Submission No 473

INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NEW SOUTH WALES

Organisation: Services for Australian Rural and Remote Allied Health (SARRAH)

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SARRAH
Services for Australian
Rural and Remote Allied Health

Submission to the NSW Legislative Council: Portfolio Committee No. 2 – Health

Inquiry into health outcomes and access to health and hospital services in rural, regional and remote NSW

15 January 2021

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1. Introduction

Thank you for the opportunity to contribute a submission to the NSW Legislative Council's Inquiry into health outcomes and access to health and hospital services in rural, regional and remote NSW.

SARRAH is the national peak body representing rural and remote allied health professionals (AHPs) working in the public and private sector, across health, disability, aged care and other settings. SARRAH was established in 1995 and advocates on behalf of rural and remote communities in order for them to have access to allied health services that support equitable and sustainable health and well-being. AHPs are tertiary qualified health professionals who apply their clinical skills to diagnose, assess, treat, manage and prevent illness and injury among all age groups and across all key health and associated service sectors.[1].

The focus of our submission is on the inequitable access people living in regional, rural and remote NSW have to allied health services in hospitals and other health settings relative to metropolitan and higher population areas, and the implications this has in terms of poorer health and related outcomes, health system performance and costs. We have drawn on information specific to NSW where possible. However, there is a relative paucity of workforce and service information collected and available on allied health (compared with medical and related services especially). This has negative impacts for health service monitoring, planning and impact analysis[2]. Where we have been unable to identify and present data specific to NSW, we have used other material we believe relevant to NSW to aid the Inquiry.

What is allied health?

The Australian Health Leadership Forum (AAHLF) *describes Allied Health Professionals as being qualified to apply their skills* ***to retain, restore or gain optimal physical, sensory, psychological, cognitive, social and cultural function of clients, groups and populations.*** See - https://aahlf.com/

Excerpt from the NSW Health website *- "In very broad terms, allied health professionals provide services to enhance and maintain functions of their patients (clients) within a range of settings including hospitals, private practice, community health and in-home care. There is an emphasis on health lifestyle and on independence; whether that is physically, psychologically, cognitively or socially. Allied health professionals also have a large role in the management of people with disabilities from childhood to adult."*

https://www.health.nsw.gov.au/workforce/alliedhealth/Pages/default.aspx (accessed 13 December 2020)

[1] There is no universally accepted definition of allied health. The term encompasses a range of professions and evolving areas of specialised therapeutic knowledge, treatment and skills development, based on recognised health-related scientific and associated knowledge and practice capability. Allied Health Professionals hold nationally accredited tertiary qualifications (of at least Australian Qualifications Framework Level 7 or equivalent), enabling eligibility for membership of their national self-regulating professional association or registration with the relevant professional National Board.

[2] This gap in information includes a lack of national data on self-regulated allied health professions (i.e. those not regulated under the Australian Health Practitioners' Regulation Agency – Ahpra), acknowledged gaps in Australian Institute of Health and Welfare (AIHW) data holdings and, was highlighted in the National Rural Health Commissioner's report *Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia* (June 2020), https://www1.health.gov.au/internet/main/publishing.nsf/Content/2922D6D8BBCE122FCA2581D30076D09A/$File/National%20Rural%20Health%20Commissioner's%20Allied%20Health%20Report%20to%20the%20Minister%20June%202020.pdf.

SARRAHs membership is national and broadly dispersed; it includes a substantial number of practitioners and corporate members who work in rural and remote New South Wales.

SARRAH maintains that every Australian should have access to equitable health and disability services wherever they live and that allied health services are fundamental to the well-being of all Australians.

SARRAH understands **the primary focus of the Inquiry is on the NSW public health system and services.** For many people living in rural and/or remote NSW public health services provide the most accessible and available health services, and are often (with the exception of Aboriginal community-controlled health services, where they exist) the only health services. The absence or severe shortage of other health services and workforce, most notably in local, primary care services, including allied health services, only magnifies the critical role of public health services in these locations. In turn, this adds to pressure on hospital and other emergency services that could be avoided if allied health and other primary care services were available. As the Inquiry aims to assess the relative health care access and outcomes of people living in rural and remote NSW, it is necessary to consider NSW publicly provided and the other health services available (or not) and the interface with health services provided / funded through the Commonwealth, community providers, private health service systems and funding arrangements. These, together, determine the level of health care access and outcomes achieved by people living in rural, regional and remote NSW.

1.1 Health outcomes for people in rural and remote NSW

Living in rural and remote Australia means you are likely to have poorer health and have greater difficulty accessing health or receiving the best treatment options. Preventable hospitalisations and mortality increases with remoteness, as do rates of chronic disease.

Reducing these disparities would deliver cost benefits, better health outcomes and a reduction in preventable suffering and mortality.

Health service access and use differs by place, with disadvantaged rural and remote communities often consuming far fewer MBS rebated allied health services, for example, than more advantaged communities: For example, MBS data shows far greater subsidisation in Double Bay than Gwabegar. Lack of access drives and compounds unequal health access and outcomes.

MBS data also shows that where you live affects your treatment profile (and presumably options): for instance higher rates of medication use when other therapeutic options might be appropriate if available. Professor Less Barclay notes 'compared with the rate at which city people access Medicare, people in rural and remote areas are at a massive disadvantage – there's a so-called "Medicare deficit" of around $1billion a year'.[3] This is despite the need for allied health professionals is most acute in rural and remote areas. The National Rural Health Alliance put the total rural health deficit at least $2.1 billion a year, which 'equates to a shortage of 25 million services'.[4]

The relative shortage of allied health professionals in rural and remote NSW is a significant factor driving health inequity. That shortage is evident and available in the National Health

[3] arclay, L. (2020, December 10). Unravelling why geography is Australia's biggest silent killer. *The Conversation*. Retrieved from https://theconversation.com/unravelling-why-geography-is-australias-biggest-silent-killer-23238
[4] https://www.ruralhealth.org.au/sites/default/files/publications/fact-sheet-27-election2016-13-may-2016.pdf

Workforce Dataset (held by the Commonwealth department of Health; in AIHW and ABS Census data.

1.2 Impacts of workforce and service mal-distribution

SARRAH notes the correlation between areas of allied health service shortages (in rural and remote areas) and higher levels of potentially preventable hospitalisations, levels of chronic disease (and/or inadequate management of it), and possibly premature death.

Spending on hospitals continues to increase markedly and is driving increasing health system overall. At the same time, Australia is identified among OECD nations as committing comparatively little to preventive healthcare – around one third of the OECD average.

The Grattan institute finds that 'at best our primary care system only provides half the recommended care it should for chronic conditions' and results in 250,000 preventable hospitalisations.[5]

Allied Health interventions can save lives, reduce health costs and prevent suffering.

2. Importance of allied health workforce and services

The mal-distribution of allied health professionals in Australia is severe, long-standing and highly metro-centric.

Professor Paul Worley, the previous National Rural Health Commissioner found that the 'undersupply and maldistribution of the allied health workforce has a significant negative impact on the accessibility of allied health services for rural communities'[6]. Further, the severity of impact increases with remoteness. Professor Worley noted that in 'rural and remote settings, they often work in areas of market failure where service delivery is fragmented and vulnerable to short-term contracts and disparate funding arrangements.[7] Unlike the city, an allied health professional in rural and remote areas may not be able to work full time, even if they want to. It may not be feasible as there may not be the demand, or a lack of support and supervision, or excessive travel.

In NSW, there are substantial allied health shortages across many parts of the state.

The 2016 ABS census data suggests there are no allied health professionals in many areas, particularly remote and very remote NSW.

[5] Swerissen, Hal. & Duckett, S. J. (2016). *Chronic failure in primary care*. [Carlton, Victoria]: Grattan Institute, http://grattan.edu.au/wp-content/uploads/2016/03/936-chronic-failure-in-primary-care.pdf

[6] Professor Paul Worley, National Rural Health Commissioner. Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia, https://www1.health.gov.au/internet/main/publishing.nsf/Content/2922D6D8BBCE122FCA2581D30076D09A/$File/National%20Rural%20Health%20Commissioner's%20Allied%20Health%20Report%20to%20the%20Minister%20June%202020.pdf

[7] Professor Paul Worley, National Rural Health Commissioner. Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia https://www1.health.gov.au/internet/main/publishing.nsf/Content/2922D6D8BBCE122FCA2581D30076D09A/$File/National%20Rural%20Health%20Commissioner's%20Allied%20Health%20Report%20to%20the%20Minister%20June%202020.pdf

Table 2: NSW AHPs by place of work (remoteness area) 2016 ABS Census

Professions	Remoteness Area				
	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote
Sonographer	1250	278	27	0	0
Medical Diagnostic Radiographer	2189	462	85	5	0
Medical Radiation Therapist	505	106	0	0	0
Nuclear Medicine Technologist	227	29	3	0	0
Dietitian/Nutritionist	1299	247	39	4	0
Optometrists*	1174	202	30	0	0
Orthoptists	355	36	0	0	0
Orthotist or Prosthetist	76	7	0	0	0
Chiropractor*	1017	199	33	0	0
Osteopath*	273	79	15	0	0
Audiologist	424	100	3	0	0
Speech Pathologist	1674	363	54	8	0
Occupational Therapist	2791	692	103	4	0
Physiotherapist	5032	963	156	3	0
Pharmacist	5458	1084	268	17	3
Podiatrist	757	182	32	0	0
Clinical Psychologist	3381	629	83	6	0
Psychologist	1151	258	50	3	0
Exercise Physiologist	651	128	10	0	0
Social Welfare Professional	240	66	10	0	0
Counsellor	2012	461	71	0	0
Drug and Alcohol Counsellor*	201	136	34	0	4
Rehabilitation Counsellor*	527	106	13	0	0

Source: ABS 3218.0 - remoteness area download

** Optometrists, chiropractors, osteopaths, drug and alcohol counsellors and rehabilitation counsellors are not employed as allied health professions by the NSW Health. These professions are regulated by AHPRA and are considered to be allied health professions more broadly across the heathcare sector.*

*** Art therapy, child life therapy, diversonal therapy, music therapy and welfare are not categorised seperately within ABS Census data and are counted within other professions listed above or have not been included in this dataset acquired from the ABS.*

SARRAH has described these issues in detail in previous submissions[8].

[8] https://sarrah.org.au/content/lodged-submissions

3. Addressing the Terms of Reference

The Terms of Reference set by the Legislative Council for the Inquiry are:

That Portfolio Committee No. 2 - Health inquire into and report on health outcomes and access to health and hospital services in rural, regional and remote NSW, and in particular:

(a) health outcomes for people living in rural, regional and remote NSW;

(b) a comparison of outcomes for patients living in rural, regional and remote NSW compared to other local health districts across metropolitan NSW;

(c) access to health and hospital services in rural, regional and remote NSW including service availability, barriers to access and quality of services;

(d) patient experience, wait-times and quality of care in rural, regional and remote NSW and how it compares to metropolitan NSW;

(e) an analysis of the planning systems and projections that are used by NSW Health in determining the provision of health services that are to be made available to meet the needs of residents living in rural, regional and remote NSW;

(f) an analysis of the capital and recurrent health expenditure in rural, regional and remote NSW in comparison to population growth and relative to metropolitan NSW;

(g) an examination of the staffing challenges and allocations that exist in rural, regional and remote NSW hospitals and the current strategies and initiatives that NSW Health is undertaking to address them;

(h) the current and future provision of ambulance services in rural, regional and remote NSW;

(i) the access and availability of oncology treatment in rural, regional and remote NSW;

(j) the access and availability of palliative care and palliative care services in rural, regional and remote NSW;

(k) an examination of the impact of health and hospital services in rural, regional and remote NSW on indigenous and culturally and linguistically diverse (CALD) communities; and

(l) any other related matters.

Specific Terms of Reference are addressed below.

a) health outcomes for people living in rural, regional and remote NSW;

People living in rural and remote NSW do not enjoy equitable access to health care services or to the health and wellbeing outcomes experienced on average by people in major NSW population centres. People in rural and remote areas have poorer health and they are more likely to smoke, be overweight, and have high blood cholesterol (as examples).[9]

[9] https://www.aihw.gov.au/reports/australias-health/rural-and-remote-health

b) a comparison of outcomes for patients living in rural, regional and remote NSW compared to other local health districts across metropolitan NSW;

We anticipate the Inquiry is able to access detailed patient outcome data from NSW Health authorities. While SARRAH does not have access to this information, we believe it will be important for the Inquiry to consider:

- episodic or specific service access and outcome data for comparison by location
- patient flows data
- health outcome data – which we understand will reflect the combined impact of many health and other factors not managed by NSW Health, but are critical for considerations such as service planning and delivery and to indicate the relative effectiveness of the health system (public and other) as a whole on peoples' outcomes.

Access and cost also affects behaviour, as the Productivity Commission when looking at Mental Health found that the 'Medicare Benefits Schedule funding disproportionately benefits people living in urban areas, as consumer use of all provider types decreases sharply with remoteness'.[10] The Grattan Institute highlights that service use differs markedly by place[11].

This creates a perverse subsidy where the most advantaged and those in cities benefit. The ABC Story Lab found that five times the money was spent on highly advantaged people living in cities as they are to remote Australians[12].

With 'people living in Remote/Very Remote areas had higher rates of using medications only than people in Major Cities (66.8 per cent compared with 48.5 per cent respectively)'.[13] Even allowing for higher rates of mental illness and chronic conditions in rural and remote areas we can clearly see that this is driven by the lack of access to Allied Health mental health professionals. As Professor Graham Meadows told the ABC *"While wealthier Australians are often getting access to quality care that combines psychology and medication, poorer Australians are often left with only medication from their GP, which can put them on the back foot with recovery"*[14]

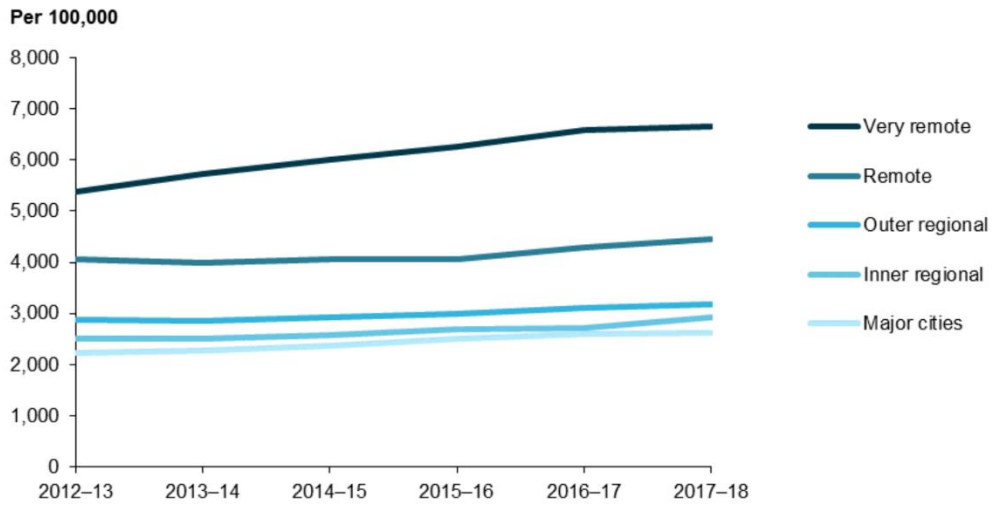
Analysis of allied health MBS rebates by the ABC shows that on a per 100 people basis close to $5,000 was spent on allied health in Darebin South (Metropolitan Melbourne) compared with and around $151 in Katherine (NT): so that despite Katherine being highly disadvantaged 33 times more is spent per person in Darebin South.

Potentially preventable hospitalisation rates show a vast disparity between major cities and remote populations. The AIHW found that 'between 2012–13 and 2017–18 rates were highest for people living in Very remote areas. Further, they found 'rates increased in this population by 24 per cent, compared with an 18 per cent increase for people living in Major cities'[15].

[10] Productivity Commission 2020, Mental Health, Report no. 95, Canberra
[11] Hal Swerissen, Stephen Duckett, and Greg Moran. (2018). Mapping primary care in Australia. Grattan Institute.
[12] https://www.abc.net.au/news/2020-12-08/covid-mental-health-system-medicare-inequality/12512378?nw=0
[13] Patterns of Use of Mental Health Services and Prescription Medications, 2011
[14] https://www.abc.net.au/news/2020-12-08/covid-mental-health-system-medicare-inequality/12512378?nw=0

[15] Australian Institute of Health and Welfare 2020. Disparities in potentially preventable hospitalisations across Australia, 2012–13 to 2017–18. Canberra: AIHW.

Figure 2.4: Age-standardised rates of Total potentially preventable hospitalisations, by remoteness area, 2012–13 to 2017–18



Source: AIHW National Hospital Morbidity Database.

c) access to health and hospital services in rural, regional and remote NSW including service availability, barriers to access and quality of services;

Relevant comments provided elsewhere.

d) patient experience, wait-times and quality of care in rural, regional and remote NSW

No specific comment.

e) an analysis of the planning systems and projections that are used by NSW Health in determining the provision of health services that are to be made available to meet the needs of residents living in rural, regional and remote NSW;

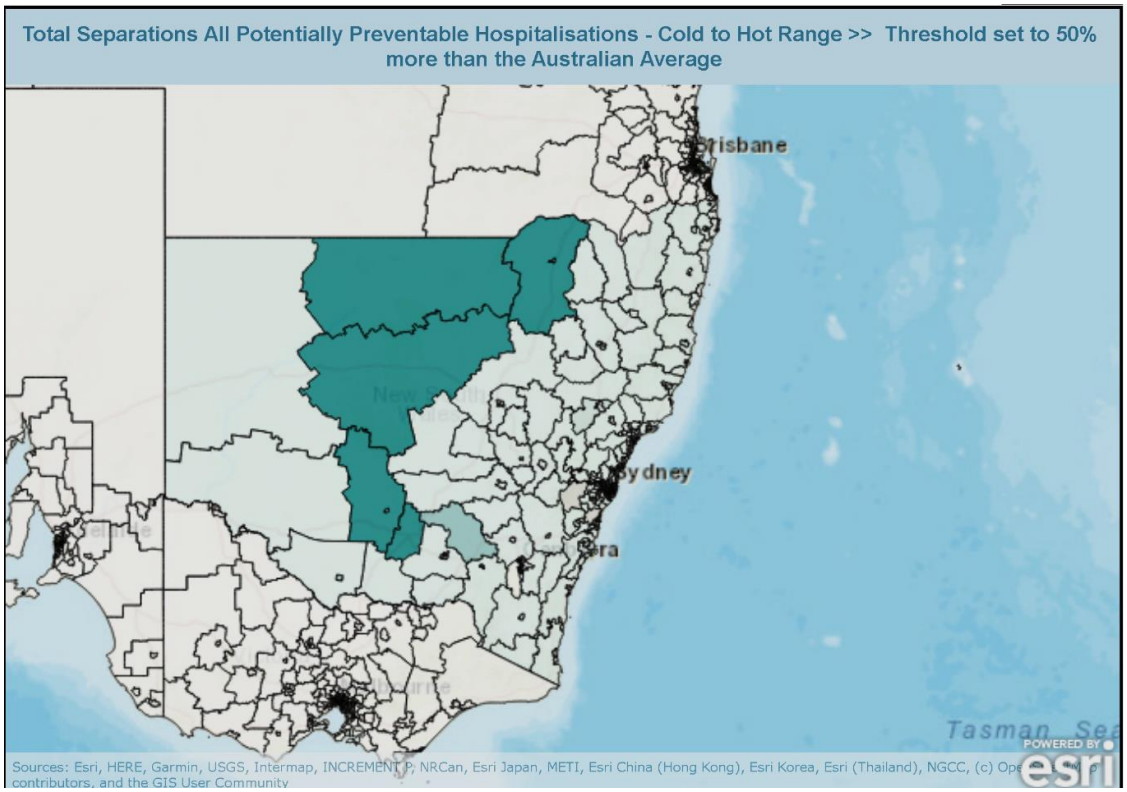
SARRAH is not in a position to comment substantially on the planning systems and projections used by NSW Health, but strongly support the analysis of these by the Committee. In undertaking the analysis, SARRAH encourages the Committee to ensure consideration includes analysis of service and potential demand measures based on population profiles and comparison / variations by location.

Planning should also take account of current and predicted workforce shortages, which are readily accessible and reinforce the need for concerted workforce development and strategies for allied and other health professional capacity to be bolstered in rural and remote NSW.

f) an analysis of the capital and recurrent health expenditure in rural, regional and remote NSW in comparison to population growth and relative to metropolitan NSW;

Hospital expenditure has grown rapidly at over 10-year period to 2018-2019 at an average of 3.7 per cent a year.[16] The Grattan Institute notes that 'growth in government spending on hospitals dwarfs growth in other spending'.[17]. Hospitalisation is expected to increase with new technologies, an ageing population, and the rise of chronic disease.[18] Hospitals are a very expensive way of treating preventable conditions.

One way to control hospital costs is to identify and reduce chronic hotspots of potentially preventable hospitalisations. In looking at recurrent 'hotspots' of potentially preventable hospitalisations. Stephen Duckett also notes that 'places that have been hot for at least three to five years have a 70 per cent or better chance of staying hot into the future' and that 'the single best predictor of future hotspots is persistent past heat'.



[16] https://www.aihw.gov.au/reports/australias-health/health-expenditure
[17] Duckett, S. J. & Breadon, Peter. (2014). *Controlling costly care : a billion-dollar hospital opportunity*. Melbourne : Grattan Institute, http://grattan.edu.au/wp-content/uploads/2014/03/806-costly-care.pdf
[18] https://www.pwc.com/gx/en/industries/healthcare/emerging-trends-pwc-healthcare/chronic-diseases.html

g) an examination of the staffing challenges and allocations that exist in rural, regional and remote NSW hospitals and the current strategies and initiatives that NSW Health is undertaking to address them;

In 2019, SARRAH undertook a review of *Strategies for increasing allied health recruitment and retention in rural Australia*, for the NSW Ministry of Health[19]. We recommend the Inquiry consider this report in detail.

h) the current and future provision of ambulance services in rural, regional and remote NSW;

SARRAH does not underestimate the complexity of planning for the provision of ambulance services across as the diverse geography and population spread of NSW. We note the vital role of paramedics and the provision of ambulance services to meet the needs of people living in rural and remote NSW and that logistics require weighting of resources toward more remote settings in order to achieve comparable levels of care and service. Inevitably, a balance needs to be struck between competing imperatives of equitable access and service quality, capacity and cost.

i) the access and availability of oncology treatment in rural, regional and remote NSW;

SARRAH notes that quality oncology treatment also involves allied health services and that this be considered by the Inquiry.

j) the access and availability of palliative care and palliative care services in rural, regional and remote NSW;

SARRAH refers the committee to the work of Palliative Care Australia (PCAs)[20], which includes highlighting the inequitable access to palliative care based on a range of factors, including location. We also note in PCAs identification of palliative care needs growing as the population ages and that population lives with increasing multi-morbidities, chronic and progressive illnesses and complex disease burdens. These developments are likely to exacerbate existing differentials in care access and quality.

We anticipate the Committee will also consider relevant aspects of contemporary major inquiries, such as the Aged Care Royal Commission, which has undertaken an in-depth examination of senior Australians' access to health care (including palliative care, allied health etc) and the particular challenges for many living in rural and remote Australia. The general shortage of allied health professionals in rural and remote NSW, described elsewhere, limits access to allied health services for people receiving palliative care, and even more so to professionals with palliative care expertise. In practical terms, addressing the underlying mal-distribution of allied health professionals is a pre-requisite for improving

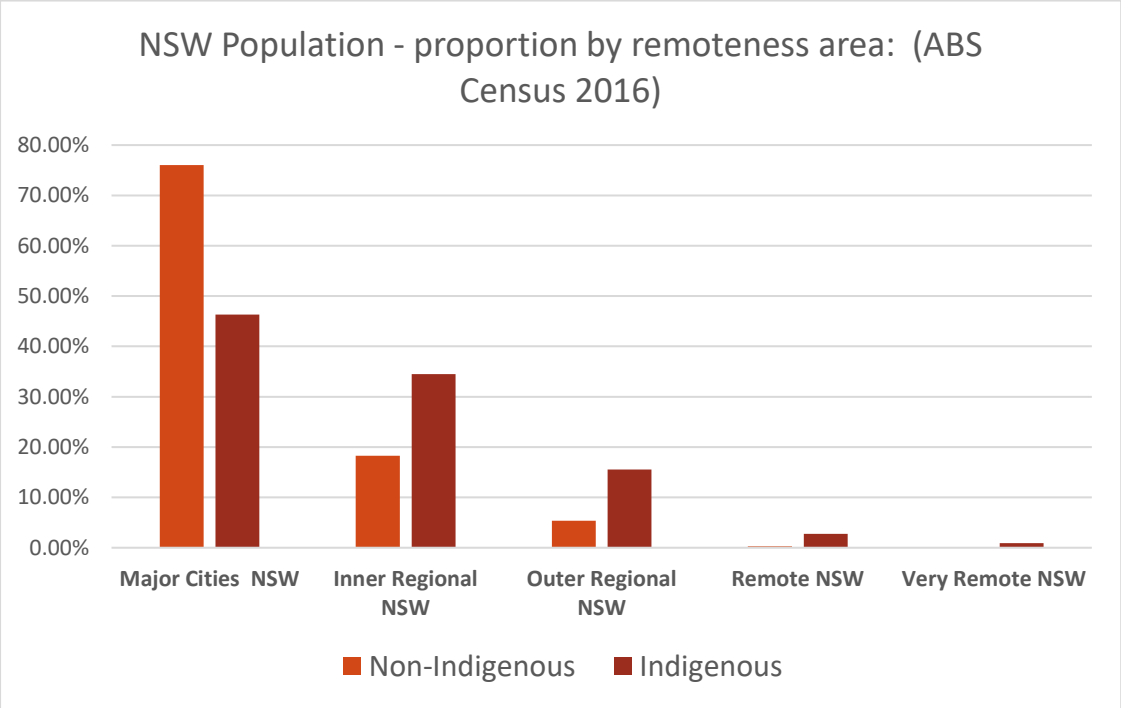
[19] Battye, K., Roufeil, L., Edwards, M., Hardaker, L., Janssen, T., Wilkins, R. (2019). *Strategies for increasing allied health recruitment and retention in Australia: A Rapid Review*. Services for Australian Rural and Remote Allied Health (SARRAH) https://sarrah.org.au/system/files/members/rapid_review_-_recruitment_and_retention_strategies_-_final_web_ready.pdf

[20] https://palliativecare.org.au/submissions-and-reports

access and availability to those with more specific expertise and capacity, such as palliative care, oncology etc.

k) an examination of the impact of health and hospital services in rural, regional and remote NSW on Indigenous and culturally and linguistically diverse (CALD) communities; and

SARRAH particularly notes the need to improve health outcomes and service access for Aboriginal and Torres Strait Islander Australians. In NSW, the ABS Census 2016 estimated that 265,685, or 33.3 per cent of Australia's Aboriginal and Torres Strait Islander people[21] lived in NSW. While making up 3.44 per cent of the NSW population it was higher than the proportion of Aboriginal and Torres Strait Islander people among the national population and the most of any State or Territory, and the proportion of the population that is Aboriginal or Torres Strait Islander increases substantially with remoteness.



SARRAH notes goals of the NSW Health *Aboriginal Workforce Strategic Framework 2016 - 2020*[22], which, which has the overall aim of building and sustaining the Aboriginal Health Workforce in NSW Health, and importantly includes approaches to enable, support and respect the particular skills and knowledges Aboriginal people are able to bring to these roles. A crucial Action identified in the Framework is (Action 1.2, page 16) *Aboriginal workforce representation targets in action plans reflect local Aboriginal populations and*

[21] Estimates of Aboriginal and Torres Strait Islander Australians, June 2016 – ABS: https://www.abs.gov.au/ausstats/abs@.nsf/mf/3238.0.55.001

[22] https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2016_053.pdf

health service needs and address a 1.8 per cent representation at all salary levels and occupations.

l) any other related matters.

SARRAH encourages the NSW Government to develop workforce pathways and opportunities to strengthen the allied health service and workforce capacity in rural and remote NSW, including through:

- Supporting development and expansion of an Allied Health Rural Generalist Pathway / Positions within NSW Health to complement and work in conjunction with developments in the private and community sectors; and
- Increasing Allied Health Assistant (AHA) training positions, including by supporting initiatives such as the Indigenous Allied Health Australia (IAHA) National Health Academy model, and in conjunction with NSW TAFE.

If you require further information, please contact sarrah@sarrah.org.au.

Yours sincerely

Director, Policy and Strategy

15 January 2021