VAADA Vision

A Victorian community in which the harms associated with drug use are reduced and general health and wellbeing is promoted.

VAADA Objectives

To provide leadership, representation, advocacy and information to the alcohol and other drug and related sectors.

Stakeholder Consultations
National Primary Health Care Strategic Directions Framework

September 2012
The Victorian Alcohol and Drug Association

The Victorian Alcohol and Drug Association (VAADA) is the peak body for alcohol and other drug (AOD) services in Victoria. We provide advocacy, leadership, information and representation on AOD issues both within and beyond the AOD sector.

As a state-wide peak organisation, VAADA has a broad constituency. Our membership and stakeholders include ‘drug specific’ organisations, consumer advocacy organisations, hospitals, community health centres, primary health organisations, disability services, religious services, general youth services, local government and others, as well as interested individuals.

VAADA’s Board is elected from the membership and comprises a range of expertise in the provision and management of alcohol and other drug services and related services.

As a peak organisation, VAADA’s purpose is to ensure that the issues for both people experiencing the harms associated with alcohol and other drug use, and the organisations that support them, are well represented in policy, program development, and public discussion.

Introduction

VAADA welcomes the opportunity to contribute the development of the National Primary Health Care Strategic Directions Framework (the Framework) stakeholder consultation. The primary health care system interacts with the alcohol and other drug treatment (AOD) sector at a number of points with AOD service users often requiring health care provision in addition to AOD treatment. The Framework is generally a positive and constructive document, however, we note that further detail on the key issues is crucial in assessing its value to community health.

A large portion of AOD service users experience a range of adverse social determinants and present with complex issues. Many report of experiencing stigma from a number of service systems, including health (and AOD). In light of this, VAADA is keen to see a primary health care system which is inclusive and readily accessible by the community at large, particularly to those experiencing high levels of disadvantage and vulnerability. There are a number of at risk populations which are under-represented in AOD service provision and may also be under-represented in accessing primary healthcare services; this includes culturally diverse populations as well as a range of other minority and hidden populations. In order to maximise accessibility, it is incumbent on all health services to ensure that they are non-judgemental, appropriate and affordable (Norman, Mugavin and Swan 2006, p 74).

A key theme which should be underlying all aspects of the Framework is the application of a robust process of population health planning. The Victorian Healthcare Association (VHA 2012, p 2) assert that, ‘population health planning takes into account the environmental, economic, political, social, cultural and behavioural factors that explain the health and wellbeing of communities and populations’. Population health planning can lead to the implementation of a number of approaches to address adverse social determinants of health and reduce health inequalities within the community (VHA 2012, p 2).
VAADA is concerned that the Framework favours a medical, rather than a social model of health. Clearly there are social determinants of health which reach beyond just medical health and this should be accounted for in the Framework and represented in population health planning.

Population health planning would help address some of the gaps in the Framework, including the absence of highly vulnerable cohorts from the discussion; this absence will result in further vulnerabilities and perpetuate existing disadvantage. Saunders (2005, p 104) cautions against assuming that services are targeted to those most at need; often those accessing services may possess the necessary internal resources to utilise and manage services to meet their (very much legitimate) needs. There are cohorts which do not possess these resources and experience acute disadvantage and therefore remain outside of the health and welfare service systems. The inability of services to access these populations perpetuates clandestine inequity.

VAADA is concerned that the Framework is being developed within a cost neutral environment and notes that reluctance from government to provide additional funds to drive the Framework will result in the necessity of increased expenditure downstream in the hospital system.

Finally, VAADA maintains concerns as to how these reforms will impact upon not for profit non-government organisations, which may find that the Framework creates further burdens for many small agencies with tight budgets.

Recommendation 1: Additional funding should be provided to drive the actions outlined in the National Primary Health Care Strategic Directions Framework.

Recommendation 2: Non-government not-for-profit health agencies should not be required to undertake further administrative duties resulting from the Framework without the provision of additional funding.

1. How can the framework add the most value to:
   - The primary health care system?

Consumers of the health system should be involved at a higher level than just locally. Through limiting consumer involvement to those already engaged in the system and ring fencing their participation to their individual health issues greatly limits the capacity of the primary health service system to engage with highly vulnerable cohorts currently not using primary health care services. The Framework should provide for actively seeking disengaged and highly vulnerable cohorts.

Recommendation 3: Consumers of health services should be involved in the development of primary care services and participate in the development of related health policy.

Additionally, the Framework emphasises building GPs to ‘the top of their scope of practice’ as a means of deriving multidisciplinary responses to complex presentations. From the perspective of the AOD treatment sector, this alone may not assist in working with vulnerable AOD service users. To date, the Victorian pharmacotherapy system is under significant strain with the dire need to increase the number of prescribers. Only a small portion of GPs prescribe pharmacotherapy in Victoria
(VAADA 2011, p 3) leading to service gaps. Whether building GPs to the top of their scope of practice results in an increase in prescriber ‘opt in’ to the pharmacotherapy program is uncertain, but from the perspective of the AOD treatment sector, the pharmacotherapy system is significantly strained and at risk of collapse due to a range of reasons, including difficulties accessing both prescribers and dispensers.

It is commendable that the National Performance and Accountability Framework set a target for reducing preventable hospital admissions. VAADA would caution however, that it is important to ensure that any reduction of hospital admissions can be reasonably attributed to initiatives emerging in the primary health care space. Attributing unrelated reductions (or increases) will result in misleading data which could have adverse impacts on future policy development.

Finally, there is a need to greatly increase service provision to culturally diverse community groups. They are largely absent from the Framework and generally, from the AOD perspective, are not proportionately represented in the treatment sector (Victorian Auditor-General 2011). Increasing the health literacy within these communities is a key action for increasing access. The Ethnic Communities’ Council of Victoria (ECCV) (2012, p 4) indicate that increasing health literacy for culturally diverse communities is a key action to improve health outcomes. The ECCV indicates that improving health literacy will assist in breaking down language and literacy barriers, address issues arising from differing cultural perceptions of health and assist in building the capacity of culturally unresponsive services to better work with diverse communities.

**Recommendation 4: Access to health services must be increased for hidden populations of at risk demographics such as culturally diverse populations. This can be achieved through a range of measures, including boosting the levels of health literacy within these cohorts.**

- The health system more broadly?

The challenges outlined for the primary health care system are generally applicable to the health system more broadly. There are, however, a number of additional considerations.

Population health planning is necessary to efficiently determine the allocation of health resources. Tony Vinson (2007) has undertaken key research in determining disadvantage by postcode and such work could contribute methodologically to population health planning.

There are a range of elements which will contribute to population health planning, many of which will be determined by service system data systems. The data systems in the AOD treatment sector are generally deficient in providing feedback to services regarding service users. Furthermore the AOD treatment sector has found these data systems disingenuous in that they often do not provide for a robust representation of the clients challenges and are generally out-dated. Comprehensive and responsive data systems are key to population health planning and the development of a responsive service system and maximises the potential of preventative health initiatives.

**Recommendation 5: Population health planning should be implemented in a manner which captures data from a wide range of service sectors. Data systems must be reformed to accommodate a robust population health planning process. Population health planning should be**
a consideration in system design and in the recommissioning of the Victorian AOD treatment sector.

The Australian National Preventative Health Agency recently ran a consultation on the development of the National Preventative Health Research Strategy (2012–2016) (2012). The development of evidence informed preventative health initiatives are crucial in improving community health whilst concomitantly reducing hospital expenditure. The Framework should support the development of such research and ensure that preventative health initiatives are responsive to population need and evidence informed.

Recommendation 6: Preventative health initiatives should be supported by a funded and evidence informed strategy which reflects on population health and engages a wide range of stakeholders, service sectors and government departments.

Nissen et al (2010, p 34) canvas key challenges facing rural and regional community access to GPs. While GP numbers have increased in metropolitan areas (90 GPs per 100 000 head of population), there has been a decrease within rural and regional areas (80:100 000). This creates significant issues regarding access to healthcare and exacerbates the challenges facing vulnerable community members which, as noted in the draft framework, are prevalent in rural and regional areas.

Recommendation 7: Primary healthcare provision in rural and regional Victoria requires further resourcing to meet the needs of local populations.

Cost neutrality presents a significant challenge for sector buy-in into the primary health service system. This will reduce the permeability between service sectors and mitigate against multidisciplinary responses to complex health issues. This is compounded by the varying funding models across the health sector which are determined in isolation and without consideration of whether perverse incentives are induced within specific service sectors. Funding models across the health sector must be developed in line with providing appropriate incentives to drive multidisciplinary responses where appropriate. Further, additional funding must be provided to cement cross sectoral capacity building as well as collaborations.

2. How can the framework maximise patient health outcomes and experiences?

The Framework must be geared towards enabling participation - and access - for disadvantaged cohorts in the development of primary health care services.

Aboriginal Community Controlled Health Organisations (ACCHO) should be involved in the development of the Framework. ACCHOs should be supported in relaying the views and experiences of Aboriginal communities and developing strategies to maximise positive health outcomes.

The Framework should also account for the full range of adverse social determinants which intersect with adverse health outcomes. This includes, in addition to that listed in the Framework, family
violence, criminal history, culturally and linguistically diverse background as well as challenges which emerge with ageing community groups.

A key issue with the Framework is its emphasis on a medical health model in response to health issues, rather than reflecting on social health determinants. This is evident in part on its reliance on GPs as key actors and, from a contextual standpoint to the emergence of Medicare Locals. This can impact on the assessment of community need for health care. Given that health status is affected by a range of factors, including familial, social, economic, physical and genetic elements, health policy must account for these variants in the priorisation, allocation and provision of health services. Importantly, populations living in rural and regional areas as well as experiencing low socio-economic circumstances have higher mortality and morbidity rates (Duckett and Willcox 2011, p 31). Disturbingly, Duckett and Willcox (2011, p 302) indicate that GP consultation times are shorter for lower socio-economic populations in comparison to more wealthy populations. This is disturbing given the higher prevalence of complexity in ill health for disadvantaged populations, and of considerable concern to the AOD treatment sector, given the complexities and challenges in pharmacotherapy prescribing and managing AOD service users generally. The Framework must support strategic engagement with these populations on a range of levels, including prevention, early intervention and primary health care in a manner which accounts for the spectrum of disadvantage evident within these cohorts.

These groups must be supported to build their health literacy so they can better contribute to improving their general health and should be attended to by an accessible and available multidisciplinary health workforce. AOD treatment services should be part of this multidisciplinary workforce.

**Recommendation 8: The full range of adverse social determinants should be considered and represented in the development of the Framework and the pending bilateral plan.**

Finally, the administration of future health reforms and the development of local health services will be guided by Medicare Locals. VAADA has concerns regarding the potential shift in priorities, with a risk that this will elicit a further shift to a medical model of service provision which may put a range of social health programs at risk. Careful diligence must be exercised in determining the membership of Medicare Locals and the priorities and regulations governing their operations. As a starting point, all Medicare Locals should have consumer representatives (as well as representatives from non-government not-for-profit agencies) with voting rights.

3. **How can governments strengthen partnerships with stakeholders to deliver strategic outcomes?**

Governments at all levels have a key role in building the foundations of strategic partnerships and building capacity between health sectors. Governments play a crucial role in the provision of funding and leadership as well as data and evidence to assist in building partnerships between key stakeholders. There is also a role for governments to facilitate and provide for the enhancement of
already existing effective networks and partnerships between providers and sectors. Existing networks which result in high levels of efficiency and are delivering health benefits to the community should be utilised to build further partnerships and showcased as a model for collaborative initiatives in other regions.

Consistent and secure funding as well as sector participation in policy development and reform are paramount to the delivery of efficient and equitable health services and the provision of funding and leadership of these endeavours is key government business.

**Recommendation 9:** Governments at all levels must provide additional resources to facilitate and maintain partnerships between both service sectors and local agencies. Such funding should be recurrent to support the ongoing maintenance and development of these partnerships.

4. When considering implementation of the framework:
   - What relevant activities are stakeholders delivering that governments could learn from?
   - Do you have any innovative ideas that could be incorporated?

Both the *Health West Partnership* in Melbourne’s western suburbs and the *No Wrong Door* initiative in Hume are good examples of collaborative endeavours which are instructive for this consultation and have been implemented from the bottom up and resulted in positive health outcomes. They are detailed below.

**Health West Partnership:** The HealthWest Partnership is an alliance of two Primary Care Partnerships which was established to support and improve the planning and delivery of health and community services in Melbourne’s western suburbs. It brings together 25 health care providers, community organisations and local government members to strengthen coordination and input into healthy public policy, prevention, early intervention and chronic care initiatives. Recently they have increased their focus on alcohol and illicit drugs and this ensures that these issues are central to the region’s approach to improve health of community members.

**No Wrong Door:** In the rural Victorian region of Hume, a consortium of 33 AOD, mental health and Psychiatric Disability & Rehabilitation Support (PDRS) services was built upon and formalised under the federally-funded Improved Services Initiative. These cross-sectoral agencies have close to 100% utilisation of the same dual diagnosis screening, assessment and referral tools, host consumer and carer forums, and have access to an education collaborative. The website for the consortium, www.nowrongdoor.org.au, provides a platform to host regional policy, procedures, protocols, pathways, committees and educational opportunities for the member agencies. The services pathways tool enables health professionals to refer clients to appropriate and relevant agencies in a timely fashion. In addition, this website is designed to host a discrete area for Consumer and Carer representatives to better support them in their roles with their employers.

**Recommendation 10:** Existing examples of collaboration and capacity building should be used to model future similar initiatives. Government should also provide support to ensure the continuance of positive partnerships as well as provide resources for timely evaluations.
5. Further comments

The Framework provides a useful basis to strengthen primary health care provision in Victoria. The bilateral plan between Victoria and the Commonwealth will however be more indicative of the effectiveness of this framework.

There are a number of additional challenges which require further articulation.

VAADA has concerns that the Framework cites the need for consumers to build strong relationships with their primary health care providers. This is redolent of the assumption that all populations have the capacity to build and maintain these relationships. There are a range of adverse social determinants which have been outlined above which restrict the development of long term relationships between consumers and primary healthcare services. The Framework should instead start from the assumption that these relationships are not implicit and build in strategies to facilitate the inclusion of these at risk and hidden community groups.

The Framework should also support the development of preventative health policy with primacy given to health related elements which should be prioritised ahead of commercial or other interests. This is particularly poignant for populations which have limited capacity to articulate the impact of inequitable distribution of health services and have limited health literacy.

VAADA is also supportive of a flexible primary health care service system which can address specific local health issues through a social health model of service delivery. Specific populations will face challenges pertinent to their region and these challenges should provide the foundation for the allocation of resources and health policy development.
References


