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A healthier future for rural and remote Australians

NRHA response to the Final Report of the National Health and Hospitals Reform Commission

September 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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Introduction

The health status of people in rural areas is poorer than that of people in the capital cities. The National Rural Health Alliance has a strong commitment to equal health for all Australians by 2020.

The seven million people living in rural and remote Australia have much to gain from health sector reform. Both general and specific improvements in the health sector are needed to overcome the barriers to equal health for rural and remote Australians, including especially people of Aboriginal and Torres Strait Islander backgrounds.

The Alliance has outlined its preferred approaches to reform in submissions to the National Health and Hospitals Reform Commission[1], the Primary Health Care Strategy[2], the National Preventative Health Taskforce[3] and through other documents and activities.

The Alliance supports a single level of government to raise and distribute health funds and to set policies, standards and benchmarks. It believes there should be a stronger regional approach to the planning and delivery of health services, with good accountability and the opportunity for community participation.

The aim of this response to the Final Report of the National Health and Hospitals Reform Commission[4] (hereafter the Report) is to help shape the Australian Government's responses to the recommendations and ensure that rural and remote issues are addressed in them.

Aboriginal and Torres Strait Islander Health

The NRHA is a strong advocate for a whole of government approach to improving Aboriginal and Torres Strait Islander health. It looks to its two Indigenous bodies to lead on the matter.

The Alliance welcomes the priority given in the NHHRC's Report to improving health outcomes for Aboriginal and Torres Strait Islander peoples.

The key to the success of the reforms will be for future approaches to spring from and be owned and managed by Aboriginal and Torres Strait Islander people themselves.

Without this, the benefits of possible improvements in health services will be less likely to eventuate. There will also be limited benefit from health reform (narrowly defined) if important social, economic, environmental and cultural determinants of health are not

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[1] NRHA, *Equal health through systemic reform, Submission to the National Health and Hospitals Reform Commission*, June 2008; and NRHA, *Submission on the NHHRC's Interim Report, A Healthier Future For All Australians*, March 2009; and NRHA, *Proposal to the National Health and Hospitals Reform Commission for a Rural Australia Dental Undergraduate Scholarship (RADUS) Scheme*, March 2009; and NRHA, *Improving access to dental care in rural and remote Australia, Supplementary Submission in response to NHHRC Interim Report*, April 2009. All available in full at www.ruralhealth.org.au/publications

[2] NRHA, *Submission to the Australian Government: Towards a National Primary Health Care Strategy*, February 2009; at www.ruralhealth.org.au/publications

[3] NRHA, *Submission to the National Preventative Health Taskforce*, January 2009; at www.ruralhealth.org.au/publications

[4] National Health and Hospitals Reform Commission. *A healthier future for all Australians* – Final Report, June 2009. http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/nhhrc-report

simultaneously addressed. These include education and employment opportunities, housing, fresh food and water, cultural respect and people's sense of control over their own lives.

NACCHO has argued that one of the most important elements of the reforms is capacity building for Aboriginal Community Controlled Health Services since "it is these that are providing the bulk of primary health care to the Aboriginal population and which broker the access to allied and tertiary health services". It seems contradictory that additional costs are not allocated for this fundamental capacity building in recommendation 60 of the Report. A national framework Agreement with NACCHO would inform the range of needed health reforms.

While the Report recognises that Indigenous people must 'own' solutions, the recommendation on a new Health Authority seems to place more emphasis on expertise in 'purchasing health services' than on the principle of community ownership.

It is also of concern that in a report identifying up to $9.6 billion of new ongoing expenditure, no estimate has been made of the additional funding required to give effect to recommendation 59 that expenditure on Aboriginal and Torres Strait Islander health be "proportionate to health need, the cost of service delivery, and the achievement of desired outcomes". While the commitment already made by the Council of Australian Governments (COAG) to $1.58 billion over the next four years to 'Closing the Gap' is welcome, this measure does not provide for sustained investment in improvements in health care for Aboriginal and Torres Strait Islander people in the years to come.

The decisions taken by Governments on changes to the health system must include, as a priority, funded measures to improve health outcomes for Aboriginal and Torres Strait Islander peoples.

The Alliance also considers that top priority should be given to recommendations in the Report to:

- improve the affordability of fresh food, particularly fruit and vegetables, for targeted Aboriginal and Torres Strait Islander communities in remote areas with limited access to affordable healthy foods;
- invest further in building the Aboriginal and Torres Strait Islander health workforce across all disciplines; and
- Indigenous health modules to better equip the health sector overall with the specific skills needed in service provision to the Aboriginal community. These modules must be developed appropriately through the joint NACCHO/RACGP/ACRRM/RACP recommendations. Such recommendations have already been developed between NACCHO and the RACGP.

A proposed complement to the approaches taken by the proposed Health Authority is to include Aboriginal and Torres Strait Islander people as eligible for enrolment with an appropriate primary health care service that is responsible for coordinating their broader multidisciplinary care needs and ensuring better continuity of care as they move around the health system. (This is part of the broader primary care reform proposals discussed later in this paper.) NACCHO is concerned that it is premature to ascertain if voluntary enrolment of Aboriginal patients with the primary health care service of their choice will make any difference to health service access to this population. It is possible that this approach might encourage more fee-for-service distortions of health care delivery. Patients are also mobile for a range of reasons and tying funding to patients usual care provider can be inequitable.

Better access to dental health care should ensure that regular and more frequent dental care is available for Aboriginal and Torres Strait Islander people living in remote communities. A

treatable condition such as dental abscess should not deteriorate into critical illness such as septicaemia because dental care visits to remote communities are sporadic or do not occur. Dental care should also be part of broader multidisciplinary care for Aboriginal and Torres Strait Islander people through primary care reforms.

Keeping the spotlight on rural and remote health

The Alliance welcomes the specific focus in the Report on delivering better health outcomes for remote and rural communities through recommendations 65-70 (Attachment A).

While these specific rural recommendations recognise current inequities in access to health care for rural people and overall poorer health outcomes, they are important first steps only.

The Alliance calls on the Government to ensure that its full package of reforms is designed and implemented in ways that ensure health care is funded and delivered to rural people in a fair and equitable fashion.

The Alliance urges the Government to ensure this principle is paramount, as it considers the proposed primary health care reforms in the Report (Attachment B) and develops its National Primary Health Care Strategy.[5]

In this response to the National Health and Hospitals Reform Commission Report, the Alliance focuses on three reforms that are particular priorities for rural and remote Australia:

- **Comprehensive primary health care and other essential services as locally as possible,** well linked to other levels of health care (such as acute hospital care, diagnostics, rehabilitation and so on) where they are needed.
- **Immediate improvements in access to health care services not available locally,** through patient assisted transport, telemedicine, outreach visits by a range of medical and allied health specialists, and support for isolated practitioners.
- **Universal access to affordable, basic dental health care,** provided in ways that will work in rural and remote Australia.

For these reforms to be effective, several other proposed reforms are necessary:

Population-needs-based funding: Rural people must receive their fair share of health funding in terms of actual health services provided as a matter of principle/equity; additional funding is required to ensure that their health outcomes catch up with the rest of the population.

Sufficient and the right mix of health professionals: Reforms that only provide infrastructure and funding mechanisms for improving health care will not help rural communities unless there are also mechanisms to ensure there are health professionals to deliver the services.

Regionally based planning and implementation: National reforms must deliver regionally appropriate health services that make the best use of available facilities and health professionals at local community level, with good accountability and opportunity for community participation.

Improved communications and e-health: Improved communications systems should be a priority to enable telemedicine support for specialists in even the most remote communities, and electronic health records will support better communications between the members of the health care team and their patients, wherever they are receiving care.

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[5] Australian Government Department of Health and Ageing. Building a 21st Primary Health Care System: A draft of Australia's first National Primary Health Care Strategy. Commonwealth of Australia, August 2009. http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nphc-draft-report-toc

Immediate improvements in access to health care services

The Alliance believes that people should have their essential health care needs met as locally as possible, irrespective of where they live. Essential services may include preventive health care; maternal, family and child health services; generalist hospital care; aged and community care; and end-of-life care, as well as primary care. Provision of these services needs to make the best use of the available health professional workforce in rural areas and ongoing priority should be given to developing more effective ways of delivering services that will not be limited by workforce shortages.

However, there will be times in many people's lives or situations when it is not practical for the necessary specialised expertise to be available locally. Further, until current health workforce shortages are addressed, stop gap measures will be needed to improve or even maintain access in many rural and remote communities.

Specialist outreach services, telemedicine and support for remote practitioners

The Alliance welcomes the specific rural recommendation 66 in the Report (Attachment A), which includes extension of specialist outreach services including, for example, medical specialists, midwives, allied health, pharmacy and dental/oral health services; telehealth; other practitioner support and advice networks; and 24 hour on-call telephone and internet consultations, advice and retrieval services for remote practitioners.

The provision of such services will be facilitated by the development of electronic health records, resulting in more effective shared patient care across virtual health care teams, and when patients have to travel for specialist care.

Patient Assisted Travel Scheme (PATS)

Given their frequent need to travel to access health services, country people are likely to benefit from the recommended increase in funding for patients' travel and accommodation support schemes. The indicative cost estimates are for $85 million at current level of demand to $244 million if demand increases (as has been estimated) 2.25 times. Where these schemes are concerned, the Commission proposes national consistency with regard to eligibility and benefits.

This improved support for travel which better recognises actual costs and the role of carers is critical for improving short term access to health care in rural and remote Australia and will remain a component of health care into the future. The implementation must be straightforward for consumers and for health care providers and supported by widespread promotion of its existence and information about how it works and how to access the scheme.

However, such a national system will need the flexibility to be delivered in ways that work at community level and within and across regions. For example, a Council bus service may help people in a rural centre attend an outreach specialist clinic, or an air ambulance may be the best solution for an acute admission for a patient with a complex condition that has deteriorated – but needs and possible solutions will vary with situations, the patients' needs and the transport options available.

Health Minsters have sought advice from their Departments on improving PATS, and there have been recent changes in some jurisdictions. Hopefully this element of the NHHRC Report will lead to immediate action as necessary in all jurisdictions.

Planned implementation

The Alliance believes that a National Rural Health Plan is urgently needed to provide the framework for flexible national funding arrangements and regional planning for immediate improvements in access to health care for rural and remote Australians.

Such a National Rural Health Plan should be forward looking to include access targets for rural people in the short term, with milestones for a planned transition to more comprehensive primary care and other essential services more locally over time, as discussed below.

A critical element of the Plan will be to ensure that existing services in small rural towns and remote communities are retained, not undermined by consolidation in major regional centres.

Well integrated, multidisciplinary and patient-centred health care as locally as possible

The Alliance believes that multidisciplinary primary health care teams, working effectively together and coordinating with hospitals and specialised medical, diagnostic and allied health care providers beyond their team, are essential for patient-centred health care delivery in rural and remote Australia. Many smaller rural communities have only basic hospital facilities or no local hospital at all, and others do not have a doctor in town. Primary care is the key to referrals to and from other parts of the health system, as well as to preventive health care and early intervention to reduce the onset of more complex and acute conditions.

Flexible and cooperative approaches to primary care funding can also contribute to attracting, supporting and retaining an appropriate and sufficient health workforce across a region. A strong primary care system would be expected to be the base in rural Australia for providing much of the other services envisaged in the Report, including for enhanced early childhood care, mental health, end-of-life care and possibly some elements of aged care, rehabilitation and subacute services.

In response to the challenges they face, health personnel in rural and remote areas and the communities they serve have long demonstrated a capacity for service innovation and development. For that reason, Government can continue to look for inspiration to what is already being done in some parts of country Australia. It should build on this and invest in new programs in rural and remote areas first, not only because innovations are strongly supported in those areas but also because the need there is greatest and urban 'fixes' often do not meet the needs of rural and remote areas.

The Alliance supports the direction of the primary health care proposals in the Report (included at Attachment B with indicative annual cost estimates) including:

- enhanced multi-disciplinary scope and nature of primary health care teams through ***networks of Comprehensive Primary Care Centres and Services*** to provide an expanded range of services, either through physical or virtual links, with better coordinated referrals and networks of community services;
- actively reaching out to under-serviced groups in the community through ***optional enrolment with a single primary care service*** for those with complex needs, young families and Aboriginal and Torres Strait Islanders, to strengthen continuity, coordination and range of multidisciplinary care; and
- enhanced ***integration across primary care services*** and more broadly through Australian Government responsibility for the policy and public funding of primary health care services through an integrated plan to bring together general practice,

currently funded by the Commonwealth and the range of primary health care services currently funded by the States.

Over time, approaches such as these will create opportunities for better integration and accountability of primary care services including community and aged care.

Population-needs-based funding

A key issue for the Alliance is to ensure that additional investment in primary care services and improved funding models is applied fairly across Australia. Implementation should be based on population health needs through grants, rather than through fee-for-service only, to target those most in need including rural and remote Australians.

Something over one third of the investment in primary health care reforms should go to rural and remote communities, based on population (32 per cent), the greater need for services (as indicated by poorer health outcomes) and the greater costs of providing equivalent services in rural and especially remote areas.

Equivalence funding

The Alliance welcomes the notion of 'equivalence' or 'top up' funding whereby the funding to under-served small rural and remote areas would be increased to an amount equivalent to urban rates for medical benefits and other primary care service funding, adjusted for remoteness and health status, as a way of reducing current inequities in access to health care.

However, the interpretation of 'equivalence funding' in the Report is too narrow to effectively address inequities in health care for rural and remote Australians. Cost estimates are based only on Medicare services provided by GPs and target 'average Medicare spending', without adjustments for the current poorer health status in many rural and remote communities.

The cost of the full range of Medicare items including diagnostics, specialists and enhanced primary care items such as psychologists, physiotherapists and care planning for people with chronic conditions is much higher than the estimated annual quantum of $55 to $143 million in the Report. Full equivalence funding would encompass the broader primary care reforms and blended funding proposed in the Report, as well as current programs such as the Practice Incentive Program and Enhanced Primary Care Items.

Adequate data collection and analysis to ensure population-needs-based funding must be a part of the reform process and include the full range of primary care services and health funding sources in rural communities.

Blended payments

The Alliance supports blended funding for primary care services to encourage collaborative, multidisciplinary teams and support voluntary patient enrolment.

The Report proposes a move over time to blended payments, comprising:

- ongoing fee-for-service payments for episodic care;
- grant payments linked to the volume of patients enrolled, to broaden services through engaging other health professionals or to support better coordination and integration through, for example, non-clinical staff and infrastructure;
- outcomes payments to reward improvements such as enrolled patient outcomes or integration of evidence-based care into practice; and

- episodic or bundled payments developed over time for the cost of packages of care for enrolled patients.

The blended funding model in the Report needs further development into a combined funding model that would work across a mix of private providers and others working on salaries in Comprehensive Primary Health Care Centres or extended services.

Rural implementation opportunities

The Alliance supports the specific rural recommendation in the Report to extend the Multipurpose Service funding model to larger towns of about 12,000 to allow pooling of primary care, hospital and aged care funding. It believes that, in order to provide the best possible services for such communities, there should be the flexibility for blended payment models of primary care to be even more broadly available.

Networks of Comprehensive Primary Care Centres and Services

The establishment of comprehensive primary care centres and networks of services is a way to enhance the multidisciplinary scope and nature of primary care teams.

The Alliance believes high priority should be given to their establishment in under-served rural communities where access to health care services under current fee-for-service arrangements is failing and contributing to workforce shortages.

Such establishment must be planned and consultative with local communities and within regions to ensure that access to services is enhanced through collaboration with existing health and community service professionals.

It is important that such centres, whether virtual or co-located, involve and engage existing practitioners in the area, rather than setting up damaging competition or creating a situation in which some clinics and patients that have access to multidisciplinary care while others are outside the net.

The Report estimates the establishment grants for Comprehensive Primary Care Centres will provide for only 25 per cent coverage of the population by 2020. Unless there is a concerted effort to keep rural equity in mind, the same factors that have driven rural inequities in the past will continue to disadvantage rural Australia.

The proposed Comprehensive Primary Care Centres and Services should be based on regions of community of interest.

Optional enrolment with a single primary health care service

Because of the greater health need in rural communities and the natural population catchments they offer, rural and remote Australia is the ideal place to develop and implement comprehensive primary care service models based on voluntary enrolment. The purpose would be to strengthen the continuity, coordination and range of multidisciplinary care for people with complex needs, young families and Aboriginal and Torres Strait Islanders.

These models would also provide a framework for supporting and involving more isolated health professionals and for maintaining links with other parts of the health system as patients move between them.

The pooling of funds would necessitate a level of regional planning and implementation of services, an approach that is favoured by the Alliance.

Enhanced integration across primary health care services and more broadly

In relation to primary care, the Report talks of the Commonwealth Government doing business (eg service coordination and population health planning, handling equivalence funding in rural areas) with and through Divisions of Primary Care, expanded at a cost of $150 million per annum.

The proposed model would provide an essential regional focus and the basis for taking on other enhanced primary care such as mental health, rehabilitation services and end of life care.

However, it would require urgent broadening of governance and goals to reflect the wider range of primary health care interests and encompass the group of health professionals that make up multidisciplinary health care teams.

Opportunities for strong community engagement would need to be developed and supported.

Some rural Divisions that are already showing innovation and leadership for coordinating and providing multidisciplinary services would provide a good starting point.

The scope of use of funds would also need to be clarified with some flexibility for rural communities to develop service models based on their particular population needs within the region and with the local health workforce and health and community services already available.

The Report proposes that such expanded Divisions cover populations of 250,000 to 500,000 people. These figures correspond to UK approaches where Primary Health Care Trusts are fundholders for a fully needs-based approach to health funding, including for funding and commissioning of diagnostics, pharmacy and hospital admissions. Canadian figures suggest that only 25,000 to 40,000 people are required for capitation funding for primary care, while Australian Division sizes where such fund holding does not exist range from less than 30,000 to about 400,000, with an average of about 175,000.

The Alliance wants to retain flexibility for a variety of options including sharing of administrative and other functions to achieve economies of scale while preserving 'natural' regions which are charged with assuring equivalence of health care at the level of local towns and communities, not simply across the region.

Such an approach could also assist regions to hold and manage funds for the package of accessibility measures already discussed, including specialist outreach and Patient Assisted Transport arrangements that could be interpreted more flexibly to suit local community needs.

It would be important for the Commonwealth to include the experience in the States through established regional planning bodies and service provider networks at community level.

Dental health

There is widespread support for better access to dental care in rural and remote Australia.

The Commission's Denticare proposal is estimated to cost an extra $3.9 billion per annum, two-thirds as much as the rest of the proposals together. (Costs are proposed to be offset by a 0.75% increase in taxation, but there is no substantial reason why Denticare costs should be hidden or singled out for special treatment.)

The Alliance supports oral health reforms, but is concerned that Denticare would have quite limited application, especially in rural and remote Australia, unless policy and funding decisions address the systemic barriers to their effective implementation.

These barriers include severe workforce maldistribution, a lack of overall supply of new professionals, resistance by the dental profession to some proposals, a siloed approach to oral health and a poor approach to preventive health.

If it were to work for people in rural and remote areas, Denticare must be complemented by appropriate workforce supply, distribution and infrastructure, and a new culture of oral healthcare with wide acceptance. The Report recommends one year internships for all oral health practitioners, similar to requirements for medical practitioners ($200 million operation and $150 million capital for five years for five teaching hospitals and ten 'academic' oral health centres). This proposal for new teaching hospital hubs and spokes outside major capital cities would have to cover a large number of medium-sized towns if it is to be successful overall in rural and remote areas.

Planning for comprehensive primary care centres and services should include planning for dental care, with an expansion of the dental health workforce to include oral hygienists and therapists supported by rural incentives for dental health professionals. Voluntary enrolment with a particular primary care service should include integration of dental care and timely access to dental prosthetics.

The Alliance also wants to see dental care included as part of the immediate priorities for access, supported by outreach specialist services and patient assisted transport schemes until essential dental services are available locally in rural and regional areas. As discussed earlier, special arrangements should be made for regular dental care visits to remote Aboriginal and Torres Strait Islander communities.

Rural access targets for dental care should be developed to address life-course requirements for dental care including expansion of pre-school and school dental programs as recommended in the Report, but also as part of ante and post natal care and changing requirements including timely access to dental prosthetics as part of aged care.

Finally, without a dental workforce that is interested in working in rural and remote Australia, the seven million Australians living there will continue to have very substantially poorer levels of oral and dental health. As a priority, dental training in Australia should be reformed so as to encourage graduates to practise in rural and remote areas.

Challenges for implementation

Governance

The Report recommends the Commonwealth having funding and policy responsibility for primary care, dental care, and aged care and, over time, moving towards 100 per cent funding of the efficient provision of acute care services. The Commonwealth Government would meet 100 per cent of the efficient costs of public hospital outpatients in the first instance, as these relate to primary care.

The Alliance supports this proposal. The Commonwealth would be something of a novice where the delivery of community services and aged care are concerned, and will need the experience of the services and people already on the ground.

Especially with responsibility for 100 per cent funding of acute care, the Commonwealth would have strong incentive for pursuing greater effectiveness, integration and efficiency of the overall system. The initial recommendations are for the Commonwealth to meet 40 per cent of the efficient costs of care for every episode of acute care and subacute care for public patients admitted to a hospital or public health care facility and for every attendance at a public hospital emergency department.

The Alliance is concerned that the Report rejects regional governance, arguing *inter alia* that it is difficult to set fair regional budgets, that there would be border issues, that it could be difficult to achieve economies of scale in some regions, and that there would be an additional layer of bureaucracy. The Alliance believes that a regional focus for planning and implementation of health reforms, with accountability for equivalent health care across the region, will lead to improvements in rural and remote health.

The Report recommends consideration of a social insurance scheme (Medicare Select) whereby people could choose a health and hospital plan offered by government, by not-for-profit or private enterprise. It suggests that this would provide consumer choice and competition, and better utilise both private and public sector health resources, but it also identifies a long list of issues to be clarified in such a scheme.

Such a scheme as is proposed would not currently suit rural and remote areas where, by definition, there are very few options for primary care provision.

In any case, the complexities to be resolved in such a social insurance scheme appear to outweigh the complexities of a regional health approach; eg risk-based funding for each person joining the scheme, managing excess risk, managing flows of people among funds (Holland allows such decisions once per three months), planning for the development of new facilities in areas of demand and in the integration of services. The Report's proposal does not address how to achieve consumer choice and competition in rural areas or the equitable distribution of workforce. Each insurance scheme would also have its own layer of bureaucracy, one of the criticisms of our current health system funded by different layers of governments.

Health workforce

Workforce support measures need to be commensurate with the levels of unmet need and allow for the already greater demands upon the existing rural and remote workforce.

The measures proposed by the Report to support the rural and remote health workforce are welcome, but do not go far enough. The proposals include:

- rural and remote practitioner support through referral and advice networks, remote on-call etc;
- allocating a higher proportion of undergraduate and graduate placements to remote and rural centres (this will require significant capital investment in accommodation and training facilities);
- the extension of some of thee current incentives for rural GPs to other health professions; and
- research program to build rural health service, clinical and workforce capability.

Measures such as giving rural practitioners preferential access to specialist colleges and internships for dental students are also attractive. The possibility of an internship year could be considered for any health profession that does not already have one, both to improve the skills of new graduates and to help improve their distribution.

The new primary care centres and those partly funded through voluntary enrolment could be attractive and better funded workplaces and assist in workforce redistribution. These measures should be prioritised for rural and remote areas and their implementation started without delay.

The measures taken in the 2009-2010 Commonwealth Budget to establish a new geographic classification and to 'scale' relocation and retention incentives payments by remoteness also

provide hope for a better distribution. However, to date the only substantially successful measure has been the recruitment of overseas doctors under the 10 year moratorium for area of practice. There needs to be further consideration of this issue because of its effect on the recruitment of Australian trained doctors to rural Australia and because of the long-term implications of relying on OTD recruitment.

Rural access to all levels of health care must be a part of the proposed National Access Targets and the Alliance supports development of a National Rural Health Plan to ensure that ongoing action on health reform contributes to better health in the bush.

Attachment A

Delivering better health outcomes for remote and rural communities

RECOMMENDATIONS

65. Flexible funding arrangements are required to reconfigure health service delivery to achieve the best outcomes for the community. To facilitate locally designed and flexible models of care in remote and small rural communities, we recommend:

- funding equivalent to national average medical benefits and primary health care service funding, appropriately adjusted for remoteness and health status, be made available for local service provision where populations are otherwise under-served; and

- expansion of the multi-purpose service model to towns with catchment populations of approximately 12,000.

(COST $55 million to $143 million per annum)

66. Care for people in remote and rural locations necessarily involves bringing care to the person or the person to the care. To achieve this, we recommend:

- networks of primary health care services, including Aboriginal and Torres Strait Islander Community Controlled Services, within naturally defined regions;

- expansion of specialist outreach services – for example, medical specialists, midwives, allied health, pharmacy and dental/oral health services;

- telehealth services including practitioner-to-practitioner consultations, practitioner-to-specialist consultations, teleradiology and other specialties and services;

- referral and advice networks for remote and rural practitioners that support and improve the quality of care, such as maternity care, chronic and complex disease care planning and review, chronic wound management, and palliative care; and

- 'on-call' 24-hour telephone and internet consultations and advice, and retrieval services for urgent consultations staffed by remote medical practitioners.

Further, we recommend that funding mechanisms be developed to support all these elements.

(Cost $50 million to $100 million per annum)

67. We recommend that a patient travel and accommodation assistance scheme be funded at a level that takes better account of the out-of-pocket costs of patients and their families and facilitates timely treatment and care.

(Cost $85 million to $244 million per annum)

68. We recommend that a higher proportion of new health professional educational undergraduate and postgraduate places across all disciplines be allocated to remote and rural regional centres, where possible in a multidisciplinary facility built on models such as clinical schools or university departments of Rural Health.

69. We recommend building health service, clinical and workforce capability through a remote and rural health research program.

70. We recommend that the Clinical Education and Training Agency take the lead in developing:

- an integrated package of strategies to improve the distribution of the health workforce. This package could include strategies such as providing university fee relief, periodic study leave,

- locum support, expansion of medical bonded scholarships and extension of the model to all health professions; and

- preferential access for remote and rural practitioners to training provided by specialty colleges recognising related prior learning and clinical experience and/or work opportunities for practitioners returning to the city, and support for those who plan to return again to remote or rural practice once specialty attained.

(Cost $27 million per annum)

Attachment B

Creating strong primary health care services for everyone

RECOMMENDATIONS

16. We recommend that, to better integrate and strengthen primary health care, the Commonwealth should assume responsibility for all primary health care policy and funding.

(No net costs)

17. We recommend that, in its expanded role, the Commonwealth should encourage and actively foster the widespread establishment of Comprehensive Primary Health Care Centres and Services. We suggest this could be achieved through a range of mechanisms including initial fixed establishment grants on a competitive and targeted basis. By 2015, we should have a comprehensive primary health care system that is underpinned by a national policy and funding framework with services evolving in parallel.

(Capital cost $300 million establishment grants)

18. We recommend that young families, Aboriginal and Torres Strait Islander people, and people with chronic and complex conditions (including people with a disability or a long-term mental illness) have the option of enrolling with a single primary health care service to strengthen the continuity, coordination and range of multidisciplinary care available to meet their health needs and deliver optimal outcomes. This would be the enrolled family or patient's principal 'health care home'. To support this, we propose that

- there will be grant funding to support multidisciplinary services and care coordination for that service tied to levels of enrolment of young families and people with chronic and complex conditions;
- there will be payments to reward good performance in outcomes, including quality and timeliness of care, for the enrolled population; and
- over the longer term, payments will be developed that bundle the cost of packages of primary health care over a course of care or period of time, supplementing fee-based
- payments for episodic care.

(Annual cost $341 million to $682 million)

19. We recommend embedding a strong focus on quality and health outcomes across all primary health care services. This requires the development of sound patient outcomes data for primary health care. We also want to see the development of performance payments for prevention, timeliness and quality care.

(Annual cost $252 - $800 million)

20. We recommend improving the way in which general practitioners, primary health care professionals, and medical and other specialists manage the care of people with chronic and complex conditions through shared care arrangements in a community setting. These arrangements should promote good communication and the vital role of primary health care professionals in the ongoing management and support of people with chronic and complex

conditions in partnership with specialist medical consultants and teams who provide assessment, complex care planning and advice.

(Cost estimates not included for this recommendation)

21. Service coordination and population health planning priorities should be enhanced at the local level through the establishment of Primary Health Care Organisations, evolving from or replacing the existing Divisions of General Practice. These organisations will need to:

- have appropriate governance to reflect the diversity of clinicians and services forming comprehensive primary health care;
- be of an appropriate size to provide efficient and effective coordination (say, approximately 250,000 to 500,000 population depending on health need, geography and natural catchment); and
- meet required criteria and goals to receive ongoing Commonwealth funding support.

(Annual cost $150 million)

Also included in primary health care costs of reforms (recommendation is under 'Working for us: a sustainable workforce for the future')

99. To improve access to care and reflect current and evolving clinical practice we recommend that:

- Medicare rebates should apply to relevant diagnostic services and specialist medical services ordered ordered by nurse practitioners and other health professionals having regard to defined scopes of practice determined by recognised health professional certification bodies;
- Pharmaceutical Benefits Scheme subsidies (or where more appropriate, support for access to subsidized pharmaceuticals under section 100 of the National Health Act 1953) should apply to pharmaceuticals prescribed from above formularies by nurse practitioners and opther registered health professionals according to defined scopes of practice;
- Where there is appropriate evidence, specified procedural items on the Medicare Benefits Schedule should be able to be billed by a medical practitioner for work performed by a competent health professional, credentialed for defined scopes of practice; and
- The Medicare Benefits Schedule should apply to specifiied activities performed by a nurse practitioner, midwife or other competent health professional, credentialed for defined scopes of practice, and where collaborative team models of care with a general practitioner, specialist or obstetrician are demonstrated

(Annual cost $140 - $330 million)