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Australian Journal of Rural Health

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Submission to the

Australian Government

TOWARDS A NATIONAL PRIMARY HEALTH CARE STRATEGY

February 2009

This Submission is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies.

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EXECUTIVE SUMMARY

Definition and disclaimer

For the purposes of this submission the Alliance has adopted the same useage of the term 'primary health care' as in the Discussion Paper. At page 10 the Paper has: "*While many Australians may not recognise the term 'primary health care', it is a term used to refer to the parts of the health system that most people interact with most of the time* (sic). *For example, around 18 million Australians see a GP and at least once a year."*

The Alliance has an interest in the complete social, economic and environmental system which impacts on health outcomes, including importantly such things as education, income, transport, housing and culture. This supports the international definition of 'primary health care' which is in contrast to the one used in the Discussion Paper - one that is much broader and includes those determinants of health which do not lie within the health system.

Some constituents of the Alliance maintain a very clear distinction between broad 'primary health care' and 'primary care' and by the latter they mean care provided from within the health system (ie by a healthcare professional) in a setting which provides the first interaction between practitioner and patient on a particular health-related issue. This definition of 'primary care' excludes care provided in a hospital or other acute setting. Such an approach sees 'primary care' and 'acute and tertiary care' as important parts of a holistic 'primary health care' system - along with education, community and economic development, health-design aspects of work places, homes and suburbs, health promotion campaigns, and much more.

It will be those people within the Alliance, and further afield, who subscribe to this alternative view who will object (and, in some instances, have objected) to the practice adopted by the Alliance for this submission of using the term 'primary health care' to mean initial contact between a patient and a health professional.

A national system for primary health care

Overall, the health of Australians deteriorates with increasing remoteness, and at the same time their exposure to health risk factors becomes greater. On average, rural and remote (hereinafter 'rural') Australians are older and experience a higher incidence of chronic illness and disability. They are also poorer than their metropolitan cousins, are confronted by higher levels of health risk factors, and have less access to primary, specialist and tertiary health care than do Australians living in major cities.

The current system of primary health care is a complex of plans, programs and streams of activity, often with a lack of continuity and information exchange for the individual patient. A new national primary health care strategy would therefore be welcomed and has the capacity to improve transparency, information flows, continuity of care and health outcomes.

Such a national strategy would:

- establish standards and protocols to enable the collection and management of patient information;

- promulgate best practice nationally in governance, engagement with community, health promotion, chronic disease and the prioritisation of population health groups (eg early childhood);
- ensure that Commonwealth-funded primary care services (GPs, Aboriginal Medical Services) and the suite of Commonwealth-funded primary care programs (eg MPSs, RHSs) are closely integrated;
- support moves towards equity in resource allocation at the regional level (allowing for rurality and health need, as proposed in the Interim Report of the NHHRC);
- support work towards the development of an appropriately trained and equitably distributed health workforce;
- inform and support investment in appropriate health infrastructure;
- help integrate the primary health care system with the acute care and community welfare and related systems; and
- improve the public reporting of health system performance against nationally-agreed indicators.

A National Rural Health Plan

A new national primary health care strategy would be developed in conjunction with a national strategy for health, such as may emerge from the work of the NHHRC. Within this national strategy there should be a National Rural Health Plan, building on the principles and goals of Healthy Horizons.

The National Rural Health Plan would include specific strategies and targets, and would help lead to:

- the distribution of health service resources on the basis of health need, within a system that includes both private (fee-for-service) and public provision of services;
- needs-based funding that takes account of those with special needs, including Aboriginal and Torres Strait Islander people, the aged and those with mental health conditions;
- health policies and programs that take account of the particular characteristics of rural health services, such as greater reliance on general practice for emergency and procedural services, and the added costs of seeking and providing service in rural and remote areas;
- an equitable share of health professionals being available in rural and remote areas;
- the development of electronic patient records, the provision of e-health case conferencing and specialist services; and
- access to primary health care services for everyone, irrespective of their location.

Regional action

The Alliance advocates the establishment of regional health plans and regional bodies to engage local stakeholders and the community, to develop plans and priorities, and to build and deliver integrated health care capabilities.

The objectives and benefits of a regional approach include the capacity for community engagement, for providing a basis for better coordination and integration of services, for working towards equity in resource allocation and for performance accountabilities.

Improved accessibility and affordability of services

A new national primary health care system, with a focus on regional planning and delivery, would support moves towards:

- a demand-driven rather than supply-driven model of health service delivery in rural Australia;
- primary health care teams with a multidisciplinary scope and composition;
- reaching out actively to under-serviced groups in the community;
- the integration of primary health care services; and
- coordination of primary care with other sectors (acute, tertiary).

There would be action within a national primary health care strategy to:

- identify areas of funding deficit due to lower access to MBS and program-allocated health funding, and to develop a plan to cover for or compensate for these deficits;
- conduct an audit of the geographic areas of greatest need and quantify the levels of further infrastructure investment required (including in implementation of e-health support);
- focus on preventative health work;
- move towards universal access to integrated care for chronic disease, including patient pathways appropriate at the regional level;
- reach Commonwealth/State agreement on shared responsibility for infrastructure funding where both primary care and other health services are co-located;
- ensure that, wherever practicable, allied health services are available in the local community and, preferably, are co-located with general practice and other services; and
- evaluate and promulgate well-designed and well-performing models of primary health care service, especially in so-called 'hard to staff' areas and for hard-to-reach groups.

Other parts of the new national strategy would be cognisant of the need for:

- further actions to bring bulk-billing rates in rural areas up to national standards;
- enhancing access to Medicare, especially where GPs are in short supply;
- incentives for active outreach by health services to under-serviced groups;
- reinvestment in rural maternity services; and
- the potential value of primary healthcare outreach, such as a visiting dentist scheme.

Safe, high quality care

Safety and quality in rural areas should be protected through:

- performance monitoring and reporting in areas of higher risk illness and treatment, such as for cancer screening, cancer survival rates, infant mortality, management of cardiovascular disease, and continuity of care plans for hospital discharge, diabetes, asthma etc;

- investment in clinical training and vocational placements in rural Australia, including in the clinical infrastructure, and in clinical trainers, to ensure placements are of the highest quality;

- high quality support for IMGs, including initial training and ongoing professional development and training pathways equivalent to those offered to Australian trained doctors, and a case management approach to orientation and support in settling IMGs and their families into the community in which they are working;

- good emergency retrieval and emergency care procedures; and

- reinvestment in maternity services.

Workforce development and distribution

A new national primary health care strategy would take a comprehensive approach to helping to resolve health workforce shortages in rural Australia. Key requirements include:

- a system for assessing the required composition of the health workforce, including the range of allied health professionals needed to combat the major burdens of disease;
- a benchmarking approach (ie checking on ratios of numbers of staff to patients) to highlight the shortages, taking account of the distances and number of communities that single practitioners often have to serve;
- the particular staffing needs in mental health, dental health and maternity services;
- an equitable approach to systems of incentives (eg scholarships and support programs) across the spectrum of health professions;
- recognition of the importance of high quality rural training and clinical placements in attracting professionals to rural Australia;
- promotion of both vertically integrated and multi-disciplinary training pathways;
- building on the expertise of rural health professionals in training the next generation and increasing the number and remuneration levels of joint academic/clinical health positions in rural and remote areas, providing support to health science students, new graduates and local practitioners;
- recognition of the greater scope of practice and the importance of the generalist in rural Australia, for example the procedural, emergency and obstetrics services provided by GPs;
- recognition of the value of the rural hospital to many people in the health workforce and as the location of the bulk of the training for a number of health professions;
- recognition of the position of health service manager in rural and remote areas as a specialist area of management;
- enhancing support programs for IMGs; and
- recognition of the importance of career development to health professionals and providing the peer support and substantial opportunities for continuing professional development in rural areas.

Remuneration and working conditions for health professionals in rural areas must be competitive with those on offer in the major cities. Larger general practices and regional health service type facilities offer the basic structure on which to develop:

- good practice management and patient support infrastructure;
- team-based practice, offering peer support and better work/professional development balance;
- clinical training facilities;
- flexibility in remuneration and commercial arrangements (eg ‘easy entry, graceful exit’); and
- wider recognition of professions under-represented in Australia such as nurse practitioners.

Additional investment in infrastructure will be required to deliver on this potential.

INTRODUCTION

The National Rural Health Alliance (the Alliance) is the peak non-government body concerned with rural and remote health issues in Australia. It comprises 28 Member Bodies, each a national body in its own right, representing health professionals, service providers, consumers, educators and researchers. (A list of Alliance Members is at Attachment 1.)

The Alliance is dedicated to the view, enunciated in Healthy Horizons 2003-2007, that:

> *"People in rural, regional and remote Australia will be as healthy as other Australians and have the skills and capacity to maintain healthy communities."*

Among other things, this means:

- people being involved in decisions about their own health, their local health services, and social and economic developments that may affect their health;
- agencies informing people of risks and benefits to health and the actions which individuals, communities and other agencies can take to maintain and improve health;
- community members, health professionals and others who work in rural, regional and remote communities working together to determine priorities for local action; and
- improvements in health and social wellbeing for rural, regional and remote communities being sustained as people and issues change.

The Alliance welcomes and supports the Government's initiative to consider a national primary health care strategy. People in rural Australia, including Aboriginal and Torres Strait Islander peoples, have much to gain from a system that will deliver better health outcomes and illness prevention in their local community and reduce the need for complex acute interventions.

The health status of rural and remote Australians is substantially lower than that of people who live in metropolitan areas. Overall, the health of Australians deteriorates with increasing remoteness, and at the same time their exposure to health risk factors becomes greater.[1] On average, rural and remote (hereinafter 'rural') Australians are older and experience a higher incidence of chronic illness and disability. They are also poorer than their metropolitan cousins, are confronted by higher levels of health risk factors, and have less access to primary, specialist and tertiary health care than Australians living in major cities.

For these reasons, the ten elements of primary health care indentified in the paper, and especially the cross-cutting themes of greater equity in access to services and healthy outcomes, and of more transparent accountabilities for performance and outcomes, are principles the Alliance supports as goals of primary health care for people in rural Australia.

No health and wellbeing issue in Australia is worse or more urgent than the impoverishment and appalling health status of Indigenous people. Most indicators for poor health are worse for Indigenous Australians. Holistic 'primary health care'[2], in all its dimensions, including housing, education and employment, early childhood development and cultural respect, should form a major plank of the Government's *Closing the Gap* strategies and the challenges faced by Aboriginal and Torres Strait Islander peoples should command a high priority.

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[1] AIHW (2005), *Rural, regional and remote health – indicators of health*, Canberra, May 2005; cat. no. PHE 59.
[2] the other sort!

Scope of primary health care

The Discussion Paper cites the definition of *primary health care* offered by the Australian Institute of Primary Health Care, which includes:

- collaboration with other related sectors such as education and housing;
- maximising community and individual self-reliance and participation;
- advocacy (for patients and families in and beyond the health sector); and
- community development.

The Alliance considers that these broader definitions have great value as a guide to ways in which the health of individuals may be strengthened through broader societal and government initiatives and where the health system itself may seek over time to develop intersectoral collaboration in the interests of achieving better health outcomes. This broader focus is particularly valuable in seeking to improve equity in health outcomes for Aboriginal and Torres Strait Islander peoples and for other lower socio-economic groups.

Nevertheless, for the purposes of this submission the Alliance has adopted the same useage of the term 'primary health care' as in the Discussion Paper.

HEALTH STATUS AND DETERMINANTS IN RURAL AUSTRALIA

Health status

In its March 2008 publication, *Rural, regional and remote health: Indicators of health status and determinants of health*, the Australian Institute of Health and Welfare provides a detailed picture of the health conditions of people outside Australia's Major Cities. It reported conditions of populations in Inner Regional, Outer Regional and Remote/Very Remote areas compared to their counterparts in Major Cities in areas as follows:

- 1.2 times the reported rate of fair to poor health;
- 1.1 times the level of mortality;
- females having 1.3 times the rate of diabetes;
- males and females were 1.3 and 1.2 times respectively more likely to report having arthritis;
- 1.1 the rate of cancer;
- 1.1 to 1.2 times the rate of perinatal deaths;
- for both females and males, 1.1 times the level of overweight and obesity; and
- males having 1.2 to 1.4 times the rates of smoking, 1.2 to 1.4 times risky alcohol consumption (for males in outer regional areas 1.2 times the likelihood to engage in risky behaviour while intoxicated), and 1.2 times the rate of injury and disability conditions.

In addition to the higher overall burden of disease, Australians outside the major capital cities also have to contend with:

- lower overall socio-economic status, a major determinant at the population level of health outcomes; and
- lower levels of access to GPs, specialists, dentists and allied health professionals.

Maldistribution of health professionals

General Practitioners

The AIHW survey of Medical Labour Force changes from 2002 to 2006 indicates that the investment in national medical workforce training and distribution initiatives is serving to increase rural access to medical practitioners, as shown in the following table. In overall terms, however, the geographical skew of the distribution of employed medical practitioners is in fact increasing, with greater increases of health professionals per 100,000 population in metropolitan areas than in Inner and Outer Regional areas.

AREA	Total Medical Workforce per 100,000		Growth Rate in Employed Medical Practitioners	Employed Primary Care Clinicians FTE per 100,000		Employed Hospital non-specialists FTE per 100,000		Specialists/ in training FTE per 100,000	
	2002	2006		2002	2006	2002	2006	2002	2006
Metro	312	332	18.5%	105	98	29	39	154	170
Inner Regional	176	184	8.3%	90	87	14	18	65	71
Outer Regional	146	154	4.9%	80	86	15	15	43	45
Remote, Very Remote	140	191	31.2%	89	108	22	34	21	35
Overall Clinicians	271 252	290 272		101	97				

Note: AIHW urges care in interpreting 2006 data for Remote/Very Remote because of few numbers responding to survey.

The AIHW survey also found that hours of work by primary care clinicians were 2.6 hours more in Inner Regional, 6.1 hours more in Outer Regional and 10.3 hours more in Remote/Very Remote, compared to their metropolitan counterparts. (Rural and remote clinicians are also likely to spend more time on call.) Thus it is clear that primary health care practitioners in rural Australia work longer hours and have a broader range of demands for their services – factors that will need to be allowed for in a national strategy.

Psychologists

The National Allied Health Workforce Report 2004 (Services for Australian Rural and Remote Allied Health, p 10) showed that 20.5 per cent of practising psychologists were reported as working in rural and remote regions. This equates to 0.83 psychologists per 10,000 head of population in very remote areas and 3.44 in Inner Regional centres, compared with 5.92 per 10,000 in Major Cities. The rural sector tended to attract the youngest and hence least experienced health professionals. Although data are scarce, there would appear to be few Indigenous people working as psychologists, regardless of whether or not they are located in rural areas.

Dental Labour Force

The AIHW study, *Geographic Distribution of the Australian Dental Labour Force, 2003*, reported a better distribution of dental therapists in regional, rural and remote Australia, but far worse distribution of dentists and dental hygienists. Taking Outer Regional Australia as a

yardstick, dentists per 100,000 population were 27.7 compared to 57.6 in Major Cities, while there were 1.1 dental hygienists, compared to 3.8 per 100,000 in Major Cities.

Nurses

The AIHW Survey shows that nurses are relatively evenly distributed across metropolitan, regional, rural and remote areas. In contrast to medical practitioners, dentists and psychologists, nurses are more likely to be in salaried employment, suggesting some merit in this approach to providing health professionals in areas of need. A new national primary health care strategy could learn from why nurses are in rural and remote areas and the circumstances in which they stay and leave.

Allied Health Professionals

There is a large diversity in the size of the various professional disciplines that comprise the allied health professional workforce in Australia. In 2001 there were four broad groups according to size:

- physiotherapy, social work, psychology and radiography recorded a workforce between 8,000-11,000;
- occupational therapy and speech pathology had workforces between 3,000-6,000;
- dietetics and podiatry were between 1500-2000; and
- orthoptics, audiology and prosthetics had workforces of under 1000 professionals.

Overall, allied health professionals in 2001 comprised some 18 per cent of the health workforce.

The table below, from the National Allied Health Workforce report, June 2004, based on 2001 census figures, shows the general decrease in numbers of allied health professionals across the disciplines covered in this report available to populations living in the regions away from the major centres. The more remote the region the lower the number of allied health professionals available – indicating a reduction in access to the services provided by these professionals in the more rural and remote regions of Australia. For all disciplines the availability in Major Cities is higher than the Australian average.

Number of allied health professionals by profession across the ASGC Remoteness regions
by 10,000 head of population in region

Allied Health Profession	Average	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote
Audiology	**0.42**	0.51	0.33	0.12	0.18	0.00
Dietetics	**1.05**	1.21	0.78	0.76	0.61	0.59
Hospital pharmacy	**0.90**	1.09	0.62	0.48	0.18	0.15
Medical Imaging	**4.39**	5.05	3.62	2.52	2.02	0.78
Occupational therapy	**2.82**	3.19	2.31	1.86	1.37	1.42
Orthoptics	**0.23**	0.31	0.12	0.03	0.00	0.00
Orthotics/prosthetics	**0.19**	0.23	0.14	0.06	0.00	0.00
Physiotherapy	**5.41**	6.14	4.35	3.58	3.65	1.57
Podiatry	**0.92**	1.06	0.78	0.53	0.44	0.00
Psychology	**4.91**	5.92	3.44	2.43	1.87	0.83
Social work	**4.80**	5.45	3.85	3.36	2.51	1.27
Speech Pathology	**1.59**	1.73	1.42	1.16	1.23	0.59
Average:	**2.30**	**2.66**	**1.81**	**1.41**	**1.17**	**0.60**

National Allied Health Workforce report, June 2004

With trends to more multidisciplinary models of care and focus on priorities such as early childhood, preventive health and care for people with chronic disease, the number and distribution of allied health professionals is becoming an increasingly significant issue.

STRATEGIES RELEVANT TO RURAL AUSTRALIA

The key concern of the Alliance is to ensure that a national primary health care strategy clearly recognises the particular needs and differences of rural Australia. To do this it must include appropriate regional and community measures to provide equity in access, effectiveness, quality and safety and, ultimately, health outcomes at rural community and individual levels.

A national system for primary health care

The Alliance considers that a system for primary health care has to be fully national in character, bringing together primary health care services provided or funded by all levels of government. A national primary care system, provided that it is well connected with other levels of health care, is crucial in meeting the increasingly complex health service expectations of Australians.

The primary health care system (as defined) is at the centre of the overall health system, generally being the first point of contact for people and the key to referrals to and from other parts of the health system. It is also the place in which preventative health and early intervention can be best provided, so reducing the onset of more complex and acute conditions.

The barriers to a systems approach to primary health care include:

- Commonwealth-State splits in responsibilities;
- the mix of public and private decisions on the location and scope of service and on costs of access by the patient/consumer;
- inter-professional demarcations on scope of practice;
- the vagaries of uncapped and capped resources for services;
- application-based and time-limited program funding, rather than planned and universal resource allocation based on need; and
- the lack of national standards and protocols for information collection and data transfer.

Current investments in strategic primary health care frameworks

As noted in the Discussion Paper, a number of States have already taken significant steps in building more strategic and integrated primary health care systems, and most States also have in place specific Rural Health Plans or Strategies that recognise the particular stresses on rural health services and the need for best use of scarce and highly valued resources. Invariably, these strategies and plans include the objectives proposed by the Discussion Paper, including planning of community health needs, increasing integration of services, a greater focus on prevention, development of patient pathways, promulgating best practice in tackling chronic disease including through patient engagement, ensuring safety and quality and increasing transparency and accountability.

For its part, the Commonwealth has sought to broaden the scope and the multidisciplinary nature of general practice through enabling MBS-funded referrals by GPs to allied health (eg podiatrists, psychologists, dieticians, dentists) through general programs such as Better Access to Mental Health services and through funding for practice nurses. The Commonwealth has also sought enhanced multidisciplinary care in rural areas through programs such as More Allied Health Services and mental health services.

There has also been substantial collaboration at the national level. Australian Health Ministers and/or COAG have combined in:

- setting strategic directions and priorities through the National Mental Health Plans;
- agreeing on a National Chronic Disease Strategy to manage and improve chronic disease prevention and care, and developing National Service Improvement Frameworks for the national health priorities of asthma, cancer, diabetes, heart, stroke and vascular disease and arthritis. Inevitably, this Chronic Disease Strategy and its components also share common objectives with the stated objectives for primary health care in general;
- improving access to health services in rural areas through joint funding of Regional Health Services and Multi-Purpose Services;
- initiatives agreed at COAG such as providing access to MBS funded services in State services where no general practitioner is available.

Despite this investment across the nation, the levels of service and less than optimal outcomes, for example in management of chronic disease, suggest that what has been done so far has been insufficient and has lacked a systems focus.

The Alliance recognises that a National Primary Health Care Plan will not be easily achieved and will require major culture change. To maintain momentum and speed the process, such a Plan should build on existing investments and experiences rather than begin from scratch.

A National Rural Health Plan

A National Rural Health Plan would provide an agreed framework for the delivery of health services to rural and remote areas, set agreed benchmarks and targets, and allow for more open scrutiny and tracking of progress toward agreed goals. It would incorporate in its scope goals and strategies from other areas, such as the Australian Government's national health priorities and agreed plans for Indigenous health, mental health and preventative health targets – as well as from the primary health care strategy.

The Rural Health Plan should be a specific subset of a national health framework rather than a stand-alone entity, in order to recognise that rural health services provision must be integrated with overall national health service provision.

The most fundamental issues that the Alliance would wish to be reflected in a rural subset of a national planning and performance framework would include the following:

- that the overall distribution of health services resources be dictated by health care needs, while allowing for both private fee-for-service and public provision of services;
- that needs-based funding take account of those with special needs, including Aboriginal and Torres Strait Islander people, the aged and those with mental health conditions;
- that policies and programs generally should take account of differences in the provision of rural health services, such as greater reliance on general practice for emergency and procedural services, and the added costs of seeking and providing service in rural and remote areas;
- that particular attention be given to attracting an equitable share of health care professionals to rural and remote areas;
- policies and undertakings be made to allow access to basic primary care services for everyone, irrespective of their location; and that
- more general national health policies and programs do not inadvertently discriminate against people and services in rural Australia.

The Alliance would welcome the opportunity to participate in the development of more detailed work on priorities for attention, a work program, specific targets and performance measures that a national rural health plan would include.

Regional action

While high level leadership will come from Australian and State and Territory Governments in partnership, action must occur where people live. The Alliance considers that the key to building an integrated health care system lies in the approach taken in the Discussion Paper to build

> "*Flexibility to best respond to local community needs and circumstances through sustainable and efficient operational models" (Objective 7).*

The Discussion Paper goes on to raise questions on regional organisational structures with responsibilities for planning, possibly funds holding, through to service delivery and for mechanisms to engage local communities and to improve accountability for primary health cares services.

The Alliance advocates the establishment of regional health plans and regional bodies to engage local stakeholders and the community, to develop plans and priorities, to build and deliver integrated health care capabilities and to provide a framework for local performance for results. There are several objectives and benefits deriving from a regional approach.

Community engagement

With the diversity of communities across Australia, planning at any level will require understanding of the locality in which services are to be provided. Each area of Australia has its differences, relevant to such planning. It is for this reason that the Healthy Horizons Framework includes among its principles:

- *community capacity,* including the social capital and physical capacity for a community to identify, develop and implement local programs to improve and maintain their health; and
- *community participation,* focusing on systematic approaches to enable individuals, communities and special groups to identify priorities, access information, participate in planning and provide feedback on progress.

Especially in rural areas where the numbers of health professionals are few and their hours of work greater, community awareness and cross-sectoral engagement are crucial to healthy outcomes and to building a healthy environment and a resilient community. This engagement will include local government, education, housing, and the community and recreational service sectors.

An ultimate objective would be to put in place a regional governance and planning framework to deliver on these principles and to ensure service coordination, integration and performance monitoring and review at a meaningful level.

Equity in resource allocation

Data on access to MBS-funded services in rural Australia are not publicly available. However with a wide disparity in MBS outlays per capita at the State level, wide and growing disparities in the numbers of employed medical practitioners between metropolitan and regional areas, and lower rural levels of access to bulk billing, it is clear that people in rural Australia do not enjoy anything like equity of access to Commonwealth-funded primary care services. The Alliance considers that regional allocation of resources, to better align service levels with the needs of the regional population, is an essential measure in improving equity in access and ultimately in health outcomes.

One particular approach to regional allocation would be to progressively provide funds to those areas clearly underserved through MBS outlays, to enable them to build compensating systems capacity to be able to attract GPs in the future and/or through employment of other health professions. GPs are central to primary health care in rural (but not so much remote) Australia, especially given that their scope of practice and essential community roles extend in many cases to maternity, procedural and emergency services. Maintenance of reasonable assurance of practice viability is vital to attraction and retention of medical practitioners to rural Australia, and approaches to regional allocation and fundholding should not be such as to deter GPs taking up positions in rural Australia.

Another step to achieve better equity in allocation would be to replace the range of Commonwealth-funded programs, currently allocated through grants or contracts, which

necessarily means choosing among competing areas, with a system of equitable allocation of funds to all regions. By way of example, as a basic principle of equity for consumers, if the Australian Primary Care Collaboratives program is effective in increasing the quality of care, then after its piloting it should be quickly rolled out to all Australian general practices and not confined to a thousand or so of the 6000-plus general practices.

Integration and coordination

Integration and coordination of services can only be achieved at the local level, reflecting local service options including linkages with health services in major regional or urban areas. It is especially important for rural people that patient pathways be developed to reflect the reality of people having to travel for some health services, but also to have coordination of those services with the ongoing care required pre- and post-acute or specialist services.

Performance accountability

The Alliance strongly supports the National Health and Hospital Reform Commission (*Ending the Blame Game*) in its proposal to show, for all national performance measures, the rural and remote rates relative to the equivalent metropolitan rate. Some of the current Commonwealth funding is through a range of grant and contract programs where there is accountability to the Commonwealth managers of those programs but not to the public in those regions whose needs are intended to be met by the funding. Public performance accountability at the regional level would put accountability where it belongs.

Accessible services – objective 1

The Discussion Paper proposes that all Australians have access to required primary health care services that are clinically and culturally appropriate to their needs and circumstances and are delivered in a timely and affordable manner.

This objective is certainly a key issue in rural Australia, going to the question of what local communities can reasonably expect to be available locally, without the major disruptions to their lives and their families of having to outlay the time and money to seek out-of-area services. The Healthy Horizons framework includes access as one of its key principles, noting its intent "to allow the easiest possible access to the largest number of people, wherever it is clinically safe and viable to do so".

The essential components of a primary health care service in the local community should include general practice, with appropriate nursing support, the right mix of allied health services, proceduralist and emergency services and community-based preventive measures, as well as primary care outreach such as to dentists where primary care workforce cannot be attracted in the right numbers or mix.

Demand driven resource allocation

The recent proposal in the Interim Report of the Health and Hospitals Reform Commission to take a needs-based funding approach funding equivalent to "national average medical benefits and primary health care service funding, appropriately adjusted for remoteness and health status" would be a key step forward in achieving equity in access to services in rural Australia.

The key will be to translate that funding into effective services. A systematic review of the literature has shown that it is possible to describe some of the general characteristics of

services which will be sustainable and effective in communities of different sizes and types. Wakerman et al have argued that "the nature of population distribution is a critical factor in designing PHC services but [that] successful models address diseconomies of scale by aggregating a critical population mass, whether it is a discrete population in a country town or a dispersed population across a region. Based on current experience, it would appear that a minimum population base of about 5000 for rural and 2000 to 3000 people for remote communities supports an appropriate, sustainable range of PHC activities".

Several models of primary health care have been identified as appropriate for regional or rural Australia to improve or maintain local access to primary care, and have been well supported by Government financial provision. These include:

- the GP super clinic model for major regions, with substantial Commonwealth funding for infrastructure, engaging of allied health professionals and attracting GPs;

- enhancement by the Commonwealth of access to nursing and allied health services through specific funding to General Practices for practice nurses, mental health nurses and some allied health professionals;

- multi-purpose service and regional health service models, bringing together some Commonwealth and (in the case of MPSs) State Government funding to provide overall service viability, an expanded range of health professions and the scope for integration or coordination of services; another example of this is the Aboriginal Medical Service model providing a range of clinically appropriate services in one location; and

- outreach models, including hub and spoke, visiting and fly-in, fly-out, designed to ensure local primary care support for smaller or more dispersed rural communities.

Particular characteristics of these models include government and/or community funding to provide or enhance the infrastructure and or additional funding to support business viability, range of service, professional support, and multidisciplinary care. However, the initiatives have multiple purposes, funding levels, continuing Commonwealth-State barriers and quite complex program administrative and reporting requirements. The goal should be to move quickly to common goals and objectives for these models, and to provide accessibility for all Australians to these models according to the needs of the local community.

<u>Recommendation</u>

Within the context of a national primary health care system, and through regional planning, the Alliance considers that there is scope and opportunity to rationalise and systematise these initiatives to establish and deliver on some common objectives:

- adopt a demand-driven rather than supply-driven model of service development in rural Australia;
- enhance the multi-disciplinary scope and nature of primary health care teams;
- actively reach out to under-serviced groups in the community; and
- enhance integration across primary health care services and more broadly.

Specific actions would include:

- identify areas of funding deficit due to lower access to MBS and program-allocated health funding, and develop a medium term plan to fund those health service deficits;
- conduct an audit of areas of greatest need and quantify the levels of further infrastructure investment required (including in implementation of e-health support);
- reach Commonwealth/State agreement on shared responsibility for infrastructure funding where both primary care and other health services are collocated;
- wherever practicable, ensure that allied health services are available in the local community and preferably co-located with general practice and other services; and
- evaluate and promulgate well designed and well-performing primary health care models of service, especially in so-called 'hard to staff' areas.

Other approaches to improve accessibility

Equity in bulk-billing

Bulk-billing rates in rural areas are generally lower than the national and State averages. 2006 figures compared to 2005 figures also show a substantial increase, in all electorates, for levels of bulk-billing, indicating that the bulk billing incentives payable to GPs are effective. While there is a differential payment for GPs working in regional and rural areas, the differential has not yet been sufficient to achieve equity. Accountability for bulk-billing rates has also been insufficient, with no electorate data available since December 2006. Policies to ensure that bulk-billing is targeted to people most in need would contribute to this equity agenda.

Enhanced access to MBS

There is already a COAG initiative to allow access to MBS services provided in State-based facilities where there is no local GP. The Alliance recognises that access to MBS is not a panacea, and indeed can be counter-productive to equitable access for rural Australians if the required health professionals cannot be attracted to practise in areas of need. However, there is clear justification based on principles of universal access to extend this policy to other special circumstances, including:

- services provided by other health professions including mental health services, and nurse practitioner services *where there are no GPs;*
- services provided by nurses and allied health professionals for and on behalf of GPs where those health professionals are not otherwise supported by Commonwealth Government funding; and possibly
- e-consultations funded by Medicare where people live in remote areas and accessibility to an available GP is not timely.

Active reach to underserviced, high need groups

Access to primary care is generally by self-referral. Differences in culture, health literacy, capacity to pay and other factors will influence levels of self-referral. Specific measures are required to address and overcome these barriers to self-referral, at least in priority situations. The inverse care law needs to be addressed.

There may be a role for culturally and community appropriate liaison officers or case managers to be engaged at the community level to work with people most at risk, eg of chronic disease, of failure to use cancer screening, of high risk or history in presenting with acute conditions, to use or enter earlier the primary health care system.

This system could be complemented by service incentive payments.

Reinvestment in rural maternity services

A key concern for rural communities is the downgrading and/or closure of rural hospitals, driven largely by the search for cost reductions within the State health system, but one which

- regards childbirth as an acute care service rather than as part of the continuum of ante, birthing and post-natal care;
- shifts the costs to local residents who are forced to travel some distance to regional hospitals; and
- discounts the value of the procedural, obstetrics and emergency skills of local GPs and forces their relocation and/or reduces their practice viability.

Alliance members consider that the provision of basic non-acute services such as birthing, either in rural hospitals or through the services of midwives, is a cornerstone of the health care network in rural areas and cannot be considered separately from other primary care services.

Whatever approach is taken to Medicare numbers for midwives, public employment of midwives, especially in areas of need, should be considered an important component of accessible primary health care, as agreed by the recent Maternity Services Review Report.

Primary health care outreach

Programs of specialist outreach services are highly valued in rural Australia as is the Rural Women's General Practice Service. It is logical that this approach also be considered where other primary health care services are in short supply, either through on-site location or through hub and spoke models. These schemes of outreach should be consolidated and broadened to include other areas of crucial need such as midwives, dental and psychological services.

Patient-centred and integrated services – objectives 2 and 4

This submission has argued for integration at the national level in terms of health objectives and policy and at the regional level in terms of integration of health services, including between the primary and other parts of the health care system. This section addresses integration at the clinical care level.

In the view of the Alliance, achievement of patient-centred and integrated service goes to the heart of an effective and equitable system. Most patients with single episode care needs will be readily able to access and 'self-coordinate' their required services. However for those with complex and chronic conditions, access to and coordination of the appropriate range of

services will generally not be easy or efficient from either an individual or systems perspective.

These objectives of patient centredness and integration have been common to a number of health plans at national and state level, for example in relation to chronic disease, mental health, and various State primary care or rural health plans and initiatives. These plans have no doubt contributed substantially to more integrated approaches to assisting and supporting people in managing chronic conditions.

However there is substantial evidence that current systems of addressing chronic disease are sub-optimal. People with chronic disease account for about 80 per cent of the burden of morbidity and mortality. In their Discussion Paper for the NHHRC, Wenck and Watts noted that less than half of patients with type 2 diabetes in general practice have levels of glycated haemoglobin (HbA1c), blood pressure, and lipids that met current target levels; less than 30 per cent of patients with hypertension are treated to target; less than 20 per cent of patients with cardiovascular disease achieve optimal levels of lipids; only 5 per cent of eligible people with asthma have received the 3+ care plan18; and less than a quarter of patients with more severe anxiety or depression receive pharmacological or specific evidence-based non-pharmacological treatments.

Evaluation of the Australian Primary Care Collaboratives has also shown both the scope and the methodology for substantial improvement in the care delivered to and the outcomes for people with chronic conditions.

The Alliance is concerned to ensure that best practice among these approaches is assessed and promulgated across the health care system to imbed the best of chronic disease management, to reach the widest practicable audience and to further shift from the episodic, specialist and acute care to holistic primary health care.

The key emphasis needs to be on systems change: through effective financing and incentive systems, through appropriate teams of care, through investment in decision-support and locally relevant patient pathways, and through effective performance assessment and reporting.

Team-based models of care

The Discussion Paper raises the question as to who is best placed to coordinate the clinical and/or service aspects of care. This can be a contentious issue. The Alliance considers that the key issue is to form the appropriate team, be it at the general practice level where scale and infrastructure is sufficient or in other cases the more rurally oriented regional health service or multi-purpose service type model of health organisation or Aboriginal Medical Service. In terms of leadership, overall clinical leadership would continue to lie with the general practitioner. Within that framework, particular decisions and undertaking of elements of clinical care could lie with the appropriately trained general practice nurses, nurse practitioners, allied health professionals or community pharmacists. Case management itself requires particular skills, assessed in a US study of nurses in rural settings as requiring "multidimensional nursing skills, creativity in the use of resources, excellent communications, high-calibre computer skills and excellent driving skills." A local base rather than visiting model was also valued.

Given the difficulties of attracting enough GPs and other professionals to rural areas, it would be unnecessarily limiting to fix the pattern of the health team. Systemic health reform must

include measures for augmenting the conventional health professions, exploring scope of practice and new work practices including recognition of professions such as clinical assistants, nurse practitioners, physician assistants, generic therapists and trained carers.

Financing and incentives

Various commentators and organisations have argued for a move away from sole reliance on MBS fee-for-service with at least some component of capitation. The capitation component could be set at levels to provide for the necessary team support, infrastructure such as patient recall, and monitoring and reporting on outcomes and at least some incentive to adopt new models. This approach also raises the question of enrolment. The move proposed in the Discussion Paper towards voluntary patient lists would appear to be a constructive step forward. Given the lesser likelihood of choice in access to general practices that already exists, rural Australia would be a sensible place in which to test the introduction of voluntary patient lists, at the practice level. The Alliance would suggest certain conditions on financial arrangements and on patient enrolment:

- that the financing model be considered not just for general practice, but for all models of service in which integrated or coordinated care for people with chronic conditions is provided;
- that incentives for general practices ensure that there is no loss of income to rural general practitioners, which would aggravate any perspective of risk to business or service viability; and
- voluntary enrolment practices be aware of the inverse-care law and provide for active outreach to encourage enrolment among those communities or people who are less likely, of their own volition, to seek primary health care support.

Patient Pathways

Patient pathways for rural Australians are complicated by distance, waiting times for access, fewer allied health professionals, longer working hours by GPs and in many cases geographic separation of primary care providers from specialists and acute care in the cities.

Accordingly, the Alliance would like to see research and development on patient pathways in priority areas, including for mental health, maternity services, post acute care and specialist services to support services in providing linked and integrated care. Work on patient pathways could also build better linkages with communities on preventative health measures.

<u>Recommendations</u>

Initiatives to ensure universal access to effective integrated chronic care should form an essential and early element of the development of a national primary health care system.

This universality of provision should be based on:

- models of service, including general practice and regional health service models, appropriate to the community;
- financial incentive arrangements for integrated or coordinated care models that are available to all models of service;
- particular investment in the development of patient pathways appropriate at the regional level; and
- patient enrolment processes that are proactive in reaching out to under-serviced communities and groups.

Focus on preventative health - objective 3

A focus on preventative health is one area in which the primary care system requires, and should take full advantage of, approaches that are cross-sectoral in nature and can build capacity in the community to survive and thrive in the face of changing circumstances. Building healthy and sustainable communities with capacity to be engaged in promoting health at community and individual level is a key health objective for rural Australia, where there is generally less recourse to the range of infrastructure and activity options that are regarded as promoters of healthy lifestyle.

The importance of building community capacity and cross-sectoral engagement within community is recognised in a number of programs and projects including Shared Care, Rural Chronic Disease Initiatives and Building Healthy Communities in Remote Australia. For example, the last-named initiative:

> "*recognises that every community is different, with different problems and priorities, and provides the necessary support for each community to find their own local answers to their local health issues."*

These programs have been in operation for many years. While they have been subject to evaluation, assessments of their levels of effectiveness and cost-effectiveness in health promotion are not readily available. The drawback with these initiatives is that they have been location-limited, time-limited and application-driven rather than universal needs-based in their distribution.

Within the health system, there have also been recent proposals to engage GPs and the uncapped MBS financing system to take a stronger focus on preventative health, for example by the Preventative Health Task Force and through submissions to the National Health and Hospitals Reform Commission. For example, the Australian General Practice Network argued for a population health prevention focus, with general practice being "tasked and funded through service, capitation and quality outcomes payments – an overall model that remunerates best practice care, recognises non-patient time and includes a component for infrastructure, to support multidisciplinary care."

The Alliance considers that there should be a careful balance in pursuing these two approaches. MBS based approaches, delivered through GPs or GP-directed nurse or allied health professionals, will have their place, especially in early intervention, screening programs and in promoting risk reduction in people with chronic conditions.

However, community initiatives are equally part of the primary health care system, and have benefits in giving people a greater sense of their capacity to manage their lives and their health conditions: to set goals for themselves, to solve problems, to manage their emotions and to strengthen their adherence to treatment and lifestyle regimes. The key challenge is to ensure that the most effective approaches are identified and that such programs become universally available and ongoing in nature. The Alliance notes and agrees with the proposition in the Discussion Paper that there be national reporting on preventive health measures and suggests that such reporting is crucial at the regional level.

<u>Recommendations</u>

Approaches to preventative measures in rural Australia should include both primary care and more cross-sectoral primary health care dimensions with a strong focus on building

community and individual capacity. Urgent evaluation should be undertaken to identify current program and project initiatives that warrant community-wide and ongoing availability and to provide a basis for comparison of cost-effectiveness with MBS-based interventions.

Reporting on the impact of preventative health measures should occur at national and regional levels.

Safe, high quality care – objective 5

Safety Measures

One of the key principles of the Healthy Horizons framework is that safety and quality are paramount in the development and implementation of health services and programs, and that there must be no compromise on the safety and quality of health services provided to people living in rural, regional and remote Australia. The Alliance considers that issues of performance monitoring and translating research into systemic practice, raised in the Discussion Paper under this Objective, are crucial areas for rural health.

Recommendation

Safety and quality in rural areas should be protected in rural Australia through:

- performance monitoring and reporting in areas of higher risk illness and treatment, such as for cancer screening, cancer survival rates, infant mortality, management of cardiovascular disease and blood pressure, and continuity of care plans for hospital discharge, diabetes, asthma etc;

- investment in clinical training and vocational placements in rural Australia, including in the clinical infrastructure, and in clinical trainers, to ensure that all such placements are of the highest quality;

- high quality support for IMGs; Australia's dependence on international medical graduates (IMGs) is well known and is particularly strong in many rural and regional areas. IMGs now account for over 25 per cent of the rural GP workforce, and over 50 per cent of rural GPs under 45 years old. Nurses and other health professionals have also been recruited overseas but not in the same proportion as for doctors. Accordingly support programs for IMGs are crucial for quality health provision in rural Australia and should be subject to urgent consideration for improvement in their adequacy and scope of support. This support should include:
    - initial training and ongoing professional development and training pathways equivalent to those offered to Australian trained doctors; and
    - a case management approach to orientation and support for IMGs in settling them and their families into the community in which they are working;

- good emergency retrieval and emergency care procedures. The ambulance paramedical sector - particularly in rural, regional and remote areas - has been playing a leading role in the safe and supported expansion of scopes of practice. The sector has had long-term recruitment and retention problems but, despite this, new flexible workforce roles have emerged to meet the needs of communities in rural and remote areas. With hospital emergency department resources becoming stretched and with the limited number of medical practitioners who can attend to patients outside their surgeries, paramedics are becoming first-line primary care providers, particularly in small rural communities. This integration of publicly-funded clinical care by

ambulance services and other local professionals has further potential to enhance services in rural and remote areas; and

- reinvestment in maternity services. The loss of maternity services in a number of smaller towns over the last 10 years has resulted in a significant proportion of rural mothers having their babies at a distance from their home and from family and community support. This is a serious adverse change. Part of what is required is to provide support for both mother and baby during pregnancy and the birthing experience. Another risk is the effective shift from health professionals to parents of the responsibility to make assessments about progress of labour and decisions about when to travel to the nearest maternity unit. The closure of maternity services has led to transfers resulting from complications in labour becoming more likely to occur in unplanned or inappropriate settings and the increased probability of other sub-optimal outcomes.

Translating Research and Innovation into Outcomes

The Alliance supports the view in the Discussion Paper that there is significant scope for synthesis of the research and data and better linking research to the policy formulation agenda. A review of the literature shows that much research is limited by resources to smaller scale research at the project level that is not easily scalable and transferable to the broader rural platform. The Alliance considers that a more coordinated and structured approach to research on rural health issues would be very beneficial. Consolidation of rural health programs itself will be conducive to broader evaluation.

Australia is now recognised as a world leader in rural and remote health education and training, but rural and remote health research here is still relatively piecemeal and generally consists of short-term projects based on limited short-term funding. The Alliance places priority on ensuring that the developments and innovations of the past decade are translated to beneficial outcomes for all rural Australians. This requires a policy intent and Government commitment to build a national primary health care system, including with a focus on health systems in rural Australia and commissioned research and evaluation with a clear objective to translate lessons learned into systemic and universal application.

There is a range of University institutions with at least substantial interest in rural health issues. The educational clinical placement and professional development roles of the dedicated rural and remote health organisations make them ideally based to link with health services in undertaking research on health systems and health outcomes. Strengthening the rural research and evaluation capacities of these institutions would be a clear priority in driving the evidence-base forward.

In terms of the specifics in shaping the research agenda and its applicability to policy development and implementation, the Alliance notes and supports the call of the Australian Primary Health Care Research Institute to move the agenda in part from identifying innovative or exemplary models of primary health care in some rural communities or in relation to clinical care, towards examination of the requirements to implement and sustain these models more broadly in rural Australia.

Improved research infrastructure and quarantined funding for rural and remote health research would not only help improve the evidence base and the research effort, but would also help support the recruitment and retention of clinicians to rural and remote Australia. It would

allow clinicians to maintain and develop their research skills and interests while working in rural and remote areas.

Recommendation

Backed by Government policy and commitment to develop an integrated primary health care environment, national research should be commissioned on translating evidence into practice at a systemic level as quickly as practicable, so that all Australians benefit from the lessons of research, innovation and pilot programs.

Particular investment should be made in rural Australia to:

- build the research capacity of University Departments of Rural Health to integrate health professional education and training with improved processes and systems for delivery of health outcomes in rural Australia;
- undertake research in:
    - linkages and clinical support pathways for the patient journey between rural and metropolitan health services;
    - comparative assessments among service models to identify the most cost-effective approaches to service provision;
    - consideration of the factors that would determine 'service access standards'. These would provide benchmarks to assist regions and others in planning health services and to define for Australians the publicly-funded health services to which they can reasonably expect access;
- examine better use of the workforce, funding evidence-based effective interventions delivered by most appropriate health professional; and
- better utilise telemedicine.

Better management of health Information, underpinned by e-health – objective 6

The Australian Journal of Rural Health (14, 95-98, 2006) noted that rural areas stand to benefit most from e-health but have the poorest infrastructure, resources, capacity and capability for successful implementation and uptake of it. While there are many examples of effective e-health in rural Australia, the capacity and the benefits are by no means well-distributed. There needs to be a strategic national approach to this issue and a focus on delivering e-health initiatives that are relevant in and will work well in rural Australia.

Rural Australia in particular stands to benefit from e-health initiatives in a number of ways

- through the development of electronic patient health records, so that patients from rural areas who are required to see a specialist or receive acute care will be automatically 'reconnected' within their primary care system on return to the local community;
- through the provision of specialist advice to local GPs and so reduce the need, and cost, of patients travelling to a major city to see a specialist;
- through its potential contribution to professional development, peer support, and decision tools that assist all health professionals in their work; and
- through providing the information systems to allow more standardised and more automated data collection and performance reporting.

Recommendation

The development of electronic patient records, the provision of e-health case conferencing and specialist services, and automated systems for performance data and reporting should be

given priority under a Rural Health Plan to ensure that the benefits of e-health are widely spread and enable health services to be provided as close as practicable to where people live.

Workforce distribution, environments and roles, education and training – objectives 8 and 9

As discussed earlier in the submission, workforce maldistribution in rural Australia has been a longstanding and continuing source of concern. The Discussion Paper clearly recognises these issues, including in its specific questions on incentives and working conditions, including models of team-based care to attract and retain staff.

The Alliance considers that a national primary health care strategy offers enhanced opportunities to pursue an equitable distribution and more attractive working conditions for many health professionals in rural Australia. A national approach should address a number of weaknesses in current training and development arrangements brought about in part by the separation of roles for health workforce planning, for tertiary education, (Commonwealth and its particular focus on funding GPs through MBS), the States' roles as service providers of hospitals and many allied health services, as well as providers of many clinical placements, and lack of clarity about responsibility for investment in the necessary infrastructure for the life-cycle of health profession training and development.

Equitable workforce distribution is a multi-faceted challenge, requiring a specific assessment of health profession mix and quantum, long-term planning and funding, the provision of education, training and professional development, adequate infrastructure of various sorts, a range of effective and attractive models of care, and attractive remuneration and work environment. A comprehensive approach is required and programs to address these issues also need to be on a sufficient scale to make a real difference.

Even with the allocation of funds to regional areas based on population health needs, service will not be available unless the right mix of health professionals can be attracted to work in rural health.

For effectiveness in attracting professionals to practise in rural Australia, it is crucial that education, training and vocational development be high quality and specially targeted to equip health professionals with the broad range of skills needed to meet the health needs of people in rural Australia, taking into account the lower access to local specialists, tertiary facilities and some diagnostic services. A key concern in rural Australia is the pressure on training facilities, especially in attracting high quality lecturers and clinical supervisors. In simple terms, remuneration for providing clinical service far outweighs remuneration for clinical supervision, and thus relies in a major way on the goodwill of the limited number of clinical educators and trainers. This system is unsustainable and needs urgent redress.

Vertical integration in rural education, clinical placements and vocational training is also crucial to maximising the chances of attracting health professionals to rural areas. The current system allows a range of rural training and placement options at undergraduate, clinical placement and vocational training phases, but does not necessarily and substantially engage graduates and provide the depth of training in the particular environment of rural health.

The ever-increasing spread and likely strategic direction of more integrated health service provision by multi-disciplinary teams has important implications for how health professionals are educated and trained, and for the infrastructure that needs to be provided for their work. The variety of successful service arrangements already in place in rural and remote areas

provides some evidence of how workforce reform should proceed in Australia and should encourage further developments in interprofessional education and professional development.

A greater reliance on multi-purpose services and on more integrated and accountable forms of service provision will also increase the importance of well trained practice or health service managers.

Workforce Development and Distribution

Recommendation

A new national primary health care strategy should take a comprehensive approach to resolving workforce shortages in rural Australia. Key workforce development and distribution responsibilities and priorities for rural Australia include:

- a system for assessing the required composition of the health workforce, including the range of allied health professionals to enhance workforce effectiveness and efficiency in meeting the major burdens of disease in Australia;
- a benchmarking approach (ie checking on ratios of numbers of staff to patients) would help highlight the shortages, especially when account is taken of the great distances and number of communities single health professionals often have to serve; the needs for health professionals in mental health, dental health and in maternity services would be areas for priority and urgent consideration;
- an equitable approach to systems of incentives, such as scholarships and support programs, across the spectrum of health professions;
- recognition of the importance of high quality and substantial rural training and clinical placements in attracting professionals to rural Australia;
- promotion of both vertically integrated and multi-disciplinary training pathways;
- building on the expertise of rural health professionals in training the next generation and increase the number and remuneration levels of joint academic/clinical health positions in rural and remote areas, providing support to health science students, new graduates and local practitioners;
- recognition of the greater scope of practice and the importance of the generalist in rural Australia, for example the procedural, emergency, and obstetrics services provided by GPs;
- recognition of the value of the rural hospital as the location for many people in the health workforce and the bulk of the training for a number of health professions;
- recognition of the position of health service manager in rural and remote areas as a specialist area of management;
- as already discussed, enhancing support programs for IMGs; and
- recognition of the importance of career development to health professionals and providing the peer support and substantial opportunities for continuing professional development in rural areas.

Remuneration and conditions of service

Reform needs to focus on retention of the rural workforce as well as on recruitment. Remuneration and working conditions need to be competitive with those on offer in the major cities. Retention can be improved through sufficient staffing (resulting in a reasonable workload), adequate infrastructure (including housing, vehicles, appropriate IT), retention bonuses, a supportive workplace culture, support for training and further education opportunities, an attractive workplace environment and clear and supported career pathways.

It would also help if the understanding of 'rural practice' was reshaped to include a number of years in a rural location rather than having the term connote only a lifetime commitment.

Remuneration practices and levels also need to reflect the preferences of new health professionals. Substantial reliance on private business models, such as small general practices, supported solely through MBS and patient co-payments, is becoming less and less feasible and attractive to new entrants to health practice, especially in rural Australia, where there is the perception if not the reality of difficulty in being able to build or on-sell a health practice.

The emergence of superclinics is illustration of this point. The 'easy access/graceful exit' or walk-in-walk out model of health services infrastructure is now becoming a more practical model for attraction of health professionals in smaller rural areas. The decline, even in rural areas, of the solo GP practice model and of single-nurse posts also illustrates the desire for greater work/life balance and peer support, and aspects of clinician safety.

Consideration should be given to providing the option of either fee-for-service or salaried health professionals working in rural and remote communities, auspiced by local authorities or other agencies, and with packages that might include community-owned practice infrastructure, support and relief. Investment in a comprehensive and high quality IT communications system is a pre-requisite for both rural development and providing equitable access to certain health services, such as digital imaging and virtual medical procedures. This should be achievable within existing funding parameters, eg through MBS 'cash-out' arrangements. Evidence suggests that a greater number of young health professionals would prefer to operate this way than used to be the case, partly because they are uninterested in commercial business practice and because their indemnity risks can be borne by the employer.[3]

On the issue of practice viability, the current National Rural and Remote Health Infrastructure Program already provides for capital funding to assist rural communities to establish walk-in walk-out primary health care facilities for medical practitioners and a range of allied health professionals. This program would seem to be of vital importance, and should be subject to ongoing monitoring and evaluation to assess the level of need and the adequacy of funding in total and at the individual project or community level.

Workplace environments / models of service

The study by Humphreys et al on *Workforce retention in rural and remote Australia; determining the factors that influence length of practice* (MJA 2002, vol176) indicated that on-call demands and access to professional development were the two major barriers to retention of GPs in rural Australia. Studies on influences for the attraction and retention of nurses in rural areas (*Who stays in rural practice; an international review of the literature on factors influencing rural nurse retention*) concluded that job satisfaction was a major influence on retention with access to tools such as diagnostic tests, work variety including management and educator roles, peer feedback, collaborative teamwork and professional development being key elements.

The size of General Practices in inner and outer regional areas generally reflects that of major cities, and even in remote and very remote locations numbers of GPs per practice are not

[3] Indemnity is a particular issue in more remote areas where there are low patient numbers and therefore minimal opportunities to earn enough to cover costs.

greatly different. Thus, with the right support of practice managers, and access to diagnostic tests and referrals to allied health, general practice in rural Australia is reasonably placed to adopt initiatives such as practice nurses, patient recall systems, patient enrolments, and e-health capacities and to provide supportive team-based environments and multidisciplinary models of care. However, general practice in rural Australia is more likely to cover a greater range of responsibilities including procedural, obstetrics and emergency medicine.

BEACH SURVEY REPORT 2004 -2007[4]

PRACTICE SIZE	MAJOR CITIES	INNER REGIONAL	OUTER REGIONAL	REMOTE	VERY REMOTE
SOLO GP	11.13%	7.98	16.03	29.41	31.25
2-4 GPS	35.2	34.47	41.60	41.18	50
5+ GPS	53.67	57.56	42.37	29.41	18.75

Models of service such as Regional Health Services or Multi-Purpose Services also provide the multidisciplinary settings for both patient-centred service provision and for clinical placement and training. The Alliance would like to see a shared approach with the States to infrastructure funding of Multi-Purpose Services and Regional Health Services, recognising that restrictions in infrastructure inhibit the attraction and retention of health professionals. Such investments have the capacity to co-locate doctors and other health professions, to provide high quality and interdisciplinary services and clinical training facilities.

Greater investment in these multi-purpose services also offers the best environment, through building of interdisciplinary respect and trust and work allocation to scope of practice, in which to explore and trial measures for augmenting the conventional health professions, implementing more efficient work practices and examining new ways of reaching under-serviced groups. This will allow wider recognition of professions such as clinical assistants, nurse practitioners, physician assistants, midwives, generic therapists, surgical assistants and trained carers.

Recommendation

Remuneration and working conditions for health professionals in rural and remote areas must be at least as attractive as those on offer in the major cities. Larger general practices and regional health service type facilities offer the basic structure on which to develop:

- good practice management and patient support infrastructure;
- team-based practice, offering peer support and better work/professional development balance;
- clinical training facilities;
- flexibility in remuneration arrangements and in easy entry, graceful exit opportunities; and
- wider recognition of professions under-represented in Australia such as nurse practitioners.

Additional investment in infrastructure will be required to deliver on this potential.

[4] BEACH data (2004–2007); personal communication Australian GP Statistics and Classification Centre, University of Sydney".

ATTACHMENT 1:

Member Bodies of the National Rural Health Alliance

ACHSE	Australian College of Health Service Executives
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AHHA	Australian Healthcare and Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association
ANF	Australian Nursing Federation (rural members)
APA (RMN)	Australian Physiotherapy Association Rural Member Network
ARHEN	Australian Rural Health Education Network Limited
ARNM	Australian Rural Nurses and Midwives
CAA (RRG)	Council of Ambulance Authorities - Rural and Remote Group
CRANA	Council of Remote Area Nurses of Australia Inc
CRHF	Catholic Rural Hospitals Forum of Catholic Health of Australia
CWAA	Country Women's Association of Australia
FS	Frontier Services of the Uniting Church in Australia
HCRRA	Health Consumers of Rural and Remote Australia
ICPA	Isolated Children's Parents' Association
NRHN	National Rural Health Network
RACGP (NRF)	National Rural Faculty of the Royal Australian College of General Practitioners
RDAA	Rural Doctors' Association of Australia
RDN	Rural Dentists Network
RHWA	Rural Health Workforce Australia
RFDS	Royal Flying Doctor Service of Australia
RGPS	Regional and General Paediatric Society
RIHG	Rural Indigenous and Health-interest Group of the Chiropractors' Association of Australia
RPA	Rural Pharmacists Australia—Rural Interest Group of the Pharmacy Guild of Australia, the Pharmaceutical Society of Australia and the Society of Hospital Pharmacists of Australia
SARRAH	Services for Australian Rural and Remote Allied Health