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Enhancing access to income support for vulnerable hospital patients

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Title

Enhancing Access to Income Support for Vulnerable Hospital Patients

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Abstract

Sudden illness or hospitalisation can exacerbate financial hardship. This paper explores the impact of an Australian hospital based pilot program designed to remove barriers to Government funded income support for vulnerable patients. Interviews with patients (n=9) and hospital social workers (n=13) describes the participant experience. Patients identified that the service was convenient, provided relevant information, clarified eligibility, simplified application processes and reduced stress. Social workers reported that the service saved time, increased access to income support, and facilitated timely discharges where financial barriers existed. We suggest that health and social services partnerships have potential to improve patient outcomes and service efficiency.

Implications

- A 12-month pilot partnership program between social work staff at Western Health and the Centrelink Community Engagement Officer (CEO) indicates improved access

to income support for patients, and reported savings in social work staff and patient time.

- Further research is needed to explore the potential for partnerships between health and social care to deliver integrated psychosocial care to vulnerable patients in hospital, improve patient outcomes and increase efficiency of hospital services.

Keywords

Hospital, financial hardship, income support, barriers, equity, partnership.

Experiencing financial hardship is bad for one's health. (Weida 2020) Financial hardship, generally indicated in Australia by the inability to pay bills (utility or housing payments), the need to sell personal assets to cover costs, going without meals, and requiring financial help (Gilfillan 2018), has been associated with increased rates of chronic illness, poor psychological wellbeing and low self-rated health (Zheng et al, 2020; Tucker-Seeley et al, 2013). Sudden illness or hospitalisation can further increase economic disadvantage, as unplanned costs associated with healthcare often exacerbate existing financial stress and unhealthy behaviours, and can result in extended hospital stays and hospital readmissions (Petrovic et al., 2018; Cuesta-Briand et al., 2014).

In Australia, treatment at a public hospital is free for Australian citizens and most permanent residents as hospitals are funded via the universal health insurance scheme, Medicare (Department of Health 2020). Despite this, patients and their families face additional costs related to their hospitalisation. These expenses can include transport, parking, meals, childcare, accommodation and loss of income through time away from work or changes in employment status (Mudiyanselage et al., 2017; Mumford et al., 2018). Once out of hospital, ongoing costs are often incurred for medications, consumables and necessary medical services. For those with little or no income available to cover these healthcare associated expenses, the outcome can be financially catastrophic, and the risk of long-term poverty increased (Chan 2016).

Many Australian's facing economic hardship experience complex psychosocial, health and financial situations, and rely on government provided income support through Centrelink (an arm of Service Australia), to cover basic needs such as housing, food and utility costs.

Centrelink is the federal government agency responsible for delivering welfare payments to eligible Australians. Difficulty accessing income support at times of illness can result in patients and their dependents living without payments, or with insufficient or incorrect payments; for many this exacerbates financial distress and further marginalises the vulnerable (Hall et al., 2012). A growing body of international evidence suggests that timely financial support interventions, including access to income and financial counselling, can provide benefit to people experiencing mental or physical ill health (Taylor et al, 2016; Shankaran & Ramsey, 2015). Despite the established link between financial hardship and poor health outcomes, there is a dearth of research exploring the development of partnerships between health care providers and income support services. This paper reports on patient and hospital social worker perspectives and experiences of a pilot partnership between a large multi-campus health service in Victoria, Australia and Centrelink.

The Study Setting

This study is located within Western Health, a large tertiary hospital in Melbourne, Australia. Western Health provides a comprehensive and integrated range of emergency, acute and subacute health and hospital services for those living in the western suburbs of Melbourne.

While Centrelink provides most of its income support services through office based, phone and online platforms, it also employs a small team of Community Engagement Officers (CEOs) who provide an outreach service to at risk individuals, for example, homeless people in their allocated geographic region. Despite the strong link between financial hardship and poor health, the CEOs are not routinely situated with local hospitals.

The Western Health and Centrelink Partnership

Anecdotal commentary from Western Health social workers indicated many patients and their families faced financial hardship while in hospital, and for some, this delayed hospital discharge or contributed to a readmission. Western Health social workers also felt their capacity to advocate for, and assist patients to access government income support had lessened in recent years, attributing this to the increased automation of Centrelink services, and loss of key professional contacts within Centrelink (Zhou 2018). These views are echoed in the literature which discusses how the domination of online and phone interfaces, increased automation of government income support programs, and policy shifts emphasising customer mutual obligation has exacerbated barriers to Centrelink access for vulnerable population groups (Hall et al., 2012; Baker 2010; Zhou 2018).

In response, the social work leadership team at Western Health and the local Centrelink CEO worked together to develop and trial a model of service which aimed to minimise barriers to accessing income support and relevant information for Western Health patients. Executive approval for a 12-month pilot program was granted and a Memorandum of Understanding (MoU) signed by the two organisations. The MoU detailed procedures relating to locations of patient contact, CEO access to patient information, referral processes and escalation pathways for income support applications.

In January 2019, the Centrelink CEO commenced a once weekly, three-hour on-site service at Sunshine Hospital, the largest of Western Health's acute public hospitals. During that time, the CEO was available for face-to-face consultations with social work staff and patients (and if required, their carers) at Sunshine hospital, and by telephone for other Western Health sites. Patients were referred to the CEO by social work staff post a psychosocial assessment.

Although CEO availability was limited at other times during the week, social workers were able to consult on patient's behalf via secure email with the CEO. Detailed service utilisation records were stored in a secure hospital database by the social work leadership team.

Study Aims

This study aimed to describe the impact of the on-site CEO service on hospital social workers and service users (patients and carers); specifically, the study explored (1) service utilisation and (2) social work staff and patient or carer experience of the service.

Methodology

Research Design

The research followed a mixed methodology, combining quantitative service utilisation data, and qualitative patient and social work staff experience data collected via focus groups and semi structured phone interviews. The methodology allowed for complementary data analysis which captured service utilisation trends and articulated key themes identified by service users. The research team consisted of 6 health social workers, all Western Health employees with variable research experience.

Ethics approval for the research project was granted 6 months into the 12 month pilot project, as the onsite service was not originally set up as a research project.

(HREC/19/WH/56476LREP)

Recruitment

The research team used purposive sampling to identify eligible staff and patient who had utilised the onsite service plus accessed existing service utilisation administrative data collated by the social work management team.

As the ethics approval was granted midway through the 12 month pilot project, patient recruitment occurred over a 3 month period to allow for data collection and analysis prior to the end of the pilot project. The focus group recruitment was retrospective, recruiting social workers who had referred to the onsite service during the life of the project.

Of the 40 social workers employed at the health service, 22 social workers (n=22) were deemed eligible to participate, as they had referred patients to the pilot project during in the previous 12 months. The research team contacted eligible social workers via email and invited them to a scheduled focus group. Attendance was voluntary, and consent forms were included in the invite. Those who attended the focus groups were advised they could choose to not answer questions or leave the focus group at any time.

The lead researcher identified 21 (n=21) eligible patients by reviewing the manager's service utilisation data throughout the 3 month recruitment period. Eligible patients were 18years and over, able to understand and speak English, deemed to have capacity to engage in the interview and had a listed contact number; plus had engaged with the onsite service within the specified 3 months.

Patient wellbeing was prioritised, if the research lead suspected the phone interview could place patients at risk (i.e. family violence) or there was impending death, they were deemed ineligible for participation.

A member of the research team contacted eligible patients or nominated carers via phone. two weeks after their referral to the Centrelink service. The research protocol specified a

maximum of 3 attempts to contact eligible patients, if no connection was made during these attempts the patient was withdrawn from the research.

Procedure

At the point of ethics being granted, a member of the research team collated the available service utilisation data (for the previous 6 months); all data was de-identified and saved into a password protected excel sheet for analysis. For the remainder of the pilot project year, the research team transferred and de-identified the administrative data on a weekly basis. By doing this the research team could identify eligible staff and patients for the focus group and semi structured interviews.

Nine (n=9) patient participants took part in one semi structured telephone interview, of up to 15 minutes, conducted by a member of the research team. Telephone interviewing two weeks post discharge was selected to maximise contact with eligible participants and allow sufficient time for a Centrelink intervention to occur (King et al., 2018). Phone interviews also reduced the impact on patient's time, removed the need for patients to be literate, did not rely on participants to action the completion of a survey and facilitated remote connection (King et al., 2018). Interviews explored issues related to accessing the on-site service and the impact of the service on the patient experience (See supplemental file for interview guide). Consent was revisited at the commencement of their interview and participants were reminded that they could withdraw at any time or choose not to answer specific questions. Rapid transcription occurred at the time of the interview.

Thirteen (n=13) hospital social workers participated in a focus group exploring their experience and perceptions of the program. Focus groups provided a time efficient way to gather information from time poor staff in a busy hospital environment (Willis et al., 2009). Two experienced practitioners who were members of the research team facilitated the focus group, monitored the group dynamics, documented the general content of the discussion, maintained focus on the evaluation questions and ensured that all participants were heard (See supplemental file for interview guide). Interviews lasted no more than 60 minutes, were audio recorded, and transcribed verbatim. Informed consent was gained prior to focus group commencement plus participants were advised of the procedures to manage confidentiality at the start of the group. Participation in the focus group was voluntary and participants could withdraw at any time, or opt not to answer a question.

Data Analysis

Quantitative data was collated and analysed using descriptive statistics. Frequency of distribution tables and graphs were formulated to demonstrate age range, referral reason and source, and Centrelink payment types. Percentages analysed country of birth, number of referrals with dependents, and if the intervention was face to face, phone or via social work consultation.

Qualitative data collected from staff and patient interviews was analysed manually by the research team using a content analysis approach. Trends and themes were identified and the frequency of common comments recorded, grouped and codified (Epstein 2010). Open coding determined patterns and themes across the data (Gibson & Brown, 2009) which

identified the perceived impact, benefits, limitations and potential of the program from the perspectives of patients and social work staff.

Findings

Service Utilisation

The service received 161 referrals between January 2019 and January 2020. Referrals resulted in 38 individual face-to-face meetings with patients, 12 telephone consultations with patients, and 111 secondary consultations with social work staff. The majority of referrals were for inpatients (78%) and more than half (52%) of patients referred had dependents in their care. The predominant age range was 45-65 (45%), followed by 24-45 (29%), over 65 (20%) and under 24 (6%). Thirty five percent of patients reported they were not in receipt of Centrelink income at the time of referral and 29% received the government job seeking allowance. Common reasons for referral were financial hardship (52%), lapsed Centrelink payments (13%) and homelessness (12%). Over half of the people referred to the onsite service were born in a country other than Australia (55%), which is near double the percentage of the state of Victoria's population percentage, at 28% (State Government of Victoria 2020).

Patient participants

In the 3 month recruitment period for patient interviews, there were 49 referrals to the service, which resulted in 21 patient contacts with the CEO; the remainder resulted in CEO consultation with social work only.

Nine of 21 eligible patients participated in the phone interviews. Of note, 5 patients could not be contacted within the three maximum attempts specified in the research protocol, two were not contacted due to identified family violence risk, four patients were too unwell to engage, one patient withdrew and one patient died while in hospital.

Table 1. Eligible patients for interview

Insert Table 1 here

Of those interviews, most (75%) were female, two described themselves as carers and all received the onsite service at Sunshine. Two patients were inpatients at the time of the interview, the remaining 7 had been discharged. The majority of those interviewed saw the CEO face to face (n=8), the other (n=1) had phone contact the CEO. Four patients had no Centrelink income in place while others were needing updates to their existing incomes.

Social work participants

Of the 22 eligible social work participants, 13 clinical social workers (including team leaders, clinical staff and new graduates) opted into the study and attended one of two focus groups based on their preferred day (Group 1 n=7, Group 2 n=6). Staff and patient perspectives of the onsite service are presented below.

Social Work Staff Perspectives

Savings in Time

Hospital social work staff reported that the onsite Centrelink service saved them time. Clear, targeted and patient specific information from the CEO assisted social workers to streamline their interventions with patients and freed them to attend to other priority matters. The ability to liaise directly with the CEO helped the social workers to clarify details and know they were on the “right track” when supporting patients. Direct phone, email or face-to-face contact with the CEO compared favourably to what one social worker described as “long wait times on the phone all the time and not being able to get through on Centrelink after an hour, hour and a half” [Acute social worker 1].

Social work staff were hopeful that the service would continue and recommended more availability for follow up and increased hours of onsite CEO attendance at the hospital. For the social work staff, the onsite Centrelink service created an enhanced communication pathway to Centrelink: “We have a contact person.... we have someone we can talk to” [Subacute social worker 1].

Enhancing Access

Staff described the Centrelink system as complex and reported that the onsite service facilitated access to income support for people with multifaceted health and social needs. They felt the personalised support from social work and the CEO assisted patients to overcome speech and language barriers (“I’m a social worker and I know what I am doing, let alone someone who doesn’t and doesn’t speak English and it’s complicated!” Sub-acute social worker 2), physical ability limitations, lower digital literacy, and supported those new to Australian government systems, particularly refugees and migrants. Social work staff found the service streamlined access for all patients and highlighted the importance of the

service for those who were very anxious or overwhelmed with their own or their family member's health issues, those living in at risk situations, or those vulnerable to having welfare payments suspended due to inactivity.

Removing Barriers to Safe Discharge

Social work staff reported that direct communication with the CEO enabled them to advocate on a patient's behalf and assist the patient to provide necessary evidence and documents needed for faster processing of claims for income support. Faster processing allowed patients to receive an income which facilitated the payment of basic needs, particularly housing, which for some patients enabled discharge. Conversely, the ability to quickly notify the Centrelink CEO of illness meant that some patients were less fearful of losing their payments due to inability to meet the conditions of income support. One of the hospital social workers gave an example of this:

“it's been really reassuring (for) patients who sometimes say they want to leave hospital because they've got to go to Centrelink and report and so talking to [the CEO] and getting a [medical] certificate to her helps alleviate some of those anxieties”. [Sub-acute social worker 3]

Patient Perspectives

Patient perspectives are supported by quantitative data collected during research interviews. Using a rating scale of 1-10, with 10 being the most helpful, eight of the nine patients interviewed rated the on-site service at seven or above. Most (77%) reported that the service assisted them to know what to apply for, over half (55%) stated that it facilitated receipt of

their payment, and for a third of the patients (33%) reported it allowed them to meet reporting requirements for Centrelink.

Convenience

The ability to access Centrelink information from the hospital was a key advantage of the onsite service for patients. For some patients, this meant that their support person did not have to choose between providing their loved one with care while in hospital or attending the local Centrelink office to seek advice about a claim for income support. For several patients, the onsite service helped them to overcome physical and psychological barriers to accessing information over the phone or at local offices. These barriers were clearly articulated by two patients: “The location was good as I couldn’t go into the [Centrelink] office, use the computer or talk on the phone because of what has happened to me” [Patient 1], the second patient stated “my immune system was low, so it was high risk to wait at Centrelink...seeing the CEO at the hospital was better. I couldn’t walk far either”. [Patient 2]

Navigating the Centrelink System

The onsite service enabled the majority of patients interviewed to successfully navigate the Centrelink system. Speaking directly with the CEO, or having a social worker act on the CEO’s information, reduced confusion and enabled patients to be clear about Centrelink services and their entitlements. This, they reported, had not been possible via standard means of accessing Centrelink information (i.e. online, phone and attendance at offices). For example, three patients interviewed were previously advised by Centrelink to review information online however they did not know how to do this and, as one patient said, “I

didn't have any idea where to start or what to start with"[Patient 1]. Another patient told us that if they had seen the CEO earlier, " I would have avoided so much stress...we didn't have payments for 4 months before we saw the CEO, then it was organised". [Patient 3]

Centrelink is often one of many services patients need to navigate and access during hospitalisation and illness. One patient highlighted the value of the onsite service and the way in which it assisted them to cope with the multiple services involved in care: "I have so much on my plate with Centrelink, NDIS and managing the family at home [the onsite service] confirmed what I needed to do, it really helped me."[Patient 4] For another patient experiencing economic hardship, the service "helped us keep a roof over our head. It really stopped me worrying about money at a really hard time for our family".[Patient 3]

Personalised Income Support Advice

Patients appreciated the personal contact and connection with a Centrelink worker who knew their medical and social context. Most associated the personalised intervention from the onsite service with expedited payments which assisted them to pay basic costs, such as rent and groceries. A parent of a child in hospital told us that the information they received from the CEO on-site service helped them to apply for entitlements, which allowed them to meet housing costs, and afford to travel into the hospital more frequently.

Patients reported a level of trust in the service provided. They described feeling listened to and respected, and had confidence that the information given was correct. A patient commented on the benefits of having "the social worker and the CEO know the context of our application. I didn't have to tell our story over and over" [Patient 6]. Another described

the onsite CEO as trustworthy and reported that the service “really reduced my stress levels, I was so thankful for the service. I didn’t have that [Centrelink] on my mind as well as everything else.” [Patient 5]

While the majority of patients described the program as one of the best services the hospital provides, they also reported that poor advertising prevented them from accessing the service in a timely manner. Some suggested that hospital staff should assess a patient’s financial wellbeing upon diagnosis of a serious illness, as this would enable early social work involvement and timely access to the onsite CEO.

Discussion and Implications for Practice

Findings from this small project support previous research suggesting that timely financial support interventions can provide benefit to people experiencing mental or physical ill health (Taylor et al, 2016; Shankaran & Ramsey, 2015). We found that the onsite Centrelink service provided a patient centred response to financial hardship and associated stressors at a time of illness. It enhanced social work staff capacity to advocate for vulnerable patients, provided clear and personalised direction to patients regarding their income support eligibility, and for a number of patients, facilitated income support payments. Overwhelmingly, social work staff and patients supported the continuation and expansion of the on-site service.

Staff cited the potential of the onsite Centrelink service to reduce barriers to income support for everyone, particularly people with diverse health, behavioural, social and cultural needs. Social workers identified that the provision of onsite Centrelink services was particularly valuable for patients where home was not safe or stable – namely those experiencing family violence and those who were homeless. This underscores the need for timely access to

income support and information during hospital admission rather than relying on income support and information post hospitalisation.

The limited access and availability of the onsite service proved to be a challenge for hospital social workers and other health professionals to accurately identify patients who were experiencing financial hardship and therefore facilitate access to the onsite Centrelink service. It is probable that there were patients who would have benefited from the onsite service but did not get the opportunity to access it while in hospital as they were either not known to social work, attended the hospital out of hours or had not disclosed financial concerns to their treating team. This supposition is supported by findings from a recent Australian study which reported large sections of the community face financial hardship and for some the hardship is “unseen” and people are unable or unwilling to ask for help.(Pollard et al 2020) If there is expansion of the onsite service in the future, it is vital that barriers to access are minimised and patients and hospital staff have greater awareness of the program. The development of clear and transparent eligibility criteria is needed to facilitate equitable and sustainable access.

While it was the intent of staff involved in this pilot project to continue the partnership into 2020, challenges to implementation and expansion of the on-site service remain. The COVID 19 pandemic meant that the on-site service was suspended from March 2020, although secure email and phone consultation arrangements between social work and the CEO has remained in place. In the future, timely contact between patients, social workers and the CEO may be supported by the adoption of electronic communication and improved health and social care internet platforms.

Limitations to this small study mean that care must be taken when generalising findings. We did not hear many patient voices. The short window of time approved for patient recruitment, reduced the overall number of patients eligible for participation in the study. Further, the challenges we experienced in recruiting from the small pool of eligible patients (9 out of 21), highlights the vulnerability of many hospital patients and demonstrates the importance of contact during hospitalisation as follow up can be challenging.

The nature of the partnership meant that social work was the only hospital profession included in the pilot project however further exploration regarding the potential impact of the onsite service with other staff groups within the hospital, Centrelink staff and community groups would be beneficial. Given the time savings identified by social work staff, and removal of financial barriers to discharge for some patients (for example, when the cost of housing could be met by income support), it is probable that there are cost efficiencies for the health care provider which could be explored in future.

Conclusion

The pilot partnership between Western Health and Centrelink aimed to improve access to government funded income support services and information for vulnerable patients. Our study explored service utilisation and the impact of the onsite service on social workers and patients. Indications from the study suggest there are potential benefits associated with greater integration of health care and social welfare services, including time efficiencies, clear information provision, and improved access. In summary, this pilot program appears to have enhanced access to income support for hospital patients. Although programs like this have potential to improve patient outcomes, the sustainability and maximum benefit of such

initiatives is dependent upon organisational commitment to the development of a collaborative, cross sector model of patient centred care.

Disclosure Statement

The authors reported no potential conflict of interest.

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TABLES AND FIGURES

Table 1. Eligible patients for interview

	Not able to contact	Family violence risk	Patient too unwell	Patient died	Patients interviewed	Total eligible patients
Patient number	5	2	4	1	9	n = 21