SARRAH

Services for Australian Rural and Remote Allied Health

10 November 2022

National Preventive Health Strategy Team
Population Health Division
Australian Government Department of Health and Aged Care

NPHS@health.gov.au

Services for Australian Rural and Remote Allied Health (SARRAH) submission: Draft National Health Literacy Strategy

Thank you for the opportunity to contribute to the development of the Draft National Health Literacy Strategy (NHLS). Services for Australian Rural and Remote Allied Health (SARRAH) strongly supports the objective that the proposed NHLS provide an evidence-based health literacy environment, where health information is person-centred, accessible and culturally and linguistically appropriate, and improves health literacy skills of Australians.

In addition to providing this submission, SARRAH would welcome the opportunity to be involved further as the work of developing the Strategy proceeds.

SARRAH is the peak body representing rural and remote allied health professionals (AHPs) working in the public, private and community sectors, across primary and other health settings, disability, aged care, and other service systems. SARRAH was established in 1995 by a network of rurally based allied health professionals and continues to advocate on behalf of rural and remote communities to improve access to allied health services and support equitable and sustainable health and well-being. SARRAH maintains that every Australian should have access to health services wherever they live and that allied health services are fundamental to the well-being of all Australians. Improving health literacy throughout the community, including among and between health professionals, and ensuring health system developments also support access to appropriate and effective health care, are vitally important in achieving the objectives of the proposed NHLS.

The *Consultation Paper: Development of the National Health Literacy Strategy* provides a very helpful framework to assist in establishing a meaningful Strategy with potential to facilitate improved health care through more equitable and effective access and outcomes. Defining the scope of the Strategy is critical. We note, from page 2 of the consultation paper:

> ***Health literacy*** *refers to how people understand information about health and health care, and how they apply that information to their lives, use it to make decisions and act on it. It is determined both by the skills and abilities of individuals as well as the demands and complexity of the environment.*

The statement reinforces health literacy not only as an attribute people may (and desirably should) possess which influencing their access to healthcare (or not), but also as a necessary consideration in policy and services designed to enable that access. As the consultation paper also acknowledges – *"The Australian health environment often does not meet the needs of many"* and, under the Context section (page 3) that *"When the health literacy environment does not meet the health literacy needs of the people it serves, it leads to poor access to health care and uptake of services and worse health outcomes, including engagement with prevention activities."*

SARRAH endorses this understanding of health literacy, its broad consideration and application. It should be a fundamental consideration in health service policy and design, with a view to actively enabling access on an equitable basis to appropriate, well-informed and effective health services. For these reasons, SARRAH supports the basis on which the consultation paper addresses the matter and seeks to reinforce several key aspects of the proposed Strategy as being imperative to its impact and success, namely:

- *adopting an equity lens to ensure the challenges faced by priority populations in improving health literacy and accessing health information are addressed, noting that partnerships and co-design processes are of particular importance in addressing the needs of priority populations;*
    - we especially stress the importance of ensuring concerted effort is made to ensure people living in rural and remote Australia are afforded tailored and comparable access to services (noting the means of delivery and access may differ considerably); and that
    - available information which demonstrates significant differentials in referrals and/or access (e.g. MBS allied health data; rates of chronic and other diseases – including the ACQSHC Australian Atlas of Healthcare Variation Series; data on life expectancy; potentially preventable hospitalisations; workforce distribution data and other sources of information be interrogated to help develop the Strategy and be included in mechanisms for ongoing performance monitoring and reporting, noting the importance of service availability and access as a means of delivery on the objectives of a National Health Literacy Strategy.
- In line with the above, that it should encompass and facilitate peoples' capacity to manage their health and wellbeing through appropriate preventive action across each stage of their life.
    - This should include the full range of health services pertinent to the populations' needs at whatever life stage – e.g., from the timely access to diagnostic and therapeutic services of early child development through to the enabling therapies that support continuing cognitive and functional capacity and, in the event of illness or injury, recovery;
- Improve access and navigation of preventive health care options – whether due to location, resources or other factors that can facilitate, impede or act as a barrier to access and future health.
- Should promote informed "consumers" able to exercise choice, based on reliable **and complete** information about treatment options.
- Improve service quality delivery and reduce (or at least contain avoidable long-term) avoidable cost burden on the health system.
- It also seeks to promote a system that is evidence-based.
    - This will be facilitated if the evidence upon which policy and systems are based are not only rigorous, but inclusive of the full range of viable service / therapy options and that research is considered and supported from across a spectrum of approaches and disciplines (i.e. to illustrate, evidence that is drawn from practice and research related to surgical interventions, but not considerate of alternative approaches to treatment (e.g. allied health therapies) will "evidence" accordingly.

This is not to suggest that Australia's health system is ineffective. Clearly, in many areas and for much of the population Australia's health and associated care and service systems deliver high quality care, among the best in the world, when compared other nations, such as through the OECD.

Nonetheless, our system is complex and, while effective for many, contributes to highly disparate outcomes across the population (as noted in the consultation paper) and the outcomes and disparities reflect in part policy and funding systems (which impact service provision and access) which distort access, referral, provision and outcomes. In many respects our health system architecture has not adapted to the contemporary and emerging pressures people face in achieving and retaining good health especially with changes in demographics and the burden of disease impacting the Australian population.

The NHLS in the context of the National Preventive Health Strategy and Australia's health system

It is critical that gaps in service and system pathways are addressed to actuate the benefits of improved health literacy. This will inevitably be an iterative process, which SARRAH expects should lead to circumstances where, for example, a child with a developmental condition does not have to face a two-three year wait to see a speech pathologist, or people in one part of Australia are many times more likely to experience a lower leg amputation because they cannot access podiatry services.

We note the NHLS was announced as a priority under the **National Preventive Health Strategy 2021-2030** (NPHS), which **aims to ensure** (page 6) that in Australia:

1. *children grow up in communities that nurture their healthy development - providing the best start to life;*
2. *individuals are living well for longer, enjoying life as they age – adding health to life;*
3. *groups that experience poorer health outcomes compared to the rest of the population have greater improvements in health – addressing inequity in health; and*
4. *prevention is valued and viewed as a worthwhile and important venture – funding is rebalanced towards prevention.*

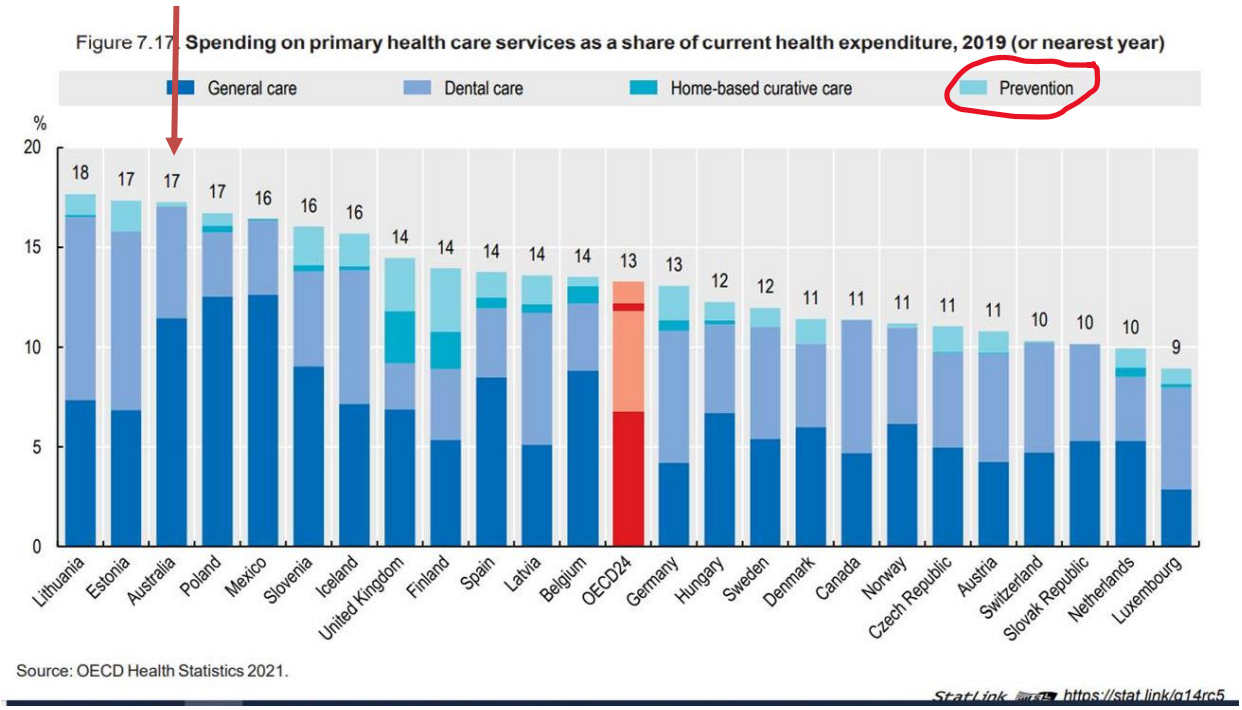
Consistent with other components of the NHPS, the effectiveness of the proposed NHLS depends on substantial development and shift in priorities across our health (and related) systems to achieve the aims of both the NHPS and NHLS. This is likely to require a significant increase in the portion of Australia's health expenditure to that is directed to prevention, which is very low by OECD standards.

As the NHPS states:

> *"In 2018-19, 2.0% of total health expenditure was spent on public health and prevention. This takes into account Commonwealth and state and territory health expenditure. This amount is significantly lower than other countries with similar health systems such as Canada (over 6%) and the UK (over 5%). Of the 33 OECD countries who reported on prevention spending in 2018, Australia ranked 20th in terms of per capita spending on prevention, and 27th in terms of percentage of overall spending on health allocated to prevention. A greater investment in preventive health would allow for more initiatives that can protect the health of Australians before they become unwell."* [1]

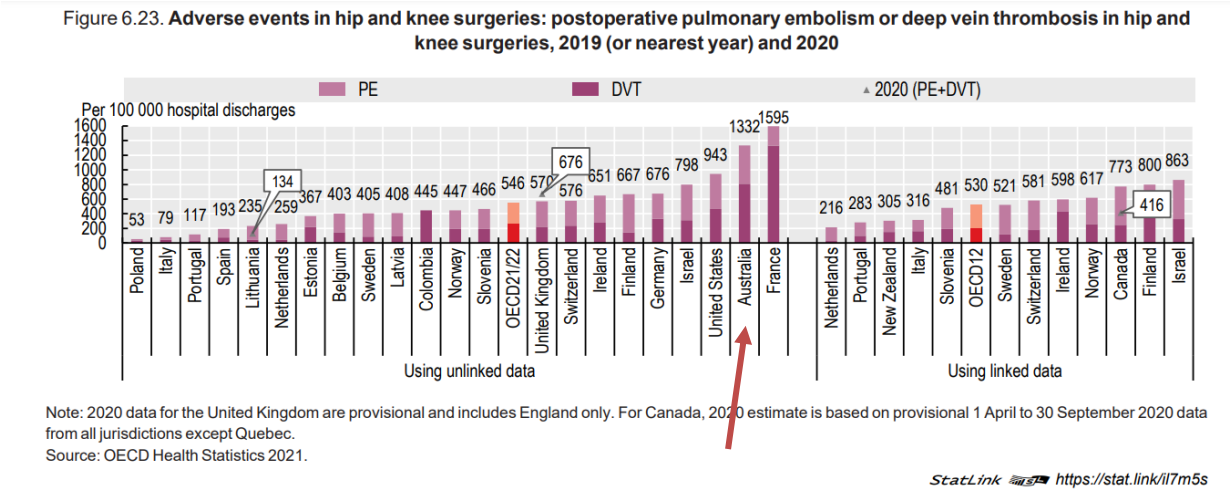
The following OECD graph illustrates Australia's relative spend on preventive health as a component of primary health expenditure.

[1] https://www.health.gov.au/sites/default/files/documents/2021/12/national-preventive-health-strategy-2021-2030_1.pdf (pages23-24)



A review of other OECD data invites further questions and possibilities about how a shift in Australia's approach to health care, and an increased focus on health literacy, might deliver better outcomes. For example, OECD Health at a Glance 2021 shows that while on a comparative basis and at a national level Australia performs well, especially in relation (for example) to mortality rates for treatable causes, and well, but less so, in relation to mortality due to preventable causes[2].

Another area in which Australia appears to be a relative "outlier" is with regard to hip and knee replacements (as an example). The OECD also reports Australia as having above OECD average rates of hip replacement and knee replacement (especially)[3]. Further, OECD data indicates Australia records a considerably higher rate of adverse events in some respects associated with such surgeries, as illustrated in Figure 6.23 (following), from page 171 of OECD Health at a Glance 2021.



It is possible that this information could indicate that the Australian health system is more likely to facilitate access to surgical interventions (at least in some situations) than more conservative therapies and treated options, and that post-operative care (including rehabilitative therapy for instance) may be a lesser focus in care delivery. These areas warrant detailed attention, not least with respect to whether Australian health care consumers are provided with the full range of treatment options, whether and to what extent

[2] OECD Health at a Glance 2021 See page 89.

[3] Ibid - pages 133 and 145.

policy and funding systems influence the choices and/or care provided, and whether these align with best-practice, fully informed and objective treatment.

Access to health care services and qualified professionals is another key factor that influences informed choice and treatment options – and consequently the capacity of a health literate population and system to facilitate appropriate care. In line with that, the NHPS identifies a list of "policy achievements by 2030" required to embed prevention in the system: and include ***"The public health workforce is 'future proofed' through the enhancement of the availability, distribution, capacity and skills of the workforce."***[4]

Health workforce shortages and maldistribution remain a major obstacle to access and improved health outcomes: and so, a health literate system. Consequently, the proposed NHLS specifically address the need for and implications of health workforce shortages and maldistribution in delivering on the intent of the NHLS. To this end, further work could be undertaken to assess the relevance of the "structural determinants on health" identified in the National Preventive Health Strategy (NHPS). Table 3 from the NHPS (page 16) is replicated below.

Table 3 - *The effect of structural determinants on health*

Structural element	Protective	Adverse
Healthcare costs[85, 90, 91]	Universal health care	Constrained by income Out of pocket costs
Service provision[87, 90]	Receive timely and quality care for all health needs	Long appointment waiting period Poor access to appropriate services, including specialists and allied health
Systemic attitudes and practices[92-94]	Access to culturally appropriate, safe and responsive care	Racism and discrimination resulting in the provision of low quality healthcare Avoidance of healthcare settings by people requiring care
Health literacy[95-101]	Crucial to effective self-care Can access, understand, appraise and use information to make informed health-related decisions	Low health literacy linked with poor health across the life course Reduced capacity to engage in self-care and preventive health care Increased healthcare costs and hospitalisations
Geographic location[102]	High quality, affordable and locally available health care	Lack of locally available health care across a range of primary and acute care settings Critical shortages of health care professionals

SARRAH recommends these issues are addressed in developing the NHLS.

Consultation questions

Does the Framework capture the important components? If not, please describe what else is needed. (See diagram page 6)

The Framework provides a good basis for further development of the NHLS. The consultation paper references several key resources, including the *National Action Plan Health Literacy Promoting health literacy in Germany*.

> *Health literacy must always be understood as being relational, because*
> - *it is based on the personal competences and abilities of every individual human being,*
> - *but is also dependent upon the challenges and complexity of the systems, organisations and living environments in which these persons are situated and make decisions*. (Page 12)

[4] Page 39 of the National Preventive Health Strategy 2021-30. They also include enhanced community referral pathways, improved continuity of care, and improving the inherent preventive health capabilities of primary health care professionals, including GPs, allied health, pharmacists and nurses, are better supported and integrated within health services

Similarly, the **ACSQHC Health Literacy National Statement** addresses in considerable the component elements of Health Literacy:

> *Definitions The Australian Commission on Safety and Quality in Health Care (the Commission) separates health literacy into two components: individual health literacy and the health literacy environment. The Commission defines these two health literacy components as follows:*
>
> *1. Individual health literacy is the skills, knowledge, motivation and capacity of a person to access, understand, appraise and apply information to make effective decisions about health and health care and take appropriate action.*
>
> *2. Health literacy environment is the infrastructure, policies, processes, materials, people and relationships that make up the health system and have an impact on the way that people access, understand, appraise and apply health-related information and services.*[5]

Both provides strong reference points against which to assess progress in developing the NHLF and following its implementation.

Is the proposed vision appropriate for the National Health Literacy Strategy? (See page 7)

Vision: All Australians are enabled to make informed decisions about their health.

SARRAH supports the proposed vision. It is a clear and unqualified statement that all Australians should be supported effectively to make informed decisions about their health care and have the means and/or mechanisms available to access that health care.

The vision should not be compromised by the practical challenges of delivering on it. The Strategy itself will need to address the gaps between the vision and our status in relation to it. Inevitably the statement is aspirational, and individuals' decisions and choice are substantially compromised/curtailed by inequitable service access and the policy settings that deliver the inequitable health outcomes, referred to in the consultation draft. To be meaningful, the proposed NHLS should commit to the vision while objectively recognising the work needed to achieve it and setting a proactive, ambitious agenda, within itself and in conjunction with other national strategies, policies etc., to deliver measurable gains in health care access, equity and performance.

We note the consultation paper states, "The Strategy will include measurable targets to assess progress towards the vision."

---

[5] The *ACSQHC Health Literacy National Statement* expands on these points. For example: From page 3 ACSQHC - *There are many factors that contribute to individual and environmental health literacy, and therefore many different strategies and approaches that can used to bring about improvements. Strategies are needed both to build the capacity of people to understand the choices they have, make decisions about their health and health care; and to build the capacity of the health system to support, encourage and allow this to occur.*

From page 3 - Embedding health literacy into systems

This involves developing and implementing systems and policies at an organisational and societal level that support action to address health literacy. These systems could include altering funding mechanisms to encourage awareness and action on health literacy, implementing policies that prioritise health literacy in program planning, and designing healthcare organisations in a way that makes it easier for people to find their way. 2. Ensuring effective communication This involves providing print, electronic or other communication that is appropriate for the needs of consumers. It also involves supporting effective partnerships, communication and interpersonal relationships between consumers, healthcare providers, managers, administrative staff and others

Page 4

Role - Government organisations, regulators and bodies that advise on health policy – among the possible actions - *Support the design and delivery of policies, pathways and processes that reduce the complexity involved in navigating the health system including across sectors and settings*

Are the key principles captured? If not, what is missing? (See page 8-9)

Six principles for action will underpin the Strategy and will be evident in the planning, design and implementation of policies, strategies, actions and services aimed at creating and strengthening the health literacy environment.

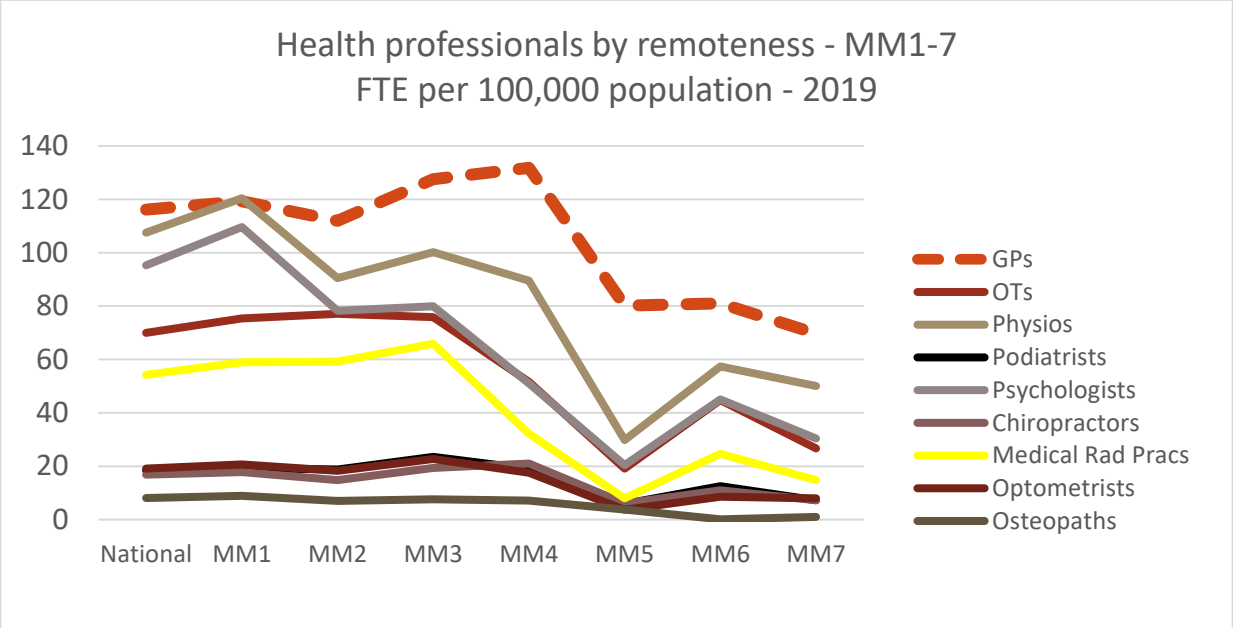
- ***Apply an equity lens – that all Australians are enabled to make informed decisions about their health irrespective of background or personal circumstance ….***

National statistics mask internal disparities (for example, the approximate decade average lifespan gap of Aboriginal and Torres Strait Islander people compared with non-Indigenous Australians and the lower life expectancy of people living in more remote Australia. The consultation paper rightly focuses considerable attention on these issues and many of the diverse factors that contribute to them.

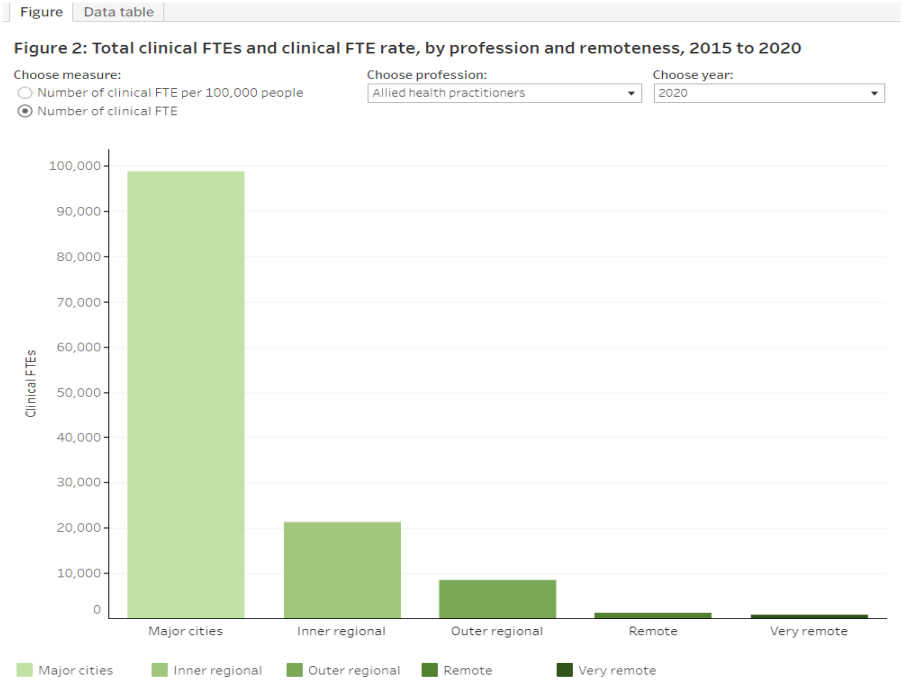
Detailed analysis of discrepancies in health outcomes and incidents (e.g., avoidable hopsitalisations), service access, service type, cost, workforce etc is essential. It will also inform policy and program development to enable more effective and efficient service provision: again, informed by and contributing to individual and systemic health literacy.

Considerable data exists to help identify areas for priority action (e.g., variations in services accessed - MBS, PBS, the ACSQHC Health Atlas and more), which also provide a basis for monitoring and evaluation.

From SARRAHs perspective health workforce distribution is a major factor impacting access and outcomes – with close correlations between relative workforce shortages and poorer outcomes. The following graph illustrates the extent of the problem for a range of health professions.



The extent of allied health mal-distribution is also evident in information held on the Commonwealth Department of Health's website and other sources, such as the AIHW, as illustrated in the following graph.



Source: https://www.aihw.gov.au/reports/workforce/health-workforce#overview. Extracted 29 September 2022

A great deal of information has been produced about the factors that contribute to the attraction and retention of health professionals in rural and remote Australia[6]. Unfortunately, despite repeated calls for a national allied health workforce plan over many years, there is none.

Essentially, people are more likely to use the service available to them, whether they provide the best mix of services (objectively) to meet their needs / maintain good health or not. If workforce and service capacity is lacking so too is choice and control.

The general point is also supported by the evidence reported in the *National Action Plan Health Literacy Promoting health literacy in Germany* (pages 24-25):

> *Type and extent of use of the healthcare system*
> *There is also a link between the level of health literacy and the use of the healthcare system. People with limited health literacy use the curative healthcare system more often, but use the prevention offers less often.*
> - *Almost every third person with limited health literacy reports frequent visits to the doctor. This is only the case for 4 per cent of respondents with excellent health literacy. Emergency medical services and the emergency room are also more frequently used by those with limited health literacy.*
> - *Clear differences exist for hospital stays: While less than 10 per cent of respondents with very good health literacy were admitted to the hospital during the previous year, this applied to almost 40 per cent of respondents with inadequate health literacy.*

- ***Address cultural and linguistic diversity***

SARRAH strongly supports this being a priority.

[6] For instance, see https://sarrah.org.au/our-work/policy-and-strategy/publications/138-strategies-for-increasing-allied-health-recruitment-and-retention-in-rural-australia

- ***Be people and community centred***

Strongly supported. This approach should fundamentally enable /facilitate communities to identify and advocate on their own behalf, from a position of informed health literacy. Community enablement is a crucial component. To cite the quoted organisation in the consultation paper "The onus is on us to make sure that we're providing opportunities in ways that people can access."

We heard of the need to leverage and build on these assets and strengths to develop locally and contextually relevant health literacy solutions. We agree.

- ***Address needs across the life-course - individuals will have different skills and needs in health literacy, and that a person's health literacy at each stage of life affects health and health literacy at other stages***

Strongly agree. To reiterate a point made earlier, the NHLS should encompass and facilitate peoples' capacity to manage their health and wellbeing through appropriate preventive action across each stage of their life.

- This should include the full range of health services pertinent to the populations' needs at whatever life stage – e.g., from the timely access to diagnostic and therapeutic services of early child development through to the enabling therapies that support continuing cognitive and functional capacity and, in the event of illness or injury, recovery.

- ***Be evidence-based - Rigorous, relevant and current evidence must inform health literacy actions and best practice***

Strongly agree. Again, to reiterate a point regarding the evidence base: This will be facilitated if the evidence upon which policy and systems are based are not only rigorous, but inclusive of the full range of viable service / therapy options and that research is considered and supported from across a spectrum of approaches and disciplines (i.e. to illustrate, evidence that is drawn from practice and research related to surgical interventions, but not considerate of alternative approaches to treatment (e.g. allied health therapies) will "evidence" accordingly.

The evidence base should promote options based on clinical evidence and across a range of professions/ approaches / therapies – rather than a hierarchy of considerations that for many might be summarised as

a) what can I access?
b) what is funded / what can I afford? and
c) what's best for me?

While these issues are inevitably complex and varied, the NHLS should help people navigate those questions and the options available/are available optimally across the health system.

- *Be practical and implementable -*

This criterion is important to ensure progress is made, but it should not be used as a rationale for inaction or lack of investment in approaches that detailed and rigorous analysis indicate are viable and considered effective in achieving the objectives of the NHLF and related priority reforms.

Are the aims the right ones for achieving the vision of the National Health Literacy Strategy? (See pages 10-13)

- *Aim 1 - Systems, policies and practices within and across sectors support an effective health literacy environment*

This is essential. Fully supported.

An aspect for further consideration in developing the NHLS relates to improving the awareness of skills, scopes of practice, efficacy of clinical care between and across health professions and system sectors, especially through the promotion of multi-disciplinary teams-based models of care (with funding and other supports aligned to this) and arrangements to promote continuity of care.

- *Aim 2 - All Australians can access health information that is easy to understand, trustworthy and culturally appropriate*

Fully supported. Information needs to be available from a range of reputable sources.

- *Aim 3 - All Australians have the skills to find and use reliable health information across the varied media they use*

Fully supported.

Do you have any example actions that could be considered under each aim? (See page 11,13 &14)

Are the categories for the leaders and partners who will mobilise health literacy action appropriate? (See page 14)

Not at this stage. We would be happy to contribute as the work progresses.

We note the Advisory Team for the National Health Literacy Strategy includes representatives from the Australian Commission on Safety and Quality in Health Care, Consumers Health Forum of Australia, Federation of Ethnic Community Councils of Australia, Healthdirect Australia, National Aboriginal Community Controlled Organisation, NPS MedicineWise, Royal Australian College of General Practitioners and Western Sydney Local Health District. SARRAH suggests that the Advisory Team be expanded to include other health professional expertise, notably allied health, and further representation from stakeholders with specific rural expertise.

If you would like to discuss issues raised in SARRAHs response or require further information, please contact me at catherine@sarrah.org.au or Allan Groth at allan@sarrah.org.au. More information about SARRAH is available on our website.

Yours Sincerely

Cath Maloney
Chief Executive Officer