Government of Western Australia
Department of Health

Interface between health, aged care and disability

Context

- Enabling and facilitating people to access the most appropriate services for their needs enhances system sustainability and brings social benefits by ensuring people get the right care, in the right place at the right time.
- The health and wellbeing of Western Australians is supported by a range of public (both State and Commonwealth Government), private and not-for-profit services. Each has distinct governance arrangements, funding mechanisms, and assessment in eligibility criteria meaning it can be difficult for consumers to access and navigate the system to receive the care they need across and within these silos.
- In Western Australia, 14 per cent of people see three or more health professionals for the same conditions.(1)
- Chronic condition comorbidity occurs when a person has two or more chronic conditions, such as diabetes and asthma, at the same time. In 2017-18, around half (47%) of Australians had one or more common chronic conditions.(2) The rate of comorbidity was higher for people aged 65 and over, with eight in ten (80%) people having one or more chronic condition. These statistics highlight the need for coordinated care within the health system.
- Support for those with complex care requirements to be able to access and use services may be required by a number of different cohorts in a range of circumstances, on either an ongoing or as needed basis. Support, including navigation and joint planning, should be provided on a scale depending on the needs of a particular cohort or individual. Navigation can range from guidance, to brokerage and actively organising a patient's care (care coordination), either within a particular sector (e.g. health, disability, aged care) or between sectors. Joint planning may entail these sectors working in partnership to organise a patient's care.
- Throughout the Sustainable Health Review (SHR) public submissions and engagement events highlighted consumers' difficulty in accessing the services they need and managing the coordination of care. Public consultation described both a lack of information about the available and most appropriate services and difficulty accessing these services once identified. Care coordination and communication was raised as requiring improvement, especially for those with complex care requirements who may need to access a range of services, or those that are separate to the health system, such as disability services delivered by the National Disability Insurance Scheme (NDIS).

- Those who may require assistance with accessing and navigating their care requirements across the health, disability and aged care sectors include, but are not limited to:
  - Individuals using a service for the first time, such as consumers with complex healthcare requirements that become eligible for aged care services (by virtue of age).
  - Individuals transitioning between services, such as consumers no longer eligible for the NDIS (people over 65 years, or over 55 years for Aboriginal and Torres Strait Islanders) who are therefore required to access services through the health and/or aged care system instead.
  - Individuals likely to be using multiple systems simultaneously, such as consumers with mental health issues eligible for the NDIS. This cohort is required to navigate two very different systems. Note there are underlying differences between the mental health sector and the NDIS. The mental health sector is built upon a recovery model while the NDIS is designed for those with disability.[1]
  - Consumers generally impacted by policy reforms to the aged care and disability service sectors as these changes are rolled out.
- People experiencing socio-economic disadvantages may require greater assistance navigating the system. These groups can include:
  - people experiencing homelessness
  - Aboriginal and Torres Strait Islander people
  - Culturally and Linguistically Diverse people
  - people located in regional and remote areas
  - people experiencing family and domestic violence
  - at-risk youth
  - older people.

Exemplars considered

A range of exemplars were identified throughout the course of the SHR in public submissions, Clinical and Consumer and Carer Reference Groups, Working Groups and in public forums. The following exemplars are indicative, however are not an exhaustive list of the exemplars considered throughout the SHR.

Southern Inland Health Initiative, Western Australia[3]

- The southern inland catchment area in Western Australia includes the Coastal Wheatbelt, Eastern Wheatbelt, Southern Wheatbelt, Western Wheatbelt, Great Southern, Warren Blackwood, Goldfields, Midwest and South West region.
- The Southern Inland Health Initiative (SIHI) represents a range of initiatives including the Health Navigator program which is a telehealth service that links health professionals and patients with chronic disease to other health providers to help people manage their condition better.
- In a 2015 survey of Health Navigator clients, 86 per cent of the 41 people who responded were satisfied or very satisfied with the service and almost all considered that they were helped to better manage their health and improve their quality of life.[3]

Victoria's HealthLinks: Chronic Care program[4]

- The Chronic Care program in Victoria was introduced to improve care for patients at high risk of multiple unplanned hospital admissions, many of whom have chronic and complex conditions. The program involves a flexible funding model and is being tested to see whether the model can remove some of the factors that prevent effective, integrated models of care without costing the health system more.
- The health services involved have the opportunity to use projected inpatient funding to plan care catered to the needs of patients at high risk of multiple unplanned hospital admissions. Care can therefore involve a range of services delivered by multiple providers which go beyond the care of the hospital.

Buurtzorg Nederland, Netherlands[5]

- Buurtzorg Nederland is a not-for-profit healthcare organisation that originated in the Netherlands. In 2006, Jos deBlok introduced the Buurtzorg model which is based on universal human values such as humanity and interconnectedness.
- The model involves self-directed teams of professional nurses and nurse assistants to manage their work and themselves rather than employing managers. The nurses work closely with general practitioners and other healthcare providers to provide holistic, relationship-based care, based on the needs that the client and family have identified.
- Buurtzorg has a low overhead due to its organisational structure resulting in financial sustainability and savings for clients and the government.
- Buurtzorg teams have since been established in in 24 countries including Sweden, United States and recently Australia.

Sustainable Health Review

This background paper was developed by the Sustainable Heath Review secretariat to inform the work of the Sustainable Heath Review Panel. Every effort has been taken to ensure accuracy, currency and reliability of the content. The background paper is not intended to be a comprehensive overview of the subject nor does it represent the position of the Western Australian Government. Changes in circumstances after the time of publication may impact the quality of the information. Background papers are published in full at: www.health.wa.gov.au/sustainablehealthreview.

This document can be made available in alternative formats on request for a person with disability.

health.wa.gov.au

References

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