SARRAH

Services for Australian Rural and Remote Allied Health

3 August 2021

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C/- Primary Health Care Reform Taskforce
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Dear Dr Hambleton and Dr Jammal,

Services for Australian Rural and Remote Allied Health (SARRAH)
Submission: Draft recommendations of the Primary Health Reform Steering Group

Thank you for the opportunity to provide feedback on the draft recommendations of the Primary Health Reform Steering Group input. We appreciate the work of the Steering Group in informing the Government's Primary Health Care 10 Year Plan. SARRAH agrees with the Steering Group's assessment that, while the Australian health care system is among the best in the world, it is not structured to enable all Australians to access adequate health care or maintain levels of health and wellbeing.

Our overarching comments are provided in this covering letter, with more detailed comment provided, where applicable in the response to specific questions, attached.

The Discussion Paper highlights the key point that large portions of the population do not enjoy the benefits of Australia's health system on anything approaching an equitable level. This is a long-standing issue. The Steering Groups' Recommendations and the Government's response must address the causes of this inequality fundamentally.

As the Steering Group notes:

> *The challenges are particularly acute for disadvantaged Australians especially many Aboriginal and Torres Strait Islander people, residents of rural and remote communities, people from culturally and linguistically diverse (CALD) backgrounds, people with chronic disease, mental health conditions and frailty, and people facing socio-economic disadvantage. (Page 2)*

SARRAH is the peak body representing rural and remote allied health professionals (AHPs) working in the public and private sector, across health, disability, aged care, and other settings. SARRAH was established in 1995 and advocates on behalf of rural and remote Australian communities to improve access to allied health services that support equitable and sustainable health and well-being. SARRAH maintains that every Australian should have access to health services wherever they live and that allied health services are fundamental to the well-being of all Australians.

The Steering Group presents a compelling case for transforming the Australian health system to one that is more integrated, collaborative, multi-disciplinary, focussed on prevention and primary care and patient centred. This will require greater flexibility to facilitate comprehensive services that are configured to meet local need and provide continuity of care. A more effective and sustainable primary health care system will be underpinned by funding systems that prioritise patient-centred and collaborative care and outcomes. It will preference prevention and the maintenance of wellbeing over illness-oriented payment incentives and throughput.

Crucially, as the Steering Group advocates (Page 3 of the Discussion Paper):

A commitment to implementation across short-, medium- and long-term horizons should be a point of difference between the 10 Year Plan and its forerunners.

SARRAH applauds the Government's ambition for Australia to become the first ranked health system globally[1].

However, our health performance must be assessed on the outcomes achieved across the entire population and consider both national-level measures (such as life expectancy and potentially preventable hospitalisations) and, critically, variations in that performance based on place, ethnicity etc (and the social determinants, recognised by the Steering Group).

Access and equity are identified as relative weak points in our system. Evidence suggests it is a fair assessment. We have for many years been well aware of substantial gaps in life expectancy; incidence of chronic disease and multi-morbidity; differential access to health services, (including in MBS subsidised services); potentially preventable hospitalisations; and concurrent acute health workforce mal-distribution. Notwithstanding the many strategies, programs and investments that demonstrate effort, the results are clear. While we continue to deliver predictable differences in health and wellbeing for Aboriginal and Torres Strait Islander people and people living in rural and remote Australia, for example, our health system should not be considered the best in the world, at least not in national comparisons.

These ongoing issues are at odds with our claims and apparent pride in having a "universal" health system, to which the MBS, PBS and the public health and hospital system provides a statutory basis but not a performance guarantee.

To achieve this ambition, we must:

[1] "Good health is essential to our happiness and wellbeing. Australians overall are among the healthiest and longest living people in the world. And "Our goal: to make Australia's health system the world's number one." (Minister's Foreword page 3 - Australia's Long Term National Health Plan).

- Lift Australia's performance with regard to Access and Equity, which rank comparatively poorly against criteria – 4th and 7th respectively (out of 11).
- Fundamentally shift policy, delivery, and funding frameworks so that concepts of equity are based on outcomes achieved and reduced disparities in (allied health and other service) access.
- Allow for greater flexibility in program design and delivery, so delivery can be tailored to actual, local, population-based, needs and strengths; and
- Establish mechanisms for broader more inclusive stakeholder involvement and independent assessment of health system effectiveness.

Further, increased system demands, and costs are being driven by factors that are well understood, and able to be planned for, such as structural ageing and the changing burden of disease. Covid-19 has demonstrated that not everything can be anticipated and planned for, but the impacts of it should underscore the urgency doing so and as quickly as possible to transform our system from an illness-orientation to a wellness-orientation – and keep people away from our crisis service capacity and infrastructure wherever possible. The Steering Group reiterates the case for immediate action well. As some Steering Group members have said, we cannot afford to just kick the can down the road, yet again.

SARRAH supports the overall direction of the Steering Group's Recommendations and, all Recommendations in principles and most of the Recommendations in detail, noting we have concerns about whether the proposed mechanisms to deliver against some of the Recommendations will be effective and not have possibly unforeseen and negative consequences.

SARRAH congratulates the Steering Group and support staff on getting the process to a point where the Discussion Paper and Recommendations represent a major opportunity to improve our health care system overall, with much needed investment in primary health care. If implemented, the Recommendations would see a move toward a more equitable system better equipped to overcome population health challenges, including addressing the longstanding gap in health outcomes between Aboriginal and Torres Strait Islander and non-Indigenous Australians.

SARRAH especially supports changes to primary care funding, building on lessons learned in the ACCHO sector, better integration and continuity of care, local governance arrangements, a greater emphasis on preventative care, recognising the impact of social determinants, building workforce capability and sustainability including comprehensive workforce planning and the progression of rural generalist pathways. The chapter and Recommendations on Allied Health Workforce (recommendation 11) is especially welcome.

Many of the recommendations around funding reform, workforce planning and red tape reduction are issues that SARRAH has been campaigning on for a long time.

While SARRAH strongly supports the Recommendations overall we are concerned about the efficacy and implications of some of the approaches advocated for as "the" response to deliver on the recommendations. This is an important issue, and the structure of the response template does not readily allow for distinctions to be

made between support for The Recommendation and proposed mechanism to address it. Scope exists to identify concerns in identifying "challenges to implementing the recommendation", but this provides limited scope for constructive alternatives to be put forward and is designed to reinforce at least tacit support. The upshot is that agreeing with a Recommendation (e.g., *Deliver funding reform to support integration and a one system focus*) is conflated with agreeing to the proposed approach to deliver on it – which is far more subjective and not always supported. A typical example from the Discussion Paper follows:

- *X.1. Do you agree with this recommendation?*
- *X.2. What do you see as the challenges in implementing this recommendation?*
- *X.3. Please provide any examples of best practice for implementation of this recommendation (from Australia or overseas).*

From an administrative viewpoint, the approach may facilitate collation and synthesis of a large amount of information. However, there are real risks of continuing system shortfalls, especially for people who currently have difficulty accessing primary health care.

SARRAH believes further analysis, development and/or consultation is needed in several key areas, including:

A clear and inclusive definition of Primary Health Care: The Discussion Paper does not provide a clear definition of Primary Health Care, or fully describe the range of providers and services that constitute this sector. This is important in order to establish the full context and scope of the services, workforce, settings, relationships, and outcomes being considered. It is well understood that the Commonwealth Government sees medical General Practice as central to primary health care. The fundamental importance of GPs in the Australian health system is not in dispute, but GP practice does not encompass the gamut of PHC expertise or practice. The Discussion Paper is written from a GP-centric position (which has been strongly supported by Australian Government policy positions), and essentially proposes a solution to current problems based on reinforced medical general practice and voluntary patient registration (VPR).

SARRAH suggests the Steering Group adopt and promulgate either the following definition, or similar:

"PHC is a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment." (World Health Organisation - Primary health care (who.int) *– accessed 27 July 2021).*

Consideration of options and further analysis of impacts: Most of the measures designed to reinforce an individuals' attachment and integration across primary health care providers will improve quality and continuity of care, but there must be alternatives to the proposed model with General Practice taking on a bolstered gatekeeping role, even in a VPR arrangement. Notwithstanding best intentions and exemplars in current practice, it is questionable the approach would enhance access to non-GP provided services, increase the broader primary health care service capacity and sustainability (especially for currently disadvantaged communities), improve the flow of appropriate referrals or services accessed. The suggested increase in MBS subsidised allied health services is welcome, but there seems

to be a suggestion that access to allied health services generally might be directed toward provision through a GP contracted or employment arrangement. If so, the ramifications for existing allied health service providers, arrangements, and interactions with the aged care, NDIS and other service streams would also need to be analysed in serious detail. There is very substantial evidence that these things could occur more than they do now, and it is vital to have a rigorous assessment from across the spectrum of views as to why. The proposed approach may be a step in the right direction but is not a panacea. These issues were considered in depth by then National Rural Health Commissioner, Professor Paul Worley, in his June 2020 report to Government *"Improving Access, Quality and Distribution of Allied Health Service"*.

Fragmented funding models result in unappealing often unfillable short term, part time allied health positions. Attracting allied health professionals to fill such positions is an ongoing challenge for public, not for profit and private employers alike. (Page 16)

GPs would face the same issues contracting or employing an AHP as anyone else. The factors identified by Professor Worley could be ameliorated by some of the Steering Group's Recommendations, such as addressing funding fragmentation, improving technical and funding support to enable broader collaborative practice. However, it is not clear how funnelling access to allied health services (via services employment, administration and/or funding arrangements) through GP practices is necessary or beneficial to improving access, coordinating care, or improving system efficiency.

Mal-distribution of allied health professionals in Australia is severe and long-standing. Service shortages inhibits awareness of and access to services that would otherwise be possible and in the patients' interests. It is crucial that where allied health professionals are working in rural and remote Australia no policy is implemented that would impinge on the viability and independence of their practice.

Progress recommendations of the previous National Rural Health Commissioner's (NRHC) report: Professor Worley's Recommendations are well considered and broadly compatible with the objectives of the National PHC Strategy and the draft Recommendations. SARRAH strongly recommends the Steering Group specifically consider and support urgent progress in implementing Professor Worley's recommendations. The work was identified among the priorities for incoming NRHC, Associate Professor Ruth Stewart, in the Statement of Expectations issued by then Minister for Rural Health, the Hon. Mark Coulton MP on 23 March 2021.

Further deep engagement is needed. The Steering Group has undertaken a large consultation process. We appreciate this requires extensive effort and cost. However, SARRAH would argue further consultation is needed, especially to obtain deeper input from stakeholders who were not as well represented at the consultations and/or to the extent needed to influence , and now assess, the findings and Recommendations as they apply where gaps in primary health care are greatest at present – notably for Aboriginal and Torres Strait Islander people and rural and remote communities, both of which experience comparatively poor access to allied health services.

Further analysis is also required, involving consumers and stakeholders who work daily, extensively, and sometimes exclusively in those areas of the system where the gaps are greatest and negative implications of these gaps are most stark for the people affected.

SARRAH believes further refinement of some Recommendations, continuing broadly-based engagement and inclusive oversight of the 10 Year Plan. The Steering Group has developed a very strong platform for that work to continue and SARRAH would

welcome the opportunity to be closely involved in the further development, implementation, oversight and performance monitoring of the Primary Health Care 10 Year Plan.

If you would like to discuss issues raised in SARRAHs submissions or require further information, please contact me at catherine@sarrah.org.au.

Yours Sincerely

Cath Maloney

Chief Executive Officer

Services for Australian Rural and Remote Allied Health (SARRAH) exists so that rural and remote Australian communities have allied health services that support equitable and sustainable health and well-being. SARRAH also supports Allied Health Professionals who live and work in rural and remote areas of Australia to carry out their professional duties confidently and competently in providing a variety of health services to people who reside in the bush.

SARRAH is a national, multidisciplinary member association and has been operating for 25 years. SARRAH is the only peak body to be fully focused on rural and remote allied health working across all disciplines. (More information is available at http://www.sarrah.org.au/).