IJAHSP
The Internet Journal of Allied Health Sciences and Practice
http://ijahsp.nova.edu

A Peer Reviewed Publication of the College of Allied Health & Nursing at Nova Southeastern University
Dedicated to allied health professional practice and education
http://ijahsp.nova.edu Vol. 3 No. 4 ISSN 1540-580X

What the People Want – Delivery of Health Services in Rural and Remote Australia

Lorraine Sheppard, PhD
Associate Professor, School of Health Sciences, University of South Australia
North Terrace, Adelaide
South Australia

Citation:
Sheppard, L. What the People Want – Delivery of Health Services in Rural and Remote Australia. *The Internet Journal of Allied Health Sciences and Practice.* October 2005. Volume 3 Number 4.

Abstract
The purpose of the paper was to discuss directions in rural and remote health based on current policies in Australia. A review of the policy framework and consideration of health and population trends provide a basis to discuss the future rural workforce. The conclusions that are drawn support present models of rural and remote practice. A commitment to primary health and public health will be the next focus in health care. A rural health workforce can respond to this direction using existing modes of practice which emphasize working in teams, planning services based on patient need rather than clinical specialty and welcoming new service providers.

Introduction
The delivery of health services in rural and remote areas is well known to be a problem. Given this focus, there is a growing history of different initiatives and policy changes. A growing body of experience, research and knowledge has developed. In 1998, with this accumulated knowledge, a national Australian framework was released entitled Healthy Horizons for rural and remote health activity for the period 1999-2004.[1]

Healthy Horizons provides guiding principles to underpin health care activities for rural and remote communities which are:

- an orientation to primary health care and public health in order to address causative factors underpinning poor health status
- increased consumer participation and community involvement in health care planning, in order to bring about real improvements in the health status of people
- accessibility, in order to ensure that health care and health services are actually available at times of need.
- flexibility, in order to cope with the diverse health needs, demographic and workforce changes, and the unique local circumstances characterizing many rural communities,
- intersectorial coordination and multidisciplinary collaboration, in order to maximize the limited resources available to service the health needs of the community,
- enhancing community capability and ensuring sustainability of the health care system.

Underpinned by these principles, *Healthy Horizons* identified seven independent goals as the focus of the national framework for rural health care activities. These goals are to:

- improve the highest health priorities first,

- improve the health of Aboriginal and Torres Strait Islander peoples living in rural, regional and remote Australia,
- undertake research and provide better information to rural, regional and remote Australians,
- develop flexible and coordinated services,
- maintain a skilled and responsive health workforce,
- develop needs based flexible funding arrangements for rural, regional and remote Australia, and
- achieve recognition of rural, regional, and remote health as an important component of the Australian health care system.

There is now a general agreement across governments on the need for a specific policy response to rural health issues and the principles that should underpin planning for the provision of health care services. There is recognition that improved health outcomes for residents of rural and remote communities may depend on changes in areas other than health services per se. A whole of health approach is required, which recognizes the wide range of social and economic determinants that impact upon health status. For example:

- Lifestyle considerations, including personal behavior such as smoking, alcohol consumption, diet and physical activity, risk taking and safety practices.
- Environment, including social factors such as education, occupation, working environment, the living environment, culture, social networks and supports, as well as the physical factors such as housing, water and food quality, efficient sewage disposal, and other physical hazards.[2]

The principles, goals and approaches of *Healthy Horizons* are laudable and universally agreed. However, the present health system is under stress with increasing budget and demand pressures. It is not sustainable.

The present health system tends to operate as an illness system with a focus on ill health rather than being healthy. The current health issues can be summarized as:

- A changing population profile
- Social determinants of health
    - Poorer socioeconomic circumstances and living standards, rates of poverty are increasing. Poverty is linked to inadequate diet, unhealthy lifestyle choices, stress and anxiety.
- Changing burden of disease
    - Increased incidence of cancer, heart disease, accidents and mental health. Diseases and injuries related to the ageing can be expected to increase such as Alzheimer's disease and osteoporosis.
- The expectation of a cure
    - Access to the latest technology, right to choice including access to complementary therapies
- Mix and distribution of services
    - There is a large expenditure on hospitals which gives access for only a small percentage of the population leaving an under resourced primary health and community care sector.
- Fragmentation and duplication of planning, funding and governance arrangements.
    - Boundaries exist at different government levels. A high number of short term, unsustainable and duplicated projects.[1]

In 2002, the South Australian Government announced its own whole of state review looking at both metropolitan and rural and remote services.[3] The aim was to develop a framework to guide the health care system over 20 years and to place the consumer at the center of health care.

The Generational Health Review identified a number of key themes critical to delivering the required health reform agenda:

Promoting a population health approach

- Promoting primary health care
- Accountability and transparency
- Workforce development
- Health inequalities and health as a human right.

The Generational Health Review acknowledges that "(these) directions are not new or world shattering. They are similar to what is happening internationally in health in countries comparable to Australia. It is not the directions that are controversial, it is the act of **implementing** them."[3]

To implement these directions South Australia will see:

- A population health approach with the following functions:
- Identify geographical populations undertake this population's needs assessment and health service planning
- Health funding distributed and devolved to these populations to provide services based on population size and need
- Population health service planning statewide
- Population based health governance; that is, a governing body for a defined geographical population

It is important to note the focus on geographical populations. A primary health care approach with:

- Networked primary care services, accessible and improving population health
    - Integrated community care services, networked across range of locations or collocated in a single center. Health services available locally.
    - Statewide referral hospitals, providing complex services as centers of excellence
    - Networked clinical services
    - Population health networks, population specific, and requiring strategic partnerships amongst providers.
- Accountability and transparency
    - Access to information to the public that is consumer friendly
    - Community involvement in priority setting and performance indicators. Issues of mis-communication in the provision of health services to Aboriginal people are significant and can result in poorer health outcomes. Culturally appropriate services.
    - Safety and quality, standards setting and monitoring for safety and achievement of improved health status
- Workforce development
    - New ways of working, teams working across professional and organizational boundaries
    - Streamlined workforce planning and development stemming from the needs of the patients not the professionals
    - Maximizing contribution of all staff to patient care, doing away with barriers that say only doctors or nurses can provide certain care.
    - Developing new, more flexible, careers for all professionals
- Health inequalities and health as a human right
    - Social determinants of health are important
    - Health is a human right and some special populations require special effort.

Workforce

The future rural allied health workforce will need to:

- Respond to expectations for a new way of working, across organizational and professional boundaries in different teams. There will be a changing face of the professions.
- Participate in workforce planning based on the needs of patients, focusing on a chronic diseases rather than provide services within a defined role of a particular profession.
- Welcome new service providers that will result in achieving integrated community care such as therapy assistants or triage experts
- Develop important skills in community development, primary health care and assessing and responding to the total determinants of health
- Be savvy in technology to access and provide information
- Be able to evaluate the evidence of health care interventions in forming novel health care approaches

For the **rural and remote clinician** there are clear and positive implications supporting current modes of operating. Population and public health approaches must be based on integrated and easy to access health services. This means linking every facet of the system together to ensure the projected health outcomes are achieved.

A definition provided by Schneider for the functional integration of health services is:

"The combining of all activities of health service provision to clients and patients in a way that ensures the co-ordination and interrelationships of an individual's required services are inherently controlled rather than extrinsically managed by the client's own actions."[4]

He sees there are three key contributors to make this happen:

1. Governance
2. Technology
3. Transport

Governance, area health boards and the like facilitate the population health focus. Primary care will be available closest to where people live. Rural and remote areas are best suited to have a clinical network of care. Within a network of care, aim for agreed area-wide treatment protocols that ensure that when conditions are diagnosed, the appropriate treatment is commenced and subsequently continued as the patient / client moves to other locations and health professionals across the area.

Networks like this need shared information, and **technology** can help. Shared information on patients is needed but also on protocols and outcomes to evaluate these protocols.

Previously, the patient / client has been the holder and relayer of treatment information from one health professional to the next. This could be in the form of verbally providing details or acting as the courier and handing a hard copy of referral letters or medical history details. An electronic medical record can help this. Separate communication systems must be avoided. Technology will be a powerful driver in changing health services. Advances in display and transmission technology will enable digital images to be forwarded widely as well as image guided surgery.

Even with technology and networks, patient movement or patient transport is still required. Emergency **transport** is provided by the health system, but to a large extent the patient/ client is still responsible for non-emergency transport from one appointment to another and one health service to another.

For some, this is not a burden but for many low income and / or disabled patients / clients it is. Transport always impacts on service access. All health care planning and needs analysis requires combined initiatives with **community partnerships**.

Service models must take into account that there will continue to be a limited number of health professionals. This must be combined with a continuing knowledge explosion for health professionals, and the requirement to remove as many burdens from those finding themselves in need of health care.

Examples of working together:

- The North West Queensland Allied Health Service is based in Mt Isa, Australia. It provides multidisciplinary allied health services to 11 culturally diverse remote communities. Many of these communities have a high prevalence of chronic disease, a large proportion of indigenous people and a preponderance of youth. They are now receiving primary health care outreach dietetics, occupational therapy, physiotherapy, podiatry, psychology and speech therapy services on a 6-week rotational basis.

A key component of the program is the recruitment of a network of local, community-based therapy assistants to provide additional support.

- The Katherine Remote Allied Health Therapy Program focuses on remote Aboriginal communities situated out of Katherine. The core elements of the model are an emphasis on aged and disability care, the employment of local residents as "community disability coordinators" to work in collaboration with the visiting allied health professionals and a minimum of monthly visits to each community from each required professional. The service is strongly influenced by the philosophy and practice of community based rehabilitation, and is being developed within a paradigm of Aboriginal community control. The allied health professionals are employed by an indigenous health organization, rather than by government or in private practice.

These two examples of service models in rural and remote areas illustrate:

- an evidence base for flexible ways of delivering services and sustainable models of practice,
- models of service delivery that can be replicated in other appropriate settings, and
- the benefits of innovative service delivery by redistributing allied health positions from professionally isolated solo practice to integrated and supported teams.

These examples were aimed at addressing the lack of access to allied health professionals in small isolated and remote communities. It seems important to construct very broad multidisciplinary businesses, teams, organizations, and managements which include the widest range of disciplines. The role of the support worker or the treatment performer, as distinct from the treatment prescriber, can be expected to increase.

Burnout, disillusionment, high stress levels, and lack of management support, family responsibilities and desire for change contribute to high levels of attrition. The lack of consistency in staffing levels in rural areas suggests variation in access to services in rural areas.

Attempts have been made to establish minimum levels of staffing. For example, physiotherapy, staffing levels in public health services have been documented. The processes recognizes that staffing levels change with the function of the hospital/ facility with key physiotherapy activity drivers incorporated into the process as well as the rurality index.[5]

Internationally computerized workload data collection models in rural primary health care have been tried.[6] However, problems of recording were encountered for the blurred roles of rural and remote practitioners, and the wide range of non clinical duties carried out. A lack of local contextual and cultural information provided other problems. This information is necessary to make sense of the data collected.

The workforce shortages are known but quantifying them consistently is more difficult. Some long standing vacancies means the position funding is used elsewhere, and recognition that the position is needed is less obvious. A population focus and assessment of need will clearly define the workforce required for a geographical region.

Who then are the people who should be delivering the rural and remote services?

Rural and remote health is a recognized academic discipline. In today's health services with disciplinary expertise, rural and remote has suffered as the "generalist", not fitting into an existing specialist discipline.7 Practitioners themselves need to recognise that rural and remote practice is its own discipline offering considerable "specialist expertise", although requiring a "generalists" breadth of knowledge. Those who want to deliver a broad variety of services, rather than focus on narrow practice areas, are well suited to rural and remote practice.

McWhinney described the criteria for a discipline requires:

- a dedicated academic body formed by its practitioners,
- an intellectually rigorous training program,
- a distinct body of literature by practitioners, and
- recognition by the wider society.[8]

The challenge is to translate a mode of practice that is predominately characterized by location and scope into a process largely designed to recognize clinical specialties. Identification and quantification of the clinical, administrative and peripheral competencies required for effective rural and remote practice has enabled establishment of benchmarks for attainment at each level, giving direction and focus for those wishing to pursue specialization. The process represents a continuum of professional development rather than discrete stages and acknowledges both formal and experiential learning pathways.[9]

Rural health professionals are well placed to embrace the approaches of public and population health. For those professionals working in a traditional biomedical model, these changes will be a challenge.

The traditional biomedical model which uses interventions that:

- are grounded in scientific knowledge of physiology and pathology,

- are aimed at addressing physical problems identified by standardized assessment and diagnostic procedures,
- use evidence-based techniques that require specific training and result in measurable outcomes, and
- provide education in the form of expert instruction.[10]

Unfortunately, concepts of health promotion and utilizing the expertise of lay networks have not been core components of physiotherapy and other health education.[10] Rural health training is now an integral part of health professionals training and programs that specialize in the rural and remote health professions are growing all the time. Changes in practice may follow. For example, responsibilities can differ, so that the patient conducts their own blood pressure testing and urine tests and other team members apart from the doctor can order x-rays in outpatient and emergency departments.

Major themes for the future include:

- Learning to look at the social determinants of health traditionally outside the health professionals training.
- More research and evaluation on service delivery models to inform practice and future education.

Social determinants

Social determinants are the conditions in which people live and work. They are the "causes behind the causes" of ill-health. They include poverty, social exclusion, inappropriate housing, shortcomings in safeguarding early childhood development, unsafe employment conditions, and lack of quality health systems. The new World Health Organization collaboration on the social determinants of health underscores this important direction.

The role of the built environment in health service delivery is an example of considering the social determinants of health. A review of the built environment and its impact on health forms part of research projects concerning the design of aged care facilities for culturally and linguistically diverse peoples, design of medical services, emergency departments, and making homes more suitable for aged people to remain in their own homes. All of these activities impact on the health of providers and clients.[11]

As an example of the importance of the social determinants of health, school canteens could act as sites for health promotion in the structured environment in an effort to promote healthy eating and better health outcomes needed. Small but significant modifications include provision for personal hygiene and food service. Bigger changes are to the kitchens of school canteens so that access for people of all abilities is provided, enabling it to be used by adults and students while accommodating the younger siblings of volunteers or the breastfeeding mother. Other changes are the position of foods in school canteens and presentation of healthier foods to facilitate their choice by students.[12]

There is more that can be done. The school canteen provides an obvious link to developing health eating in children and learning about nutrition. The link to obesity and poor health status are obvious. School vegetable gardens create other skills too.

In designing school canteens to facilitate healthy choices, the aim is to reduce the need for queuing and to facilitate traffic flow. The movement of students through the canteen, innovatively designed, can be used to apply a simple screening tool for co-ordination and fitness. This is a little easier than asking a student and family to attend a health screening in a clinical setting.

Broader thinking about health is always needed. Lifestyle factors affecting health status such as nutrition, social support, better housing and education are always important. Perhaps the skilled health professional will audit the aging person's home, considering the built environment (firstly, looking for hazards for falling, then safety of access and ease of use of facilities). Then audit the home for its effect on quality of life, for such things as lighting, security and privacy, not usually considered in a health audit but part of the reason people remain in their own home independently.

More Research

Rural and remote practice is not merely an agglomeration of general practice and other select medical specialties together with allied health providers. The context of relative professional isolation, rural culture, demographics and epidemiology, and the practicalities of service provision without the ready access to resources, technologies and specialist personnel in the cities, combines to create a distinct practice paradigm, requiring a distinct body of investigation.[7]

The push for evidence-based practice will continue, requiring a large knowledge base and information sources for rural and remote health professionals given their diverse client group. McWhinney proposes that for a discipline to be truly independent, there should be some research questions that can only be addressed from inside the discipline.[8]

Rural and remote health by its very natures enables the whole sector to be involved and all the professions to be included in any research question. New models of interdisciplinary care are high on any research agenda.

The skills when working in rural and remote communities
What the people want is health services that are accessible, affordable and feasible.

The skills working in a rural and remote community could be:

- determining population based needs and facilitating community involvement,
- focusing on appropriate communication strategies to clients and communities, search for other means and ways,
- devising responsive strategies to individual and community needs with new ideas about service models,
- learning new and changing professional identities,
- working in teams and networks, developing protocols and ways of working together, and
- evaluating results of health efforts, with appropriate communication to peers stories.

Most of all, we need to develop the clients self efficacy or empowerment to determine their own health choices. The roles allied health care providers develop in primary health care, population health and health promotion will all need to be implemented in a lower resource framework often associated with rural and remote areas.[13]

As an allied health rural and remote provider knows their community well, this gives an opportunity to develop discrete and integrated programs which aid the particular health needs of the community. Allied health professionals will adopt a leadership role in their community.

References

1. Australian Health Ministers' Conference, *Healthy Horizons 1999-2003: A framework for improving the health of rural, regional and remote Australians.* 1999, Canberra: AGPS.
2. Humphreys, J. ed. *Health service models in rural and remote Australia. The new rural health,* ed. D. Wilkinson and Blue, I. 2002, Oxford: Melbourne.
3. Government of South Australia, *Better choices Better Health: final report of the South Australian Generational Health Review*. 2003, Government of South Australia: Adelaide., p.2
4. Schneider, S. Functional integration of health services. *Australian Journal of Rural Health*, 2004; 12: 36-37.
5. Adams, R. Progress in the development of recommended staffing levels for rural physiotherapy services. in *Walking together side by side*. 2004. Alice Springs: SARRAH.
6. West, C., Farmer, J and Whyte B. Implementing computerised workload data collection in rural primary health care. *Australian Journal of Rural Health,* 2004; 12: 11-16.
7. Wronski, I. Rural and remote medicine: comes of age. *Australian Journal of Rural Health,* 2003; 11:161-162.
8. McWhinney, I.R., *Textbook of Family Medicine*. 1989, New York: Oxford University Press.
9. Holden, L. The specialist rural and remote physiotherapist: mapping a process. in *Walking together side by side*. 2004. Alice Springs: SARRAH.
10. Litchfield, R. and MacDougall, C. Professional issues for physiotherapists in family-centred and community-based settings. *Australian Journal of Physiotherapy*, 2002. 48: p. 105-112.
11. Sheppard, L. and C. Landorf, Australian Research Council Research Grant Applications 2001-2005, unpublished. 2004.
12. Drummond, C. and Sheppard L. Comparing rural and urban school canteens: A snapshot. *Australian Journal of Rural Health*, 2005: In review.
13. Sheppard, L. and Nielsen, I. Rural physiotherapy: its own discipline. *Australian Journal of Rural Health* 2005; 2:135-136.