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Services for Australian
Rural and Remote Allied Health

Feedback to the Department of Health

on a

Review of Medicare Locals

December 2013

INTRODUCTION

Services for Australian Rural and Remote Allied Health (SARRAH), welcomes the opportunity to provide input into the review of Medicare Locals.

SARRAH is nationally recognised as the 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: Audiology, Dietetics, Exercise Physiology, 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 people residing in rural and remote Australian communities. Allied health professionals are critical in the management of their clients' health needs, particularly for those with chronic disease and complex care needs.

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. It is noteworthy that in many smaller and more remote communities, people in need of primary health care (PHC) are reliant on nursing and health services because of workforce gaps. If these health professionals are well supported, 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' PHC and wellbeing. It is the government's responsibility to ensure the provision of this care.

GENERAL COMMENTS

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. 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 and consequently SARRAH supports the retention of Medicare Locals. However, to ensure that the delivery of PHC services across rural and remote Australia meets the needs of local communities, SARRAH strongly supports the following principles:

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.

RESPONSES AGAINST THE TERMS OF REFERENCE

The role of Medicare Locals and their performance against stated objectives.

- Medicare Locals should produce periodic public reports on their performance against key performance indicators. For example, a one page summary published every six months.
- In a Senate Community Affairs Reference Committee report titled *The factors affecting the supply of health services and medical professionals in rural areas – August 2012*, recommendation 18 states that:
'the Department of Health and Ageing prepare a brief for COAG's Standing Council on Health on existing or emerging gaps affecting the delivery of health services to rural and remote communities caused by mis-alignment between Commonwealth and state policy, including options for measures to remediate such gaps. The brief is to be based on engagement with relevant stakeholders, including state and territory governments, Medicare Locals, representatives of peak bodies such as RDAA, SARRAH and NRHA at both national and state level, and to be provided on at least a bi-annual basis'.
 SARRAH strongly supports the implementation of this recommendation.
- Another report released on 24 May 2013 titled *The Mason Review of Australian Government Health Workforce Programs*, recommendation 8.8 states that:
 ...'the Commonwealth should consider providing seed funding to establish allied health networks and professional hubs in rural areas. This would assist in peer support, ensuring adequate supervision of students and new practitioners, and access to continuing professional development. This is essential to ensure service delivery is based on contemporary practice and is more sustainable (particularly in the private sector). Innovative methods of communication and activities such as telehealth, online training and assistance to develop new professional support networks could be funded through this approach'.
 SARRAH also strongly supports the implementation of this recommendation.
- The lack of national and local workforce data on allied health makes it difficult for Medicare Locals to plan, deliver and measure the success of meeting the PHC needs of their communities. Government funding of a national workforce data base is therefore an urgent priority.
- Medicare Locals with rural and remote geographical coverage need to be supported and monitored to ensure that more remote, smaller communities are receiving adequate PHC services which meet local community needs.

The performance of Medicare Locals in administering existing programmes, including after-hours.

- Our comments above on public reporting equally apply to this criterion.
- Medicare Locals should consider increasing their use of technology such as on-line/videoconferencing in administering and evaluating programmes as well as for staff training. This is important for remote regions where travel is costly and time consuming, resulting in a further reduction of available service delivery providers which is already impacted by remoteness.

- The government, as a matter of urgency, must improve internet coverage in rural and remote Australia, specifically by prioritising health services in the roll-out of the National Broadband Network.

Recognising general practice as the cornerstone of primary care in the functions and governance of Medicare Locals.

- The PHC team includes a mix of health practitioners including allied health, Aboriginal health workers and nursing alongside general practice. Medicare Locals must support and have a clear and functional understanding of this principle – it is critical to well-coordinated, multi-disciplinary health professional teams which are the optimal means of providing effective PHC services to local communities.
- Medicare Local governance structures must include community members with skills that consider the broad needs of the region. For example, an understanding of remoteness and associated effects on health service delivery, Indigenous health and cultural considerations etc.

Ensuring Commonwealth funding supports clinical services, rather than administration.

- The key focus must be to provide clinical services across Medicare Local regions, delivered by local established public and private sector practitioners as well as support for new service providers to assist in filling service gaps.
- The government in consultation with Medicare Locals should establish a benchmark setting of a ratio for the number of clinicians delivering services measured against the number of program administrators. Ratios will vary between Medicare Locals depending on their geographical coverage for example; a Medicare Local whose geographical coverage is remote will incur higher costs in administering and delivering PHC services as compared to a metropolitan Medicare Local. Consequently, the remoteness of a Medicare Local region and service delivery barriers must be considered to achieve equitable PHC services.
- It must be recognised that rural and remote PHC service arrangements present unique challenges to the delivery of sustainable, cost-efficient health services. For example, the rural PHC service model is often complex and/or cobbled-together, comprising a combination of different providers including local, visiting and 'virtual' via tele-health. Consequently, Medicare Locals must invest in service planning, coordination and case management which are critical to the provision of efficient, effective clinical PHC services in rural settings.
- Medicare Locals must engage and develop partnerships with the local Aboriginal Community Controlled Health Service and other government health agencies to deliver PHC services to Indigenous communities.

Assessing processes for determining market failure and services intervention, so existing clinical services are not disrupted or discouraged.

- The economic sustainability of local rural and remote communities is a major factor in market failure and the type of service intervention available such fly-in fly-out or drive-in drive-out PHC services.
- A whole of government approach is required to address the social health determinants in rural and remote communities such as the availability of education, employment, health, housing, transport and other community facilities which are readily available in metropolitan and larger regional centres.
- Special consideration and support must be given to existing private sector service providers delivering PHC services to people in rural and remote communities. Helpful measures include subsidies for commercial leases or providing consulting rooms/clinics in district hospitals or community health centres.
- Cultural differences must also be considered in an assessment framework. It is also important that any assessment framework considers what is working well, enabling ongoing national learning to occur.

Evaluating the practical interaction with Local Hospital Networks and health services, including boundaries.

- Our previous comments on public reporting equally apply to this criterion.
- Strong partnerships between local networks are critical in maximising health and wellbeing outcomes for local communities and reducing duplication. Evaluating these partnerships periodically is vital to ensure strategic directions are relevant to local community requirements and meet changing operating environments.

Tendering and contracting arrangements.

- Medicare Locals should be required to report on the outcomes of tendering and contracting arrangements, in excess of specified dollar limits, as part of a public reporting framework. For example reporting should include details of service providers awarded a contract and the contract price.
- To assist in the sustainability of local health services in smaller communities, Medicare Locals may need to consider tendering and contracting arrangements with existing public and private sector services providers.

Any other related matters.

- Medicare Local service providers from the private sector appear to be concerned due to uncertain, variable and time consuming reporting requirements of Medicare Locals and ultimately the Commonwealth.
- Medicare Locals need greater clarity and surety from the Commonwealth to enhance their capacity to provide longer term PHC services within their regions and maximise efficiencies in delivering these services.
- The Commonwealth should consider introducing independent clinical governance audits of Medicare Local PHC services. For example audits of allied health services that are either provided or brokered by a Medicare Local to ensure that the service is managed efficiently and effectively to deliver the best outcome for the local health consumer.

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 on-going operation of Medicare Locals.