



S·A·R·R·A·H
Services for Australian
Rural and Remote Allied Health

PRIMARY HEALTH CARE

POSITION STATEMENT

August 2009

Table of Contents

EXECUTIVE SUMMARY	ii
BACKGROUND.....	1
PRIMARY HEALTH CARE	2
Health	2
Primary	2
Primary Care.....	2
Comprehensive Primary Health Care.....	3
Selective Primary Health Care	4
WHAT IS REQUIRED?	5
A National Primary Health Care Strategy	5
Access	5
Workforce.....	7
Education and Training	9
Client centred care.....	10
Community Participation	11
A change to a health system based on wellness.....	12
Multi-professional Team Care	13
Chronic and complex conditions	14
Research and Evaluation	15
Conclusion	16

Executive Summary

Services for Australian Rural and Remote Allied Health (SARRAH) supports the World Health Organisation's view of world's best practice health system which is one that is led by primary health care (PHC) where the focus is on health promotion, illness prevention, early intervention, and acute and chronic disease management in the community. PHC must be viewed as the foundation principles for achieving the best health and most equitable well-being across all communities within a nation.

The implementation of a comprehensive PHC strategy in Australia requires a national policy approach. SARRAH supports changes in the following areas to ensure a consistent national approach to the delivery of PHC services across rural and remote Australia:

1. Access – to ensure equitable, affordable and comprehensive care;
2. Workforce – to build, sustain and support the PHC workforce;
3. Education and training – to build the rural and remote PHC workforce and to ensure competency in inter-professional practice;
4. Client-centred care – putting the health consumer first to ensure that the health consumer has access to the right service at the right time delivered by the right health professional in the right place;
5. Community participation – to enable communities to participate in health service policy and planning in their local region;
6. A health care system based on wellness rather than the treatment of illness;
7. Multi-professional¹ team care – to ensure high quality, coordinated care;

¹ Multi-professional – Is used in this paper to indicate that team care is provided members from different health professions. The term commonly used is multidisciplinary – however this has a different context within the medical profession where different medical specialities are regarded as different disciplines. A multidisciplinary team comprises GP and medical specialist.

8. The management of chronic and complex conditions – for better prevention and to ensure quality management; and
9. Research and evaluation – to ensure quality and safety and an evidenced based approach to the delivery of PHC services.

Background

SARRAH believes that allied health professional services are essential to improving the quality of life and better health outcomes for rural and remote communities. It is also SARRAH's view that every Australian should have access to basic health services according to need irrespective of where they live, and that allied health professional services are basic and core to Australians' health and wellbeing.

Allied health professionals provide a range of clinical and health education services to individuals who live in rural and remote communities. Allied health professionals are critical in the management of their clients' health needs, particularly in relation to chronic disease and complex care needs.

SARRAH supports the World Health Organisation's view of world's best practice health system which is one that is led by PHC where the focus is on health promotion, illness prevention, early intervention, and acute and chronic disease management in the community.

Irrespective of geography, socio-economic status and cultural background, all Australian residents have a right to access good quality health care. It is the Government's responsibility to ensure the provision of this care.

The Australian health care system is facing a number of challenges including an ageing population, the rising burden of chronic disease, technological advances in health care and health workforce shortages. All of these challenges are impacting on the costs of health care.

To meet these challenges, it is crucial to invest in building a strong PHC sector. PHC is the first stage of health care and aims to prevent illness in individuals and the community. PHC professionals include General Practitioners, Pharmacists, Nurses, Physiotherapists, Dieticians, Dentists, Psychologists, Audiologists, Occupational Therapists, Podiatrists, Optometrists, Social Workers, Exercise Physiologists, Speech Pathologists and Aboriginal Health Workers.

Primary Health Care

Primary health care (PHC) is a term which has come to have many different meanings to different people².

Health

The World Health Organisation in its Constitution defines health as: a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity³.

Primary

Primary can mean highest in rank or importance, but also first in order in any series or sequence, or first in time⁴.

Primary Care

Primary care, which Mosby's Dictionary of Medicine, Nursing and Health Professions (2005) defines as: "*The first contact in a given episode of illness that leads to a decision regarding a course of action to resolve the health problem. Primary care often is provided by a doctor, but primary care functions are also provided by nurses*"⁵. A number of the allied health professionals also define themselves as primary care practitioners.

² Rogers W, Veale B. Primary Health Care and General Practice: a scoping report. Adelaide: National Information Service, Department of General Practice FMC; 2000 February.

³ The Constitution was adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States (*Off. Rec. Wld Hlth Org.*, 2, 100), and entered into force on 7 April 1948. Amendments adopted by the Twenty-sixth, Twenty-ninth, Thirty-ninth and Fifty-first World Health Assemblies (resolutions WHA26.37, WHA29.38, WHA39.6 and WHA51.23) came into force on 3 February 1977, 20 January 1984, 11 July 1994 and 15 September 2005 respectively and are incorporated in the present text.

⁴ The Macquarie Dictionary.

⁵ Mosby's Dictionary of Medicine, Nursing and Health Professions (2005). P. Harris, S. Nagy, N. Vardaxis (Eds). Elsevier Australia, NSW.

Comprehensive Primary Health Care

Primary health care, which has become known as *comprehensive PHC*, is defined by the World Health Organisation as:

“Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of both the country's health system, of which is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.”⁶

The philosophy behind PHC is based upon:

- holistic understanding and recognition of the multiple determinants of health;
- aspects of national and community development in addition to the health sector including agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors;
- equity in health care;
- community participation and control over health services;
- promotable, preventative, curative and rehabilitative services;
- accessible, affordable, acceptable technology;
- local and referral services which is supported by a sustainable health workforce; and
- health services supported by research methods.

⁶ Declaration of the Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978, Accessed 22 June 2009 from:

http://www.who.int/publications/almaata_declaration_en.pdf

Selective Primary Health Care

The concept of *Selective Primary Health Care* (SPHC) emerged in 1979 from an article by Warren & Walsh, which argued that PHC was idealistic⁷ and too costly.⁸ SPHC was defined as being: “...concerned with which medical interventions are most cost-effective to improve the health status of the majority of the people in the less developed countries⁹”.

The table below details the differences in the two PHC health approaches.

	Comprehensive PHC	Selective PHC
View of health	Positive Wellbeing	Absence of disease
Locus of control over health	Communities and individuals	Health professionals
Major Focus	Health through equity and community empowerment	Medical solutions for disease eradication
Health Care Providers	Multi-disciplinary teams	Medical doctors
Strategies for health	Multi-sectoral collaboration	Medical interventions

(http://www.phconnect.edu.au/defining_primary_health_care.htm)

SARRAH supports comprehensive PHC as the most effective model to provide allied health and other services in rural and remote communities.

⁷ Rifkin, S. & Walt, G. (1986); Why health improves: defining the issues concerning ‘comprehensive primary health care’ and ‘selective primary health care’, *Social Science and Medicine*, 23(6), pp. 559-566.

⁸ Werner, D. & Sanders, D., with Weston, J., Babb, S. & Rodriguez, B. (1997); The demise of primary health care and the rise of the child survival revolution in *Questioning the Solution - The Politics of Primary Health Care and Child Survival*. Health Wrights, Palo Alto, Ch. 4, pp. 23-25.

⁹ Walsh, J. & Warren, K. (1979), Selective primary health care: an interim strategy for disease control in developing countries, *New England Journal of Medicine*, 301(18), p 967-974.

What is required?

A National Primary Health Care Strategy

The Australian Government is currently developing a National Primary Health Care Strategy as part of its national health and hospital reform agenda. The strategy is being developed in consultation with key stakeholders. For implementation, the strategy will require resources (financial, infrastructure and workforce) and evaluation (to measure impact).

Access

SARRAH maintains that every Australian should have access to equitable health services wherever they live and that allied health professional services are basic and core to Australians' PHC and wellbeing.

Medicare, Australia's universal health insurance scheme provides access to health care services. However, the level of expenditure from this scheme per capita in rural and remote Australia is less than in metropolitan areas, indicating unequal access. Limited Medical Benefits Schedule (MBS) funding is currently spent on allied health professional services, further exacerbating lack of access to services required by the people. This is particularly true in rural and remote areas.

SARRAH contends that using the term 'accessible' does not have the same meaning as the term 'equitable access'. Rural and remote clients do not have the same access to the range and scope of PHC services as clients attending metropolitan PHC services.

There is currently a mix of responsibility for the delivery of allied health services in rural and remote communities including state funded services (hospital and community based); Australian Government funded services (More Allied Health Services, Regional Health Services, Medicare) and allied health professionals working in the private sector.

SARRAH recommends:

1. The benchmarking of allied health professional services within a multi-professional team context, that reflects the practice of the individual disciplines within allied health and in rural and remote geographic locations. This is required to establish allied health professional workforce requirements to better enable access in rural and remote communities.
2. Proactive leadership from the Australian Government to take responsibility for the delivery of allied health services in rural and remote Australia.
3. The further review of Medicare to better align with PHC focusing on multi-professional health services, rather than the current focus on acute primary care services.
4. The continuation and expansion of rural and remote allied health programs under the Rural Primary Health Services Program outlined in the 2009-2010 Federal Budget and Allied Health MBS items which offer additional allied health referral pathways. These programs must be evaluated and refined to ensure that they properly target the delivery of allied health services to meet the needs of the community.
5. Flexibility in funding and planning arrangements to support the development and delivery of locally-tailored solutions based on consideration of local population health needs and service gaps. Locally-tailored solutions can overcome local barriers to access such as affordability, geographical accessibility and lack of integration of the service provider within the community. For example, pooling of funds from State/Territory and Australian Government sources, including Medicare.
6. The development of flexible models of care adapted to suit local needs and conditions and financed to provide better access to team-based care for rural and remote populations. Flexible models will include the use of e-health initiatives such as videoconferencing, tele-health,

online health consumer self-management and health education, virtual teams, hub and spoke, and outreach services.

7. The adoption and implementation of recommendations focusing on a re-orientation of care around team-based care, regional PHC organisations and voluntary enrolment for health consumers with chronic conditions. This approach will introduce flexibility into PHC enabling disadvantaged groups, particularly those in rural and remote locations, to access systems which best meet local needs.
8. Innovative solutions to support health consumer access to PHC professionals in rural and remote areas including service incentive payments for all PHC professionals and infrastructure grants to support the development of infrastructure necessary to deliver services.
9. Health consumer Assisted Transport Schemes should be extended to provide transport and accommodation assistance for rural and remote health consumers to access PHC, including dental and allied health care, not just treatment by medical specialists.

Workforce

The delivery of comprehensive PHC services is dependent on having an adequate and sustainable health workforce, including allied health professionals, nurses and medical practitioners.

SARRAH believes that there are not enough available positions for allied health professionals in rural and remote communities. Lack of workforce benchmarking for allied health professionals working in multi-professional teams and in rural and remote communities has resulted in an inability to determine the required number of allied health professional positions, across the different disciplines, required for different locations and services to meet the needs of the resident populations. Not having enough positions results in poorer access to these services for rural and remote communities, even when all available positions are filled and also impacts on the ability to retain staff in those positions that do exist due to excessive workloads.

For those positions that are available, current rural and remote allied health practitioner recruitment and retention levels cannot meet client needs across all geographical areas and population groups.

- There are lower numbers of allied health professional positions in rural and remote communities compared with metropolitan centres.
- This is further exacerbated by greater vacancy rates.
- Funding by State/Territory and Australian Government health programs does not usually allow for locum cover so that service continuity and relationships can be maintained in rural and remote settings.

To resolve this critical issue will require funding to undertake allied health workforce benchmarking and continuing increases in investment in allied health education, modification of education across professional roles, and investment in strategies for retaining staff in rural and remote communities.

SARRAH recommends:

10. The funding of a major national project to undertake allied health workforce supply and demand which includes the development of appropriate workload measures for the different allied health professions in rural and remote Australia.
11. The collection of workforce data on the PHC workforce to inform workforce planning.
12. The provision of incentives that support more equitable distribution of the PHC workforce. The allied health workforce requires access to equitably distributed incentive programs to encourage staff to work in rural and remote areas.
13. The development of national locum programs for the allied health disciplines to provide continuity of care for health consumers.
14. The development and implementation of a national mentoring and clinical supervision training program for the rural and remote allied health workforce to provide professional support, reduce professional isolation, and enhance the development of clinical skills.

15. The recognition of rural practice as a speciality should continue and be extended beyond the medical workforce to include allied health professions, supported by the provision of education and training to gain expertise in rural practice competencies (e.g. Australian College of Rural and Remote Medicine)

Education and Training

Education and training of the PHC workforce at undergraduate and postgraduate levels is essential to ensure safety and quality in health service delivery in rural and remote areas.

SARRAH recommends:

16. Programs that support rural origin and Indigenous students to train as health professionals should be continued and extended to cover all PHC professionals. Strategies should include:
 - Affirmative action to enable rural origin and Indigenous students to enrol in allied health professional courses;
 - Teaching rural health as a core component of health professional education; and
 - Positive student placement experiences in high need areas.
17. Preventative strategies, self management training, PHC, rural and remote health care and Aboriginal and Torres Strait Islander people's health care must become mandatory or core components of courses in undergraduate and post graduate health education programs in order to equip staff with the skills to deliver new models of care.
18. The establishment of nationally accepted inter-professional practice (IPP) health professional graduate attributes and health professional practice capabilities, included as part of national registration for the PHC professions. For the non-registered and self regulating PHC professions, these attributes and capabilities will be part of accreditation and/or other requirements determined by the professional associations.

-
19. The establishment and funding of a model curriculum for inter-professional education (IPE) in health professional education, commencing at undergraduate level but continuing throughout professional practice in accordance with adult learning principles to enable primary health professionals to obtain the attributes and capabilities necessary for IPP.
 20. A national collaboration across universities is required to drive the IPE agenda nationally. The collaboration may include members from the health sector who employ health practitioners working in IPP. Without a broad collaborative approach strategies will continue to be ad hoc, dependent on individual institutions and limited by course structure. Collaboration is needed to:
 - Develop curriculum and teaching mechanisms;
 - Enable collaboration between universities with different courses so IPL structure incorporates the broad range of health science qualifications; and
 - Enable collaboration between education and health service providers to enable clinical education in IPP to be part of curricula activity.
 21. Development and implementation of a national approach to postgraduate IPE for qualified health professionals through the delivery of training programs must be made accessible to all members of the health professional team. Funding for training providers must be dependent on the training being delivered to a range of health professionals.

Client centred care

SARRAH recommends that a primary healthcare system that supports a health consumer-centred approach must:

22. Respect the health consumers' rights to self-determination in their healthcare management;

23. Provide continuity and coordination of care;
24. Involve a partnership approach between healthcare providers and health consumers that respects health consumers' rights to self-determination in their healthcare management;
25. Provide health consumers with the opportunity to influence healthcare provision through opportunities to engage with health service providers at local, regional, State/Territory and national levels;
26. Empower health consumers to better self-manage their conditions/ health needs through supporting appropriate health consumer self-management, including through access to evidence-based chronic disease self management;
27. Promote well-informed and knowledgeable health consumers who are empowered to be "effective health consumers"; and
28. Uphold a health consumer's right to privacy and choice, including the choice of health care provider.

Community Participation

Community participation is a cornerstone of a comprehensive PHC system. Community engagement needs to occur at a number of levels (individual care, health service and health system) and in a manner that is appropriate to meet particular community needs. Effective engagement of health consumers and communities results in individual and community empowerment – a cornerstone of comprehensive PHC.

SARRAH recommends that a commitment to meaningful health consumer engagement must be realised through a partnership approach between healthcare providers and health consumers that respects:

29. Processes which support health consumer consultation and input into the planning and reviewing of service provision at local and regional levels. Such engagement, whilst including health consumer representatives on boards and committees, must include opportunities for engaging which is appropriate to the culture of the population.

Examples include attending meetings of community organisations, convening community forums at local and regional levels including a citizens' parliament at State/Territory or national level.

30. Reflect the principles of health consumer engagement in performance indicators for the health system nationally.
31. Plan the transition to Aboriginal community control of PHC services to Aboriginal communities, where these communities aspire to this. This is a fundamental principle to community participation in Aboriginal health.

SARRAH recommends that to build community capacity the PHC system must:

32. Provide training to policy makers, managers and health workforce to work with health consumers, carers and community groups.
33. Include health consumers and carers in training programs for multi-professional team practice for health professionals.
34. Implement policy and programs which will assist the health consumer to become health literate and well informed, leading to more effective engagement and input into health care at individual, service and policy level.

A change to a health system based on wellness

Health promotion and illness prevention is an integral part of a comprehensive PHC system. A major change from a system based on illness to one based on wellness is required.

SARRAH recommends:

35. The expansion of evidence based population health policies and programs that support healthy lifestyle, including nutrition and activity, and strengthen prevention.

36. Inter-sectoral collaborations focusing on the social determinants of health including access to health lifestyle for food and exercise, housing, water, education and transport.
37. Greater emphasis on proactive preventative health care facilitated through incentive payments to practitioners or practices, standardised risk factor assessment tools and health consumer access to a range of subsidised preventive health care options.
38. The establishment of prevention clinics for targeted conditions in local communities which are well resourced, include all relevant allied health and other professions, and are funded to continue over a long term.

Multi-professional Team Care

A multi-professional team based approach to the delivery of PHC must be instigated with due recognition of the specialised contribution that allied health professionals provide in addressing the health needs of the individual person.

Enhanced support for team-based care that promotes comprehensive health consumer care and efficient use of practitioner time through optimal matching of health consumer needs and practitioner skill – the right care by the right health professional at the right time and cost and in the right place.

SARRAH recommends that team-based care should be facilitated through:

39. Electronically-enabled shared individual health records accessible by **all** members of the health care team (i.e. not limited to doctors, nurses, and the registered allied health professions).
40. Inter-professional learning so that all health professionals develop the competencies and attributes required for inter-professional practice.
41. Health consumer access to subsidised care from all members of a care team including allied health practitioners.

SARRAH recommends that the implementation of blended funding systems must provide greater access to quality multi-professional team care through:

42. Fee for service payments to support provision of subsidised care from all members of a multi-professional care team; and
43. Fund holding by regional PHC organisations that supports regional entities to develop local solutions to meet local health needs and address service gaps.

Chronic and complex conditions

Well-integrated, coordinated, and providing continuity of care, particularly for those with multiple, ongoing and complex conditions is part of a comprehensive PHC system.

SARRAH has identified PHC priority groups which include: aged clients; paediatric care; clients with chronic and complex health disorders; Aboriginal and Torres Strait Islander people; and clients for whom communication with and understanding of health services and access is problematic.

SARRAH recommends:

44. Access for rural and remote allied health professionals (all disciplines involved in health consumer care) to electronic health records to assist in the integration and coordination of health care services.
45. Care coordinators in practices who can link with both acute and community care services may be of enormous benefit to improving coordination and continuity of client care.
46. Local health consumers must be engaged through regional community groups and support groups to improve the integration and continuity of care.
47. The development of PHC Organisations (e.g. Divisions of Primary Health Care, Integrated Primary Health Care Centres) appropriate to a local region/community, which is funded to provide the coordination and care required for those with chronic complex conditions.
48. Where a range of health professionals are available, co-location of services is recommended for timely management of the person's

needs, peer support for health professionals, integration of services and improved continuity of care.

E-health

Developments in information technology and communication systems enable the delivery of flexible, integrated health care services by multi-professional teams. The use of technology will enhance access to PHC services for health consumers in rural and remote communities.

SARRAH recommends:

49. All health professional groups are included within any e-Health initiatives, not limited to doctors, nurses and the registered allied health professions.
50. Access to electronic health records particularly across health provider organisation boundaries must be established. This is particularly relevant in rural and remote areas where distance, time and access to information can cause unnecessary delays and complexities to the safe, effective and efficient delivery of health care services.
51. Broadband and internet access and adjuncts for professional use must be developed as a priority particularly in rural and remote settings. For example: e-Health including information management of health records; online support for remote clients through tele-health services; online scientific library services and professional development programs.
52. Allied health professionals involved in multi-professional team care in rural and remote communities have subsidised access to necessary hardware and software infrastructure to enable participation in e-Health initiatives.

Research and Evaluation

Currently there is insufficient evidence measuring the outcome and cost effectiveness of PHC strategies versus acute based care. SARRAH

recommends that the Australian PHC system includes research practices that expand the evidence-base in PHC.

53. A national PHC research must be funded and maintained as a priority program within health and medical research.
54. A national framework to evaluate PHC services must be developed and implemented.
55. Assessment of the effectiveness of a preventative care framework is required and may include the establishment and measurement of key milestones for chronic conditions and utilisation of prevention/wellness services. This would require incentive based support to facilitate research and health consumer outcome measurement systems. The performance framework would be maintained by the Australian Government.
56. Current work practices need to be changed to make research and Quality Improvement (QI) mandatory components of workload. Support needs to be in place for quarantining research and QI activities during work time and abolishing unrealistic workload targets. For example, it is time to reduce the reliance of service funding by health consumer throughput recording and look at client and community benefits.
57. Training in research processes and writing for research should be a core component of undergraduate and be made available in post graduate training.
58. Nationally coordinated clinician and other research capacity building programs need to be sustained, for example the PHC-RED programs and the NSW IRCST Research Capacity Building Program. This could be achieved through expansion of the University Departments of Rural Health agenda to include allied health.

Conclusion

SARRAH recommends that PHC be viewed as the foundation principles for achieving the best health and most equitable well-being across all communities in a nation.