SENSW PHN NEEDS ASSESSMENT

AFTER HOURS PRIMARY HEALTHCARE

PRIMARY HEALTHCARE HOMELESSNESS ACCESS

PRIMARY HEALTHCARE CALD ACCESS

RUBRIC CONSULTING & COORDINARE PLANNING AND INSIGHTS TEAM

MAY 28, 2024

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Executive summary

This report presents primary healthcare needs in the South Eastern New South Wales Primary Health Network (SENSWPHN) catchment, focussing on three specific topic areas:

- Primary healthcare needs during after-hours
- Primary healthcare access among people experiencing or at risk of homelessness
- Primary healthcare access by people from culturally and linguistically diverse backgrounds

The report has been prepared with inputs from SENSWPHN's Planning and Insights Team and Rubric Consulting.

Primary health care during after-hours

Unmet demand during standard hours was identified as a significant driver of the need for primary health care after-hours. Affordability of services, a GP workforce shortage, and disparities in the distribution of primary health care services were seen as key challenges hindering the timely delivery of primary health care during standard hours, thus leading to increased demand during after-hours. This was also reflected by a higher number of low-acuity presentations to emergency departments during standard hours compared to after-hours. In addition, the temporary population increase during holiday periods in coastal and snow destinations of the catchment was another factor driving up the need for after-hour services.

In terms of high-need populations, older and paediatric patients were identified as the most common users of after-hours primary healthcare services. Disadvantaged cohorts such as people with low socioeconomic status, the Aboriginal population and those experiencing homelessness were also recognised as high-need populations. Due to limited access to regular primary care, they were perceived to be accessing urgent health care from after-hours or emergency departments.

On-call arrangements by general practices was the most common after-hours service model used across the catchment but was found to have a low uptake for urgent care after-hours needs and was more commonly utilised for non-urgent needs. Insufficient financial incentives for General Practitioners (GPs) and security concerns about opening a practice after-hours were significant barriers to providing urgent after-hours care. Outside general practice on-call arrangements, there were found to be minimal services available to cater to after-hours primary health care needs. Radio Doctors Illawarra is the only medical deputising service in the catchment that provides after-hours home visits and services in the Illawarra and Shellharbour regions. However, the service was found to be facing funding and recruitment challenges, that were limiting their ability to sustain services. Urgent care centres/clinics, though open 8:00 am to 8:00 pm, were found to be addressing urgent healthcare needs during their opening hours and thus reducing after-hours service needs. However, limited geographical coverage by Urgent Care Clinics paired with transport challenges in rural and remote areas was seen as a gap in after-hours service availability.

The Needs Assessment identified a need for after-hours primary healthcare services that support continuity of care. Local practitioners' acceptability of after-hours services was also seen as a vital enabler of a sustainable after-hours service provision model. The need to improve messaging on when to access which service was identified to ensure consistent information across the health services. During the consultation, all participants strongly voiced an integrated approach to meet the after-hours needs, stressing that the SENSWPHN should support collaboration and engagement among primary, acute and urgent care providers to co-design locally-adapted after-hours service delivery across the catchment.

Primary health care access among people experiencing or at risk of homelessness

Being homeless is associated with higher morbidity and reduced life expectancy. Data shows an alarming number of people experiencing or at risk of homelessness in the SENSWPHN catchment. The Snowy Monaro region was found to have a higher rate of population experiencing homelessness than the NSW state, Wollongong LGA was found to be the third highest user of specialist homelessness services, and Southern NSW had a high surge in homelessness after the 2019 Bushfires, which COVID-19 further impacted.

Recognising the unique and complex needs of people experiencing or at risk of homelessness, this Needs Assessment explored challenges and gaps limiting primary healthcare access among people experiencing or at risk of homelessness. Given the vulnerabilities of being homeless, there is low preparedness among people experiencing homelessness to seek care for their health conditions. Stigma, poverty and social exclusion not only resulted in poor health outcomes for people experiencing homelessness but were also seen as barriers to seeking care for their health conditions. Affordability, transport challenges, missing documentation and previous negative experiences were perceived to limit primary healthcare access among this cohort.

However, there was found to be a lack of a policy directive to strategically enhance primary health care, particularly GP access, among people experiencing, or at risk of, homelessness. Consultation with stakeholders working closely with the homeless population, such as Specialist Homelessness Services, revealed that there is a need to introduce robust referral pathways between local homelessness services and primary healthcare providers, including mental health and drug and alcohol services. Additionally, there is need for regionally tailored and collaborative efforts among social and health services to address primary healthcare for people experiencing or at risk of homelessness. Considering the stigma around health service utilisation among this cohort, there is a strong need for GP or nurse-led outreach services co-located with social services where this cohort meets their basic requirements, such as meals, showers, and housing. The need to upskill the primary healthcare workforce to provide non-judgemental care to this vulnerable population also emerged as a high priority.

Primary healthcare access among Culturally and Linguistically Diverse (CALD) communities

With the ever-increasing diversity of the Australian population, it is crucial to consider health needs and service access among people from CALD communities. Older migrants, refugee migrants and recently-arrived skilled migrants were found to be key subgroups of CALD communities with diverse health needs, while noting further variations within these subgroups.

Language barriers paired with low availability and uptake of interpreter services in primary healthcare settings was identified as a key factor that was limiting access to primary healthcare among CALD communities with limited English language skills. Also, there appeared to be a gap in the availability of health programs targeted at health promotion, prevention, and management of the CALD population with high and complex health needs. Given the varied cultural preferences and fear of racism and discrimination, a need to provide skills and knowledge to the health workforce for the provision of culturally appropriate primary healthcare services was identified. The Needs Assessment found that long-term funding and collaborative efforts among primary healthcare services, broader health system and migration support services are required to implement sustainable and scalable solutions to enhance primary healthcare access among CALD communities.

Introduction

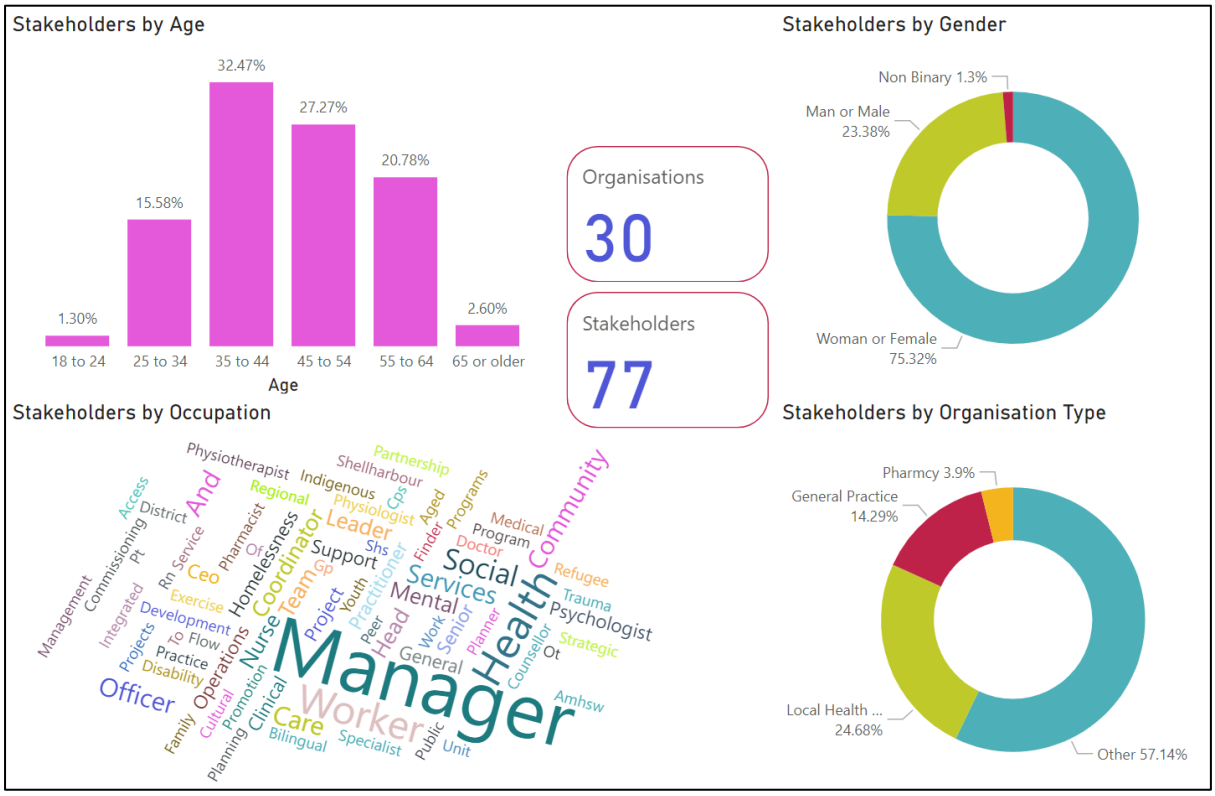
SENSWPHN has undertaken a region-wide primary care Needs Assessment to inform the service planning and commissioning across three areas, given below:

- Primary healthcare needs during after-hours
- Primary healthcare access among people experiencing or at risk of homelessness
- Primary healthcare access by people from culturally and linguistically diverse backgrounds

Methodology

A mixed-method approach has been utilised, with a detailed quantitative analysis of relevant data, a review of literature across the three Needs Assessment areas, and a qualitative inquiry comprising a regionwide stakeholder consultation to comprehensively understand the local needs, service provision barriers, and enabling factors to address those barriers across these three topic areas. The consultation aimed to corroborate and enrich the data trends from quantitative data analysis and address gaps identified from quantitative data analysis. A pictorial illustration of the overall profile of the stakeholders consulted is shown below.

Figure 1. Stakeholder Profile for Needs Assessment Consultation, Dec 2023 to March 2024



Key inputs

SENSWPHN's Planning and Insights Team has conducted quantitative data analysis. Rubric Consulting has undertaken a literature review, stakeholder consultation, and report writing functions for this Needs Assessment.

Section 1: After-hours Primary Healthcare – Needs Assessment

Background

The Alma Ata declaration emphasises the role of primary health care services in providing need-based comprehensive services to prevent disease progression and promote health promotion, thus establishing primary health care as the cornerstone of a health care system[1]. Access to primary health care for individuals seeking access to health care outside regular business hours is an essential element of a robust primary health care system.

Based on the Department of Health and Aged Care's guidelines, After-hours primary health care is defined as "accessible and effective primary health care for people whose health condition cannot wait for treatment until regular primary health care services are next available"[2]. Within this definition, after-hours primary health care is to meet urgent patient needs that cannot wait until a patient's regular general practice is open; it is not intended to be a substitute for medical care that could otherwise occur 'in hours'.

It is generally defined as service provision outside social hours, which is:

- before 8:00 am and after 6:00 pm on weekdays
- before 8:00 am and after 12:00 pm on Saturday
- all day on Sundays and public holidays

It is further categorised into the sociable after-hours period (6 pm to 11 pm on weeknights) and the unsociable after-hours period:

- 11 pm to 8 am on weekdays
- outside 8 am to 12 pm on Saturdays
- all day Sundays and public holidays

For continuity of care, it is considered preferable for after-hours primary care to be delivered by a patient's usual GP. When a patient's usual GP is not available, other after-hours services should only be used for an urgent health concern that cannot wait until regular services are next available[2,3].

Many GPs provide after-hours care to their patients through extended practice hours, on-call arrangements, and GP cooperative arrangements involving GPs from several practices providing after-hours care by participating in a shared roster system. Several other after-hours primary care arrangements exist outside of general practice settings to provide urgent care. These include medical deputising services (where GPs contract another service to provide after-hours services on their behalf), dedicated after-hours services (GP and nurse-led clinics that only open during the after-hours period), telephone triage and advice services (which involve telephone-based nurses and GPs providing advice and directing people to the most appropriate point of care) and hospital emergency departments.

The availability and accessibility of after-hours primary health care are crucial elements of high-quality health care, as they facilitate timely management, improved health outcomes, and lower avoidable hospitalisation rates.

Purpose of SENSWPHN's After-hours Needs Assessment

SENSWPHN is one of 31 PHNs in Australia that were established to increase the efficiency and effectiveness of health services for patients, particularly those at risk of poor health outcomes, and improve coordination of care to ensure patients receive the right care in the right place at the right time.

SENSWPHN receives funding from the Commonwealth Department of Health and Aged Care to address gaps in after-hours primary health services and improve service integration within the PHN Region.

The key Program Objectives of the PHN After-hours Program are to

1. To develop regional responses to address the after-hours primary healthcare needs of local communities and support the after-hours primary healthcare workforce
2. To promote coordination between services at a local level and support after-hours service providers to integrate care with a patient's usual primary care provider
3. To address gaps in the availability of after-hours primary health care services
4. To reduce non-urgent attendances at hospital emergency departments in the after-hours period

In line with these key objectives, SENSWPHN undertook a regional Needs Assessment to understand key after-hours primary health care needs and service provider perspectives around enablers and barriers to delivering effective, efficient, and appropriate after-hours services in accordance with regional needs.

Methods

A mixed-method approach was utilised where:

- A rapid review of the relevant literature was undertaken to gather existing information on demand, service models, policy context, previous reviews and evaluations of after-hour services
- Quantitative data from multiple applicable sources were used to understand the need, availability and uptake of After-hours services, including insights from SENSWPHN's Population Health Profile and Health Needs Assessment.
- Quantitative data and the literature review's findings were used to inform stakeholder mapping and the line of inquiry for a qualitative exploration of health service providers' perspectives, which was undertaken through extensive stakeholder consultation.
- In-depth semi-structured interviews and focus groups were conducted with representatives from General Practices, Pharmacies, Illawarra Shoalhaven Local Health District (ISLHD), Southern New South Wales Local Health District (SNSWLHD), and Urgent Care clinics.
- Thematic analysis of qualitative data was undertaken using NVivo12

Literature review

Need for after-hours services

Demand for health care services, including after-hours, is on the rise due to an increasing population, a higher burden of chronic disease, an aging population, and a shortage of GPs, particularly in the after-hours period. Health service user data for 2022-23 shows that 45.6% of people waited for 24 hours or more for urgent medical care by a GP[4].

The types of health issues requiring access to primary after-hours care can vary greatly (e.g. sudden onset of an acute illness, injuries, exacerbations of chronic conditions, worsening of conditions while on palliative care, emergence or exacerbation of a mental health issue, running out of a prescription). Urgent need for health care might also arise in situations where patients are unable to communicate their symptoms, such as infants or patients who have dementia.

Overall, demand for after-hours primary health care services is usually driven by[5,6,7]

- Sudden illness, injury, or worsening of an existing condition outside working hours.
- Patient perception of urgency and need to seek immediate attention for advice, treatment or reassurance
- Inability to access primary care during standard hours because of various reasons such as work schedule or not being able to secure an appointment because of affordability and accessibility barriers

Current after-hours service landscape in Australia

After-hours service availability and access vary greatly across the country. Below are the main models of after-hours service provision, which can be used alone or in combination[8].

1. ***General practice-based services*** - GPs typically offer after-hours access to patients through phone triage, in-office consultations, MDSs, or home visits. RACGP practice guidelines/ accreditation
2. ***GP Cooperatives*** - Cooperatives are groups of GPs who collaborate to offer treatment to patients outside of their regular practice hours, typically through roster arrangements. Patients receiving care under these agreements are directed back to their regular clinic for further monitoring.
3. ***Medical Deputising Services*** - The National Association for Medical Deputising Services defines a Medical Deputising Service (MDS) as an organisation that arranges for medical practitioners to provide after-hours medical services to registered medical practitioners' patients during their absence or request. An MDS must offer continuous access to care, including home visits, during after-hours. There is a mix of national and local MDS available across Australia, such as Doctors on Demand,
   An Approved Medical Deputising Service (AMDS) belongs to a subset of MDSs whose accreditation under a Commonwealth workforce program enables 'other medical practitioners' (OMPs), usually prevented from claiming MBS rebates, to provide MBS-rebatable services. The AMDS program aims to increase the number of doctors available to provide after-hours services. The program also provides OMPs, including overseas trained and junior doctors, with vocational experience in supervised deputised positions.

4. ***Telephone and Triage services*** - Healthdirect is a 24/7 telephone-based nurse triage, information, and guidance service available in all states and territories except Queensland and Victoria, which have state-specific programs.
   After-hours GP Helpline (AHGPH) is an extension of Healthdirect that offers telephone-based medical advice for those who cannot access their usual health service. The AHGPH is for those who cannot wait for regular general practice services, are unable to see their usual GP after-hours, do not know where to seek after-hours care, or are unsure about what to do. The AHGPH is open from 6 p.m. to 8 a.m. Monday through Saturday, noon on Saturday to 8 a.m. Monday, and 24/7 on national and state/territory public holidays.
5. ***Urgent care services*** – There are various Commonwealth and state-funded targeted services for providing urgent primary care nationwide.
   Urgent care refers to medical attention required within 2-12 hours for a non-life-threatening illness or injury, such as sprains, bone fractures and dislocations, insect bites, rashes, gastrointestinal illness, urinary tract infections, sexually transmitted infections, minor cuts and abrasions, minor ear and eye problems, and minor burns. Urgent care does not replace health and medical services that a doctor would provide in a regular general practice setting.

Challenges with after-hours service provision

Current arrangements for after-hours service provision have several complex challenges that must be addressed to ensure that services are appropriate and support quality and continuity of care for consumers. Research and previous reviews of after-hours services in Australia show that difficulty in accessing in-hours care leads to high demand in the after-hours period[2,5,8]. Thus, the challenges and complexities of providing after-hours care are compounded by obstacles associated with delivering primary health care during regular business hours.

Disparities in the availability of primary healthcare

Disparities in the availability of primary care services are a significant accessibility barrier for populations residing in regional areas. The number of services per person in the rural lowest-access regions is less than half that of the major cities[9]. There is considerable evidence that rates of potentially preventable diseases and avoidable hospitalisations increase significantly with geographical remoteness[10]. Data from the Australian Institute of Health and Welfare shows relatively lower access to after-hours services in rural and remote areas; only 9% of people living in regional areas accessed a Medicare-subsidised GP compared to those living in metropolitan areas (20%)[10].

GP Workforce shortage

In Australia, health workforce planning has typically been supply-led rather than need-based, resulting in oversupply in some areas and under-supply in others. There is a shortage of GPs in rural and remote areas, further compounded by recruitment and retention challenges[9,11]. This workforce shortfall is exacerbated by issues specific to after-hours, such as GPs prioritising work-life balance, employee GPs being less keen on working after-hours than partners, feminisation of the GP workforce, female GPs being less inclined to work after-hours, ageing GP workforce in rural areas[12]. In the 2014 review of after-hours primary health care, the GP workforce issues were consistently highlighted as the biggest challenge in providing after-hours primary care arrangements[5].

Affordability

Increasing out-of-pocket costs immediately impact patients' access to free and timely GP health care for patients, particularly those of low-income groups. The maldistribution of GPs, particularly in regional and remote areas and the failure of the Medicare benefit schedule fee to keep pace with increases in practice costs are key factors driving up the out-of-pocket expenses for primary health care. For GPs to provide affordable care to their patients, financial viability is crucial for sustainable after-hours service delivery in general practice settings.

Awareness and appropriateness of services

In events of onset or exacerbation of a health issue outside regular business hours, patients' decision-making on where to seek help is influenced by a range of factors such as location, time of the day, available services and mode of delivery. Factors such as health literacy, knowledge of how to navigate the healthcare system, fluctuation in availability of after-hours services, age, and health conditions impact help-seeking behaviours[8].

Perceived necessity and urgency are the primary reasons for seeking after-hours medical care. Nevertheless, physicians rarely evaluate presentations with the same urgency as patients[14]. An Australian study found low levels of agreement between patients and clinicians on perceived urgency and safety to wait for issues to be assessed, which indicates potential inefficiency in primary care use after-hours[15].

In addition to patient perception, patient awareness plays a huge role in assessing where to seek help for their health needs. The 2020 PHN After-hours program review identified the need for clear information for consumers about where and how to access services[16]. National primary care policies have been focused on reducing unnecessary emergency department attendances by providing more responsive urgent care services and guiding patients to 'the right place'. However, various services have created a complex, urgent care landscape for people to access and navigate. Evidence suggests that patients often struggle to differentiate urgent, emergency and routine care, and their decision to seek help is based on their previous experiences, knowledge of and access to available services[14]. This results in the use of after-hours services as an alternative or extension to general practice services and emergency departments for low acuity conditions.

MBS task force review in 2017 noted that a significant proportion of patients attended after-hours services for all their primary care needs and received no standard GP care during business hours at all[17]. Similarly, a study on patient behaviour in the Australian Capital Territory (ACT) found that non-urgent after-hours presentations were more common in General Practice settings with extended hours than dedicated after-hours services such as walk-in-centres[6]. This shows a lack of awareness around the appropriateness of certain after-hours services and indicates that a mismatch exists between the intended purpose and usage.

Increased demand paired with complexities around awareness, availability and accessibility of after-hour service is believed to increase low acuity presentations to emergency departments, resulting in long waiting times, higher costs and fragmented care[7,16]. There has been an increasing trend of low-acuity presentations to the emergency department both during and after standard GP hours. In a retrospective analysis of 11 million presentations over an 11-year period in the greater Sydney area, it was found that 40% of presentations could be classified as GP presentations and reported an increasing trend of such presentations to emergency departments across all age groups during the study period[18]. Several studies have shown that

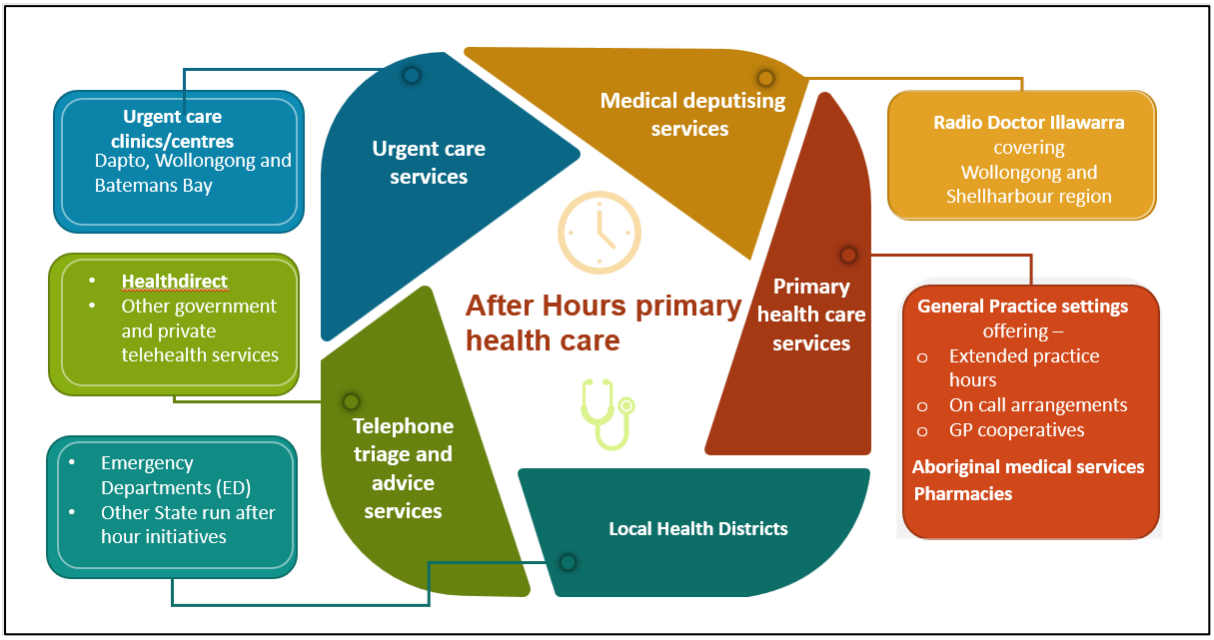
patient preference for attending the emergency department for a lower triage acuity during GP hours was determined by multiple factors such as inability to timely access a GP service or preference, reference from Healthdirect,family orfriend to visit ED, convenience of having access to investigation in ED and patient perception of the severity of their condition to be treated at an emergency department[7,18,19,20].

After-hours services in SENSWPHN

Service Availability

In the SENSWPHN region, the main service providers of after-hours primary care include general practices, pharmacies, Healthdirect, Urgent Care Clinics, state urgent care services, emergency departments, a Medical Deputising Service (MDS) and Aboriginal Medical Services (see Figure 2).

Figure 2. Key service providers of after-hours primary care in SENSW PHN



General practices

General practices provide urgent and non-urgent after-hours care using different service delivery models such as:

- Extended opening hours: General practices providing services outside standard business hours
- On-call arrangements – One dedicated point of call to seek advice, triage and/or treatment from a GP after-hours
- GP collaborative - GPs from different practices forming a collaborative to provide after-hours service to their patients on a shared roaster basis.

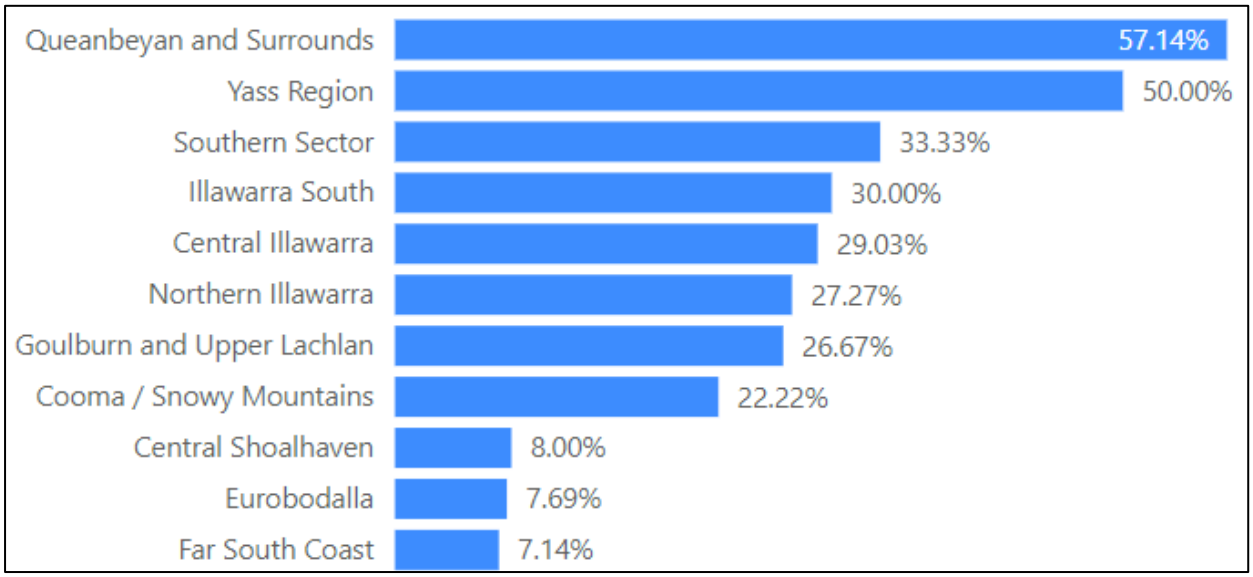
As shown in Figures 3 and 4, in the SENSWPHN catchment, only a handful of general practices are open during the after-hours ascertained periods, with substantially lower after-hours service availability in the southern half of the coastal parts of the catchment.

Figure 3. Percentage of Key Primary Care SENSWPHN Services that are open during at least an hour of the MBS ascertained after-hours period[1]

Service Type	No. of Services Open During the After Hours Period	% of all Services Open During the After Hours Period
General Practice/GP (doctor)	48	24.00%
Pharmacy	74	47.44%
Total	**122**	**34.27%**

Figure 4. Percentage of SENSWPHN General Practices that are open during at least an hour of the MBS ascertained after-hours period by SENSWPHN clusters (medical neighbourhoods)

[as per latest general practice opening hours information drawn from SENSWPHN's stakeholder relationship management system database]



Pharmacies

As shown in Figure 3, a little less than fifty per cent of pharmacies operate after-hours across the catchment. Central Illawarra and Queanbeyan had the highest rates of pharmacies opening after-hours.

Aboriginal Medical Services

Four Aboriginal Medical Services in the PHN catchment provide comprehensive primary health care to Aboriginal people. One of the Aboriginal Medical Services, Waminda, provides an after-hours telephone-based mental health support line for Aboriginal people in the Illawarra, Shoalhaven and Eurobodalla regions who are experiencing worrying thoughts, social isolation, or issues affecting their social and emotional well-being. The service is delivered seven days a week via a telephone service.

[1] Ghosh A, 2024. Secondary Analysis of COORDINARE – South Eastern NSW PHN's Stakeholder Relationship Management Platform. COORDINARE – South Eastern NSW PHN (*Unpublished*)

Medical Deputising Service

Radio Doctor Illawarra is a local MDS available in the catchment, servicing the Illawarra region with after-hours home visits and telehealth consultations.

In addition, some other MDSs operate nationally and provide after-hours telehealth services and in-home visits, such as doctors on demand, 13 SICK. However, none of such services provide home visits across the SENSWPHN catchment.

Urgent care services/clinics

The PHN catchment has three urgent care initiatives – 2 Medicare Urgent Care Clinics (UCCs) funded by the Commonwealth Government (located in Wollongong and Batemans Bay) that work on a model of walk-in clients and 1 Urgent Care Service (UCS) funded by New South Wales Government (in Dapto) where the model requires clients to go through the HealthDirect to obtain an appointment instead of walk-in. These initiatives operate seven days a week, from 8:00 a.m. to 8:00 p.m. (excluding public holidays), and provide free walk-in services for urgent health conditions.

Telephone triage and advice services

Healthdirect – A national helpline offering 24/7 telephone-based nurse triage, information, and guidance services.

Local Health Districts

Illawarra Shoalhaven and Southern NSW Local Health districts cover the PHN catchment. The local districts provide emergency services across the catchment and play a vital role in providing after-hours health care. Emergency departments (EDs) often serve as the primary entrance point into the healthcare system after-hours. However, the high use of EDs for low-acuity conditions may impede their ability to provide appropriate care to those in need.

Utilisation of after-hours services in SENSWPHN

General Practices

At a PHN level, the uptake of after-hours services provided by general practices by the SENSWPHN population seems higher in females and highest for the older age groups of 80 years and over persons, followed by the 65-79 years old persons (see Figure 4 and 6). Demographic breakdowns are not available in smaller geographic areas. At a PHN level, the utilisation in our catchment seems lower than Australian averages, with less than 10% of the population having accessed at least one occasion of service in 2021-22. Except for the South Coast area, the utilisation seems to have dropped in 2021-22 for all areas in the PHN catchment (see Figure 7).

Figure 5. Number of after-hours GP services in SENSWPHN, by age group and sex, 2022-23

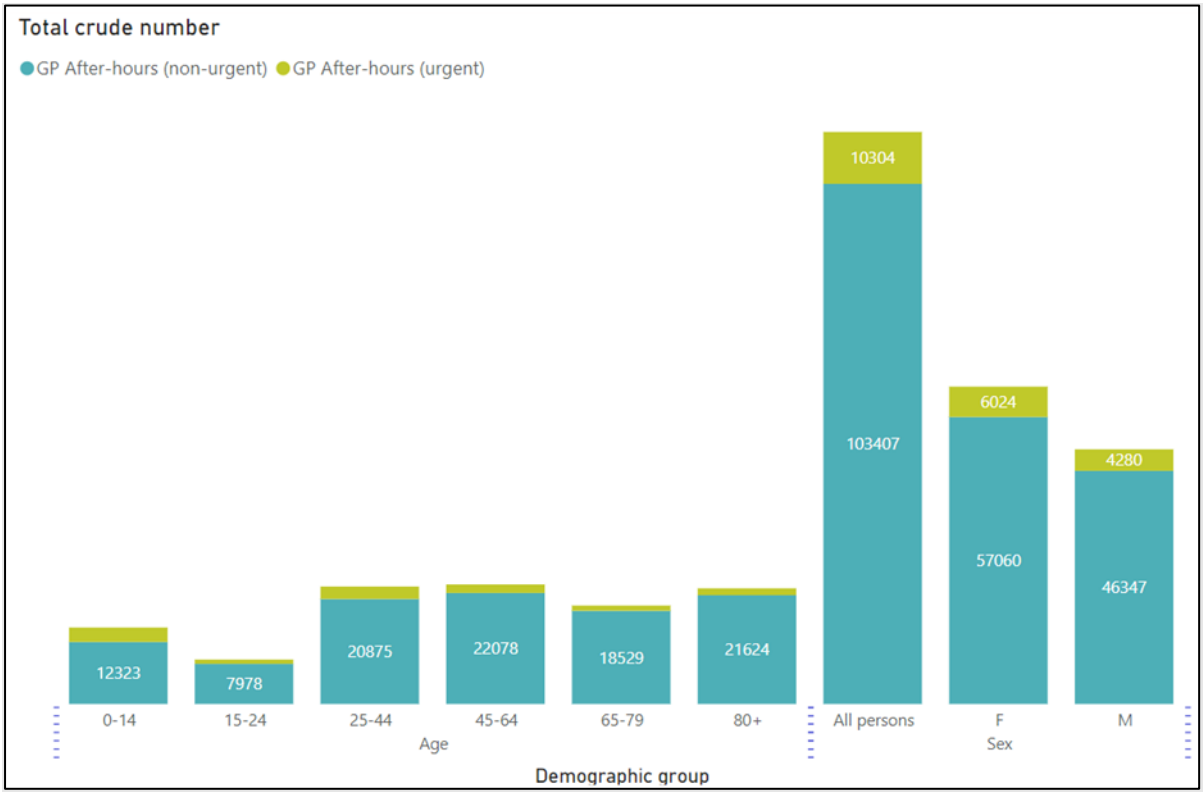
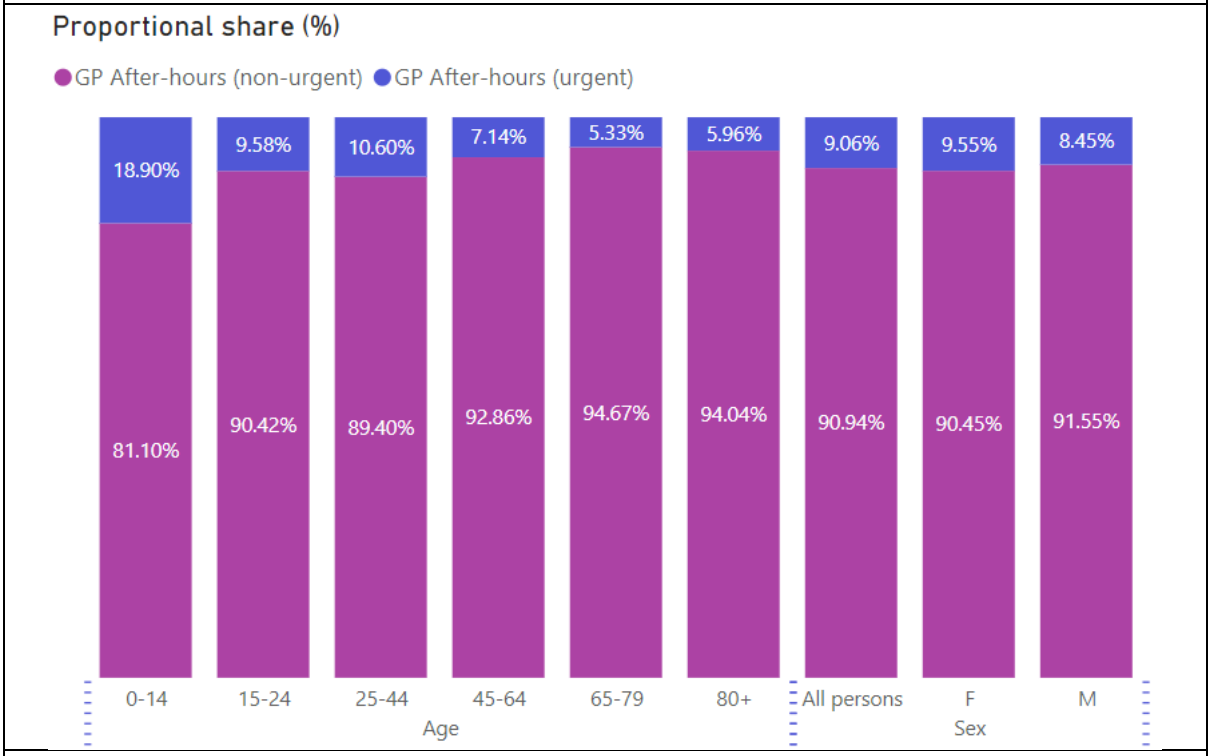


Figure 6. Percentage of non-urgent vs urgent after-hours GP services in SENSWPHN, by age group and sex, 2022-23

South Eastern NSW PHN



Australia (National)

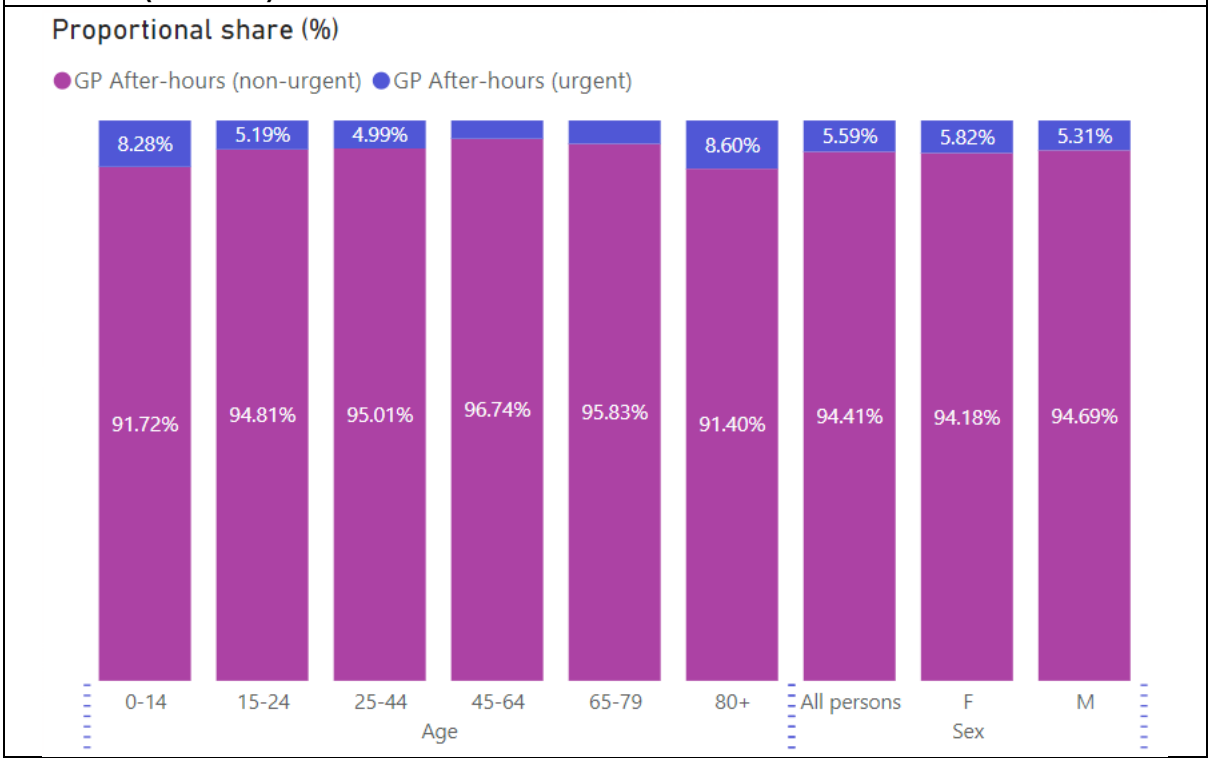


Figure 7. Trends in total GP after-hours service utilisation across Statistical Area Level 3 areas in SENSWPHN - % of resident people who received at least one service

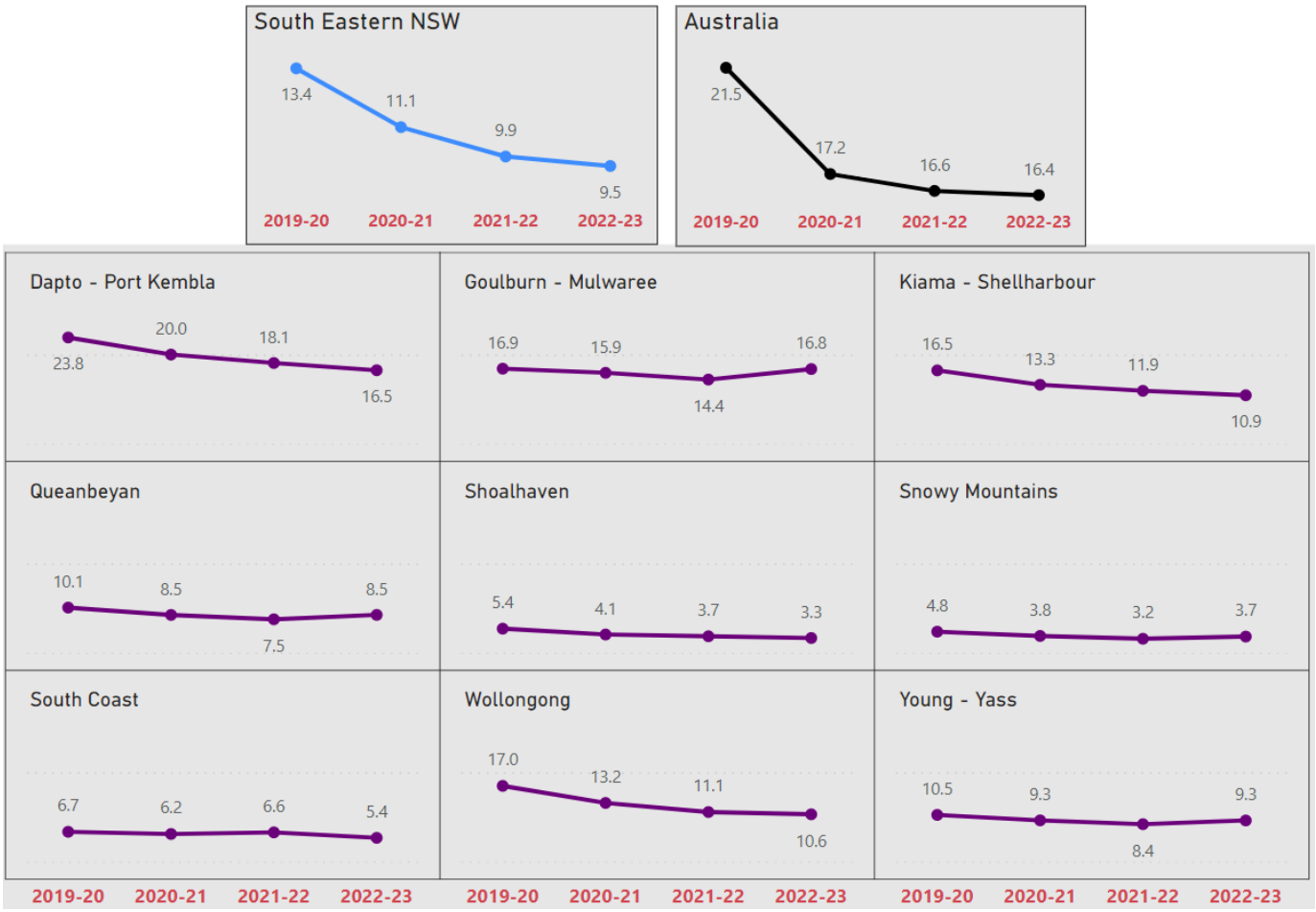
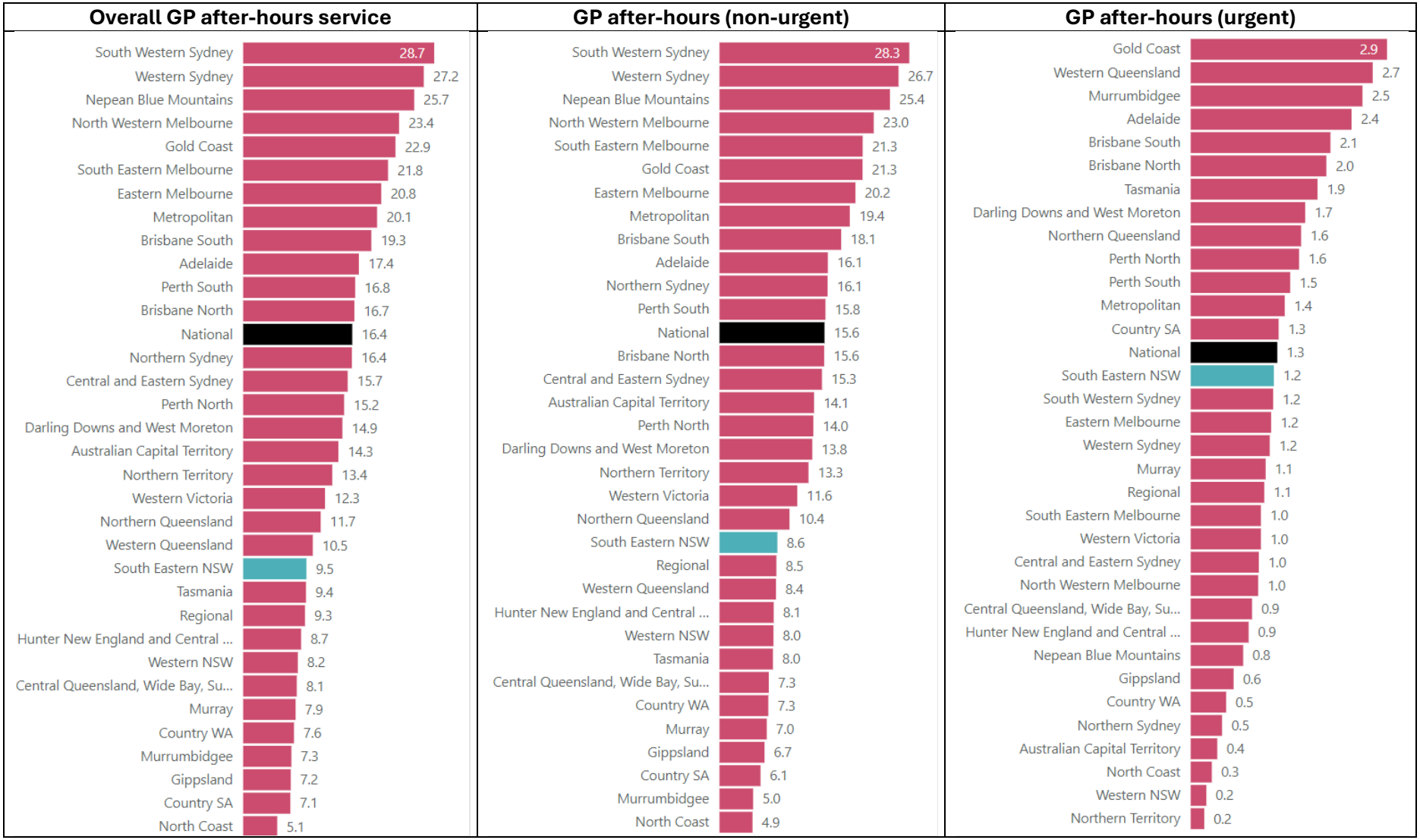


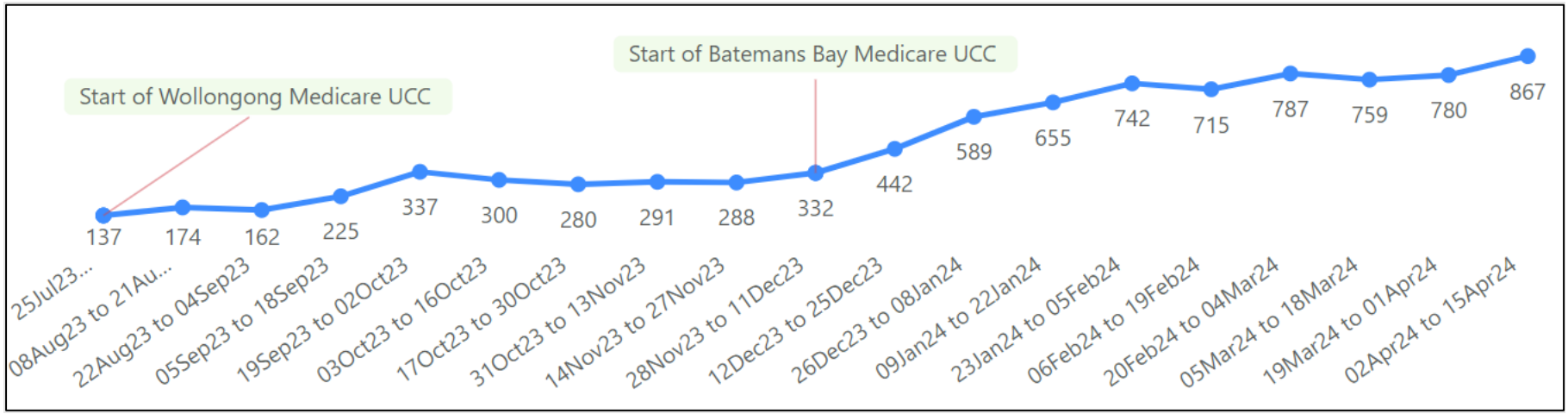
Figure 8. SENSWPHN vs other PHNs - The percentage of resident people who received at least one service, 2022-23



Urgent Care Clinics

Data for Urgent Care Clinics/Services shows an increasing trend in the number of presentations to Urgent Care Clinics across the catchment (see Figure 8).

Figure 9. Total presentations to Urgent Care Clinic sites in SENSWPHN[2]

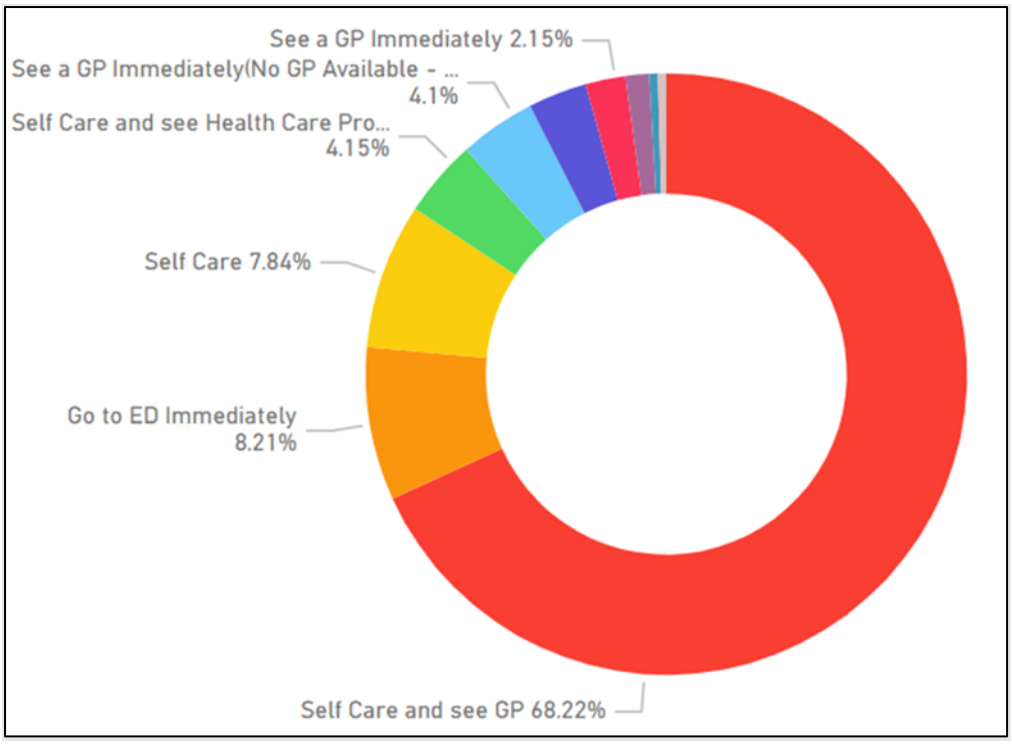


[2] Ghosh A, 2024. Performance Snapshot of SENSWPHN Medicare Urgent Care Clinic (UCC). COORDINARE – South Eastern NSW PHN (*Unpublished*)

Healthdirect

For patients calling Healthdirect, the majority were advised to self-manage and see a GP when next available. Approximately eight per cent of patients were advised to attend the emergency department.

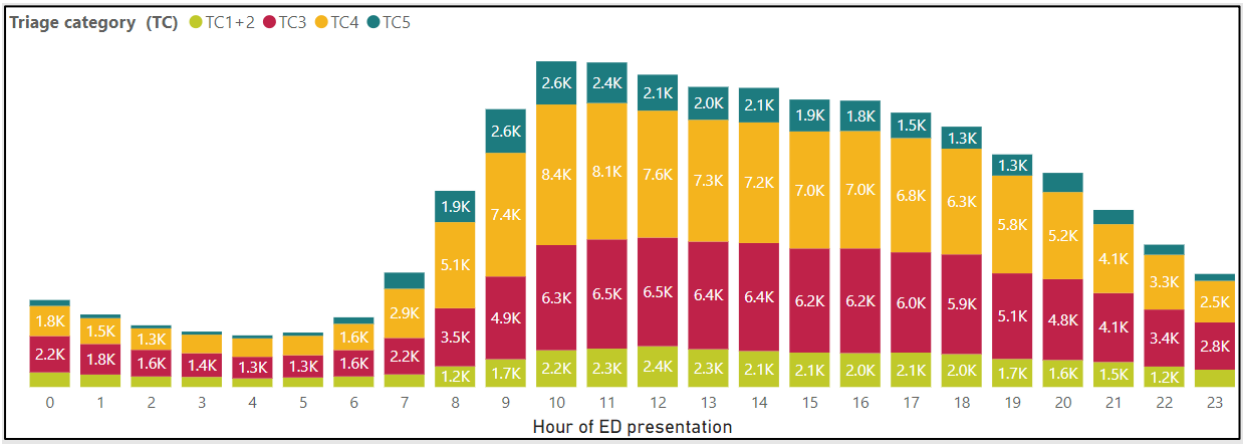
Figure 10. GP After-Hours Helpline – Call Outcomes in SENSWPHN, Jan 2022 to Sep 2022



Emergency Departments (EDs)[1]

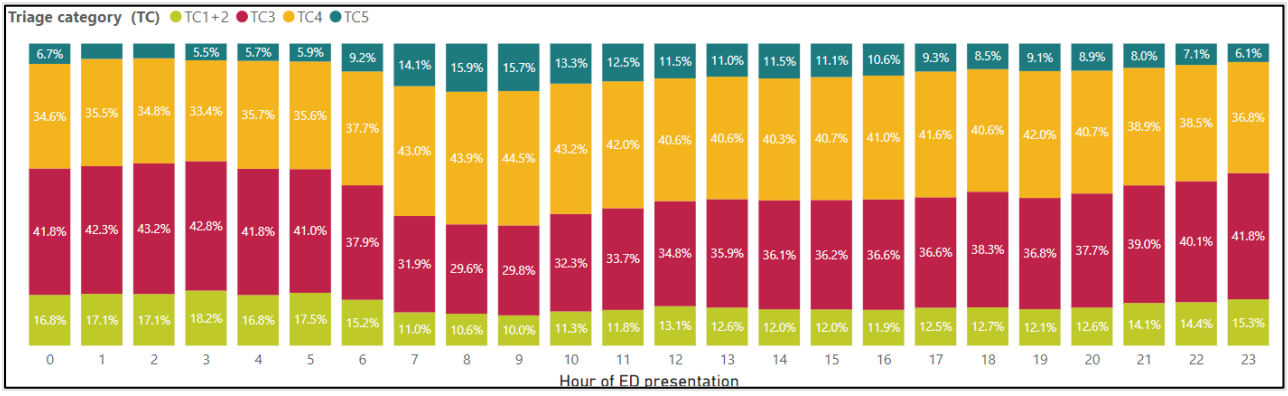
There were 273,840 presentations to emergency departments (EDs) by residents of the South Eastern NSW PHN catchment in 2021-22. The hours of the day for these presentations are shown below.

Figure 11. ED Presentations by hour of the day for SENSWPHN residents, 2021-22[3]



While it is rather clear from the above graph that the bulk of ED presentations occur during the usual business hours, the distribution of the 5 triage categories* of ED presentations for each hour of the day for the entire financial year of 2021-22 are shown below.

Figure 12. Proportional share of each triage category in every hour of the day for ED Presentations for SENSWPHN residents, 2021-22



* Triage category (TC): This is used in hospital emergency departments to indicate the urgency of the patient's need for medical and nursing care. Patients are triaged into 1 of 5 categories on the Australasian Triage Scale. The triage category is allocated by an experienced registered nurse or medical practitioner.
Resuscitation (triage category 1)
Emergency (triage category 2)
Urgent (triage category 3)
Semi-urgent (triage category 4)
Non-urgent (triage category 5)

In assessing the needs from a primary care service provision perspective, the concept of Low Urgency Care is more pertinent to be analysed. 'Low Urgency Care'[4] is defined to include presentations at formal public hospital Emergency Departments (ED) where the person had a type of visit to the ED of emergency presentation; was assessed as needing semi-urgent (triage category 4) or non-urgent care (triage category 5); did not arrive by ambulance, or police or correctional vehicle; was not admitted to the hospital, was not referred to another hospital, and did not die.

Amongst all the total presentations in 2021-22, 41.3% of ED presentations by SENSWPHN residents were low-urgency care presentations (see Figure 12). However, even for low urgency care presentations, the volumes in South Eastern NSW PHN were higher during regular business hours rather than after-hours, as shown below.

Figure 13. Percentage of after-hours vs in-hours low urgency care ED presentations in SENSWPHN, by age group and sex, 2021-22

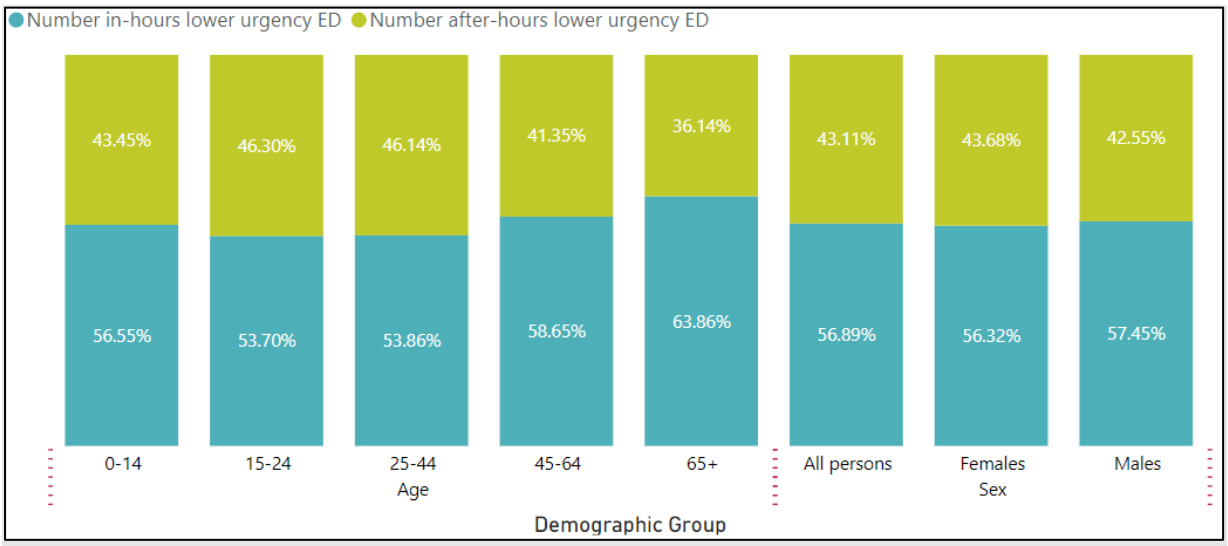
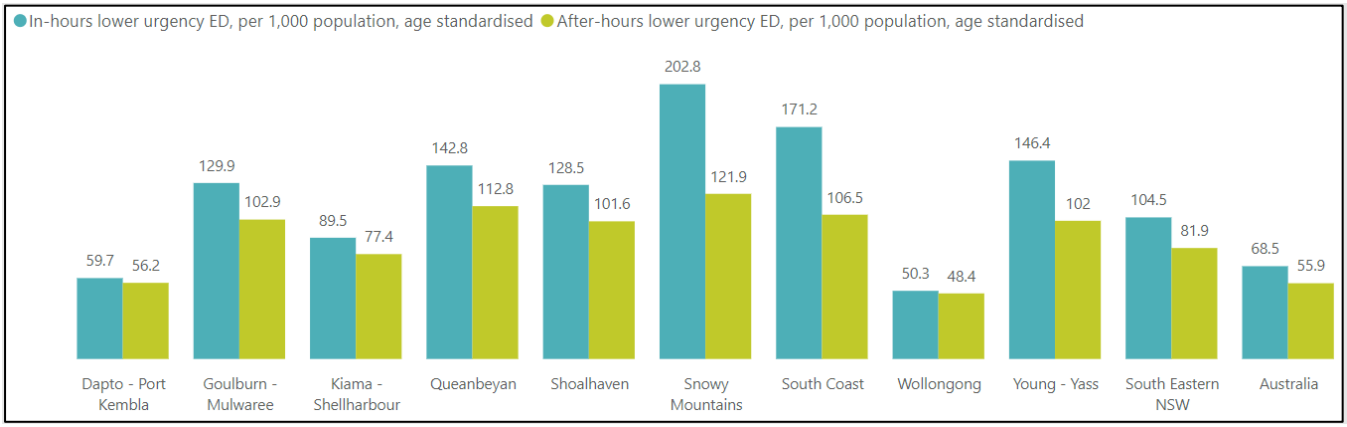


Figure 14. Age-standardised rates of after-hours vs in-hours low urgency care ED presentations in SENSWPHN, by age group and sex, 2021-22



Nevertheless, looking at the crude population rate of low urgency care after-hours presentations it seems the burden is highest among younger age groups and there are some pockets in the catchment with relatively higher population level usage of EDs for lower urgency care that could be deemed as GP-type presentations.

Figure 15. Crude rate of after-hours low urgency care ED presentations for per 1,000 population by demographic attributes, 2021-22

Demographic Category	Age					Sex		
GeoNames	0-14	15-24	25-44	45-64	65+	All persons	Females	Males
Dapto - Port Kembla	65.90	86.60	63.70	36.00	25.00	52.80	55.10	50.50
Goulburn - Mulwaree	117.60	165.90	107.80	67.00	59.90	94.60	93.10	96.00
Kiama - Shellharbour	87.40	104.60	90.20	55.70	37.10	71.90	71.80	72.00
Queanbeyan	151.60	161.40	112.50	71.20	77.70	109.70	112.70	106.80
Shoalhaven	115.10	145.00	120.00	65.60	47.40	87.40	88.80	86.00
Snowy Mountains	146.50	170.80	118.30	88.00	93.90	115.30	115.40	115.20
South Coast	115.80	157.70	121.00	68.00	50.90	86.30	83.90	88.80
Wollongong	55.00	70.60	55.20	36.00	19.80	46.30	45.30	47.20
Young - Yass	124.90	151.60	99.90	66.10	68.00	94.40	96.20	92.40
South Eastern NSW	96.90	115.50	90.40	56.70	43.80	75.60	75.70	75.60
Australia	77.20	75.20	57.50	38.40	27.50	53.50	52.70	54.20

Consultation Findings

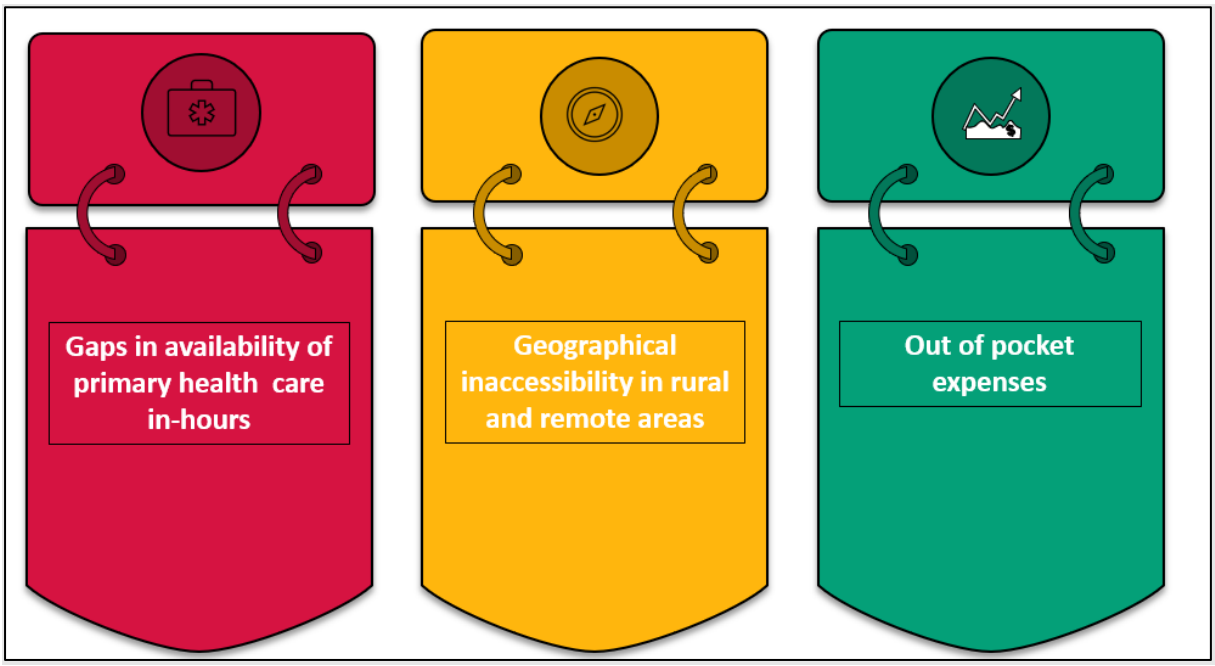
The following essential themes emerged regarding factors driving local demand for after-hours services, factors impacting delivery and utilisation of after-hours services, and factors enabling the provision of after-hours care in the SENSWPHN area.

Factors driving the need for after-hours services

Unmet demand during in-hours

The consultations commonly raised the point of unmet demand for urgent care appointments in the early afternoon pushing into the after-hours period. Figure 16 illustrates the key themes that emerged regarding general barriers to primary health care in standard hours that contribute to the high demand for after-hours care and usage of after-hours primary care outside general practice settings.

Figure 16. Unmet demands during in-hours



Gaps in availability of primary care in-hours – All participants agreed that all regions in the PHN catchment struggled to provide adequate services during regular hours, and this was exacerbated after-hours. Participants emphasised that more availability/flexibility in terms of opening hours could lead to reduced demand for non-urgent medical needs after-hours.

Participants stated that there were substantial wait times to visit a GP during regular business hours within the PHN catchment. It was often raised that as more practices gradually closed their books for new patients, individuals without a regular GP, particularly vulnerable demographic groups such as homeless persons, were at a higher risk of delayed care, resulting in increased demand for after-hours or emergency departments.

"So you might end up having a load of people who turn up to the Batemans Bay Emergency Department in the morning because they've waited overnight until it's daylight hours to access care, and they go to the emergency department because the GPs can't provide them with an appointment in a timely fashion" – A representative from Southern NSW Local Health District.

Geographic inaccessibility in rural and remote areas - Focusing on older people living in rural areas, participants commonly stated that being unable to get a timely appointment with local GPs, combined with a lack of transportation, resulted in delayed or no access to care, confirming that the issue was not always a lack of after-hours service, but rather the availability of primary care in general. GPs from Radio Doctors Illawarra remarked that delivering urgent care through home visits in rural and isolated areas was more complex and often not economically viable.

Out-of-pocket expenses - Affordability was recognised as a barrier to obtaining timely primary health care, particularly for financially poor and vulnerable populations. The decreasing number of practices offering bulk billing to fewer and fewer patients was noted to reduce timely access to primary care, resulting in a significant demand for primary care outside of general practice settings.

"You just can't afford to go and see their GP, so that lower socioeconomic group of patients that are sometimes our most vulnerable can't get into see a GP. So the default is always coming into ED," – A Representative from Illawarra Shoalhaven Local Health District (ISLHD).

The lack of bulk billing practices in the region appeared to be a driving force behind patients reaching out to after-hours urgent care or emergency care providers for their health needs. Radio-doctors, a supplier of medical deputising services in Illawarra, stated that as a bulk billing after-hours service provider, they often attracted patients from disadvantaged groups needing urgent care across the Illawarra region.

In conclusion, there was consensus from stakeholders that limited access to services during working hours typically placed pressure on after-hours systems. Participants from Local Health Districts were particularly critical of ever-changing after-hours service models aimed at reducing unnecessary ED presentations, implying the need to shift the focus to providing more accessible primary care rather than preventing over-burden at emergency departments, as they believed the likelihood of achieving both improved access and utilisation if that is what services were aimed at.

"So it is very frequently talked about as a, you know, ED avoidance strategy, but you know. If you kind of go back to what's the problem you're trying to solve is that people can't get to services during the day," – A representative from ISLHD.

Increased demand in the holiday periods

The SENSWPHN catchment welcomes thousands of tourists over the peak tourist seasons, with coastal locations seeing a seasonal surge in the summer and snowy mountains attracting visitors in the winter months. Discussions commonly raised the issue that low GP availability, along with increasing seasonal demand from visitors during the holiday rush period contributed to a greater need for primary care services. Representatives from both Local Health Districts informed that they often needed to introduce pop-up clinics to meet increasing demand and ease pressure on local emergency departments.

"So it's like over Christmas and the New Year period, for example, in Shoalhaven, which is some of our busiest times, all of the GPs are closed, and we actually have to put on extra clinics to cover that work because people are just can't get into see a GP and it feels like the backup is always you can just go to ED" – A representative from ISLHD.

GPs also indicated increased demand for after-hours services with high number of tourists visiting small towns needing urgent care for cuts, lacerations, respiratory and other general acute illness.

"They're not the chronic disease patients we're seeing in holiday periods. They are a single issue, respiratory illnesses, small injuries, cuts, abrasions, lacerations, those sorts of things that can occur 24/7" – A GP.

People with a high need for after-hour services

General Practices, pharmacies, Urgent Care Clinics, and Local Health Districts all stated that older patients used after-hours services often. All participants agreed that the aging population, along with the burden of chronic illnesses, had resulted in high healthcare demands for older people, both residing in the community and aged care facilities.

"The usual calls that we get, you know, from the care facilities, there's more than 30 nursing homes in town. And there's obviously people who are sick, you know, usually with children" – A GP.

Similarly, health professionals reported increasing numbers of families accessed after-hours urgent face-to-face medical assessments for childhood illness. GPs indicated that parents of young kids frequently contacted them after-hours for reassurance and advice on the clinical urgency of their child's condition.

It is notable that ED data demonstrated a higher after-hours usage by younger patients for low acuity conditions (see Figure 13). According to qualitative data from the consultation, one probable cause is that older persons were perceived to have difficulty driving to EDs and relied heavily on local general practices for their after-hours needs.

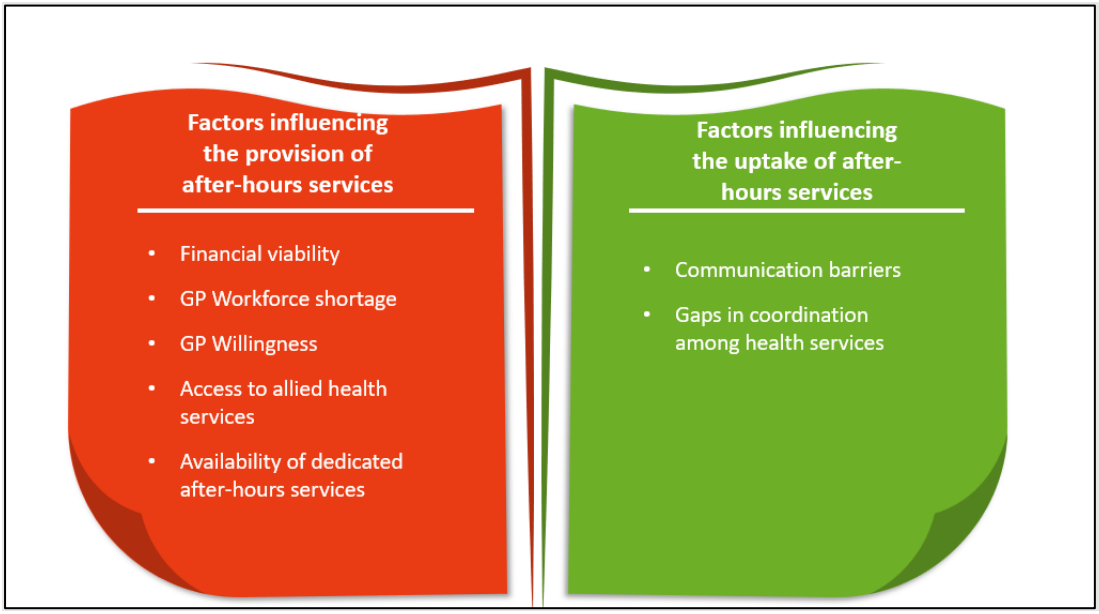
The consultation also emphasised the need to assist hard-to-reach individuals who were perceived to access urgent health care from after-hours or emergency departments due to limited access to regular primary care. Participants suggested that there was a clear need to improve primary healthcare access for these groups, including:

- Aboriginal and Torres Strait Islander population
- People experiencing homelessness
- People with lower socioeconomic status

Factors influencing the provision of after-hours services

The consultation explored challenges and barriers faced by health sector experts and health professionals to assess service provision barriers relevant to local service models and population health needs. Figure 17 illustrates the key themes identified in terms of barriers to after-hours service provision and uptake.

Figure 17. factors influencing the provision and uptake of after-hours services



Financial viability of providing after-hours care

During the stakeholder consultation, representatives from general practices emphasised that MBS rebates for after-hours primary care did not adequately cover the costs of after-hours service provision, making it a financially unviable element for their medical practices. General practices providing on-call after-hours phone services reported that their service provision was driven by goodwill, not financial incentives, as they considered the government rebates insufficient to support their after-hours work.

"Sunday afternoon, I did an urgent call for a terminal patient. I was not going to charge them for that reason. I don't feel comfortable too and the rebate was, I think, $137 for an after-hours emergency call, and the reality is if you had a plumber and electrician, they wouldn't even bring you back in for $137.00" – A GP.

Moreover, it was commonly raised during the consultations that rural practices were at a disadvantage to metropolitan GP practices as it did cost more to run clinics in isolated regions and was more difficult to retain the workforce in comparison to metropolitan areas. GPs stated that the expenses of maintaining a medical practice had greatly increased since the pandemic and Medicare payments had not kept pace. It was also raised that there was a high cost of locums for rural locations if practices did wish to employ someone to provide after-hours care.

As shown in Figure 6, MBS data for SENSWPHN showed that uptake of non-urgent medical services during after-hours was significantly higher than that of urgent medical services. When concorded with responses from stakeholder consultations, it became evident that general practices were not actively delivering in-person after-hours care for urgent health needs

because of low financial return in terms of MBS rebates for urgent care items and lack of remuneration to support non-GP staff members.

GPs noted that when providing after-hours services (as a contractor, employee, member or otherwise) for a general practice or clinic that routinely provided services to patients in after-hours periods at consulting rooms, they were not eligible to bill urgent after-hours. Also, it was emphasised that Medicare payment for urgent care provision after-hours only paid for the time of the health practitioner and didn't include any remuneration for additional general practice staff required to open the practice rooms after-hours. In a nutshell, there was consensus from GPs that their involvement in urgent after-hours services would only be viable if there was a sufficient financial return.

Similarly, pharmacists who were consulted during these consultations raised concerns about the financial viability and security of extending their services to after-hours.

GP Workforce shortage

The stakeholder consultation identified a shortage of GP workforce as a key barrier to the provision of after-hours care across the SENSWPHN region, particularly in the rural and remote areas. Participants stressed that GP shortage not only affected the availability of after-hours care but also impacted access to primary care during normal business hours, with many practices not accepting new patients and long waiting times for patients to secure an appointment within standard hours. It was found that after-hours care models that utilise deputising GP services or GP Co-operatives were also limited by the GP shortage in non-metropolitan areas.

"GP shortage or internal primary workforce shortage internal not specific to after-hours. And if you've got a lack of sustainability in your core hours services, then how do you even have a conversation about what extended after-hours services could look like" – A Local Health District representative.

A 2013 report from the Grattan Institute identified the southeast of NSW, including Queanbeyan, Goulburn, Bega, and Cooma, as having some of the lowest GP access areas in the country[9]. Unfortunately, the trend has not changed much since then as, according to SENSWPHN's Health Needs Assessment, a portion of the Shoalhaven region and predominant areas within the Southern NSW boundary are classified as Distribution Priority Areas, indicating shortages of GP workforce. Based on an assessment of FTE as a rate of the residential, it shows very low GP workforce figures for the Queanbeyan-Palerang Regional and Shellharbour regions[24].

Another key aspect of the GP shortage that emerged from this consultation, was evidence of many GPs supporting both the local emergency department and the practices they owned or worked at. This implied that emergency departments may need to shoulder an additional lack of doctors if general practices in such areas are extended to after-hours without increasing the GP workforce in the region. It was also shown that GPs looking to work outside of ordinary hours preferred emergency departments over general practice since they offered better pay, and their revenue was not affected by changes in the number of patients seeking after-hours care.

"I think probably we don't do it because any doctor that that I know in our area who wants to work after-hours will work at the hospital" – A GP.

As a result, recruitment of GPs was reported to be challenging, particularly for private practices and deputising services, as they could not match wages and conditions offered by the public hospital system.

GPs from rural practices and representatives from Local Health Districts noted that the aging GP population in rural areas was another workforce concern. Older GPs working in rural areas had strong relationships with local communities and were willing to work after-hours when someone was in need. However, stakeholders suspected that there might be a shift in the workforce when these GPs retire and are replaced by younger GPs, who might not be as eager to work after-hours in the absence of significant remuneration.

GP Willingness to work after-hours

The GPs consulted noticed a shift in the medical industry, with a decreased willingness to work after-hours, particularly among younger GPs.

General practices reported that their workforce is tired and overworked. Even if they tried to provide after-hours services, they expected difficulties in getting GPs to work after-hours, as those on contracts had little to no obligation to do so, and those working as employees could not be made to work after-hours due to financial constraints and existing recruitment and retention challenges.

There also appeared to be a decline in the number of practices participating in a GP cooperative model for after-hours care. Though this model of care had positives in terms of continuity of treatment and improved patient access, concerns were raised about practices' waning enthusiasm in participating, with many opting out because of GPs pulling out of after-hours work and lack of financial returns.

Access to allied health services after-hours

During consultations, it was commonly mentioned that limited access to allied health services such as pharmacy and radiology impeded the provision of after-hours treatment. Several GPs stated that even if they strived to extend their working hours to provide after-hours services, their patients might still be unable to obtain pharmacological or diagnostic services unless they attended an emergency department or waited until the next day. Representatives from Urgent Care Clinics also expressed worry about a shortage of local imaging providers who provided after-hours services.

Availability of dedicated after-hours services

Stakeholders reported a significant gap in the availability of dedicated after-hour services such as dedicated after-hour GP clinics and local medical deputising services. Outside of the Illawarra area which is serviced by Radio Doctors, there were no local medical deputising services available where GPs could refer their patients for urgent care. For remote and rural areas, emergency departments were seen as the only alternative where patients could seek after-hours care in the unavailability of their GP.

“I'm not aware that there are any other after-hour services that our patients could access, and that's really what the emergency departments is for, it is a catch all” – A GP.

Factors influencing uptake of after-hours services

Communication barriers leading to limited awareness

Acknowledging that the variety of after-hours arrangements was perplexing for both consumers and healthcare professionals, participants highlighted the need to clearly and consistently communicate to consumers the availability and pricing of after-hours services. Some recommended that a single-entry point for after-hours treatment could be used to direct patients to the most appropriate alternatives, making it easier for consumers to navigate the healthcare system.

For example, several pharmacists reported that they frequently sent patients to the hospital if they needed after-hours care. Although the pharmacists interviewed did seem to be aware of local GP partnerships that provide rotating\ after-hours care, they felt they were not up-to-date on which practice or GP was working on a given weekend.

"We do know that the local GPs take it in turns to open after-hours but nobody lets us know in advance. What GP it is or like where to send patients so we always have to call up and get the phone number, and it's I think that's what makes it more difficult for patients too is the fact that we can't direct them straight to a place or straight to a number" – A Pharmacist.

It was found that many practices had an on-call arrangement in place to provide after-hours care, with a GP accessible to answer phone calls for triage, advice, and/or potentially assessing their patients. However, GPs reported extremely low uptake of this service, with some claiming that it was not heavily advertised or communicated to patients because their practices would be unable to cope with high demand for such services due to funding, GP availability, and security concerns about re-opening practice rooms for urgent consults.

The MBS Review 2017 found that advertisements by medical deputising services and general practices operating for longer hours were creating supply-driven demand, and uptake was driven by patient convenience instead of need[17]. As a result, advertisement restrictions were placed on medical deputising services, general practices and other regulated health services to ensure appropriate uptake of services. However, stakeholders believed that such restrictions on advertising had negatively impacted consumer and health professionals' awareness, resulting in reduced uptake of medical deputising services.

In the case of Urgent Care Services/Clinics, differences between state and federal marketing strategies were found to cause patient awareness complications in the Illawarra area. The state model preferred Healthdirect as the first point of contact before a patient enters an Urgent Care Service, but the federal model advocated a walk-in approach.

Gaps in coordination among health services

The RACGP's Standards for General Practices (5th edition) requires general practices to have awareness and suitable arrangements in place for their patients to access after-hours services[3]. However, the consultation found some gaps in coordination for after-hours services among health professionals, including GPs, demonstrated by variance in views on what after-hours arrangements were available and how they were advertised to patients. On some occasions, patient needs were seen to be perceived as either emergency or something that could wait until their GP was available, not acknowledging the urgent nature of some low acuity conditions.

Representatives from Local Health Districts reported a significant number of inappropriate ED referrals by GPs that could have been better managed by referring them to hospital outpatient

departments. They also noted a need for improved awareness of state-run after-hours programs, such as virtual care clinics in general practices, so that GPs can make appropriate referrals.

Similarly, GPs reported a significant gap in contact with the hospital system to ensure continuity of care for discharged patients and to keep the general practice informed of upcoming hospital redevelopments or expansions, which can significantly impact primary health care delivery. GPs also expressed that limited information was available about specialist clinics run by the hospital system.

"I think the other thing from my point of view that that sort of underpins this lack of contact in the whole system is that there's no process by which the hospital links to us as GP in any meaningful way" – A GP.

Factors enabling delivery of after-hours services

Acceptability of services

Multiple GPs highlighted the need for new services or models of care to be acceptable for local GPs in terms of impact on their business and continuity of care for their patients. Some GPs raised that short-term programs funded to provide after-hours care negatively impacted their patient retention and resulted in fragmented care. They emphasised the importance of long-term and sustainable after-hours services to ensure consistency in patient expectations and awareness.

It was commonly raised that service providers must grasp the sociological and geographical aspects of their local communities and service landscape to provide appropriate services and referrals. Some participants were sceptical that Healthdirect and private telehealth after-hours services lacked insights into local context and consumer needs. Some expressed concerns about a lack of engagement with local service providers and the community over the location of Urgent Care Clinics.

Overall, it was also noted that introducing new services in competition with established general practices would negatively impact care delivery and consumer-clinician relationships, emphasising the importance of codesigning service models with local primary health care providers that were tailored to the community's needs.

Appropriateness of services

Participants' perspectives on the distinction between urgent care and after-hours within the context of extended-hours services were diverse, implying that more clarity is needed about what constitutes appropriate use of after-hours care and how it differs from normal service provision for extended hours.

Many respondents expressed concerns about the use of after-hours and urgent care services for routine conditions. They believed that inappropriate uptake of after-hours services for non-urgent treatment resulted in fragmented care. However, some respondents highlighted that such uptake was driven by patient perceptions of urgency, bulk billing or no cost to patients, and unmet needs from primary health care in general.

Themes conveyed to enable appropriate delivery of after-hour services included adequate triaging across all service models and service providers' understanding of the extent of available alternatives.

Continuity of care

There was consensus from participants that there was a need for improved coordination and integration of after-hours services to ensure continuity of care so that when a practitioner other than the individual's regular GP provides after-hours services, notification should be communicated to the regular GP as soon as possible for follow-up and continuity of care. Representatives from general practices highlighted that changes in availability and uptake of after-hour services created fragmented care for their patients.

Telehealth

The discussions explored how telehealth may improve access to after-hours care, particularly given the fast use of telehealth services during the COVID-19 pandemic. Participants were generally supportive of utilising telehealth measures to enable better access to after-hours care and concluded that telehealth was increasingly becoming a part of primary health care, including after-hours services. At the same time, it was emphasised that telemedicine cannot replace in-person consultations, particularly for physical examinations. Thus, it was urged that telehealth be integrated into a broader range of services for advice and triage purposes rather than as a standalone component.

Recommendations

After-hours care is complex and challenging to deliver and needs joint planning and implementation across key health service providers. The consultation identified that primary, acute and urgent care services need to engage, collaborate and integrate to address the gaps in after-hours care provision. Suggested areas for improvement included:

- Facilitating collaborative planning and coordination efforts with local general practices, medical deputising services, urgent care services and local health districts to address systemic concerns impacting the availability of accessibility after-hours primary healthcare
- Improving engagement and communication between GPs and the acute health sector to share their respective experiences of after-hour service provision and to facilitate collaboration
- Educating GPs on how to utilise and refer to state-led clinics such as virtual care clinics
- Strengthening referral pathways between acute and primary care services
- Ensuring consistent messaging regarding where to access appropriate care after-hours and how to determine what is available

Section 2: Primary health care access for people experiencing or at risk of homelessness – Needs Assessment

Background

Homelessness is a significant health and social concern in Australia. The most recently available data from the 2021 Australian Bureau of Statistics (ABS) census estimates that more than 122,000 people are experiencing homelessness in Australia. However, this figure is likely underestimated given the challenges in gathering this data[25].

The Australian Bureau of Statistics (ABS) defines homelessness as when a person does not have suitable accommodation or if their current living arrangement:

- is in a dwelling that is inadequate; or
- has no tenure, or if their initial tenure is short and not extendable; or
- does not allow them to have control of and access to space for social relations.

The ABS definition of homelessness is based on an understanding of 'homelessness rather than rooflessness[26].

The impact of homelessness on health

The health of homeless people in Australia is substantially worse than that of other Australians. Individuals who lack access to suitable, safe, and secure housing are more vulnerable to violence, harsh weather, unclean living circumstances, increased risk of contracting infectious diseases, and less control over their living arrangements and the individuals they share them with. Severe overcrowding is the most common type of homelessness in Australia, with many health consequences. For example, high overcrowding strains the dwelling's infrastructure, including kitchen, bathrooms, laundry facilities, and sewerage systems, resulting in infectious diseases and psychological stress[27]. Evidence shows that homelessness is strongly associated with increased morbidity, considerable barriers to accessing primary health care, greater hospital use and premature death[28,29]. As a result, there is an elevated incidence of a wide range of chronic ailments and diseases among homeless people, including mental health issues, infectious infections, respiratory conditions, and cardiovascular disease[28].

Primary health care is the entry point into the health system, providing preventative and early management. However, evidence suggests that people experiencing homelessness face a range of barriers to accessing primary health care such as cost, stigma and poor health conditions. Instead, meeting basic physical needs like food, water, and a place to sleep can be the most critical day-to-day priority for people experiencing homelessness, especially those who sleep rough. As a result, health issues are typically disregarded until an emergency arises[27].

Risk factors must be identified and addressed early on to address the complex health requirements of the homeless population and provide timely and appropriate care. Improved connectivity between health and community services and the ability to provide safe and secure housing is critical for holistically addressing the health challenges of those experiencing homelessness[28,30].

Purpose of SENSWPHN's Homelessness Needs Assessment

South Eastern New South Wales Primary Health Network (SENSWPHN) is one of 31 Primary Health Networks (PHNs) in Australia that were established to improve the efficiency and effectiveness of health services for patients, particularly those at risk of poor health outcomes, as well as to improve care coordination to ensure patients receive the right care at the right time.

To support primary health care access for people experiencing or at risk of homelessness, SENSWPHN undertook a bespoke regional Needs Assessment to:

1. Assess the needs of people experiencing homelessness or at risk of homelessness
2. Identify service gaps and barriers in providing primary health care access for people experiencing or at risk of homelessness
3. Inform the development and implementation of evidence-based homelessness primary health care planning

Methodology

A mixed-method approach was utilised where:

- A rapid review of the relevant literature was undertaken to gather existing information on the health needs and healthcare access among people experiencing or at risk of homelessness
- Quantitative data from The Australian Bureau of Statistics (ABS) and SENSWPHN's population heath profile was used to quantify the extent of homelessness and resulting local needs in the SENSWPHN catchment
- The literature research and quantitative data were utilised to inform stakeholder mapping and questionnaires for the qualitative exploration of perspectives through stakeholder consultation
- In-depth semi-structured interviews and focus groups were conducted with various stakeholders, including representatives from the Department of Community and Justice, Local Health Districts, Specialist Homelessness Services, Mental Health Services and General Practices.
- Thematic analysis of qualitative data was undertaken using NVivo12

Literature review

Health and homelessness

Individuals who are homeless or at risk of becoming homeless are among the world's most socially and economically disadvantaged. Being homeless is associated with higher morbidity, reduced life expectancy and more significant usage of acute health services[28,29,31]. People who experience homelessness struggle with high rates of medical illness, substance use disorder, and psychiatric illness[28,29]. Social determinants of health, such as living in crowded shelters, lack of access to clean water or bathrooms, poor nutrition, sleep deprivation, trauma, and exposure to extreme weather, all contribute to higher rates of illness and certain conditions among persons who experience homelessness[27].

The bidirectional relationship between homelessness and poor health is complex, resulting in a negative feedback cycle. Some people become homeless as a result of illnesses; for others, homelessness can lead to or even exacerbate mental and physical health problems. This cascading causal reciprocity has been documented globally[30,31,33].

Regardless of which issue came first, once a person becomes homeless, maintaining their health condition(s) becomes unattainable, and the probability of developing new health problems expands drastically. Both national and international literature indicate that individuals experiencing homelessness had much higher rates of nearly every indicator of health inequity, including a higher prevalence of mental health disorders, multimorbidity and increased mortality[31,32]. Recent Australian studies have suggested people who are homeless die an average of 22 to 33 years younger than those who are housed[33,34].

Barriers to accessing healthcare

According to ABS data, 13% of those who experienced homelessness at least once in the preceding ten years reported facing a barrier to getting health care, compared to 4.4% who had not experienced homelessness[27]. Despite their higher health burden, those who are homeless are less likely to receive primary care due to a variety of social, physical, and accessibility difficulties. A consistent finding in the literature is that despite having a clear need for ongoing healthcare support, individuals experiencing homelessness are often not registered with a GP[29]. This non-engagement with primary care usually means that individuals experiencing homelessness often do not get timely management of their health conditions, resulting in becoming more seriously ill and more likely to experience premature death than the general population. Reduced utilisation of healthcare services can largely be attributed to often insurmountable barriers, which this population faces across all levels, including challenges related to access, stigma and discrimination, financial constraints, inadequate transportation and low health literacy. The issue of access to accessible or affordable health care repeatedly arises as a critical barrier for individuals experiencing homelessness[30,32,34].

Regional context

Although individuals experiencing homelessness living in regional areas face many of the same challenges confronting individuals experiencing homelessness in urban areas, their experience is often pronounced due to higher unemployment rates, limited educational and employment opportunities, transportation challenges, reduced rental availabilities, lack of specialised services, lower incomes, as well as lower housing standards[35]. This highlights the importance of understanding the potentially specific issues of homelessness in a regional context. However,

data related to the utilisation of Specialist Homelessness Services indicate that since 2012, enormous growth in service demand has been experienced in regional locations[36]. This emphasises how crucial it is to comprehend the localised problems associated with homelessness.

Strategic context

Enhancing the lives and health of those who are homeless necessitates a multifaceted strategy that addresses social structures, institutional policies and practices, and individual health determinants. Multiple state-level partnerships have been formed across the health, housing, and human service sectors to enhance regional collaboration among key stakeholders in mental health, hospital intake and discharge, care coordination, and housing difficulties. However, aside from mental health, there appears to be no other policy or initiative to provide a state-level or regional strategic direction on different aspects of primary care, such as access to general practice and allied health care and housing sector partnership within the SENSWPHN catchment. This indicates a significant gap in addressing primary healthcare access barriers for those experiencing or at risk of homelessness.

Below are the key policies and initiatives relevant to the SENSWPHN catchment, which are targeted towards collaborative efforts to support people experiencing or at risk of homelessness.

- **The NSW Homelessness Strategy 2018-2023**[37], led by the Department of Community and Justice, emphasises the need for accountability across government so all agencies share responsibility for preventing homelessness and increasing access to support and services to:
    - Identifying people who are vulnerable early;
    - Providing better support and services; and
    - Making the system simpler, more integrated and person-centred
- **No Exits for Government Services into Homelessness**[38] - a framework for multi-agency action 2020 outlines agreed service principles for effective and coordinated planning across NSW government agencies to support people to move into stable accommodation with the vision that no one should leave government services into homelessness. The framework aligns with and supports NSW Health in delivering commitments to work across the health system and interacting with social care to improve outcomes for people experiencing or at risk of homelessness.
- **The Housing and Mental Health Agreement 2022 (HMA 22)**[39] is an agreement between NSW Health and the Department of Communities and Justice (DCJ). It acknowledges the critical relationship between housing and mental health and commits the agencies to work together and engage key stakeholders to achieve a shared vision that:

"People who live with mental illness have timely access to safe, secure, appropriate housing; and mental health supports in place when needed, to sustain housing, live well in the community and lead their recovery."

- **The Pathways to Community Living Initiative (PCLI)**[40] is an initiative under the NSW Mental Health Reform 2014-2024, coordinated by the NSW Ministry of Health in collaboration with

Local Health Districts. It aims to support the transition of long-stay mental health patients (12 months or more) into appropriate community-based living and services.

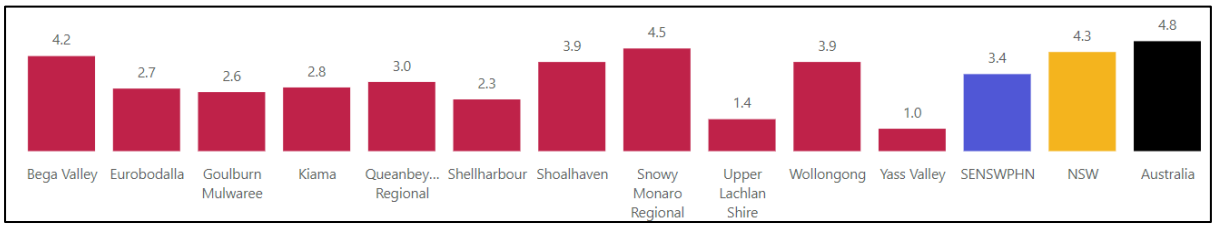
- **End Street Sleeping Collaboration**[41] is a cross-sector partnership among NSW's leading homelessness organisations, the NSW Government, the city of Sydney, and solo philanthropists with a mission to end rough sleeping in NSW. The approach is built around developing a comprehensive understanding of the experiences faced by individuals sleeping rough. Lived experience journeys and encounters within the system are collected and stored in a resource called By-Name List (BNL).
- **The Homelessness Mental Health Program**[42] is a program run by Illawarra Shoalhaven Local Health District that collaborates with referring and supporting organisations to help establish new or maintain existing accommodation for clients with a mental health diagnosis who are at risk of homelessness, have a tenancy at risk, have a history of homelessness, or are transitioning to secure accommodation.
- **Street Side Medics**[43] is a not-for-profit organisation that provides a GP-led mobile outreach medical service for people who are experiencing or at risk of homelessness. There is one Street Side Medics clinic in the SENSWPHN catchment, located in Wollongong. The clinic partners with The Community Kitchen, a not-for-profit organisation offering multiple services to homeless people, such as free meals, laundry, and haircuts.

Homelessness and Housing Issues in SENSWPHN

Homelessness NSW's analysis of the recently released Australian Institute of Health and Welfare (AIHW) figures revealed that the Wollongong LGA now has the third-highest number of people in the state receiving assistance at specialist homelessness services, with figures rising by 6 per cent in 2023.

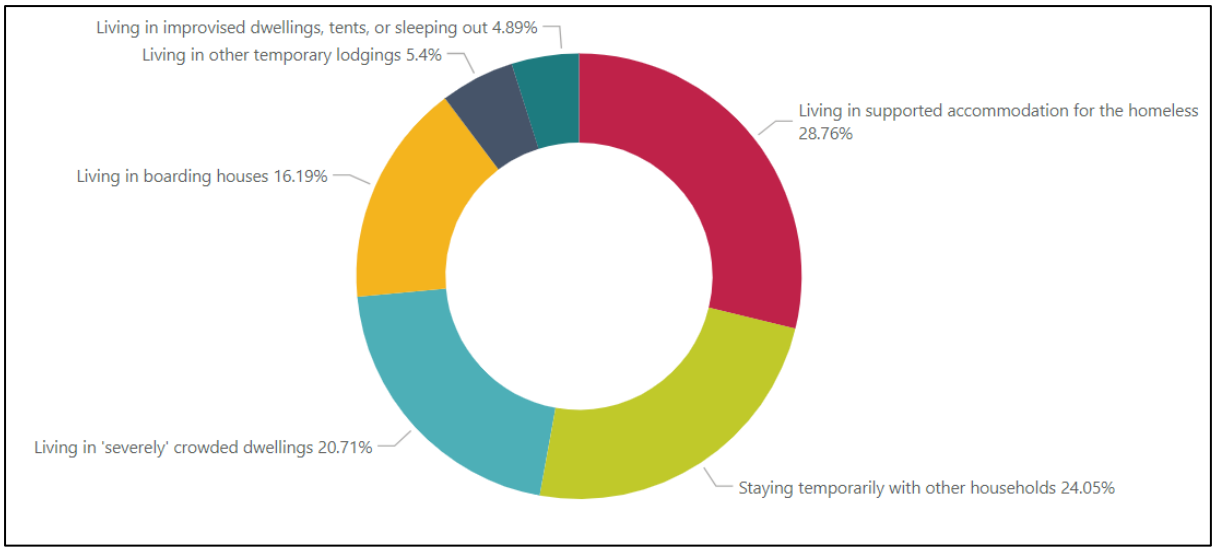
According to the most recent available estimates, some areas of the SENSWPHN catchment have an alarmingly high proportion of homeless people (see Figures 18 and 19). The rate of people identifying as homeless per 1,000 resident population in the Snowy Monaro was found to be greater than the NSW state rate, with Bega Valley, Shoalhaven, and Wollongong also having high rates of homelessness.

Figure 18. Rate of Homelessness per 1,000 resident population in SENSWPHN, 2021[24]



Homelessness in Southern NSW has surged following the 2019 Black Summer fires. The fires damaged hundreds of homes, which had a significant effect on homelessness in this already precarious area. Reduced home supply put more strain on the already tight rental market, further impacted by the COVID-19 pandemic when many buyers and renters from Sydney and Canberra relocated to regional locations. The most vulnerable individuals in the region have suffered even more significant disadvantages due to these causes.

Figure 19. Breakdown of the living arrangements of homeless persons in SENSWPHN, 2021[24]



Data on housing has also identified areas throughout the SENSWPHN catchment where the resident population experiences high levels of vulnerability with financial and living arrangements, thus resulting in a high risk of homelessness. Figures 20 and 21 show other substantial markers of need within households around housing vulnerability.

Figure 20. Households in dwellings receiving rent assistance from the Australian government in SENSWPHN, 2021[24]

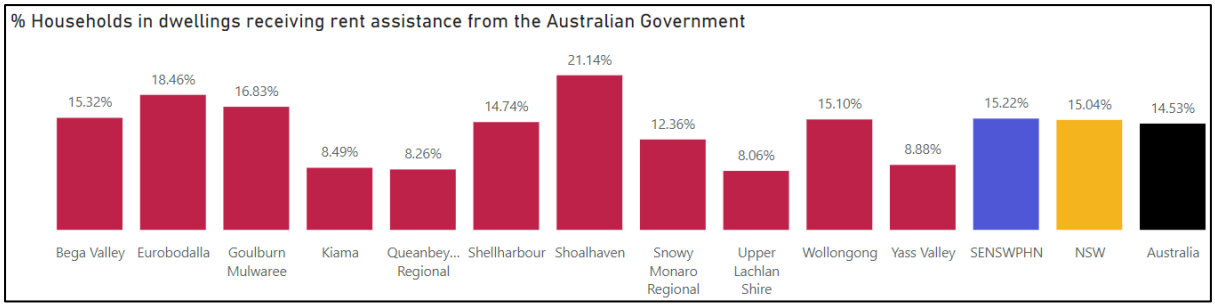
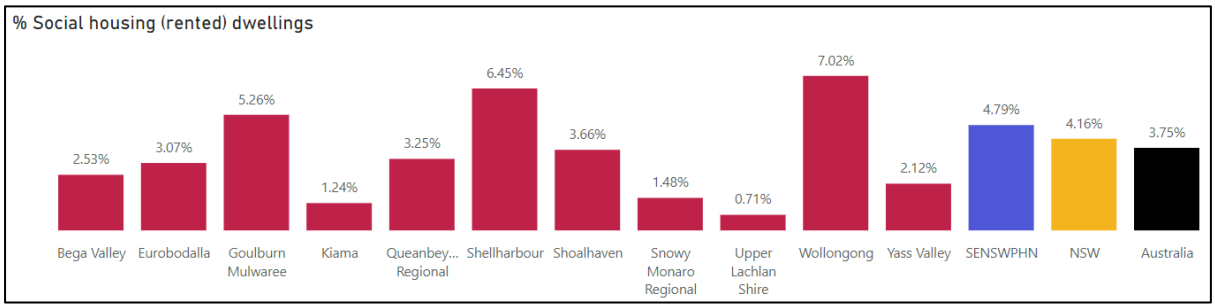
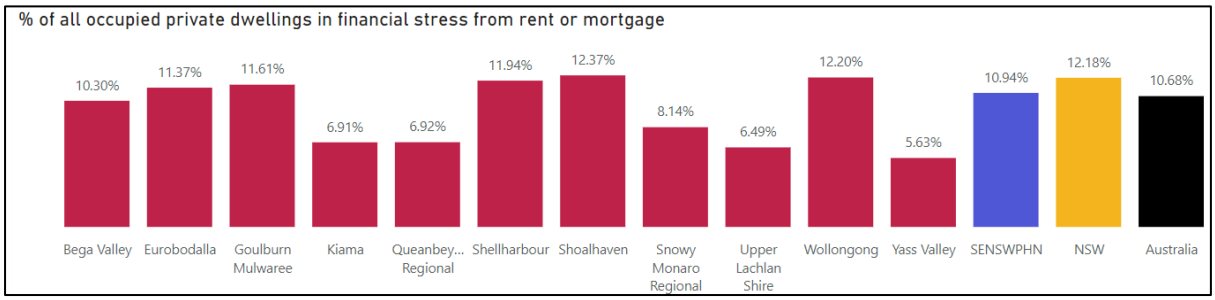


Figure 21. Social housing dwellings in SENSWPHN, 2021[24]



The latest Census data reveals a substantial proportion of households in the SENSWPHN catchment in the bottom 40% of the income distribution, and a large proportion of them spend more than 30% of their income on mortgage repayments or rent (see Figure 22).

Figure 22. Private dwellings in financial stress in SENSWPHN 2021[24]



Consultation Findings

The Needs Assessment involved stakeholder consultation with – representatives from key stakeholder organisations across housing, social and health sectors, including representatives from the NSW Department of Community and Justice, Illawarra Shoalhaven Local Health District, Southern NSW Local Health District, Specialist Homelessness Services, Housing Services, General Practices, Care Coordination and Mental Health Services. The consultation aimed to:

- Explore the needs and gaps in access to primary health care among people experiencing or at risk of homelessness
- Barriers and enablers in providing primary health care to those experiencing or at risk of homelessness, spanning the nexus of health, housing, and social systems

The following key themes emerged regarding health needs, gaps, service—and system-level barriers, and enablers for primary health care access among people experiencing or at risk of homelessness.

Health needs of people experiencing or at risk of homelessness

Being homeless and being at risk of homelessness

Participants emphasised the need to recognise homelessness as a complex health and social issue, rejecting the usual approach of considering homelessness as a "non-health" issue. All participants agreed that lack of access to sustainable housing, nutritious food, and hygiene are the basic health needs of people experiencing homelessness.

Participants emphasised the need for adequate housing as a preventative health strategy for those at risk of homelessness and as a health remedy for those experiencing homelessness.

"Your health's not gonna be good because you don't have shelter and you don't have all of the things like a good diet and, you know, a safe place to sleep and all of that kind of stuff. So a lot of people not only have mental health and drug and alcohol but also have a whole lot of primary healthcare needs that go unmet" – A Specialist Homelessness Service Representative.

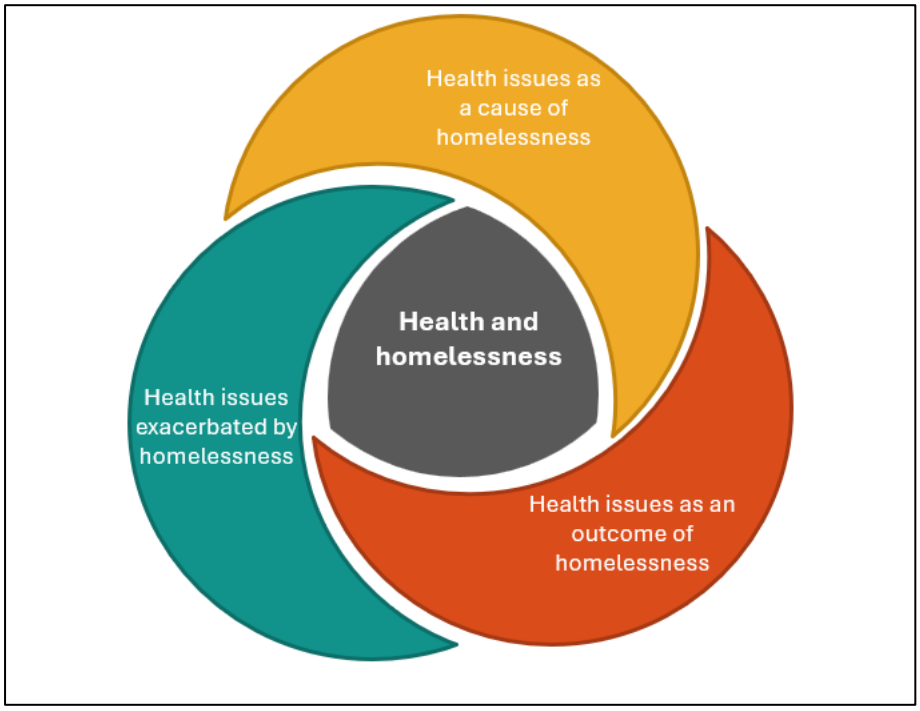
Social determinants of health

Participants acknowledged that the social determinants of homelessness and health issues are frequently linked, and long-term homelessness exacerbates ill health. Participants stated poverty, social exclusion, and low levels of social support as key factors contributing to ill health among homeless persons, highlighting the need to view poor socioeconomic determinants as health needs for those experiencing homelessness.

Health issues

Emphasising the complex relationship between homelessness and health, participants identified medical illness, mental illness and drug and alcohol abuse as the three primary health needs. Overall, the views of all participants conveyed three key overlapping areas where health and homelessness interacted (visualised in Figure 23):

Figure 13. Health and Homelessness



Health issues as a cause of homelessness - Major health issues such as disability and severe mental illness were seen as some essential precursors of homelessness with their impact on an individual's ability to find employment and sustain tenancies.

Health issues as an outcome of homelessness - Poor health outcomes from living in extreme weather conditions, malnutrition, compromised foot health, infections, complications from drug and alcohol uptake, accidental injuries, and dental diseases were seen as some of the leading health problems stemming from a lack of adequate living arrangements and poor social determinants of health.

Health issues exacerbated by homelessness - Participants identified that inadequate living conditions contributed to the worsening of existing physical and mental health issues, increased secondary complications from chronic conditions such as diabetes due to poor disease management, and a high risk of drug and alcohol abuse as a coping strategy.

"We do have a lot of people that, you know have cancer, and then them getting treatment is hard because they're living in the Bush." *A Specialist Homelessness Service Representative*

For those at risk of homelessness, the stress of sustaining tenancies paired with poor access to health care was seen as a critical driver of worsening physical and mental health symptoms among those at risk of homelessness.

Participants indicated that these relationships overlapped in a complex manner. For example, the high frequency of mental health issues such as depression, schizophrenia, PTSD, and anxiety among those experiencing or at risk of homelessness was repeatedly mentioned. Participants emphasised that poor mental health not only hindered the individual's ability to find and keep a place to live but also affected their ability to navigate complex referral processes and follow instructions from health professionals, resulting in a vicious cycle with further exacerbation of their physical and mental illnesses.

Perceived barriers to accessing primary health care for people experiencing or at risk of homelessness

Low preparedness for accessing healthcare

During the consultation, participants agreed that homeless people were not prepared to access healthcare, including their awareness of the need and desire to access healthcare, as well as their knowledge and ability to do so.

Not prioritising health

It was commonly raised that people who are homeless or at risk of homelessness frequently do not put their health first since they have more important things to worry about, like food, safety, and housing. Because of the precariousness of their living arrangements, they were believed to be living day by day in a survival mode while lacking the ability to perceive or prioritise their health needs. Perceiving low priority for health among the homeless population, participants quoted:

"If your main goal is just to survive the next day, you will ignore a whole lot of other things, including health."

"I think the expectation that people who are vulnerable and at risk or sleeping rough come to a service is actually one of the greatest barriers because people don't want to come to us."

Not willing to engage

It was commonly perceived by participants that there was a stigma associated with homelessness that limited access to health care by those experiencing homelessness. Some representatives from Specialist Homelessness Services, who work very closely with people experiencing homelessness, noted that previous negative experiences of poor interaction with health services or health professionals further impacted their engagement with health care. Many participants stated that obtaining care from general practices caused homeless persons to feel alienated and unwelcome. Perception of being judged for homeless status was also perceived as a barrier by most of the participants. A participant quoted:

"It's not about security guards. It's about feeling safe and welcoming, connected and connected and having relationships."

Low ability and knowledge to navigate the health system

In addition, social determinants of health such as family and domestic violence, low access to education and employment opportunities and poor living conditions were perceived as factors impacting the ability to access primary health care among people experiencing or at risk of homelessness. Participants also perceived a lack of knowledge and ability to navigate healthcare systems, particularly among chronically homeless people. Lack of empowerment and autonomy was also believed to be a driver of low engagement with health services among people experiencing homelessness.

Practical accessibility issues

Participants identified a range of issues impacting the ability to access primary care services for people experiencing or at risk of homelessness:

Financial barriers

Lack of ability to afford out-of-pocket expenses paired with an increasingly high number of practices moving away from bulk billing was seen as a significant barrier to accessing primary health care. It is noteworthy that participants noted a distinct cohort that ended up being or at risk of homelessness because of inability to bear the cost of rent and living and so, ending in couch surfing, sleeping in cars or shelters. This cohort was usually believed to be aware of health systems and services available butcould not access them mainly for financial reasons and the prioritisation of sustaining housing arrangements over health. Expressing concerns about the increasing number of middle class homeless, a mental health service provider quoted:

"We've got stories of intensive care nurses living in their cars, in between shifts, and these people are, you know, the backbone and backbone of our community. They're keeping people alive, but they're sleeping in their car because they have nowhere to live"

Lack of transport

The scarcity of public transport was commonly raised as a barrier to accessing timely healthcare, particularly in rural and remote locations.

Missing documentation

Many individuals struggle to obtain and preserve appropriate healthcare documentation, such as Medicare and concession cards. This can be challenging for individuals without a fixed residence and those with limited privacy in overcrowded accommodations.

Difficulties navigating the health system

Difficulties in securing appointments, a lack of devices such as a phone, strict appointment schedules, and complex referral pathways were seen as factors limiting access to primary care compared to emergency departments, where people could walk in without any prior formal steps.

"A lot of them have challenges navigating the health system. That may be contributing to why we see crisis presentations because of those barriers that prevent earlier access to healthcare" – A representative from Illawarra Shoalhaven Local Health District.

Gaps and service provision barriers

Right care is not available at the right time

Participants working closely with the homeless cohort voiced a shortage of general practices and difficulty getting in on behalf of a homeless client. Participants from Specialist Homelessness Services frequently mentioned that, despite efforts to connect homeless clients with primary care, it was challenging to schedule timely appointments due to significant wait times and a limited number of practices accepting bulk billing. This was believed to be exacerbated by the GP shortage in regional and rural communities.

"There's still a huge issue with actually getting access, even when you've got a worker who's trying to help you"

"Cause a lot of these people don't have cars or don't have petrol to get to a doctor's and then obviously being the area that we live in, it's also even if you have a home and a car, it's super difficult sometimes to get into see a doctor anyway"

In addition to the GP shortage, participants also expressed their concerns regarding the low availability of accessible mental health and drug and alcohol services.

"We are a poor town and so an awful lot of people that are employed still can't afford psychological services" A GP

Consistent with the findings of the literature review, it was noted during the consultation that due to a lack of access to preventative and primary care, people experiencing homelessness ended up in emergency departments when their health conditions deteriorated to a crisis point.

Representatives from the Local Health Districts consistently raised that emergency departments were effective at dealing with acute health difficulties. Still, they were not the best setting for managing the chronic multimorbidities that are often faced by people experiencing homelessness, thus emphasising the gap in the availability of targeted primary health care arrangements to provide timely, easily accessible and non-judgemental care for people experiencing homelessness.

Among many other examples, a representative from a Specialist Homelessness Service recalled their experience of facing difficulties in getting timely and appropriate care for a homeless client with complex health issues, quoted below:

"I recall vividly working with one young girl. It was quite a number of years ago, but I kept taking them into the doctor's and they were kind of fobbing her off all the time. And I finally took her to a Doctor who actually sat and spoke with her. And she had, like, she had the onset of diabetes. She had sleep apnoea. She had a whole multiple things that no one had picked up. Yeah, it's that system. Letting them down, and then the young person died."

Additionally, participants raised concerns about the need to fit in eligibility criteria such as having an existing diagnosis or referral as a barrier to accessing mental health services and drug and alcohol services, stating the need to tailor services for people experiencing homelessness.

Lack of formal pathways into primary care

In discussions exploring the existing referral pathways for the Specialists Homelessness Services and Mental Health Services to connect people experiencing or at risk of homelessness to primary health care, a major gap was identified in the integration of primary health care

services with homelessness, mental health and drug and alcohol services systems. Participants working closely with people experiencing, or at risk of, homelessness reported that they struggled to secure appointments for their clients, given accessibility issues with the mainstream primary care services, including cost and long waiting periods.

"It's not just navigation issues for people experiencing homelessness, it's also service navigation for those who are in charge of service provision to direct them in the right direction" – A Representative from a Mental Health Service.

Though not seamlessly integrated, there have been accounts of hospital-based and mental health services working closely with local Specialist Homelessness Services. However, no such formal integration links primary healthcare services to mental health and housing services. Instead, participants from Specialist Homelessness Services and Mental Health Services commonly noted that they leveraged their existing relationships with local General Practices to help their homeless clients receive primary care.

Participants from both social and health systems frequently raised the issue of a lack of awareness and coordination among service providers regarding how to cross-refer between health, housing, and other social services.

"There seems to be a gap where social services do not know a lot about health, where sometimes they're not sure where they should send the clients that they get and I have heard similar things from many health places where they're unsure about housing options and how to refer a client" – A Representative from a Mental Health Service.

Complex health needs

Complexities of health needs of people experiencing homelessness were seen as both a barrier to access and an outcome of poor access to health services. Stakeholders acknowledged that, particularly for people experiencing homelessness for a long time, both physical and mental health needs were significantly more complex than the needs of the general population. Some stakeholders viewed such complexities as a barrier for primary health care service providers, citing a lack of time, increased pressure with complex health needs, and a lack of health professionals trained to care for vulnerable populations. One of them quoted:

"They're difficult patients, they're complex and have huge needs. Healthcare professionals aren't necessarily equipped, and you know if you're trying to deal with a whole lot of people and you've got a 15 minute window, it's all the constraints, time constraints, system constraints."

For people at risk of homelessness, mental health service providers noted that it was hard to address their mental health needs because of low patient preparedness for therapy and because of uncertainties in their living arrangements. Drug and alcohol abuse was seen as an added complexity that further impacted accessing healthcare. Noting a link between drug and alcohol abuse and mental health conditions among this population, some mental health service providers emphasise the need to be 'clean' from drug and alcohol addiction before they could receive mental health services. Being older was believed to be linked with even more complexities, given the unpredictability of disease trajectory and lack of access to the right services at the right time.

Reach and engagement challenges

There was a consensus among participants that given the transient nature of people experiencing homelessness, follow up for appointments and continuous health care was

difficult. Moreover, given the stigma of being judged for their disadvantaged social status, participants reported poor engagement from people experiencing and at risk of homelessness with their service providers. Participants highlighted the need for spontaneity in caring for homeless people as their interest in health services fluctuated rapidly.

"They don't respond to your calls, et cetera, because they're becoming embarrassed, or they become fearful that they're going to be judged or won't be allowed to access your service anymore." A mental health service provider.

Short-term funding cycles

Participants frequently highlighted concerns regarding short-term health programs aimed at those experiencing or at risk of homelessness, as these were thought to have a detrimental influence on engagement and confidence in the services offered. Participants emphasised the need for well-planned, locally-adapted, and sustainable programs to enhance primary health care access rather than many short-term, fragmented care alternatives that confuse the community and service providers.

"These short term funding cycles are always really difficult. We want to really ensure that whatever we set up doesn't have such a short term that we're setting up people to have an expectation and then not having been able to deliver it," – A representative from a homeless hub.

A GP, who proactively engaged in working for people experiencing or at risk of homelessness, expressed concerns about the limited availability and capacity of mental health and drug and alcohol services in regional areas, as well as the short-term funding cycles that limited their ability to refer their patients to an accessible service in a timely manner. The GP quoted:

"There have been so many services that come and go and we get all excited and then later they're gone."

Enabling factors to enhance primary healthcare access for people experiencing or at risk of homelessness

In discussions about enabling factors to enhance primary care access among people experiencing or at risk of homelessness, participants strongly voiced that secure housing is the most crucial step in improving health outcomes for this cohort. This report acknowledges the 'housing first' approach and emphasises the need for collaborative advocacy to end homelessness across the catchment.

Given that the purpose of this Needs Assessment exercise is to provide actionable insights for SENSWPHN to use in service planning for improved access to primary care services for people experiencing or at risk of homelessness, this section focuses on primary health care specific themes that emerged from our participants' expert opinions.

Six key enabling factors were identified, including system integration, local partnerships, strong referral pathways, priority access to primary care, GP outreach services, and training for the health workforce (see Figure 24).

Figure 24. Key enabling factors to enhance primary health care access among people experiencing or at risk of homelessness

Regional collaboration

Participants strongly voiced the need to build regional interagency partnerships and implement effective system integration strategies. This would allow primary health care services, local health districts, housing services, and other key organisations working with people experiencing or at risk of homelessness to collaborate to tackle health disparities among this vulnerable cohort holistically.

Participants conveyed that systemic coordination at the local and state levels is critical to enhancing primary healthcare access for those experiencing or at risk of homelessness. This could be achieved through joint strategic planning by health and housing organisations, leveraging cross-sector expertise with a shared commitment to improving healthcare and housing access for people experiencing or at risk of homelessness. A representative from the NSW Department of Community and Justice quoted:

"I see this massive need for much better coordination and collaboration between the health system, health services and the other sort of service system with our common clients because we could do much better work if we were doing it together" – A representative from Southern NSW Local Health District.

Participants underscored the significance of cross-sector knowledge and skills, suggesting that cross-sector placements or employment opportunities could help bridge the knowledge gaps between the health and housing sectors by transferring knowledge and skills. Such arrangements could include a particular position with the SENSWPHN that employs a housing expert to enhance primary healthcare access for those experiencing or at risk of homelessness.

Building strong referral pathways

Recognising the bi-directional relationship between housing and health, participants suggested the need for strong referral pathways between housing and health services. Focusing on primary health care, participants emphasised that vital referral pathways between General practices and housing services can enable GPs to identify people at risk of homelessness due to health issues, allowing for early intervention to prevent homelessness. Similarly, such bi-directional pathways can support timely referrals from housing services to primary healthcare services, facilitating the provision of the right care at the right time for people experiencing or at risk of homelessness.

"We need a number of agencies to respond, and general practice, in particular, is in a very good spot in that they can look at the whole person presenting at them, provide more holistic healthcare, do referrals" – A representative from the NSW Department of Community and Justice.

Participants emphasised the importance of systematically linking primary care services to housing and social services to facilitate a 'No wrong door' approach, in which a variety of social and housing services can connect people experiencing or at risk of homelessness to primary health care as needed.

Building local relationships across key service providers

Throughout the engagement, it became clear that local partnerships between health service providers and housing services were critical to improving access to primary health care for those experiencing or at risk of homelessness. Without such local contacts, health and housing

service providers struggled to connect their most vulnerable clients to the appropriate resources at the right time, resulting in delayed or no access to primary care.

In addition to relationships among local health and housing service providers, participants identified a disconnect between primary health care, specialist mental health and drug and alcohol services. Participants emphasised the diverse requirements of those experiencing or at risk of homelessness and advocated for increased collaboration across various health providers to provide comprehensive health care to this population.

Recognising the critical role that SENSWPHN plays in collaborating with local General Practices, Specialist Mental Health Services, and Drug and Alcohol Services, participants suggested that the PHN should take the lead in fostering regional relationships among these service providers. These relationships are essential in meeting the health needs of people experiencing or at risk of homelessness.

Priority access to primary health care

Highlighting the personal and practical barriers faced by people experiencing or at risk of homelessness in accessing primary health care, participants emphasised the need for flexible and free-of-cost primary health care services that can provide priority access to vulnerable population cohorts. Flexibility to accommodate people experiencing or at risk of homelessness, offering low barrier access such as no identification or Medicare required, flexible cancellation and rescheduling services and longer than usual appointments were raised as the key enablers to enhance primary health care access among people experiencing or at risk of homelessness.

There were examples of some General Practices that had good relationships with the local Specialist Homelessness Services and were proactive in accommodating their clients on a priority basis. These practices were reported to provide priority care to these clients without financial motivation, instead focusing on serving the community.

A notable example of such work came from a general practice in Bega that accepted referrals for persons affected by domestic abuse and homelessness. The practice also operated a teen clinic, which provided preventative and ongoing health care to vulnerable teenage patients. Such examples were particularly impressive because both literature and this consultation exercise have shown that homelessness is frequently experienced at a young age and, if not addressed thoroughly, can lead to a vicious cycle of poor health and homelessness.

Participants praised the work of such primary care services and recognised the need to support primary care services that work with people experiencing or at risk of homelessness.

Acknowledging the financial constraints of providing free primary health care, some participants suggested the need for a systemic method to incentivise General practices, similar to the Practice Incentives Program, where General Practices are incentivised to continue providing quality care, enhance capacity, and improve access and health outcomes for patients.

Participants regularly stressed the need for a systemic shift in the primary health care landscape to make it more inclusive and responsive to the needs of local communities, with a particular emphasis on the most disadvantaged groups. Throughout the consultation, the importance of care models that prioritise access to persons who are homeless or at risk of becoming homeless was consistently emphasised. Suggesting a potential program targeted at

providing priority primary care to those identified to be experiencing or at risk of homelessness, a participant quoted:

"This is where you can turn up at the practice anytime and you'll be prioritised by the receptionist. All you need to do is show them a yellow card or whatever system you have in place, and you'll be fast-tracked" – A representative from the NSW Department of Community and Justice.

Care coordination was seen as a supporting enabler that, when paired with priority access to primary health care, would contribute to improved health outcomes for people experiencing or at risk of homelessness. Participants pointed to a high need for care coordination for homeless people who suffered from multimorbidity conditions and could not keep up with medical appointments and care plans. It was emphasised that the lack of well-established linkages between services meant that the homeless population was lost to follow-up while moving from one service to another.

Having a chaperone to facilitate access to healthcare was recommended by a few stakeholders, stating that effective care coordination can address the system navigation and engagement barriers for people experiencing or at risk of homelessness.

"So it's almost like you need a buddy system for some of those clients to go into places so someone sits with them, so they feel safe" – A representative from the NSW Department of Community and Justice.

Overall, there was a shared sentiment that primary health care services should be easily accessible and available to accommodate people experiencing or at risk of homelessness. Participants expressed that the SENSWPHN should advocate for priority and flexible access to local primary healthcare services for this vulnerable population.

Skilled Workforce

Recognising the vulnerabilities associated with homelessness, such as complex mental health, trauma, domestic violence and substance abuse, participants noted that the right combination of skills, knowledge, experience and personal attributes is required to care for people experiencing or at risk of homelessness appropriately. The need to provide non-judgemental care while supporting people experiencing or at risk of homelessness in being more aware of their health care choices was repeatedly mentioned by participants. A GP quoted,

"I think allowing people to feel like feel heard, because most of these people I know it's a sweeping judgment but they never do feel any autonomy and never feel heard."

An adverse health care experience for such vulnerable clients could lead to disengagement from health services, resulting in poor health outcomes. Participants were optimistic that primary health care workers trained with skills to provide nonjudgmental and trauma-informed care will significantly contribute to positive interactions for those experiencing or at risk of homelessness, resulting in increased access to primary health care.

Co-located outreach services

Participants collectively voiced the need for primary healthcare outreach services in the catchment to bring healthcare to "where people are" or "where they prefer to go".

The proposed outreach model envisions an outreach service aiming to address the health needs of people experiencing or at risk of homelessness in a setting where they often seek

assistance for their housing or basic needs. All participants acknowledged that this strategy solves barriers to primary healthcare, such as the inability to secure an appointment, a lack of willingness to engage with healthcare, fees, transportation, etc. A representative from Street Side Medics quoted:

"We always make sure that at least one of those services is a food service because people are usually coming to get food and we're capitalising on that because nobody wants to come and see the doctor."

Participants frequently praised Street Side Medics' performance in the Wollongong area (see Figure 25). They called for establishing similar GP or nurse-led outreach programs in other parts of the catchment, notably along the South Coast.

Figure 25. Street Side Medics – an example of a local GP outreach model

Participants emphasised that this method removes the barriers to primary healthcare and proactively enhances the homeless population's involvement with healthcare services by instilling trust and confidence. Participants stated that by establishing rapport and trust with

this vulnerable group, such a service could play an essential role in connecting people to other health services, such as mental health and substance abuse.

Participants frequently advised co-locating such an outreach program within a housing hub that provides a one-stop shop. Co-location was identified as a potential strategy to solve not only the access and engagement issues but also to promote streamlined referrals by incorporating representation from a range of services, such as medicine specialists, physiotherapy, mental health, and drug and alcohol, within the hub.

Participants from housing and specialist homelessness services applauded the performance of previous GP or nurse outreach clinics that were co-located with housing services, such as food vans or homeless hubs, a participant from a Specialist Homelessness Service commented:

"We had a Women's Health outreach nurse that would come, and she could do general, pap smears and things like that, even for Women's Health, and that was amazing."

Recommendations

Homelessness is a complex issue with multiple contributing elements, numerous adverse effects, and no single solution. People experiencing or at risk of homelessness face significant challenges in getting primary healthcare due to their daily survival needs. They require both safe and stable housing, as well as social support, to address their health requirements effectively. To enhance primary healthcare access among people experiencing or at risk of homelessness, policymakers and stakeholders from the housing, health and social service sectors must collaborate. To holistically address the health needs of people experiencing or at risk of homelessness, there is a need to intervene with innovative and sustainable models of partnership among health and housing organisations that enforce strong referral pathways promoting robust linkages with mental health and drug and alcohol services. Finally, to reduce homelessness and its adverse health impacts, the Primary Health Network has a role to play through avenues such as:

- Facilitate collaboration among key stakeholders for a regional approach to enhancing primary health care access for people experiencing or at risk of homelessness
- Engage and support General Practices with training on the knowledge and skills required to engage and care for people experiencing or at risk of homelessness
- Identify and support General Practices actively working with people experiencing or at risk of homelessness
- Support Mental health and Drug and Alcohol services to provide improved access for people experiencing or at risk of homelessness
- Foster relationships between General Practices and locally commissioned mental health services and drug and alcohol services to promote connectedness among service providers
- Commission sustainable and locally informed models of care to address barriers to accessing primary care, thus improving health outcomes for people experiencing or at risk of homelessness

Section 3: Primary healthcare access among people from Culturally and Linguistically Diverse (CALD) communities – Needs Assessment

Background

Australia is an ethnically diverse country. People from culturally and linguistically diverse (CALD) backgrounds may experience more difficulty navigating the health-care system than those who do not identify as CALD. This can lead to poor access and engagement with health care services. Given that primary health care is the cornerstone of health care, it is crucial to ensure that people from CALD communities have timely access to primary health care services.

Purpose of SENSWPHN's CALD Health Needs Assessment

South Eastern New South Wales Primary Health Network (SENSWPHN) is one of 31 Primary Health Networks (PHNs) in Australia. These networks were established to improve the efficiency and effectiveness of health services for patients, particularly those at risk of poor health outcomes, and to improve care coordination to ensure patients receive the right care at the right time.

To support primary health care access for people from CALD backgrounds, SENSWPHN undertook a bespoke regional Needs Assessment to:

1. Update the PHN Needs Assessment by assessing the diverse cultural needs of people from CALD backgrounds of the SENSWPHN Region
2. Identify key challenges and barriers to accessing and navigating primary health care services by people from CALD backgrounds
3. Identify gaps in the provision of culturally appropriate primary health care services

Methodology

A mixed-method approach was utilised where:

- A rapid review of the relevant literature was undertaken to gather existing information on the health needs and healthcare access among CALD populations
- Quantitative data from many sources were used to understand the demographics and geographical spread of the CALD population in the SENSWPHN catchment
- The literature research and quantitative data were utilised to inform stakeholder mapping and questionnaires for the qualitative exploration of perspectives through stakeholder consultation
- In-depth semi-structured interviews and focus groups were conducted with various stakeholders, including representatives from the Illawarra and Shoalhaven Local Health District, Southern NSW Local Health District, Multicultural Communities Council of Illawarra, Illawarra Multicultural Services and Russell Vale Medical Practice.
- Thematic analysis of qualitative data was undertaken using NVivo12

Literature review

The CALD population is a diverse and complex group, encompassing temporary migrants (e.g., international students or temporary skilled workers), refugees, asylum seekers who typically settle through Humanitarian Support Programs (HSP), and permanent residents and citizens of migrant backgrounds[44].

As per 2021 data from the Australian Bureau of Statistics (ABS), nearly 30% of the Australian population was born overseas[45]. Furthermore, the combined proportion of Australian residents born overseas or with a parent born overseas has risen above 50%. Currently, migration to Australia is highest from the Asian continent, particularly China and India. Australia's migration strategy emphasises' regionalising migration within the country. Hence, the proportion of CALD populations living in regional areas is increasing[46].

Multiple Australian research studies have highlighted that people from CALD backgrounds confront multilayered socioeconomic and health issues, including access to relevant care care[47,48]. These are especially pronounced among individuals with a refugee background, who have more complex requirements[47,49,50]. As a result, people from CALD backgrounds, particularly those with lower socioeconomic status, have a higher burden of diseases. Evidence suggests even greater multimorbidity among refugees and asylum seekers, with a higher burden of mental health disorders such as post-traumatic stress disorder and anxiety and a higher burden of infectious, metabolic and chronic conditions[49,50].

Evidence highlights that conflicting sociocultural values of the country of origin and host country often result in difficulty adhering to a healthy lifestyle and seeking relevant care[47]. Variations in values, culture, beliefs, diet, and healthcare system, stigmatisation of many health conditions and racism contribute to high unmet health needs among the CALD population[47,48,49,52]. However, various barriers to accessing health care, such as language, affordability, accessibility and appropriateness of services, result in poor utilisation of health services. For specific subgroups of the CALD population, lack of information and lower health literacy levels further hinder their readiness to access timely health care[47,50]. Temporary migrant groups appear to be significantly disadvantaged in terms of affordability and accessibility of healthcare options, given that they are not eligible to claim benefits under Medicare[51].

Health services must be affordable, culturally acceptable, and appropriate to address the unmet health needs of the CALD population and remove barriers to accessing health care. However, research suggests a range of service provision-level barriers in delivering required services to the CALD population[4]. Providers' lack of language and cultural competence has been shown to influence treatment utilisation among CALD populations[47,52]. Lack of or low utilisation of interpreters further limits the ability of the CALD population with language barriers to access health care efficiently[47]. Such service level barriers exaggerate the impact of general barriers to primary care accessibility, such as GP shortage, transport challenges, and affordability.

Several models and service reforms have been found to be effective in enhancing primary healthcare access among CALD populations in Australia. Opportunistic GP screening, community-based mental health interventions, health promotion programs, and health professional capacity building have been shown to improve access and health outcomes among CALD populations[47,48,53]. However, the literature suggests the need for system and policy-level strategies to enhance primary healthcare access among the CALD population. A

four-year-long mixed-method study has highlighted that PHNs have a crucial role in prioritising migrant and refugee health while leveraging the local community connections and expertise of organisations experienced in working with CALD populations[54].

CALD Population Profile in SENSWPHN

The SENSWPHN catchment is home to CALD diverse communities, with the Wollongong and Queanbeyan regions being the most diverse. As shown in Figures 26-28, about ten percent of the resident population (aged five years and above) in the PHN catchment speaks a language other than English at home. Wollongong has the highest number of residents with poor English proficiency, followed by the Shellharbour and Queanbeyan regions.

Figure 26. Population born in predominantly non-English speaking countries as a percentage of resident population[24]

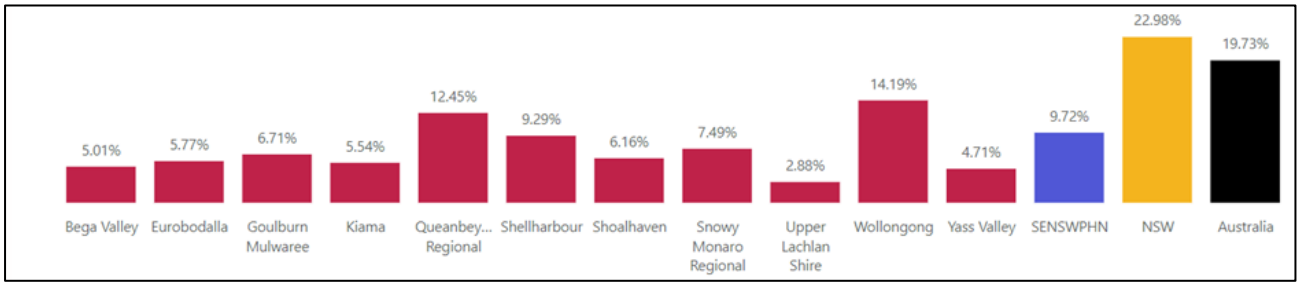


Figure 27. Population that speaks a language other than English at home as a percentage of the resident population aged five years and above[24]

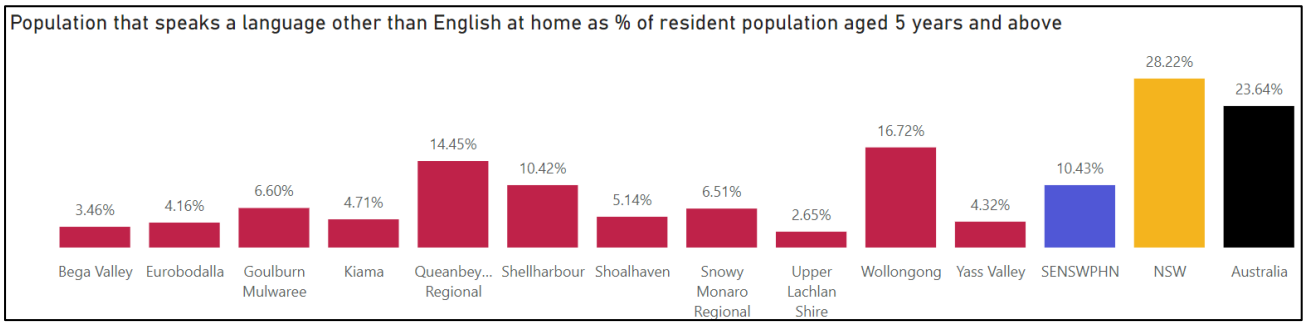
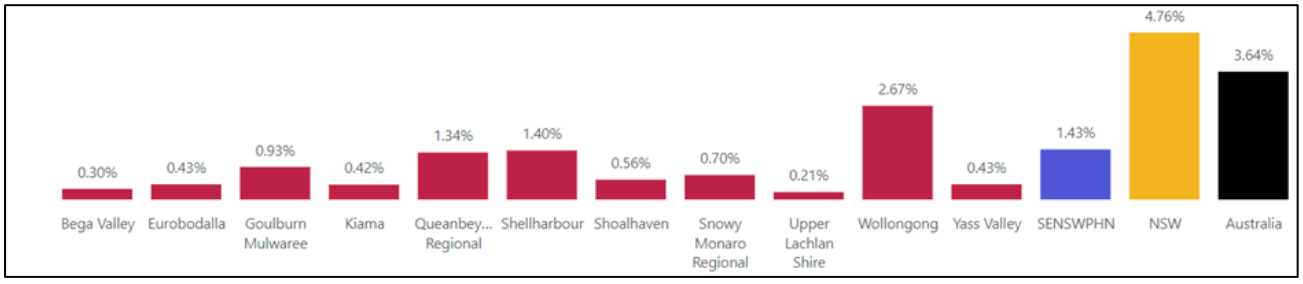


Figure 28. Population with poor English proficiency as a percentage of the resident population aged five years and above



In the SENSWPHN catchment, the majority of CALD residents born outside of Australia are from India, followed by North Macedonia and Italy. Among the CALD population, Macedonian is the most often spoken language at home in the Illawarra Shoalhaven region and Punjabi in Southern New South Wales (see Table 1 and 2).

Table 1. Top ten non-English speaking countries of birth of persons in SENSWPHN[24]

Top 10 non-English speaking countries of birth of persons		
Illawarra Shoalhaven	**Southern NSW**	**SENSWPHN**
North Macedonia	India	India
India	Philippines	North Macedonia
Italy	Germany	Italy
Philippines	Nepal	Philippines
China excludes SARs and Taiwan	Italy	Germany
Germany	Netherlands	China excludes SARs and Taiwan
Netherlands	North Macedonia	Netherlands
Vietnam	China excludes SARs and Taiwan	Thailand
Thailand	Thailand	Croatia
Croatia	Croatia	Vietnam

Table 2. Top ten languages spoken at home by persons in SENSWPHN[24]

Top 10 languages spoken at home by persons		
Illawarra Shoalhaven	**Southern NSW**	**SENSWPHN**
Macedonian	Punjabi	Macedonian
Italian	Italian	Italian
Arabic	Macedonian	Arabic
Spanish	Nepali	Mandarin
Mandarin	Mandarin	Spanish
Greek	German	Greek
Serbian	Spanish	Serbian
Vietnamese	Greek	German
Portuguese	Tagalog	Vietnamese
Turkish	Hindi	Portuguese

Consultation findings

Diverse health needs of CALD populations

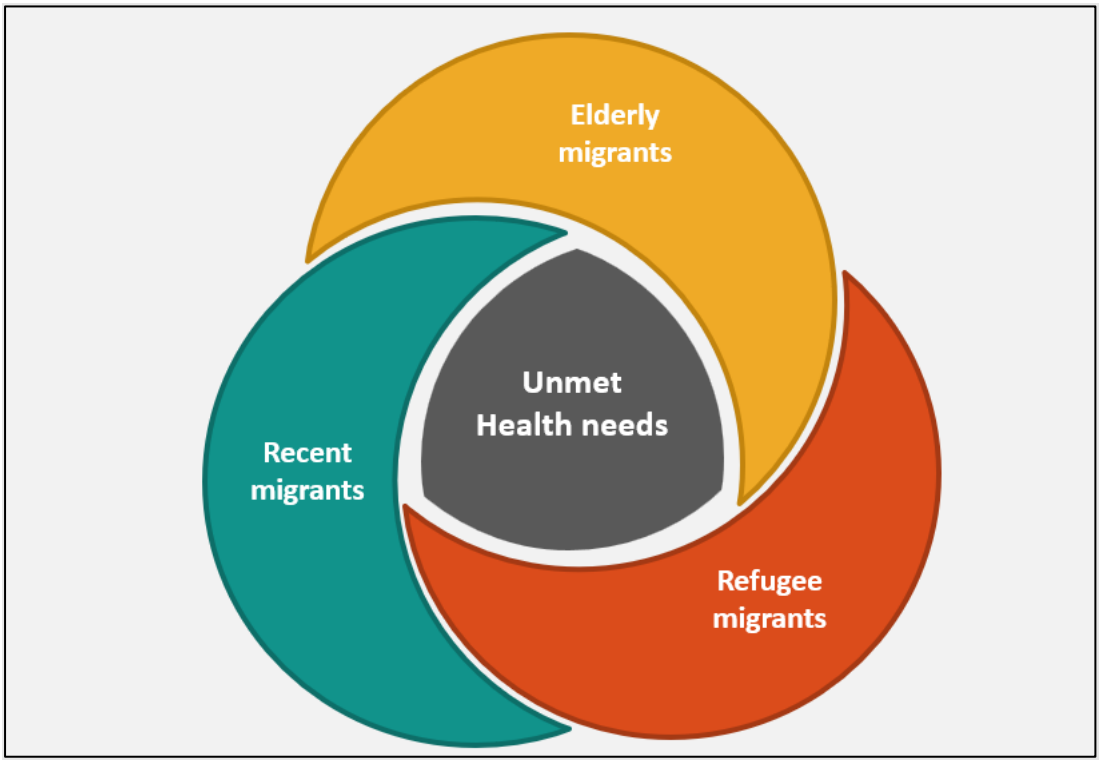
Participants agreed that due to variation between and within CALD demographic groupings, it is impossible to generalise the CALD community's individual medical needs. Nonetheless, all participants acknowledged that the health challenges faced by the CALD population are more severe and complicated, with limited access to primary healthcare.

Participants emphasised the heterogeneity of the CALD population based on time and type of migration, stating that migrants who came for work may have different health patterns than those who came as refugees and that health patterns may differ between newly arrived migrants and those who have lived in Australia for a long time.

"It is about the migration stories and journeys of people" – A representative from MCCI

Overall, participants discussed the three main subgroups of the CALD population (see Figure 29), each with distinctive physical and mental health patterns. They also noted that health needs varied within these subgroups based on ethnicity, age, gender, and various other health factors.

Figure 29. Key groups of the CALD population with distinctive health needs



Elderly migrants: This group was described as older people residing in Australia for a long time, primarily because of post-World War II migration. Participants frequently mentioned that, despite their extended stay in Australia, this generation had limited English language abilities, which they saw as a barrier to healthcare access. Participants also remarked that elderly migrants tend to revert to their mother tongue with aging and cognitive impairment. Chronic illnesses, psychological problems and aged and palliative care were reported to be the most pressing health concerns among this group.

Recent migrants: This group was described as relatively recent migrants, mainly young people or families who had immigrated to Australia as skilled workers or on temporary visas. Preventative health, mental health, maternal and child health, and chronic illnesses emerged as critical health needs in this population. Participants emphasised the need for assistance navigating social and health services for this group. Recognising a significant transformation in the environment following migration, participants stressed the need for preventative physical and mental health initiatives to assist this group as they seek to establish themselves in Australia.

Refugee migrants: This group was described as people who had migrated to Australia as refugees, including through the Commonwealth Humanitarian Settlement Program and people with similar backgrounds, such as people seeking asylum. Participants viewed this group as the one with the most complex health needs, including but not limited to post-traumatic stress disorder (PTSD), anxiety, depression, infectious conditions, chronic conditions, and maternal and child health. Participants repeatedly noted that though the number of refugee migrants was small compared to other migrants, their health needs were very high.

Participants acknowledged that the demographic spread of the CALD population varied across the catchment. Wollongong region appeared to be home to many refugee migrants. In contrast, Goulburn and Queanbeyan regions were reported to have more recent migrants under the skilled pathway and those on temporary visas.

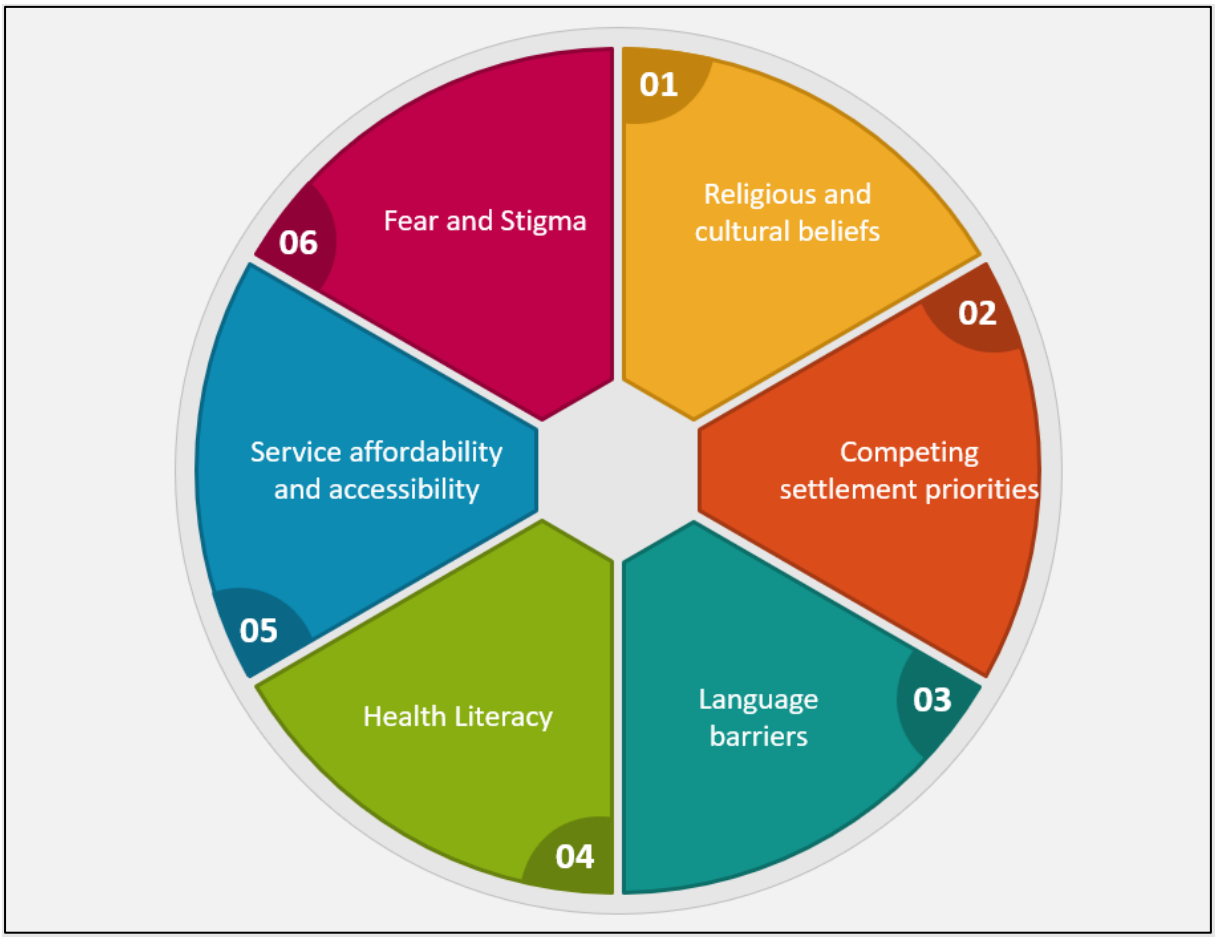
In terms of health needs, participants conveyed the following key health priority areas across diverse CALD populations:

- Mental
- Preventative health
- Maternal and child health
- Aged and palliative care
- Chronic conditions

Factors affecting healthcare-seeking among CALD communities

Most of the discourse concerning client-level barriers to accessing primary health care among the CALD population focused on low help-seeking behaviour due to a variety of complexities that arise in CALD experiences, such as intergenerational trauma, identity challenges, religious and spiritual beliefs, cultural inconsistencies, and CALD perspectives on health and wellbeing. Figure 30 illustrates the key themes that emerged while discussing factors impacting health care-seeking among the CALD population.

Figure 30. Key themes identified as factors impacting healthcare-seeking behaviour among the CALD population



Fear and stigma

Participants identified shame and stigma among people from CALD backgrounds, especially among refugee migrants, as a significant impediment to seeking care for their health-related needs. Participants emphasised that discrimination and racism had a negative influence on CALD people's interactions with the health system because they felt more ashamed and stigmatised for their health conditions than their Anglo counterparts who had identical health concerns. Feeling intimidated and afraid was commonly perceived as a barrier to accessing health services. These impediments were perceived to exist in the CALD population, independent of their English language skills.

Religious and cultural beliefs

Participants commonly noted that cultural beliefs about the causes and management of health conditions influenced people's health-seeking behaviour and use of health services. As an example, some participants discussed the stigma associated with mental health disorders in various cultures, regardless of service availability, acceptance, and quality, which was believed to limit people from using mental health services.

Competing settlement priorities

Participants noted that despite the availability of national and state-funded settlement programs to support humanitarian entrants' transition into mainstream services, there was a low access to primary health care services among people with refugee backgrounds as they had competing settlement priorities to secure employment, housing and other basic needs. Also, participants perceived a delay in the onset of mental health conditions in this group, as early signs of their mental ill health were believed to be masked by their settlement priorities and thus suggested the need for longer support programs.

Language barriers

The participants' consensus highlighted insufficient language and communication skills as barriers to health-seeking behaviours, understanding of the health system, and poor patient-provider relationships. Inappropriate use of interpreters, poor translations, and the requirement to communicate in a language different from one's mother tongue were all identified as barriers.

Participants provided examples from their experiences where poor understanding of the English language impacted access and utilisation of health services among people from CALD backgrounds. Talking about low general literacy levels in Burmese refugee migrants, a participant from IMS commented:

“Communities from Burma, Myanmar, a lot of them didn't have the chance to get an education in their own language. So, they don't read and write in their own language”

However, participants repeatedly raised the issue that language is not the only barrier hindering primary health care access among the CALD population and should not be seen as a limitation of a client.

Health literacy

Health literacy appeared as a key element influencing CALD populations’ perceptions of their health needs and where to seek care. Participants agreed that low health literacy, particularly difficulty in finding and using health information and obtaining the right services at the right time, was an essential impediment to CALD populations' capacity to navigate the healthcare system. A representative from MCCI commented:

“A range of services, whether it's mental health, your local neighbourhood centre, domestic violence services and so on, is that it's very rare for people to actually self-refer”

Service affordability and accessibility

Many of the access concerns raised during the interviews and focus groups related to the affordability of primary healthcare services. Participants repeatedly raised the increasing living costs and employment challenges faced by the CALD population. Participants also highlighted the disadvantage that migrants on temporary visas and asylum seekers living in the community face with no access to the National Medicare Scheme.

Other accessibility issues perceived as barriers to primary health care access among the CALD population included the availability of GPs, allied health professionals, and specialists, significant turnover of health providers in regional locations, vast distances to obtain services and transportation barriers. Participants often commented on the impact of high GP turnover in the catchment to the continuity of care and patients' engagement with their health services.

"There's high turnover as well, which is really hard for people who are trying to or who potentially don't want to see a stranger or trying to develop a relationship with a GP, build a relationship for their family" – A Council representative

Although the abovementioned accessibility issues were perceived to be faced by the regional population in general, it was acknowledged that finding appropriate services, scheduling appointments, and travelling was more difficult for CALD populations with limited English communication skills.

"There is a huge gap in mental health service provision for everyone. And then it's how you access that if you've got additional barriers like language or literacy or transport." – A Local Council representative

Also, it was noted that multicultural support services were usually geographically centralised in the Wollongong region; however, people from CALD backgrounds were perceived to be increasingly relocating to more regional areas because of jobs, cost of living and migrant regionalisation policies, thus resulting in poor access to support services.

Gaps in the provision of culturally appropriate primary health care services

The consultation identified the following gaps in the provision of culturally appropriate primary health care services (see Figure 31).

Low availability and uptake of Interpreter services

Interpreter services were viewed as a significant solution for overcoming language barriers and assisting CALD groups in engaging with and navigating the healthcare system. Participants noted that, despite the documented link between interpreter access and improved patient health care experiences and outcomes, interpreters were underutilised, particularly in general practice settings. The reasons for not using interpreters were perceived as low availability, the perception of a lack of interpreter availability, and the extra workload when using interpreters. A representative from IMS commented:

"The doctors or the pathologists are not using interpreters, and we have to do a lot of advocacy. It is very time-consuming, and it's very hard to get the message across to the service provider that you know, like it's the clients right, to understand what's happening"

Participants stated that for CALD people with limited English abilities, the lack of interpreting services meant missing a medical appointment. Furthermore, it was noticed that some minority CALD communities, such as Burmese migrants with refugee experiences, lacked interpreters, putting already vulnerable people at a disadvantage.

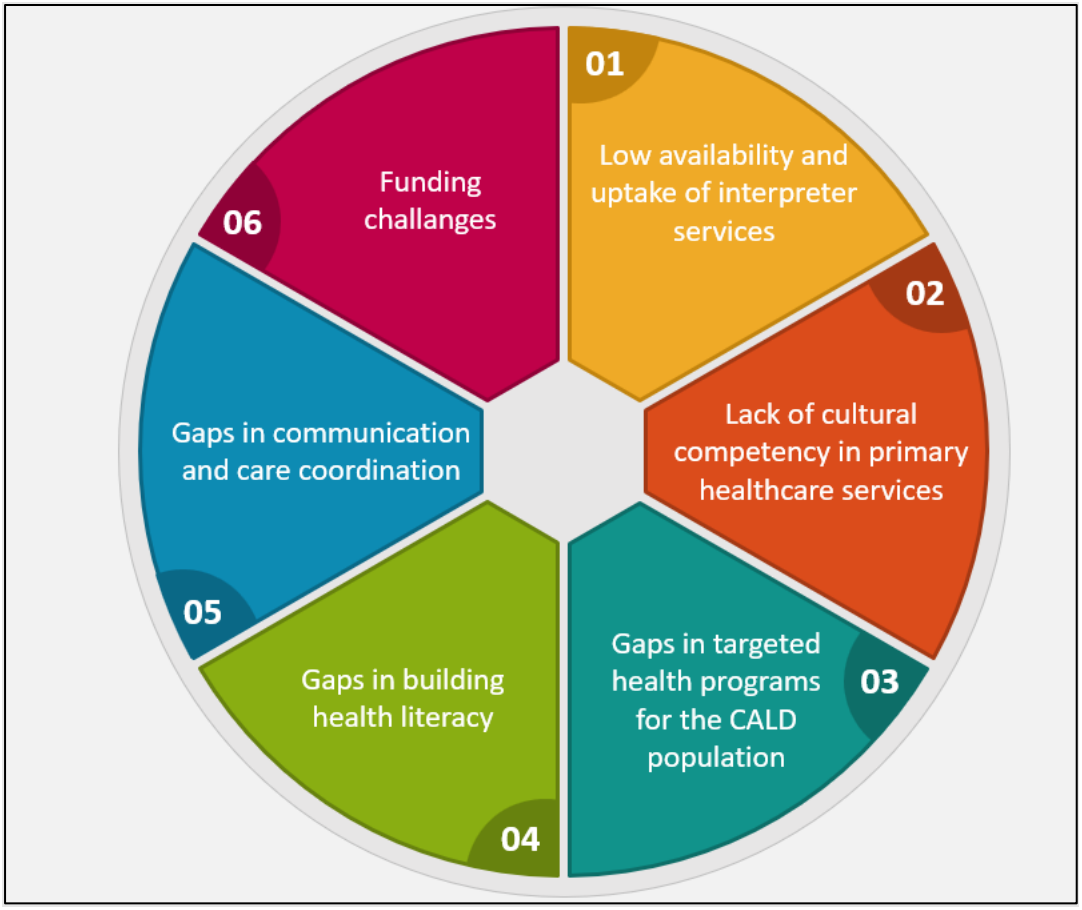
Participants commonly expressed worries about using family members, particularly children and acquaintances, as interpreters for the CALD population with limited English language abilities.

"There is never a situation where a minor should be used to interpret medical information and we see it all the time" – A Multicultural Health Representative

Participants recognised using non-accredited interpreters as compromising the quality of care because they lacked the vocabulary to interpret complex medical terminology that could lead to misunderstandings and errors in translating key care components, such as symptom identification and participation in medical decision-making.

Some participants raised limited knowledge among health professionals on accessing and using interpreting services and suggested training programs to upskill health professionals on how to organise and use interpreters and translators.

Figure 31. Gaps in the provision of culturally appropriate primary healthcare services



Lack of cultural competency in primary healthcare services

One of the most frequently raised issues from the consultation was a lack of cultural competency among health professionals. Almost all participants mentioned the need for ongoing cultural competency training for health professionals to enhance their cultural understanding and capability of working with CALD clients. Participants viewed the lack of culturally competent services to result in poor experiences for the CALD population, thus impacting their future access to those services.

"They're not going to go and self-refer to something like headspace or a psychologist, but even if they did, those organisations may not be culturally appropriate or equipped to deal with that appropriately" – A Multicultural Health Service representative.

"Culturally inclusive, culturally competent training should be ongoing for the health providers" – A General Practice representative.

Participants emphasised that societal discrimination and unconscious bias had a negative influence on CALD people's interactions with the health system. These impediments were perceived to exist in the CALD population, independent of English language skills. Stating the unconscious bias among health care providers as a barrier to the CALD population's involvement with the health care system, a participant commented:

"There's already this unconscious bias that shouldn't be there with professionals, but it's there and that and that obviously translates in really, really bad health outcomes" – A General Practice representative.

When asked about the meaning and characteristics of cultural appropriateness, participants opined that it is a mix of empathetic attitudes and behaviours among health professionals to recognise cultural diversity among the CALD population in a nonjudgmental way. Participants repeatedly emphasised that cultural perspectives must be considered in planning, promoting and delivering services. Providing an example of varying cultural and spiritual views of mental health, a participant commented that the Westernised focus of conventional health care did not fit right with CALD populations as they could not relate to the concept of mental health. The participant quoted:

"If you want to promote mental health, maybe we shouldn't promote mental health. But, like, there are individuals available to help you in your difficult times. We have a very westernised view of this is what mental health services should look like and less, we're prepared to adapt outside of that." – A Multicultural Health Representative.

Similarly, participants highlighted that gender preferences vary across cultures and general practices were not always seen as proactively engaging with the CALD population to address those cross-cultural barriers. Emphasising the importance of providing a culturally appropriate setting while raising patient awareness regarding subjects such as contraception and cervical screening among the CALD population, a participant commented:

"The discussion around contraception needs to be something that clients should feel comfortable asking their GP about, but that's not often the case" – A General Practice Representative.

All participants acknowledged that providing culturally competent care beyond translation and interpretation depended on effective communication and recognising and respecting cultural differences. It was repeatedly raised that interpreting cultural competency to be predominantly about addressing language barriers was too simplistic but, unfortunately, this perception was quite common in the primary health care landscape. It was also raised that despite this view, interpreters were still not used enough. A participant quoted:

"A lot of GPs speak another language and if you say, oh, there's training around cultural understanding and interpreter use, they just perceive that they know it and they don't need it" – A Local Health representative.

Gaps in targeted health programs for the CALD population

Participants identified gaps in the availability of targeted programs or services to support people from CALD backgrounds who speak a language other than English and have little to no English language skills. As an example, the lack of appropriately funded cancer survivorship programs for cancer patients speaking a language other than English was described as a massive gap in the provision of culturally appropriate services. A participant commented:

"There is absolutely nothing for CALD communities around supporting people living with, having lived and survived a cancer diagnosis and treatment" A Local Health District representative.

Though there were accounts of some local cancer support groups in the catchment, those were believed to be volunteer-based and very limited in capacity.

Underscoring the complex health needs of refugee migrants, participants often raised concerns about limited access to primary health care for refugee migrants. Participants observed that despite the availability of Commonwealth and State-funded initiatives to support the transition to mainstream health services, refugee migrants had limited engagement with primary health care services, particularly General Practices. Participants stressed the need to support and upskill General practices to provide targeted refugee engagement.

Gaps in building health literacy

Participants identified systemic gaps leading to poor health literacy among some CALD populations. Many participants pointed towards a gap in support services that connect the recently arrived CALD population to local health services. Similarly, participants frequently raised the lack of the correct information at the right place to facilitate health service access among CALD populations with limited English language skills. For example, one participant discussed the lack of translated resources on the Advance Care Planning website, noting the gap in providing health information to elderly migrants.

"The advance care planning website, is one of the best websites I've seen. It's so detailed. It has so many resources and it's fantastic, but it's fantastic for me as an English-speaking person with access to computers, with the knowledge of the information, but it's not helpful to somebody in their 90s whose second language is English and who needs to be doing that stuff now and something that they need face-to-face hands-on" – A Multicultural Health Representative.

Furthermore, there was consensus among participants that online and printed health promotion materials were insufficient, and there was a strong need for outreach health promotion for the CALD population. Stating a gap in spreading the health information resources to relevant communities, a participant commented:

"Sometimes there's lots of investment in resources, but the promotion of those resources and their distribution remains a gap" – A Local Health District representative.

Citing the limited reach and utilisation of translated resources, participants pointed towards:

- A need for outreach in building health awareness and literacy among CALD populations.
- A need to broaden the reach of translated health resources.

Gaps in communication and care coordination

Participants providing social and health support services to the CALD population pointed out a gap in care coordination and communication across the health system, which was found to

hinder the delivery of social support services. Participants commonly said that people from CALD backgrounds, particularly refugee communities, had established relationships with their local social support services. However, there was a lack of systemic coordination between those support and primary health care services. Participants emphasised that improved communication and coordination among social and health services could enhance primary healthcare access among the CALD population.

One focus group during the consultation covered a gap in data collection on CALD status in primary health care. Participants raised the idea that a structured dataset would support tailored planning and delivery at the service and system levels by objectifying the health needs and outcomes of the local CALD population.

Funding challenges

Participants commonly expressed worries about short-term health programs for the CALD population, which negatively impacted involvement and confidence in the services provided. Participants emphasised the importance of well-planned, locally adapted, and sustainable programs to improve primary health care access over several short-term fragmented care choices that confuse the CALD community and service providers.

"Thousands of times, the government rolls out six-month, one-year programs, and then it changes, and it changes, and it changes. If you've got really good evidence-based programs, why did they start and stop? Why are they not just part of the health system?" – A Multicultural Health Representative.

"Health promotion and multicultural health are really sidelined and unresolved and under-resourced in a giant health bureaucracy" – A Local Council representative.

The consultation also found that many local service providers across the social and health sectors were proactive in providing dedicated services to the local CALD communities but were limited by a lack of funding to sustain their work. Participants, on multiple occasions, pointed out that the SENSWPHN could identify and support such existing service providers by relocating resources to them, quoting:

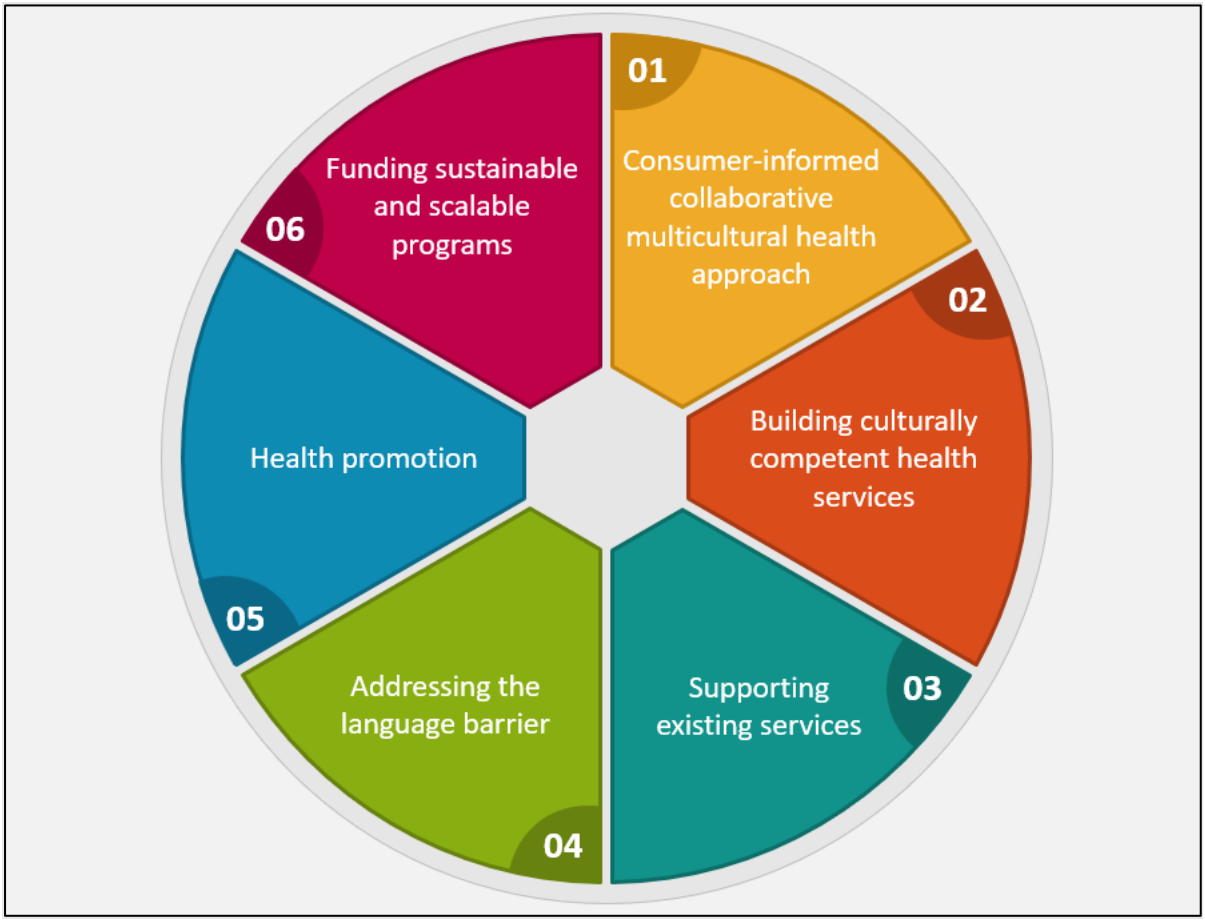
"A handful of people in health promotion in Wollongong and one NGO that is going hand to mouth with their programming, it's not enough." – A Local Council representative.

"If you look at health promotion, Healthy Cities Illawarra, an amazing organisation, likely who do wonderful stuff, but they're caught in their short-term funding cycle often, and they deliver these brilliant, impactful programs and then they stop" – A Multicultural Health Representative.

Enabling factors to enhance primary healthcare access among CALD communities

Participants discussed several ways to enhance primary healthcare access among the CALD population. Given below are the key themes that emerged as enabling factors in the consultation (see Figure 32).

Figure 32. Key enablers to enhancing primary health care access among the CALD population



A consumer-informed collaborative multicultural health approach

The consultation demonstrated that a range of social, not-for-profit and health services have been proactively providing or coordinating accessible primary care for CALD populations, particularly for migrants with refugee backgrounds. However, there appeared to be a need to map such services in the PHN catchment and subsequently collaborate and integrate at the regional level to enhance primary healthcare access among the CALD population.

Participants advised implementing a regional framework identifying CALD health as a priority area. This would enable joint planning and collaborative efforts among local organisations and primary health care providers to provide accessible, appropriate, and affordable services.

Participants repeatedly stressed the role of involving CALD communities in planning culturally appropriate services, emphasising the varying cultural beliefs related to health service uptake.

One participant commented:

"As services, we have a point of view, but you'll get gold Nuggets from community members themselves because they're the ones facing it" – A Multicultural Health Representative

Building culturally competent health services

Participants suggested that health services must ensure appropriate ongoing and compulsory training for primary health care services to comprehend how patients from CALD groups interpret their illness's cause and prognosis, describe their symptoms, understand how treatments work, and view their participation in it.

It was repeatedly stressed that generic and online cultural competence training would not be enough. Instead, it had to reflect the local CALD demographic and their health care preferences. Participants were optimistic that if general practices implemented such learning in their practice, it would improve engagement from CALD communities. One participant exemplified a scenario, stating:"

"It is about gestures and signalling. If you know your local community, then you can know what days might be significant to them. You can signal that you at your practice know these things you can acknowledge Ramadan, Karenni people have Deeku festival, and all of these different things that you can do." – A Local Health District representative.

Participants strongly voiced that health professional development courses need to be expanded beyond Aboriginal and Torres Strait Islander peoples to include cultural training for CALD populations. Participants believed that this would considerably improve the capacity of health professionals to recognise and appreciate cultural diversity and their communication skills when working with people from CALD backgrounds.

Recruitment and retention of a culturally diverse workforce also emerged as an enabling factor to enhance primary health care access and engagement among the CALD population. Participants perceived that shared migration experiences and cultural and linguistic similarities made people from CALD backgrounds feel connected with the services and service providers.

Supporting migrant support services to facilitate health system navigation

General support services must be provided during the early settlement period to help people better grasp the resources and navigate the health system. The consultation found that the local migrant support organisations contributed to the health and well-being of the CALD population and had been covering a wide range of communities with an extensive network of bilingual community workers and volunteers. Their understanding of the local context and demographics emerged as an enabler to support health care navigation in the CALD population. A representative from MCCI commented:

"Those local services that start to build that rapport and trust with somebody who bring a lens of, of generalist expertise to see what's going on for that person"

Nevertheless, their resources, coverage, and range of practice were constrained. Participants advised that a more expansive support system be provided by allocating resources to local health services or migrant health organisations competent in understanding the cultural and language barriers CALD populations face in rural settings. These roles will be critical in assisting health services and CALD populations in finding the correct services at the right time.

Addressing the language barrier

Improving the availability and uptake of interpreter services was seen as the leading enabler of addressing the language barrier in providing primary health care. Participants repeatedly recognised using interpreter services as a skill that health professionals should be well-equipped with.

Participants suggested that interpreting services, primarily in-person interpreters, must be improved and expanded to maximise the benefits of telecommunication strategies. It is also critical to make multilingual health information broadly accessible to communities. To this end, bilingual health workers should be promoted.

Health promotion at the community level

Participants expressed the need to invest in culturally relevant and community-oriented health literacy and health promotion programs to improve their understanding of choice and control, health care system navigation, and self-management skills. According to some participants, focusing more on health promotion, including group activities, would not only reduce the need for acute care but also allow the community to build relationships and improve their health literacy by connecting with other people and health services. This, in turn, would improve the accessibility and acceptability of health care.

"I see the most value is in the preventative health and the health prevention programs" – A Local Council representative.

Participants also suggested that co-location and outreach approaches would better engage people from diverse backgrounds. Examples of such models included providing health services or health promotion within culturally safe and trusted community services. Participants opined that such models could reduce barriers to access, encourage engagement, and lead to more integrated support for the CALD population.

In addition, participants consistently emphasised the necessity of incorporating community leaders or representatives in health promotion or literacy programs, underscoring that community representatives were in close contact with the people they represent and were familiar with the needs of their community. Empowering community representatives to be aware of available health and social care services and how to navigate them can help bridge the gap between the two.

Funding scalable and sustainable programs

Throughout the consultation, participants raised the need for sustainable funding models to ensure the ongoing delivery of health programs to meet identified service gaps and needs for multicultural communities. Acknowledging the diversity within the CALD population, participants emphasised that the funded models of care should be scalable to meet the needs of different communities.

Recommendations

Over the last few decades, Australia's population and ethnic landscape have evolved substantially. The expanding population of culturally and linguistically diverse (CALD) groups necessitates improvements in health service delivery to meet their distinctive health requirements. CALD people experience numerous barriers to obtaining health care. Access to and utilisation of health services are varied and influenced by various individual and social factors. Furthermore, health systems, organisations, and provider characteristics all impact poor access and utilisation of health services. Given Australia's increasing number and diversity of CALD populations, notably in regional locations, local knowledge of these characteristics is critical to identifying existing gaps and health service needs and motivating action towards addressing these issues. This consultation highlighted that the SENSWPHN has a role to play in enhancing primary health care access among the CALD population by:

- Collaborate and co-design with CALD communities, health and social services to support regional integration and collaboration for improving access and utilisation of primary health care services among the CALD population
- Identify and support local health services working towards improved health outcomes for the CALD population
- Provide training opportunities to general practices and commissioned services to improve cultural competency and use of interpreter services
- Encourage general practices to understand their local demographics better and promote engagement with the CALD population
- Support recruitment and retention of bilingual health workforce
- Commission sustainable and scalable initiatives

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