

KEY MESSAGES

Overcoming barriers for transitioning vulnerable clients from targeted programs to mainstream primary care

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Policy context

Demands on the Australian health system require primary health care (PHC) delivery to be cost-effective and sustainable. It is recognised that some people need more health care than others in order to become and remain healthy. “Vulnerable” groups are identified through analysis of population health and service data. Identifying need at the level of population groups is an important strategy in policy development to focus attention on groups that would otherwise often be very marginalised in the health system. Programmatic funding and targeted fee-for-service approaches build expertise to provide specialised PHC to consumers from some vulnerable populations; however, a systematic response is required to ensure PHC for vulnerable consumers is timely, appropriate and able to respond to new demands. This project considered the refugee health response of a large inner suburban community health service in Victoria as a case study to investigate ways to improve the management and coordination of primary health care service delivery to vulnerable consumers over the long term.

Key messages

- > At the service level, defining consumers as “vulnerable” only by virtue of their belonging to a population group—rather than as a dynamic set of individual characteristics, experiences and circumstances that can change over time—undermines the health system’s capacity to ensure access to care for those with most need. The example of refugees in particular highlights changes that can occur in the circumstances of an individual over time, affecting their vulnerability to poor health and/or poor access to health care. It is important that targeted funding supports PHC delivery to those most in need within a population group.
- > Providing PHC to consumers from vulnerable groups is complex and time-consuming with significant implications for service/practice sustainability. Should transitioning in the level of care delivered over time not occur, access for new consumers with greater need may be reduced. Transitioning between levels of PHC can occur within a service or practice as well as between them—it does not necessarily mean a change in PHC provider.
- > There is a conflict between the general ideal of continuity of PHC relationships and a service model that requires transitioning of clients to other providers as their vulnerability changes (increases or decreases). Resolving this conflict requires both strong program protocols and mechanisms to support transitions between PHC providers within the Australian health system.
- > There is no systematic approach to transitioning vulnerable consumers from intensive or specialised PHC in times of high need to “mainstream” PHC when need is reduced. Regular assessments of individual consumers receiving specialised PHC are required to establish individual health needs and determine what level of ongoing care they require.
- > The study also demonstrates the importance of recognizing that the choices GPs make about who they provide care to is based in part on their personal interests and preferences, often in spite of financial disincentives in the case of vulnerable consumers. A systematic and sustainable approach to matching particular vulnerable consumers to GPs who have relevant interest and suitable training needs to be explored.
- > The study highlighted the importance of encouraging a multi-lingual, multicultural workforce (in addition to use of official interpreting services) as a means of meeting needs of CALD consumers, including refugees.
- > Further exploration of the Australian community-health model of comprehensive primary health care as a mechanism for providing quality PHC to “vulnerable groups” is indicated – particularly around strategies for managing access, ensuring financial sustainability and transitioning consumers between levels and types of care.