Response to the Productivity Commission Human Services: Identifying Sectors for Reform Issues Paper

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Key messages

The Productivity Commission Human Services: Identifying Sectors for Reform Issues Paper (henceforth the Issues Paper) outlines a framework for identifying human services that would benefit from market reforms including increased competition, contestability, and user choice.

cohealth, one of Australia's largest community health organisations, notes the following in relation to the Issues Paper:

- We question the presumption that increased competition and contestability are preferred – or even demonstrably effective – strategies to improve the human services sectors.
- We call for the separation of the principle of increased user choice from the concepts of increased competition and contestability, noting that there is no logical or necessary connection.
- We strongly support the principle of increased user choice and offer a number of suggestions for how this can be advanced without increasing competition or contestability.
- We endorse the importance of equity as an attribute of the human services sector, and note that this relates not only to access but also to outcomes.
- We point out a number of costs of contestability and competition which are not articulated in the Paper, including uncertainty and workforce management challenges for organisations, damage to effective collaborative partnerships between providers, and loss of trusted relationships for service users.
- We highlight the role of active, meaningful consumer engagement in effective reform.
- We note the importance of a clear concept of "vulnerable" or "disadvantaged" groups, which avoids simplistic categorisation based on demographic variables.
- We draw attention to the myriad examples of vulnerable consumers being exploited and abused in competitive markets, and the responsibility of government to ensure adequate consumer protections.
- We are concerned with the conceptualisation of "access to information" and "capacity to make informed choices" as individual user characteristics, which does not recognise the structural barriers impacting on individuals' access to information or capacity to make informed choices.

Recommendations:

1. Retain equity as one of the key attributes of human services, and amend the definition to incorporate reference to equity of outcomes in addition to equity of access.
2. Assess equity by comparing recognised priority groups to identify and analyse inequities in access, utilization, experience, and outcomes.
3. Include measures of client experience in assessment of quality.
4. Actively engage service users in designing and monitoring reforms to get their perspective on the impacts of changes. This includes providing support, where necessary, to enable meaningful engagement.
5. Adopt a comprehensive definition of "vulnerable" or "disadvantaged" which recognises the complex factors which contribute to disadvantage.
6. Ensure that any introduction of increased competition or contestability includes a suite of appropriate strategies to ensure adequate consumer protection.
7. Require organisations to provide information about their services which is clear, accessible, and understandable to potential service users.

8. Provide support to individuals to increase their knowledge and experience in order to expand their capacity to make a range of informed choices.
9. Ensure providers change their practices so that they do not unreasonably constrain individual choice (e.g. relating to low or limited expectations).

See Appendix 1 for further information for further information about cohealth.

Introduction

If increased competition, contestability, and user choice are the answer, what is the question?

The Issues Paper, and the Inquiry itself, are premised on an assumption that increased competition, contestability, and user choice are the preferred choice for, and will be effective in, improving outcomes, efficiency, effectiveness, and access to affordable, appropriate, high quality human services. We question the assumption that it is simply a matter of identifying which services within the human services sector are appropriate targets for these market reforms. A genuinely open process of analysis of the human services sector could, in theory, lead to the conclusion that further competition or contestability would not be of benefit.

The Issues Paper identifies existing examples where competition, contestability, and user choice are already a feature, including general practice (GP) and dental services. The Productivity Commission's own work indicates concerns about access to GP services, including long-standing lower availability of GPs in outer regional and remote areas, and one in twenty people delaying or not visiting a GP because of cost.[1] Similarly, median waiting times for public dental services are 2.5 years in Tasmania, and almost doubled in Victoria in the year to 2014/15.[1] At the same time, non-government spending on dental services comprised 78% of the total, indicating significant out-of-pocket costs for individuals to access private dental care.[1] The Issues Paper does not address the current level of unmet need, such as in the case of dental services. The introduction of competition or contestability reforms is unlikely to address this fundamental problem, and if anything, may exacerbate it.

The Issues Paper does not include any recognition of the significant related reforms that are already underway in the sector, including:

- client-directed funding models under the NDIS and My Aged Care, which in turn build on approaches such as Individualized Care Packages in Victoria;
- commissioning of services in mental health, alcohol and drug, and possibly other sectors through the Primary Health Networks
- Health Care Homes in the primary health care sector.

In the context of multiple streams of major reform, it is likely to be difficult to measure the impacts, either positive or negative, of specific reforms.

There is no consideration of other potential policy options for improving outcomes, efficiency, effectiveness, and access to affordable, appropriate, high quality human services. Such policy

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[1] Productivity Commission. Report on Government Services 2016. http://www.pc.gov.au/research/ongoing/report-on-government-services

options might include social benefit bonds (social impact bonds), social enterprise development, or altered payment mechanisms (outcomes-based funding, pay for performance). There is no discussion in the Paper of extensive relevant literature with regard to the success, or otherwise, of reform efforts in human services, such as commissioning reforms in the United Kingdom, nor is there any consideration of recent attempts at competition reforms in the Australian setting. Those in the vocational education sector, for example, are widely regarded as having extensive negative consequences for quality, equity and efficient use of public funds.[2]

The recently-completed Royal Commission into Family Violence undertook a comprehensive examination of family violence services in Victoria. Not one of its 227 recommendations to improve the system involved increasing competition or contestability of services. Instead, it focused on improving collaboration, integration, access, and responsiveness, as well as investing in prevention and early intervention.[3]

Finally, there is a complete absence in the Paper of any reference to behavioural economics, which has fundamentally challenged many of the assumptions of traditional market models and economic theory.[4] This approach offers an additional set of evidence-based options for policy reform (including 'nudges' and other behaviourally-focused strategies).

In short, the range of potential solutions canvassed in the Issues Paper for the complex and important challenges facing human services sectors are unnecessarily constricted.

User choice is separate from competition and contestability

The Issues Paper consistently groups the three concepts of competition, contestability, and user choice together, but the principle of user choice is quite distinct from the other two. Competition or contestability reforms are not necessary to increase user choice. Furthermore, while areas that already have increased competition (such as GP and dental services as noted above), may have increased choice for those who can afford to pay, but this does not extend to those on low incomes to the same degree.

The health sector has been a leader in facilitating a more active role for consumers, to support them to make informed decisions in relation to health care services they receive. This is apparent is the global, long term trend towards patient-centred or client-centred care,[5] which encompasses specific approaches including goal-directed care planning, patient activation, health literacy development, and advanced care planning. This shift recognises that providers are the experts in the technical aspects of health care, and clients are the experts in relation to their own preferences and values, both of which are equally important consideration in decisions about health care.

Elsewhere in the human service sector, the principle of 'wrap-around' service models is growing in prominence, predicated on the principle of client-centredness, and the recognition that responsibility for identifying and coordinating the required services to meet individual needs sits, at

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[2] Leahy M. Reforming vocational education: it's time to end the exploitation of vulnerable people. *The Conversation* 2015. http://theconversation.com/reforming-vocational-education-its-time-to-end-the-exploitation-of-vulnerable-people-51396
[3] Royal Commission into Family Violence. Final Report March 2016. http://www.rcfv.com.au/Report-Recommendations
[4] Finighan R. Beyond nudge: The potential of behavioural policy. Melbourne Institute Policy Brief 4/15. Melbourne Institute of Applied Economic and Social Research 2015. https://www.melbourneinstitute.com/downloads/policy_briefs_series/pb2015n04.pdf
5 Shaller D. Patient-Centered Care: What Does It Take? The Commonwealth Fund, 2007. http://www.commonwealthfund.org/publications/fund-reports/2007/oct/patient-centered-care--what-does-it-take

least in part, with the service system rather than the individual. This is reflected in the recommended principles of the Shergold Report in 2013 for example, which included: a holistic approach, choice of providers, and citizen control.[6]

A specific example of a strategy which increases user choice is service purchasing. cohealth has been trialling the use of flexible funds to purchase services on behalf of consumers of our mental health community support service programs.[7] Purchased services are directly related to clients' identified goals and are not available from cohealth, and are part of a client's overall package of support. Being able to purchase services matched to individual clients' goals increases flexibility, responsiveness and choice for clients, while also supporting capacity-building among mainstream providers to meet the needs of this client group. Examples of purchased services include literacy skills, personal training, driving lessons, hoarding management and timely access to specialist assessments.

In line with cohealth's values statement ("*we care about the whole person and place people at the centre of everything we do*"[8]) we fully support increasing informed user choice in all sectors of human services. This can be achieved through a range of different strategies which support the development of user capacity as well as addressing the structural barriers to the exercise of choice. This is discussed further below (page 10).

Notwithstanding our objection to the presumption that increased competition and contestability are reforms which should be pursued, in the remainder of this paper, we provide feedback on the Framework as presented in the Issues Paper.

Key attributes of human services

Equity

The Paper identifies "equity" as one of the five key attributes of human services, and defines it in relation to the accessibility of human services. We agree that equity is one of the most important attributes, but would like to see the definition of this amended.

The concept of equity as presented is a narrow one, compared to, for example, the definition provided by the World Health Organization (WHO):

> "*Equity is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically.*"[9]

The WHO definition recognises that equity relates not just to access but to outcomes. This is further explained by the concepts of "formal equality" and "substantive equality". Formal equality focuses on equal treatment of individuals, while substantive equality acknowledges that "*rights, entitlements, opportunities and access are not equally distributed throughout society and that a*

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[6] Shergold P. Service sector reform: a roadmap for community and human services reform (Final report). 2013. http://vcoss.org.au/documents/2013/11/FINAL-Report-Service-Sector-Reform.pdf

[7] Scott R. Through the looking glass. Paper presented at the VICSERV Towards Recovery Conference, Melbourne May 2016. http://conference.vicserv.org.au/images/Thu_103_1525_Rachael_Scott.pdf

[8] cohealth Strategic Plan 2015-2018. https://www.cohealth.org.au/about/our-vision/

[9] World Health Organization. Health systems: Equity. http://www.who.int/healthsystems/topics/equity/en/ .

one size fits all approach will not achieve equality"[10].

While there is some acknowledgement of this in the Issues Paper, it is referenced in relation to geographic accessibility only. Factors such as cultural background, socio-economic disadvantage, and other structural barriers are not explicitly recognised. A rights-based approach highlights how the focus needs to be outcomes (substantive equality) rather than solely access to services.

The use of the term "accessible" as part of the definition of the concept of equity begs the question of how "accessibility" is defined. There is a rich literature within the health sector about accessibility of services. Levesque and colleagues, for example, have developed a comprehensive model of access which includes characteristics and capabilities of services (e.g., approachability, appropriateness) and users (e.g. ability to pay, ability to engage).[11] This model once again highlights that "accessibility" is not a simple matter of availability of services, but a multidimensional concept which includes both structural issues and individual ones.

Furthermore, people's capacity to access services is amenable to change – through actions taken by services to make them more appropriate and available, and though actions to support individuals to increase their capacity to engage (e.g., by supporting development of health literacy). Supporting people's capacity to engage also includes educating people about their right to access services and about how to do so. Providing advocacy for people with limited capacity to exercise their rights, to articulate their preferences and exercise their choices, is a fundamental requirement for equity.

Equity is the attribute which is most likely to be adversely affected by increased competition and contestability. Measures of equity therefore should include comparisons of more disadvantaged groups compared to those who are less so, with regard to access to services, utilisation rates, experiences of service, and outcomes. This disaggregation of data to allow for comparisons between different groups is an essential element of a rights-based approach, as this enables the identification and analysis of inequities.[12] Specific groups which should be included for analysis are discussed further below (page 8).

Quality

Providers must have clear accountability for the quality of their services through appropriate mechanisms including regulation, and development and enforcement of quality standards. Quality is further discussed below in relation to the protection of vulnerable consumers.

Measurement of quality should incorporate measures of client experience. While responsiveness is identified as a separate attribute, client experience is now recognised as a key element of quality within the health sector, and has been incorporated into National Quality Standards. Measures of quality in human services should reflect this by incorporating indicators of client experience of services.

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[10] Australian Human Rights Commission. Implementation of the United Nations Declaration on the Rights of Indigenous Peoples – Declaration Dialogue Series - Discussion Paper 5: Equality and nondiscrimination. AHRC 2013. http://www.humanrights.gov.au/about/publications/ .

[11] Levesque JF, Harris MF, Russell G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *International journal for equity in health.* 2013 12(1):1. https://equityhealthj.biomedcentral.com/articles/10.1186/1475-9276-12-18

[12] Office of the High Commissioner of Human Rights, United Nations. A Human Rights Based Approach to data. 2016. http://www.ohchr.org/Documents/Issues/HRIndicators/GuidanceNoteonApproachtoData.pdf

Recommendations:

1. **Retain equity as one of the key attributes of human services, and amend the definition to incorporate reference to equity of outcomes in addition to equity of access.**
2. **Assess equity by comparing recognised priority groups to identify and analyse inequities in access, utilization, experience, and outcomes.**
3. **Include measures of client experience in assessment of quality.**

The benefits and costs of competition, contestability and user choice

Some of the costs of contestability and competition are not well captured in the Paper. These costs include the following, which are illustrated in the case study below (see over):

- Uncertainty and loss of continuity for organisations which are required to bid in contestable processes for future service provision funding. This impacts on their capacity to plan, and therefore on decisions about investment and innovation. In the short term, it also impacts on organisations' capacity to provide continuity of service while also preparing bids or tenders.

- Workforce management challenges for organisations, and more specifically their ability to recruit and retain the required staff. Market models often necessitate a shift to a more casualized workforce, which can impact on an organisation's capacity to provide quality, reliable services.

- Damage to relationships between organisations within a service provision sector as a result of competitive processes, destroying long traditions of effective collaboration. Collaboration can be an effective means of improving efficiency within human services.

- Smaller, niche providers closing down, resulting in less diversity of providers, and less choice for consumers.

- Loss of trusted relationships with providers for service users. As acknowledged in the Issues Paper, trust is a central element of the service model in many human services. This is particularly the case for groups which experience particular barriers to accessing services, especially stigma and discrimination. These groups include people who are homeless, LGBTIQ communities, people who inject drugs, and people with mental health conditions, among others. When a trusted service provider is de-funded, service users experience reduced choice, if their preference is to stay with a known, trusted provider but government will no longer fund or subsidise this provider.

Case study: Recommissioning of alcohol and drug services and mental health community support services in Victoria

Competitive processes were undertaken during 2013 In Victoria to recommission a range of services including: delivery, catchment-based intake, assessment and service planning of community-based mental health support services; and alcohol and other drug (AOD) programs including pharmacotherapy, intake and assessment for nonresidential services such as care and recovery coordination, counselling and non-residential withdrawal services.

There were many adverse impacts which have been identified.[13,14] Well-established partnerships and collaborations between providers were seriously damaged. There was a significant loss of capacity from the sector as experienced staff left to pursue more stable employment opportunities. Most important, and of most concern, was that access to services was diminished, with the most disadvantaged groups the hardest hit. An independent review concluded that:

> *"…since the recommissioning, vulnerable Victorians who were seeking help have found it more difficult to access treatment and support because the system was harder to navigate…"[15]*

The adverse impacts on access resulted from the separation of intake and assessment functions from service delivery (with the former provided by one organisation for a defined catchment, and the latter provided by a range of organisations within the catchment) and the shift to a telephone-based intake and assessment process. In order to access services, people now need to speak by phone, to a person with whom they have no relationship, and then wait to be referred to a service provider, to whom they must repeat their story. The possibility of opportunistic, immediate access to services through an existing relationship with a service provider has been lost. For example, where consumers come to a needle & syringe program in their local area, they cannot access AOD counselling or recovery services available from the same provider, without having to go through intake with a different organisation.

Many consumers of mental health and AOD services experience compound disadvantage, facing additional complexities such as homelessness, social isolation, refugee status, justice system involvement and English language barriers. Stigma and discrimination are a common experience. As such, trust and personal relationships are an essential feature of effective service models. This includes specific strategies to support engagement and relationship development, such as assertive outreach, drop-in (no appointment) services, and priority access (no waiting). While catchment-based, telephone-delivered intake and assessment systems may be "efficient" within a market model, consumers' experience of these systems is far from efficient or streamlined – in fact they create barriers to access.

Another important feature of this recent Victorian experience was that the process involved changes to service delivery models as well as changes to providers. Some service types which had previously been offered are no longer available, as they are not funded under the new models. Consumers were particularly devastated by the loss of group day programs for people with mental health conditions. These programs were highly valued by consumers, and they experienced the new system as less responsive to their preferences because of the loss of these programs.

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[13] Joyce C. Person-centred services? Rhetoric versus reality. *Australian Journal of Primary Health* 2015. [online early] http://dx.doi.org/10.1071/PY15035 .

[14] Community Sector Reform Council (Victoria). Reflections on the recommissioning of community mental health and alcohol and other drug services. CSRC 2014.

[15] Independent review of new arrangements for the delivery of Mental Health and Drug Treatment Services. Aspex Consulting 2015. https://www2.health.vic.gov.au/about/publications/ResearchAndReports/review-of-mental-health-community-support-services-and-drug-treatment-services

One of the key aspects which can mitigate the potential for the adverse consequences seen in the Victorian example is active engagement of consumers in reform processes, to ensure that their perspectives are well understood and are taken into account in the design of new approaches. Consumer engagement has been identified as a key element of successful commissioning based on the UK experience.[16]

Vulnerable populations

There is some good acknowledgement in the Issues Paper about the needs and interests of disadvantaged groups, including:

- Recognition that service models which rely on more pro-active engagement by providers rather than users (e.g. outreach) "might be less well suited" to more market-based models (page 15)
- Importance of considering these groups in relation to equity (page 16)
- Importance of safeguarding the interests of disadvantaged users, and identifying this is part of government stewardship under a reformed market model (page 18)

There is no discussion in the Issues Paper however, of exactly what is meant by "disadvantaged" or "vulnerable" groups. Vulnerability relates to complexity of health and social needs.[17] It is not about a specific diagnosis (in health) or a specific demographic group. There are some groups which are acknowledged to experience disadvantage, with clear evidence of poorer health and social outcomes. These include Aboriginal and Torres Strait Islander people, those who are experiencing homelessness or at risk of homelessness; refugees and asylum seekers; and people recently released from prison.

Approaches in the health sector increasingly make use of "risk stratification" models which take into account "complexity variables" known to impact on risk of poor health outcomes, including cultural and linguistic diversity, and social disadvantage (e.g., living alone; being a carer).[18]

Groups who experience stigma and discrimination are particularly at risk of experiencing barriers to accessing services, and hence poor outcomes. These include, but are not limited to, LGBTIQ communities and people who inject drugs.

There are significant risks for vulnerable people in the future state being considered. Vulnerable people are the most likely to be exploited in more de-regulated environments, and appropriate protections must be put in place to balance the potential financial gains for suppliers in the market. Perhaps the clearest example of this in recent Australian history is the vocational education and training (VET) sector, where major reforms involved a rapid shift to a demand-driven, market-based system.

A review of these reforms in Victoria concluded that they resulted in lower quality products and services, and significant costs both for the users (i.e., students) and for taxpayers. Users were not supported to make informed choices, and were not protected from unethical conduct of providers. The Review noted:

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[16] Dickinson H. Commissioning public services evidence review: Lessons for Australian public services. Melbourne School of Government, 2015. https://government.unimelb.edu.au/research/research-publications

[17] Lewis V et al. *Understanding vulnerability in primary health care: Overcoming barriers to consumer transitions through the primary health system.* APHCRI, Australian National University, Canberra, Australia, 2013. http://aphcri.anu.edu.au/aphcri-network/coordination-and-vulnerable-consumer-health-care-research

[18] NSW Agency for Clinical Innovation 2014. Risk stratification: A discussion paper for NSW Health's approach to Risk Stratification. From www.aci.health.nsw.gov.au

> *"Government cannot simply declare something contestable, open up the market, and hope that it works. It needs to design and administer the market more carefully, guided by the outcomes it seeks to achieve."* [19]

It is not at all clear what the proposed reforms of increased contestability and competition are intended to achieve, or what mechanisms will be put in place to protect users, particularly those who are vulnerable.

Additional examples where consumer protection has been ineffectual include residential disability settings (the subject of numerous inquiries which have brought to light egregious breaches of rights and of duty of care); and the out of home care sector[20]. In the case of human services, the consequences of being exploited are not simply financial as may be the case in other markets. The exploitation of people in relation to the provision of health and social services has profoundly negative consequences for their health and wellbeing.

Any shifts to more contestable or competitive market models in the human services sector must embed adequate consumer protection in the design and administration of the model. While it would undoubtedly be a difficult task to design and implement a system of effective checks and balances, government has a fundamental responsibility to do so as part of its stewardship role. Possible mechanisms may include:

- The development of enforcement of quality standards (as noted above)
- Clear and effective regulatory frameworks
- Accessible mechanisms for redress
- Individual and systemic advocacy

The latter point is a particularly important one which must be recognised as a responsibility of government to support. Advocacy for individual cases and for system-level issues by non-government organisations has been, and will continue to be, a key contributing factor to ongoing improvements in social policy:

> *"Australia is a far better place thanks to the activism and engagement of Australia's community sector. Many of the rights, laws and policies we now enjoy in areas as diverse as discrimination, family violence, homelessness, consumer protection, disability and workplace safety have been secured after years and sometimes decades of advocacy by community organisations."* [21]

Recommendations

4. **Actively engage service users in designing and monitoring reforms to get their perspective on the impacts of changes. This includes providing support, where necessary, to enable meaningful engagement.**
5. **Adopt a comprehensive definition of "vulnerable" or "disadvantaged" which recognises the complex factors which contribute to disadvantage.**
6. **Ensure that any introduction of increased competition or contestability includes a suite of appropriate strategies to ensure adequate consumer protection.**

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[19] VET Funding Review: Final Report (Chair B Mackenzie) 2015. http://www.education.vic.gov.au/about/department/Pages/vetfundingresponse.aspx

[20] Mariadassou M & Feltis G. Out of home care and child abuse. Human Rights Law Centre 2016. http://hrlc.org.au/out-of-home-care-and-child-abuse/

[21] Human Rights Law Centre Safeguarding Democracy 2016. http://hrlc.org.au/safeguardingdemocrac/

Factors to be considered when identifying human services best suited to reform (Figure 2)

Access to information about services is identified as one of the factors influencing the potential benefits of increased competition, contestability, and user choice. This is conceptualized as a user characteristic rather than a characteristic of services or the market. This is a limited conceptualization which provides no recognition of the fact that (potential) service users do not necessarily have control over what information is available about services and how useful it is to them. Users may face significant challenges in accessing unbiased, readily understandable information about the options available to them and the potential benefits and disadvantages of these options. The critical factor here is actions by service providers to make such information available. This suggests a role for government in setting requirements about information provision, as part of its stewardship role.

"Willingness or capacity" to make informed choices is another user characteristic identified as one of the factors influencing the potential benefits of market reforms. The implication in the Issues Paper is that the onus is on individuals to develop capacity to make choices. But many people's capacity to make informed choices is impacted by structural barriers, it is not simply a (fixed) personal characteristic. Past experience influences choices, and so limited past experience tends to lead to narrower and/or less well informed choices. Individuals who have had limited opportunities (such as people with lifelong cognitive disability) can express a preference for a familiar option with which they have experience, because they do not have knowledge or understanding of the alternatives and their relative merits. This is known as "adaptive preferences" (i.e., expressed preferences are adapted to reflect past, limited experiences).

Ramcharan and colleagues have developed a framework to overcome this inherent bias for people who have had limited opportunities, which entails looking at what the constraints on choice are rather than actual choices made.[22] In other words, the focus is on providers, and the extent to which they are supporting or constraining the choices available to an individual. In addition to more overt restrictions, constraints can be more subtle and often invisible to the service user. Examples include:
- oncologists choosing which patients to tell about non-PBS treatment options, based on their assumptions about who might or might not be able to afford them
- disability employment services failing to offer specific positions, based on their assumptions about an individual's (low or limited) capacity to engage with these
- housing providers not offering accommodation options, based on their assumptions about an individual's "readiness" for stable housing.

Recommendations:

7. **Require organisations to provide information about their services which is clear, accessible, and understandable to potential service users.**
8. **Provide support to individuals to increase their knowledge and experience in order to expand their capacity to make a range of informed choices.**
9. **Ensure providers change their practices so that they do not unreasonably constrain individual choice (e.g. relating to low or limited expectations).**

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[22] Ramcharan P, Leighton D, Moors R, Laragy C, Despott N, Guven N. It's My Choice! Toolkit (Volume 5). Inclusion Melbourne/RMIT University, Melbourne, 2013. http://www.inclusion.melbourne/wp-content/uploads/2013/06/Its_My_Choice_Vol5_web.pdf

Appendix 1: About cohealth

cohealth is a not-for-profit community health service operating across the north and western regions of Melbourne. cohealth provides an *integrated platform* of health care and social support services. This integrated platform includes medical, dental, allied health, counselling, mental health, health promotion and prevention, youth services, community support services and other programs to promote community health and wellbeing. These services are delivered from over sites across 14 local government areas in the north and west of Melbourne.

Our service offering includes mental health community support services in the northern and western regions, as well as other mental health services funded by the Commonwealth Government. In addition cohealth undertakes catchment-based planning for mental health community support services in the North West Metropolitan Region.

cohealth prioritises people who experience disadvantaged social circumstances and who are consequently marginalised from many mainstream health and other services. This includes people who are homeless or at risk of homelessness, people who live with serious mental illness, vulnerable families, Aboriginal and Torres Strait Islanders, refugees and asylum seekers, people who use alcohol and other drugs, recently released prisoners and LGBTIQ communities.

cohealth's approach is based on human rights[1] and a social model of health. We believe that health services should be provided to individuals and communities that are locally based and tailored to the community through a process that involves the community in the design of services. This response is founded on an empowerment model which emphasises the rights of communities rather than the needs of communities.