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Services for Australian
Rural and Remote Allied Health

**Feedback to the Department of Health
and Ageing**

**Potential Boundaries for
Medicare Locals and Local
Hospital Networks**

September 2010

INTRODUCTION

Services for Australian Rural and Remote Allied Health (SARRAH), welcomes the opportunity to provide feedback on the potential boundaries for Medicare Locals (MLs) and Local Hospital Networks (LHNs).

SARRAH is nationally recognised as a peak body representing rural and remote Allied Health Professionals working in both the public and private sector.

SARRAH's representation comes from a range of allied health professions including but not limited to: Aboriginal Health Workers, Audiology, Dietetics, Occupational Therapy, Optometry, Oral Health, Pharmacy, Physiotherapy, Podiatry, Psychology, Social Work and Speech Pathology.

These 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 with chronic disease and complex care needs.

Allied Health Professionals work across the Primary and Acute Health Care Services continuum. They have significant roles in health care and health education across the sectors.

The Allied Health Professional, particularly in rural and remote areas, is required to adapt to workforce shortages and is well versed in the interdisciplinary and team approach to health care, especially for management of chronic disease and to improve health behaviour.

It is noteworthy that in many smaller and more remote communities, people in need of primary health care are reliant on nursing and allied health services because of workforce issues. If these health professionals are well supported then the need to access specialist and hospital services will be reduced.

It is repeatedly demonstrated that skilled and supported Allied Health Professional services are essential to improving the quality of life and better health outcomes for rural and remote communities.

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' primary health care and wellbeing.

SUMMARY

SARRAH wishes to acknowledge that the report indicates a sound grasp of primary health care models and principles.

However SARRAH's general comment is that we urge the government to establish localised MLs and LHNs as actual entities. If the entities are not localised then a number of significant and important issues must be addressed including:

- The entities must be small enough to reflect and represent local communities of interest.
- The entities must have common LHN and ML boundaries.
- The entities with economies of size issues must be addressed by means other than aggregation into bigger structures covering large geographical areas.
- The entities must cross State/Territory borders where appropriate.
- The entities must have shared strategic plans, governance and personnel arrangements.
- The MLs in rural and remote areas must receive additional weighting for extra resources to compensate for the higher cost per head in service delivery.
- The entities should merge in instances where the community and clinicians/health service providers agree.

SARRAH is also concerned that the reorganisation of services does not create perverse incentives for a capped and Commonwealth funded hospital system based on the notion to transfer activity to an open-ended fee for service system in primary health. SARRAH members are concerned that this shift in service delivery focus will increase pressures on already huge caseloads as there is a paucity of Allied Health Professional positions based in community settings. We therefore offer the following comments on the above issues.

Represent Local Communities

COAG agreed that:

In regional Australia, a flexible approach will be adopted to determine the regional, rural and remote network structure that best meets the needs of these communities and best takes into account the challenges of managing multiple small hospitals.

It is proposed that the Northern Territory (NT) and Tasmania will each have a single LHN for their jurisdiction. If this becomes public policy it

may not reflect a structure which will represent local communities – that is a geographic community of interest and each of these jurisdictions have multiple communities of interest.

For example the NT has several communities of interest but there are good arguments, especially when it comes to the administration of public policy, for seeing the NT as being two: the Top End and Central Australia.

In Tasmania, it may be beneficial to have a single LHN with two or three MLs. A key principle to this type of structure will be ensuring that appropriate representation at a jurisdictional level by local MLs occurs. Also it will be important that cohesive communication and service arrangements between the MLs are built into the management system as key performance indicators, breaking down parochial practices.

Common Boundaries

COAG has determined that the boundaries of the MLs will be agreed by December 2010 and that, wherever possible, those boundaries will be shared with LHNs.

SARRAH supports this principle subject to other feedback raised in this document being taken in account.

Economies of Size

The size of the LHNs and MLs is a major issue and it will be critical for all stakeholders to get the various models for all entities right - it will not be a case of one size fits all entities. From both a service planning and an allied health workforce perspective our members have experience with local and regional health boards where competition for services through parochialism, and dilution of the allied health workforce results in staff retention issues.

It can be argued that the greater the critical mass, the better chance entities have to support the allied health workforce and create career opportunities etc. Small governance structures also struggle to address some of the power issues that exist. An example is the difficulty local boards regularly experience in providing effective oversight of whether the services provided by clinicians match community needs or are driven by other factors such as profit or simply clinical interest areas. Entities need to provide a balance between local advocacy/representation roles and be able to provide health services that meet community needs within their catchment area. Mechanisms must be established to ensure that the above issues are addressed.

Conversely SARRAH is concerned about some of the larger remote geographic areas proposed, for example in South Australia and NT. In particular, SARRAH has concerns about Outer Metropolitan growth areas for example outer Adelaide. Although these areas have relative proximity to urban areas, they continue to experience major difficulties in either creating allied health positions or recruiting and retaining allied health and other staff within both public and private health services.

The lack of transport infrastructure in outer urban/rural boundary growth corridors and the intention to consider semi-rural as just a part of urban services will not address this workforce issue but continue to maintain the relative disadvantage.

If Outer Metropolitan growth areas are going to be linked with the urban ML areas then SARRAH recommends that specific service targets be set and met (based on urban criteria) that require MLs to meet service access and delivery within a 5-10 year period.

Consideration should be given to areas that could be special cases due to geographic constraints for example Kangaroo Island. Whilst it is relatively small with a population of less than 5000, health services are very limited and few specialist services are available. For example there is 1 Psychologist (private) on the island. The island is 100km from Adelaide, but transport costs via ferry or air are extremely expensive and few visiting services are funded and consequently not provided. These factors directly contribute to the local community's inability to attract and retain experienced health workers.

Irrespective of the different approaches towards determining the number of LHNs it is imperative that Allied Health Professionals are not overlooked as key stakeholders in this important and major reform process.

Strategic Plans, Governance and Personnel Arrangements

Effective planning, governance and service delivery arrangements cannot be provided from a distance and must be based on reasonable geographic areas. In regions of relative population sparseness, this may be for population sizes well below 100,000.

LHNs and MLs should be encouraged to have shared vision statements and strategic plans in order to work closely together towards a common purpose which focuses on keeping people healthy and out of hospital.

Residents in any LHN or ML need to know that the people responsible for making decisions for the region, including the distribution of resources, live and work in their region. The regional governance

processes must be completely transparent so that people know and can see local accountability working.

It has been agreed that the governing bodies for LHN and ML will include expertise in health management, business management and financial management, as well as clinical expertise. It has also been agreed that there should be cross-membership between the two entities wherever possible and, where appropriate, representatives of universities and similar institutions with other relevant skills and experience. SARRAH supports these principles.

However SARRAH does not support the proposed exclusion of local clinicians from LHN boards, and that there is no provision for community representation. This proposed approach towards the governance of LHNs is highly contentious and unworkable for these structures to represent local communities.

SARRAH supports the role of MLs to:

- establish baseline levels of health services for their jurisdiction, taking into account the distribution of illness and population groups;
- identify unmet health service needs in their jurisdiction including participate in population health planning;
- directly provide, commission or broker health services to meet needs and drive workforce planning within their jurisdiction; and
- have a critical population mass sufficient to retain all health professionals whilst at the same time avoiding the duplication of health services.

Indigenous Health

SARRAH supports community control of primary health care as a means of improving quality of care and access for Indigenous people, and therefore as a key approach to closing the life-span gap. SARRAH is not at all convinced that the proposed ML system will adequately address key issues and needs in Indigenous health. In fact MLs may reverse the benefits of direct Commonwealth funding to Indigenous health services that has been fought for with great passion over the past 40 years.

Mainstream structures have always struggled to adequately prioritise Indigenous health needs amongst the myriad of broader community health concerns and pressures. SARRAH therefore proposes that the Commonwealth Government consider the establishment of Indigenous primary health care organisations to sit alongside the MLs, to ensure

that the benefits of direct Commonwealth funding is maintained for Indigenous health services, at least until the gap in life-span is closed.

Borders

COAG has agreed that the arrangements for cross-border LHNs “may be agreed with the Commonwealth”.

SARRAH strongly supports the concepts of cross-border flows and applauds any models which overcome jurisdictional borders. For example SARRAH recommends that to progress cross-border flows across Northern Australia, the Australian Government and governments of the Northern Territory, Queensland, Western Australia, Aboriginal Community Controlled Health Services and local health professionals must work together. It is paramount that these stakeholders develop models that will overcome current health service barriers experienced by communities across Northern Australia.

More broadly, it will be critical for the effectiveness of both LHNs and MLs for them to encompass communities in more than one jurisdiction. Examples of regions where these arrangements would work include Albury-Wodonga, Mildura-Riverland, Tweed-Gold Coast, Darwin-Northeast WA.

In addition, it is noted that there is no arrangement for a cross-border flow from Broken Hill (NSW) to South Australia which could be a logical flow given the geographic proximity of health services available in South Australia for residents in the Broken Hill area.

Weighting

SARRAH considers that it is essential that equitable health service access and delivery targets be set across all LHNs and MLs regardless of geographic location. However, targets for rural and remote areas including areas that deliver remote outreach services, must receive compensation or special weighting to ensure an equitable level of service can be expected and provided. Rural and remote residents should not receive lesser quality health services than their metropolitan counter parts.

SARRAH is concerned that health service providers in rural and remote areas such as community health services which run without a GP presence and provide vital continuing primary health care are not able to access funding support. This means that the opportunity to expand services and/or infrastructure is not possible without a GP. This matter needs to be resolved.

As mentioned earlier Kangaroo Island is only one of many examples where people residing in rural and remote Australian communities are

disadvantaged in terms of the limited availability and provision of health services.

Conclusion

SARRAH notes that in drafting the report, stakeholder consultation was limited and only involved some members of the Australian General Practice Network.

SARRAH is of the view that other stakeholders have valuable information to provide, relevant to the mapping of LHN and ML boundaries.

SARRAH recommends that the Commonwealth Government consider a supplementary consultation process with key stakeholders at jurisdictional and regional levels including Allied Health Professionals delivering health services to people residing in rural and remote communities.