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Services for Australian
Rural and Remote Allied Health

Submission to the Senate Select Committee into Health

to inquire and report on health policy, administration and expenditure.

September 2014

INTRODUCTION

Services for Australian Rural and Remote Allied Health (SARRAH) welcomes the opportunity to provide a submission to the Senate Select Committee on Health inquiry into and report on health policy, administration and expenditure.

SARRAH is nationally recognised as a peak body representing rural and remote allied health professionals (AHPs) working in the public and private sector.

SARRAH's primary objective is to advocate for, develop and provide services to enable AHPs who live and work in rural and remote Australia to confidently and competently carry out their professional duties in providing a variety of health services to rural and remote Australians.

SARRAH's representation comes from a range of allied health professions including but not limited to: Audiology, Dietetics, Exercise Physiology, Occupational Therapy, Optometry, Oral Health, Pharmacy, Physiotherapy, Podiatry, Psychology, Social Work and Speech Pathology.

These AHPs provide a range of clinical and health education services to individuals who live in rural and remote Australian communities. AHPs are critical for the management of their clients' health needs, particularly in relation to chronic disease and complex care needs.

SARRAH maintains that every Australian should have access to equitable health services wherever they live and that allied health professional services are basic and fundamental to Australians' health care and wellbeing.

Rural and remote Australia is defined using the Australian Standard Geographic Classification system for Remoteness (ASGC) and comprises categories RA2 (Inner Regional), RA3 (Outer Regional), RA4 (Remote) and RA5 (Very Remote), with a particular emphasis on the RA3-5.

SARRAH recognises rural and remote as a continuum of communities outside major metropolitan centres of Australia and is committed to ensuring that people living in these areas have equitable and high quality access to allied health services.

COMMENTS AGAINST THE TERMS OF REFERENCE

The following comments aim to specifically address the areas listed under the terms of reference of the Inquiry, whilst highlighting the need to recognise the important contribution of allied health in the provision of services in rural and remote communities.

a. the impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting;

The impact of reduced Commonwealth funding for hospital services will have an adverse effect on the health and wellbeing of many Australians. The concept of the right health service, at the right time, in the right place would not be possible for many health consumers particularly those from disadvantaged groups such as the elderly, residents in rural and remote communities and Aboriginal and Torres Strait Islander peoples.

SARRAH believes that a reduction in funding would directly and inevitably result in bed closures, operating theatre shut downs, closing of outpatient clinics and reducing emergency services.

Reduced Commonwealth funding of other health services will also negatively impact State and Territory governments', who are major employers in the Australian health system, capacity to continue to employ AHPs. This will have a direct and immediate effect on the availability of AHP services at the primary health care level, as well as in hospitals. Generally, when health budgets are cut, AHP services are the first component to be reduced.

All of these factors impact on health consumers' access to care and treatment and ultimately to the quality of care provided resulting in:

- an increase in acute and/or emergency admissions due to cutbacks in funding for allied health teams to provide preventative care and management of chronic conditions;
- a real reduction in the number of services provided – because the funding amount does not cover the cost of providing timely and effective care;
- a reduction in the quality of hospital and community care, with poorer patient outcomes, complications and major increases in delays to care; and
- a diminution in the number of training places, and the quality of the training experience for health professionals – with a focus on higher throughput in order to attract more funding for activity.

Recommendation 1: Governments should not reduce the funding of public hospitals through adjustments of the health funding agreements as it would reduce the current capacity in the system.

b. the impact of additional costs on access to affordable healthcare and the sustainability of Medicare;

People who live in rural or remote Australia experience poorer health outcomes on a wide range of health measures than those in metropolitan areas. The overall health status of people worsens on a continuum as they move away from metropolitan centres. Contributing factors include:

- Greater social and economic disadvantages such as reduced opportunities for education and skilled employment and higher costs of living;
- Poorer access to health services and a range of health professionals in particular AHPs;
- Higher levels of health risk behaviours such as smoking, binge drinking and lack of physical activity;
- Lower environmental factors including poorer housing, greater distances travelled and higher risk occupations; and
- Higher proportions of vulnerable population groups, including but not restricted to Aboriginal and Torres Strait Islander people, people living with disabilities, people from culturally and linguistically diverse backgrounds and older people.

SARRAH believes that health care planning, programs and service delivery models must be implemented to meet the widely differing health needs of rural and remote Australian communities. This approach will contribute towards overcoming the challenges of geographic spread, low population density, limited infrastructure and the significant higher cost of health care delivery in the bush.

A significant component of affordable health care for people residing in a rural and/or remote setting is the cost of travel to access health services. These costs are higher with increasing rurality.

Australia currently has limited measures on the national impact of allied health interventions on patients with chronic diseases or disabilities. However, imagine a public health service that did not include Podiatrists for patients with diabetes, Occupational Therapists for dementia patients or Speech Therapists for children with autism.

Ensuring that Medicare items reflect the need of patients with chronic conditions requires inclusion of allied health services that will achieve the greatest outcomes.

Further comments about Medicare are made below under section f.

Recommendation 2: Governments enhance their effectiveness towards implementing strategies creating equitable health services and reducing the gap in social inequity, by measuring the impact of multi-disciplinary teams on patient welfare and health costs.

c. the impact of reduced Commonwealth funding for health promotion, prevention and early intervention;

The need for a national health agency to drive the preventative health agenda was identified by the Council of Australian Governments in 2008. As a consequence, the Australian National Preventative Health Agency (ANPHA) was established on 1 January 2011. However, the ANHPA functions were transferred to the Department of Health from 1 July 2014 and it could be argued that a reduction in Commonwealth funding for health promotion, prevention and early intervention has already commenced in this country.

ANPHA focussed on alcohol, tobacco and obesity – all significant lifestyle risk factors associated with chronic disease. ANPHA found that approximately 40% of potentially preventable hospitalisations for chronic conditions are associated with alcohol, tobacco or obesity.

SARRAH recognises that population focused efforts to prevent chronic disease and promote health are critical to maintaining a sustainable health system and a fuller life for all members of the Australian community. The Australian Government is responsible for leading, facilitating and promoting policies and programs that keep people healthy through the implementation of an effective primary health care system.

Building the capacity of a primary health care system to promote and deliver early intervention health services requires structural reform and funding to:

- better support the primary health care sector to provide preventative health care directed at improving local health outcomes; and

- improve the link between individual care provided in the primary health care setting and broader community based prevention.

Despite greater need in rural and remote Australia, there are a number of circumstances in which 'standard' population health measures are less likely to reach people in rural areas as readily as they reach urban populations. These barriers to prevention measures include less access to a range of health professionals, lower levels of health literacy, less supporting infrastructure through community and work settings, and more technical and logistical barriers to true community participation.

SARRAH believes programs that provide ongoing support for community-based initiatives to build healthy communities need to be further developed and implemented. Consequently, governments need to acknowledge and take action to address these circumstances enabling better alignment of prevention programs with areas and communities of greatest need. The expertise of AHPs are core to effective prevention programs and capable of addressing the health needs of people in rural and remote areas.

Overall, health promotion and prevention programs for people in rural and remote Australia should take account of the special characteristics, challenges and diversity of these communities, and be planned and implemented in ways that will make them effective in those areas.

Recommendation 3: Governments support a preventative health agenda through:

- implementing a governance framework which comprises representatives from local communities in leadership on health promotion and illness prevention, including strong representation from Aboriginal and Torres Strait Islanders;

- enabling people to increase control over their health for example; development of preventative measures with greater ownership at the community and individual level; and

- providing equitable access to AHP services, essential for the effective implementation of health prevention programs.

d. the interaction between elements of the health system, including between aged care and health care;

Social determinants of health include elements such as; health, housing, education, employment, transport and other social services which collectively are all important to the infrastructure and sustainability of local communities. Consequently, the availability of these elements in a community has a direct impact on the health and wellbeing of its citizens.

Using aged care as an example many older Australians receive some form of aged care and support each year. Services are generally delivered in the community and in residential facilities, and include assistance with daily living, personal and health care. However, these services and facilities are not always available in many rural and/or remote settings across Australia to meet community demand.

The aged care system interacts with many other areas of social policy, including primary health, acute care, disability services, housing, transport and income support. Service delivery in each of these areas affects the performance of the aged care sector and access

to a range of AHP services is an essential component of effective health care for older Australians.

SARRAH believes that the underpinning principles to an aged care policy framework should be equity, efficiency and sustainability. The pressures associated with population ageing and growing diversity among older people are stimulating debate about how these concepts are interpreted and applied to the delivery of aged care services.

Recommendation 4: Governments consult with communities to decide how much weight should be given to equity, efficiency and sustainability including possible trade-offs between these objectives and those relating to quality and choice.

e. improvements in the provision of health services, including Indigenous health and rural health;

AHPs play a critical role in a sustainable health system across Australia. They prevent hospital admissions, reduce length of stay and offer cost and clinically effective alternatives or adjuncts to medical specialist interventions such as surgery.

SARRAH commenced undertaking a concise literature review on the benefits of allied health intervention services to patient outcomes and cost savings. Examples of the preliminary findings of that review are presented below.

Yearly podiatry visits for diabetic patients could reduce Australia's amputation rate by 40%

- Australia has second highest rate of amputations in the developed world.
- Diabetes affects over 1 million Australians, resulting in 10,000 hospital admissions for diabetes-related foot ulcerations per year.
- If diagnoses continue to grow at the current rate, up to 3 million Australians over 25 will have diabetes by the year 2025.
- Amputation rates have increased by 30% in the last decade compared to Norway who have, in the same period, decreased their rate by 40% through introduction of basic and regular diabetic foot screening and at least an annual review by a Podiatrist.
- Australia's current amputation rate is 18 per 100,000 of the population.
- In excess of 4,300 amputations are performed annually due to diabetes, costing the Australian healthcare system $32,086 per amputation (2005 cost), plus aftercare costs.
- In South Australia during 2005, the prevalence of diabetes for people living in rural and remote communities was 10.2% compared to 7.8% in metropolitan areas. South Australia in 2013-14, approximately 20% of potentially preventable admissions to country hospitals were related to diabetes and it's estimated that half of these were foot-related.
- Rural people are four times more likely to be admitted to hospital with diabetes-related foot disease.

- People hospitalised for diabetes-related foot disease have a long length of stay averaging 12 to 13 days. Those requiring limb amputations stay for 26 days.
- Overwhelming evidence exists to show that podiatry-led foot clinics reduce diabetes-related foot disease admissions and the length of stay. For example, in the UK over an eight-year period, a diabetes foot clinic reduced the length of stay by 13.8 bed days.
- Australia would save an estimated $397 million annually by implementing best practice research, including a yearly podiatric foot assessment for all diabetic patients, according to the *Australasian Podiatry Council*.

Physiotherapy management could prevent 63% of costly knee replacements

- Annual cost of joint replacement surgery in Australia is $1 billion per year.
- A physiotherapy screening clinic for potential knee replacement patients found that 63% were appropriate for non-surgical management by a physiotherapist. The cost of a physiotherapy service is 25% of the cost of surgical intervention.
- With physiotherapy screening in place, patient waiting time for surgery reduces from 18 months to 3 months.

Yearly optometry visits would prevent 94% of blindness in Indigenous Australians

- The high rates of vision loss in Aboriginal and Torres Strait Islanders are preventable with yearly check-ups by an optometrist, but more than one-third of Indigenous adults have never had an eye examination.
- Indigenous adults have six times more blindness than non-Indigenous adults and nearly three times as many cases of vision loss – but 94% of this is preventable.
- Up to 98% of the blindness from diabetes can be prevented by timely laser treatment. In order to know if treatment is required, diabetic patients need regular eye examinations – every two years for non-Indigenous Australians and every 12 months for Indigenous Australians.
- Only 20% of those Indigenous people with diabetes are currently receiving eye examinations.

A final report presenting the findings from a larger review will be finalised in October 2014.

SARRAH believes that Government must fund the production of a researched and referenced paper produced by a health economist providing evidence demonstrating how allied health services reduce costs and improve patient health. This work will contribute toward achieving the government's Health and Aged Care Reform agendas.

Recommendation 5: Government fund a health economist to produce a researched and referenced paper demonstrating the range of allied health interventions and savings to the Australian health budget.

f. the better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services;

Australia's Medicare Legislation is based around the notion that all Australians have the right to basic health services according to need. However, there are considerable human, social and economic consequences for people in rural and remote Australia with chronic illness or disability, through not being able to access even basic AHP services.

Cant and Foster[1] critically examined the utilization of the 13 allied health services provided through the Medicare Chronic Disease Management program and related general practitioner care planning initiatives. Their study included billing data from July 2005 to June 2009. Their study clearly indicated "*Inequality of accessibility for patients was apparent*." As part of their conclusions they state: "*Five years into the program, a review of Medicare Allied Health SDM policy is warranted*". To date such a review has not been undertaken.

SARRAH raises the following questions about Medicare:

- What is the review process for Medicare when adding new items and removing existing items that do not meet evidenced based best practice?
- Will the uptake, impact and effectiveness of allied health services claimable under Medicare be evaluated? If so, when?
- What is the differential in the uptake of MBS item numbers and services provided under the allied health initiative between remote, rural, regional and metropolitan Australia?

In order to improve access to allied health services for consumers with chronic and complex conditions in rural and remote Australia, a review of the current MBS allied health provisions and other related Australian Government programs is required. Programs need to reflect the true nature of the service delivery by the different professions under the allied health category, the number of services needed, and be flexible enough to enable access to the required services to be met for consumers in rural and remote communities.

SARRAH is therefore calling for a transparent review of all Medicare allied health items, informed by rigorous evaluation of health outcomes and required number of occasions of service to generate an evidence base for intervention and feed into efficient price for community outpatient services for chronic disease management.

At the same time, SARRAH is advocating for the removal of legislative, policy and program funding barriers in federal funding schemes that inhibit access to allied health providers where services are of proven benefit.

Recommendation 6: Government review and enhance Medicare allied health items available for chronic disease management including the level of reimbursement to AHPs for services provided.

g. health workforce planning; and

The Australian media publishes many reports about shortages of doctors and nurses, particularly in rural and remote areas across Australia. However, there are not a similar

[1] Cant, RP & Foster MM, 2011, *Investing in big ideas: utilisation and cost of Medicare Allied Health Services in Australia under the Chronic Disease Management initiative in primary care,* Australian Health Review 35(4) 468-474.

number of reports on shortages in the allied health workforce. The nature, size, distribution and effectiveness of the health and community service workforce are the subject of study and debate.

Access to health services provided by the AHP workforce is essential to the health and wellbeing of all Australians. Yet, those who undertake analysis of the workforce, report on gaps in the data available on the allied health workforce. This is particularly true of the self-regulating allied health professions.

For example, the National Health Labour Force Series produced by the Australian Institute of Health and Welfare are problematic because:

- The range of allied health professions covered is limited.
- The data on self-regulated allied health professions is either non-existent or incomplete.
- A breakdown of data into metropolitan, rural or remote areas is not provided.

It has become increasingly apparent that the problem with the lack of detailed data about the allied health workforce is not just confined to Australian regional, rural and remote areas. In capital cities and other metropolitan locations, very little is known about the nature and distribution of allied health services and the workforce.

SARRAH is calling for a nationally-funded database framework capable of collecting meaningful data for future planning. Specifically, this would need to include a large, longitudinal national e-cohort study of allied health professions (similar to those well-established for medicine and nursing), providing analysis by geographic region, public, private and non-government sectors, skills mix and relationships between professions within a service, as well as profession-specific information.

Recommendation 7: Government fund a national database framework capable of collecting meaningful data for future AHP workforce planning.

h. any related matters.

Government policies and programs – rural impact statements

SARRAH believes that the impact of health policies on rural and remote communities is often overlooked.

For example, the Helping Children with Autism package offers federal funding of $12,000 per child to help families with the cost of early intervention therapies. It means every young Australian child with autism (aged up to 8) is entitled to funding for speech pathology, psychology and occupational therapy. This is great for city residents with a wide choice of providers, but if there are no providers for hundreds of kilometres, rural children miss out. It is not acceptable to expect a parent in rural Australia to drive four hours to access this entitlement for their autistic child, which is a common scenario. This policy, while welcome, obviously did not intend to exclude rural families, but in many cases it does.

A rural impact statement would have identified this obvious gap before the policy was rolled out across Australia – and allowed for solutions such as providing targeted services in areas with no local providers.

Recommendation 8: Government rural-proof all new government policies and programs to include a Rural Consumer Impact Statement that is publicly available.

Allied health rural workforce incentive programs

Staff shortages were identified as the single biggest issue affecting AHPs in a recent survey of SARRAH members (October 2013). A majority of respondents (38.5%) nominated recruitment and retention of staff as the main workforce issue impacting on them. Retention of experienced professionals and not backfilling positions were some of the recurring comments. This leads to burn-out of existing staff and a lack of experienced colleagues to provide mentoring and advice in complex patient cases – which impacts significantly on rural patients.

SARRAH works hard to address this by administering the Australian government-funded Nursing and Allied Health Scholarship and Support Scheme (NAHSSS). This provides financial help to rural-based service providers and students to train at university, take up rural placements and complete ongoing professional development. However, demand is so high that hundreds of applicants are unsuccessful every year due to funding constraints.

Recommendation 9: Government continue and increase funding levels under the allied health stream of the Nursing and Allied Health Scholarship and Support Scheme as well as introduce a new program to address a national rural allied health mentoring program.

CONCLUSION

SARRAH strongly supports this inquiry and will continue to develop and support initiatives that adequately address the needs of rural and remote AHPs and communities in partnership with government and other stakeholders. Consequently, SARRAH would welcome the opportunity to elaborate on this submission.