Summary of key points

- Over the next couple of minutes, I'll tell you a little bit about the International Centre for Future Health Systems. One of the exciting aspects of this center is that it recognizes the multi-dimensional aspects of health. And so this is a pan University Institute with representations, particularly in the post-doctoral fellows, some of whom are here today. The center represents some really interesting opportunities, particularly in the context of community health navigators, when we look at the intersection of healthcare services and social services, which is a really, I think one of the keys to moving us forward. But if we look at the way government policy and universities are structured in silos, so the aims of the center are really to engage in research, policy and advocacy across these key pillars, from equity through to pandemic planning. There are so many lessons learned about how health systems respond in crises such as the pandemic. The pandemic exposed many of the frailties in our system. So, across each of these pillars, we are trying to tackle some of these complex health issues, and the theme of community health navigators resonates across all of these themes, from primary health care through to health care workforce but also how we care for priority populations.
- Even getting that nomenclature is very challenging. You would have seen the recent editorial in the Medical Journal of Australia about people pushing back around the terms culturally and linguistically diverse. So, you know, I think getting because it's sort of naming and othering, particularly in a diverse and culturally pluralistic society such as Australia. So, I think there's such a lot of work that we have to do.
- And I also want to echo the Secretary's words in that if we are living in very concerning times the erosion of democracy, the naming, blaming and vilification of specific populations, the rise of nationalism and populism. These are the things that that concern me each and every day, and so I think together, we can collectively work to address this, and it has to be about community being the heart of care.
- So I'm just going to quickly set the scene. Community health navigators are trained individuals, often from the communities they serve. They help us navigate these very complex health and social care services, and they are effective in addressing barriers to care. Nomenclature and the language can be something that limits advancing the science. Patient navigators, lay health workers, community health workers, all of these terms are often used synonymously. And as a nurse, can I say that has not served nursing well? Because a nurse could be someone who's done a six-week course at TAFE and is working in a facility through to an advanced practice nurse inserting central lines or delivering anesthesia. Getting the nomenclature right and defining the scope of practice are really critical issues for the field.
- There's a lot of lessons learned in community health navigation. I had the honor and privilege of working at Mount Druitt Aboriginal Medical Service for nearly a decade, one day a week. I learned so much about Aboriginal Health workers, who play such a critical role, and this is an interesting model to develop and evolve. In the United States, community health navigators are embraced across many healthcare systems. Increasingly, they're being used in acute care. Interestingly, just in the recent report on the funding in New South Wales, it was recommended by Commissioner Beasley that healthcare navigators be used for people with individuals with intellectual disability.
- And of course, in global health, community health workers are the bedrock of most health interventions. And even if you think back to the Ebola outbreak, it wasn't until the WHO and other agencies really started embracing community health workers that there was any really action to

address Ebola. So we know these people are critically important. But I think today there's going to be a lot of discussion about how we meaningfully embed them structurally in our healthcare systems.

- I'm just going to tell you a little bit about my time in Baltimore. Baltimore has huge structural issues of racism and generations of trauma that impact health and wellbeing. For young people, particularly young black men, it's a huge area of vulnerability. Living in Baltimore, I've never been so impressed by the importance of social determinants of health. Within eight kilometers, there are decades of difference in life expectancy and many other social indicators. Where you have world leading health systems in that area, such as Johns Hopkins and University of Maryland, why are health outcomes like that?
- Community health workers, community health navigators, really were embedded across the whole of the Johns Hopkins Health System. However, CHW have had to lobby legislators to formalize their role and function, because there's a lot of fragility in that role when you're often seen as the bridge or the add on. When health funding is precarious, CHW may be the first to be let go. There has been a need to standardize the scope of practice. And so, there's been a lot of work through Maryland legislature to advance the health worker role.
- John Hopkins School of Nursing incorporated community health workers as part of a lot of our functional units. It would run community clinics where community health workers and navigators were a big part of it. However, these clinics needed to not only provide accessible care they also needed to ensure that poor people had the same access to advanced care when it was needed. Why should poor people have only access to limited health care? Because most of the African American population in Baltimore actually qualified for Medicaid, a lot of the work we did was navigating people into the health system. One study was funded by Medicare to really look at efficiencies. This was a really big program at Johns Hopkins that integrated community health navigators into a broader model of care.
- My point is that community health navigators are critically important. But the question is, how do we meaningfully embed them in the system? You know, where do these people sit? You know, you can see so many logical places. Do they sit in a primary healthcare network? Do they sit in a healthcare system. And there's probably strengths and weaknesses. What is the model of sustainable funding and program support. How do they integrate into healthcare teams? What level of training and credentialing should they have? This is highly variable. What roles should nurse, allied health providers or physicians devolve to community health workers. In my experience of working with community health workers, there's a range from Aboriginal community health workers, where there is this embedded traditional knowledge and health workers embedded in community, through to people who help people to navigate a cancer diagnosis and therapy, but don't necessarily have those cultural and social affiliations. There is much variability. So, I think if anybody has the appetite, it would be great to see an equator statement on criteria for reporting Community Health Navigator trials.
- Today, from my perspective, I think there's a call to action. I think that Susan Pearce has given us a great outline of some of the challenges in the system. I think she's clearly identified that New South Wales Health should be a community health system. And I think for us, particularly researchers and clinicians and community members, it's up to us to provide some solutions. Many Community Health Navigator projects have been incremental. Why have we not moved on from pilot projects to being embedded in systems? We need a critical review of the scope of practice of all health care

worders. We need to think about what the models for compensation and regulation are and recognize that many people from different populations suffer similar issues. Community health workers, navigators are often women, and there's a whole feminization of this of carers and care system.

- I think there is a great opportunity to think boldly and creatively, dream big, think about breaking down those silos and making a difference. And I think really, if we are going to have high quality, high value care, we have to walk the talk. We have to create Person Centered models. How are we going to think differently and address the inflexibility and challenges of our health system. Sometimes people are defined as being non adherent, non-compliant, when it is the system that is not necessarily supportive or enabling of their healthcare needs.