BISHOP ADDRESS 2016

Relevance Resilience Resolve
SARRAH: PRIMARY OBJECTIVE

SARRAH exists so that rural and remote Australian communities have allied health services that support equitable and sustainable health and well-being.
to make sure we keep the issues that matter front and centre

in your face... as was often said in the early days of SARRAH.
...that skilled services provided by AHPs are essential to improving quality of life and health outcomes for many rural/remote residents

..that every Australian should have access to equitable health services wherever they live and that allied health services are fundamental to Australian health care and optimal patient/community wellbeing
THE SARRAH LOGO
Inaugural Annual General Meeting
Services for Australian Rural and Remote Allied Health
Perth, Western Australia 27 September 1995
...drawing upon interviews with some longstanding SARRAH members to frame this next conversation on achievements, challenges and solutions
... a useful touchstone for considering the ongoing relevance of SARRAH
The biennial conferences and SARRAH Summits
Supporting networking of rural/remote AHPs
Providing a collective national voice for rural allied health practice
Creating opportunities to engage with national policy & stakeholders
Nurturing allied health leadership
Managing the rural AHP Scholarships Program
Producing useful resources for rural/remote practitioners
Supporting innovative AHP projects in the field
The biennial SARRAH conferences have been pivotal in bringing people together to share information, debrief, and empower one another to take chances and advocate.

The SARRAH Summits have always been great forums for developing a sense of solidarity and for fostering leadership amongst rural AHPs.

- We were invited to step beyond our usual boundaries and engage with the power-brokers and decision-makers, and we learnt a lot from this – it was truly exciting.
SARRAH has always been about networking, bringing people together with common cause to try to bring about change and improved health services for rural/remote Australians.

The networking role of SARRAH has been enormous in connecting AHPs from around the country into collaborative forums and actions, and often into enduring friendships.
\textit{SARRAH} has given us an effective seat at the table so, as rural AHPs, we are no longer ‘out of sight, out of mind’

\textit{SARRAH} has raised the profile of rural/remote allied health. Prior to \textit{SARRAH} most rural health discussions were focused on doctors, and occasionally on nurses.

\textit{SARRAH} put people at the table and significantly broadened the agenda to include consideration of the broader service needs of rural residents, including the need for AHP services in scarce supply

\textbf{SARRAH ACHIEVEMENTS}

- Providing a collective national voice for rural allied health practice
Politically, SARRAH created opportunities for rural AHPs to meet and form relationships with key national politicians and health bureaucrats.

- Eg, SARRAH led work to achieve MBS reform so that clients could access at least some allied health care.

SARRAH has been very actively engaging at the political level. We’re now well known in Canberra, by politicians of all political persuasions and by senior health bureaucrats.

- This high profile has been demonstrated by the establishment of the Parliamentary Friends of Rural Allied Health in Parliament House

Creating opportunities to engage with national policy & stakeholders
SARRAH has provided great opportunities for the development of allied health leadership.

Members who became active participants in representational and advocacy roles were thrown into environments where they met with a whole range of political, bureaucratic and professional players with influence in the Australian healthcare system.

As a consequence, people broadened their scope of interest, sharpened their knowledge, and learnt how better to present themselves and AHP issues to high-level audiences.
SARRAH Summits

- 1993 Toowoomba QLD
- 1995 Perth WA
- 1997 Whyalla SA
- 1999 Mudgee NSW
- 2001 Cairns QLD
- 2004 Alice Springs NT
- 2006 Albury NSW
- 2008 Rockhampton QLD
- 2010 Broome WA
- 2012 Launceston TAS
- 2014 Kingscliff NSW
- 2016 Port Lincoln SA
... rural and remote allied health service provision
...for SARRAH
ONGOING CHALLENGES FOR RURAL ALLIED HEALTH

- **Workforce maldistribution** …
  - High proportion of AHPs living and working in metro areas (>75%)
  - AHPs per 100,000 population decreases with remoteness

- **Changing political and organisational environments and service models**
  - MBS reform
  - State/Territory government budget priorities
  - The NGO sector
  - New service and funding models including consumer based purchase models
    - Eg NDIS and aged care

- **…and we still need to work on**
  - Meeting rural/remote community need
  - Workforce Support
  - Improving recruitment & retention; addressing morale issues…
KEY CHALLENGES FOR SARRAH

- Dependence on government funding
- Low SARRAH membership numbers
- National advocacy versus AHP issues in the regions
- Changes in governments and national health policy
- Providing benefits for membership
- Leveraging member energy to further SARRAH’s objects
Our dependence on government funding has made life a bit precarious. It would be great if SARRAH was able to achieve an independent funding base.

The recent loss of Federal funding for the SARRAH Secretariat represents a fundamental new challenge to SARRAH’s viability...

...but it also probably represents an opportunity to build more independence as a peak body, and possibly a stronger voice for rural communities and AHPs.
It has always been a challenge for SARRAH to build its membership base to a level that more strongly validates SARRAH in its representational role as a voice for rural AHPs.

- Low SARRAH membership numbers
Building the SARRAH secretariat and office in Canberra, and the advent of the Scholarship program with all its admin responsibilities, has led to SARRAH developing more of centrist and corporate modus operandi.

The challenge may now be to shift back to a regional focus with more attention to what’s happening on the ground in local communities regarding health services and AHP access.

Transitioning from a grass roots organisation to corporate business model has been a huge change and a challenge, with both positives and negatives for the organisation and the members.

CHALLENGES

- National advocacy versus AHP issues in the regions
- It is hard to maintain our influence with government, particularly when Federal governments change.

- For example, we were really getting some legs with Health Minister, Nicola Roxon, in terms of the getting acknowledgment of the important role of AHPs in primary health care... then we seem to have completely lost this engagement and our arguments when the Coalition came into government.

- Advocacy work is now more complex and uncertain since the fall of the Labor Government and the lack of clear positions and action coming from the Coalition Government. No one really knows what’s going on, so it’s hard to know how to pitch advocacy and representational work.
A percentage of members are concerned with what specific benefits they get from their subscriptions.

This is problematic given that SARRAH is not like a traditional single-profession association, where specific member benefits are a central to the membership transaction.

Instead SARRAH members are asked to contribute to improving the delivery of allied health services to rural communities, and SARRAH provides a forum to come together for this purpose. It offers far less in terms of direct benefits and services to its individual members.
SARRAH members are busy people working in their communities and it is a challenge for people to commit enough time to the SARRAH cause to get things done to bring about change.

Working out how to engage younger AHPs is an issue for SARRAH

- …how to get information about SARRAH to students and new grads in a way that is appealing and relevant.
- We need to have newer graduates see the value of allied health as well as their own specific profession

Leveraging member energy to further SARRAH’s objects
SARAHH Presidents (6 of 8…)

1995 –1997 Michael Bishop
1997-1998 Kathryn Fitzgerald
1999-2001 Christine Ward
2001-2003 Robyn Adams
2003-2005 Owen Allen
2005-2008 Michael Bishop
2008-2009 Scott Wagner
2009 -2011 Helen McGregor
2011-2016 Tanya Lehmann
2016-2018 tbc
....despite the many positive achievements, there is a frustrating familiarity to the challenges and issues still being discussed.
RESILIENCE... RESILIENT SYSTEMS

- “... the system’s capacity to cope with stress and failures without collapsing, and more importantly, learning from the experience.”
RESILIENT SYSTEMS ... TWO TRENDS

1. **Big mainstream players**
   - Resilience here is often interpreted as
     - the reinforcement of the socio-economic status quo
     - a reduction in diversity....
     - and an increase in the overall fragility of the system

2. **Small connected players**
   - Growing wave of socio-technical **innovation** moving in the opposite direction...
     - with **small and connected actors**
     - experimenting with **agile flexible, context related, highly diversified systems**
Resilient systems

- Risk taking and chaos embracing
- Disrupting and regenerating
- Trusting and collaborating
- Hybrid and distributed
- Open and reactive
- Diversified and tolerant

"...deeply rooted in local context in which they are to be used..." p13

"a set of words ... the ones needed to build the narratives..." p13

SELF LEARNING SYSTEMS

... coping with a changing environment
... adapting to new circumstances, and
... learning from these experiences

...these words refer to the resilient systems' learning capacity
... how these systems receive and elaborate signals and how they learn from them
... tell the story of systems coping with a changing environment, adapting to new circumstances and learning from these experiences

Openness Porosity Accessibility Evaluative
Reflexivity Reactiveness Feedback Self-Learning

...they are systems that improve themselves
... in order to do that, they are to be open, to receive signals from their environment; sensitive to recognise signals; intelligent, to give signals meaning; flexible, to transform their nature and reorient their evolution on the basis of this new information [p20]
Collaboration

...is not a given, but must be consciously built
...is found through care for others

Trust Generosity Care Empathy
Investment Motivations Rewards
Participation Exchange Reciprocity
Complementarity Collaboration

The words suggest that resilience is found through care for others, and thus brings an ethic with it

Culture of resilience p.17

REFRAMING OUR PERSPECTIVES

- ..on concepts of resilience
- .. on recent changes
- .. on the way forward

To build flexible, context related solutions
To better connect the innovations of our local AHPs
THE WAY FORWARD
THE WAY FORWARD: SOME SUGGESTED SOLUTIONS

- Re-energise SARRAH in order to survive
- More focus on member issues in the field
- Re-establish our funding base for viability
- Strengthen partnerships with key rural health organisations
- Build advocacy work of relevance to the membership
- Acknowledge AHPs in the field in rural health
- Build evidence for rural allied health practice
• **SARRAH needs to refresh and revamp its structure to achieve more direct relevance to its members in the field.**

  • It needs a renewed commitment to a bottom-up approach working with the individual and corporate members to achieve change.

• **People involved in SARRAH need to have more fun, be more creative in finding solutions to challenges and enjoy themselves in the process.**

  • *Bringing rural practitioners together is important in itself and the networking and bonding that comes with it is affirming of the need for SARRAH.*

**SOLUTIONS**

• **Re-energise SARRAH in order to survive**
We need to move to a regional model in order to deeply listen to the issues of our members and to be better able to respond to these issues.

This means moving away somewhat from our centrist business model built around Canberra and lobbying Federal politicians.

We need to keep doing this, but not at the expense of responding to members in the bush.

SARRAH must keep building up the Advisory Committee and the Networks in order to improve communication with the membership. Better communication with the membership is vital for the future.

We must keep an ear to the ground with what’s happening in allied health in the regions, and then make sure we as SARRAH are able to assist people with their challenges.
We now need to rapidly diversify our funding base in the light of the recent cut to Commonwealth funding for our Secretariat functions.

We must continue to build our corporate membership base & grow our engagement with philanthropics & our partnership with these entities.

SARRAH must find ways to build our level of untied income which will allow us to plan and implement more work on behalf of rural AHPs and Australians.

**Solutions**

- Re-establish our funding base for viability
- We need to build our partnerships with other organisations in the field.
  - In particular, we need to work closely with organisations like the National Rural Health Alliance.
    - They were incredibly influential in our formation and early development and it important for us to remain close with them if we are to be effective.

- To overcome many of the impasses we face in advocating for improved AHP services, SARRAH needs to create new and energetic partnerships with other organisations and stakeholders relevant to rural health care.
  - We need to move beyond our efforts to engage government and engage other players on the ground to affect change from the ground up.
• We need to make noise and be a squeaky wheel for rural communities and service providers too.
  • ...and we need to be there right now, influencing change and taking more control over our working lives. We need to show and tell people what we can do – don’t get drowned out.

• We must continue to have strong representation to the politicians and health bureaucrats.
  • We must be at the policy table in order to take any opportunities as they arise to improve our services and access in rural Australia
- **SARRAH** must better acknowledge the good work being done on the ground in rural Australia by rural/remote AHPs.
  - To this end we probably need to make more annual awards to recognise this good work.

- There’s always a need to generate regional leadership amongst the membership.
  - **SARRAH** must always be looking at ways to nurture rural AHP leadership.

**SOLUTIONS**

- Acknowledge AHPs in the field in rural health
SARRAH

Strong Voice
Access to Services

Rural and remote allied health advocacy
Recognition of members and their contribution

Amazing network
Host organisation for projects and funds
Relevance
- SARRAH was established to address identified challenges
- Should continue only if activities impact current and emerging challenges

Resilience
- Can assist in development of innovative, local solutions
- Worth nurturing resilience and concepts of resilience in our rural allied health colleagues

Resolve
- Often considered an intractable problem, improving health and access to health services in rural and remote areas takes resolve.
- Are we up to it?
We know that rural/remote health is not a powerful sector
- SARRAH is no powerhouse organisation

Therefore, in order to take our opportunities we must be:-
- Resilient
- Persistent
- Patient
We have heard from our SARRAH elders that SARRAH needs to:-
- Revamp and refresh its structure
- Re-focus on the issues of members on the ground in rural Australia

Both perspectives point to getting back to the basics,
....back to the village
....to nurture a healthy rural/remote allied health sector
THE WHY.....THE POINT OF THIS PRESENTATION

Regional Disparity of AHP Workforce
..and our thanks to the SARRAH members who took the time to talk to us and to provide their perspectives
**WHERE ARE THEY NOW?**

Robyn Glynn Thursday Island FM AJRH
Owen Allen Atherton FM Pres 2004-6
Robyn Adams Townsville FM Pres 01-3
Michael Bishop rural QLD Founder, FM and Pres x 2
Jason Warnock Brisbane Treasurer +
Helen McGregor Lismore Pres ‘09-11
Rob Curry Wauchope FM and Board M
Elaine Ashworth Berri FM Board Mx2-3
Cassie Bonython Berri SA NAC
Tanya Lehmann SA Pres x2
Kathryn Fitzgerald Geraldton Pres 97-98

FM = Foundation Member
M= Member
- disturbed by the limited AHP services available for people in rural/remote areas
- rural/remote AHPs, experiencing fundamental challenges in meeting the health needs of their communities
- the need to improve rural/remote recruitment and retention of AHPs
- becoming conscious of the bigger issues in health care
- the potential of coming together with others for more effective advocacy
- saw what the possibilities might be in advocacy work and working as a collective
The graph omits approximately 1% of services whose postcodes could not be geographically located. The graph uses actual population data sourced from the Australian Bureau of Statistics (ABS) for each Statistical Area 1 (SA1) region. An estimate has been used for 1994 – 2004 for each SA1 region based on ABS data for SA2 regions. Patient data is based on postcodes where Modified Monash Model proportions are based on population distribution within each postcode.
… SARRAH not a research agency… but we need to encourage and facilitate the development and collation of...

- Discipline-specific evidence for treatments/interventions
- Cost-benefit of applying these interventions
- Impact of multi-disciplinary models of allied health care for complex conditions
- Relative cost benefits of AHP models versus provision costs
- Models of whole of team care for complex conditions: efficacy and cost benefit

NEXT STEPS

There will be many… but an important one is
to build the evidence for rural allied health practice
“Get a life, go rural, go very very very remote and participate in health care and the changes needed to provide better health to our communities.”

“My message is to get involved, participate, you can make a difference by joining with others.”

“Ask not what SARRAH can do for you… but what you can do for rural and remote communities…”

“The more effort you put into the advocacy work for allied health services, the more you will get in return. You will learn through this involvement and build your leadership skills”.

KEY MESSAGES FROM SARRAH MEMBERS

..some key messages for conference delegates from the SARRAH members who provided their perspectives
Services can be seen to be many things
• if what is provided is not clear, then it is hard to manage expectations

SARRAH services include intangibles such as
• advocacy,
• information collation and dissemination,
• fund holder for projects and schools etc,
• a repository for information...
• establishing a network..
• and of course the voice for rural AH

So perhaps we need some expectation management in this area...
## SARRAH provides

<table>
<thead>
<tr>
<th><strong>A voice</strong></th>
<th>for rural allied health</th>
<th>… a critical subset of each of our professions and allied health as a collective</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A focus</strong></td>
<td>on access to services</td>
<td>… activities of SARRAH have this as the touchstone for decision making… eg SAY YES to fund holding and administering scholarships as they will help develop and retain AHPS in rural areas which in turn impacts access to services</td>
</tr>
<tr>
<td><strong>A vehicle</strong></td>
<td>to advocate for service and workforce improvements in rural and remote communities</td>
<td>Attendance at consultative forums and contribution of submissions to inform policy etc</td>
</tr>
<tr>
<td></td>
<td>for governments to access perspectives of allied health professionals in RRR Aust.</td>
<td>Invitations to SARRAH to provide representatives for committees etc</td>
</tr>
<tr>
<td><strong>Leadership development</strong></td>
<td>opportunities for the individual rural allied health clinician members of the SARRAH board and committees</td>
<td>Experiential learning beyond the clinical sphere Exposure to individuals and organisations</td>
</tr>
<tr>
<td><strong>Recognition</strong></td>
<td>of the contribution of individuals</td>
<td>Squawk award Kate Scanlon Life membership</td>
</tr>
<tr>
<td><strong>A network</strong></td>
<td>to connect rural AHPS (reducing isolation)</td>
<td>Professional and state networks PLUS those made at conferences and meetings</td>
</tr>
<tr>
<td><strong>Conferences</strong></td>
<td>To share evidence and experiences</td>
<td></td>
</tr>
<tr>
<td><strong>An incorporated organisation</strong></td>
<td>to administer Commonwealth/other funds eg for scholarships</td>
<td>Scholarships support students and rural AHPs to work in rural regional and remote communities…in order to improve access to services…</td>
</tr>
</tbody>
</table>

More …. …in order improve the access to the services of the allied health professions in rural, regional and remote communities of Australia.
Often considered an intractable problem, improving health and access to health services in rural and remote areas takes resolve.

Are we up to it?