Flinders University
Southgate Institute for Health, Society & Equity

Regional Primary Health Care Organisations: population health planning, participation, equity and the extent to which initiatives are comprehensive

Report on the consultation workshops on population health planning and Medicare Locals:

Migrant/Refugee health stakeholders

Project description

The National Health and Medical Research Council funded project *'Regional Primary Health Care Organisations: population health planning, participation, equity and the extent to which initiatives are comprehensive'* is examining population health planning processes in Australian regional primary health care (PHC) organisations (which were Medicare Locals at the time of the study) and the extent to which a population health approach is undertaken in planning and implementing comprehensive primary health care. The study in particular focuses on how PHC organisations address the needs of groups whose health status is typically worse than that of the broader population including people with a mental illness, new migrants and refugees, and Aboriginal and Torres Strait Islander peoples.

As part of the research, workshop consultations were conducted with people working in community organisations across Australia. The focus of these workshops was on Medicare Locals, the previous form of PHC organisations, which have been superseded by Primary Health Networks. A range of topics were covered including the awareness of Medicare Locals' priorities, their experience of working with Medicare Locals and involvement in planning for PHC for their target population, factors that facilitate or constraint effective collaboration, and ways to enhance collaborative approaches in the future. The study was approved by the Flinders Social and Behavioural Research Ethics Committee and the Aboriginal Health Research Ethics Committee.

This report details the findings of consultation workshops with **new migrant/refugee health organisations.**

Methods

One consultation session was conducted in each state and territory (total of 8). We approached key new migrant/refugee health organisations in each jurisdiction and invited them to nominate one or two people to participate in the session. The sessions were held between May and June 2015. Between 3 and 14 people from different migrant/refugee health organisations attended the workshops: (NSW 7; VIC 9; ACT 3; QLD 6; WA 5; TAS 6; SA 14 and; NT 11 people). Key points for discussion were developed in the research team and members of the Critical Reference Group with migrant health expertise. Two members of the research team facilitated each group session. With consent from participants, the group discussions were audiotaped and transcribed. The key themes that emerged from the consultation sessions were discussed in research team meetings. The findings below summarise the key findings from the 8 consultation sessions with new migrant/refugee health organisations.

Feedback received

The consultation sessions provided a great opportunity for interaction and group discussion about access to migrant/refugee health services, the role of Medicare Locals in population health planning for migrant/refugee health, and the extent to which their organisations were involved in the Medicare Local's needs assessment, decision making and migrant/refugee health planning for PHC in their jurisdiction.

Participants provided examples of where the collaboration with a Medicare Local went/didn't go well and recommendations on the direction of primary health care policy and planning in

the future if the needs of new migrants and refugees are to be met. The section below summarises the feedback we received from representatives of migrant/refugee health organisations in relation to their relationship with Medicare Locals and population health planning for new migrants/refugees health.

Equity in access to migrants/refugees health services

Poor access to primary health care services for new migrants and refugees were reported as a major challenge. The cited barriers were:

- Language barriers and poor access to interpreting services. This was in particular an issue for accessing allied health services where government's free interpreting service is not available. There was a perception that GPs were reluctant to use interpreting services due to insufficient training of how to use the service, a lack of awareness of on-call phone interpreters, and concerns about interpreting making appointments longer;
- Poor access to bilingual GPs and health workers partly due to the improper registration system for bilingual GPs that could be easily accessible to migrants organisations for clients referral;
- Lack of awareness in new migrants and refugees about PHC services available and how and where to link with different health professional. The problem around service navigation was reported as a major access barrier for new migrants and refugees.
- Cost and low number of GPs bulk billing. Varied access to Medicare rebate for different categories of migrants made this barrier more complex (eg. some temporary visa holders who don't have access to Medicare).

Collaboration with Medicare Locals in population health planning and needs assessment

In general, there was a mixed experience of collaboration with Medicare Locals in addressing new migrant and refugee health issues. Some reported no relationship with the Medicare Local in their region with little knowledge about what they do and what their priorities are:

> *'..In terms of the planning with the Medicare locals the communities of refugees or migrants [have] never been involved… I know they were established, they came up and then they're going, but in actual sense I don't know what they were doing there.' (Jurisdictional migrant organisation)*

Engagement with Medicare Locals, as reported by a number of migrant organisations, was only limited to attending a few orientation meetings when Medicare Locals established with no feedback and ongoing working relationships.

> *'Even I was involved in their initial planning a bit, you don't necessarily get the feedback as to what was actually achieved from a plan or not and what is still lacking.'(Migrant health service)*

A smaller number of organisations reported positive experience in collaboration with Medicare Locals mainly at program level and client referrals. Factors enabled stronger collaboration were: pre-existing collaboration with previous division of general practice and involvement in Medicare Locals' governance including migrant advisory committees and working groups. Examples of programs that promoted successful collaboration between Medicare Locals and migrant/refugee health organisations were:

- Migrant health clinics funded and/or run by Medicare Locals in some jurisdictions such as Tasmania. These clinics provided an opportunity to work closely with

migrant organisations for client referrals for health checks and GP visits. *'Since the Medicare Local come into place and STRHC [refugees health clinic], it's been a great relief. At least people get to see a doctor first-hand, they get all their referrals done before they are being transferred to regular GP' (Jurisdictional peak body)*

- Triage program in Victoria an example of successful collaboration between Medicare Local and settlement services to undertake health screening for refugees arriving detention centres. The financial support and PHC services from Medicare Local were cited critical in making a difference in refugees' access to health services and health outcomes. *'That's [addressing refugees health] probably the key crisis that pulled those alliances together and actually created some synergies to get really meaningful in terms of outcomes and productive collaboration. So instead of just observing and measuring, this was actually making a difference.' (Migrant health organisation)*
- Ethnic community health worker program in Victoria was another example of successful collaboration between Medicare Local and migrant health organisations to improve PHC navigation and access to services. *'Their focus has been very much about the health literacy component. How to assist communities in being self-sustaining around access and health care and understanding health care.' (Migrant health organisations)*

Despite positive examples of collaborative work, participants in most consultation sessions shared views that:
1) contact and relationships with Medicare Locals, in most cases, had been initiated by community organisations than Medicare Locals '*we've got to keep dragging them in', 'they're responsive but you've got to work really hard, if you're not there and in their face, and you don't build relationships and networks it's not like it's natural to them to think yes, we've got to do something for this population group.'(Jurisdictional migrant organisations)*
2) addressing new migrant and refugee health is not a policy priority and therefore Medicare Locals have varied approaches in planning for, prioritising, and implementing migrant/refugee health programs, mainly driven by personalities: *'if we approach things rationally we're supposed to target people at the head of organisations so that they can ensure that certain attitudes and ideas are implemented through policy throughout the organisation but, in reality, it seems to depend a lot on individuals within the organisation.'*

<u>Barriers to collaboration</u>

A number of factors were identified that made collaboration between community organisations and MLs difficult:

- Competition between Medicare Locals and community organisations in tendering processes. Having Medicare Locals as part of the competitive tendering process to deliver services was believed to be discouraging in building a collaborative working environment.
  'It's kind of like a paradox: you can't have a collaborative, equitable, good public health model with people co-operating and collaborating, and have competition: competition for funding, competition for knowledge…to have everything based on a business competition model just doesn't work'(Refugee health organisation)

- Migrant health not being a priority health policy area for Medicare Locals and the broader health system. **T**here was a perceived lack of political will in prioritising migrants and refugees' health. The lack of political and policy support was seen to be clearly reflected

in Medicare Locals funding mechanisms, reporting system as noted by one participant *'Unless you're reporting on it then you don't have to do it. What gets measured becomes what you do'.*

- The federal-state division on policy, planning and funding. This, from the perspective of community organisations, caused confusion in policy direction, priorities, roles and expectations as well as service gap for clients '*Everyone will tell you, to say 'oh this is my patch, this is not my patch' so that really creates gaps for the clients'.* Another participant noted:

  The whole scheme is complicated by the fact that you have state funding and you have commonwealth funding, we don't seem to talk to each other very well and I think - I'm always in favour of either making it all commonwealth or making it all state, I don't care, but this idea of our health system, which we're trying to connect and integrate and cross-pollinate, is being funded by state, commonwealth. Commonwealth do primary, state do secondary/tertiary. You know, that is a fundamental thing that's wrong, irrespective of the services you're trying to access or make sure it's delivered' (Migrant health organisation)

- Time and resource constrains. There was an acknowledgment from new migrant and refugee community organisations that Medicare Locals did not have enough time and resources to plan, build trusting relationships, and implement and evaluate their programs:

  'I was frustrated for years because I couldn't form a relationship because there was constant change and restructuring within the Medicare Locals and you couldn't really form a relationship and you couldn't depend on certain decisions being made. And then just over the last year or two, as things started to work well, they started to do what they were supposed to do and then they're demolished. And personally I think that we just need to get used to constant change now, and that constant change is like juggling balls, so you just have to do the best that you can in a state of flux. Because I can't see something being consistent and continuous ever again in terms of funding' (Migrant health organisation)

- Poor collaboration to address social determinants of migrant health. The social determinants of health including culture, employment status, income, housing, language and transport were seen critically important in addressing new migrants and refugees health issues. However a lack of meaningful collaboration was identified between health including Medicare Locals and migrant settlement organisations to address social determinants of health. The lack of funding and resources to address SDH was also noted *'we actually do not yet see a kind of collaborative approach to address both the medical aspect of the health of migrants as well as conjunctively with the social determinants of the health of the people'.* (Migrant health organisation)

<u>Opportunities and risks with Primary Health Networks</u>

Despite a optimistic view that commissioning role in general would encourage collaboration, there was huge concerns around the process of commissioning, limited capacity and resources of community based organisations to win tenders and bids, and risk of losing the expertise and community links that such organisations have in providing culturally appropriate services to the migrant and refugee population. *'If it's going to be a*

commissioning model then I think they need to think about how they commission services from the organisations that are already in the field and are already experts.'

In some jurisdictions, where Medicare Locals were played a key role in providing clinical health and screening services to the migrant and refugee population, the shift from service delivery to commissioning role was a concern that may further reduce new migrants and refugees' access to PHC services.

The other concerns expressed about PHNs included that migrant health has not been listed as one of the priority areas in the initial documents. This will definitely increase the risk of migrant health being paid less attention in terms of funding, planning, and priority setting.

Although population health planning is noted as a key function of PHNs, majority of community health organisations were concerned that PHNs will further move away from looking at broader health promotion and community based activities. '*The KPIs for the Primary Health Networks, it's very individually-medically-based focused. I think with the Medicare Locals at least they talked about work collaborating, where it's gimmicky organisations and more of a public health and health promotion model. I don't think that's even talked about in the KPIs for the Primary Health Networks.'(Migrant organisation)*

Policy and practice implications

The issues raised in the consultation sessions have potential policy and practice implications for Primary Health Networks and primary health care policy in Australia:

- Strategies to encourage the meaningful involvement of community organisations in migrant health planning and implementation are needed. This can be done through migrant health representation and input in Primary Health Network governance.
- Equity in migrant health access and outcomes cannot be realised unless a priority given to new migrant and refugee health in PHC policy, planning, performance measures and funding models.
- Addressing the social determinants is crucial to implement comprehensive primary health care for migrant and refugee health.
- PHC organisations require long term investment and organisational stability to make sure they have enough time and certainty to build and maintain collaborations.

As noted below, we are currently conducting research with Primary Health Networks in their initial implementation phase, and we will be further investigating how Primary Health Networks can best support equitable mental health outcomes.

What next

- We have reported our research findings back to Primary Health Networks through a conference workshop, and will continue to share our findings with the Department of Health and Primary Health Networks and the project continues
- We are working with Primary Health Networks to examine their performance and practice in migrant/refugee health planning and programs. Six PHNs have been selected as case study sites for an in-depth understanding of planning processes and

their engagement strategies to work with community organisations in their region. The case studies are being undertaken in 2016.

- The findings from each stage of the study will be disseminated in the form of academic papers, conference presentations, policy briefings and reports. These will be available from the project website, on the Southgate Institute website - http://www.flinders.edu.au/medicine/sites/southgate/.
- The research team have applied for a new funding to expand our current study by continuing the work with PHNs and community organisations in relation to mental health.

We thank you all for your contribution to this study. If you have any questions or comments please contact:
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