australia and found it difficult to connect as a family.

Shortly after, Maria became pregnant and her uncle died of a terminal illness. Maria was afraid of the future and was not sure what to do. She was not sure if her aunt would accept her in the house. The refugee health program supported Maria to discuss her options with her aunt, who agreed to accommodate her and the baby when born.

Her local community health service supported her and connected her with a range of key supports to ensure all her social and health needs were met. They also developed a care plan in collaboration with Maria, which was reviewed regularly. At the hospital, the community health service supported Maria to engage with the youth midwife and social worker – attending the antenatal clinic and educational sessions regularly until the baby was born.

Similarly, Maria was linked to the Enhanced Maternal and Child Health nurse who supported Maria and her baby after she was discharged by the hospital, ensuring developmental checks and immunisations for the baby were up to date. The community health service also supported Maria to engage the local child care, which provided a family day carer for the baby so Maria could keep attending school.

The youth team from the community health service helped Maria secure transitional accommodation through Salvo Connect and later public housing. Maria was also referred to family planning services from the sexual health clinic at the community health service six weeks after delivery.

There are a number of immediate opportunities for community health services to partner with the government to drive integration across broader system reforms, including:

Community hospitals

Most community health services also deliver a significant proportion of services that are expected to be delivered by community hospitals such as allied health, mental health and nursing services. Community health services also have experience in the development and delivery of integrated primary care models.

By leveraging the capabilities of existing community health services, the government can maximise the resources allocated and achieve optimal results. This will require the expansion of services and a formalised partnership with hospitals.

Community mental health supports

Community health services have an established role in delivering mental health services and responding to high levels of social complexity. They are active players in providing step-up and step-down care for many people requiring psychosocial support in the community.

The current Royal Commission into Victoria's Mental Health System is an opportunity for community health services to expand and leverage their existing mental health work. Community health services have well-established relationships with vulnerable communities, coupled with expertise in primary prevention and health promotion.

As a result, many community health services could implement service and system enhancements to better meet the needs of people with mental illness.

NDIS service gaps

These gaps generally affect people ineligible for the NDIS who previously accessed state-funded services that transitioned to the NDIS, such as community mental health programs.²⁷

Community health services can address these gaps, given their geographic spread and their historic delivery of community mental health services and other disability supports.

In addition, community health services can play a role in addressing regional and rural market failures by providing accessible care in these regions.

As a key partner in reform, community health services will need investment and increased capability.

Community health services could offer an alternative service response to some acute services. For example, they could target families and individuals involved with the justice system. This would play an important role in health promotion and outreach. In Victoria, community health services provide the right environment to scale up prevention, early intervention and lower-cost care.

ACTIONS FOR GOVERNMENT

- Support community health to source funding to update ageing infrastructure, including exploring innovative finance options such as zero or low interest loan schemes and shared equity models.
- Facilitate sourcing innovative financing options for community health service delivery such as social impact bonds.
- Build data capability to enable greater integration.
- Ensure community health is a fundamental part of Victoria's health workforce planning.
- Develop sector capability to maximise use of Medicare Benefits Scheme (MBS) items and other funding sources.
- Support development of a business model that facilitates service delivery in thin markets, particularly the delivery of general practitioners, allied health and mental health workers.

B. SUPPORT FOR A SUSTAINABLE SECTOR

To maximise quality and integration, government needs to provide funding for capital and digital upgrades

Despite the growing pressure on the health system, the community health sector has received little investment to redesign the way services are delivered or to upgrade ageing infrastructure. This impedes providers from responding to the changing health needs of Victorians. In some instances, it affects their ability to take a greater role in delivering lower-acuity services in the community.

Support to update or redesign ageing infrastructure would create opportunities for greater collaboration and partnerships between service providers to provide more integrated and coordinated care. This is necessary to facilitate integration across acute, subacute and community health services.

Over time, a lack of infrastructure development has limited the government's ability to achieve a sustainable, effective and transparent health system. Many existing ICT systems are not adequate for the delivery of healthcare services.

To maximise the quality and extent of integration with acute services, the government needs to support and invest in the community health sector. This could include assisting community health services to explore innovative finance options to update ageing infrastructure. This would include enhancing community health information, communication and technology infrastructure and interoperability. Similarly, funding initiatives that have been reserved for hospitals to date, such as electronic medical records projects, should be made available to community health services.

Improvements in digital health and data systems will enhance the government's ability to track, measure and report on outcomes. Effective digital health initiatives will enable community health to better manage chronic disease and other complex health and social conditions in the community. These improvements will also allow us to understand the true impact of community health, including hospital diversion.

With improved digital capability, community health providers will be able to deliver higher-quality, timely and integrated care. More importantly, it will empower people to better manage their own health and wellbeing, supported by digitally enabled personalised systems.

There is an opportunity for community health to play a more established role in primary care

The increasing corporatisation and consolidation of general practitioners, and workforce shortages in Victoria, have led to pockets of market failure where access to general practitioners is limited and costly, such as in regional Victoria.

There is an opportunity for community health services to optimise alternative funding sources. These include MBS and other Commonwealth-funded programs such as primary health initiatives and other grants. This is particularly important in areas where access to affordable private general practice is limited. General practitioner shortages are a major cause for concern in western Victoria and Gippsland, with some communities relying on locums due to the lack of a permanent general practitioner.²⁸

Ensuring community health services can access alternative funding sources would enable many community health services to support a general practice in their communities.

Case study: Preventing admissions to emergency departments

Nexus Primary Health opened its general practitioner clinic just before Christmas 2013 in the rapidly growing outer north of Melbourne.

Within two years, the services had expanded to seven days a week. However, there was a growing demand for after-hours services, which was flowing to the Northern Hospital Emergency Department.

With funding from the Eastern Melbourne Primary Health Network, Nexus piloted a medical neighbourhood model. Using After-Hours Service Navigators and promoting other general practitioners and services in the area, people have been encouraged to attend Nexus GPs after hours rather than the Northern Hospital. After seeing a patient after hours, where permission is given, Nexus GPs send treatment information to the patient's usual GP for continuity of care.

Evaluation data has shown that approximately 1,000 people each month attend Nexus instead of an emergency department. The project has also enabled the expansion of other after-hours services including allied health and counselling.

Government needs a health workforce strategy that includes community health

By 2025, the number of health professionals and workers required to meet healthcare needs is forecast to increase by as much as a third. This will further be impacted by demographic changes, resulting in relative shortages in some traditional workforce groups such as nurses and social workers.²⁹

A committed and skilled workforce is central to the sustainability of health services and quality outcomes for the people who use them. However, the sector is experiencing challenges in recruiting and retaining staff. We need to take a statewide approach to the recruitment, retention and upskilling of the community health workforce.

An ageing workforce combined with fewer health professionals opting to work outside metropolitan areas has resulted in some geographic regions being unable to recruit and retain staff. Rural and regional Victoria face major shortages in access to general practice, nursing and some allied health practitioners.

In May 2018, the Department of Jobs and Small Businesses found that regional Victoria had difficulty recruiting registered nurses. Unfilled regional vacancies were predominantly found in western regional Victoria.³⁰

A number of past initiatives have attempted to address general practitioner shortages, including recent efforts led by the Primary Health Networks. Despite this, we need to take a more strategic approach to addressing health workforce gaps.

The shortage of general practitioners and allied health workers is a major driver of health inequity in Victoria. When this is coupled with similar workforce pressures across sectors such as disability and aged care, Victorians living outside of metropolitan Melbourne experience poorer health and wellbeing outcomes.

ACTIONS FOR GOVERNMENT

- Develop a community health outcomes framework.
- Develop a performance management framework and sector capability framework.
- Provide flexible and outcomes-based funding that is adjusted for social complexity.
- Enable community health services to deliver and design models for greater active care coordination, and referral pathways for complex clients.
- Leverage community health services to reduce avoidable hospital demand by providing incentives for collaboration and integrating acute interfaces with primary and community health.
- Develop innovative models of care for target groups such as children in out-of-home care and people with complex chronic conditions.
- Test digitally enabled models to support the delivery of high-quality care for Victorians, including exploring the expansion of telehealth capabilities to facilitate greater care coordination.

C. FOCUS ON QUALITY AND OUTCOMES

Community health services need flexible funding that adjusts for complexity

Enabling greater flexibility across funding streams, and establishing incentives that drive person-centred care, will create personalised approaches and better outcomes.

The current funding model has not been comprehensively reviewed in over a decade and does not promote the delivery of flexible and integrated models of care. It requires providers to report on outputs, rather than the quality of care delivered and outcomes achieved for clients. This affects the way providers deliver services, collect data and measure their overall performance.

The inflexible funding model that currently exists must be reviewed. Community health services need to be supported to make fundamental changes that embed a truly patient-centred and outcomes-focused approach. Funding models should encourage targeted support for people experiencing vulnerability. This will create incentives for innovative and responsive solutions to complex social and health issues.

International and local trials such as HealthLinks show that when healthcare providers can use funding more flexibly, they achieve improved health outcomes for the same or lower cost.

A revised funding model needs to adjust for complexity. The service models needed to meet the needs of people experiencing complexity and vulnerability are costly to deliver. This is due to the intensive nature of the interventions and the additional cost of care coordination. The government needs to adequately price and fund services delivered to people with complex needs, and those living in regional and rural areas.

Funding needs to be linked to outcomes

There is an opportunity for the government to reconsider the way it measures outcomes in the community health sector. People using health services are becoming increasingly active in their health care, with heightened expectations around access, outcomes, transparency and joint decision making. Service users are also demanding more individualised care that is delivered in settings of their choice, which is contributing to disruption and innovation in health care.

Case study: Unit price review

The Taskforce engaged in an external review of the unit price paid for allied health and nursing services under the Community Health Program to ensure it reflects the true cost of service delivery. The Taskforce noted the following findings of the review.

The unit price is generally higher than that paid by other service payers such as WorkSafe and TAC.

The delivery of supports to people with complex needs requires a higher volume of service delivery and more specialised skill sets.

The level of service delivered per dollar of funding varied significantly across agencies.

There are variations in attitudes about the unit price, with some services considering that the current unit price was sufficient and supported flexible service delivery, while others raised concerns such as lack of granularity and exclusions.

Some services provided feedback that the unit price did not adequately support the integrated service models required for more complex clients, for example by meeting costs associated with care coordination.

The review did not establish a basis for any adjustment to the unit price, but it recommended the department undertake further funding model reform. This work should be underpinned by broader consultation and a robust cost study.

The 2018 VAGO audit found that community health services lack quality-based performance measures that provide an accurate indication of the outcomes achieved by community health services. Meaningful outcome measures will drive consistent performance across community health agencies. They will also ensure those in most need have access to the right services.

The government can drive improved health outcomes by leveraging the community health sector. Community health services are keen to be accountable for the services they deliver and the outcomes they achieve. However, this can only happen when providers are supported by government to implement robust and modern accountability tools, which incorporate measurable outcomes and value-based health care.

Hearing consumers' voices is essential to delivering high-quality, person-centred care. Many community health services already have mechanisms to engage consumers in program design and decision making. However, there are opportunities to further enhance consumer participation. Patient and consumer involvement is a critical component in delivering high-quality services. Proper measurement of consumer participation will improve our understanding of the outcomes and impact of funded programs.

Community health needs dedicated funding for innovation

Community health services are well placed to pilot innovative models of care to address client complexity and meet health system challenges. The community health sector wants to build on and expand initiatives that shift care for some lower-acuity conditions from hospitals to community health settings. Many community health services are already involved in successful collaborations in diabetes support and prevention. Such models could be scaled, and knowledge shared across the wider sector.

Community health services are already involved in cross-sectoral partnerships with hospitals and other services, including Primary Health Networks, to deliver innovations in integrated care. The HealthLinks programs at Monash Health, Western Health and Barwon Health demonstrate early positive outcomes for enrolled patients.³¹

Case study: Keeping vulnerable patients healthier at home (Monash Health)

MonashWatch (part of the department's HealthLinks initiative) is delivered in collaboration with community health services and acute services. It is currently being piloted in Dandenong, Doveton and Noble Park. Early evaluation demonstrates that patients engaged in HealthLinks programs are less likely to access emergency departments and have extended hospital stays.

MonashWatch uses a health coaching model to keep some of their most vulnerable patients, especially those with complex chronic health issues, healthier at home. Each small MonashWatch team is located in the local area it services and works together with the patient, their local GP, local council services, community health services and the hospital. Community health services support MonashWatch by delivering supports in the community to the patient, including in an early intervention and ongoing capacity.

MonashWatch stays in regular contact with patients (two to five times a week). If MonashWatch identifies a deterioration in their patient's health, they help patients get the most appropriate care in a timely fashion. MonashWatch offers alternatives to in-hospital care and support patients to manage their health better at home by providing integrated seamless care within and across the hospital and community care sectors.

Source: [Monash Health](https://monashhealth.org/services/services-f-n/monashwatch/) <https://monashhealth.org/services/services-f-n/monashwatch/>

The Back-Pain Assessment Management Service (BAMS)³² is another example. This collaboration between the Royal Melbourne Hospital, Merri Health and co-health optimises back pain management in a community setting. It integrates service and care pathways to reduce the pressure on the acute care system and minimise referral duplication. Community health services assess patients in conjunction with acute health specialists. They also deliver ongoing conservative management in the community. They work closely with clients in a multidisciplinary modified pain management group program. Results from 2018 indicate that 578 patients are removed from outpatient surgical waiting lists annually, with a reduction of neurosurgery and orthopaedic outpatient waitlists reduced from an average of two years to six months.³³

Case study: Chronic disease management in community-based settings (IDEAS – Eastern Melbourne Primary Health Care Collaborative)

Eastern Metropolitan Region implement the Integrated Diabetes Education and Assessment Service (IDEAS) in response to a rise of type 2 diabetes within local communities.

The initiative involves Eastern Health employing endocrinologists offering clinical care and management for clients with type 2 diabetes. This is done in partnership with community-based teams, including diabetes educators, in several Eastern Metropolitan Region community health services, including Carrington Health, ACCESS Health and Community and Eastern Access Community Health (EACH).

Since its establishment in 2010, 30 per cent of all diabetes outpatient referrals to Eastern Health have been diverted to IDEAS, and with increasing numbers referred directly from GPs. This has reduced demand on hospital outpatient clinics in the region.

Clients also identified that they were more comfortable in the IDEAS setting, less worried, more confident and achieved greater behaviour change related to their diabetes management.

These initiatives currently operate in isolation and rely on the goodwill of individual organisations to create local partnerships.

Initiatives that help remove barriers to care, such as distance, time and cost should be considered. The use of telehealth or telemedicine is becoming an increasingly valuable tool to drive greater coordination and efficiency in the way health care is delivered. Community health could use telehealth to create viable alternatives for many people, particularly in rural and regional Victoria.

A key barrier to achieving scalable integration across the sector is in part due to the ad-hoc, small-scale investment and a lack of commitment from government to expand successful programs. Without reasonable scale and support from government, many services are unable to demonstrate the positive return on investment needed to warrant ongoing funding.

The community health sector provides an environment in which innovative community-based models of prevention, early intervention and lower-acuity care can be combined and scaled. Dedicated funding is required to support initiatives that seek to divert people from hospital or provide integrated models of care.

CONCLUSION

Victoria's community health sector is a nationally unique asset that exists within a complex and dynamic health system.

Community health services integrate and connect with the broader system in a range of innovative and localised ways. They have great potential to play a more significant role in the broader health sector.

Community health services are keen to work with government to test innovative models of care at scale. They also want to drive new approaches to delivering health services. However, to fulfil this potential, the sector needs improved capacity and capability. This will also tackle the structural and systemic challenges facing Victoria's health system.

Some of this work is already underway, with the government committing to implement recommendations from the VAGO report into the Community Health Program. Similarly, there are opportunities for innovation and partnership with strategic initiatives in other parts of the health and social services sector. This includes the Royal Commission into Victoria's Mental Health System and the Royal Commission into Aged Care and Disability. However, further work is needed to strengthen the community health sector. This work needs to be built on an understanding of the foundations required for an effective, efficient and sustainable system.

With a strong policy commitment from government, and adequate investment to support initiatives, an improved community health sector could provide joined up, integrated services. These integrated services would demonstrate clear pathways through partnership or shared care between community, primary and acute service providers and offer new ways of working. This will ensure that Victorians accessing community health services receive the very best health and wellbeing outcomes.

The community health sector also has a clear role to play in driving change to address the challenges that currently exist across the sector. It also has a responsibility to demonstrate the value and outcomes it is achieving for individuals and communities.

Lasting and successful change relies on strong collaboration and partnership. The community health sector is willing and ready to work with government and other stakeholder to enhance Victoria's health system and ensure that it better meets the needs of all Victorians.

APPENDIX A: TERMS OF REFERENCE

Purpose

The Community Health Taskforce will provide advice to government on opportunities to strengthen the community health sector, including proposed actions.

Sector input will be a critical element of this work. The experience and expertise of community health services will be essential in identifying issues and opportunities to grow the sector.

Role

The Community Health Taskforce will:

- **Oversee a review and** consultation process to identify a shared vision for the role and priorities of community health services now and into the future.
- **Identify opportunities to strengthen** the community health sector's capacity to meet the needs of Victoria's disadvantaged and priority populations.

In undertaking this role, the Taskforce will contribute to, and inform the Department of Health and Human Services' action plan in response to the Victoria Auditor General's performance audit of the Community Health Program (tabled in June 2018).

Please see below the Taskforce members

Phillip Bain	(Chair, Community Health Taskforce)
Kerryn Anderson	Director, Primary and Community Services, South West Healthcare
Leanne Beagley	Chair, Victorian Primary Health Network Alliance
Carlo Carli	Chair, Merri Health
Dale Fraser	Chief Executive Officer, Ballarat Health Service
Ian Hamm	Chief Executive Officer, Victorian Aboriginal Community Controlled Health Organisation
Suzanne Miller	Chief Executive Officer, Nexus Primary Health
Lyn Morgain	Chief Executive Officer, cohealth
Patricia O'Hara OAM	Professional Officer, Australian Nursing and Midwifery Federation
Tom Symondson	Chief Executive Officer, Victorian Healthcare Association
Danny Vadasz	Chief Executive Officer, Health Issues Centre

Guiding principles

Principles guiding the review of community health services include:

1. **Clarity of role and function:** the core role of community health services in meeting the needs of disadvantaged populations should be affirmed. Community health services provide services that are targeted to meet the needs of their priority populations. Specifically they provide an integrated service platform for people with complex health and social care needs, and should be a key provider services that bridge the gap between hospital-based services and universal services (such as primary care services funded under the Medicare Benefits Schedule) that are often experienced by priority populations.
2. **Funding:** community health services should have funding arrangements that are:
 - fit for purpose to deliver services in alignment with their role and function.
 - flexible for providers to allow them to respond to evolving population trends and the needs of their priority populations.
 - sustainable.
3. **Collaboration and engagement:** community health services should work in conjunction with other sectors such as local government, primary health providers, acute health services, education, Aboriginal Community Controlled Health Organisations, immigration, housing, employment, justice, child protection, and disability services to keep people healthy.
4. **Governance and performance monitoring:** community health services should meet rigorous corporate and clinical governance standards, and performance monitoring and reporting standards and benchmarks. Community health service boards and management should be supported with the skills and knowledge they need to ensure services provided are safe, of high quality, and sustainable.

Consultation topics

The Taskforce will consult and propose actions in relation to the five topics listed below:

1. **Defining priority populations and identifying the core role of community health.** This includes articulation of the current disadvantaged populations that are prioritised by community health services, including recognition of the variation in levels of need for different services in different geographic locations.
2. **Demand management and future service planning.** This includes assessment of the current service levels to meet demand within the growing Victorian population, noting the importance of geography and volume of services required.
3. **The funding model and funding requirements for delivering services in line with the core role and function of community health services.** This includes the appropriateness of the unit price (for Community Health Program activities), options for meeting the costs associated with the community health platform and the basis for the allocation of any future growth funding (including equity and population considerations).
4. **Strengthening clinical and corporate governance.** The quality and safety of all services is a priority for the Victorian Government. Service delivery should be underpinned by rigorous and robust governance standards.
5. **Performance and outcomes measurement.** This includes consideration of:
 - performance measures that have a greater focus on the quality of services, and the development of consistent approaches to performance monitoring and measurement.
 - providing for a unified set of outcomes for the community health service sector. A unified set of outcomes would clearly set priorities that focus and sustain effort and articulate an overall purpose and role, while acknowledging the diversity of the sector.

The Taskforce will consider how the department's outcomes framework can be applied to the community health context.

Consultation processes

A consultation framework will be developed for approval by the Taskforce. This will step out the timing and methodology for broad-based consultation with the community health sector. The consultation will also involve other stakeholders such as peak bodies and funded organisations in the health and social care sectors, other government departments and funded entities at State, Commonwealth and Local Government level, people who are currently accessing community health services and their carers, and other relevant community health advocates.

Consultation methods may include but are not limited to face-to-face meetings with key stakeholders, workshops, telephone and online consultations, and a call for submissions. Consultation methods will be tailored to priority populations.

The **purpose of the consultation** is to develop a clear pathway for strengthening community health through close engagement with the sector, including concrete proposals and actions.

Membership

Members

An Expression of Interest process will be undertaken to select up to 10 members to serve on the Taskforce (in addition to the Chair). Members will be selected for their broad expertise and understanding of the health and social care systems, the role of community health, and the broad range of priority populations that community health serves.

Chair

The Minister for Health has appointed Mr. Phillip Bain, former chief executive of Plenty Valley Health to chair the Taskforce. The Chair will be responsible for ensuring the Taskforce is accountable for:

- fostering collaboration
- maintaining the focus of the Taskforce on the agreed scope and outcomes as detailed in the Terms of Reference.

The membership of the Taskforce will commit to:

- attend scheduled meetings
- make timely decisions and take action so as to facilitate the work of the Taskforce.

Remuneration

The Chair's position will be remunerated in recognition for the additional leadership and relationship management responsibilities and in recognition to the intensity of the workload and the expertise required.

The Taskforce member positions are not remunerated, however department pre-approved expenses deemed relevant to complete their roles will be reimbursed.

Meetings and duties

Taskforce members will be expected to play an active role in facilitating sector consultations, including leading and /or attending specific consultations with a wide range of key stakeholder groups and advocacy organisations.

Meetings of the Taskforce will be held monthly or as required. A quorum shall be a simple majority of the membership. The work of the Taskforce will be supported by a Project Plan and defined timelines to be developed by the Taskforce secretariat.

Advice and updates may be provided or requested out-of-session.

Guest speakers and or expert advisers may also be invited to attend a meeting at the request of the Minister for Health, the Taskforce and or its Secretariat.

Conflicts of interest

Standard Declaration of Private Interests and Conflict of Interest processes will apply. Conflicts of interest will be managed by establishing a register for members to declare any conflict of interest. The register will be reviewed and updated periodically during the term of operation for the Taskforce.

Governance

Chair – the Taskforce Chair will report to a senior departmental representative (to be confirmed).

Secretariat – the Primary and Community Health Unit will provide project management and secretariat services to the Taskforce.

Timing

It is expected that the Taskforce will commence in late July or early August 2018, and be operational for up to 12 months or as required.

Reporting

The Chair will be supported by the Secretariat to provide regular updates for the Minister for Health on issues and opportunities identified through the consultation. This includes briefing the Minister for Health on the key findings and proposed actions from the consultation process.

A quarterly bulletin will be provided to the community health sector.

Amendment, modification or variation

This Terms of Reference may be amended, varied or modified in writing after consultation and agreement with Taskforce members.

APPENDIX B: FIGURE DESCRIPTIONS

Quotes

‘We just can’t meet demand. We’re so limited by our funding and infrastructure which limits us ...’

‘The range of activities that a community health provider now provides can be extremely varied and that actually dilutes peoples understanding of what it is they actually do and what role they play.’

‘In community health, we currently have no capacity to report in clinical data to demonstrate health improvements. Most reporting focuses on statistic and not recording clinical outcomes.’

‘Our clients really value the fact that they can have several needs met from one service, all the “one-stop shop” model.’

‘It’s all in one place. It’s flexible, it caters for the whole family.’

Figure 1: Potentially preventable hospitalisations from 2014–15 to 2016–17, Victoria


Potentially preventable hospitalisation type	2016–17	2015–16	2014–15
Total potential preventable hospital separations	27.3%	26.5%	25.2%
Chronic conditions (excluding diabetes)	10.7%	10.2%	9.7%
Chronic conditions	12.5%	12.1%	11.5%
Acute conditions	12.2%	12.6%	13%
Vaccine-preventable conditions	1.8%	2%	2.1%

Figure 2: Community health service delivery by program, 2016–17

Program type	Percentage of community health service delivery
Housing assistance	1%
Public health	1%
Mental health Community Support Services	3%
Child Protection and Family Services	3%
Drug Services	6%
Disability Services	10%
Dental Services	13%
Community Health Services	20%
Aged and Home Care	20%
Small Rural Services	23%

ENDNOTES

- 1 The Community Health Program is a distinct program area funded by the department that delivers allied health, nursing and counselling services.
- 2 Australian Institute of Health and Welfare 2018, Health expenditure Australia 2016–17, Health and welfare expenditure series no. 64., cat. no. HWE 74, AIHW, Canberra.
- 3 The Royal Australian College of General Practitioners 2018, General practice: health of the nation 2018, RACGP, Victoria.
- 4 Australian Institute of Health and Welfare 2019, [Potentially preventable hospitalisations in Australia by small geographic areas](https://www.aihw.gov.au/reports/primary-health-care/potentially-preventable-hospitalisations/contents/overview), <<https://www.aihw.gov.au/reports/primary-health-care/potentially-preventable-hospitalisations/contents/overview>>
- 5 Australian Institute of Health and Welfare 2017, Aboriginal and Torres Strait Islander Health Performance Framework 2017: Online data tables. Measure 3.07: Selected potentially preventable hospital admissions, AIHW, Canberra
- 6 For example, the Alaska-based Nuka (USA) system of health care delivers integrated care across a person's engagement with the health service, where routine care is delivered by a team of four clinicians.
- 7 Malcolm M, Frost H, Cowie J 2019, 'Loneliness and social isolation causal association with health-related lifestyle risk in older adults: a systematic review and meta-analysis protocol', *Syst Rev*, vol. 8, no. 1, p. 48, doi:10.1186/s13643-019-0968-x.
- 8 Australian Institute of Health and Welfare 2018, Australia's Health 2018: in brief, cat. no. AUS 222, AIHW, Canberra.
- 9 Ibid.
- 10 Knaak S, Mantler E, Szeto A 2017, 'Mental illness-related stigma in healthcare: barriers to access and care and evidence-based solutions', *Healthc Manage Forum*, vol. 30, no. 2, pp. 111–16.
- 11 Shepherd CCJ, Li J, Cooper MN, Hopkins KD, Farrant BM 2017, 'The impact of racial discrimination on the health of Australian Indigenous children aged 5–10 years: analysis of national longitudinal data', *Int J Equity Health*, vol. 16, no. 1, p. 116, doi:10.1186/s12939-017-0612-0.
- 12 VicHealth 2015, VicHealth Indicators Survey 2015: Sexuality supplement, VicHealth, Melbourne.
- 13 Duckett S and Swerissen H 2018, Mapping Primary Care in Australia, Grattan Institute, Melbourne.
- 14 Ibid.
- 15 More than 80 per cent of general practitioner consultations last less than 20 minutes.
- 16 Duckett S and Swerissen H 2017, Building better foundations for primary care, Grattan Institute, Melbourne.
- 17 Duckett S and Swerissen H 2018, op. cit.
- 18 Ibid.
- 19 Ibid.
- 20 Health in Australia: a quick guide (2018)
- 21 Duckett S, Swerissen H 2017, op. cit.
- 22 Cohn J, Corrigan J, Lynn J, Meier D, Miller J, Shega J, Wang S 2017, 'Community-based models of care delivery for people with serious illness', discussion paper, National Academy of Medicine.
- 23 Edwards N 2014, 'Community Services: how they can transform care', The Kinds Fund.
- 24 Rosen A, Gurr R, Fanning P 2010, 'The future of community-centred health services in Australia: lessons from the mental health sector', *Australian Health Review*, vol. 34, no. 1, CSIRO Publishing.
- 25 Cohealth 2018, cohealth annual report, cohealth, Melbourne.
- 26 Name changed
- 27 Productivity Commission 2019, Review of the National Disability Agreement, Study Report, Canberra p. 69



28 The Hon. Dr David Gillespie, MP Assistant Minister for Health 2017, 'Working together to solve GP shortages in Western Victoria'; GML media release 2019, 'Task group formed to address GP shortages and workforce issues across East Gippsland.'

29 Department of Health and Human Services 2015, Health 2040: A discussion paper on the future of healthcare in Victoria, State Government of Victoria, Melbourne.

30 GML media release 2019, 'Task group formed to address GP shortages and workforce issues across East Gippsland.'

31 Department of Health and Human Services 2019, HealthLinks Chronic Care evaluation: summary of implementation and outcomes for 2016–17, State Government of Victoria, Melbourne.

32 A partnership between North Western Primary Healthcare Network, Melbourne Health, cohealth and Merri Health.

33 The Collaborative 2019, '[The Collaborative update](https://collaborative.org.au/wp-content/uploads/2019/02/CollabUpdate-Feb2019-2.pdf)', <<https://collaborative.org.au/wp-content/uploads/2019/02/CollabUpdate-Feb2019-2.pdf>>.