

POLICY OPTIONS

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

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Policy context

Population health data provides an insight into factors that may contribute to some people being vulnerable to poorer health. These include a range of well-recognised socio-demographic characteristics as well as past experiences, current life circumstances and co-morbid health conditions. These various factors and characteristics lead to the notion of groups of people in the population being “vulnerable” to poor health.

Policy responses to addressing the health needs of population groups who are identified as vulnerable often involve the development and delivery of programs and services specific to that group. This may include setting up special services targeting particular populations, providing programmatic funding to existing services to address particular population groups, or offering incentives (support and/or financial) to “mainstream” services to provide care to people from these population groups.

Primary health care in particular, as the first level of contact that individuals, families and communities have with the Australian health care system, is seen as important in addressing the needs of vulnerable population groups. This project considered the refugee health response of a large inner suburban community health service in Victoria (Western Region Health Centre [WRHC]) as a case study to investigate issues around improving the management and coordination of primary health care service delivery to vulnerable consumers over the long term.

Key findings

A literature review was undertaken to develop a framework for the study and guide the synthesis of findings. Staff in WRHC (including GPs n=6 and other staff n=12) were interviewed individually using semi-structured interview schedules. Consumers were also interviewed (n=22), with interpreters assisting as required. In addition, GPs from private practices in the surrounding area who have refugee clients were interviewed as representatives of the mainstream PHC services available to refugees (n=6 GPs). Interviews were also undertaken with a Refugee Health Nurse from a different community health centre and a nurse working with refugees who was not part of the state-funded Refugee Health Nurse Program.

Key findings from interviews with the diverse range of informants included the following:

- > The factors and characteristics that are considered to represent quality PHC by refugees are the same as for other consumers and include:

- Quality of communication with the health professional, which includes having a common language or effective use of interpreters and perceived empathy and care.
 - Perceived level of knowledge, skill and experience relevant to each individual's physical and mental health conditions.
 - Cost and affordability.
 - All other things being equal/acceptable, geographic convenience.
- > Even when individuals from vulnerable groups move to a different area, they often return to the community health service that provided initial targeted PHC programs. Where they do change provider, they usually find their new GP through their own contacts rather than through referral by their original PHC provider.
 - > The cost of providing care to vulnerable consumers is perceived to be higher by providers (including health service managers and private general practices), because of the frequent need for longer consultations (due to complex needs and/or using interpreters), higher “no show” rates, inefficient use of GP time for non-PHC matters (e.g., helping clients to complete administrative forms) and duplication of health services (because of inadequate documentation of the services already provided and/or “doctor shopping” by some consumers).
 - > There was a high level of personal commitment to refugee consumers as a population group among health professionals interviewed, with some expressing a preference for providing care to refugees from particular countries and/or cultures. This commitment and personal interest was demonstrated in a tendency to provide services beyond traditional PHC.
 - > There was little acknowledgement by GPs of the consequences of their service delivery behaviour; in particular, that continuing to provide “enhanced” PHC to refugees long after their settlement could impact on access to appropriate care for newly arrived refugees. There was little evidence of systematic consideration of the potential change in need for care over time.
 - > There did not appear to be a systematic approach for transitioning vulnerable clients from targeted to mainstream primary health care when intensive or specialised services were no longer required. No optimum indicators were identified for when transitioning to mainstream services is appropriate. Some services have no process for this and others use different approaches and criteria.
 - > There was little evidence that GPs were providing consumers with advice about alternative PHC care arrangements or actively supporting transitions, even when consumers moved residence.
 - > There was a consensus among all interviewees that there is a lack of consistency in the quality of PHC available across the whole system.

Policy options

While governments and policy advisers predominantly deal with populations, health professionals and services work with individuals. There are differences in understanding the concept of “vulnerability” and in implementing an appropriate health system response at each level. There need to be policies, procedures and strategies across the PHC system to ensure that appropriate kinds and levels of service are provided to individual consumers.

PHC programs and services with the expertise necessary to meet the needs of vulnerable consumers (with or without additional funding) require strategies that encourage and support people who may no longer need this enhanced model of care to make the transition to mainstream primary

care to manage their ongoing health, thus increasing opportunities for other vulnerable consumers to have access to care that is appropriate to their level of need.

The results of this study indicated areas for action to improve the cost-effective and sustainable delivery of PHC services to consumers who may be vulnerable.

Consumers

- > Develop and promote programs to improve health literacy of vulnerable groups including supporting realistic expectations of the capacity of the health system and enabling individuals to manage their health care.
- > Inform consumers of targeted and specialised services at the outset of policies on retention and referral on to other levels of care or services, and regularly reinforce the information.

Health professionals (including GPs)

- > Promote person-centred care to GPs to support care for vulnerable consumers regardless of population category, disease or health condition.
- > Encourage GPs to regularly ask their clients from vulnerable groups if they are seeing other GPs and, if so, arrange the appropriate transfer of client files or discuss responsibility for case management.
- > Encourage and train GPs to better utilize existing resources such as case workers and practice and specialist nurses for tasks such as completing forms, general health literacy information and basic diagnostic testing to support their vulnerable clients.
- > Recognise the impact of GPs' personal preferences on access to PHC and consider how this fits with individual and community need.

Health services (public and private)

- > Develop a generic priority tool to regularly assess individual vulnerability to poor health, to be implemented by an experienced professional but not necessarily the treating GP.
- > Develop policies and procedures for an appropriate and consistent approach to vulnerable groups and ensure staff compliance with these.

Health policy and system

- > Identify, document and promote good models of care for vulnerable groups that include appropriate indicators for transitioning to mainstream services and for referral to targeted services when this is appropriate.
- > Promote a more nuanced understanding of vulnerability that recognises some generic factors are shared by many vulnerable populations, and that some factors contributing to individual vulnerability change or are ameliorated over time. Capacity building and system-level support to provide care to vulnerable consumers should focus on generic factors for vulnerability rather than being narrowly targeted to specific populations.
- > Develop a mechanism/tool for GPs to assess their own interests/capability/skills to provide care to vulnerable groups, together with provision of appropriate training if indicated (including specialist clinical skills and cultural competency).
- > Support the development of a multi-lingual, multicultural workforce as another means of meeting the needs of CALD consumers including refugees.

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