



SUBMISSION TO:

AUSTRALIAN GOVERNMENT
Department of Health and Ageing

TOWARDS A NATIONAL PRIMARY HEALTH CARE STRATEGY
A Discussion Paper from the Australian Government

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SPEECH PATHOLOGY AUSTRALIA

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The following document outlines the Speech Pathology Australia submission to the
National Primary Health Care Strategy



TOWARDS A NATIONAL PRIMARY HEALTH CARE STRATEGY

SPEECH PATHOLOGY AUSTRALIA SUBMISSION

February, 2009

Speech Pathology Australia welcomes the opportunity to respond to the Discussion Paper released by the Department of Health and Ageing on a National Primary Health Care Strategy for Australia. Speech Pathology Australia is the national peak body for speech pathologists in Australia, representing approximately 4,500 members. Speech pathologists are university qualified specialists who provide a variety of services to people with communication and swallowing difficulties that may present across the life span. Speech pathologists may be the first point of contact within the health system for clients with communication and swallowing disorders, and thus play a crucial role in the provision of services that keep people healthy and out of hospital. As such, the profession believes it is ideally placed to provide meaningful input into the development and implementation of a National Primary Health Care Strategy for all Australians.

Speech Pathology Australia commends the Department of Health and Ageing on its commitment to pursuing this agenda. The Association supports the introduction of a national strategy that will improve access to quality primary health care services for all Australians. In this submission, Speech Pathology Australia wishes to provide comment in relation to issues specifically relevant to the profession of speech pathology and to the clients the profession serves; however, comment will also be provided on broader issues relevant to the primary health care agenda.

Key points integral to this submission:

- There is a need for a shared understanding among health policy makers, health care professionals and the public as to what primary health care involves;
- The role and scope of practice of speech pathologists and other professionals within the primary health care setting needs to be clearly defined;
- The profession of speech pathology is ideally placed to provide services to consumers with complex primary health care needs;
- Education of health care professionals, including GPs, about the role of speech pathology in primary health care is essential.





OBJECTIVE 1: ACCESSIBLE, CLINICALLY AND CULTURALLY APPROPRIATE, TIMELY AND AFFORDABLE.

Speech Pathology Australia (the Association) strongly supports Objective 1 of the Primary Health Care Strategy. Specifically, access to ‘appropriate’ services is the key. Consideration must be given to identification of the specific service needs of consumers and consumer groups, rather than a one size fits all approach. To improve health outcomes throughout the community, Australia’s primary health care system must offer an effective, comprehensive and timely response to people’s total health needs, through direct access to multi-disciplinary health care. Direct access to a variety of health professionals, without a GP acting as gatekeeper, would facilitate ease of access to services in a timely manner and would promote a holistic approach to health care. To facilitate such an approach, health professionals and consumers require education regarding the benefits of interdisciplinary and multidisciplinary care approaches, with appropriate funding provided to ensure widespread and effective public education programs, and support of professionals to attend training programs. A comprehensive, equal and cooperative partnership between allied health professionals, nurses and GPs, together with government-funded services is required, which through equity of funding and access, mandates such a partnership.

Speech Pathology Australia believes it imperative that consideration be given to models of service delivery that best meet the needs of consumers from different demographics and geographical areas. Whilst innovative and flexible solutions to promote and support consumer access to primary healthcare are required in all areas of Australia, geographical remoteness and cultural diversity pose specific challenges. Providing culturally appropriate services requires a holistic approach that encompasses the values and principles of an organisation, the organisation’s service delivery and management style, and staff competencies¹. Cultural appropriateness must include meeting an individual’s needs, their personal goals and the goals of the community. Flexibility of service delivery is essential, as is coordination of services to reflect a holistic approach.

It is imperative that adequate funding be made available for primary health care initiatives. Comprehensive primary health care must be viewed as cross-sectoral, i.e. involving health, education, housing and transport, and funding arrangements must reflect this complexity. If professionals are to participate fully as part of a primary health care team, and if programs are to be sustainable, there must be adequate, long term funding that enables health professionals and other team members to engage in cross-sectoral work and to undertake training in multidisciplinary and interdisciplinary approaches to primary health care. Further to this,

¹ National Disability Administrators. (2004). *Sharing Stories*. Retrieved 18 October 2006 from the NT Government website: http://www.nt.gov.au/health/comm_svs/aged_dis_ccs/disable_svs/NDAsharingstories4.pdf
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funding must provide the opportunity for strategies to be developed and implemented that will permit professionals to meet the demands of increasing numbers of health consumers.

Community participation in decision making about health care is imperative for effective service delivery. Community participation can mean anything from individual inclusion in decision making to complex ways of engaging an entire community. A key aspect in influencing the level of community participation is the willingness of service providers to encourage and facilitate community participation in decision making. Successful community participation in priority setting, decision making, planning and implementation can result in service ownership and community empowerment¹.

Specifically in relation to speech pathology service provision, waiting lists and waiting times vary significantly from one geographical location to another. This is due to a number of factors, including workforce shortages, limited community resources, cultural diversity and geographical remoteness. Such issues have particular relevance to indigenous communities who have specific needs, both culturally and with regard to access. The Association has explored the complexity of providing services to indigenous communities, and of meeting the service demands to those in rural and remote locations². However, there are currently no national labour force surveys or universal standardised data collection regarding speech pathology practice within Australia. This lack of data makes it extremely difficult to evaluate adequacy of current service provision and/or to set projections regarding the future supply of and demand for speech pathologists. There have been attempts to establish benchmarks in staffing levels for speech pathology in some specific health areas, e.g. rehabilitation services³, but figures are not reflective of primary health care service needs and are based on therapist to bed or patient ratios rather than evaluation of adequacy of current service provision. Speech Pathology Australia urges the Federal Government to prioritise the collation of profession-specific data that will identify the current state of health service provision and inform the primary health care agenda in a meaningful way.

Utilisation of existing services is also key to timely, affordable access. For example, if speech pathologists are provided with referral rights for services previously undertaken by a GP or other medical practitioner, this has the potential to significantly reduce the work load of GPs. A specific example in relation to speech pathology is referral of patients for instrumental assessment of swallowing (known as videofluoroscopy or modified barium swallow). Currently,

² Speech Pathology Australia (2007). *Working with aboriginal people in rural and remote Northern Territory. A resource guide for speech pathologists*. Speech Pathology Australia, Melbourne.

³ Allied Health in Rehabilitation Consultative Committee (2007). *Guidelines for allied health – resources required for the provision of quality rehabilitation services*. Version 10. Viewed 2nd Available at: <http://www.speechpathologyaustralia.org.au/library/Guidelines%20for%20Allied%20Health%20Resources%20for%20Rehab.pdf>



speech pathologists are required to refer patients back to GPs for onward referral to a radiologist for assessment. This not only results in an increased workload for the GP, but also an unnecessary delay in access to services by consumers. This is also the case in relation to children with a diagnosis of autism. As key professionals in the management of children with autism, speech pathologists should be able to refer a child directly for an assessment to a paediatrician or other specialist without having to first refer the child back to their GP.

Medicare - Enhanced Primary Care Program

Allied health professionals, as part of a multidisciplinary team, play a major role in the management of complex and chronic diseases. Modifications to the Enhanced Primary Care (EPC) program, as occurred in 2004 with the Chronic Disease Management Medicare items, acknowledge the role of allied health in chronic disease management by enabling rebates to be paid for individual allied health professional services, with up to five allied health visits available per health consumer per year.

Whilst the Association applauds the Federal Government's initiative to draw attention to and provide services for those with complex and chronic health care needs, the Association recommends a number of key changes be made to the EPC that would facilitate increased ease of access by consumers to allied health services.

Speech Pathology Australia urges the Federal Government to consider increasing the number of subsidised allied health sessions available to consumers. Current arrangements emphasise assessment and brief intervention rather than the sophisticated mix of care that is most effective for chronic care⁴. Five subsidised sessions may not be adequate to facilitate improvement for some consumers and may result in the provision of care that is not consistent with best practice guidelines. Further to this, lack of flexibility does not permit variations in treatment requirements for different conditions or for people with co-existing chronic conditions⁴.

Information provided by Speech Pathology Australia members indicates that referrals to speech pathology through the EPC are inconsistent and dependant on the particular GP, resulting in uneven access to speech pathology services for consumers. This reflects an urgent need for greater education and understanding of complex communication and swallowing disorders by GPs. A study conducted by Murdoch Children's Research Institute, Melbourne and Speech Pathology Australia also indicated 97% of speech pathologists speak to clients about the EPC program if they believe it is relevant to the client. Thus, speech pathologists

⁴ Foster, M., Mitchell, T., Tweedy, S., Cornwell, P., & Fleming, J. (2008). Does Enhanced Primary Care enhance primary care? Policy-induced dilemmas for allied health professionals. *MJA* 188 (1) 29-32



may act as initial informers to EPC, prior to consumers seeing a GP⁵. Therefore, it is critical that speech pathologists and other allied health professionals also be included in discussions and professional education about the criteria for access to programs such as the EPC, so that there is a common understanding across health care professionals about who should and who should not access these programs.

Speech pathologists also indicate varying levels of understanding of the requirements for their own reporting back to GPs under EPC. Clearly, more is needed to create processes (with incentives at both ends) to support greater communication between professions, which will enable truly multidisciplinary care for people with complex needs⁵.

It is reasonable to assume that due to the inadequate Medicare rebate, patients are, in some cases, paying a gap to access services through EPC. Although some practitioners have indicated they have been willing to reduce their fee-for-service to patients under the EPC program, this has resulted in unsustainable out-of-pocket expenses for many, with some practitioners now reporting they have ceased to accept patients under the EPC program. Patients who are unable to afford the gap fees also report ceasing to attend treatment sessions. When launching the EPC program in 2004, Health Minister Tony Abbott suggested in reference to the rebate, that “my feeling is that with a lot of needy patients, the allied health professionals will be happy to accept the rebate in full payment”. The Association believes small business owners should not be out of pocket when providing services. Further to this, the Association is greatly concerned that consumer inability to meet out-of-pocket expenses for health care will further reduce access to care for those who are financially disadvantaged and for those with complex and chronic health care needs.

How could primary care services/workforce be expanded to improve access to necessary services?

The use of technology (not just videoconferencing) for consultation requires greater consideration. Professionals and consumers require education regarding the potential role of technology in the provision of health care and an understanding that quality care may be available through means other than just face to face contact. At the same time however, it is imperative that due consideration be given by Government and organisations such as healthcare facilities, provider groups, insurers, etc to the ethical and logistical challenges that will inevitably arise through the use of telehealth and e-technology. Specifically, the use of e-health tools will require consumers to have access to the internet and technology, including hardware and software. Consumers will be required to operate and maintain equipment, and to

⁵ Skeat, J., Morgan, A., & Nickless, T. (in press, accepted 5th February, 2009). Playing by the rules: speech pathologists' views about client suitability for enhanced primary care. [Australian Family Physician](#).



find, navigate and identify relevant information. For those consumers who lack access to such services due to geographical, economic, educational, social or and cultural factors, significant disadvantage may ensue.

The increased focus on the use of health information technology has coincided with the push in public health policy within Australia and internationally for individuals and communities to take greater responsibility for their own health⁶. This means that consumers will be required to understand health information to a level that facilitates their decision making in relation to their own health. Unfortunately for those consumers without sufficient 'health literacy' or lack financial, educational or other means to support their use of e-health, there will be further disadvantage.

What more needs to be done for disadvantaged groups to support more equitable access?

The concept of equality needs to acknowledge the inherent inequalities that exist between groups. These presenting inequalities may mean that when the same, equal principles and ideas are applied to different groups, there will be significant inequalities as to the outcome. It is therefore important that service providers be cognisant that the same 'rules' cannot apply to all groups and that some 'rules' may need to be waived to allow more equitable access. For example, referral pathways which require either an appointment to be booked via telephone, or forms to be filled out and returned via post will not allow equal opportunity for an indigenous family without a telephone or a client from a culturally and linguistically diverse background with minimal English literacy to access a service.

With limited public health dollars, how could priorities for accessing primary health care services be determined and targeting of public resources improved?

As noted previously in this submission, fundamental changes to the EPC and Medicare Benefits Scheme would facilitate improved access to and utilisation of services. Further to this, assessment of priorities for accessing primary health care services must be based on both immediate and long term social, community and financial costs, not financial costs alone. As will be discussed later in this submission, research has indicated that long term benefits are to be gained by the early identification of children at risk for delayed language and cognitive development⁷.

⁶ Baur, C. (2008). An analysis of factors underlying e-health disparities. *Cambridge Quarterly of Healthcare Ethics*, 17, 417-428

⁷ Snow, P., & Powell, M. (2004). Developmental language disorders and adolescent risk: A public health advocacy role for speech pathologists? *Advances in Speech-Language Pathology* 6 (4), 221-229



Further to this, provision of and access to services by disadvantaged groups within society must be a priority. Identifying and meaningfully engaging consumers with low income or limited education, different ethnic groups and those with limited English and/or literacy skills is essential to ensure the best health outcomes for all Australians. As noted in the Discussion Paper, it is these groups of Australians who are most at risk of poor health and who lack appropriate resources to improve their health outcomes.

OBJECTIVE 2: PATIENT-CENTRED AND SUPPORTIVE OF HEALTH LITERACY, SELF MANAGEMENT AND INDIVIDUAL PREFERENCE.

Are there specific strategies that are needed to better support consumer engagement and input?

It is essential that consumers be appropriately informed and actively engaged in understanding and meeting their health needs. Knowledge should be developed and facilitated by the health professionals with whom the consumer engages, and through the provision of services that enable meaningful access to information. Health literacy, defined as “the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions”⁶, (p. 419) is determined by a host of factors such as lay and professional knowledge of health topics, cultural factors, and the demands of the particular situation or context. As such, any strategy to support consumer engagement and input must first address the factors that will influence the success or otherwise of health initiatives. Emphasis upon consumer rights to self-determination with regard to their healthcare, including their willingness or otherwise to actively participate in their own health care must be respected.

OBJECTIVE 3: MORE FOCUSED ON PREVENTATIVE CARE, INCLUDING SUPPORT OF HEALTHY LIFESTYLES.

How could primary health care be enhanced to better support prevention activities?

Proactive assessment of communities, either by geographical location or subgroups of a population to determine potential areas to target is worthy of consideration. It is known that people will generally present to the health system if they perceive a problem or when a crisis point has been reached (by which time it is too late for prevention activities). For example, a parent will not take their child to a speech pathologist if they are not aware their child has delayed communication development when a comparison to the child’s peers appears normal – peers may also be delayed as the entire population group is at risk. Education of professionals regarding early intervention measures such as the Australian Early Development



Index⁸ (AEDI) would provide professionals with the opportunity to target areas for prevention prior to a person having to present to the health system. The AEDI provides a checklist of questions along five developmental areas - physical health and well-being; social competence; language and cognitive skills, communication skills and general knowledge. It provides a measure of how children within a particular community are doing developmentally and compares the community's measure to that of children nationally and in other communities. Such measures provide important information that allows communities to identify their developmental strengths and vulnerabilities, and enables them to consider and plan for the resources and service requirements necessary to facilitate the development of children within the community.

As a contributor to the development of the "Get Set 4 Life – Habits for Healthy Kids"⁹, Speech Pathology Australia applauds the Commonwealth Government's commitment to reform of early childhood education and care. Such strategies will assist in the early identification of children with specific speech and language difficulties and other developmental delays, and provide the opportunity for timely intervention and remediation. Strong evidence exists to show that children aged 0-3 years derive long term benefits from programs that support the family's capacity to provide a positive learning environment. Both national and international research has clearly demonstrated a link between early childhood development and school readiness, academic performance, employment and social integration¹⁰.

Research further indicates that in Australian communities, a conservative figure of 10% of children are developmentally vulnerable in their language and cognitive development, including basic literacy skills, and/or in their communication skills (including participation with other children and ability to understand others), by the time they start school¹¹. This may be as high as 33% in some Australian communities¹². Around 20% of children may be slow to develop spoken language¹² and for 50% of these children, language problems persist into the early school years¹³. Across the primary and secondary years, communication disorders (including any or all of difficulties with: understanding language, using language, social communication, speech, voice and fluency) affect as many as 12-13% of Australian children¹². Speech and language disorders not only lead to difficulty in acquiring literacy and poor long term

⁸ Centre for Community Child Health (2007). *Australian Early Development Index*. Melbourne: CCCH

⁹ Australian Government Department of Health and Ageing (2008). *Get set for life: Habits for Healthy Kids*. Available at http://www.health.gov.au/internet/main/publishing.nsf/Content/Healthy_Kids_Check

¹⁰ McCain, M.N., & Mustard, J.F. (1999). *Early years study final report: Reversing the real brain drain*. Toronto: Ontario Minister Responsible for Children.

¹¹ Centre for Community Child Health. (2007). *Australian Early Development Index (AEDI)*. Australian Results 2004-2006. Melbourne: CCCH

¹² Reilly, S., Wake, M., Bavin, E.L., Prior, M., Williams, J., Bretherton, I., et al. (2007). Predicting language at age 2 years: A prospective community study. *Pediatrics* 120 (6) , 1441-1449

¹³ McLeod, S., & McKinnon, D.H. (2007). The prevalence of communication disorders compared with other learning needs. *International Journal of Language and Communication Disorders* 42 (S1), 37-59



achievement, but are also associated with reduced employment options, social, emotional and behavioural problems across the life span, mental health problems, and criminal behaviour leading to juvenile offending and imprisonment^{7 14}. Access to timely, appropriate intervention for children and their families has the potential to impact positively upon the ability of children with vulnerable language and cognitive skills to contribute meaningfully to society and to reach their full potential.

Speech pathologists possess the knowledge and skills that allow them to work with children, families and education agencies to develop programs which would ensure that ‘at risk’ children are provided with a home and social environment that maximises their health and development. Longitudinal studies have provided strong evidence of the positive impact such intervention plays in relation to educational success, social engagement and long term health outcomes.

How could health professionals be better supported to provide lifestyle modification advice and support consumers in behavioural change?

Health professionals and health organisations would benefit from targeted training to improve their knowledge and expertise with regard to working with consumers to influence change. Whilst these area of practice have traditionally fallen to psychology and social work, dissemination of skills in change management to the broader health workforce would not only reduce the workload of social workers and psychologists, but would also facilitate a multidisciplinary approach to improving the health and lifestyle of Australians.

What measures have been, or could be, effective in addressing prevention for specific population groups (e.g. indigenous, rural and remote, low socio-economic status, CALD)?

The pre-requisite needs of consumers must be addressed before they can actually participate in prevention activities. Professionals can often overlook these or assume they are already in place. For example, an indigenous client will not be able to participate in a physical activity group without appropriate footwear; families from lower socio-economic backgrounds will not be able to attend language development playgroups if they have no transport (no car or money for fuel) to get there. It is essential that due consideration be given not only to an “illness” model of prevention but also to environmental and social determinants of health.

¹⁴ Smart, D., et al. (2004). Patterns of antisocial behaviour from early to late adolescence. Trends and issues in crime and criminal justice. No. 290
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OBJECTIVE 4: WELL-INTEGRATED, COORDINATED, AND PROVIDING CONTINUITY OF CARE, PARTICULARLY FOR THOSE WITH MULTIPLE, ONGOING AND COMPLEX CONDITIONS.

What target groups would most benefit from active clinical care and/or service coordination?

Groups with low social determinants of health and/or those who are not able to engage well with the health system would benefit from a more integrated approach to healthcare – this would include consumers from culturally and linguistically diverse (CALD) backgrounds, indigenous communities, consumers with a history of mental health issues, the aged, those with low literacy, and those with an intellectual disability.

Specifically in relation to the field of speech pathology, a number of complex, ongoing conditions require mentioning. Whilst the Federal Government is addressing chronic disease through a number of key initiatives, it is important to acknowledge that chronic disease extends beyond those diseases with which the public is most familiar, such as Type 2 diabetes, heart disease and respiratory disease. Patients with conditions such as Parkinson's disease, Multiple Sclerosis, cerebral palsy, stroke, acquired brain injury, and developmental disabilities such as autism, require coordination of and access to ongoing, long term services provided by allied health and other health professionals. It is possible for people with chronic diseases such as these to maintain their health and avoid hospital stays if they have access to comprehensive, timely and appropriate primary care. This requires access to direct services across the full spectrum of allied health professionals, nursing and general practice.

Who is best placed to coordinate the clinical and/or service aspects of care?

Coordination of clinical services should be by the professional most appropriate to a client's condition. Whilst initial contact with the client may be with the GP, multidisciplinary team management must be integral to patient management, providing a comprehensive and holistic approach.

Non-clinical and clinical service coordination must be closely tied. Non-clinical service coordinators have the potential to play a significant role in the management of complex and chronic conditions, supporting and integrating the delivery of patient care and reducing the workload of practitioners. The role of a non-clinical service coordinator should be determined by the particular needs and capacity of an area, and filled by a professional with skills to meet these specific needs.

How could information and accountability for patient handover between settings (e.g. hospital and general practice) be improved?



Standardised note taking and report formats would facilitate ease of handover between settings, although the inherent difficulties and significant costs associated with implementation of such a process are acknowledged.

Effective e-Health systems that enable the sharing of consumer health information have the potential to reduce inefficiencies that currently exist due to duplication of material, delays in obtaining and transferring medical information, and in the prescribing and dispensing of medication. However, Speech Pathology Australia cautions against the implementation any form of e-Health system until the very important issues of privacy and confidentiality are addressed. Speech Pathology Australia supports the Consumer Health Forum of Australia's commitment to informing consumers regarding the development of electronic health record systems; specifically, the Association supports the right of consumers to have access to their own information and have their privacy assured through secure systems that are subject to regular and robust audit.

Would there be advantages in patients having the opportunity to 'enrol' with a key provider?

The advantage of voluntary 'enrolment' with a GP is that ease of follow up by a GP would be facilitated. However, voluntary enrolment would only improve access to GPs if a GP truly limits the number of patients that they have registered with their practice.

A significant disadvantage to 'enrolment' may ensue for those consumers and consumer groups who already experience disadvantage in relation to access to health services. Such groups include indigenous persons, those without fixed addresses, and clients with mental health issues.

The Association believes it imperative that consumers retain the right to choose if they wish to register and with whom.

OBJECTIVE 5: SAFE, HIGH-QUALITY CARE WHICH IS CONTINUALLY IMPROVING THROUGH RELEVANT RESEARCH AND INNOVATION.

What aspects of performance of the primary health care sector could be monitored and reported against (e.g. for each Element in this Discussion Paper, what are key areas of performance that could be monitored and how)?

A long term approach to the monitoring and evaluation of performance is required to ensure results are representative of performance. It will be important for the Department of Health to monitor results in a longitudinal manner using validated and reliable tools so that results are representative and comparable across time.



With respect to specific aspects of performance monitoring, health outcomes and ease of access to health care are key. This is never more so than for disadvantaged populations, especially indigenous persons and those in rural and remote regions. Both quantitative and qualitative measures should be reported, ensuring that not only are facts and figures obtained for review, but the opportunity is also provided for consumers and professionals to report on the less measurable aspects of health such as subjective impressions of services provided and health outcomes as reflected through quality of life indicators.

How can we improve the current research culture and evidence-base in primary health care?

Currently there is very limited Commonwealth support for post graduate education or financial incentive to undertake further education. For example, there is time available for speech pathologists undertaking post graduate study in the health sector equivalent to 4 hours per week for 13 weeks/semester. Within the private sector there is no remuneration for undertaking post graduate training or obtaining higher qualifications.

Speech Pathology Australia recommends the Commonwealth Government consider the development of specific resources that would increase the understanding of evidence based practice and the importance of research to primary health care. Such a resource could resemble a recent Speech Pathology Australia initiative developed to assist practitioners' access and understand evidence based practice in speech pathology. In 2008, speechBITE™ (Speech Pathology Database for Best Interventions and Treatment Efficacy), was launched. Sponsored by Speech Pathology Australia, the NSW Motor Accident Authority, Guild Insurance and supported by The University of Sydney, speechBITE™ is an internet based resource designed to assist speech pathologists in evidence based clinical decision making. Included on speechBITE™ are Systematic Reviews, Randomised Controlled Trials, Non-Randomised Controlled Trials, Case Series and Single Case Experimental Designs. The speechBITE™ database is to be continually expanded for clinicians, with more treatment studies and ratings added on a regular basis. To date, feedback from speech pathologists regarding the database has been extremely positive, with ease of access and interpretation of information cited as the database's greatest benefit.

How can we translate evidence or innovation into practice more systematically?

Dissemination of information is crucial. It will be important for government to ascertain how professionals are currently finding out about best practice. Currently there is limited emphasis upon allied health practitioners attending professional development, and there is no obligation for employers to support their staff in attending professional development activities. Little



information is realistically disseminated outside attendance at formal conference, courses and seminars (with obvious barriers for rural and remote allied health). Other means must be developed to facilitate the dissemination of information about evidence and innovation – e.g. databases like speechBITE™, web forums, Interest Groups, and telehealth.

A culture of ‘best practice’ needs to be developed and become the norm. Professionals must be encouraged to try new things rather than maintain the status quo. There needs to be recognition that the introduction of new practices or ideas may initially decrease activity (e.g. decrease occasions of service) but have the potential for significant long term benefits to consumers. Adequate funding to support the development of new resources and practices, and access to appropriate support (such as access to experts, legal opinion, etc) are required to facilitate such an initiative.

What options could be used to support health care professionals’ involvement in research and innovation?

Until recently, health professionals have reported that establishing protected positions or time for research would facilitate their ability to contribute to the research and evidence base of their professional practice. However, it has become apparent that whilst this model may be highly desirable, it often does not fit well with existing practices which measure performance by ‘occasions of service’. Professionals will continue to sacrifice research time or time spent searching the evidence base if their performance is only measured by number of people seen.

Consideration needs to be given to the provision of opportunities for small, short term research participation. Many professionals are reluctant to enrol in further tertiary studies due to financial costs, family constraints or other factors, and may not have the skills required to initiate independent study. If strong research support is provided (e.g. provision of financial support and assistance with development of measurement tools, analysis of data, etc) at an organisational level, professionals may be more inclined to engage in research.

Whilst emphasis is upon the ongoing development of skills and the completion of post graduate training and education, most employers and third party payers fail to recognise and remunerate higher levels of skills. The remuneration offered through relevant awards for higher education training is minimal, thereby further reducing the attractiveness of completing post graduate studies.



6. BETTER MANAGEMENT OF HEALTH INFORMATION, UNDERPINNED BY EFFICIENT AND EFFECTIVE USE OF eHEALTH.

As discussed previously in this submission, the use of technology, including eHealth, has the potential to expand consumer knowledge and facilitate access to health services. However, there are a number of key ethical considerations that arise in relation to electronic health care that must be addressed. These include but are not limited to the conflicting information needs of participants, the place information and communication technologies have in individuals' lives, appropriate evaluative tools that meet the needs of different participants, the effect of eHealth on professional-consumer relationships and overarching concerns related to privacy and information access¹⁵. The Association cautions that eHealth not be seen only as a medical technology/treatment, or in terms of an information system supporting information needs within formal health institutions, but also as an information service. The overriding ethical concern behind the concept of information service is the idea of information as a right, as a tool that empowers individuals and communities¹⁶. Any proposal for the development of eHealth technologies, whether for record keeping, transfer of information, or for patient treatment and management, must give due consideration to these underpinning principles.

7. FLEXIBILITY TO BEST RESPOND TO LOCAL COMMUNITY AND CIRCUMSTANCES THROUGH SUSTAINABLE AND EFFICIENT OPERATIONAL MODELS.

How could planning for primary health care services at the local level be improved?

A reduction in the disparity between agency boundaries is a priority. For example, a local community might have health services provided by one region, local government services provided from another region, and education department services by a further region. If streamlining of service provision was undertaken to ensure services were provided by the same or a limited number of regions, the capacity for professionals to work together locally and collaboratively would be greatly enhanced.

Local agencies could also be provided with an ability to make autonomous decisions that were demonstrated to be applicable to their local region. If this was to occur, discretionary funding could be provided at a local level which could be used varyingly across different areas of a region.

What mechanisms could be used to improve the accountability of primary health care services being delivered in a locality (in respect to quality of care, reach and equity)?

¹⁵ Cornford, T., and Klecun-Dabrowska, E. (2001). Ethical perspectives in evaluation of telehealth. *Cambridge Quarterly of Healthcare Ethics*, 10, 161-169



Any mechanism would need to demonstrate a sound rationale for the service, based on a needs analysis of the community, or at a minimum an examination of the applicability of a service if a program from another area was being used. Participation could be measured by the number of people accessing the services, but could also be measured by the spread of information from those people to other community members (e.g. dissemination of information through a family or friends within a sub-population). Key performance indicators that were valid and measurable would need to be developed and agreed upon.

How can greater community engagement be supported in primary health care?

Programs need to demonstrate a sense of purpose, longevity and relevance. It is essential that communities do not feel a sense of duplication of services across agencies. As remote communities have not traditionally engaged well with visiting services, programs need to be driven by a key local facilitator rather than a professional visiting the area. Up-skilling of local people (not necessarily professionals) is essential as they have the potential to influence the community on an ongoing basis and will be able to sustain the results longer than a visiting service. This is not just relevant to rural areas - key people can also be sought from within sub-populations in any geographical location – for example, a key person within a location with a high migrant population could facilitate local programs for another area with similarly high numbers of immigrants.

OBJECTIVE 8: WORKING ENVIRONMENTS AND CONDITIONS WHICH ATTRACT, SUPPORT AND RETAIN WORKFORCE

What changes in working arrangements and conditions will better support primary health care professionals?

Speech Pathology Australia has recently supported a research project looking at factors that impact upon retention and attrition in the speech pathology workforce¹⁶. Information suggests that limited career paths, non-family friendly workplace arrangements and limited remuneration are significant major factors in attrition from speech pathology. Current remuneration and career structuring may be failing to provide adequate flexibility or incentive to remain within the profession. There is potential for considerable loss of experience and expertise from the profession, particularly for those clinicians with several years' experience who commence families and/or whom make lifestyle choices to move to part time employment. Often these are clinicians who may have moved into middle and senior clinical or management positions. Data suggests that these are the positions where vacancies are most difficult to fill.

¹⁶ McLaughlin, E., Lincoln, M., Adamson, B., Pallant, J., & Cooper, C. (2008). Turnover and intent to leave among speech pathologists. Manuscript submitted for publication. [Australian Health Review](#)



Award structures vary between states and sectors. Lack of appropriate award structures across all sectors (Disability, Aged Care, Education and Health), may influence attrition through loss of discipline-specific professional supervision, lack of skill recognition, limited career progression and enhancement. Specifically however, Disability, Aged Care and Education sectors are seen as less attractive than the Health sector due to poor award structuring and devolution of services, resulting in limited or no professional supervision and support by experienced speech pathology colleagues. Private Practice is a growth area for speech pathology, possibly reflecting both a demand not met by the public services and attractiveness with regard to remuneration and family friendly options.

The issue of attracting and retaining professionals within rural and remote regions has special challenges, with better pay not always an incentive. Other incentives need to be considered, including the provision of professional development and structured mentoring support and opportunities for short-term postings to these areas. Specifically in relation to this last point, professionals may not wish to undertake these positions on a 'permanent' basis but may be more willing to do three or six month short term locums.

Whilst shortages in funding relate to recruitment and retention, indigenous communities also require a higher level of service and a different skill mix to other communities. The increased incidence of cerebrovascular complications of diabetes, mental health issues, cancer, acquired brain injury, child speech and language delay and hearing loss within indigenous communities all require the expertise of a speech pathologist. Targeted initiatives must address the provision of speech pathology services in consultation with local communities – services for indigenous communities should not be guided solely by qualified allied health professionals but specifically, should aim to train community members. Likewise, services for indigenous communities should be directly funded to employ allied health professionals.

How can newer models of care or newer workforce roles (such as nurse practitioners and physician assistants) better support health professionals to meet demands created by a changing primary health care environment?

Qualified allied health assistants are increasingly being employed to support the services of allied health professionals and it may be appropriate to consider their role in the primary health care environment. Allied health assistants are currently employed to support the work of speech pathologists in their clinical practice in a number of clinical settings, including rehabilitation, community care and mental health. Speech pathologists are directly responsible for assistants' clinical activities, and must provide supervision and be responsible for medico legal accountability, supervision and training, safety of clients and family, compliance with government legislation and the efficacy of treatment which relies on an assistant.



In response to the potential widening of assistants and other health workers roles, Speech Pathology Australia has released its “Parameters of Practice”¹⁷ document that outlines recent developments in some states throughout Australia regarding training, employment and conditions of practice of allied health assistants and other health workers, e.g. nurses, care attendants and community workers. Health workers must only operate within the limits of their training and competency, and in relation to speech pathology, support roles operate under the supervision and direction of a qualified speech pathologist. Currently, additional regulatory and administrative frameworks are required to ensure the roles undertaken by allied health assistants and other health workers address legal, safety, professional and quality of care issues.

It is important to ensure the use of assistants or health workers with non-discipline specific skills is an initiative to improve the quality and timeliness of care provided to consumers rather than a response to budgetary considerations or a shortage of speech pathologists and allied health professionals in general. This latter point is particularly relevant in rural and remote areas where there is an acknowledged shortage of qualified allied health professionals in all disciplines. It is important to note that health care workers without recognised, specialised qualifications should not be a substitute for specialist allied health professionals, including speech pathologists. High quality care by qualified professionals should be a consumer expectation regardless of geographical location.

Are there specific changes needed in those regions or populations where there is difficulty attracting and retaining staff?

Further to the suggested changes as noted above, there is a need to address personal and lifestyle issues of professionals. Examples include consideration of employment opportunities for partners and spouses, quality of available housing, and quality/availability of local services which a professional might need to access (e.g. schools for their children). Further to this, differing career prospects should be supported and promoted. For example, it may be necessary to address the lack of opportunities for clinical specialisation through the provision of management experience, more independent budget management for the department and provision of mentoring and supervision. Remuneration also must match job requirements and responsibilities.

9. HIGH QUALITY EDUCATION AND TRAINING ARRANGEMENTS FOR BOTH NEW AND EXISTING WORKFORCE

What improvements are needed to primary health care education and training?

¹⁷ Speech Pathology Australia (2007). Parameters of Practice: Guidelines for delegation, collaboration and teamwork in speech pathology practice. Speech Pathology Australia. Melbourne
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As mentioned previously, additional education funding is required to increase training in change management and behaviour intervention. Further to this, clinical education of students must address issues specifically related to primary health care, including but not limited to defining the scope of primary health care, promoting multidisciplinary and interdisciplinary care as best practice and identifying social and educational factors that impact upon the utilisation and effectiveness of primary health care services. Particular emphasis must be upon the unique challenges facing disadvantaged groups in their access to and understanding of primary and preventative health care.

Are there other funding models for primary health care that need to be considered?

Speech Pathology Australia urges the Federal Government to consider the provision of designated funding for allied health services to a range of specific disability groups, e.g. severe language disorder, young adults with acquired head injury, and complex and severe disability of congenital origin. Such funding, as is currently provided for children with autism, would assist in meeting the very complex and chronic health care needs of these specific groups that historically have been under-resourced in terms of access to services on an ongoing basis.

The option of tendering out services to local providers in regional areas, rather than provision of ongoing services by visiting professionals also requires consideration. An example of this may be a local private practitioner running an ongoing program so that a visiting specialist could focus on the development of new initiatives and new clinical services and activities. This would also free the visiting professional to address management and other non-clinically related issues as they arose.

Patient-centred and supportive of health literacy, self management and individual preference.

Speech Pathology Australia strongly supports an increased emphasis on preventative health care. In addition to large scale public awareness campaigns, adequate funding must be made available to engage the services of skilled health professionals to work in lower socioeconomic areas. As it currently stands, inadequate funding is available to support the utilisation of professionals at the grassroots level of working with communities in primary health care prevention campaigns. Through this initiative, health professionals will be able to develop and implement community development agendas in partnership with local providers and community groups most in need.



CONCLUSION

Speech Pathology Australia applauds The Federal Government, through the Department of Health and Ageing, for its commitment to developing a National Primary Health Care Strategy. The objectives of the proposed strategy demonstrate appreciation of many of the complex issues that impact upon the ability of all Australians to access timely and appropriate primary health care services. The Association is particularly pleased that due consideration has been afforded those members of the community who are disadvantaged in their ability to access primary health care services, namely indigenous Australians, those living in rural, remote and lower socioeconomic urban areas, and Australians experiencing hardship due to mental illness, homelessness and disability. We trust that our comments will be considered positively and we look forward to ongoing consultation regarding the specific details of the National Primary Health Care Strategy.

For further consultation, please contact:

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