Summary key points:

- Australia faces multiple health system challenges. We've got an aging population increasingly living with chronic diseases. Access to care is high, but it's decreasing, particularly for marginalized or disadvantaged people. The costs of care are increasing for individuals, but also the broader health system. We've also have increasing expectations of care, whether that's using technology, but also patient demand, all of which further can increase cost. We've got a growing health workforce, but increasingly, there are some blurring of scope of practice and responsibility, which can make it confusing for healthcare workers and patients. And we have ongoing inequity, particularly for Aboriginal and Torres Strait Islander Australians, people living in rural and remote Australia and people with socio economic disadvantage.
- We have an increasingly complex health system, which is exacerbated by a dual funding federated health system where states and territories have the constitutional responsibility to fund hospitals, while the federal government has responsibility for providing out of hospital care. Medicare, which is a universal health system operating since 1984 covers all costs of public hospital care, but it subsidizes community medical care, including the care provided by GPs. Patients often have significant out of pocket costs. Around 40% of the population have private health insurance, which allows them access to private hospital health services, but again often with significant out of pocket costs. And then we also have separate funding systems for disability, for war veterans, for aged care and for social services.
- There are more than 7,000 general practices around the country, but the majority of them are small to medium enterprises, and they're private businesses. Australian general practice nearly universal use of electronic records, but people are often surprised to hear that we've got very rudimentary communication, like we can't communicate between practices, and there is very little communication between a practice and anywhere else, such as the local pharmacy or the tertiary hospital. Most of the funding comes through Medicare billings, on a fee for service basis. This creates an incentive to get people in and see them, but it doesn't create appropriate incentives to provide more preventative or longer-term care. There are some workforce and practice incentive programs, but now, they make up less than 10% of the funding that goes to a practice.
- The Commonwealth Fund do an international study that compares the health systems of high-income countries. In the most recent survey, Australia comes out on top as the number one health system overall, with very high health outcomes and efficiency. However, there are a couple areas of under-performance – in relation to affordability and access to services. In prevention, safety and coordination we come towards the middle.
- Australia has a growing population, an aging population, and more and more of the population are living with chronic health conditions like diabetes, asthma, epilepsy, depression. Close to 50% of adults over 45 have multiple conditions or are living with multi morbidity, and that means they've got complex care. They have multiple diseases, they have multiple treatments, which often interact with each other. And a lot of this care is being provided in the community, in primary care, but it's complex, it's time consuming, and the way that Medicare is structured, it doesn't acknowledge that complexity and make it harder for patients to be seen properly. There's a major increase in the treatment and recognition of mental health conditions, and that's an important part. One in five people had a mental health disorder in the previous year.
- More than 22 Australians saw a GP and the last available statistics in the same year, over 160 million visits. Visit rates increase as people get older and their visit rates are slightly higher for women compared to men, and only 1.1% of people said they couldn't

see a GP when they needed to. Among the 18 million Australians who saw a GP in the last year, about three out of 10 now report delaying or not seeing a GP when they needed to - because they couldn't get an appointment or due to cost, Over a million people delayed seeing a GP due to cost, and that's more than doubled in the last decade.

- The healthcare sector is the fastest growing part of the Australian workforce and also growing demand for care as we age and due to expectations. However, our health supply of health providers hasn't been keeping up with the demand for a number of years. One review, released in 2023, predicted that by the end of 2026 Australia is going to be short by 13,000 medical practitioners, 40,000 nurses and over 25,000 allied health providers. GPs are aging, are retiring and on average, are working a bit less as they do more portfolio work. About 40 years ago, almost 50% of medical students went into general practice. Now it's about one in seven.
- The Strengthening Medicare task force report describes a vision for the future of our health system, led by strong primary care along four main priorities: All Australians are supported to be healthy and well, through access to equitable, affordable, person centred primary care services, regardless of where they live, with financing that supports sustainable primary care and a system that's simple and easy to manage, simple and easy to navigate. And this plan talks about different funding models, beyond fee for service that would enable this. There's also a lot of a focus on coordinated multi-disciplinary teams of health professionals, and the need for them to work to their full scope of practice to provide quality, person-centred continuity of care, including a focus on prevention and early intervention and primary care, working with other parts of the health system and reducing fragmentation. We need data and digital technology to inform value-based care and to empower people to participate in their own health care. And finally, we need a primary care sector that's well supported to embrace organizational and cultural change and consumers to be empowered to have a voice in the design of services, particularly for disadvantaged groups.
- This provides a roadmap for addressing this issue. We've been training more health professionals progressively over the last 30 years, by training our own doctors, nurses, allied health providers, and encouraging international health practitioners to come to Australia. We can try to increase the efficiency of health professionals, and one idea is that health professionals should be supported to work to the full scope of their practice, This does rely on health providers working more in teams.
- Australia spends a bit under 10% of our GDP on the health system. That's a little bit above average for the OECD. We could improve our efficiency is by putting a greater focus on prevention, health promotion, keeping people well in the community, stopping them from needing to attend expensive hospitals, emergency departments and tertiary care. But in order to do that, we've got to strengthen primary care or shift some of the care back into primary care. We can also try to reduce fragmentation or duplication, but that's a difficult thing in our dual funded system when different systems don't communicate.
- We need to improve health literacy, self-management, and communication between providers, particularly clinical handover. These are all potential areas where community health navigators may be able to help. This is non-clinical role, supporting navigation to health and social care services and programs. Their use with marginalized populations in the in the USA, began in the early 1960s and these workers are now in many countries, working with community organizations, with health departments in primary care, in clinics, hospitals, schools, churches. In Australia, we've had a long history of Aboriginal Health workers, and they are the best example of a Community Health Navigator in

Australia. We've got other lay and peer workers, although they've often not been acknowledged as having a formal role in our health system. Community health navigators establish strong connections with community members, understand their unique needs and challenges, and support them to navigate, acting as a link between the community and the health system.

- There are multiple potential benefits of CHNs: enabling access to health services for people who might otherwise struggle either due to financial reasons, language reasons, socio economic reasons, and by working in the community to better address the social determinants of health, providing better access to preventative and primary care and reducing the burden on the rest of the health system. There is a growing evidence base about the benefits of CHW and CHNs. This includes evidence of improved cancer screening, management of chronic diseases such as diabetes, hypertension, even in delivery of HIV care, and they've been particularly effective in improving maternal and child health outcomes and preventing under-nutrition.
- I'm just going to touch on a few examples of CHNs to highlight their range of roles:
    - The largest roll out of community health workers worldwide is Brazil's Family Medicine Program which started back in 1994, comprising community-based clinics which have a physician, a nurse, and up to 15 community health workers These serve the poorest populations in Brazil. There are over 250,000 community health workers each assigned to care for 150 families, or up to 750 individuals. But the key criteria used to select the community health workers, and this is one of the important factors, is they are residents in the community. They have a strong understanding of local geography and culture, and they're endorsed by the residents. And in this setting, the CHW received training in basic health concepts, healthy lifestyles, sanitary living conditions and public health strategies, and the impact on that has been quite amazing. So they're looked on as one of the most comprehensive and cost effective changes to a health system, and they're thought to have saved over 400,000 lives between 1996 the introduction of this program in 2020 12, through improved access to screening, improved immunization and also early detection of disease, so particularly cardiovascular disease, they also found that infant mortality rates dropped by over 25% in areas that had access to this program compared to areas that didn't have access to their program. So really powerful this, this model has recently been adapted in 2022 for use in the UK and in a deprived area of South London, there's a trial of community health workers set up within a housing estate, and with it's linked to general practices. And so the goal of this, at this this pilot, was to improve access for health services for people living in this setting, and they've proven effective at providing counselling, mediating, building trust relationships and rapport, helping with medication management, low level social prescribing and providing practical advice and motivation.
    - This is the Impact trial, which is the individualized management of patients with action plan. In this trial in the USA, among low-income adults with multiple chronic health conditions, community health workers assessed social needs, provided everyone with a unique plan, and followed up with them with weekly communication and it found that for every dollar spent on the CHW program, delivered $2.47 in terms of benefits to the health system. Now over a third of that reduction was like was due to reduced hospitalization rates, which I think is important, and that's easy to measure, but the comments of the authors here was that it probably underestimates the sort of social return from this, because it's harder to measure the cost benefit of keeping people healthy.

    - Primary health care for First Nations Australians is driven by nearly 200 Aboriginal primary health care services operating around the country. Nearly 150 Aboriginal community-controlled health organizations, federally funded and just over 50 state run Aboriginal medical services. But in both models, Aboriginal Health Workers work within these services, and they are the most successfully integrated CHWs in Australia. They are instrumental in creating a culturally safe and responsive health system for First Nations people, they provide nonclinical support, - advocacy liaison, health promotion in community settings and also hospital settings. As members of the communities within their practice, Aboriginal Health Workers have an innate understanding of the strengths, the concerns and the lived experiences of the people they serve, and are uniquely positioned to be cultural brokers between the community and the health system, Studies have shown that they improve the uptake of preventative services, screening programs and chronic disease management in their communities, and also facilitate culturally appropriate care, reducing communication gaps and ensuring referral linkage. Wee survey GPs every year about their work satisfaction. The most satisfied are the ones working in the multidisciplinary teams in Aboriginal and community-controlled health organizations.
- In a particularly complex health system characterized by multiple funders, multiple delivery models and multiple care systems, having a trusted advisor to support the most marginalized people to access care makes sense and appears to be useful in practice. CHNs do not provide clinical care. But they do help link people to the care they need. Our systems communicate poorly and coordinate services inadequately. The need for navigation support will grow as our population ages and more people have chronic health conditions. One other thing that the community health navigators hopefully can help with is they might be able to help people to identify and avoid the often unpredictable and even invisible costs that you face by navigating through our health system.
- What do we need to do now to help CHNs to grow? We do have a promising emerging database, but that research agenda needs to expand, and we particularly need clearer guidance about how successful implementation might work. You've seen the range of roles that CHN can have, but we need to draw that evidence tighter. We need to develop clearer guidelines for training and supervision and what that CHN role will look like. And really, we need to move from pilots and to embed CHNs more broadly. And then finally, we need to look at how we fund these CHN programs now, whether that be through bundled payment, through the federal government, through collaborations with our Primary Health Networks, or with the local health districts, or through new payments to primary care providers, or all of the above. There is hope that with this increasing there's potential of community health navigators to improve health outcomes, to improve patient experience, and lead to cost savings. And we're now with the strengthening Medicare Task Force, we have a reform agenda which is likely to lead to more team-based care and is considering alternative funding models and how we can create a multi- layered health workforce that meets the needs of our communities