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Services for Australian
Rural and Remote Allied Health

**A Submission to the Australian Government
Department of Health and Ageing**

Comment on ‘Towards a National Primary Health Care Strategy’

February 2009

INTRODUCTION

Services for Australian Rural and Remote Allied Health (SARRAH), welcomes the opportunity to comment on the **Towards a National Primary Health Care Strategy** discussion paper.

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 disciplines 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 Health continuum. They have significant roles in health care and health education across the sectors. This includes disability and other services with education departments, family and community services and non-government organisations, Centrelink and CRS Australia.

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

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

The importance of the contribution to primary health care of the professions that SARRAH represent is acknowledged by the Government through funding of scholarships including professional development schemes. It is repeatedly demonstrated that 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.

The following comments specifically address the questions raised in the sections from the Discussion Paper highlighting the need to recognise the important contribution of rural and remote Allied Health Professionals in primary health care. They are submitted in anticipation that a **National Primary Health Care Strategy** and any reforms implemented as a result of this review make a positive difference to the health and wellbeing of Australians living in the bush.

What are the key elements of an enhanced primary care system?

- 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 where the focus is on health promotion, illness prevention, early intervention, and acute and chronic disease management in the community.
- SARRAH supports the request to carefully define the meaning of primary health care as a necessary starting point for any planning of an enhanced health system. Currently the term 'primary health care' is used with differing meanings across the health care provider sector and recipient communities. *Primary* can mean highest in rank or importance, but also first in order in any series or sequence, or first in time¹. Where there is health workforce shortage, as there is in rural and remote areas, timely care often falls to Allied Health Professionals. This should be recognised.
- Attention needs to be drawn to the specific meaning of the language contained in the strategy document for example 'equitable access'.
 - SARRAH contends that using the term 'accessible' does not have the same meaning as the term 'equitable access'. Rural and remote clients accessing primary health care services currently available do not have the same access to the range and scope of services as clients attending metropolitan primary health care services.
- Key elements in Sections 8 & 9 of the strategy document are considered to be particularly crucial making the workforce more flexible, and improving access to primary health care services in rural and remote communities.

Section 1. Accessible, clinically and culturally appropriate, timely and affordable.

- In rural and remote areas, the local community primary health care needs should be identified and flexible service delivery arrangements implemented with appropriate funding.
- A multidisciplinary team based approach to the delivery of primary health care should be instigated with due recognition of the specialised contribution of Allied Health Professionals to addressing the health needs of the individual person.
- The strategy must include goals to improve the health of Aboriginal and Torres Strait Islander communities. This can be facilitated through targeted support for recruitment and education of more Aboriginal and Torres Strait Islander Allied Health Professionals and the provision for funding of cultural safety education for all Allied Health Professionals.

¹ The Macquarie Dictionary

- Culturally appropriate primary health care for humanitarian immigrants must include recognition and education of Allied Health Professionals that people with severe post-traumatic syndromes will have barriers to good health. Allied Health Professionals are frequently the health care workers who spend most time with this group.
- The direct client access to non-GP services should be increased specifically to those allied health professions represented by SARRAH. This would maximise the efficient use of the existing workforce.
- Current rural and remote Allied Health Practitioner recruitment and retention levels cannot meet client needs across all geographical areas and population groups (See table below). To resolve this critical issue will require 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.

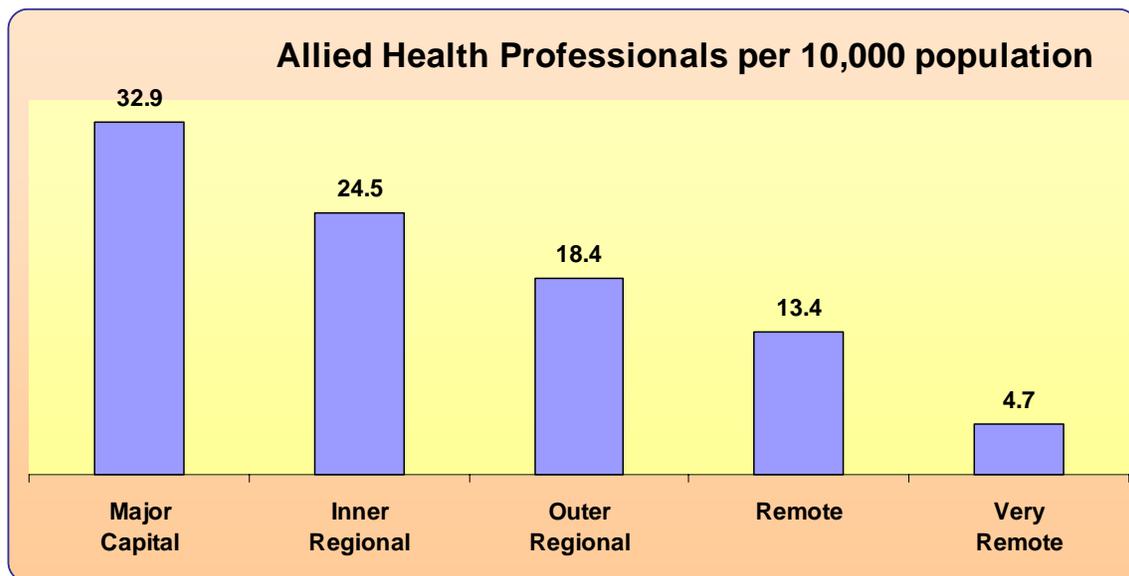


Figure data based on SARRAH *National allied health workforce report* (2004) which is available at: <http://www.sarrah.org.au/site/index.cfm?display=65820>

- There are lower numbers of Allied Health Professional positions in rural and remote communities compared with metropolitan centres which is further exacerbated by greater vacancy rates. Funding by State and Commonwealth health programs does not usually allow for locum cover so that service continuity and relationships can be maintained in rural and remote settings.
- Recruitment processes take longer in rural and remote areas. Some communities find it very difficult to attract the correct mix of Allied Health Professionals. Consequently flexible models could be used where the community and other health providers' work together to create a more

attractive alternative for experienced Allied Health Professionals to move from urban areas.

- The allied health workforce requires access to equitably distributed incentive programs to encourage staff to work in rural and remote areas. Targeted incentive programs will assist in attracting staff and maintaining appropriate levels of service access to rural and remote communities.
- Statistically, access to allied health services may appear to be adequate however, the availability of individual professions or services are limited along with the scope of therapy approaches available. This situation either promotes a heavier reliance on GP care or requires clients to travel excessive distances to access health services.
- Accessibility to primary health care services can be enhanced through an increase in program investment to assist with client transportation for those residing in rural and remote communities e.g. IPTAAS, Community Transport, and Health Transport.
- More emphasis must be placed on the provision of broad based prevention, screening and community support and the development of flexible initiatives in local communities to reduce the need for access to acute based health services.
- The use of Enhanced Primary Care items must provide greater program flexibility in particular, expanding the range of subsidised services including covering provider costs, for example travel to/by service providers. The provision of services has to be cost effective for the clinician whether in the public or private sector in order for clinicians to continue to provide health care services in rural and remote settings.
- Prioritising of services must address those clients who access the health system the most and/or absorb the greatest amount of the health budget for example rural and remote clients, chronic health disorders, aged care.

Section 2. Patient-centred and supportive of health literacy, self-management and individual preference

- Strategies supporting local community and consumer engagement to become active partners in developing appropriate and effective communication strategies must be retained and in some cases enhanced. This approach will contribute towards a patient centred approach to primary health care.
 - Effective and user friendly health promotion strategies, for example easy to read literature, needs to be developed and distributed to communities.
- Individual understanding of self-initiated health practices would be facilitated by developing a language that changes the focus and understanding of the service role from a treatment to a well-being focus.

Language focussed on prevention, self management and community development would be of advantage in promoting self responsibility for health and self managed care. For example, words like 'clinic', 'referral', 'waiting list monitoring' reflect the reliance on treatment, but a change in facility name could promote a different way of providing care and promoting health.

- Funding flexibility is required to support Allied Health Professionals in service delivery models which reflect the needs of local communities. Changes need to be made to the medical focussed model of care as the overriding principle of service delivery and remuneration. Flexible funding would enhance the traditional medical assessment gate keeping processes which may limit access to the right health services at the right time, at the right price.
- Improvements in primary health care providers' working arrangements, in particular communication strategies, may assist in improving client focussed care. For example regular use of case and family conferencing, cross agency conferencing, communication systems between acute and community based services, and other methods/systems that work well in the local communities need to be introduced for rural and remote communities.
 - The engagement of case management services to assist with pathways through the health system may also assist with improving client focussed care.

Section 3. More focussed preventive care, including support of healthy lifestyles

- Fund and implement evidence-based programs and strategies needs to occur which are conducted by Allied Health Professionals who have shown to promote healthy lifestyles, prevent or manage chronic conditions. Examples include improved nutrition, early management of arthritis, prevention of diabetes and cardio-respiratory disease.
- Changes are also required to current discharge planning procedures in acute care in particular to include some eco-psycho-social mandatory items. This means that to ensure optimal health outcomes after discharge to rehabilitation or home, personal environment, mental health, and family or other support systems are addressed or there will be a relapse of the condition. A well-resourced multidisciplinary allied health team is able provide this service.
- Significant changes in primary health care will require a revolution in thinking by health professionals working in the health system in particular, public health structures, about how to deliver client focussed day to day services. This proposed approach will not be achieved if services and practices do not change such as:

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- timing and scheduling of appointments to meet new demands;
 - addressing crucial workload management issues;
 - increasing frequency of consultations in early self management uptake;
 - limiting frequency of consultations in later self management uptake;
 - allowing appropriate time and resources for longer term strategies; and
 - allowing sufficient time for new evidence/data collection requirements and many more daily work management issues.

It will be critical for senior executives and on site managers to actively support changes to long established and out-dated work patterns.

- A focus on delivering flexible preventative services could be improved by increasing shared public/private funding arrangements to engage the private sector more in providing preventative care services.
- A strategy for linking clients to primary health care services through identifying key health indicators and mandatory links to preventative health services when a client reaches an indicator (e.g. BMI over certain number) may be of value in preventative health care planning.
- Establish 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.

Section 4. Well-integrated, coordinated, and providing continuity of care, particularly for those with multiple, ongoing and complex conditions

- SARRAH has identified primary health care 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.
 - Access for rural and remote Allied Health Professionals to electronic health records would assist in the integrated and coordinated provision of health care services.
- 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.
- Local consumers must be engaged through Regional Community Groups and Support Groups to improve the integration and continuity of care. These concepts are expanded further in Section 7.
- 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.

- Increase funding for programs in rural and remote areas for timely availability of equipment will enable people to function in their communities. This will reduce the need for dependence on admission to care providers, reduce lengths of hospital stays and continuing care costs. Programs such as PADP/Enable (NSW), MASS (Qld) and equivalents in other states should be expanded.

Section 5. Safe, high-quality care which is continually improving through relevant research and innovation

- 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 patient throughput recording and look at client and community benefits.
- Training in research processes and writing for research should be a core component of undergraduate and be available in post graduate training.
- Currently there is insufficient evidence measuring the outcome and cost effectiveness of primary health care strategies versus acute based care. A nationally funded project to research this issue is required.
- Assessment of the effectiveness of 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 patient outcome measurement systems. The performance framework would be maintained by the Commonwealth.
- 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.

Section 6. Better management of health information, underpinned by efficient and effective use of eHealth

- 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 rapid access to information can cause unnecessary delays and complexities to the safe, effective and efficient delivery of health care services.

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- Priority for electronic Medical Records should include the acute/community interface including that between public and private providers with access for all services and service providers involved with the person. In particular this would improve timely communication at the acute/community interface and would lead to greater improvement in chronic/complex continuum of care and future re-admission prevention.
 - 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 telehealth services; online scientific library services and professional development programs.

Section 7. Flexibility to best respond to local community needs and circumstances through sustainable and efficient operational models

- The GP gatekeeper system fails in many rural and remote areas where access is compromised by the unavailability of GP services, lack of transport and increased costs. There is a flow on effect of this lack of access to GPs to access to allied health services which can result in unnecessary admission to hospital based services. Consequently a failure to manage conditions that should otherwise be readily managed in the community end up in more costly acute settings.
- Regional organisational structures may be the best way of managing better the use of community based primary health care services. A government funded body that manages 'patient pathways' may also be an improved option for recording the effectiveness or service outcomes and costs, community engagement and planning of services rather than giving governance to professional entities, for example Division of General Practice.
- Regional planning organisations including public, private and community based representatives need to be established to:
 - identify the primary health care needs of those living in the local community; and
 - monitor the implementation and delivery of appropriate primary health care services to ensure that they meet local community needs.
- A more efficient and effective health service delivery model would involve a single agency being responsible for managing and delivering services to communities. This approach would avoid duplication and/or gaps which exist under the current service arrangement. In establishing a significantly reformed agency consideration must be given to the elements that work under current Commonwealth/State/Territory departments of health, Divisions of General Practice and other systems across Australia.

Section 8. Working environments and conditions which attract, support and retain workforce

- Based on the recently conducted Rural Allied Health Workforce Survey (RAHWS) in NSW, one third of a total of 1,757 respondents considered their workload to be unmanageable, and nearly half the sample reported being short-staffed.
- A comprehensive review is urgently required of the workload expectations and roles of those allied health professions in primary health care that SARRAH represents. This is needed to meet the new strategies and focus on preventative care roles. A review should include recognition and documentation of prevention strategies, education, data recording, resource development, community consultation, research, Quality Improvement activities, student supervision, mentoring, continuing professional development programs, responses to policy, policy and procedure development.
- Further development of structures and incentives for health professionals to work in multi-disciplinary teams in the primary health care setting should be supported. Examples include:
 - Peer support and teamwork could be fostered by collocated or virtually co-located primary health care multi-disciplinary teams (public and private under a policy similar to that which exists in NSW Health).
 - Whatever the setting, to ensure that teams best meet the needs of clients/patients and communities, they should be led by the most appropriate professional to the situation, taking into account the opportunities and available workforce in local communities.
- Facilities and infrastructure for the effective provision of care to rural and more significantly to remote areas is lacking. This includes accommodation and professional facilities for health workers and students, and vehicle and air transport for remote health workers including students on clinical placements.
- Changes to health regulation and registration systems which allows for expanded scope of practice for Allied Health Professionals is recommended, particularly where related services do not exist within an accessible distance. Examples include: referral rights, prescribing rights and new therapeutic skills. This is already occurring for some professions such as Podiatry, Physiotherapy and Optometry and should be further extended to other allied health professions.
- National Registration for all allied health professions that SARRAH supports would be advantageous to improve the focus on and monitoring of client/patient safety and establish the professional status of health professionals critical to health care service provision.

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- Workforce succession planning in rural and remote settings should be the norm rather than the exception. This could be achieved by the funding of postgraduate training in rural generalist or specialist positions. This would attract newer graduates to rural and remote areas to be mentored and supervised by more senior colleagues and thus create a pool of expertise for succession.
 - Incentives to encourage Allied Health Professionals to practice in rural and remote Australia include introducing broad tax reforms. This should involve offering Higher Education Contribution Scheme credits for practitioners moving to a rural or remote settings – the more remote and time spent in these settings the higher the credit.
 - Other proposed tax based incentives include rebates or higher tax free allowances for accommodation, living, professional and/or education support items.

Section 9. High-quality education and training arrangements for both new and existing workforce

- Establish a national role for clinical educators in allied health to improve critical support factors such as clinical training, uptake of clinical research and specialisation, supervision and mentoring program penetration, student placement coordination and inter-professional learning opportunities. Successful establishment of clinical educators as per various state awards will require local employer recognition, appropriate remuneration, and workload adjustments.
- Preventative strategies, self management training, primary health care, 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. This would assist to equip staff with the skills to deliver new models of care.
- Establish as a matter of urgency a nationally accredited training course for clinical supervisors to enable improvements in the quality and penetration of supervision and mentoring activities in allied health professions.
- Create Allied Health Professional undergraduate and post graduate education opportunities based in regional universities by preference. This will ensure that professional educational bodies are located closer to rural and remote area graduates and employers to provide effective student, graduate and post graduate support services.
- Establish as a matter of urgency direct recognition of Allied Health Assistant Cert IV training by higher education providers to progress potential students to higher levels of education if desired.

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- Universities must be funded to collaborate across health professional course boundaries and commence the process of establishing and elaborating inter-professional learning with practical experience in the working environment.
 - Increased access to postgraduate training and education needs to occur including designated training positions in allied health professions for specialist training areas. These postgraduate courses should be grouped according to age, such as aged care or paediatrics, or condition specific, such as diabetes or mental health with recognised specialist qualifications resulting.
 - Ensure universal coverage by University Departments of Rural Health sites for all of rural and remote Australia, and appoint allied health academics at all sites to support rural and remote area Allied Health Practitioners. This would increase the research capacity of clinically engaged Allied Health Professionals.

Section 10. Fiscally sustainable, efficient and cost-effective

- Establish an evidence based approach towards the cost/outcome effectiveness of primary health care strategies (broad system based evidence not single programs or interventions) to sustain and build funding specifically for primary health care services.
 - At the time of collection of this evidence a review of international evidence of the same parameters would be informative.
- Medicare also requires reform if it is to remain the primary method of payment for health services. There needs to be recognition that in rural and remote communities most allied health services are delivered within the public sector.
 - To ensure a critical mass of Allied Health Professionals in one agency, which is required for recruitment and retention of staff, Medicare must provide access either through direct State services or contracting of public health employees to private/NGO services. This would increase the supply and equity of health services in areas where the uptake of Medicare items is low.
 - A concept of ‘cashing out’ also would increase opportunities for other providers to increase successful services or to move into new areas.
- Expanding access to allied health services under Medicare may be informed by addressing the client’s ability to self refer to Allied Health Professionals and that allied health practicing rights are independent of medical body regulation.