Submission for

2025-26 Victorian Budget

COMMUNITY HEALTH FIRST

COMMUNITY HEALTH FIRST PARTNERS

Community Health First unites all 24 registered independent community health services in Victoria with one shared goal – improving the health, wellbeing and quality of life of all Victorians.

ACCESS Health & Community

Ballarat Community Health

Banyule Community Health

bch Bellarine Community Health

bendigo Community Health services

BHN Better Health Network

cohealth care for all

DPV Health®

each health . hope . opportunity

gateway health People living well

Gippsland Lakes Complete Health

Grampians Community Health

healthAbility

ipc Health

inspiro health

Latrobe Community Health Service

Merri Health Healthcare that moves with you

nexus Primary Health living well in your community

north richmond community health Wulempuri - Kertheba

NDCH

Primary Care Connect

Sunbury Cobaw Community Health

SCHS Sunraysia Community Health Services

your Community Health

Community Health First acknowledges the Traditional Owners of the land on which we live and work. We pay our respects to Elders past and present and recognise that sovereignty was never ceded.

Foreword

Addressing health inequities through cost-effective, proven solutions should be a priority in the upcoming budget to ensure all Victorians have fair access to healthcare services.

Cost-of-living continues to place pressure on Victorians, and as household costs continue to rise, more families are forced to make difficult choices between housing, food, energy, and healthcare. These pressures are being felt more acutely by Victorians on low incomes, those with complex health needs who may require more regular healthcare, and rural and regional communities that lack access to specialist services close to home.

Investing in community health has never been more critical to meeting the needs of Victorians as our acute sector remains under strain with stretched emergency departments and lengthy planned surgery wait lists.

The recommendations in this submission focus on practical and cost-effective solutions that can be delivered by community health to create a sustainable foundation for health equity across the state.

We are recommending funding community-based services that provide care closer to home, reduce emergency department visits, and emphasise prevention and early intervention. By prioritising these investments, we can support equitable access and improved health outcomes, consistent with the objectives of the recently announced Health Services Plan.

Community health plays a crucial role in alleviating pressure on the acute care sector; however, our organisations are also facing rising costs, which impacts our ability to meet increased demand. In the past year, the number of people accessing community health services grew by twenty per cent.

Community health organisations now reach over 600,000 Victorians each year, through our network of over 250 service locations state-wide. Our submission calls for ongoing investment to support community health organisations, enabling them to deliver safe, effective, and accessible services. Such funding is essential to strengthen the health and wellbeing of all Victorians and support a sustainable healthcare system for the future.

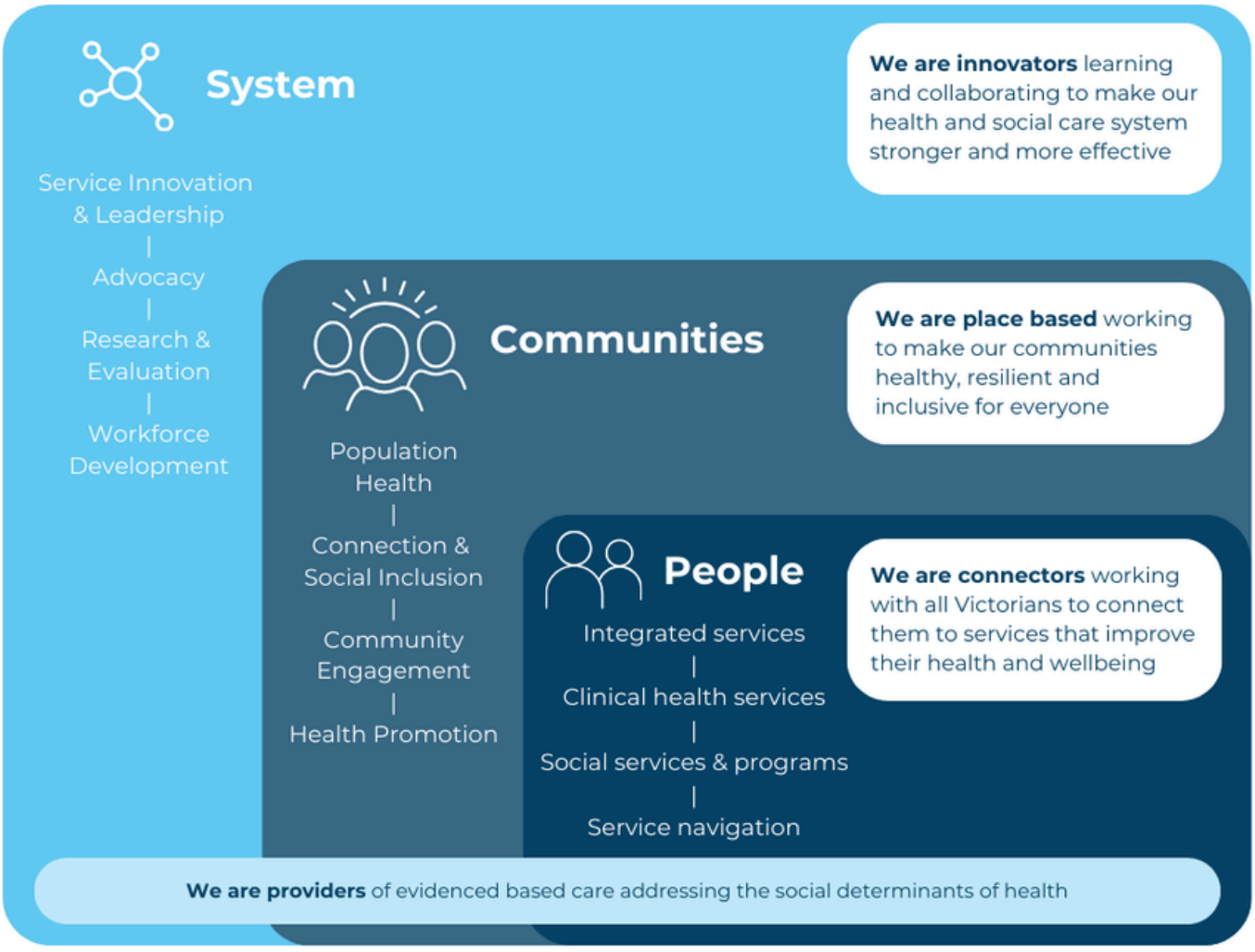
Table of Contents

About Community Health in Victoria

Registered independent community health services play a unique and important role within the Victorian health and social service systems to support people at every age and stage of life. To do this, community health works at multiple levels – with individuals and families, communities and systems – to achieve improved health outcomes and lasting community impact.

Community health works within a social model that recognises that health outcomes are largely determined by social factors such as economic stability, education access, and community context. By combining robust clinical health service delivery, a wide range of social services, and population health initiatives, community health services can address these social determinants of health to achieve change.

A key focus of the work of community health is prevention and early intervention. By working to prevent health and social needs arising or stepping in early to stop issues escalating, community health services play a key role in reducing the burden on hospitals and ambulance services, while helping address long-term acute service challenges and down-stream expenditure.



11,075
employees

608,000
Victorians supported

24
registered independent community health organisations

259
sites across Victoria

91.2%
said receiving support from their local community health organisation helps to keep them healthy and well

89.5%
said their local community health organisation provides services at a cost they can manage

58.3%
said the help they receive from their community health organisation has reduced the frequency of hospital visits

84.9%
said their local community health organisation makes it easier for them to access the supports and services they need

Recommendations for investment in a healthier Victoria

Community Health First has identified four areas for investment that have been proven to deliver outcomes in Victoria and that can be further expanded to support targeted communities across Victoria with the goal of improving health equity and increasing access to services.

Each investment area has a strong evidence-base, and demonstrated ability to reduce demand on acute services, avoid long-term costs and provide care close to where people live.

An investment of $31.1 million will mean an additional 20,600 Victorians will have access to the services they need to keep them healthy and well and will result in:

- **15,400** hospital bed days avoided annually
- **3,435** emergency department presentations and hospital admissions avoided annually
- **7,000** emergency ambulance callouts avoided annually
- **$90 million** in acute healthcare costs avoided – a return of nearly $3 for every $1 invested on average.

READY FOR SURGERY PROGRAM

A Ready for Surgery Program would work with patients already on the planned surgery waitlist to deliver personalised support to improve health prior to surgery. Evidence shows that this leads to better surgery outcomes, improved patient experiences, shorter recovery periods, and less bed days required in the acute system.

Investment
$13 million per year

Reach
7,000 people

Impact

- **10,400** bed days avoided
- **223** unplanned readmissions avoided in 30 days following surgery
- For every dollar invested in the program, **$1.80 is avoided in future acute care costs**

CP@ CLINICS IN REGIONAL VICTORIA

Scaling early intervention outreach across rural and regional communities through the establishment of weekly CP@clinics with community paramedics giving community members easy access health checks, health education and assistance with service navigation.

Investment
$7 million per year

Reach
5,200+ people across rural and regional communities

Impact

- **7,000** emergency call outs avoided
- **2,300** emergency department presentations avoided
- Job creation in regional Victoria
- For every dollar invested in the program, **$1.61 is avoided in future acute care costs**

CHRONIC DISEASE COACHES

Supporting chronic disease patients to effectively manage their health conditions at home and within community and avoid unnecessary hospital visits. As the number and proportion of Victorians with chronic disease continues to skyrocket, this service can alleviate demand on our hospitals.

Investment
$7.5 million per year

Reach
2,400 people

Impact

- **4,900** bed days avoided
- **435** emergency presentations avoided
- For every dollar invested in the program, **$1.40 is avoided in acute care costs within two years**

COMMUNITY HEALTH PROGRAM REACH

Increasing access to services for low and middle income families and individuals who are struggling to access affordable healthcare and vulnerable population groups unable to access mainstream services.

Investment
$3.6 million per year

Reach
6,000 people

Impact

- **30,000** additional hours of support across nursing, allied health and case coordination reaching at least **6000** Victorians
- For every dollar invested in preventative health, **$14 is avoided in future acute care costs**

PRIORITY ONE

READY FOR SURGERY PROGRAM

Ready for Surgery Program

Fitter, healthier, active patients recover from surgery more quickly. A Ready for Surgery Program would work with patients already on the planned surgery waitlist to deliver personalised support to improve health prior to surgery – leading to better surgery outcomes, improved patient experiences, shorter recovery periods, and less bed days required in the acute system.

The Ready for Surgery Program would bring together multidisciplinary teams to deliver care coordination, education, exercise, nutritional information and psycho-social support over a 6-8 week pre-surgery period ahead of the planned surgery.

The program would be delivered by trained community health staff specialising in relevant disciplines including physiotherapists, exercise physiologists, dietitians, counsellors, occupational therapists, social workers, case managers and nurses.

The program would have a centralised intake across community health to support easy access and referral pathways for health services and be underpinned by an independent evaluation to measure efficacy and develop an evidence-base for scaling the service state-wide.

$13m
investment in year one

7000
people reached

10,400
bed days avoided

Who it will help
Patients on the planned surgery waitlist who have significant modifiable risk factors that could contribute to an increased risk of perioperative morbidity and mortality.

How it will help
As of 30 June 2024, there were 58,722 patients on the planned surgery waitlist. Lifestyle factors such as obesity, smoking, physical inactivity, and poor nutrition have been increasingly linked to poorer postoperative outcomes. These lifestyle risk factors compromise surgical outcomes, resulting in an increased burden on the healthcare system following surgery.

Research shows increased length of stay post surgery and unplanned readmission rates is 1.8 times the average for those with risk factors prior to surgery occurring. By addressing these lifestyle factors before surgery, the number of bed days required following surgery and unplanned readmissions can be reduced.

Ready for Surgery Program

CASE STUDY: Ready for Surgery program in action: The UK's 'Fit 4 Surgery' program

A preoperative 'Fit 4 Surgery' school was established at University Hospital Southampton to provide classroom based sessions covering the benefits of exercise, nutrition, and lifestyle modification advice regarding smoking and alcohol intake. The aim of the school was to provide patients with advice and tools to enable behaviour modification and improve fitness prior to major elective surgery.

Of the 450 patients who attended over the first two years, 63% stated they intended to make a lifestyle change as a result. Patients who attended the school made more positive lifestyle changes prior to their surgery than those who did not attended. 46% of patients attending school reported becoming more active, 88% of smokers reduced tobacco, 71% reduced alcohol intake, and 42% made positive changes to their diet.

For every dollar invested in the program, $1.80 is avoided in future acute care costs

PRIORITY TWO

CP@ CLINICS IN REGIONAL VICTORIA

CP@Clinics in regional Victoria

Scaling early intervention outreach across rural and regional communities through the establishment of weekly CP@clinics with community paramedics will give community members easy access health checks, health education and assistance with service navigation.

The drop-in centre services would run from the same location at the same time each week to increase connection and awareness of the service, and include the offer of a warm meal and the opportunity for social connection. Run by community paramedics, the CP@clinics will create new jobs in regional areas as well as offering different opportunities for existing paramedics.

Who it will help
Regional and rural Victorians who are isolated, struggle to access healthcare close to home or have difficulty navigating mainstream services.

How it will help
Nearly one quarter of all Victorians live in regional and rural areas, and many have a lack of affordable healthcare close to home. Victorians living in rural and regional areas experience longer wait times to see a GP or a dentist, may have to travel long distances to see a specialist, and struggle to access disability and aged care services.

$7m
investment in year one

7000
emergency call outs avoided

2,300
emergency presentations avoided

This leads to worse health and wellbeing outcomes, higher rates of cancer, chronic disease, mental ill health, and substance abuse in regional areas. Potentially avoidable deaths for regional Australians are 2.5 times higher. Combined, these factors place additional strain on hospitals, with higher rates of preventable hospitalisation rates and emergency department presentations.

Building off a well-established and proven model in Canada that saw a 19-25% reduction in emergency call outs, clinics have been piloted by Sunraysia Community Health, Gateway Community Health and Primary Care Connect. Pilots have proven to be able to reach high-risk community members, reduce emergency department presentations and improve health outcomes.

CP@Clinics in regional Victoria

CASE STUDY: Community paramedics in action: CP@clinic run by Sunraysia Community Health

Tony is 38, living in a caravan park because he cannot find permanent housing, and is unable to work due to a complex medical history that includes mental health issues and other co-morbidities. He is also on a disability pension and needs to manage his type 2 diabetes and epilepsy – problems further complicated by a lack of access to a GP or diabetes educator. Tony turned to CP@clinic for help with his medication management after suffering several seizures.

At the time he was using his medications sparingly as he was forced to go to his local Emergency Department for scripts due to not having a GP or diabetic educator. The hospital only provides a script for one week's medication, prompting Tony to reduce his dose below therapeutic levels to try to make his supply last longer. As a result, Tony would often have seizures, resulting in regular presentations to the emergency department.

The community paramedic at CP@clinic organised for Tony to have scripts filled promptly at his local pharmacy and then linked him with a GP and Nurse Practitioner diabetic educator at Sunraysia Community Health Services. Tony is now managing his diabetes much better and through education has given up drinking soft drinks. He returns regularly to CP@clinic for follow ups and health information. Tony has not had a seizure or needed an ambulance since attending CP@clinic, and no longer uses the emergency department for scripts and general health care.

For every dollar invested in the program, $1.61 is avoided in future acute care costs

PRIORITY THREE

CHRONIC DISEASE COACHES

Chronic disease coaches

Health organisations work collaboratively with existing practitioners to identify clients that would benefit from improved coordination of their care due to the complexity or chronic nature of their condition.

Chronic Disease Coaches would work with each client and the health services they are engaged with to improve their care coordination, help them better understand their condition, and build their confidence to manage their health.

The program would develop a sustainable workforce development pathway for Coaches from a range of disciplines including nursing, allied health and paramedicine.

Who it will help
Those currently experiencing longer waitlists to access services, in particular people living in the North-West growth corridors and women experiencing complex chronic conditions.

How it will help
Many chronic disease patients who access hospital services do not need to be there or could have had their hospital presentation avoided had they received care earlier. Supporting patients with chronic conditions through care coordination, information and support to self-manage has been proven to dramatically reduce hospitalisations and improve health outcomes and quality of life.

$7.5m
investment in year one

2,400
people reached

4,900
bed days avoided

Growing populations: Chronic conditions place a significant and growing burden on our healthcare system. The Grattan Institute estimates that 37% of all hospitalisations relate to chronic conditions such as heart disease, type 2 diabetes and asthma and that this is projected to increase as the number of Australians with chronic conditions grows to 47% of the total population.

Women's health: Health and wellbeing outcomes are significantly worse for women due to the additional barriers many women face in accessing services and structural sexism within the health system. This results in a lack of attention on women's health and can lead to women not being taken seriously when they present with chronic health needs. Australian women are more likely to bear the burden of chronic disease in Australia, with a higher prevalence as compared to men. These conditions often present differently in women and coupled with their longer lifespan, require gender-sensitive approaches to chronic disease management.

Chronic disease coaches

CASE STUDY: Chronic Disease coaches in action: Pathways Program, delivered by EACH

The Pathways program commenced in 2023, building off earlier successful trial programs, to address chronic health conditions in the east of Melbourne. The program provides access to quality ongoing chronic disease management and social services through outreach and telehealth consultations outside of the hospital system to meet the individual needs of the client.

Evaluation has shown that this program has demonstrated the ability to reduce the demand on hospital beds and programs through reducing Emergency Department presentations by 61%, reducing hospital admissions by 54% and reducing total bed days by 64%. For clients who had undertaken the program for more than six months, 61% had no further hospital admissions.

In addition, the hospital admission risk program (HARP) length of stay reduced by 26%, enabling this program to increase its ability to impact acute bed flow and demand. Clients' ability to self-manage their chronic health condition was measured and saw 72.1% of clients improve their self-management between program admission to program discharge. More than 95% of clients enrolled reported positive experiences.

PRIORITY FOUR

MEETING COMMUNITY DEMAND

Meeting community demand

The demand for accessible and affordable services continues to rise as Victoria's population grows, the rates of chronic disease rises, and more families and individuals are struggling to meet their healthcare needs due to the rising cost of living.

Community health will need to be properly equipped, with a minimum 5% increase to annual funding, to manage the growing population and meet rising costs of service delivery in order to be able to effectively support the long-term health outcomes of communities growing in size and diversity.

Who it will help
Low and middle income families and individuals who are struggling to access affordable healthcare, and vulnerable population groups unable to access mainstream services.

How it will help
Community health is experiencing increased service demand and extended waiting times as the number of people seeking affordable care grows. At present, community health organisations cannot keep pace with demand and unavoidable cost pressures continue to impact organisations' ability to deliver the volume of services required.

Indexation of community health funding over the last five years has not kept up with increases in staff wages, work cover, inflation and the increasing costs of consumables. A lack of growth in MBS funding has also limited organisational ability to expand service delivery.

$3.6m
investment in year one

6,000
people reached

30,000
additional hours of support

Community Health Program funding is less than 0.5% of the total Victorian health budget and equates to an average expenditure of $22 per Victorian, as compared to $190 spent per person on ambulance care and $3,166 on hospital care. The community health sector also generates significant economic and social benefits, particularly through increased workforce participation and productivity, employing over 10,000 Victorians and supported by a strong volunteer workforce.

Meeting community demand

CASE STUDY: A proven model in Victoria

Registered community health services play a unique and important role within the Victorian health and social service systems to support people at every age and stage of life. To do this, community health works at multiple levels – with individuals and families, communities, and systems – to achieve improved health outcomes and lasting community impact.

Community health works within a social model that recognises that health outcomes are largely determined by social factors. By combining robust clinical health service delivery, a wide range of social services, and population health initiatives, community health services can address these social determinants of health to achieve change.

The sector's deep knowledge of the health and social service systems and the needs of communities has developed over the last 50 years, to now support over 600,000 Victorians every year from over 250 locations across the state.

The Community Health First Client Sentiment Survey 2024 showed the significant impact community health is having for Victorians:

- **91%** said community health keeps them healthy and well
- **84%** said community health makes it easier for them to access the supports they need
- **66%** said community health helps them to stay connected to their community
- **58%** said community health has reduced their use of hospital services.

COMMUNITY HEALTH FIRST

www.communityhealthfirst.org.au