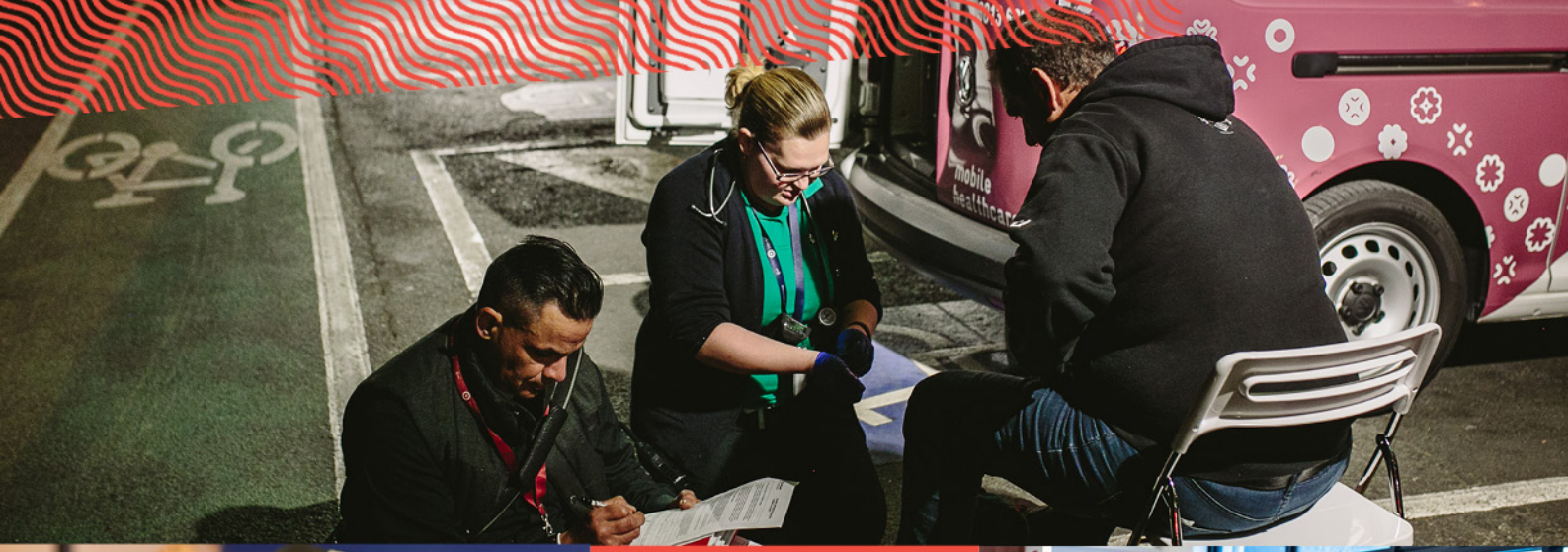

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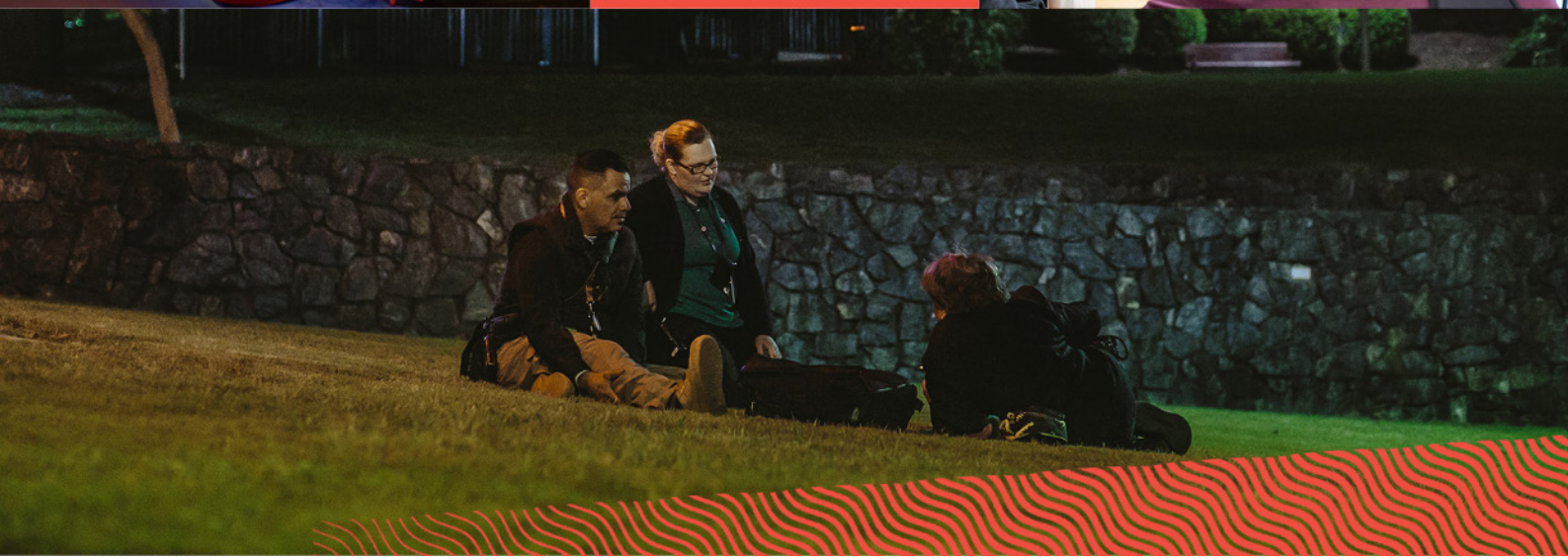

Leaving No-one Behind

A National Policy for Health Equity, Housing and Homelessness

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Australian Alliance to End Homelessness

Leaving No-one Behind – A National Policy for Health Equity, Housing and Homelessness

16 January 2020

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Cover photos courtesy of Inclusive Health Partnerships, RUAH Community Services, and Micah Projects' Street to Home. Top and bottom photographs by Katie Bennett.

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Executive Summary

Despite having a universal health system, not all Australians enjoy health equity. Physical and mental health outcomes in this country follow a social gradient, which means the higher up the social scale a person is, the better their health outcomes and overall life expectancy. A study by the Australian Institute of Health and Wellbeing between 2009-11 found that people in the lowest socio-economic areas died three years younger on average than people in the highest socio-economic areas.

Research has shown that the people who have experienced long term rough sleeping have an average life expectancy of just 47 years compared to 77 years amongst other Australians. We need to close this 30-year life expectancy gap for people who sleep rough.[1]

Understanding the causes of the disparity in health outcomes requires a holistic analysis of what contributes to good health. It is impossible to stay healthy if you don't have a roof over your head or enough money to afford nutritious food. Together with other considerations like education and health literacy, employment opportunities, and cultural or language barriers, these factors are known as the social determinants of health.

Without addressing these social determinants, we can never achieve equitable health outcomes for all Australians. Not only should health equity be an aspiration for a country that cherishes the fair go but the pursuit of health equity is an economic necessity.

The most vulnerable and disadvantaged groups in our community are more likely to have complex, compounding health needs but they face the biggest barriers to accessing treatment. The result is preventable presentations to hospital, which are significantly more expensive and a drain on resources. People are dying on our streets or in social isolation in housing without adequate care, monitoring or review of the cause and frequency of deaths associated with homelessness and vulnerability in housing across Australia.

For example, people experiencing homelessness have some of the highest levels of mental health, drug and alcohol and chronic physical health problems of any cohort in society. National and international research corroborates the profile of disproportionately high baseline rates of chronic health conditions, psychiatric and substance related morbidities.[2] Targeted interviews with over 8,000 people sleeping rough or otherwise homeless in Australia confirmed high rates of chronic conditions, mental illness and alcohol and other drug use and

[1] Council of Homeless Persons (2018); https://chp.org.au/counting-homeless-deaths-remembering-those-who-died-while-homeless/

[2] Gazey, A et al (2018); Hewit, N (2010); https://www.crisis.org.uk/ending-homelessness/homelessness-knowledge-hub/health-and-wellbeing/

found substantially higher rates of cancer, heart disease, HIV/Aids, hepatitis C and diabetes.[3]

The appropriate setting for managing this complex morbidity is in Primary Care. Unfortunately, for a variety of reasons, particularly the need to prioritise basic survival, people experiencing homelessness tend not to seek medical care in this setting. Instead, they delay treatment until their condition deteriorates and present to the tertiary sector with acute exacerbations of illness.

The relationship between healthcare and homelessness has created a reciprocating and multiplying cycle. Poor health conditions contribute to homelessness and homelessness further exacerbates ill health. Poor mental and physical health is both a cause and consequence of homelessness.

While there needs to be greater investment in housing and social support services, it is important that our health system is complemented by targeted health services for people experiencing homelessness to ensure that all Australians can live fulfilling and healthy lives.

On 15 November 2018, a national health, homelessness and vulnerably housed roundtable convened by the Australian Alliance to End Homelessness (AAEH) to share intelligence to improve health outcomes for vulnerably housed populations.[4] Participants called for development of a national policy on health equity housing and homelessness to ensure that no one is left behind, by providing access to timely and appropriate services that can meet the multiple psycho-social and health needs of vulnerable groups.

[3] Flatau, P et al (2018).

[4] Refer Appendix 1 for list of Roundtable contributors

The Problem

The Social Determinants of Health

- Social determinants of health such as socio-economic position, social exclusion, social capital, employment, housing and lifestyle can either strengthen or undermine individual health and are primarily responsible for health inequities and avoidable differences in health status[5]
- People who are socioeconomically disadvantaged have, on average, a greater disease burden and require greater investment and sustained effort to reduce risk, health complications, multi-morbidities and disabilities associated with their conditions[6]
- People who have or are experiencing homelessness are more likely to have poor physical and mental health compared to the general population and are far more vulnerable to problematic drug and alcohol use [7]
- People experiencing homelessness carry a heavy burden of trauma and disease and are dying at unacceptably high levels because their healthcare is not being addressed adequately.[8]

78% of homeless people report having a physical health condition compared to 37% for the population and 44% of homeless people have a mental health diagnosis, in comparison with 23% of the population. – Health Needs Audit, 2016 - Homeless Link.

Studies have shown the need to better link homelessness and suicide prevention services for high risk individuals.

The Cost of Treatment

- Health crises frequently precipitate presentations at primary or tertiary health services[9]
- The pattern of only seeking help when health has deteriorated to crisis level results in a high rate of presentation to emergency departments and a high rate of usage of non-elective, acute hospital healthcare. [10]
- Homelessness significantly impacts on ambulance use; the number of presentations to emergency departments, the number of hospital admissions and the length of stay. [11]

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[5] World Health Organization (2011)
[6] COAG Health Council (2017)
[7] https://www.crisis.org.uk/ending-homelessness/homelessness-knowledge-hub/health-and-wellbeing/
[8] Paul Flatau et al (2018)
[9] Gazey et al (2018)
[10] Wood et al (2018)
[11] Hewit, N (2010)

The total cost to provide services to 635 homeless patients over a three-year period was estimated by the Royal Perth Hospital Homeless team to be over $19 million. – Royal Perth Hospital Homeless Team: A Report on the First 18 Months of Operation 2018

In relation to mental health, the West Australian Auditor General conducted an assessment of the State Managed Adult Mental Health Services in 2019 and found that the main customers were 10% or 21,000 people who, over the 5 years reviewed, consumed 90% of the hospital care provided and around half of the community treatment services and ED mental health care. Homelessness people make up a significant portion of this small group of people who are consuming a disproportionate amount of the care.

> "International evidence indicates that homelessness is associated with delayed accessing of health services, hence greater need for acute care, longer hospital admissions, and by extension, greater treatment costs"
>
> *– Gazey, A., Vallesi, S., Cumming, C., and Wood, L. (2018).*

The Solutions

A National Policy on Health Equity, Housing and Homlessness

Both the Federal and State Governments have invested heavily in transforming health care systems, however research confirms that traditional health sector service models do not provide optimum health and psycho-social outcomes for people experiencing homelessness.

Many barriers impact on equitable health access and quality of life outcomes for people experiencing homelessness. For example, having no fixed address, unreliable telecommunications and focussing on day-to-day survival significantly inhibits compliance with appointment-based health services.

The aim of a national policy on health equity, housing and homelessness is to improve health outcomes, enrich quality of life, and simultaneously drive down the rising costs of healthcare.

Using innovative approaches to removing barriers to service

Many innovative models have been trialled in Australia and Internationally that have been shown to reduce the barriers to healthcare for people experiencing homelessness and improve outcomes at a reduced cost.

Flexible service delivery and street outreach allows primary health care to be delivered in spaces where homeless people feel welcome, increasing engagement and improving outcomes. Models for healthcare include fixed site, drop-in centres, accommodation services and street outreach.

Medicare billing requirements prohibit practitioners from billing for street outreach services. Enabling practitioners to bill for these services would significantly reduce the barriers for street present people in accessing primary health care. In fact, it would remove an inequity that prevents people from accessing health care because they have no fixed address.

Trust is a major issue for people experiencing homelessness. The current the practice of offering service providers with 12 months' funding at a time undermines the capacity of those organisations to build and maintain this trust and reliability. Securing existing funding through Primary Healthcare Networks for five-year periods would give service providers greater operational and strategic efficiency, benefiting clients and generating a greater return for government.

Primary health services for people experiencing homelessness should not just address physical health issues but must also address mental health and alcohol and drug issues. A current pilot of embedding an addition psychiatric team within a specialised homeless service in Perth is showing promising reduction in unnecessary tertiary health care utilisation.

As many people experiencing homelessness only access the tertiary health system, primary care in reach is vital to get them better engaged with primary health care. The homeless team at Royal Perth Hospital, which is a collaboration with Homeless Healthcare in Perth and Inclusive Health Partnerships projects, are examples of such hospital in-reach.

Emerging practice in Australia has seen service providers innovate by integrating health practitioners into housing and community teams. For Example, Ruah Community Services and Homeless Healthcare in Perth, Micah Project's Inclusive Health Partnerships in Brisbane and St Vincent's step-down respite centres in Melbourne and Sydney.

An investment of $503,000 in the Street to Home Nurses program saved the Queensland public health system between $6.45 – 6.9m by proactively addressing the health and housing needs of Brisbane's homeless population – reference tbc

An international example is the Canadian Pathways to Housing model, which takes a person-driven Housing First approach, providing immediate access to an apartment without requiring initial participation in treatment. However, it is coupled with Assertive Community Treatment, which is an integrated health approach where people are proactively provided with access to a team of nurses, mental health specialists and substance abuse specialists 365 days a year.

A National Health, Housing and Homelessness Network

There are many services and individual practitioners who seek to better connect the health systems with housing and homelessness systems. We need to give these leaders are greater voice in the policy deliberations nationally. The Canadian Alliance has successfully established a Canadian Network for the Health and Housing of the Homeless (CNH3). The AAEH believes that a similar network is required in Australia, to bring these leaders together and to support their efforts to integrate these service systems. In particular the network would:

1. To promote collaboration amongst the healthcare, homeless and housing sectors to drive innovative responses to the health and housing needs of the homeless.
2. To provide a national forum for the sharing of experiences and models of care and support amongst health and housing providers and organizations.
3. To support and develop strategic national initiatives to address the health and housing needs of people experiencing homelessness in Australia.
4. To collaborate with local and national partners to advocate to end homelessness in Australia.

Recommendations

1. A Policy - The Federal Government should create a taskforce on health equity, housing and homelessness to develop a national policy response in collaboration with State Governments, Primary Healthcare Networks and the community sector. Included in this policy should be a nationally consistent commitment of no exits into homelessness for people with mental illness who are discharged from institutional care, including hospitals and prisons.
2. A Network - The Federal Government should support the AAEH to establish a Health, Housing and Homelessness network with a broad range of health, and community organisations, professionals and people with a lived experience.
3. A Pilot Project - The Federal Government should fund an Assertive Intervention pilot in every state and territory, featuring flexible medical and outreach service delivery – including primary healthcare and psychiatric response, 365 days a year. The pilot would cost $2.5 million per city, plus evaluation costs.
4. Funding Certainty - Existing funding arrangements between Primary Healthcare Networks health, homelessness and vulnerably housed services should be secured a baseline commitment for a five-year period. This will give services the certainty they need to operate with the greatest effectiveness.
5. Funding Equity - The Federal Government widen policy provisions to allow medical practitioners to bulk bill patients who have no fixed address and enable bulkbilling for street based and outreach consultations.
6. A meeting – Recognising the urgency of this task the Federal Government should call a special COAG meeting of health and housing ministers to consider, support and drive the implementation of these recommendations.

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Appendix 1: Roundtable participants

- Andrea Ryan, ARAFMI
- Lauren Mitchell, ARAFMI
- Nicole Laffoley, ARAFMI
- Kelly Hansen, Nova Women
- Lee Liewes, Nova Women
- Louise Litchfield, Brisbane South PHN
- John Willis, St Vincent's Health Australia
- Margaret Stewart, SVHA
- Andrew Chan, SVHA
- Rebecca Howard, SVHA
- Matthew Kearney, SVHA
- Lisa Eastment, SVHA
- Naomi Laauli, Brisbane North PHN
- Donisha Duff, Queensland Health
- Helen Darch, Queensland Health
- Warwich Pawsey, Brisbane North PHN
- Kay Nicholls, Price Waterhouse Coopers (PWC)
- Michael Kastrissios, Price Waterhouse Coopers (PWC)
- Chris Rogan, Price Waterhouse Coopers (PWC)
- Madonna McGahan, Mater Brisbane
- Selina Tually, University of Adelaide
- Olga Vujovic, Monash University
- Chris Farrelly, Auckland City Mission
- Richard Davies, Auckland City Mission
- Margaret Dotchin, Auckland District Health Board, NZ
- Sari Gehle
- Mary-Anne Rushford, Bolton Clarke
- Jenny Ranft, Wentworth Community Housing
- Jeanelle Gibson, Brisbane North PHN
- Julie Fry, Bolton Clarke
- Marlene Redelinghuys, Mater Brisbane
- Paula Lazzarini, Heart Foundation
- Randall Frazer, Institute for Urban Indigenous Health (IUIH)
- Karyn Walsh, Micah Projects
- Janelle Kwong, Micah Projects
- Kim Rayner, Micah Projects
- Bevan Warner, Launch Housing
- Catherine Beadnell, Carers Queensland
- Debra Zanella, Ruah Community Services
- Felicity Reynolds, Mercy Foundation
- Heather Holst, Department of Justice and Regulation, Victoria
- Kate Dawson, Common Ground Canberra
- Kathy Kaplan, Launch Housing
- Keith Bryant, PSI Managers
- David Pearson, University of Adelaide
- Samson Knight, Ruah Community Services
- Paul Flatau, University of Western Australia

Appendix 2: AAEH Partners

Founding Partners

Campaign Partners

Major Partners

International Partners

Research Partners