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Services for Australian
Rural and Remote Allied Health

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

**Medicare Locals discussion paper
on Governance and Functions**

November 2010

INTRODUCTION

Services for Australian Rural and Remote Allied Health (SARRAH), welcomes the opportunity to provide feedback on the Medicare Locals (MLs) discussion paper on Governance and Functions.

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. It is the Government's responsibility to ensure the provision of this care.

EXECUTIVE SUMMARY

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 that the delivery of PHC services across rural and remote Australia meets the needs of local communities:

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-professional team care – to ensure high quality, coordinated care;
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.

WHAT WILL MEDICARE LOCALS DO?

What features will Medicare Locals need to have in order to achieve their objectives?

1. Identification of the health needs of local areas and development of locally focused and responsive services.
 - Conduct population and health service planning activities that meet the varying needs of the area covered. For example employing staff with the capability to collect, analyse and manage data on the health status of people residing in the ML catchment area. Specific activities may include reviewing patient records, conducting patient surveys and coordinating community consultation forums. Other identification methods may also include regular liaison with key community organisations including Aboriginal community controlled health services and other Aboriginal organisations, community leaders, government agencies, schools and sports clubs.
 - Provide access to PHC services that meet rural and remote community needs which include addressing service gaps. This may involve purchasing or recruiting and retaining a skilled PHC workforce, working together collaboratively in multi-professional teams delivering health services to meet the needs of the local community at the right time, delivered by the right health professional and in the right place.
 - Provide services which proactively focus on prevention and early intervention rather than responding reactively to local community health needs.

2. Improving the patient journey through developing integrated and coordinated services, including across the transitions between primary and acute and aged care.
 - Establish health care team coordinators for patients particularly those with chronic and complex conditions to facilitate access to services which require transition between service areas or within a service area. For example health care team coordinators working with Local Hospital Networks on transitioning patients out of hospital and/or into aged care.
 - Create communication and support systems to facilitate health care team meetings for PHC staff to discuss service coordination issues and to develop and implement solutions.
 - Implement national e-Health systems including electronic health records which will assist to improve the coordination of patients' information and the ease with which they can navigate the health system especially people with chronic diseases who need to see multiple health professions. The success of this strategy in rural and remote communities will be subject to the roll out of the National Broadband Network in those settings.
 - Introduce the concept of cross-border flows and models which will assist to overcome jurisdictional borders. For example cross-border flows need to

occur 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 to ensure that borders are not a barrier to providing health services into rural and remote communities.

- Implement a national patient assistance travel scheme to be administered by the Commonwealth Government to facilitate a team practice approach enabling patients to access clinical services not locally available – bring the patient to the service.
3. Providing support to clinicians and service providers to improve patient care.
 - Establish appropriate clinical governance structures and systems including mentoring and clinical supervision for all clinicians.
 - Provide access to inter-professional education and training to facilitate team practice and clinical skills reflecting the health needs of the local community.
 - Adopt best practice human resource principles and policies to recruit and retain clinicians with an emphasis on delivering a high standard of patient care.
 4. Facilitation of the implementation and successful performance of primary health care initiatives and programs.
 - Develop a national performance framework that will be appropriate and able to measure performance without creating an excessive burden of reporting.
 - Demand a track record in managing finances, resources and meeting accountability requirements in accordance with sound program management principles.
 - Create a funding system that is flexible, enabling initiatives and programs to be implemented to meet the varying health needs, over time, of local communities in rural and remote areas. For example establish an approach of pooling funds to reduce the number of silos created by individual PHC initiatives and programs within a ML. This may allow clinicians to be employed on a full time basis to deliver services to those who need them rather than as determined by program guidelines.
 5. Be efficient and accountable with strong governance and effective management.
 - Provide training to all ML Board members in the roles and responsibilities of a director.
 - Ensure a broad range of skills are present within the ML Boards.
 - Establish a system that identifies, trains, supports and mentors across all levels of operation, people for future leadership roles.
 - Acknowledge that a mainstream ML may not be able to address the needs of Indigenous Australians, as previous mainstream structures have failed, and other mechanisms may need to sit beside MLs to address these needs and close the gap.

Are there other roles and functions Medicare Locals could potentially adopt?

- Identify and implement effective models to increase access to allied health and other health clinicians to deliver services in regions where there is not a critical population mass to support the full-time employment of clinicians. For example the North and West Queensland Primary Health Care deliver allied health services through a hub and spoke model to remote communities.

What challenges will there be for Medicare Locals in performing the proposed roles and functions?

- Requires a significant institutional and cultural change from the current focus on medical based boards and support for GP services to one involving multi-professional teams and governance structures that reflect an all encompassing team based PHC organisation.
- Ability to shift the range of services delivered to meet the changing health needs within a local community including changes required to address cross border issues.

How should Medicare Locals and Local Hospital Networks work together?

- Consider establishing a selection of shared members on both boards for an initial term, or regular Board to Board meetings to discuss strategic directions and issues as well as establishing cross organisational meetings at a management level.
- Consider that Boards come together as a single entity, where relevant.
- Facilitate regular forums for clinicians from both organisations to meet and discuss opportunities and operational issues which may also include facilitating joint training events. In many rural areas there may be considerable overlap in the workforce of both organisations. For example in many country areas GPs provide hospital and community care, as do allied health professionals.
- Provide a mechanism to share e-Health information including electronic health records as outlined earlier in this paper.

WHAT WILL MEDICARE LOCALS LOOK LIKE?

What other broad principles or characteristics are important in establishing governance arrangements for Medicare Locals?

- Develop a clear and concise Corporate Governance Charter which should set out, but not be restricted to defining roles and functions, skills and appointments, induction and training, code of conduct, conflict of interest, strategy setting, stakeholder management, public speaking, interaction with the media, risk management, financial and operational reporting and monitoring performance.

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- Select the Board based on skills – some may be elected and some directly appointed.
 - Establish a robust and effective clinical governance structure that recognises all health professionals working in PHC including allied health professionals, medical, nursing and pharmacy.
 - Build special mechanisms for addressing Indigenous health needs.
 - Create consumer and community engagement mechanisms and structures.

What formal linkages are required between Local Hospital Networks and Medicare Locals to ensure good coordination of services to the community?

- This has been addressed earlier in this paper.

Legal structure and internal governance

What is needed to ensure that the structures and governance arrangements for Medicare Locals are flexible enough to deal with future changes in the health care system, including potentially different roles and responsibilities in primary health care?

- Build in and fund as a core responsibility of MLs the capacity for an evidence based approach towards researching local health service requirements including service delivery. This may include the employment of research officers or contracting the services of Universities, University Departments of Rural Health or the non-government research sector.
- Establish an evaluation and reporting framework on what is or is not working and why, as an approach to share successful strategies across the national ML network. This may be achieved via a central repository of best practice initiatives or the showcasing of those strategies.

What other types of internal governance structures are needed to support the Board and the operations of the Medicare Local?

In addition to those outlined earlier in this section of the paper structures and responsibilities of the Board and management must be clearly defined in a Corporate Governance Charter. Furthermore, MLs must have the capacity 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 and apply a needs based planning regime for equity.
- Directly provide, commission or broker health services to meet needs and drive workforce planning within their jurisdiction.
- Ensure that a critical population mass is sufficient to retain all health professionals whilst at the same time avoiding the duplication of health services and disadvantaging remote areas where there is a low population density. Where the ML is not large enough to achieve this critical mass of

health professionals ensure that cross-organisation/boundary arrangements are in place to support the retention of health professionals.

Membership

Who should the members of Medicare Locals be?

MLs should be the overarching planning and where relevant service provider body. The membership base should reside locally and consist of representatives from the community and clinician sectors.

How should membership be structured to ensure Medicare Locals focus on the health needs of their local community?

The membership structure should have the capacity to determine and advocate for local health services that meet the needs of their community. ML membership structures will vary however they must reflect the population characteristics of the community.

What rights should members have and should they be able to influence the governance or the activities of Medicare Locals?

Members should have the ability to provide input into the what, how and when health services are to be delivered.

Clinical governance

What aspects of clinical governance should Medicare Locals be responsible for?

- In rural and remote regions ML will have a critical role in the support of clinical governance to ensure that health consumers have access to the right service at the right time in the right place. This role also extends to the integration between the primary health care/community and hospital based services.

What is required to ensure appropriate linkages between Medicare Locals' clinical governance and Local Lead Clinician Groups?

- Health professionals providing clinical governance within the ML must be a part of the Local Lead Clinician Group and facilitate the participation in group activities such as training and mentoring. In rural and remote areas it is not sensible to have a lead clinician group that focuses only on hospital services – it should cover all health services.

Boundaries

During September 2010, SARRAH provided formal feedback on the 'Potential Boundaries for Medicare Locals and Local Hospital Networks' report. Our general comments were that we urged 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. However MLs should not be so small that they duplicate services and have workforce recruitment and retention issues.
- 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 MLs need special arrangements established to address Indigenous health challenges, given the failure of mainstream structures historically to meet these challenges.
- The entities should merge in instances where the community and clinicians/health service providers agree.

HOW WILL MEDICARE LOCALS INTERACT WITH PATIENTS AND PROVIDERS?

How can communities best be supported to fully participate in the activities of Medicare Locals?

Through formal and informal mechanisms such as:

- Representation on the ML Board either as individuals or through community structures such as local government.
- Contact with management or staff visiting local communities.
- Attendance at community panels and forums.
- Contact with health professionals delivering clinical services.

What can Medicare Locals do to facilitate stronger community participation in local primary health care service planning and delivery?

- Ensure significant representation of community leaders on the boards of MLs with broad ranging leadership skills beyond health care.
- Ensure that community consultation occurs at the various stages of local health service planning, delivery and evaluation.
- Ensure that a communication strategy is developed and implemented targeting the local community. The strategy should include a reporting mechanism on the performance of the ML as well as an opportunity for input and feedback from the community.

What kinds of information would be appropriate to provide in Healthy Communities Reports?

- Ensure reports include the social determinants of health such as access to fresh food, clean water, housing, education and transport facilities.
- Ensure that reports identify the more 'hidden' health issues such as mental health, aged care and obesity rather than activity figures only.

CONCLUSION

SARRAH as the peak body representing Allied Health Professionals delivering health services to people residing in rural and remote communities across Australia is well positioned to continue to work with the Commonwealth Government and other stakeholders to assist in the establishment and operation of MLs.