AASW
Australian Association of Social Workers

# *Submission to the Standing Committee on Health*

## *Re: Inquiry into Chronic Disease Prevention and Management in Primary Health Care*

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# Introduction

**The Australian Association of Social Workers (AASW) welcomes the opportunity to provide input to the Inquiry into Chronic Disease Prevention and Management in Primary Health Care. The AASW is the professional body representing more than 9000 social workers throughout Australia. The association sets the benchmark for professional education and practice in social work and have a strong voice on matters of social inclusion, social justice, human rights and issues that impact upon the quality of life of all Australians.**

## The social work profession

The social work profession is committed to the pursuit of social justice, the enhancement of the quality of life, and the development of the full potential of each individual, group and community in society. Social workers work with individuals, families, groups and communities in numerous fields including primary health care. Professional social workers consider the relationship between biological, psychological, social, cultural and spiritual factors and how they impact on a client's health, wellbeing and development. Accordingly, social workers maintain a dual focus in both assisting with and improving human wellbeing and identifying and addressing any external issues (known as systemic or structural issues) that may impact on wellbeing, such as inequality, injustice and discrimination.

## Our submission

The Australian system of chronic disease prevention and management is fragmented. This leads to poorly coordinated care that is not client centred and contrary to best practice guidelines. Social workers provide a range of interventions and supports in relation to chronic diseases including psychosocial assessments, counselling, resourcing, advocacy, group, community and multidisciplinary work. Most importantly, social workers play a key role in the coordination of care as they have the necessary value orientation and expertise in collaboration, resource management and advocacy.[1] The current model of funding has created 'professional silos' where medical and allied health workers work independently of each other leading to poor overall services and outcomes, especially for those in lower socioeconomic and disadvantaged groups. We call on the federal government to act on the evidence, clearly highlighting the need for collaboration, and reform the health care model.

In addressing the terms of reference our submission will focus on two major themes: the need for collaborative care and health inequality in chronic disease management and prevention.

# Response

## Collaboration in chronic disease management and prevention

There are significant amounts of research and evidence to argue that coordinated and multidisciplinary care is essential to providing effective and sustainable interventions in the prevention and management of chronic diseases.[2] [3] The prevalence of chronic diseases presents one of the most significant health challenges in Australia as they are the leading cause of illness, disability and death. The current model of care fails to fully appreciate the psychosocial factors that directly contribute to their prevalence.

[1] Allen K & Spitzer WJ, 2015, *Social work practice in healthcare: Advanced approaches and emerging trends*, Sage Publications, UK.
[2] McDonald K & United States Agency for Healthcare Research and Quality & Stanford-UCSF Evidence-based Practice Center & National Library of Medicine, 2007, 'Vol. 7 Care coordination a critical analysis of quality improvement strategies', *Closing the quality gap,* Agency for Healthcare Research and Quality, USA.
[3] Thornhill J, Dault M & Clements D, 2007, 'Ready, set... collaborate? The evidence says" go," so what's slowing adoption of inter-professional collaboration in primary healthcare?', *Healthcare quarterly*, 11(2), 14-16.

In order to improve the health and wellbeing outcomes for those with chronic diseases, management and prevention needs to be underpinned by a clear focus on the collaboration of services as no single profession has the expertise necessary to address its complexity.

## Care coordination and social work

Best practice guidelines identify care coordination as a key strategy to deal with the prevention, management and treatment of chronic conditions.[4] Professional social workers, with their expert knowledge and skills in addressing the psychosocial aspects of health, play a central role in the delivery of coordinated services and their assessments and interventions contribute greatly to the decision-making processes of other health professionals. Social workers are particularly skilled in dealing with complex social issues and relationship building. Social work interventions can help identify and overcome factors that may be contributing to ill-health and that may be inhibiting and limiting the sustainable management of chronic diseases, including social isolation, mental health issues, family breakdowns and poor health literacy.[5]

Social workers can address service users' needs by[6]

- Conducting prompt, thorough screenings and assessments of psychosocial circumstances, functional impairment, pain, depression, and anxiety of patients with chronic illnesses.
- Delivering patient-centred and culturally tailored chronic disease-management programs in conjunction with coordination of care in health facilities and non-traditional settings that focus on disadvantaged populations.
- Collaborating in developing and implementing enhanced outreach, screening, and assessment strategies for use with vulnerable and disadvantaged groups.
- Providing counselling, resourcing and referrals.
- Improving health literacy by educating patients about diagnoses and prognoses and adhering to medical regimes.

## Models of care coordination

Currently the delivery of primary health care for chronic diseases from a Commonwealth funding perspective is mainly provided through the Medicare Benefits Schedule, which is managed by general practitioners. A 2011 study found that only a relatively limited number of allied health professionals are actually accessed through this highly limiting model of funding.[7] Although social workers contribute to this field, mainly through private practice and community health networks, they are not explicitly part of the national strategy. There is an inherent contradiction in government policies that recognise the need for integrated and collaborative care,[8] but do not adequately fund a profession whose expertise lies in the ability to work collaboratively, as well as understanding the broad complexity of issues and barriers that prevent effective management and treatment of chronic diseases.

International studies have shown that the incorporation of social workers into chronic disease core treatment teams can have positive effects on patient wellbeing and health outcomes leading to reduced

[4] Corrigan JM & Adams K (Eds.), 2003, *Priority areas for National Action: Transforming health care quality*, National Academies Press.
[5] Cox LS, Moczygemba LR, Dungee-Anderson D, Goode, JVR, Gatewood S, Alexander A & Osborn R, 2014, 'Collaboration between Schools of Pharmacy and Social Work to promote care for a medically underserved population', *Currents in Pharmacy Teaching and Learning*, 6(4), 535-542.
[6] Allen K & Spitzer WJ, 2015, *Social work practice in healthcare: Advanced approaches and emerging trends*, Sage Publications, UK.
[7] Cant R & Foster M, 2011, 'Investing in big ideas: Utilisation and cost of Medicare Allied Health services in Australia under the Chronic Disease Management initiative in primary care', *Australian Health Review*, 35(4), 468-474.
[8] Department of Health, 2005, *Chronic Disease National Strategy*, ACT Australia.

hospital admissions.[9] [10] Professional social workers have the knowledge and experience necessary to work in complex social circumstances and identify the psychosocial barriers that may be limiting effective interventions. Furthermore, social work interventions have been shown to be strongly aligned and can greatly assist with two of the most widely used and researched models of chronic disease management in primary health care: **Wagner's Chronic Care Model**[11] and **Stanford Chronic Disease Self-Management Program**[12].

The **Chronic Care Model** (developed by Wagner et al. and endorsed by the World Health Organisation) has been shown to improve outcomes and preventive care for people with chronic diseases and provides an evidence-based framework for an accessible and effective primary health care system. It has been strongly argued that within this model, professional social workers provide an important service as they possess the necessary knowledge and skills to engage with patients as proactive partners in their ongoing care and identify psychosocial barriers that may be preventing sustainable outcomes.[11] The **Stanford Chronic Disease Self-Management Program** was developed at Stanford University, USA in the 1990s and has been implemented throughout the world, with considerable success.[13]. The program is a time-limited, co-facilitated group course that focuses on reducing isolation and facilitating self-efficacy and empowerment with a goal-setting and problem-solving focus. Social workers in Australia play a central role in the implementation of the model in both a facilitator and master trainer capacity.

## Recommendations

The AASW proposes that, given the importance of collaboration, a national strategy on chronic disease management and prevention between the state and federal governments is absolutely necessary. The Chronic Care Model provides a suitable model that has been shown to improve outcomes. Wagner suggested that primary health care needs a substantive redevelopment 'from a system that is essentially reactive, responding mainly when a person is sick, to one that is proactive and focused on keeping a person as healthy as possible'.[14] The Chronic Care Model identifies the essential elements of a health care system that encourages high-quality chronic disease care including: the broader community, the health system, self-management support, delivery system design, decision support and clinical information systems with a focus on prevention and collaboration. It has been strongly argued that within this model professional social workers provide an important service.

Furthermore, the AASW strongly supports the recommendations arising from the Commonwealth's Diabetes Care Project (DCP), which was a three-year pilot program that analysed new models of chronic disease management in primary care.[15]

These include:

1. Changing the current chronic disease care funding model to incorporate flexible funding for registration with a health care home, payment for quality and funding for care facilitation, targeting resources where they can realise the greatest benefit.

[9] Sommers LS, Marton KI, Barbaccia JC & Randolph J, 2000, 'Physician, nurse, and social worker collaboration', *Primary Care for Chronically Ill Seniors*, 160(12):1825-1833.
[10] Fouche C, Butler R & Shaw J, 2013, 'Atypical alliances: The potential for social work and pharmacy collaborations in primary health care delivery'. *Social Work in Health Care*, 52(9), 789-807.
[11] Findley PA, 2014, 'Social work practice in the chronic care model: Chronic illness and disability care', *Journal of Social Work*, 14(1), 83-95.
[12] Siu AM, Chan CC, Poon PK, Chui DY & Chan SC, 2007, 'Evaluation of the chronic disease self-management program in a Chinese population', *Patient Education and Counselling*, 65(1), 42-50.
[13] Panagioti M, Richardson G, Small N, Murray E, Rogers A, Kennedy A & Bower P, 2014, 'Self-management support interventions to reduce health care utilisation without compromising outcomes: A systematic review and meta-analysis', *BMC health services research*, 14(1), 356.
[14] Wagner EH, Austin BT, & Von Korff M, 1995. Improving outcomes in chronic illness. *Managed care quarterly*, 4(2), 12-25.
[15] Leach MJ, Segal L, Esterman A, Armour C, McDermott R & Fountaine T, 2013, 'The Diabetes Care Project: An Australian multicentre, cluster randomised controlled trial', BMC public health, 13(1), 1212.

2. Continuing to develop both eHealth (Personally Controlled Electronic Health Record) and continuous quality improvement processes.
3. Working to better integrate primary and secondary care and reduce avoidable hospital costs.

The Primary Health Network (PHN) model may be well suited to develop collaborative and holistic approaches to chronic disease prevention and management. In previous years when the Medicare Local system was in place, there were social workers in several regions already playing a central role in the development and implementation of best practice interventions based on the principles outlined in this submission. However, PHNs may be only one appropriate vehicle for implementing such a system.

The AASW would also like to highlight the significant need for early intervention and education programs for children and young people in order to prevent, identify and better manage chronic conditions.

Ultimately, the research is clear that a collaborative, evidence-based and multidisciplinary model of care is critical in the delivery of primary care for chronic diseases and that within this model social workers play a central role. In order to achieve improved and sustainable outcomes any reform must be reflective of this.

## Health inequality in chronic disease

In Australia chronic diseases are most prevalent in the more disadvantaged sectors of the population; these include people from diverse cultural and Indigenous backgrounds, socioeconomically disadvantaged groups, abuse victims and survivors, rural populations and people with disabilities. It is important to acknowledge the higher prevalence of chronic diseases for Aboriginal and Torres Strait Islander peoples. As many as two thirds of deaths for Aboriginal and Torres Strait Islander peoples are accounted for by diseases of the circulatory system, respiratory system, and endocrine, nutritional and metabolic diseases and self-reported diabetes is almost four times as high as for other Australians.[16] Furthermore, chronic diseases are major contributors to the mortality and health gap between Indigenous and other Australians. These statistics present an inequality in terms of outcomes that highlights the significance of understanding the socioeconomic and cultural dimensions of chronic diseases. Psychosocial assessments and interventions by social workers are highly attuned to these factors and can assist medical professionals, and other allied health staff, in better understanding these complexities in order to improve health outcomes for services users.

The AASW Code of Ethics highlights the importance of collaborative and culturally appropriate models of care for working with Indigenous Australians. The focus continues to be on the need for health care that is collaborative, culturally sensitive and holistic in the prevention, treatment and management of chronic diseases. Our members have repeatedly emphasised the need for proactive, rather than reactive care and the lack of services targeting early intervention.

In our submission we highlight the significant contribution made by community health organisations and hospitals, mostly in an outpatient capacity, to this field. Organisations such as Inala Indigenous Health Service (The Centre of Excellence) and Mount Isa Hospital, within which social workers provide a key service by focusing on prevention, collaboration and culturally meaningful interventions, with research demonstrating its effectiveness.[17] [18] The AASW recommends that the Committee further examines

[16] Reading J, 2014, *The crisis of chronic disease among Aboriginal people*, University of Victoria Centre for Aboriginal Health Research.
[17] Maher CM & Askew DA, 2014, 'Health and well-being of urban Aboriginal and Torres Strait Islander women at their first antenatal visit: A cross-sectional study', *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 54(1), 88-90.
[18] Hayman NE, Askew DA & Spurling GK, 2014, 'From vision to reality: A centre of excellence for Aboriginal and Torres Strait Islander primary health care', *The Medical journal of Australia*, 200(11), 623-624.

these examples as evidence of successful models of chronic disease prevention and management for Indigenous Australians that have been shown to greatly improve health outcomes.

### Recommendations

The AASW supports several of the policy recommendations from the Audit and Best Practice for Chronic Disease Project (ABCD)[19] in their assessment of Indigenous primary health care services.

These include:

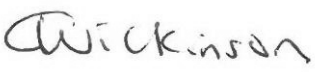
- **Strengthen partnerships:** Utilise existing government processes and structures to strengthen partnerships. For example, include chronic disease prevention and control as a specific item in the Indigenous component of the Commonwealth/State Health Agreements.
- **Integration of policies:** Focus whole-of-government strategies on prevention.
- **Workforce:** Develop specific chronic disease prevention and care roles for Aboriginal Health Workers within multidisciplinary primary care teams.
- **Funding:** Further reform Medicare to allow for funding of team-based care and cycles of care. Ensure that financial models and incentives are aligned with best practice care and high prevalence populations identified as being more at risk of chronic disease.
- **Improved information systems:** Implement the national service development reporting framework and monitor evidence–practice gaps in crucial chronic disease process indicators nationally.

These recommendations highlight the significance of collaborative, integrated and culturally appropriate care, within which social workers already play an important role.

## Conclusion

Chronic disease prevention and management presents one of the most significant health challenges in Australia. The Australian model of primary health care is characterised by a fragmented service delivery, dominated by medical staff to the exclusion of allied health and against best practice standards and the best interests of the client. The evidence is clear that collaborative and integrated care is fundamental to improving outcomes for Indigenous Australians and the broader population. Professional social workers, with their knowledge and skills in addressing the psychosocial aspects of health, play a central role in the delivery of coordinated services and whose assessments and interventions contribute greatly to not only the health and wellbeing of service users, but also the decision-making processes of other health professionals. We urge the government to reform the health care system in order to foster collaborative models of care and incentives that are based on the quality of outcomes.

Submitted for and on behalf of the Australian Association of Social Workers Ltd



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[19] Schierhout G, Brands J & Bailie R, 2010, *Audit and best practice for Chronic Disease Extension Project, 2005–2009*, The Lowitja Institute, Australia

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