



## Council of Social Service of New South Wales

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NSW Community Health Review  
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1 December 2008

Dear Sir/Madam,

Please find attached a submission to the NSW Community Health review from the Council of Social Service of New South Wales (NCOSS).

This submission presents evidence from a number of non-government organisations (NGOs) gathered through a variety of consultation mechanisms undertaken by NCOSS in relation to the review. This submission provides a broad, thematic analysis of the information collected, pointing to some of the structural factors and issues raised throughout NCOSS consultations.

One such overarching issue was the need for there to be a significant enhancement to the functions of community health, both NSW Health-operated or those provided by NGOs. There was a strong sentiment that funding for community health was vulnerable within an over-extended health budget, with a trend over time towards disinvestment in non-hospital programs. NCOSS does not see that anything further can be cut out of community health, and in fact has highlighted a number of gaps and recommendations for enhancements to community health (See Appendix C and D). It is our view that a significant investment in community and other primary health services would improve the overall function of the health system, in particular the increasing demand on hospitals and emergency care.

What is needed is the political leadership to draw together health services in NSW into a coherent Health system with a focus on keeping people health and well. NCOSS believes that both the final report of the Garling Special Commission of Inquiry and the new national Healthcare Specific Purpose Payment, along with the National Partnership Payments, provide an exception opportunity to begin to reframe the functions and purpose of the NSW health system.

There are a number of organisations, including NGOs, who can provide more detailed or targeted comment on particular areas, models of care and locations or activities of well functioning community health services. NCOSS notes that a number of submissions reflecting this expertise have already been made to the CHSD.

If you require any further assistance, please don't hesitate to contact Kristie Brown, NCOSS Senior Policy Officer, Health on 02 9211 2599 ext 130 or [Kristie@ncoss.org.au](mailto:Kristie@ncoss.org.au)

Sincerely

Alison Peters  
Director

**Submission to Centre for Health Service  
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**Review of NSW Health operated  
Community Health Services**



**November 2008**

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## About NCOSS

The Council of Social Service of NSW (NCOSS) is an independent non-government organisation (NGO) and is the peak body for the non-government human services sector in NSW.

NCOSS has as its vision a society where there is social and economic equity, based on cooperation, participation, sustainability and respect. NCOSS works with its members on behalf of disadvantaged people and communities towards achieving social justice in New South Wales.

It was established in 1935 and is part of a national network of Councils of Social Service, which operate in each State and Territory and at Commonwealth level.

NCOSS membership is composed of community organisations and interested individuals. Affiliate members include local government councils, business organisations and Government agencies. Through current membership forums, NCOSS represents more than 7,000 community organisations and over 100,000 consumers and individuals.

Member organisations are diverse; including unfunded self-help groups, children's services, youth services, emergency relief agencies, chronic illness and community care organisations, family support agencies, housing and homeless services, mental health, alcohol and other drug organisations, local indigenous community organisations, church groups, peak organisations and a range of population-specific consumer advocacy agencies.

### **NCOSS' approach to health advocacy and policy**

NCOSS convenes a number of forums and Policy Advice Groups to inform our work so that it reflects the expertise and views of the sector. One such forum is the Health Policy Advice Group (HPAG). The NCOSS HPAG is a forum of peak consumer and community non-government organisations that advise NCOSS on health policy issues, particularly access and equity issues for low-income and disadvantaged groups. The NCOSS Health Policy Advice Group provided information to NCOSS which has been used in this submission.

NCOSS believes that health policy and systems need to be based on principles that recognise health as a human right, the social determinants of health, and the importance of strengthening the role of the community and consumers in the development and delivery of health services.

The World Health Organisation Constitution states that:

*"The enjoyment of the highest attainable standards of health is one of the fundamental rights of every human being without the distinction of race, religion, political belief, economic or social condition."<sup>1</sup>*

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<sup>1</sup> World Health Organisation Constitution, available at: [http://www.who.int/entity/governance/eb/who\\_constitution\\_en.pdf](http://www.who.int/entity/governance/eb/who_constitution_en.pdf) (last accessed 19 March 2008)

More specifically, the United Nations have explained that seeing health as a human right can be understood as:

*“The right to... an effective and integrated health system encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all. Underpinned by the right to health, an effective health system is a core social institution, no less than a court system or a political system.”<sup>2</sup>*

Simultaneously, a social determinants of health approach recognises that the cultural, social and economic environment in which people live shapes their health, and that inequalities in these areas lead to inequalities in health. Recognising the social determinants of health as a principle in the development and delivery of health and other human services builds on the recognition of health as a human right, and facilitates a process of integrated service delivery.

NCOSS also believes that across health policy and service delivery the community generally, and consumers of health services more specifically, should be involved in all aspects of health care design, from individual to systemic levels. Consumer engagement is essential to the development and delivery of accessible, effective, appropriate and patient-centered health services that lead to positive health outcomes.

These principles form the foundation of the work NCOSS undertakes in relation to advocacy and policy in Health.

## **Consultation process for this submission**

Despite the terms of reference for the review being driven towards ‘NSW health operated’ community health services, NCOSS has taken a strong interest in the review in order to ensure that some inclusion of community health functions carried out by non-government organisations (particularly those funded through the NSW Health NGO Grants Program) was available, and to strongly support the role that community health services play within the NSW Health System, including in relation to disadvantaged and marginalized populations groups.

NCOSS has worked cooperatively with the consultants undertaking the review in order to provide this information, including through their attendance at NCOSS’ Health Policy Advice Group (HPAG) and the Home and Community Care (HACC) issues forum, which is also convened by NCOSS. We would like to express our appreciation to the CHSD, particularly Alan Owen, for going beyond what was required by the terms of reference and contract for the review in order to ensure some level of engagement with the NGO sector.

NCOSS also held a dedicated consultation for the NGO sector on the Community Health Review. Fourteen organizations were represented at the consultation, the discussion of which is reflected throughout this submission.

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<sup>2</sup> UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of mental and physical health, 2006

Based on a recommendation from this consultation, NCOSS also circulated a brief questionnaire to NGOs in order to gather any additional information that may be available. Ten responses were received. This information is also reflected throughout this submission.

The intention of gathering this information is to reflect the expertise and experience of the NGO sector. In doing so it should be noted that the experiences, opinions and advice of NGOs reflect the broad diversity of organisations that constitute the sector. As such, this submission provides a broad, thematic analysis of the information collected, pointing to some of the structural factors and issues raised throughout NCOSS consultation. This approach is consistent with the nature and scope of NCOSS activities in health policy. There are a number of organisations. Including NGOs, who can provide more detailed or targeted comment on particular areas, locations or activities of community health services. NCOSS notes that a number of submissions reflecting this expertise have already been made to the CHSD.

NCOSS takes a collaborative approach to the development of policy and advice. As such, a consultation draft of this submission was circulated to organisations with an interest in Health policy and/or the review. Amendments were then made to reflect the comments and advice received before the submitting the final version.

## **Executive Summary**

Community Health Services are an essential element of the NSW Health System, at their best providing a holistic framework for the promotion and maintenance of good health within community settings, whilst responding to and meeting the changing and diverse needs of local communities and priority population groups.

NCOSS believes that at a state-wide level the functions, benefits and importance of Community Health are poorly understood and inadequately supported. The importance of community based primary health care, particularly early intervention, prevention and health promotion activities, are subsumed by the at times unrelenting perception of major crisis and dysfunction within the public hospital system.

NCOSS and a number of other NGOs have consistently argued that a review of community health services cannot be conducted sensibly without reference to the NGO sector. The quarantining of 'NSW Health operated' community health services for the purposes of this review does not allow for a comprehensive understanding of the true range of community health services available either at a local or state-wide level, which has significant ramifications for understanding the true nature of the scope, capacity, service delivery gaps and enhancements needed to community health services across NSW.

Whilst relationships vary, NGOs generally work very closely with NSW Health operated community health services. Feedback received by NCOSS in preparing a submission for the review has allowed us to identify some broad themes and recommendations relating to the current functions and future directions of community health. These key issues are summarized below.

## **1. The need to reframe the NSW health system**

What is needed is the political will and drive to reframe the NSW Health system into one primarily focused on the wellness and 'health' of the population, rather than one geared towards 'sickness' responses. A key component in this framework is a recognition that primary and community health services, including those provided by NGOs, need to be solidly positioned at the centre of the health care system. This requires a considerable policy, political and financial shift towards investment in primary and community services, and a substantial reframing of how health care is delivered.

## **2. A social view of health**

NGOs and NSW Health operated community health services share many common features, and are seen to have some natural compatibilities within the health system. In particular, the functions and practice of both are more inclined towards a social view of health, that is, a model of health care which takes into account the social, cultural, political and environmental factors that shape the health of individuals and communities (often referred to as the social determinants of health). This is seen as an important point of commonality within a health system often considered to have a lack of respect for non-medical models.

## **3. NGOs play a complementary function**

NGOs play an important and complementary function in the delivery of community-based health service. A prime example can be seen in responses to the HIV/AIDS epidemic in the 80s and 90s, where NGOs led the way in a very successful community health response on a public health issue where Governments, and consequently government-based services, faced constraints.

At a general level, NGOs:

- Can fill gaps in the delivery of government operated health services.
- Can access people that government-based services can't
- Do not face the same constraints that government-run health services can in delivering some services, particularly where there may be political sensitivity to a particular health issue
- Can have more flexibility and independence in developing and responding to the changing health needs of their clients
- Can have a better track record in delivering services in some areas and with some population groups
- Can present better value for money and a more cost-effective service delivery option
- Are often strongly linked with local communities, and draw on a community development framework, providing a strong consumer and community-driven base
- Provide a comprehensive response to clients with a range of complex needs.

## **4. Getting the right mix of services**

The aim of a review of community health services should be to get the mix of services provided by clinical programs, NSW health operated community health services and NGOs right with consideration to cost, health outcomes, community participation and engagement and social inclusion at the forefront of thinking. As a fundamental element of this it should be recognised that it *does* matter who provides a service, and that sometimes NGOs are better placed to provide a service.

## **5. Integrated planning processes**

If a sensible and evidence based approach is to be taken to establishing the right mix of community health services, better integrated planning processes need to be established, particularly between NSW Health operated community health services and NGOs. This would provide a number of advantages, including: coordination of services to ensure better consumer pathways; the targeting of resources to emerging and priority issues; the prevention of duplication of services; ensuring that a services are prepared for increased demand resulting from public health campaigns; greater involvement of local communities in determining the type and mix of services available; improved data collection by coordinating local NGOs and NSW Health data collection systems to support local planning and decision making.

## **6. A strong role for local communities**

Whilst the setting of statewide directions and priorities is an important process, Local planning processes involving strong consumer and community engagement combined with a local evidence base should be the driving force behind the delivery of community health services.

Community health services are a vital element of the NSW Health System, and NCOSS is strongly supportive of an increase in the profile and investment of these services.

## **Introduction**

Community Health Services are an essential element of the NSW Health System, at their best providing a holistic framework for the promotion and maintenance of good health within community settings, whilst responding to and meeting the changing and diverse needs of local communities and priority population groups.

NCOSS believes that at a state-wide level the functions, benefits and importance of Community Health are poorly understood and inadequately supported. The importance of community based primary health care, particularly early intervention, prevention and health promotion activities, are subsumed by the at times unrelenting perception of major crisis and dysfunction within the public hospital system.

Despite a number of plans and strategies that display an admirable commitment to 'making prevention everybody's business', 'strengthening primary health and continuing care in the community' and 'making smart choices about the costs and

benefits of health services'<sup>3</sup>, financial and political imperatives continue to be dominated by the 'crisis' end of the health spectrum.

This argument is not new. The distinction drawn between acute and tertiary services, with their focus on emergency departments and hospitals on the one hand, and primary and community services, with their focus on community based wellness models on the other, often characterizes discussion and debate about health care.

The simplicity of this distinction can, however, be deceiving. The challenge for the NSW Health system, as with many other human service systems, is how to identify and achieve the right balance between the functions of prevention, early intervention, treatment and emergency/crisis care. Drawing all facets of health care into an integrated and coherent health care system also presents significant challenges.

Within this context, the interface between community and acute services is an essential one. In addition to providing a range of services that can ideally prevent people from requiring acute care, community health services play an essential role in supporting people leaving hospitals, thereby preventing unnecessary readmission.

Likewise, a review of community health services cannot be conducted sensibly without reference to the NGO sector. NCOSS and a number of other non-government health Peaks and services have repeatedly expressed concerns that the quarantining of 'NSW Health operated' community health services for the purposes of this review does not allow for a comprehensive understanding of the true range of community health services available either at a local or state-wide level, which has significant ramifications for understanding the true nature of the scope, capacity, service delivery gaps and enhancements needed to community health services across NSW.

Motivated by these factors, NCOSS has worked with the consultants undertaking the review to provide both verbal feedback, ongoing advice and now a written submission. As outlined above, this submission provides a broad-level discussion of issues based on the experiences a range of NGOs. It is intended as a piece of additional evidence, largely experientially based, and not a comprehensive review of models, literature or data, all of which are being undertaken by the consultants as part of the review process.

## **The need to reframe the NSW health system**

In providing this Submission, NCOSS is mindful that a significant review of NSW public hospitals is currently underway under the auspices of the Special Commission of Inquiry into acute care services in NSW Public Hospitals.

In responding to the establishment of the Special Commission of Inquiry, NCOSS argued that it was misleading to separate the challenges and difficulties being faced in the delivery of acute care services in NSW public hospitals from the operation of

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<sup>3</sup> NSW Health 2007, *A New Direction for NSW: State Health Plan towards 2010*, NSW Department of Health, North Sydney.

the health care system more generally, particularly from primary and community health services.

The need to consider the co-dependence and interwoven nature of the NSW health system as an entity in any review of its component parts is similarly relevant for a review of community health services.

NCOSS has repeatedly stated that if the Government is serious about decreasing the strain on our public hospital system it needs to invest in health prevention and early intervention services. The functions and future of primary and tertiary services are inextricable, and failure to recognize this is counterproductive to the long-term sustainability and quality of the NSW health care system for the entire community.

The relationships between acute and community services are reflected through a number of quantitative measures:

- Potentially avoidable deaths are those that through health and related activities and interventions could have been prevented, such as through health promotion, disease screening and management, or intervention. In NSW, almost a quarter of all deaths, and 67.4% of deaths that occur before the age of 75, are potentially avoidable<sup>4</sup>. The majority of these deaths could have been avoided through prevention-based health interventions<sup>5</sup>. Of particular concern to NCOSS, this data reflects clear inequities, with higher rates of potentially avoidable deaths evident amongst people with low socioeconomic status compared to those with high socioeconomic status (in 2004 this was 188.4 to 122.7 per 100 000 people, a difference of approximately 66 people).
- Avoidable hospitalisations arising from ambulatory care sensitive (ACS) conditions are those that are considered potentially avoidable through prevention and early intervention in diagnosis and disease management – activities often undertaken in a primary health setting<sup>6</sup>. NSW figures for 2002/03 to 2004/05 indicate that there are 141, 806 hospital separations for ACS conditions in NSW each year. Once again there is a marked difference in avoidable hospital admissions as a result of ACS conditions based on socioeconomic status, with national figures indicating that rates in lower socioeconomic areas are more than 60% above those in higher socioeconomic areas.<sup>7</sup>

There is also mounting evidence of the cost-effectiveness of investing in a prevention and early-intervention based health framework.<sup>8</sup>

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<sup>4</sup> NSW Health 2006, *The health of the people of New South Wales: Report of the chief health officer*, Sydney: NSW Department of Health p.85

<sup>5</sup> *ibid*

<sup>6</sup> Page A, Ambrose S, Glover J, Hetzel D. 2007, *Atlas of Avoidable Hospitalisations in Australia: ambulatory*

*care-sensitive conditions*, Adelaide: University of Adelaide. Available at:

[http://www.publichealth.gov.au/pdf/atlasses/avoid\\_hosp\\_aust\\_2007/avoid\\_hosp\\_full.pdf](http://www.publichealth.gov.au/pdf/atlasses/avoid_hosp_aust_2007/avoid_hosp_full.pdf) (last accessed 19 March 2008)

<sup>7</sup> Page et al 2007 *op cit*

<sup>8</sup> See for example: Health Outcomes International Pty Ltd 2007, *The impact of HIV/AIDS in NSW: Mortality, morbidity and economic impact, Final Report*, NSW Health AIDS/Infectious Diseases Branch

Despite the NSW Government developing a 10 year State Plan<sup>9</sup> that sets a longer term framework for the state, and which includes an overall government commitment towards early intervention and prevention, we continue to see the Government focus on the crisis end of the spectrum, often at the expense of prevention and early intervention services.

The average annual growth rate of government expenditure on public health activities between 1999-00 and 2006-07 in NSW was 4.7%. This was the lowest of all states, with the average growth in expenditure on public health activities for all states, territories and federal government was 5.6%.<sup>10</sup> Total Government expenditure on public health in NSW as a proportion of total recurrent Government health expenditure has declined from 2.43% in 1999-00 to 2.37% in 2005-06, placing NSW below the national average of 2.66%<sup>11</sup>. The small and declining investment in public health in NSW contributes to a health system that focuses on 'sickness' rather than 'wellness' – that is, a system that focuses on treating the sick rather than, and perhaps at the expense of, keeping people healthy

As it stands, the NSW health system is broadly and publicly criticized as unsustainable. In a recent performance audit of our of hospital programs, the NSW Audit Office pointed out the need for change:

In 1971-72 health expenditure represented 14.6 per cent of the total NSW budget, but by 2007-08 this had increased to around 28 per cent. At this rate, funding for health will consume the entire State budget by 2033.<sup>12</sup>

NCOSS believes that what is needed is the political will and drive to reframe the NSW Health system into one primarily focused on the wellness and 'health' of the population, rather than one geared towards 'sickness' responses. A key component in this framework is a recognition that primary and community health services, including those provided by NGOs, need to be solidly positioned at the centre of the health care system. This requires a considerable policy, political and financial shift towards investment in primary and community services, and a substantial reframing of how health care is delivered.

## **Relationships between NSW Health operated community health services and NGOs**

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and Muir et al 2007, *Housing and Accommodation Support Initiative: Stage 1 evaluation report*, Sydney: NSW Department of Health. P. vii Available at:

[http://www.health.nsw.gov.au/pubs/2007/pdf/hasi\\_evaluation.pdf](http://www.health.nsw.gov.au/pubs/2007/pdf/hasi_evaluation.pdf)

<sup>9</sup> NSW Government Premier's Department 2006, *State Plan, a new direction for NSW*, Sydney: NSW Government

<sup>10</sup> AIHW, 2008, Public health expenditure in Australia 2006-07, *Health and Welfare Expenditure Series*, Number 34, Canberra, Cat. no. HWE 41, Table 4.2, p.13

<sup>11</sup> Australian Institute of Health and Welfare 2008, *National public health expenditure report 2005-06*, Canberra: AIHW. Available at <http://www.aihw.gov.au/publications/hwe/npher05-06/npher05-06.pdf> (accessed 19 March 2008)

<sup>12</sup> NSW Audit Office 2008, *Delivering Healthcare out of hospitals, Department of Health*, [The Audit Office of New South Wales]. (Performance audit)

As detailed above, in putting together this submission, NCOSS has drawn on information collected from a number of Non-Government Organisations, as well as the experiences of NCOSS staff. A number of key issues emerged from this process, which are detailed below. It should again be noted that the NGO sector is extremely diverse, and that this information presents a broadly-based overview of key issues. Where NGOs wanted to present more specific or detailed information they were encouraged to provide this in a submission to the consultants, and many appear to have done so.

## **A social view of health**

NGOs and NSW Health operated community health services share many common features, and are seen to have some natural compatibilities within the health system. In particular, the functions and practice of both are more inclined towards a social view of health, that is, a model of health care which takes into account the social, cultural, political and environmental factors that shape the health of individuals and communities (often referred to as the social determinants of health). This is seen as an important point of commonality within a health system often considered to have a lack of respect for non-medical models.

There is a strong sense that the driving force of community health, whether provided by NGOs or NSW Health, needs to be modeled on a social view of health and holistic health care to be, supported by clinical frameworks.

Community health has emerged as an alternative to clinical and medical models of health care, providing a greater focus on health promotion and prevention. As has been discussed above, there is a need to support and reinforce these functions by reframing the NSW Health system to be more focused on wellness and holistic care, rather than a primary focus on sickness and acute interventions.

## **The role and scope of non-government organisations**

NGOs play an important and complementary function in the delivery of community-based health service. Whilst these functions are different across the 'streams' of community health, there are some general consistencies in the role and scope of NGOs in the delivery of community health services.

1. Government operated health services often result in gaps which NGOs seek to fill
2. NGOs can access people that government-based services often can't. For example, family planning NSW provided the following description:

“FPNSW has good working relationships with all of the Area Health Services, both at a clinical, professional education and health promotion level. As an NGO we have more flexibility in terms of delivering health promotion on reproductive and sexual health and in terms of advocacy. The AHS also commonly comment on our ability to access the hard to reach populations as they do not have the ability to

spend the time in recruiting the clients or simply don't have the long term relationships or expertise to do so.”

3. NGOs do not face the same constraints that government-run health services can in delivering some services, particularly where there may be political sensitivity to a particular health issue. A prime example of this is the response to the HIV/AIDS epidemic in 80s and 90s, where NGOs led the way in a very successful community health response on a public health issue where Government's, and consequently government-based services, faced constraints.
4. NGOs can have more flexibility and independence in developing and responding to the changing health needs of their clients, with their central drivers often reflecting a conceptual framework that puts the social determinants of health and human rights framework at the hearts of their functions. As such, NGOs are often better placed and have greater experience and focus in providing comprehensive care and support to clients with a range of complex needs.
5. With some population groups and in some areas NGOs have a better track record in delivering services. This is a particularly important capability where tension exists within NSW Health operated services between providing universal programs and targeting special needs groups. Financial limitations can result in specialist services being lost to generic or universal ones.
6. NGOs can present better value for money in the delivery of some service, providing a more cost-effective option.
7. NGOs are often strongly linked with local communities, and draw on a community development framework, being consumer and community driven. As such, they often link well from the 'bottom-up' across local service systems, including with local government. Consumer pathways are important and often indicate where there are problems with a system. NGOs can be more in tune with this, making their advocacy functions particularly important for the development of effective and comprehensive health service delivery.

These factors and characteristics demonstrate that NGOs currently do, can and should play an important role within the NSW Health system.

## **The right mix of services**

The aim of a review of community health services should be to get the mix of services provided by clinical programs, NSW health operated community health services and NGOs right with consideration to cost, health outcomes, community participation and engagement and social inclusion at the forefront of thinking.

As a fundamental element of this it should be recognised that it *does* matter who provides a service, and that it is inappropriate to provide some services through

bureaucracy. Health reforms in New Zealand illustrate this thinking, with \$552 million in grants going to NGOs from a total budget of \$1.25 billion.<sup>13</sup>

As such, greater planning is needed based on an economic and health outcomes model. Decisions about the kind of services provided by public health services and those provided by NGOs should be based on evidence. Under current processes, programs which potentially could be more economically and successfully provided by the NGO sector are being provided by clinical services without reference to a current evidence base.

This issue is particularly important in the context of the current negotiation of the next Commonwealth-State health funding agreement, the National Health and Hospitals Reform Commission, and the development of the National Primary Health Care Strategy and the National Preventative Health Care Strategy. The Commonwealth Government has given strong indications that a focus on primary and preventive health is a key plank of their health policy, and will be a key driver across these processes.

At a State level, this heralds significant implications for Community health, including those services provided by NGOs, as a key piece of infrastructure in the delivery of such service. As such, many NGOs have taken a keen interest in the rationalization of Specific Purpose Payments (SPPs), many of whom receive funding through SPP agreements, which could be placed at risk without adequate targeting in a generic health agreement. In partnership with a number of peak health NGOs, NCOSS coordinated the development of a position paper of reform of SPPs, which is available in Appendix A.

Focusing on getting the mix of services right, particularly in the face of a potential expansion of such services through Commonwealth health reform processes, exacerbates the alarm experienced by NSW Health funded NGOs at the recent NSW mini-budget, particularly the intention to *Reform grants to non Government organisations through efficiencies and limiting new agreements*. Beyond the more immediate fact that this will see \$11m cut from the NSW Health NGO grants program over three years, the intention to 'limit new agreements' presents a significant potential barrier to the fact that NGOs may be better placed to deliver some primary and community health services, a decision which is at odds with the development of good public policy. More information on this issue is available in Appendix B.

## **Localised planning processes**

If a sensible and evidence based approach is to be taken to establishing the right mix of community health services, one aspect of the relationship between NSW Health operated community health services and NGOs requiring particular attention related to planning processes.

As described above, NGOs are able to offer a range of specialist advice and service delivery advantages within community health. Greater integration of planning

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<sup>13</sup> Office of the Auditor General New Zealand, <http://www.oag.govt.nz/2008/ngos-practice/> (accessed 17 November 2008)

processes within Area Health Services and NSW Health would provide a number of advantages, including: coordination of services to ensure better consumer pathways; the targeting of resources to emerging and priority issues; the prevention of duplication of services; ensuring that a services are prepared for increased demand resulting from public health campaigns; greater involvement of local communities in determining the type and mix of services available; improved data collection by integrating/coordinating NGOs and NSW Health data collection systems to support local planning and decision making.

Despite a requirement under the NSW Health *Integrated Primary and Community Health Care Strategy Implementation Plan* that Area Health Services “as part of their integrated service planning processes, establish consultative relationships between themselves and non-government organisations (et.al)...to improve the delivery of services to patients and the communities.”<sup>14</sup> There remains significant inconsistency between Area Health Services as to the inclusion and consideration of NGOs within planning processes. In the first instance, ensuring that NGOs are included as equal partners in health service planning and development should be a priority. Under current ad hoc arrangements to NGO consultation, there is no transparency or accountability to which organizations get consulted on what issues and when.

Whilst the setting of statewide directions and priorities is an important process, Local planning processes based on strong consumer and community engagement should also be a driving force behind the delivery of community health services, and not, as is often the current perception, a focus on what services NSW Health and clinicians would prefer to provide.

In order to achieve this, strategic links must be established that incorporate NGOs into service planning. NGOs are often linked more closely with communities, and as such need to be recognized to bring vital knowledge and skills to the table when it came to providing community health services. NGOs involvement in planning appropriate and accessible services is vital for local communities.

## **Gaps and issues in service delivery in NSW Health Operated Community Health Services**

Gaps in service delivery are often identified through NCOSS work with NSW Health and the NGO sector. As it is a specific item of relevance under the terms of reference of the review, the NCOSS pre-budget submission for NSW Health for the 2008-09 and 2009-10 period have been included in Appendix C. These recommendations are based on significant consultation with the NGO sector, including through rural and regional consultations, specific PBS consultations, and discussion with NCOSS policy and other advisory groups. They are based on the need for either new programs to meet gaps in services, or enhancements to existing programs in order to meet demand. These recommendations usually relate to state-wide programs, rather than being oriented towards a particular area health service or region.

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<sup>14</sup> NSW Health, 2007, *Integrated Primary and Community Health Policy 2007 -2012: Implementation plan*, p15

In addition to this, through NCOSS consultation process a number of organizations sought to identify gaps based on their experiences. These have been compiled and are available in Appendix D.

It should be explicitly noted that these issues do not provide a comprehensive list, and that, as described above, there is a strong role for local communities to identify these gaps through an integrated planning process.

## **Conclusion**

Community health services are a vital element of the NSW Health System, and NCOSS is strongly supportive of an increase in the profile and investment of these services.

Whilst dismayed at the narrow terms of reference provided for this review, we welcome it as a first step in establishing the current functions of NSW Health Operated Community Health services.

However, NCOSS strongly believes that any consideration of the future functions of community health services must be driven by local communities, based on an integrated planning framework that engages NGOs as partners in the delivery of community health services, driven by an evidence based assessment of who is best placed to delivery particular services.

# Appendix A: Joint position statement on reform of Specific Purpose Payments (SPPs) and Health funding to NSW

## Position Statement on Reform of Specific Purpose Payments and Health Funding to NSW

### What are Specific Purpose Payments?

Specific Purpose Payments (SPPs) are grants provided by the Commonwealth government to the States and Territories for specific purposes (as differentiated from those provided for general purposes).

### How do SPPs affect Health funding for NGOs and disadvantaged groups?

There are many SPPs that affect funding for health programs, including those provided by community and non-government organisations. SPPs that particularly affect health NGOs and health programs for disadvantaged groups include:

- The Population Health Outcome Funding Agreements (PHOFAs), which provide funding for sexual and reproductive health, women's health and HIV/AIDS programs, Immunisation, the National Drugs Strategy, Breast and cervical screening programs, the Alternative Birthing Program and female genital mutilation education and prevention programs.
- Innovative Health Services for Homeless Youth (IHSY), which provides funding for health programs for homeless and at risk youth.
- Communicable disease control, including for needle and syringe programs and hepatitis C education and prevention.

- Prevention of hazardous and harmful drug use, including for the Illicit Drug Diversion Initiative (IDDI) and NGO treatment grants program.

### How much money is spent in NSW on SPPs?

In the 2007-08 Commonwealth budget \$9,850 million was allocated to NSW in Specific Purpose Payments, including \$3,537 million for Health. This makes NSW the largest recipient of SPP funding of all the States and Territories, with Health funding being the largest type of funding received. Commonwealth SPP funding to NSW for health in 2007-08 included \$75.7m for the PHOFA and \$859,000 for youth health services.

### What is currently happening with SPPs?

The communiqué from the January 14, 2008 meeting of Commonwealth, State and Territory Health Ministers and Treasurers indicated that there had been in-principle agreement to reform Specific Purpose Payments (SPPs), including a reduction in the number of SPPs by at least three quarters. A heads of treasuries working party will be producing a draft report for reform by the end of February, which will go to a Ministerial meeting in March, and then on to the Council of Australian Government's (COAG) meeting in March.

**Endorsed by:**

The endorsed organizations are: NCOSS (National Council of Offenders Support Services), acon (Australian Community Organisation), mhcc (Mental Health Co-ordinating Council), NAAH (National Alcohol and Alcoholism Helpline), WINSW (Western Sydney Health Services), FAMILY PLANNING NSW, Hepatitis C Council of NSW, NADA (Network of Alcohol and Other Drug Agencies), and mental health association nsw inc.

## How will the review of SPPs affect Health funding?

The review of SPPs may affect health more immediately than other areas as the review is happening concurrently with the renegotiation of the Australian Health Care Agreements (due to expire 30 June this year) and general health reform, including the establishment of the National Health and Hospitals Reform Commission.

There have been indications that reform of the SPPs may include some current health SPP funding becoming part of the Australian Health Care Agreements (AHCA), and speculation that all current SPPs for Health may be rolled into one broad 'health' payment.

In 2005-06 estimated total government expenditure on public health activities across Australia was 2.66% of total recurrent government expenditure on health – a decline from 2004-05 and lower than the percentage in 1999-2000<sup>1</sup>. **We are alarmed that without adequate guarantees the amalgamation of health funding agreements will jeopardise already inadequate funding allocations for primary health and prevention services.**

### Our Position

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1. We welcome reform that provides greater transparency of responsibilities for health funding and policy.
2. Given the current level of vertical fiscal imbalance<sup>2</sup>, we believe it is appropriate for both the States and the Commonwealth to contribute funding to health programs.
3. Greater financial and policy emphasis must be placed on primary health, particularly early intervention, prevention and health promotion services. With this in mind, we welcome the establishment of the health and hospitals reform commission. Funding for health should be undertaken in a coordinated way across the health system, and reform should include a priority focus on how greater emphasis and funding can be directed to early intervention and prevention services, particularly amongst disadvantaged and vulnerable population groups.
4. Streamlining bureaucratic administration costs should be an essential component of reform of Specific Purpose Payments. Any cost-savings achieved through reform should be committed to primary and community health services, and not shifted to state-based bureaucracy or the administration of other funding programs (such as AHCAs).

5. Funding for primary health services, prevention and early intervention services should be expanded and guaranteed in a broadbanded health funding agreement. In particular, where funding agreements cover primary and acute services funding allocations should be clearly demarcated. This could be achieved through the continuance of specified funding or the use of Key Performance Indicators (as are currently employed in the PHOFA agreements).
6. The negotiation of health reform and funding agreements should be transparent. The development of funding agreements should be based on consultation with appropriate ministerial, departmental, non-government and community input – particularly in relation to agreement priorities, funding allocation, targets and any outcome or result measures.

### Conclusion

We acknowledge the need for broad-based health reform, including reform of funding arrangements. Our priority is that specific and identified funding for primary and community health is guaranteed to these programs, whatever form the funding agreements ultimately take.

### For more information please contact:

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**email:** kristie@ncoss.org.au

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<sup>1</sup> Australian Institute of Health and Welfare, 2008, National Public Health Expenditure Report 2005-06

<sup>2</sup> Revenue collection of State/Territories and Commonwealth does not match their spending responsibilities. In Australia the States have a high-level of responsibility for spending and little revenue collection, whilst the opposite occurs at a Commonwealth level.

*The NCOSS Health Policy Project is funded by NSW Health*

## Appendix B: NCOSS comment on cuts to NSW Health NGO Grants Program, announced in NSW mini-budget, 11 November 2008



### Council of Social Service of New South Wales

66 Albion St, Surry Hills NSW  
phone 02 9211 2599 fax 02 9281 1968  
email [info@ncoss.org.au](mailto:info@ncoss.org.au) web [www.ncoss.org.au](http://www.ncoss.org.au)

abn 85001 797 137

#### NSW Health NGO Grants Program Update on Issues

##### NSW Mini-Budget

On the 11<sup>th</sup> November the NSW Government delivered the mini-budget.

The papers for health include a measure: *Reform grants to non Government organisations through efficiencies and limiting new agreements.*

Estimates indicate that over three years \$11m will be cut from the NSW Health NGO Grants Program (\$2.5m in 2009-10, \$3.5m in 2010-11 and \$5m in 2011-12.) Funding to NGOs for the 07/08 financial year was \$118.1m.

The NGO Grants program provides for the delivery of a range of health services, including mental health, Aboriginal health, drug and alcohol services, women's health centres, sexual and reproductive health services, services for people with HIV, hepatitis C and a range of other health promotion. As such, a cut in the NGO Grants Program budget is likely to lead to a direct cut in health services to the most disadvantaged groups, and exacerbate health gaps between these groups and the rest of the community.

It is not yet clear how these cuts will be implemented, but the Minister's office has indicated that some funding contracts may not be renewed when they expire, and that some 'efficiency savings' could be made by streamlining the grants.

NGOs generally run very tight budgets, do not have significant or broad administrative or infrastructure bases, and are generally a more efficient and effective way of delivery some types of services, including some health services. As such, it is very difficult for NCOSS to see the logic in applying efficiency savings to NGOs.

Whilst NCOSS is supportive of moves to create better coordination of NGO grants to remove unnecessary and burdensome reporting and administration requirements, our position has been (and continues to be) that the increase in compliance and reporting requirements over time has taken away from NGOs capacity to deliver the services they have been contracted to provide. This has been exacerbated by the fact that increasing grants administration requirements have not been met with an increase in funding, and in many cases inadequate indexation has been applied to NGO programs, which has led to a decrease in NGO grants in real terms.

As such, the need to review compliance and reporting of NGOs is about creating efficiencies within administrative functions so that service delivery levels can be maintained. NCOSS has significant concerns that under the Mini-budget framework, the service delivery capacity of NGOs is lost as a funding cut to the NGO Grants Program.

NCOSS and the Minister's office will be meeting to discuss this issue further in the near future. We will provide more information as it is available.

### **Further Action**

It is important that the Minister for Health understands the implications of a cut of this size to the NSW Health NGO Grants Program. There are a number of simple actions that can be taken to ensure that the ramifications of this decision are fully understood:

1. If you are an NGO funded by NSW Health, NCOSS would urge you to write or call the Minister with your concerns about how a funding cut would affect your service.  
Contact details are:  
The Hon. John Della Bosca,  
Level 30 Governor Macquarie Tower,  
1 Farrer Place,  
Sydney NSW 2000  
Phone (02) 9228 4777
2. Each cut to the budget of an NGO has consequent effects on the services available within particular areas. NCOSS would encourage you to raise concerns about the impact of these changes with the relevant State Member and request that they seek an explanation from the Minister for Health. Contact details for all Legislative Assembly Members by electorate are available from the NSW Parliament website: <http://www.parliament.nsw.gov.au/prod/parlment/members.nsf/V3ListCurrentLAMembers?open&vwCurr=CurrLAByElectorate>
3. The people who bear the brunt of funding cuts to NGOs are the clients of these services. In the case of NGOs, clients are often some of the most marginalized members of the community, and it is their voices that are often not heard on these issues. It may be worth your service giving consideration to raising this issue amongst your clients, and encouraging and supporting them to contact both the Minister for Health and the Member for the electorate to communicate their concerns about what a cut in services would mean. The nature of services provided by NGOs can be sensitive, and careful consideration should be given to whether this is an appropriate action for your client group and service.
4. Contact your local newspaper and encourage them to write an article on what this might mean for services in your area.

### **More Information**

For further information please contact:

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## Appendix C: NCOSS Pre-Budget Submission expenditure recommendations for Health, 2009-10 (*Towards Triple A rated community services*) and 2008-09 (*A Fairer NSW*)

TOWARDS TRIPLE A RATED COMMUNITY SERVICES: BUDGET PRIORITIES FOR A FAIR AND SUSTAINABLE COMMUNITY

of rising fuel costs has recently been recognised by the NSW Government with an additional \$6.7m being given to HACC funded organisations to subsidise volunteers for the rising costs of petrol.<sup>57</sup> It has also been reflected in recent increases in taxi fares to allow for rising fuel costs. However, the needs of community transport programs facing similar issues have not been addressed.

Enhancement of this program would assist NGO community transport providers to meet the increasing needs of the community and to expand the range of services that they offer. It will also enable them to respond to the diverse community needs outside of traditional program areas such as HACC.

### Actions

- Double the funding to existing Community Transport Program providers to enable them to meet increasing fuel costs and service demands.
- Provide additional funding to establish Community Transport Program providers in areas that currently do not have this service

**Cost:** An additional \$7.05m recurrent from 2009-10 to increase CTP funding to \$10m per annum

### ■ Recommendation 4: Transport Services for Aboriginal Communities

State Plan Priorities: R4, S1, F1, F2, F3, F4, P4, P6, P7, E3, E8

### Results

- Improved availability and appropriateness of existing services for Aboriginal and Torres Strait Islander communities.
- New services that reduce the social isolation of transport disadvantaged Aboriginal communities.
- Improved coordination between transport providers to meet the needs of Aboriginal people.

### Evidence/Rationale

Due to a long history of social exclusion many Aboriginal and Torres Strait Islander people face geographic isolation from services and are unable to take advantage of existing services because they are not culturally appropriate. This is exacerbated by isolation from transport services and infrastructure. Poor consultation often reinforces this situation, with Aboriginal people often locked out of planning processes for transport services.

There are a number of key issues that impact upon the ability of Aboriginal people to access transport

services, including physical isolation from public transport routes, lack of flexibility of in existing services, discrimination and poor coordination of services. Affordability of services is an important issue, particularly for low income Aboriginal people. Services can be expensive, particularly for people who don't have access to concession public transport fares.

Frequently there is poor coordination between local, public and community transport providers, which can make existing services difficult to use, or fail to take opportunities to share resources in order to solve community problems. The long travelling times mean that many people who do not have access to a motor vehicle are discouraged from attending medical appointments. Better coordination of services can help to improve links to vital services.

Solving transport disadvantage in Aboriginal communities will require a concerted approach from Governments, transport operators and local communities. We must begin to acknowledge that transport issues are a key factor in understanding the barriers that face many Aboriginal people. An important starting point is to create processes for Aboriginal people to be involved in planning for future transport needs.

### Actions

- \$292,000 to fund two innovative Aboriginal transport projects to improve the delivery of transport to Aboriginal people.
- \$1.4m to fund Aboriginal Regional Coordinators and local Aboriginal community based development workers, with a priority on inland areas of need.

**Cost:** \$1.4m recurrent from 2009-10 for Aboriginal Regional Coordinators and Community based development workers; \$292,000 in 2009-10 for the transport projects.

## ■ NSW Health

### ■ Recommendation 1: Reproductive Health

State Plan Priorities: S1, F3

### Result

An improvement to women's access to information, support and appropriate counselling around pregnancy options, with a focus on increasing access to services for young women, women living in rural and remote areas, and women who experience socio-economic disadvantage.

**Evidence/Rationale**

The National Health and Medical Research Council<sup>68</sup> and other researchers<sup>69</sup> have recommended that counselling for pregnancy options (motherhood, adoption and termination) is available for all women seeking it in decision making, and where relevant post-abortion.

Since 2001 several factors have combined to restrict access to pregnancy termination services in NSW. These changes have included a decrease in the number of bulk-billing abortion providers, which has in turn led to an increase in the cost of termination of pregnancy. The overall outcome has been an increase in the up-front costs for a termination and an increase in the overall out-of-pocket expense of up to \$130.

In addition, since the mid-90s the proportion of pregnancy terminations conducted in NSW public hospitals has almost halved. In 2003-04, 4.8% of terminations were carried out in New South Wales public hospitals, compared to 96% of terminations in South Australia.<sup>70</sup> There has been some suggestion that the number of NSW public hospitals providing terminations is as little as three. This results in significantly fewer options for low-income women seeking to terminate a pregnancy.

Increasing upfront costs and difficulties obtaining a termination from public hospitals has a disproportionate affect on women who are socio-economically disadvantaged, particularly young women and women in rural and regional areas who often face additional transport costs to access termination services. It has also been recommended that local information about services for pregnancy termination be improved.<sup>71</sup>

**Action**

NSW Health to fund a state-wide Pregnancy Options Counselling and Support Service to provide counselling, advocacy and brokerage, and to develop and maintain a state-wide referral database and network of health care providers working in the field.

**Cost:** \$391, 598 recurrent

■ **Recommendation 2: Provision of Appliances for Disabled People (PADP)**

**State Plan Priority: F2**

**Results**

People with disability are supported to live more independently in the community, facilitating their participation in all aspects of society.

*Solving transport disadvantage in Aboriginal communities will require a concerted approach from Governments, transport operators and local communities.*

**Evidence/Rationale**

The PADP program provides equipment, aids and appliances to people with a life-long or long-term disability in order to support them to live independently in the community.

PADP is an integral part of the network of services that allows individuals to leave hospital under earlier discharge strategies and to live in the community rather than in residential facilities. The timely provision of appropriate equipment helps people to avoid future hospital admission (e.g. walking frames that prevent falls), enable community care services to provide assistance, and reduce demands on community care services by supporting people in the tasks of daily living.

The administration and resourcing of PADP has recently been the subject of review and reform. A report released in 2006 by PricewaterhouseCoopers found that there was a 'failure of the available funds to adequately satisfy the reasonable expectation of the client group'.<sup>72</sup> The report also found that demand on PADP would continue to increase with estimated increases in population prevalence of disability.

Whilst there has been some additional investment in PADP, including \$11m in July 2008 to reduce the waiting list, there has been no substantial change to core or ongoing funding for the program, leaving issues such as unmet and increasing demand, long waiting lists and under-investment in the program largely unresolved beyond the short term.

Many people with disability experience substantially higher costs of living in comparison to other members of the community.<sup>73</sup> Many low income people with a disability already devote a large proportion of their weekly income to meet the costs of having a disability.<sup>74</sup> These higher costs generate significant hardship for low and middle income households. Given that we know that the vast majority of people with disability are likely to come from a low income household, and that the high costs of disability will adversely impact on a range of households, NCOSS believes that PADP should be an entitlement for all

people with disability, and that exclusions should only apply to *very high income earners*. Copayments for the program should also be removed on the grounds that they are prohibitive and inflict unnecessary financial hardship.

#### Action

That additional core funding for the PADP is provided at an amount that ensures ongoing capacity for the provision of equipments, aids and appliances to people with a life-long or long-term disability.

**Cost:** An additional 24.4m in 2009-10, rising to a total budget of \$100m in 2014-15<sup>75</sup> to meet eligible population forecasts

### ■ Recommendation 3: Smoking cessation support programs

State Plan Priority: S3

#### Result

A decrease in smoking prevalence amongst low-income and disadvantaged population groups in NSW.

#### Evidence/Rationale

Whilst smoking rates across the community have declined in the last decade, smoking rates for low income and disadvantaged population groups have remained higher than those for higher socioeconomic groups (26.5% compared to 15.6%).<sup>76</sup> Smoking rates are also higher amongst a range of vulnerable and disadvantaged groups:

- 82.1% of Aboriginal people and 77.2% of non-Aboriginal people in custody are current smokers;<sup>77</sup>
- 51% of Aboriginal women report smoking during pregnancy;<sup>78</sup> and
- Between 60-80% of people with a mental illness smoke.<sup>79</sup>

Despite the high prevalence, many people from disadvantaged groups express a desire to quit smoking. Community organisations report that the cost of cessation interventions such as Nicotine Replacement Therapy (NRT) is cited by clients as a key barrier to quit smoking. Given that a combination of NRT and counselling has been shown to be an effective intervention within these groups, and that NRT almost doubles the chances of a quit attempt being successful, NCOSS believes that increasing access to NRT for low income and disadvantaged groups will contribute to a decrease in smoking rates amongst these groups.<sup>80</sup>

NCOSS believes that in order to implement effective smoking interventions in disadvantaged groups, interventions need to be tailored to their particular needs and circumstances. As such, with appropriate support and training NGOs are well-placed to deliver effecting smoking interventions to low-income and disadvantaged groups, given that they often have established support relationships, frequent contact and already assist their clients across a range of areas.

#### Actions

- The NSW Government provide funding for an additional smoking cessation trainer to work with non-government agencies to promote and implement smoking cessation support and activities with low-income and disadvantaged people.
- The NSW Government establish a fund administered by area health services for the provision of free nicotine replacement therapy to clients of non-government agencies who wish to quit smoking.

**Cost:** \$2m per annum

### ■ Recommendation 4: Public dental services

State Plan Priorities: S1, S2, F4, F5

#### Result

Improved oral health amongst socio-economically disadvantaged groups and increased preventive oral health treatment.

#### Evidence/Rationale

NSW has the lowest per capita expenditure on public dental services of all states and territories, with approximately 160,000 people currently on public dental waiting lists in NSW.<sup>81</sup> Public dental patients suffer from poorer oral health,<sup>82</sup> are less likely to receive preventive services and experience higher levels of tooth loss,<sup>83</sup> the majority of which is preventable.

In 2006 the Legislative Council's Standing Committee on Social Issues reported on dental services, finding that socio-economically disadvantaged groups bear the brunt of underfunded public dental services:

*The committee notes the level of treatment that the public system is able to provide to users contrasts with the wide range of general and elective treatments provided to people who can afford to pay for services provided by private practitioners. The reduced treatment available in public dental services is affecting*

*the health of public dental patients, who can suffer in a range of ways from social embarrassment up to serious medical conditions and, in extreme cases, the death of patients who do not receive adequate and timely treatment.<sup>64</sup>*

The report also highlighted the particular shortages in the public dental workforce, finding that this led to reduced access to dental services, growing waiting lists, increased waiting time and a reduction in the provision of preventive care. Recent data reinforces the argument that the oral health workforce in NSW, particularly the public health workforce, requires significant enhancement:

- Only 13% of dentists in NSW work in the public sector;<sup>65</sup>
- The number of dentists practicing as specialists in NSW is 5.2 per 100,000 population, the third lowest rate of all states and territories;<sup>66</sup>
- NSW has the second lowest rate of dental hygienists of all states and territories, at 2.2 per 100,000 population;<sup>67</sup>
- NSW has the lowest number of dental therapists per 100,000 population, at 3.9. This well below the national average of 7.5;<sup>68</sup>
- The number of dental prosthetists has remained relatively stable at 4.6 per 100,000 population, however 89% of dental prosthetists work in the private sector.<sup>69</sup>

Whilst the Commonwealth Government has committed funding to the States and Territories through the Commonwealth Dental Health Program (CDHP) and the Medicare Teen Dental Plan (MTDP), this funding alone will not resolve the significant funding and workforce challenges facing public dental services in NSW, and may in fact exacerbate demand both in the short term through the MTDP and following the expiry of the CDHP.

#### Actions

- Enhancement to core funding for public dental services to meet the NSW Legislative Council's that public dental funding be increased to be comparable to other states.
- Funding for a five-year strategy for comprehensive oral health workforce initiatives.

**Cost:** \$193.86m in 2009-10, increasing to \$252.14m plus indexation in 2013-14

*Public dental patients suffer from poorer oral health, are less likely to receive preventive services and experience higher levels of tooth loss, the majority of which is preventable.*

#### ■ Recommendation 5: Health NGOs

**State Plan Priorities:** S1, S2, S3, F1, F3, F4, F5

##### Result

Increased viability and sustainability of the Health non-government organisation (NGO) sector, leading to the enhanced health and well being of the community, especially for those who are the most disadvantaged.

##### Evidence/Rationale

NGO Health services are a vital component of mainstream health services, in many cases providing core services that have not historically been, or would not be, provided by the public sector. Many health NGOs specifically target marginalised groups in their community who do not use mainstream health services, or do not use them until they are seriously ill. Their flexible structures and client-focused ethic make them well suited to responding to the needs of these groups.

The NSW Health NGO program receives less than 0.9% of the NSW Health Budget.

The Health NGO Sector has a broad range of strengths that include the ability to provide a cost effective service. However, over the last five years there has been a significant increase in operation costs, with figures indicating that Workcover costs alone rose by 142% from 2001-02 to 2004-05, while total insurance costs over the same period rose by 68%.<sup>70</sup> In addition to this, indexation levels have failed to provide for the true cost of increases in service delivery. In addition to the rise in rental and maintenance costs, NGOs have also reported increasing administrative burdens and information technology costs.

The cumulative effect of these funding shortfalls is significant. As such costs accumulate, the NGO sector's capacity to provide services to the community is reduced, with many services forced to decrease direct service delivery to cover increased costs.

**Action**

NSW Health increase funding to Health NGOs by 15% to meet increased core costs of service delivery

**Cost:** \$17.7m recurrent (indexed to CPI)

■ **Recommendation 6: Transport for Health**

**State Plan Priorities:** S1, S2, F1, F3, F5

**Results**

- Significant improvements in health connectivity for rural, regional and remote communities, Aboriginal communities and people on low incomes.
- A reduction in the number of people missing health appointments due to transport problems
- Improvement in survival rates and quality of life for people with potentially fatal or chronic illness by improving access to health care.
- Improved health for Aboriginal and Torres Strait Islander people.

**Evidence/Rationale**

The Transport for Health program is aimed at supporting Area Health Services to be more strategic in identifying, consolidating and integrating a full range of transport services and resources to increase effectiveness and reduce duplication.<sup>99</sup> Furthermore it promotes the use of a mobility management approach to non-emergency transport by all Area Health Services, through coordination between the appointments system and transport service providers, the encouragement of closer cooperation and the development of partnerships with external service providers such as the community transport industry.

There is also funding available specifically targeting health related transport through the Transport for Health Program. Eligibility for support under this program is wider than for HACC and it is provided on the basis of a patient's inability to reasonably gain access to local health services by either public or private transport. Passengers whose trips are subsidised by Transport for Health in rural areas can be taken to regional and Sydney-based health facilities as well as local facilities. As with the HACC program, Transport for Health is based on eligibility rather than entitlement.

In rural and regional areas there are many barriers to accessing transport, which affects people's ability to seek treatment when needed. For example regionalisation of services has meant that many people who do not own a motor vehicle are likely to face significant difficulties travelling to access health services. In some areas this can mean a trip of 200

–300kms just to get to the appointment. The problem can be even greater in Aboriginal communities where it is not uncommon for people to walk or hitchhike long distances in order to attend medical appointments.

Although transport to health services is clearly a problem in rural and regional NSW, it can also be a problem in metropolitan areas. For example, consolidation of health services has increased the distance required for specialised treatment i.e. Oncology and Dialysis treatment. Poor planning for public transport to health destinations, inaccessible transport services, and limited resources for community transport all create barriers to accessing health services. Many patients resort to unaffordable forms of transport, such as taxis, in order to get to important health appointments.

Another aspect of the Transport for Health Program is the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS). This program is designed to assist with access to specialist medical treatment and oral surgical care, for people living in isolated and rural communities. It provides a partial reimbursement of actual accommodation and travel costs. To be eligible people need to live more than 100km (one way) from where specialist medical treatment that they need is provided.

There are a number of problems relating to IPTAAS, including: the high upfront costs of the scheme, relatively high non-refundable personal contribution levels, low levels of reimbursement for accommodation costs (\$46 per night for a double and \$33 per night for a single) and fuel (15c per km), the lack of ability to elect a carer and the intensive paperwork required for each claim. In addition IPTAAS reimbursement can take up to three months. These barriers especially the upfront costs and complex paperwork means that many low income and Aboriginal people will not use the scheme.

Despite ongoing reforms of the health system in NSW, there has been little attention paid to the transport needs of patients. Despite increasing demand for access to health appointments reported by community transport providers there has been little increase in funding to health related transport services. In light of increasing fuel costs and increasing demand NSW Health needs to significantly increase funding to the Health Transport program for both transport to health and IPTAAS.

**Actions**

- Increase NSW Health funding for non-emergency transport services to \$10.4m per annum (as per the *No Transport No Treatment Report* released in December 2007).

- Improve monitoring and evaluation of the Transport for Health Program, especially of the number of people that are refused a service (to determine actual demand).
- Reform administration of IPTAAS in NSW to minimise paperwork and allow administration by local services.
- Reform payment processes through IPTAAS so that travel and accommodation expenses can be estimated and paid in advance.
- Ensure that travel and accommodation expenses for IPTAAS are reimbursed to the equivalent of the public service rate. These reimbursements should be adjusted by CPI each year and take account of different accommodation costs associated with staying in large rural and metropolitan centres.
- Improve affordability of IPTAAS for low income people by removing the administration fee for Health Care Card Holders, pensioners and people with demonstrable financial difficulties.
- Broaden IPTAAS to cover generalist medical appointments (not just specialists) if people live in isolated areas and especially for Aboriginal communities.

**Cost: \$10.4m recurrent from 2009-10 for health related transport**

*(NCOSS is unable to cost the IPTAAS recommendations without access to relevant NSW Health expenditure and usage data.)*

## ■ NSW Treasury

### ■ Recommendation: Indexation for NGOs

State Plan Priorities: R4, S8, P1, P6

#### Results

- Improved outcomes for people and communities in line with the recommendation through effective partnerships between non-government organisations (NGOs) and Government
- More effective delivery of services by NGOs on behalf of Government providing value for money.

#### Evidence/Rationale

The Australian Community Sector Survey 2008 shows that despite an increase in funding that demand for community services is still outstripping the sector's capacity to deliver those services.<sup>92</sup> In NSW in 2006-07 respondents to the survey provided services to 422,233 people, an increase of 2% on the previous year. However, they also turned away just over 18,000 people which was a 16% increase on the previous 12 months. This was despite a 6% increase in overall funding.

*While demand for services continues to exceed capacity the costs of providing these services continues to rise.*

Other key findings showed that the majority of services (54%) were targeting their services more tightly than in the past to cope with the demand and that 46% had longer waiting lists than in previous years. Services had also increased the number of paid hours for staff to cope with the demand (41% of respondents) but even more agencies had increased "unfunded" hours (62% of respondents).

The overwhelming majority of respondents believed that Government funding did not cover the true cost of delivering contracted services (84%) and a significant number (32%) felt that contract requirements adversely affected their organisation's ability to deliver contracted services. This was much higher than the national figure of 24% and suggests that there is still a lot to do in NSW to truly deliver a fair and effective working partnership between the sector and Government to deliver desperately needed community services.

While demand for services continues to exceed capacity the costs of providing these services continues to rise. Wages, rent, transport and insurance costs have all continued to increase in excess of the indexation provided by Government to NGOs in recent years. The result is even further reductions in capacity to meet demand and poorer outcomes for disadvantaged people and communities. It is important that Government, in entrusting NGOs to deliver critically important services and programs on its behalf, recognises the need to ensure NGOs are both adequately funded to do this work properly and that increases in costs are met in full through indexation.

#### Actions

To apply full indexation based on CPI or SACS Award wage increases, whichever is the higher, to all NGOs.

**Cost: Between \$52.5m (based on projected CPI of 3.5%) and \$63.75m (based on projected labour cost index of 4.25%)**

In its 2004 submission to the Taxi Transport Subsidy Review, NCOSS also suggested varying the subsidy limit to ensure that it reflects the typically longer distances some users travel, eg. people in Western Sydney and in rural and regional NSW. There was also an acknowledgement from IPART of higher regional costs in its 2006 *Review of Fares for Taxis in NSW*.

#### Actions

Provide an additional allocation to the Taxi Transport Subsidy Scheme to enable:

- An increase in the subsidy limit to 75% of the metered fare;
- Variation of the upper limit of the subsidised fare to reflect typical distances covered by users in different regions; and
- Annual CPI indexation of upper subsidy limit.

Cost: \$8.5m

### ■ Sustainable Transport Development Projects

#### Results

- Sustained community-based transport development services for growth areas in NSW.
- Improved location-based planning processes; better identification of transport needs in community.
- Closer stakeholder collaboration to ensure improved transport outcomes.
- Improvements in the availability of services for disadvantaged communities, including Aboriginal communities.
- Ongoing policy development on statewide issues relating to transport disadvantage.

State Plan: P2, P6

#### Evidence / Rationale

NCOSS believes there are opportunities to promote sustainable transport planning and development in growth areas across NSW through local non-government organisations. The NSW Government currently provides full or partial funding for a number of NGO based transport development workers in South East and Western Sydney, Cessnock and the Northern Rivers. These officers have proved successful in identifying transport needs, promoting local transport services, encouraging walking and cycling, and working with local communities to develop innovative solutions to transport problems.

These workers also have worked actively with local and state governments to promote long term sustainability goals in transport planning and

*NCOSS believes there are opportunities to promote sustainable transport planning and development in growth areas across NSW...*

development, and provide and complementary function to other workers, such as the Ministry of Transport Regional Coordinators.

NCOSS recommends that the Ministry of Transport expand the network of NGO based transport development workers in order to promote sustainable transport outcomes. Ideally these positions should be targeted to growth areas such as the Central Coast and Mid North Coast. NCOSS also recommends that two of the positions be targeted to work with Aboriginal communities experiencing transport disadvantage.

#### Action

Provide \$580,000 recurrent funding to establish four Sustainable Transport Development projects in 2008-09.

Cost: \$580,000 in 2008-09

### ■ NSW Health

#### ■ Aboriginal Health

#### Results

- Improved mental and physical health and well-being outcomes for Aboriginal men, women and communities.
- Aboriginal health outcomes and life expectancy in line with health outcomes for the general community.
- Lower rates of chronic disease in the Aboriginal population.

State Plan: S1, S2, S3, F1, F3, F4, F5

#### Evidence/Rationale

The health status of Aboriginal Australians is the worst in the developed world.<sup>44</sup> It is significantly poorer than that of non-Aboriginal Australians,<sup>45</sup> with the life expectancy of Aboriginal Australians in NSW approximately seventeen years less than non-Indigenous Australians.<sup>46</sup>

NSW has the highest percentage of the Aboriginal and Torres Strait Islander population of any State or Territory (29.2%),<sup>47</sup> making the health status of Aboriginal Australians a particular priority for NSW.

A key component of improving the health of Aboriginal people is prevention and early intervention. In NSW in 2004, more than three-quarters (76.4%) of all premature Aboriginal deaths were potentially avoidable.<sup>48</sup> Similarly, hospitalisation rates for conditions for which hospitalisation can be avoided through prevention and early management were twice as high for Aboriginal people as non-Aboriginal people.<sup>49</sup>

Aboriginal people are more likely to be affected by a range of chronic health conditions, including chronic respiratory diseases, diabetes, cardiovascular disease and kidney disease.<sup>50</sup> Prevention of chronic disease is an essential element in improving Aboriginal Health and life expectancy.

As set out in *Two Ways Together*, improving the health and wellbeing of Aboriginal people in NSW requires the development of a genuine partnership approach that will enable Aboriginal people and communities to take responsibility for the solutions.<sup>51</sup> The right to self-determination is a fundamental component of this framework.

#### Actions

- NSW Health to fund 55 Women's Health workers in NSW Aboriginal Medical Services at \$4.125m per annum
- NSW Health to fund 55 Men's Health workers in NSW Aboriginal Medical Services at \$4.125m per annum.
- NSW Health to fund the Aboriginal Health and Medical Research Centre to undertake preventive work around chronic disease at \$351,200.

Cost: \$8,601,200 p.a.

### ■ Co-morbidity – Mental Illness and Substance Dependency

#### Results

- Reduction in long term hospitalisation for people with co-morbidity resulting in improved health outcomes and reduced costs for the health system.
- Reduction in pressure on the criminal justice and homeless service systems.
- Increased access to services by young people with co-morbidity.

- An improvement in the health outcomes of people with a co-existing mental illness and substance dependency across NSW.

State Plan: R1, R2, S1, S3, F1, F2, F3, F5

#### Evidence/Rationale

Prevalence rates of substance abuse issues in mental health settings have been consistently reported at between 30% and 80%.<sup>52</sup> Similarly, more than half of the people who use or abuse substances have experienced psychiatric symptoms significant enough to fulfil diagnostic criteria for a mental illness.<sup>53</sup>

Co-morbidities are associated with a host of social, behavioural, psychological and physical problems, including: increased symptom severity and suicidal behaviour, greater non-compliance with treatment, more hostile and aggressive behaviours, increased risk of violence to others, higher rates of offending, imprisonment and homelessness, and longer duration of admission to psychiatric inpatient units.<sup>54</sup> As a result, integrated program responses are essential to prevent people falling between the gaps of separate service systems.

There are significant barriers in access to services for young people with co-morbid mental illness and substance dependency, particularly in rural and regional areas.<sup>55</sup> Evidence suggests models in the mental health system and some adult-oriented services are not appropriate for young people with co-morbidity. Despite this, there is a significant lack of co-morbidity services responding specifically to young people, and "even when present, residential youth alcohol and drug programs are frequently limited in numbers and scope".<sup>56</sup>

#### Actions

- NSW Health to fund a statewide three-year trial of an integrated residential treatment and rehabilitation facility for people with a mental illness and substance dependence co-morbidity followed by an independent evaluation. If proven as a successful intervention, an ongoing commitment to funding should be guaranteed.
- NSW Health to fund a statewide three-year trial of an integrated residential treatment and rehabilitation facility for young people with a mental illness and substance dependence co-morbidity, followed by an independent evaluation. If proven as a successful intervention, an ongoing commitment to funding should be guaranteed.

- NSW Health to provide ongoing funding for comprehensive workforce initiatives for all workers involved in assisting people with a dual diagnosis.

**Cost:** \$2.7m p.a. for two trial projects

\$900,000 p.a. (recurrent) for workforce initiatives

## ■ ComPacks and SAFTE / Healthy at Home

### Results

- Improved before and after hospital care and support, thereby reducing unnecessary hospital admissions and readmissions, both generalist and mental health.
- Reduced surgical and emergency department waiting times by the freeing up of hospital beds.
- Patients will experience improved health outcomes through decreased infection rates, higher survival rates and decreased costs associated with hospital stays.
- Enhanced overall health of the community by:
  - a. meeting the 'life' needs of people to avoid unnecessary emergency presentations and on discharge from hospital; and
  - b. ensuring that people are appropriately supported until they can manage their own care or make more permanent arrangements.

**State Plan:** S2, F4, F5

### Evidence/Rationale

The NSW Health ComPacks program is a strategy that involves community case management for hospital inpatients with multiple needs. The aim is to rapidly assemble an individualised community care package of brokered support services designed to meet each patient's assessed clinical and support needs for up to eight weeks after they are discharged from hospital. Community case management reduces the impact on other community and health services, including acute care.

ComPacks is a joint hospital discharge process involving multidisciplinary health teams and non-Health community care case managers (i.e. Community Options Projects) where the patient requires two or more services to remain safely at home. ComPacks is designed to maximise independence, capacity and preferences of the client and to improve access to sustainable community services.

Also known as Healthy at Home Program, SAFTE (Sub Acute and Fast Track Elderly) Care is an interagency approach to provide integrated community care for frail older people who show the first signs of an

*Aboriginal people are more likely to be affected by a range of chronic health conditions, including chronic respiratory diseases, diabetes, cardiovascular disease and kidney disease.*

escalating medical condition or crisis. SAFTE Care aims to avoid hospital admissions by providing a combined assessment by a health clinician and ComPacks Case Manager within 24 to 48 hours of referral, fast tracking diagnostics and assessment and then up to 6 weeks of case management and access to long-term sustainable support. An interim evaluation of the SAFTE Care program conducted by the University of Wollongong in June 2006 found that 81% of the clients seen by SAFTE would have presented at an Emergency Department, in the absence of the service (staff judgement).

ComPacks has proved to be a resounding success in terms of improved patient support as well as better targeting of resources. SAFTE is designed to provide similar outcomes but identifies the person as their needs escalate before avoidable hospital presentation.

ComPacks costs on average \$30 per person per day, compared to \$600 per day for an acute bed and \$350 per day in a sub-acute bed hospital situation. Any savings in bed days delivers important hospital improvements in responding to patient needs. This saving in bed days was evident for people with complex and very complex medical conditions. Discharge planners and social workers reported that ComPacks improves their capacity to address a person's acute care needs without adversely affecting capacity to support people with less acute discharge needs.

While there is an imperative for increased funding to complete the coverage of ComPacks in metropolitan hospitals, an urgent priority will be to extend ComPacks to all regional and rural areas across NSW. Current experiences in rural and regional areas identify similar outcomes with only minor differences.

### Actions

- An additional \$8m recurrent funding to complete the coverage of all public metropolitan hospitals and expand to public regional and rural hospitals.

- Monitor ComPacks for effectiveness, especially in regards to providing case management that is appropriate to people from CALD backgrounds and Aboriginal people.
- Accelerate funding to the SAFTE Care/Healthy at Home Program by \$10m in 2008-09.
- Quarantine the funding for out-of-hospital care only and attach it to the individual for brokering services.

Cost: \$ 18m recurrent

## ■ Health NGOs

### Results

- Increased viability and sustainability of the Health non-government organisation (NGO) sector, which is an integral part of the health system and health care delivery.
- Enhanced health and well being of the community, especially for those who are the most disadvantaged.
- Improved health within the general community, reducing the need for more expensive acute care interventions and hospitalisation.

State Plan: S1, S2, S3, F1, F2, F3, F4, F5

### Evidence/Rationale

Ensuring the viability of the NSW Health NGO Sector

NGO Health services are a vital component of mainstream health services, in many cases providing core services that have not historically been, or would not be, provided by the public sector. Many health NGOs specifically target marginalised groups in their community who do not use mainstream health services, or do not use them until they are seriously ill. Their flexible structures and client-focused ethic make them well suited to responding to the needs of these groups.

The NSW Health NGO program currently receives less than 0.8% of the NSW Health Budget.

The Health NGO Sector has a broad range of strengths that include the ability to provide a cost effective service. However, over the last five years there has been a significant increase in operation costs, with figures indicating that Workcover costs alone rose by 142% from 2001-02 to 2004-05, while total insurance costs over the same period rose by 68%.<sup>37</sup> In addition to this, indexation levels have failed to provide for the true cost of increases in service delivery. In addition to the rise in rental and maintenance costs, NGOs have also reported increasing administrative burdens and information technology costs.

The cumulative effect of these funding shortfalls is significant. As such, costs accumulate, the NGO sector's capacity to provide services to the community is reduced, with many services forced to decrease direct service delivery to cover increased costs.

## ■ Workforce Development

Workforce development is increasingly being recognised as an important component of creating sustainable organisations that continue to meet the changing needs of communities.<sup>38</sup> NSW Health explains that:

*Workforce development refers to a process initiated within organisations and communities, in response to the identified strategic priorities of the system, to help ensure that people working within these systems have the abilities and commitment to contribute to organisational and community goals.<sup>39</sup>*

The Australian Health Ministers' Conference has recognised that the health sector faces both current challenges – workforce shortages and maldistribution – and future challenges – new technology, demographic change and empowered consumers – in relation to the health workforce. These issues are particularly acute for the NGO sector, where staff recruitment and retention and funding availability for professional development are additional challenges. (Also see NCOSS Industry Development Plan on Workforce Issues.)

### Actions

- NSW Health increase funding to Health NGOs by 15% to meet increased core costs of service delivery at an additional \$14.9m per annum.
- NSW Health to fund NGO Health Peak Bodies to develop and implement workforce initiatives and programs for NSW Health-funded NGOs at \$500,000 per annum (recurrent).

Costs: 15.4m recurrent

## ■ Health Resource Teams

### Results

- Improved quality of life and health and well-being of people with intellectual disability and therefore a reduction in health costs across the person's life span.
- Improved diagnostic assessments of the health care needs of people with intellectual disability and complex medical conditions.

- Improved referral processes to and from general practitioners and other health and disability professionals.

**State Plan:** R4, S1, S2, F5

#### Evidence/Rationale

Australian research has shown that the life expectancy of a person with an intellectual disability is 17 years lower than the general population, even lower for those with severe disabilities. Obesity in people with intellectual disability is up to three times the level in the general population, however a significant proportion of people with disability who died in care were underweight and some died because of critical illnesses. Dental disease is also up to seven times more frequent than in the general population.

The poor health status of people with intellectual disability arises from a wide range of factors including:

- Communication issues between the health professional and the patient.
- Vulnerability of people with intellectual disability to various health conditions.
- Diagnostic overlay – assuming that symptoms are related to the disability.
- Inadequate multidisciplinary focus on health problems.
- Lack of an established expertise in intellectual disability medicine.
- Disability services have rightly moved away from a 'medical model' but without systems being established to ensure appropriate health care.
- Inadequate cooperative planning between health and disability departments and between the various levels of government.
- People with disabilities being undervalued within society.
- Health promotion campaigns not being accessible to people with intellectual disability.

The development of multidisciplinary intellectual disability health resource teams would provide a focus of expertise to assess the complex health care needs of people with intellectual disability in liaison with general practitioners. Such a multidisciplinary approach would include a doctor who specialises in intellectual disability and professionals in nursing, dietetics, speech pathology, neurology, psychiatry, oral health and alcohol and other drugs. The teams would be ideally placed to foster the development of better local networks to address the health care needs of people with intellectual disability and to provide advice and training to doctors and other health and disability professionals.

*Australian research has shown that the life expectancy of a person with an intellectual disability is 17 years lower than the general population...*

#### Actions

NSW Health to create two multidisciplinary intellectual disability health resource teams, specifically for people with intellectual disability, one metropolitan and one rural/remote.

**Cost:** \$2.2m recurrent

#### ■ Mental Health

#### Results

- Increased savings in mental health dollars through the reduction and prevention of relapse and decreased re-admissions to hospital.
- Reduction in pressure on the NSW homeless service system, particularly the Supported Accommodation Assistance Program (SAAP).
- Reduced rates of re-offending and reduction in pressure on the criminal justice system.

**State Plan:** R2, S1, F2, F3, F4, F5

#### Evidence/Rationale

Stable, appropriate and adequate housing is fundamental for mental wellbeing.<sup>60</sup> The Housing and Accommodation Support Initiative (HASI) assists people with mental health problems to acquire and maintain stable housing and facilitate their ongoing community connectedness and wellbeing.

HASI Stage One provided 100 'high support' places for people with 'complex mental health problems and disorders'. Evaluation of the program indicated that:

- 70% of clients remained in the same home for twelve months or more;
- 78% of people who started HASI remained in the program in March 2006; and
- 84% of participants have spent less time in emergency departments or psychiatric units since joining HASI.<sup>61</sup>

Evidence indicates that up to three quarters of the homeless population may have mental disorders,<sup>62</sup>

and that people from lower socio-economic groups are linked with more extreme and long-lasting symptoms and a higher chance of being hospitalised.<sup>63</sup> Yet despite recognition in program information of the suitability of HASI for people experiencing homelessness, it has been suggested that people experiencing homelessness have difficulty accessing HASI, and that a targeted program working in collaboration with homelessness services is needed to facilitate access.<sup>64</sup>

There is also a complex nexus between mental illness and homelessness in people exiting prisons. The prevalence of mental illness amongst inmates is considerable when compared to the general community.<sup>65</sup> Data indicates that:

- Approximately three quarters (74%) of the NSW inmate population have experienced a psychiatric disorder in the last 12 months, compared to one-fifth (22%) of the general population.
- At the point of reception almost half (46%) have suffered a mental disorder (psychosis, affective disorder, or anxiety disorder) in the previous 12 months. Over one-third (38%) of sentenced inmates have suffered a mental disorder in the previous 12 months.<sup>66</sup>

Similarly, the association between recidivism in ex-prisoners and homelessness is significant, particularly for ex-prisoners with a mental illness, who are more likely to end up without adequate housing.<sup>67</sup>

This model would see current HASI partners working collaboratively with support services for people exiting prison and people experiencing homelessness to determine client access to the program and deliver targeted support and accommodation to these two groups.

### Actions

NSW Health to continue to expand the Housing and Accommodation Support Initiative program with the Department of Housing to provide a targeted focus on people who are experiencing or at risk of homelessness and people exiting prison by:

- providing 100 places for people experiencing or at risk of homelessness with very high support needs at \$7m recurrent;
- providing 100 places for people exiting prison with high support needs at \$7m recurrent; and
- conducting evaluations of each of the programs at \$50,000 per program

**Cost: \$14m recurrent plus \$100,000 non-recurrent**

*For more information on Mental Health see 'Sexual Assault Services'.*

## ■ Non-Emergency Health Transport & IPTAAS Health

### Results

The Transport for Health recommendations will result in:

- Significant improvements in health connectivity or rural, regional and remote communities, Aboriginal communities and amongst low income earners.
- A reduction in the number of people missing health appointments due to transport problems of at least 50%.

**State Plan: S1, S2, F1**

### Evidence/Rationale

Barriers to accessing transport affect people's ability to seek treatment when needed. For example, many people located in rural and regional areas who do not own a motor vehicle are likely to face significant difficulties travelling to specialist services, some of which are located 200 or 300kms away from their home.

Many Aboriginal communities report that they are dislocated from services to connect them to health providers. This means that it is not uncommon for Aboriginal people in isolated communities to walk or hitchhike long distances to attend medical appointments, or routinely miss health appointments because of the poor availability of transport.

People who require intensive treatment for an illness – such as cancer or dialysis treatment – may often be required to travel long distances many times per week. Dialysis patients in Western NSW, for example, can travel 300-400 km a number of times per week in order to receive treatment.

Health related transport is a significant issue for people with physical and other disabilities who may need treatment to avoid adverse health outcomes.

Although transport to health services is clearly a problem in rural and regional NSW, it can also be a problem in metropolitan areas. Poor planning for public transport to health destinations, inaccessible transport services, and limited resources for community transport all pose barriers for access to health services. Many patients resort to unaffordable forms of transport, such as taxis, in order to get to important health appointments.

- Approximately 700,000 people across NSW experience difficulties accessing health care when they need it.<sup>68</sup> 50% report a shortage of general practitioners in their area.<sup>69</sup>

- Almost one quarter of people living in rural and regional areas will face difficulties accessing health care when they need it.<sup>70</sup>
- Access to health treatment is getting progressively worse in NSW: there has been a significant increase in the proportion of people having difficulties getting health care; from 9.9% in 1997 to 13.9% in 2005.<sup>71</sup>

People on low incomes experience comparatively poorer health outcomes than the general population;<sup>72</sup> transport is a significant contributing factor. Approximately 16.4% of people in a low income category have difficulty accessing health treatment when they need it.<sup>73</sup> This means:

- Some low income people routinely miss health appointments because of transport problems.
- For some low income households, the ability to meet food, energy and other essential bills is compromised as a result of high health transport costs.
- Some low income people, particularly in rural and regional areas, must move away from family and support networks in order to access health services.

There are a number of services and forms of support available to people who need to access health services, but they all have limitations.

Public transport is not always available to some locations, particularly in country NSW. Services in some regions can be inaccessible to people with mobility impairment. Costs can be high – rural and regional bus services are expensive, and do not offer the same range of concessions as metropolitan services. For some people physical access to transport is a barrier to it being used.

Resources for Community Transport (Home and Community Care Program) are inadequate and there can be long waiting lists. Community transport providers must respond to high demand for health related transport. This means that a significant proportion of trips, sometimes up to 90%, are to health related destinations. A report *No Transport No Treatment* commissioned by The Cancer Council NSW, the NSW Community Transport Organisation and NCOSS (to be released late 2007) describes a major study of community transport in NSW. This report found that community transport must turn away 90,000 requests for transport to health services each year. This is due to insufficient resources.

Non emergency health transport has a very limited state-wide budget, and has inconsistent availability and eligibility.

*Despite significant restructures, health services in NSW have not generally taken into account the transport needs of patients.*

The Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) is designed to assist with access to specialist medical treatment and oral surgical health care, for people living in isolated and rural communities in NSW, through the partial reimbursement of actual travel and accommodation costs. To be eligible patients need to travel more than 100 km (one way) from where they usually live to obtain specialist medical treatment not available locally. There are several grounds on which exemption can be sought from the nearest treating specialist rule, but there is a low level of awareness of these exemptions.

There are a number of other problems relating to IPTAAS, including: the high upfront costs of the scheme, relatively high non-refundable personal contribution levels, low levels of reimbursement for accommodation costs and fuel, the lack of ability to elect a carer and the intensive paperwork required for each claim. These barriers (in particular the upfront costs) mean that many low income people simply don't use the scheme.

NSW Health does provide some funding for non emergency transport services, but a comparatively small amount of money is available for community services. The 'Transport for Health' Program has a limited budget. Many area health services, particularly in metropolitan areas, have access to few resources through the program, and have been unable to set up transport units and employ appropriate staff.

Despite significant restructures, health services in NSW have not generally taken into account the transport needs of patients. NCOSS estimates that NSW Health spends a 1/1000th of its annual budget (or \$1 in every \$1,000 allocated to health in NSW) on non emergency health transport services to the general community. Any expansion in funding for health transport in NSW would need to be strategically allocated in order to provide a range of options for people, and promote greater responsibility in response to transport issues by health services.

Funding must lead to delivery of services. The program should focus not only on transport coordination and demand management objectives, but also provide services for people who are not able to access other forms of transport.

### Actions

- *Non Emergency Health Transport*

  - Increase access to health treatments by expanding funding for non-emergency health transport services to \$10m per annum;
  - Create health transport options for Aboriginal people, by providing dedicated services to Aboriginal communities, including the consolidation and growth of the network of Aboriginal transport coordinators.
  
- *IPTAAS*

  - Improve the affordability of IPTAAS for low income people by removing the administration fee for Health Care Card holders.
  - Ensure travel and accommodation expenses are reimbursed to the equivalent of the public service rate.
  - Ensure flexibility around upfront payments so that low income people, including Aboriginal people, are able to use IPTAAS.

**Cost: \$7m in 2008-09 for non-emergency health transport.**

NCOSS is unable to cost the IPTAAS recommendations without access to relevant NSW Health expenditure and usage data.

### ■ Oral Health

#### Results

- Improved oral health for all people living in NSW, especially those who are the most socio-economically disadvantaged and people living in rural and remote areas.
- A reduction in other costlier health problems through the treatment of oral health problems as evidenced by the link between oral and general health.
- Increased preventive treatment and timely interventions, reducing the need for extraction and enabling people to maintain their own teeth for a greater length of time.

**State Plan: S1, S2, F4, F5**

#### Evidence/Rationale

Good oral health is not simply the absence of oral health problems but a state of well-being in which a person can eat, speak, work and socialise without

discomfort or embarrassment. Poor oral health results in difficulty eating, impaired speech, loss of self-esteem, restriction of social and community participation, and can impede a person's ability to gain employment. Poor oral health has also been linked to other serious health conditions, such as heart disease.<sup>74</sup>

There are an estimated 200 000 people, including children, currently on public dental waiting lists in NSW.<sup>75</sup> NSW spends less per capita on public dental services than every other state and territory, and significantly less than the Northern Territory, Tasmania, Queensland and South Australia.

In 2006, the Legislative Council's Standing Committee on Social Issues reported on dental services, finding that socio-economically disadvantaged groups bear the brunt of underfunded public dental services:

*The committee notes the level of treatment that the public system is able to provide to users contrasts with the wide range of general and elective treatments provided to people who can afford to pay for services provided by private practitioners. The reduced treatment available in public dental services is affecting the health of public dental patients, who can suffer in a range of ways from social embarrassment up to serious medical conditions and, in extreme cases, the death of patients who do not receive adequate and timely treatment.<sup>76</sup>*

The report also highlighted the particular shortages in the public dental workforce, finding that this led to reduced access to dental services, growing waiting lists, increased waiting time and a reduction in the provision of preventive care, concluding that "it is paramount that more funding is provided to implement a comprehensive range of workforce initiatives."<sup>77</sup>

The fact that, despite the majority of tooth loss being preventable,<sup>78</sup> most public dental treatments are extractions indicates that the public dental system is failing. As a result of poor resourcing and funding, the public dental system is concerned only with immediate emergency care. There is no long term care and there is very little in the way of prevention. Throughout the NCOSS regional consultations, communities consistently raised oral health as a priority health issue, with workforce shortages and long waiting lists being cited in Albury, Wagga Wagga and Muswellbrook.

#### Actions

- An initial \$102.5m to bring core public dental funding to a minimum \$231m per year recurrent, in line with the NSW Legislative Council's recommendations that public dental funding be increased to be comparable to other states.

- \$50m in first year rising to \$123.7m in the fifth year for comprehensive oral health workforce initiatives including enhancements to the public dental workforce, particularly in rural and regional areas.

Cost: \$152.5m

## ■ Provision of Aids to Disabled People (PADP)

### Results

- People with disability have easier access to aids and equipment that support them to live more independently in the community.
- Avoidance of increased dependence caused by lack of timely and appropriate aids and equipment.

State Plan: F2, F4

### Evidence/Rationale

The resourcing and administration of the Provision of Aids to Disabled People Program (PADP) is an ongoing problem for consumers seeking equipment to assist them to live in the community. Long waiting lists remain a major concern, leaving consumers without basic equipment to assist with mobility or other impairments. In recent years, NCOSS regional consultations have revealed very worrying examples of people waiting years for basic equipment including mobility aids and beds. The shortfall in PADP funds is resulting in increasing pressure on families in crisis and NGOs to find resources for equipment to meet this gap. Substantial time is also being spent by health professionals seeking funds from service clubs and other charitable sources to obtain equipment.

As a result of a substantial community campaign, the NSW Government announced a \$3m enhancement to the PADP program in 2007-08, bringing the total funding for the program to \$26.8 m. NCOSS welcomes recent initiatives to establish a consistent policy for the program, and to initiate a review process. These initiatives will go some way towards addressing funding and administrative concerns associated with the program, but NCOSS seeks a sustained commitment to grow the program in order to meet the dramatic funding gap that exists for people with disability who require equipment.

NCOSS emphasises that PADP is an integral part of the network of services that allows individuals to leave hospital under earlier discharge strategies and to live in the community rather than in residential facilities. The timely provision of appropriate equipment will help people to avoid future hospital admission (e.g. walking frames that prevent falls), enable community care services to provide assistance, and reduce demands on community care services by supporting people in the tasks of daily living.

*The need to address refugee health concerns has grown exponentially over the recent years.*

### Action

That the NSW Government increases funding by 33% for the Provision of Aids for Disabled People Program from \$26.8m to \$35.7m p.a.

Cost: \$8.9m recurrent

## ■ Refugee Health

### Results

- Improved health outcomes for people of refugee background settling in NSW.

State Plan: S1, S2

### Evidence/Rationale

NSW receives more refugees than any other state in Australia with over 4,000 each year. Many have major health needs, often as a result of persecution, psychological trauma, disrupted access to health care and other adverse effects of conflict.<sup>79</sup>

The Royal Australasian College of General Practitioners<sup>80</sup> outlines that refugees are more likely to be affected by psychological disorders (such as anxiety and depression), the physical consequences of torture (such as deafness), undermanaged or unrecognised chronic pain, diabetes and hypertension, poor oral health, infectious diseases (such as TB) and delayed growth or development in children.

The need to address refugee health concerns has grown exponentially over the recent years. Factors contributing to increasing demand for health services for refugees include:

- A rapid demographic shift with over half the quota of refugees now coming from African countries. The health needs of these communities are more complex, interpreter usage has increased, and educational needs of health professionals are greater.
- Department of Immigration policy of settling more humanitarian entrants in rural and regional areas (e.g. Coffs Harbour). Many of these areas have no experience with refugee populations and local health providers require significant support.

- Service providers increasingly recognising that a specialist refugee health service is one of the few medical services that will assist asylum seekers living in the community without Medicare. This is an extremely high needs group with a large and growing impact on clinical staff time.
- The Department of Immigration's practice of charter flights bringing up to 100 refugees from Africa at a time into Sydney and nearby regional areas. The existing refugee health service has been tasked with coordinating health screening across four Area Health Services.

Additional targeted funds are needed to ensure the health needs of refugees are appropriately met.

#### Actions

- NSW Health to increase existing funding to the State-wide refugee health service in order to enhance and expand the provision of existing health services, in keeping with other states and territories, over three years from \$1.28m in year one to \$3.3m in year 3 per annum.
- NSW Health to provide additional funding in order to increase the range and type of health services that are available to people who are refugees, by implementing projects targeted at rural and remote refugee communities, oral health, nutrition and African communities at \$450,000 per annum.

**Cost:** \$1.73m recurrent in 2008-09 to \$3.75 recurrent in 2010-11

### ■ Reproductive Health

#### Results

An improvement to women's access to information, support and appropriate counselling around pregnancy options, with a focus on increasing access to services for young women, women living in rural and remote areas, and women who experience socio-economic disadvantage.

**State Plan:** S1, F3

#### Evidence/Rationale

Since 2001 several factors have combined to restrict access to pregnancy termination services in NSW. These changes have included a decrease in the number of bulk-billing abortion providers, which has in turn led to an increase in the cost of termination of pregnancy. The overall outcome has been an increase in the up-front costs for a termination and an increase in the overall out-of-pocket expense, with some estimates indicating an increase of \$130 in out of pocket expenses.

In addition to this, since the mid-90s the proportion of pregnancy terminations conducted in NSW public hospitals has almost halved. In 2003-04, 4.8% of terminations were carried out in New South Wales public hospitals, compared to 96% of terminations in South Australia.<sup>81</sup> There has been some suggestion that the number of NSW public hospitals providing terminations is as little as three.

Increasing upfront costs and difficulties obtaining a termination from public hospitals has a disproportionate affect on women who are socio-economically disadvantaged, particularly young women and women in rural and regional areas who often face additional transport costs to access termination services. It has been recommended that local information about services for pregnancy termination be improved.<sup>82</sup>

The National Health and Medical Research Council<sup>83</sup> and other researchers<sup>84</sup> have recommended that counselling for pregnancy options (motherhood, adoption and termination) be available for all women seeking it to aid in decision making and, where relevant, post-abortion.

#### Action

NSW Health to fund a state-wide Pregnancy Options Counselling and Support Service to provide counselling, advocacy and brokerage, and to develop and maintain a state-wide referral database and network of health care providers working in the field.

**Cost:** \$374, 610 recurrent

### ■ Sexual Assault Services

#### Results

- Improved mental health outcomes for adult survivors of child sexual assault.
- Decrease in demand on other health and community services, including corrections and homelessness services.

**State Plan:** R1, R2, S1, F3, F4, F5

#### Evidence/Rationale

Researchers estimate that 30% of all women and 16% of all men in Australia have been sexually assaulted as children.<sup>85</sup> Developmental trauma resulting from childhood sexual assault can lead survivors to fall into chronic patterns of disorganisation and destructiveness, which in turn results in increased use of medical, hospital, correctional, social and mental health services.<sup>86</sup>

Sector estimates indicate that that 90% of adults represented in mental health services, drug and alcohol services, corrective services and psychiatric units have a history of childhood sexual assault.

Leading international experts in the treatment of complex trauma argue that survivors require a minimum of three to five years of weekly therapy with an adequately skilled counsellor who can work with these impacts and effects in a holistic way to overcome the impacts and effects of chronic abuse in childhood.<sup>87</sup> Effective, specialist trauma therapy has been shown to dramatically decrease the use of other services such as emergency departments, corrective services, drug and alcohol services and mental health facilities, and is also a more appropriate and humane response.<sup>88</sup>

Adult survivors of childhood sexual assault are routinely turned away from many health services, as they are often considered to be too complex, and their needs beyond the scope of the resources of generalist services. Provision of increased funding for specialist services is urgently required.

#### Actions

- NSW Health to provide additional recurrent funding of \$4.4m to employ 22 additional full time specialist workers in Women's Health Centres and 22 additional full time specialist workers in Community Health Centres in NSW to provide services to Adult Survivors of Child Sexual Assault, men and women. These specialists will provide face to face therapeutic counselling, group work, health education, recreation groups, resources and activities.
- NSW Health to fund four coordination positions, based within a state wide NGO service, to provide supervision, therapeutic direction and professional development of sexual assault counsellors across NSW, and support collaborative practice between agencies to respond to the needs of adult survivors at \$400,000 recurrent.

Cost: \$4.8 million recurrent

### ■ Substance Dependency

#### Results

- An increase in residential rehabilitation services in order to effect lasting change and provide assistance with reintegration into community living for people with a substance dependency.
- A reduction in other costlier health problems by treating substance dependency and enabling the person to improve their health and well being.
- Reduction in personal and social disruption, loss of life and poor quality of life, and a reduction of costs within the justice system.

*Adult survivors of childhood sexual assault are routinely turned away from many health services...*

- Reduction in family and other violence perpetrated to and by people with a substance dependency.

State Plan: R1, R2, S1, S3, F4, F5

#### Evidence/Rationale

Residential rehabilitation is a term used to describe 24 hour, staffed, residential treatment, which offers drug and alcohol intervention programs. It is based on the principle that a structured drug-free residential setting provides an appropriate context to address the underlying causes of substance dependence. The aim of residential rehabilitation is to effect lasting change in an individual and to assist with the person's reintegration into the community.

The Australian Treatment Outcome Study suggests that residential treatment services see clients that are "harder cases".<sup>89</sup> Clients in residential treatment have a significantly higher number of previous treatment episodes, a lower age of first intoxication, have used and injected more classes of drugs, experienced more overdoses and have significantly higher levels of previous suicide attempts and psychopathology than clients in methadone maintenance or withdrawal programs.

In the context of these characteristics, residential rehabilitation services were found to have good levels of short and long-term retention in treatment. After 12 months, residential treatment produced significantly higher levels of abstinence than either methadone maintenance or withdrawal programs, while non-treatment had a 0% rate of abstinence.<sup>90</sup> These findings indicate that residential rehabilitation is an effective treatment option, especially for those clients with more severe drug use and psychological issues.

Although residential treatment has success with "harder cases", this client group should not be considered the sole treatment population for residential rehabilitation services or therapeutic communities. People with less entrenched histories and less dysfunctional characteristics are also responded to appropriately in residential rehabilitation settings.

### Actions

- NSW Health, in consultation with relevant NGO providers, reviews current government funding for residential rehabilitation beds and identifies the actual cost of providing an effective service for a range of client needs with skilled and appropriate staffing.
- NSW Health appropriately funds residential rehabilitation services, taking into consideration specific issues for rural and remote services, services for people with a dual diagnosis of mental illness and substance dependency, young people and Aboriginal and Torres Strait Islander people.
- NSW Health, in conjunction with key NGO services, develops a range of relevant and appropriate residential rehabilitation services across NSW.
- NSW Health increases the number of residential rehabilitation services available especially in rural and remote areas and for Aboriginal communities.

**Cost: Estimates of residential rehabilitation bed provision in NGOs vary from \$117 to \$185 per bed per day.**

NB: It is recommended that all government grant contributions for this type of service be based on the existing benchmark developed by NSW Health (currently \$85 per bed day) and that the costing details be further reviewed. At the existing figure the average 20 bed unit should attract \$620,500 or each bed should be funded at \$31,025.

### ■ Youth Health

#### Results

- Increased access to health services for young people in NSW.
- Improved health outcomes for young people who are at increased risk due to marginalisation related to homelessness, isolation, poverty, unemployment, educational disengagement, abuse, age, cultural background, family breakdown, mental health, drug and alcohol misuse and sexual health problems.

**State Plan: S1, S2, S3, S4, F3, F4, F5**

#### Evidence/Rationale

Young people are the future of our society. Young people aged 12-24 years represent 17.4% of the population of NSW.<sup>81</sup> Young people who are healthy and connected to their communities are better equipped to encounter adverse influences, which in turn enhances their ability to build the social and economic wealth of their community and NSW.

According to the third national statistical report on the health and wellbeing of Australia's young people aged 12-24, most young people in Australia are faring well, however significant areas of concern remain: Aboriginal and Torres Strait Islander young people and young people from lower socio-economic backgrounds continue to be disadvantaged across a broad range of health and socioeconomic indicators. The report also indicates that there are rising hospital separation rates for some chronic conditions and high rates of mental illness and some communicable diseases amongst young people, with mental disorders accounting for almost 50% of the total disease burden among young people in 2003.<sup>82</sup>

Youth health services, youth centres with health outreach models, and youth health coordinator positions are currently limited in number and geographical reach. For example, the majority of young people living in rural NSW do not have access to these services/positions and where youth-specific health services do exist, young people are likely to experience lengthy waiting lists due to under-resourced services.

Young people continue to experience barriers in accessing health services making targeted health service provision essential. Mainstream services have demonstrated a limited capacity to provide appropriate services that reflect young people's developmental stage, cultures and changing needs.<sup>83</sup> Barriers to health services broadly relate to the availability, accessibility and equity of health service delivery. In two studies based in Sydney and wider NSW,<sup>84,85</sup> young people identified barriers to accessing health services. These included concerns about confidentiality breaches, trust in the service providers, feelings of embarrassment when discussing personal issues, cost of services and lack of awareness of services and how to access them. In addition, youth workers and community-based health service providers indicate that the number of bulk-billing general practitioners available to young people is declining, creating further disincentives for young people to access preventive primary health care when needed.

#### Actions

- NSW Health to establish area-based Youth Health Coordinators for all Area Health Service zones in NSW at \$1m recurrent.
- NSW Health to establish youth health services in Area Health Service zones which currently do not have youth specific health services. This will include \$2m recurrent for outreach youth health facilities for regional and rural NSW; \$1.25m recurrent for youth health facilities for regional and rural NSW; and \$1m recurrent for new youth health services in metropolitan Sydney.

- NSW Health to enhance existing youth health service provision to ensure equity of health service provision to young people across NSW at \$2m recurrent.

Cost: \$7.25m recurrent

## ■ Women's Health Program

### Results

- Women's health and well-being is improved, especially amongst disadvantaged groups
- Enhanced sustainability and capacity of the NSW women's health program to deliver services that support the health and wellbeing of women in NSW through community development and prevention and early intervention strategies that use a social approach to health care.
- Decrease in demand on other health services.

**State Plan:** S1, S2, S3, F2, F3, F4, F5

### Evidence/Rationale

Gender is a core determinant of health. Across their lifespan women's health is fundamentally shaped by biological factors and gender roles.

In 2000, NSW Health adopted a policy framework approach recognising that gender leads to different social, economic and political opportunities for women and men.<sup>95</sup> These inequalities can create, maintain or exacerbate exposure to risk factors that endanger health. They can also affect access to and control of resources, including decision making and education, which protect and promote health.

A multiplicity of factors - including biological, social, cultural, environmental and economic - influence women's health status, their need of health services and their ability to access appropriate services. In particular women's health needs stem from the fact that:

- Women are more socially disadvantaged than men in terms of poverty, education and power. Socially disadvantaged people are more likely to become ill.
- Women are more likely to use health services because of their social role as carers of children, older people or people with disabilities and the extra strain this places on their health.
- Women have particular sexual and reproductive health needs, for example, menses, pregnancy, childbirth and menopause.
- Women are treated differently from men in society generally because of gender inequality resulting in, for example, violence against women and sexual assault.

*Young people continue to experience barriers in accessing health services making targeted health service provision essential.*

As a result of their social circumstances women can experience particular health issues and conditions, for example:

- Women are more likely than men to report at least one long term health condition.<sup>97</sup>
- Women are more likely than men to suffer long and short sightedness, migraine, hayfever and allergic rhinitis, asthma, hypertensive disease, chronic sinusitis and arthritis.<sup>98</sup>
- Women are more likely to report having a long-term mental or behavioural problem.<sup>99</sup> In particular women report anxiety related problems and mood (affective) disorders at one and a half times that of men. Women are also more likely to report high to very high levels of psychological distress than men.<sup>100</sup>
- Stroke, dementia and related disorders, and pneumonia and influenza are more frequent causes of death in women than men.<sup>101</sup>

### Actions

- NSW Health increases funding to Women's Health Centres to ensure a base core recurrent funding minimum of \$300,000. This measure will total \$800,000 recurrent.
- NSW Health increases funding to women's health centres to enable them to meet growth in demand and provide additional services to address the needs of local populations. This measure will total \$1.38m recurrent.

Cost: \$2.18m recurrent

## Appendix D: Gaps in community health identified in responses to NCOSS.

Aboriginal Health	<ul style="list-style-type: none"> <li>• The discreet Aboriginal service system brings a complexity to how NGOs work with this population. There are sensitivities around engagement with Aboriginal people and this area requires clarification to enable better access to assistance via mainstream NGOs.</li> <li>• Huge gap in terms of low cervical screening rates in Aboriginal communities and higher rates of morbidity and mortality from cervical cancer.</li> <li>• Higher rates of sexually transmissible diseases and higher rates of teenage pregnancy in rural Aboriginal communities.</li> <li>• The current sexual health clinics and women's health nurses are stretched to provide services across large AHSs and are often visiting small towns infrequently with little capacity to do more recruitment of the hard to reach clients.</li> <li>• Community health services need to work in partnership with relevant NGOs such as Family Planning NSW and the AMS to provide coordinated clinical services, health promotion and community education to address these gaps.</li> <li>• In 2003, RACGP conducted the Aboriginal and Torres Strait Islander project and highlighted the need for the following to occur:             <ul style="list-style-type: none"> <li>• Breast and cervical screening should be promoted in such a way that women understand why it is important and can make informed decisions about participating.</li> <li>• Education should be an integral part of screening programs and services.</li> <li>• Indigenous women should be actively involved in the design and delivery of health promotion for their communities.</li> <li>• Peer educator programs should be supported and evaluated in Aboriginal and Torres Strait Islander communities.</li> <li>• Locally culturally appropriate health promotion resources should be available for use in screening programs for Indigenous women. These should use appropriate language and content, be piloted before use, and be made readily available to local service providers, including GPs.</li> </ul> </li> </ul>
Aged & Extended Care	<ul style="list-style-type: none"> <li>• Many NGOs working in the mental health area do not have age as a criteria for service access rather they focus on function.</li> </ul>
Community Rehabilitation	<ul style="list-style-type: none"> <li>• It is vital that access to community rehabilitation be possible direct to NGOs from the community rather than via clinical services which is the current situation for some of the newer mental health programs.</li> </ul>
Drug & Alcohol	<ul style="list-style-type: none"> <li>• Prevention.</li> <li>• Early Intervention.</li> <li>• Partnership with mental health services.</li> <li>• Availability and access.</li> <li>• The difficulty for some clients to access a clinical model.</li> <li>• No evidence that best practice is being used.</li> <li>• Conduct thorough need assessment of community that informs service planning.</li> <li>• Service planning not inclusive of NGOs.</li> <li>• Need to promote their activities and services to the</li> </ul>

	<p>community.</p> <ul style="list-style-type: none"> <li>• Real partnerships with NGOs to compliment each other's work.</li> <li>• Community health defines itself.</li> <li>• Seeks robust partnerships with other local service providers.</li> <li>• Start promoting to the community the services available.</li> <li>• Focus on services to rural and remote communities.</li> <li>• Youth specific services are lacking</li> <li>• Youth Specific services in regional and rural areas</li> <li>• Increase in youth residential services</li> </ul>
Health Promotion	<ul style="list-style-type: none"> <li>• It is recognised that funding for health promotion over the years has never been optimal both within community health services and NGOs. Much of the funding available is given to the specific campaigns and there is often a lack of general health promotion funding.</li> <li>• NSW Health needs to examine funding for public health services and strive to increase funding to derive the long term benefits to the community.</li> <li>• Funding for health promotion should allow for innovative solutions to local communities or targeted population groups. Current funding models appear to be more directed to population wide messages which are often poorly targeted at disadvantaged groups.</li> <li>• Peer-education models should be better supported as a health promotion model.</li> </ul>
Mental Health	<ul style="list-style-type: none"> <li>• dual diagnosis services</li> <li>• services for young people</li> <li>• broad community based services – specific issues relating to coordinated service provision within and between services; access to services and clinicians; provision of multidisciplinary approach</li> <li>• Evidence is gathered through NSW CAG's consultations. Current consultations focussing on community services are being conducted – a report on these is expected in early 2009.</li> <li>• Crisis response is stretched, no management of clients with dual diagnosis or personality disorders is available</li> <li>• More staff! Also longer term case management programs for complex dual diagnosis and personality disorder presentations</li> </ul>
Multicultural Health	<ul style="list-style-type: none"> <li>• NSW Health has recently identified people from CALD backgrounds as a priority population in its NSW HIV/AIDS Strategy 2006 – 2009. Of particular relevance the strategic directive to: Achieve annual reductions in the rates of gonorrhoea, infectious syphilis and chlamydia among priority populations, one of which is people from CALD backgrounds; and In terms of health promotion, prioritise HIV prevention among people from priority CALD backgrounds.</li> <li>• Refugees have a distinct set of needs in relation to accessing sexual and reproductive health services, and NSW Health have made refugee populations as a priority group, along with recently arrived and emerging communities.</li> <li>• NSW Health continue to implement the strategies in the NSW STI Strategy and follow the principles in the document which include to work in partnership – “Establishes and maintains</li> <li>• effective partnerships with both health and nonhealth</li> </ul>

	<p>agencies and organisations.”</p> <ul style="list-style-type: none"> <li>• Improve access for refugees to a range of health services both public and private; and</li> <li>• Enhance collaboration between health services directed to refugees within NSW, in partnership with community organisations and other government agencies.</li> </ul>
Oral Health	<ul style="list-style-type: none"> <li>• Youth specific services are lacking</li> <li>• Youth Specific services in regional and rural areas</li> <li>• Increased services for young people especially 18-24</li> </ul>
Sexual Assault	<ul style="list-style-type: none"> <li>• Adult survivors of child sexual abuse do not get dequate services within the health system. Community health is the only place for male survivors</li> <li>• Currently sexual assault services have adult survivors as the lowest priority as NSW state health policy. In practice they are not offered a service. Our recommendation is that sexual assault services are adequately funded to provide services to all survivors of sexual abuse, including adults who experienced child sexual assault</li> </ul>
Sexual Health	<ul style="list-style-type: none"> <li>• Long waiting lists, stretched after hours medical response and few counselling services for adult survivors</li> <li>• NSW Health continue to implement the strategies in the NSW STI Strategy and follow the principles in the document which include to work in partnership – “Establishes and maintains effective partnerships with both health and non health agencies and organisations.”</li> <li>• Again, more staff. Designated counselling positions for adult survivors.</li> <li>• There continues to be an increase in sexually transmissible infections (STIs) throughout NSW and more widespread health promotion and screening needs to be performed to curb the increase.</li> <li>• Chlamydia, an STI, continues to rise, especially amongst young people. In the period July 2007 to June 2008, there were 7,463 chlamydia notifications in NSW in the 15 to 24 year old age group, compared to 3,739 in their 25 to 34 year old counterparts.</li> </ul>
Women’s Health	<ul style="list-style-type: none"> <li>• Lack of availability of longer term counseling for women affected by depression, domestic violence, sexual assault etc. This is particularly acute in rural and regional areas.</li> </ul>
Youth Health	<ul style="list-style-type: none"> <li>• Secure funding arrangements are urgently needed for specialized services for marginalized young people. This could be achieved through formal agreement of IHSY Funding arrangement between Commonwealth and NSW Health.</li> <li>• An increase in, or at the very least, continuation of specialized health services for marginalized young people in NSW;</li> <li>• More funding made available for research in to developing and measuring outcomes for services.</li> <li>• More funding made available for increase of resources and services in regional and remote areas.</li> <li>• Limited resources to support and give feedback in regards to impact of youth health services.</li> <li>• Limited resources and services in regional and remote areas</li> <li>• Review of Youth Health Policy to reflect early intervention/prevention framework aimed at improving health</li> </ul>

	status and ensuring identified health outcomes for young people in NSW.
Other issues	<ul style="list-style-type: none"> <li>• Health-related transport is a priority issue, particularly in rural and remote areas. Transport is essential in facilitating access to a range of health services, including community health services. As the provision of health services becomes more centralized it is essential that health-related transport services are adequate.</li> </ul>