The Australian system of universal health care and services for homeless people.

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Melbourne, Australia

PAPUA NEW GUINEA
Arafura Sea
INDONESIA
Cape York
Darwin
Gulf of Carpentaria
Katherine
Wyndham
Cooktown
Indian Ocean
Derby
Cairns
Coral Sea
Townsville
NORTHERN TERRITORY
Tennant Creek
Mount Isa
Port Hedland
Mackay
Karratha
Alice Springs
Ashburton
QUEENSLAND
Rockhampton
WESTERN AUSTRALIA
Bundaberg
Charleville
Lake Eyre
SOUTH AUSTRALIA
Brisbane
Gold Coast
Geraldton
Bourke
Kalgoorlie
Lake Torrens
Darling
NEW SOUTH WALES
Perth
Port Augusta
Fremantle
Newcastle
Sydney
Adelaide
Wollongong
Murray
Canberra
Albany
VICTORIA
AUSTRALIAN CAPITAL TERRITORY
Mount Gambier
Melbourne
Geelong
Traralgon
Launceston
TASMANIA
Indian Ocean
Hobart

Background

- Australia has 24 Million people
- Melbourne has 4.4 Million people, Sydney 4.8 Million
  - A First Fleet of British ships arrived at Botany Bay in January 1788 to establish a penal colony.
  - Autonomous Parliamentary democracies began to be established throughout the six British colonies from the mid-19th century.
  - The colonies voted to unite in a Federation in 1901, and modern Australia came into being.
- Same size as USA (excluding Alaska)

Politics and Finances

- Taxes are raised nationally, and distributed to States.
- Divided responsibility for service delivery.
- States have responsibility for social housing and hospital based healthcare.
- National government is responsible for non-hospital healthcare and social security.
- The division is blurred and there is often conflict, in part due to voters not appreciating the details of who is responsible for a particular issue.

Homelessness 2011: 49 persons for every 10,000
115,000 people (0.5% of the population)

- Australian Bureau of Statistics Census 2011
  - **Primary homelessness** - people without conventional accommodation (living in the streets, in deserted buildings, in parks, etc.) 7,000
  - **Secondary homelessness** - people moving between various forms of temporary shelter including friends, emergency accommodation, youth refuges, hostels and boarding houses 39,000
  - **Tertiary homelessness** - people living in crowded boarding houses without their own bathroom, kitchen or security of tenure 69,000
  - **Marginally housed** - people in housing situations close to the minimum standard. 78,000

THE ROYAL AUSTRALIAN REGIMENT
MEMORIAL
KOREA
1950-53
SOMALIA
1993
AFGHANISTAN
2005
MALAYA
1955-63
IRAQ
2003

Why do some countries have universal healthcare systems?

- International differences of opinion in providing services
  - Shared community responsibility, or individual responsibility, for health.
  - Availability of social services including support for people out of work, people with disability, low income families, elderly people etc.
  - Availability of affordable housing.
  - Is healthcare an essential service or a risk?

Essential service or risk

- The community in Australia (and most developed nations) has an expectation that the government provides health care as a service to all citizens. This is similar to the provision of basic education services, transport structures, judicial systems, etc.
- Insurance, in any form, is seen as a method of managing an unexpected or infrequent event or risk.
- This relates to whether health care is a right of all citizens or a privilege that must be earned and paid for

Medicare

- Medicare is the Federal funded health insurance scheme that provides free or subsidised health care services to the Australian population. It provides free hospital services for public patients in public hospitals through the States, and provides benefits for out-of-hospital medical services such as consultations with general practitioners or specialists (85 per cent of the Schedule fee).
- There was an increase in the number of Australians covered by private health insurance plans through the 1950s and 1960s. However, a large proportion of the population continued to lack coverage for health risks in the early 1970s. In 1972, 17% of were uninsured, most of whom were on low incomes.
- Medicare commenced on 1 July 1975.

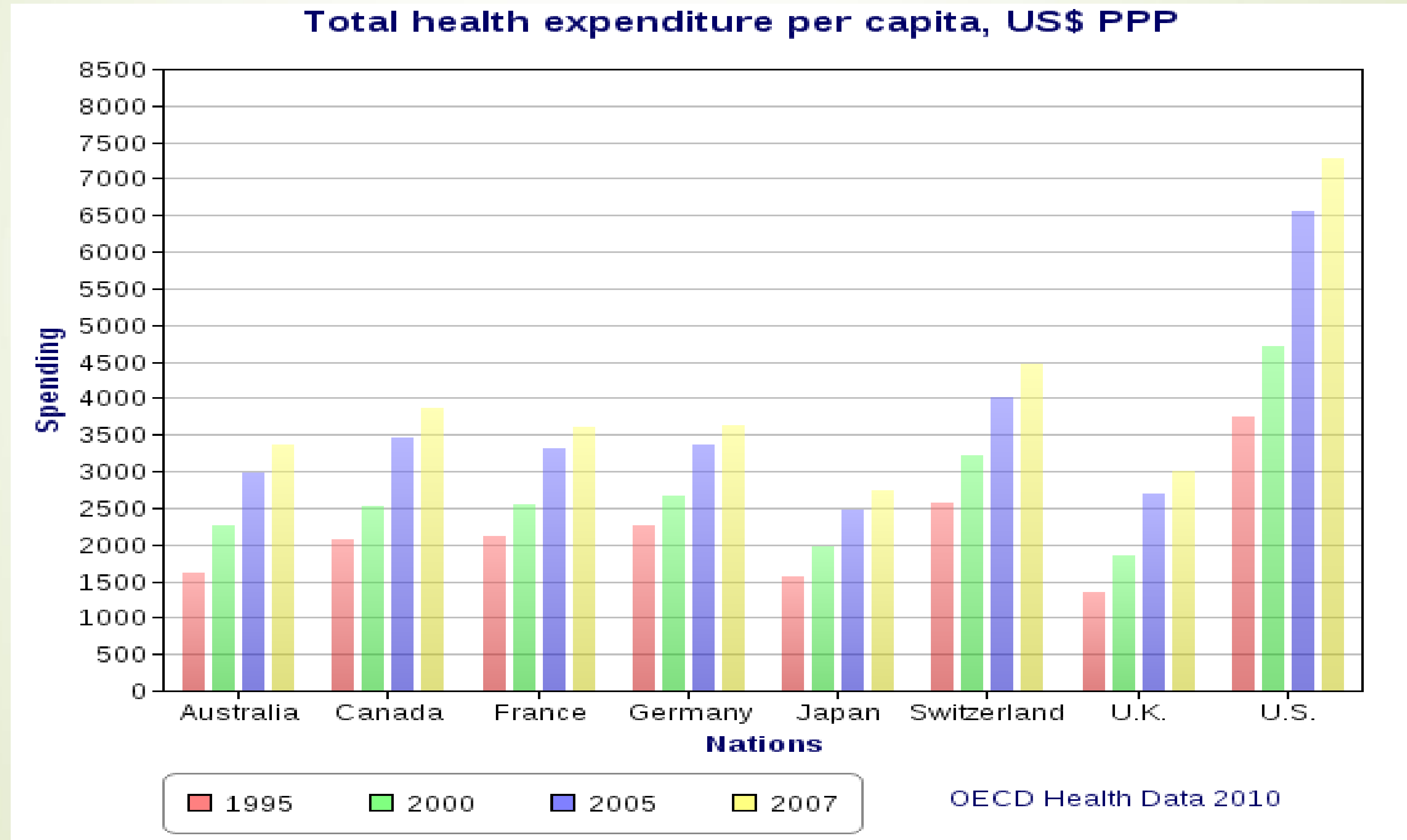
Medicare funding

- The program is now nominally funded by an income tax surcharge, known as the *Medicare levy*, which is currently set at 2% of a person's taxable income. An exemption applies to low income earners, with different thresholds applying to singles, families, seniors and pensioners, with a phasing-in range.
- There is an additional tiered levy of 1.0%-1.5%, known as the Medicare Levy Surcharge, for individuals on high annual incomes (starting at $80,001 for individuals and $176,001 for families) who do not have adequate levels of private hospital coverage. This was part of an effort by the Federal Government to encourage people towards private health insurance.
- The levy raises $20 Billion annually and covers about half the cost of the Medicare program.
- A related program, the Pharmaceuticals Benefits Scheme, subsidizes the cost of medication.

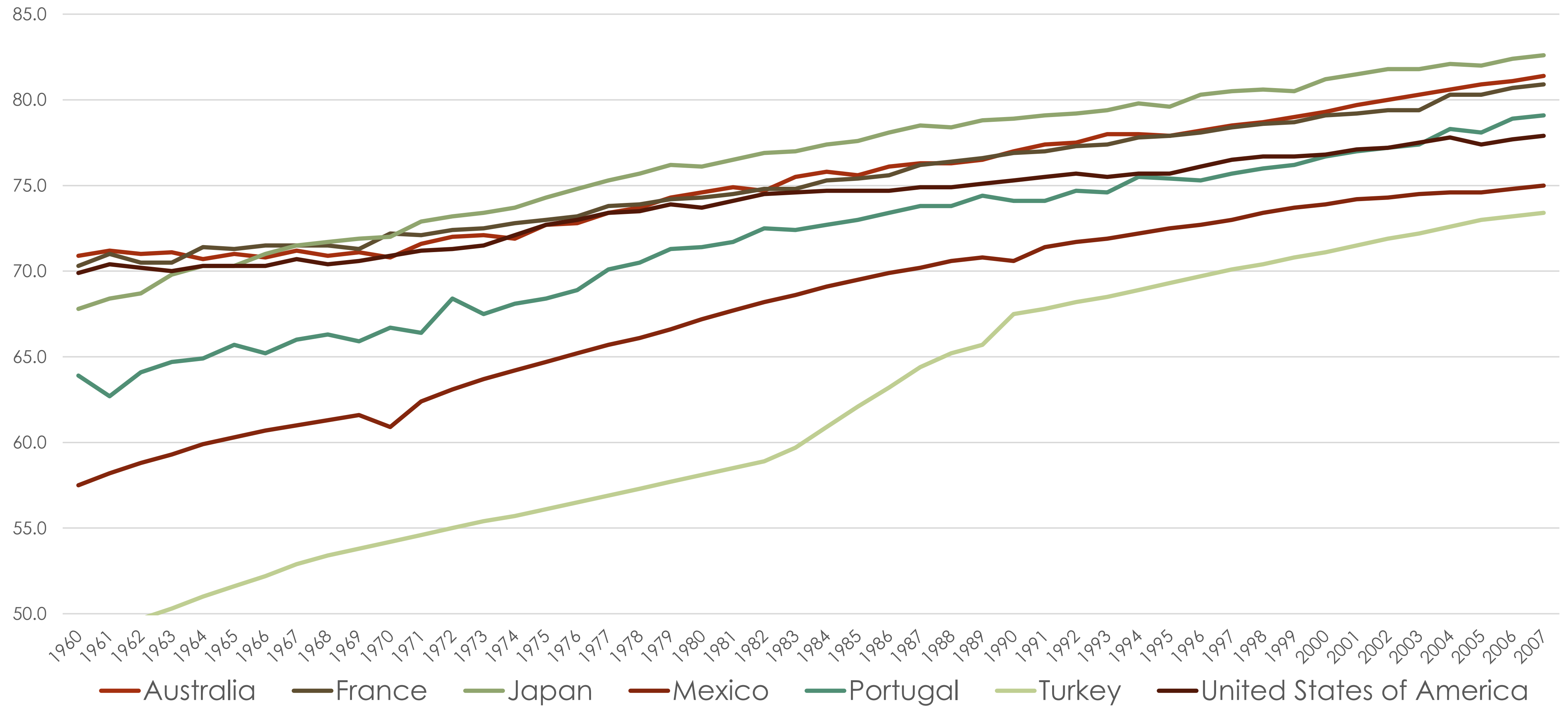
Medicare problems

- Healthcare is becoming more expensive.
- People live longer.
- Constant fights between the States and the Federal Government over cost sharing and cost shifting.
- Increasing funding gaps for primary care services.
- Meeting demand in rural and remote areas.
- Meeting the need of marginalized communities including people who are homeless.

Total health spending per capita of various first world nations.



Life expectancy



Physical Healthcare for the Homeless in Australia

Physical Healthcare for the Homeless in Australia

- Theoretically everyone is able to access primary care providers who are prepared to accept the Medicare fee (over 80%).
- Full access to public hospital emergency department, inpatient and outpatient services.
- Hospitals generally attempt not to discharge people to street homelessness.

Physical Healthcare - Problems

- No National approach, with States and local areas then developing some services.
- While inpatient care is generally adequate, with longer length of stay than the general population, processes of community and preventative care are more complex and difficult.
- The assumption that generic services are available to homeless people may result in poor funding to specialized homeless services.

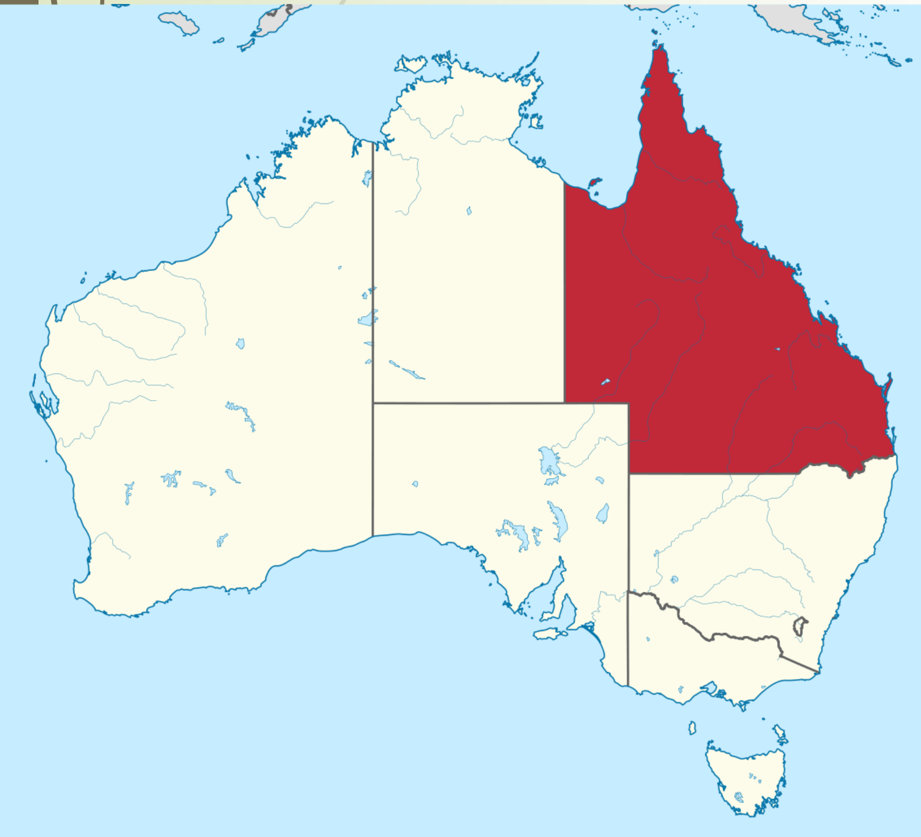
Physical Healthcare – Problems with generic services

- Access
  - Waiting times
  - Hours of service operation
- Acceptance
  - Different needs to the general population
  - Dress, behaviour
  - Poor attendance and compliance with advice
- Understanding
  - Of the homeless life and experience
  - Of the complexity of problems

Physical Healthcare – Some Models

- Specialist primary care clinic for homeless people
  - Acceptance and understanding of the issues
  - No appointments needed
  - Broad range of clinical and non-clinical services
  - Multi-disciplinary team approach
  - Links to public hospitals
  - Funding support from not-for-profit sector eg Salvation Army, City Council.
  - Relatively few, and mainly in inner city settings

Physical Healthcare – Some Models



- Homeless to Home Healthcare in Brisbane, Queensland
  - Integrates nurses with non-clinical homeless outreach teams
  - By combining mobile healthcare with assertive homeless street outreach, teams can make it easier for homeless people to get the care they need while simultaneously helping them to escape the streets permanently.
  - The goal is to create a single, mobile access point for after-hours housing and healthcare services in order to end homelessness and address poor health at the same time.

Physical Healthcare – Some Models

- Royal District Nursing Service Homeless Persons Program in Melbourne, Victoria
  - Team of specialist community health nurses providing contact at agencies visited by people experiencing homelessness
  - Actively reaching out to people in rooming houses, crisis accommodations, hotels, parks and on the street
  - Providing primary care, including health and social assessments, professional nursing care, counselling and active support, first aid, medication management, and follow up
  - Promoting and maintaining health and preventing illness to individuals experiencing homelessness (individually and in groups)
  - Implementing collaborative programs between homeless people and other health services, including public hospitals

Physical Healthcare – Some Models

- Doorway Program – Mental Illness Fellowship Victoria
- Small Housing First programs demonstrated improved healthcare.
  - More engaged in the development and management of health plans and with their primary health providers
  - Having more stable accommodation made it easier for participants to attend appointments with clinicians, and for their formal supports, including clinicians, to stay in touch with or seek out their clients if need be
  - Decreased Emergency Department presentations across all participants and decreases in urgent presentations
  - Decreased general hospital admissions

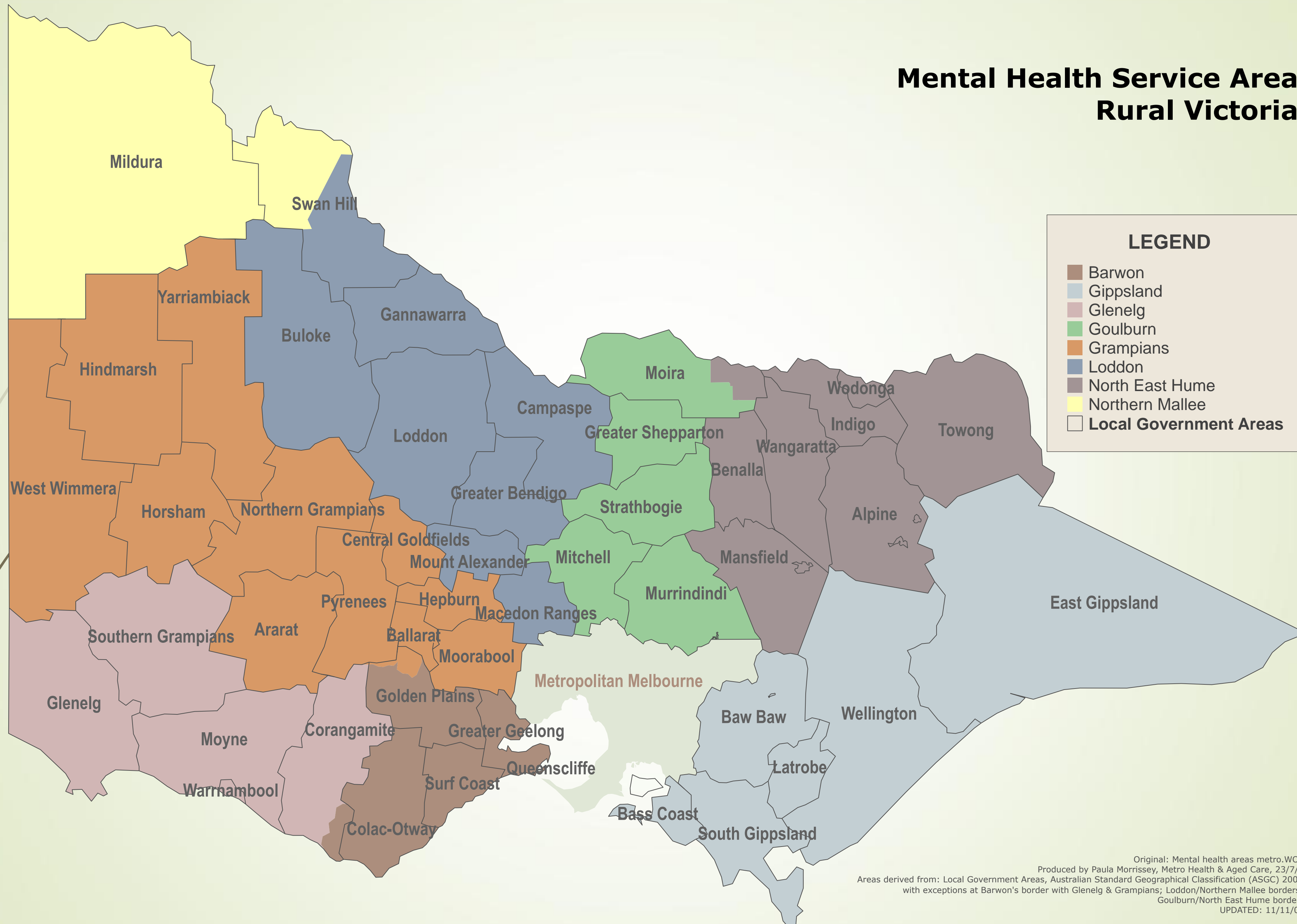
Service gaps are significant

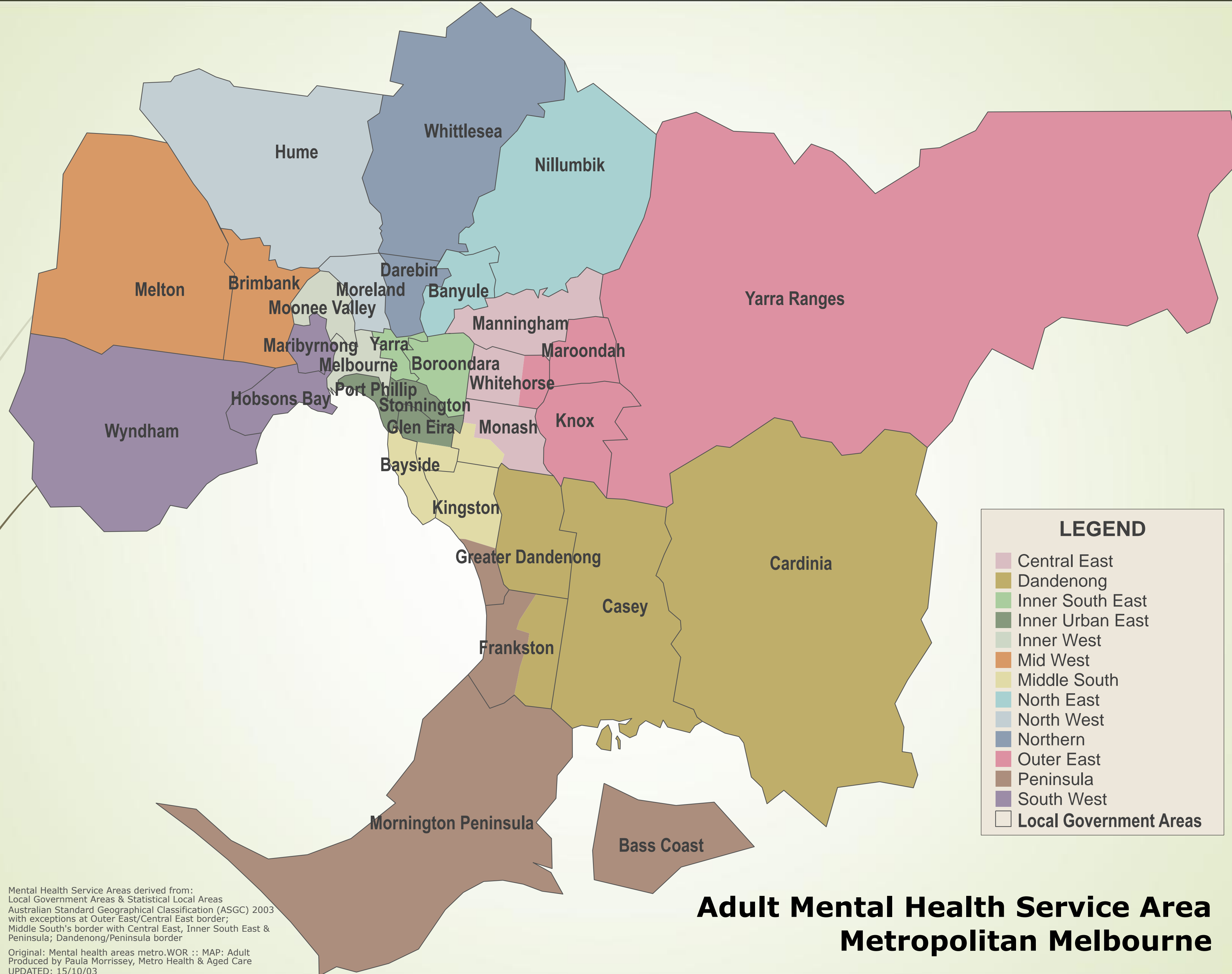
- Few specific street medicine programs, only some with nursing services.
- No respite care facilities, although these may not be needed.
- No national identification of need and no co-ordination of homeless health services.
- Poor linkage between community and hospital services.
- Very limited dental services.

Mental Healthcare for the Homeless in Australia

Service System

- Each State operates similar mental health services, with a National Plan attempting to provide some degree of standardization..
- State managed from Federal funds.
- Adult Mental Health Services in Victoria
  - 21 Catchment Areas (about 300,000 people)
  - Acute Beds in general hospitals
  - Community Services developing since mid 1990s
- Separate services for Child and for Aged.
- Community based rehabilitation and recovery programs run by not-for-profits


Mental Health Service Area
Rural Victoria
LEGEND
Barwon
Gippsland
Glenelg
Goulburn
Grampians
Loddon
North East Hume
Northern Mallee
Local Government Areas
Mildura
Swan Hill
Yarriambiack
Buloke
Gannawarra
Hindmarsh
Campaspe
Moira
Wodonga
Indigo
Towong
Greater Shepparton
Wangaratta
Loddon
Benalla
West Wimmera
Horsham
Northern Grampians
Greater Bendigo
Strathbogie
Alpine
Central Goldfields
Mount Alexander
Mitchell
Mansfield
Murrindindi
Pyrenees
Hepburn
Macedon Ranges
East Gippsland
Southern Grampians
Ararat
Ballarat
Moorabool
Metropolitan Melbourne
Golden Plains
Glenelg
Baw Baw
Wellington
Moyne
Corangamite
Greater Geelong
Queenscliffe
Latrobe
Warrnambool
Surf Coast
Bass Coast
Colac-Otway
South Gippsland
Original: Mental health areas metro.WOR
Produced by Paula Morrissey, Metro Health & Aged Care, 23/7/3
Areas derived from: Local Government Areas, Australian Standard Geographical Classification (ASGC) 2003
with exceptions at Barwon's border with Glenelg & Grampians; Loddon/Northern Mallee borders;
Goulburn/North East Hume borders
UPDATED: 11/11/03


Hume
Whittlesea
Nillumbik
Melton
Brimbank
Moreland
Darebin
Banyule
Moonee Valley
Yarra Ranges
Manningham
Maroondah
Maribyrnong
Yarra
Melbourne
Boroondara
Whitehorse
Hobsons Bay
Port Phillip
Stonnington
Wyndham
Glen Eira
Monash
Knox
Bayside
Kingston
Greater Dandenong
Cardinia
Casey
Frankston
Mornington Peninsula
Bass Coast
LEGEND
Central East
Dandenong
Inner South East
Inner Urban East
Inner West
Mid West
Middle South
North East
North West
Northern
Outer East
Peninsula
South West
Local Government Areas
Mental Health Service Areas derived from:
Local Government Areas & Statistical Local Areas
Australian Standard Geographical Classification (ASGC) 2003
with exceptions at Outer East/Central East border;
Middle South's border with Central East, Inner South East &
Peninsula; Dandenong/Peninsula border
Original: Mental health areas metro.WOR :: MAP: Adult
Produced by Paula Morrissey, Metro Health & Aged Care
UPDATED: 15/10/03
Adult Mental Health Service Area
Metropolitan Melbourne

Adult specialist mental health services

- People with severe mental illness who have associated significant levels of disturbance and psychosocial disability due to their illness.
- Commonly these will be people with a diagnosis of a illnesses such as schizophrenia or bipolar disorder.
- Some people with other conditions such as severe personality disorder, severe mood disorder, or those who present in situational crisis that may lead to self-harm or inappropriate behaviour towards others.
- Increasingly, adult mental health service consumers have more than one disorder, with drug and alcohol related disorders (dual diagnosis) being most prevalent.
- Most people with less severe mental illness are managed through primary care (general practitioners) and private systems.

Service components

- All specialist mental health services are required to provide a range of components so that consumers have access to similar service responses and functions wherever they live.
- However the health services and hospitals deliver their public specialist mental health services differently depending on the local service environment and catchment area.
- Bed-based services are a combination of acute beds within a general hospital, and rehabilitation beds based in community settings for short term or long term care.

Community services

- Clinic based Continuing Care Teams
  - These are the largest component of adult community based services.
  - These services provide non-urgent assessments, treatment, case management, support and continuing care services to people with a mental illness in the community and are generally clinic based.
  - Short term intensive case management is provided for people who are temporarily more unwell, including outreach and home visits.
  - A full time case manager would have about 25 to 30 clients.
- Crisis Assessment and Treatment Teams
  - These services operate 24 hours a day and provide urgent community-based assessment and intensive short-term treatment interventions to people in psychiatric crisis as an alternative to hospitalisation.

Community services

- Mobile Support and Treatment Teams
  - These services provide intensive long-term outreach support to people with prolonged and severe mental illness and associated high-level disability.
- Early Psychosis Program
  - Early psychosis services focus on providing service to young people between 16-25 who are experiencing a first episode of psychosis.
  - They aim to provide for earlier and more intensive treatment as well as minimising disability associated with psychosis, including the impact of distress/trauma on both the young person and their family.
- Homeless Programs
  - In some areas

Involuntary Community Treatment Orders

- Reflects a community attitude of responsibility for people who have severe and disabling illness.
- Criteria varies between States; generally a high levels of risk of harm and lack of mental competence due to severe mental illness.
- Chronic severe disorders, particularly psychosis.
- People who avoid, or have limited or no engagement with clinical services.
- Independent judicial review, with Orders lasting up to 12 months.
- Clinic based services have rates of CTOs up to 20% to 25%, assertive outreach teams of 50% to 60%.
- Generally used to facilitate the administration of medication, with return to hospital the only consequence of non-compliance.
- Experience indicates that many people who receive involuntary community treatment over time develop insight and social stability, avoid prison, and accept ongoing treatment.

Mental Illness and Homelessness

- Similar problems as services for physical healthcare
  - access,
  - funding,
  - flexibility
- Difficulties in primary care.
- Difficulties attending community mental health clinics.
- Multiple and complex needs cannot be met by single agencies or providers.

Homeless Outreach Psychiatric Services (HOPS) in Victoria

- HOPS provide a specialist clinical and treatment response for people who do not engage readily with mental health services. Developed 20 years ago as part of de-institutionalization.
- HOPS work with homelessness services and use assertive outreach to locate and engage with their clients to create a pathway out of homelessness by providing early and appropriate treatment.
- HOPS link clients into the mental health service system, including access to long-term housing augmented with outreach support, and improve the coordination and working relationships between mental health and homelessness services.
- HOPS also provide assessment and secondary consultation to homelessness services and other health workers.
- HOPS are not currently available in all catchment areas, only inner Melbourne.
- A full time case manager would have about 8 clients.

Service Model – Alfred HOPS

- Staffing
  - 1.5 Medical
  - 4.2 Psychiatric Nurses
  - 1 Social worker
  - 1 Occupational Therapist
- Provide intensive case management, crisis assessment and early intervention, and secondary consultations to partner homelessness agencies and primary care.
- Case load of 35 to 40 active clients and about 3 new assessments each week.

HOPS work with non-clinical partners

- Link mental health staff to non-clinical community organizations that provide rehabilitation services, day programs, housing and support for people with severe and persistent illness.
- Clinicians work at locations frequented by people who avoid engagement with traditional mental health services.
- Community partnerships aims
  - Consultation and education to non-clinical staff
  - Results in up-skilled staff
  - Encourages early intervention in a non-clinical setting
- Partnerships are difficult (but essential)
  - Different service models
  - Different perceptions of issues
  - Challenges regarding model of care and philosophy require regular discussion

Homeless Health Outreach Teams (HHOT) in Queensland

- The Queensland Health Homeless Initiative was a State-wide response involving District Health Services with a primary focus in mental health and alcohol and other drugs.
- Specialist mental health teams were developed.
- Provide comprehensive case management, assessment and interventions for homeless people who have a mental illness.
- In addition, alcohol and drug specialist positions were funded to provide assessment, treatment and prevention programs for homeless people with substance use concerns.
- Physical health is also a focus with some general health care provided and linkage to other health providers occurring.

Homeless Health Outreach Teams

- Five Homeless Health Outreach Teams were established, one has lost funding.
- HHOT provides:
  - assessment and intervention services to people experiencing a diverse range of mental health concerns, including psychosis, mood disorders, and substance
  - assertive outreach service to people where they reside in the community or where they access food and support
  - support through linking people with appropriate community services
  - support and education to the non-government and government agencies we work with.
- HHOT is a multi-disciplinary team made up of various staff including:
  - Social Workers
  - Rehabilitation Therapy Aides
  - Occupational Therapists
  - Nurses
  - Psychiatric Doctors.

Conclusions – Australia

- Universal health care was implemented 40 years ago and was expected to meet the needs of the entire population.
- The realisation that people who are homeless and have severe and persistent illness are not well served by standard health care systems, and need specific services, has evolved in Australia over the last 20 years.
- Service development for mental illness services has been greater than for physical illness.

Conclusions - General

- In countries where there is a willingness to address both homelessness and illness, standard health services developed for the general population struggle.
- People who have multiple needs require, and should expect, the range of service providers to work well together.
- Service providers must find ways to work in partnership and coordinate care.

Final Words

- A system of funded healthcare is essential, but not sufficient for homeless people.
- Specialist homeless health services will always be needed, as standard services generally fail to manage the complexity of a homeless person's needs.
- There also needs to be a culture of inclusion and support of the disadvantaged, with the community taking some responsibility for assisting the most needy.