Australian National University

Centre of Research Excellence in Rural and Remote Primary Health Care

POLICY OPTIONS

Overcoming access and equity problems relating to primary health care services in rural and remote Australia

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John Wakerman, John Humphreys, David Lyle, Matthew McGrail & Lisa Lavey

Policy context

Nowhere is the problem of access to health services greater than in rural and remote areas. Problems of access to services are at the heart of health outcome inequalities and inequities, they have persisted over time, and remain the single biggest remediable impediment to improving the health outcomes of geographically disadvantaged groups of the population.

The Centre of Research Excellence in Rural and Remote Primary Health Care (CRERRPHC) was established in 2011 to undertake research which aimed to better understand key access and equity issues relating to the provision of appropriate, effective and high quality primary health care (PHC) services in rural and remote communities of Australia.

The integrated research program comprised several broad streams of research activity. Stream 1 research aimed to assess differential access to PHC services and service utilisation on a national level, with a view to producing an improved measure of access to inform national PHC workforce and service planning. Stream 2 research aimed to identify what 'core' PHC services rural and remote Australians should reasonably expect, and to collect primary data from high-performing PHC services operating in different rural and remote contexts in order to develop benchmarks for key service requirements and performance. Stream 3 research aimed to highlight PHC models that minimise barriers (such as distance and affordability) and maximise access to optimal care in different contexts, particularly focusing on aged care, mental and Indigenous health.

In short, the CRERRPHC research program sought to provide a national platform showing how improved access to appropriate PHC services for populations with poorest access will increase equity in health care through improved health literacy, service utilisation and health outcomes.

Key findings

Ensuring optimal access and equitable health outcomes requires a systemic approach that addresses service performance and sustainability rather than simply *ad hoc* responses to immediate problems. The research undertaken by the CRERRPHC demonstrated the importance of rigorous evidence to underpin effective rural and remote health policies and programs. The evidence advanced our understanding on,

- How to measure the complex concept of access, taking account of the impact of its different dimensions on health service utilisation
- The importance of different rural and remote contexts in developing fit-for-purpose PHC service models, both in terms of defining the nature of needs for health care and the effectiveness and sustainability of PHC services in meeting those needs
- How best to allocate scarce resources, by targeting support to PHC workers on the basis of the nature of their practice activities and the context in which they deliver PHC

- What is required to ensure appropriate sustainable PHC services, particularly through validating how environmental enablers and service requirements impact on PHC services in different rural and remote setting
- The 'core' PHC services rural and remote residents should be able to expect to access
- The complex data requirements and methodology required to define the resource requirements of diverse rural and remote primary health care services
- How different PHC models can better meet community needs, through delivering 'core' PHC services effectively in a form that is accessible and appropriate to patient needs
- What factors affect and drive PHC workforce retention, so that workforce support strategies can better target the 'triggers to leave', thereby avoiding premature turnover
- The critical role of community participation and engagement, without which improvements in health literacy and service utilisation fail to materialise despite access to PHC services
- The complexity of knowledge transfer, such that researchers must disseminate their research widely in different forms and actively advocate for implementation of recommendations with key stakeholders and policymakers
- Measurement of research impact is complex, important and achievable, and
- The key role of building capacity in rural and remote health research, ensuring that programs are well-targeted to the needs of PHC workers and service providers and that policymakers are actively engaged throughout the research training process.

Detailed results are widely available in the form of peer-reviewed publications and presentations available on the CRERRPHC website.

Policy lessons and options

Policies designed to enhance the provision of effective and sustainable PHC services must be evidence-based and the result of engagement of both consumers and policymakers. While this partnership approach may have the effect of slowing down the research process, it maximises the likelihood of take-up and implementation of recommendations designed to increase access and equity for rural and remote Australians. Several components are required to ensure a successful knowledge generation/ knowledge transfer outcome.

Data access: Central to undertaking rigorous research is access to high-quality, unit-record data - the building block of PHC research. Primary data collection is expensive and time-consuming, so it is imperative that policymakers and service providers facilitate access to existing administrative unit record and small-area health data.

Community participation: The successful implementation of appropriate, effective and sustainable PHC services in small rural and remote communities depends on the full engagement of local residents. Exactly what comprises services that 'work' to improve access to care and equity of health outcomes depends on 'asking the user and not the manufacturer'.

Defining and operationalising access for service planning: Measures of access need to take greater account of health needs, ability to access care, and the availability of appropriate PHC services.

Retaining workforce: Geographical classification systems underpinning rural and remote health workforce planning and resource allocation need to be evidence-based and fit-for-purpose.

Defining and benchmarking 'core' PHC services: Indicators and benchmarks are essential for monitoring PHC services and evaluating national policies designed to provide effective and equitable health. Despite the significant advances made to existing knowledge by the research undertaken by staff from the CRERRPHC, more research is required to develop an efficient methodology to develop benchmarks for 'core' PHC services. Strategic monitoring of rural and

remote PHC services and workforce issues is vital if governments are to ensure accessible, equitable, effective and sustainable PHC for all consumers, regardless of where they live.

Identifying and providing effective PHC service models for small rural and remote communities: Previous research highlighting important environmental enablers and service requirements necessary to ensure accessible equitable and sustainable PHC services was validated. PHC service models need to be fit-for-purpose, something that is best achieved by policymakers and funders working in very close association with local health providers and consumers.

Improved access to comprehensive PHC services leads to improved equity in health outcomes: Evidence from detailed case-studies in rural and remote communities indicates that appropriate, high-performing PHC services result in improved access to and utilisation of services, better health literacy, and significantly improved population health outcomes.

Building research capacity for the purpose of monitoring service performance and evaluating the effectiveness of policy initiatives: Research capacity building programs should be tailored to meet the interests of the rural health stakeholders, the contexts of their services, and the types of research and evaluation skills perceived to be most valuable by the service. Engagement of policymakers in all aspects of research capacity building programs should be encouraged.

Methods

The evidence generated by the CRERRPHC resulted from adopting both multivariate quantitative and qualitative methodologies. Extensive systematic literature reviews were undertaken to capture all relevant current Australian and international literature. Secondary data relevant to access components of PHC services (numbers of GPs, volume of GP services, population measures, age demographics, socio-economic status, measures of health needs, and transport availability) and workforce retention were obtained from State and Territory Health Authorities, Rural Workforce Agencies, the Australian Bureau of Statistics and the Australian Government Department of Health.

In addition, primary data were collected from a stratified survey of small high-performing rural and remote primary health care services. These data comprised the costs for nurses, doctors, allied health staff, Indigenous health workers and managers; key PHC services provided, the nature and costs of service delivery; and characteristics of service catchment populations. Individual data for rural and remote PHC workers and services were analysed using survival curve analyses and proportional Hazards (Cox) methods to model the risk of employees leaving their current position.

An extensive delivery-and-collection survey of residents from five small rural communities was conducted in order to derive empirical data relating to access behaviour when seeing a doctor for a non-emergency consultation. Differences were analysed between residents of densely-populated and sparsely-populated rural communities and most important access dimensions (when deciding to utilise health care) using multivariate regression models and paired-comparison methods.

Data obtained using a Delphi technique were analysed using both multivariate statistical and qualitative thematic analyses. Sophisticated Geographical Information System (GIS) to evaluate spatial accessibility to health services, and floating catchments were used as the framework for calculating accessibility. An independent expert health economist and the National Advisory Committee supplemented the bio-statistical and research expertise of the CRERRPHC team.

The CRERRPHC provided five PhD scholarships and post-doctoral positions, supported by high level research supervision and extensive use of interactive technology to maximise support. Funding support and supervision was also made available to release nine staff from rural and remote PHC services for one day a week for a period of two years to conduct research relevant to the interests and needs of their practice and community culminating in a peer-reviewed publication.

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