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

Final Report

Centre of Research Excellence in Rural and Remote Primary Health Care

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<td>ABS</td>
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<td>RRMA</td>
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SECTION 1 - INTRODUCTION

Background

Nowhere is the problem of access to health services greater than in rural and remote areas.1 “Lack of access to quality healthcare providers is one of the primary root causes of health inequity and is disproportionately experienced by people living in remote and rural communities”.2 While poor access and social inequity are not confined to non-metropolitan areas, for geographically large countries such as Australia and Canada, this problem translates into major inequities in resource distribution and service provision in rural and remote areas, with consequent unacceptable inequalities in the health and well-being of their populations.3,4 For example, rural and remote Australians have poorer health outcomes, die sooner than people living in urban areas, and Medicare has a $1 billion underspend on people in rural and remote areas. Not only are problems of access to services at the heart of health outcome inequalities and inequities, but importantly they have persisted over time,5,6 and remain the single biggest impediment to improving the health outcomes of geographically disadvantaged groups of the population.7

The Centre of Research Excellence in Rural and Remote Primary Health Care (CRERRPHC) was launched in 2011 at Parliament House in Canberra by the Honourable Mr Mark Butler, the Minister for Mental Health and Ageing (see Figure 1). The CRERRPHC was established to undertake research on access and equity issues in relation to rural and remote primary health care (PHC). This focus is premised on the following:

> The inequality of health outcomes between the one-third of Australia’s population living in rural and remote regions and their metropolitan counterparts is unacceptable;8
> The acute compounding effect of geography on socio-economic disadvantage in rural and remote areas;9
> Evidence that effective PHC services diminish problems of workforce recruitment and retention;10,11
> Evidence that PHC services are the most efficient and effective vehicle for improving health outcomes;12 and
> A logic model that provides the explanatory associations between health service inputs in specific contexts, service outputs and health outcomes.13

The initial CRERRPHC was funded for four years until 31 December 2014, but received a one-year extension of funding through 2015.

Figure 1: Launch of the CRERRPHC 2011 - L to-R: Professor David Lyle (CI), Professor John Humphreys (CI), Hon. Mr Mark Butler (Minister for Mental Health and Ageing), Professor Lesley Barclay (Chair, National Rural Health Alliance) & Mr Gordon Gregory (CEO, National Rural Health Alliance)
Aims of the CRERRPHC

The research program of the CRERRPHC aimed to better understand key access and equity issues relating to the provision of appropriate, effective and high quality primary health care services in rural and remote communities of Australia. The integrated research program comprised three broad streams of research activity:

Stream 1: the geography of access

Arguably, one of the most important aspects of equity and access to PHC services is the location and distance to these vital resources. Stream 1 research aimed first to assess differential access to PHC services and service utilisation on a national level, using sophisticated geo-spatial methodologies; and, secondly, to produce evidence and generate an improved measure of access (the Index of Access) to inform national PHC workforce planning and evaluation necessary to ensure citizens have an equal opportunity to be healthy.

During 2015, the CRERRPHC externally validated the Index of Access with key stakeholder groups, policymakers, service planners and other experts; outlined its appropriateness and application as a national health service, and workforce planning tool for rural and remote areas; and investigated the relationship between rural and remote population dynamics, service availability and access patterns.

Stream 2: the impact of rural and remote context on primary health care practice

Far from being provided ubiquitously, the availability of PHC in rural and remote areas relates very closely to the context in which services are provided and the nature of activity that PHC workers do. Different models of provision are required to take account of differences in population size and density, location, and needs. Unfortunately, a major gap limiting current health reform initiatives designed to increase equity of access to health care, is lack of knowledge about what mix of PHC services communities of different sizes and locations require (and could reasonably expect) in order to maximise quality health outcomes. Ensuring equity of access requires a good understanding of the service requirements in terms of funding, infrastructure and human resources.

Stream 2 research aimed to collect primary data from high-performing PHC services operating in different rural and remote contexts, to identify indicators and develop ‘benchmarks’ for key service requirements (such as workforce and funding), and service performance (for example, early intervention, treatment of acute and chronic disease) that can be used to quantify the volume and distribution of available care (that is ‘who gets how much of what services’).

Extension of this stream in 2015 enabled completion of this work and contributed to an examination of the fly in/fly out workforce in remote communities. The extension also provided ongoing support for 3 PhD students.

Stream 3: evaluating sustainable PHC service models

Research has shown how a “one-coat-fits-all” model of health care fails many rural and remote Australians. The aim of Stream 3 research was to evaluate innovative PHC services which fill service gaps, better target health needs and promote rural workforce recruitment. This research aimed to highlight PHC models that minimise barriers (such as distance and affordability) and maximise access to optimal care in different contexts, particularly focussing on aged care, mental and Indigenous health. Building on previous research, the CRERRPHC sought to apply generic environmental enablers and essential service requirements to differing contexts in order to identify ‘what models work best where and why’.

In short, the CRERRPHC research program sought to provide a national platform showing how improved access to appropriate PHC services for populations in locations with poorest access will increase equity in health care through improved health literacy, service utilisation and health outcomes.
In 2015, a comprehensive evaluation and synthesis of studies undertaken in Stream 3 was undertaken.

Conceptual basis and rationale

Penchansky & Thomas’s landmark paper\(^{15}\) captures the multidimensional concept of accessibility – incorporating availability, accommodation, affordability and acceptability.\(^{1,14}\) This concept of accessibility is operationalised within a logic model framework that underpins the CRERRPHC research program (Figure 2). Previous research (shown in stipple) has empirically validated the relevance of this framework through developing (i) a typology of PHC service models appropriate in different rural and remote contexts; (ii) a framework that defines the environmental enablers and essential health service requirements across these different models; and (iii) indicators and benchmarks specifically for workforce retention.\(^{10-11,16-19}\) This research has received national and international acclaim by academics and policymakers through its explanation of the context of, and inputs to, effective and sustainable PHC services.

The research investigated in detail, how appropriate and sustained PHC service inputs contribute to direct and indirect health outcomes that ensure improved health status for all Australians (see shaded area in Figure 2). The CRERRPHC research helps to generate measures by which to link PHC models with improved efficiency, acceptability and appropriateness of care necessary to ensure sustainable improved health outcomes. Specific studies focused on sustainable models of aged care and mental health service delivery (two of the most important national priority areas relevant to under-served populations), and the role and importance of health knowledge and literacy in improving access to PHC.

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**Figure 2: An evidence-based logic model for primary health care for small rural and remote communities (After: Watson et al., 2009.)**
The research demonstrates how geographical disadvantage (felt most acutely in rural and remote areas) exacerbates the effects of social determinants on health and organisational problems that contribute to poor health outcomes. Importantly, too, it highlights the urgent and critical need for, and importance of, sentinel measures by which to monitor the impact of improved access to appropriate PHC on health behaviour and health outcomes. Geographic-based indicators and benchmarks are essential for monitoring the provision of PHC services$^{13,20}$ and evaluating national policies designed to provide effective and equitable health care to all Australians regardless of their place of residence.
SECTION 2 - METHODS

The CRERRPHC research program combined Australia’s best rural and remote health researchers across four sites with pre-eminent early career researchers, post-doctoral research fellows and PhD students, and international experts from North America. The CRERRPHC comprised staff from departments across four universities (Figure 3):

> Monash University School of Rural Health in Bendigo
> Monash University Graduate Medical School, Churchill
> Centre for Remote Health, a joint Centre of Flinders & Charles Darwin Universities, Alice Springs
> The Broken Hill University Department of Rural Health (University of Sydney)

Associate investigators from Macquarie University, the Northern Territory Department of Health, and overseas, provided invaluable input to the research program.

![Figure 3: Location of CRERRPHC sites in Australia](image)

Organisational arrangements for the CRERRPHC

Strong leadership, efficient management and administration, minimal bureaucracy, effective and transparent communication, and collaborative decision-making are key to any successful and sustainable organisation. With this in mind, the CRERRPHC spent some time initially in putting into place good governance and management measures, together with strong and efficient organisational arrangements, to complement the strong academic leadership:

Governance, leadership and management

The management of the CRERRPHC was maintained through a Management Committee comprising the Chief Investigators (CIs), and was chaired by CIs Humphreys and Wakerman who took overall responsibility for the effective operations of the CRERRPHC. Face-to-face meetings of CIs were held from the outset to put into place necessary strategic planning and agreements. In addition, to ensure efficient organisational arrangements and that academic programs were on track, annual face-to-face meetings were supplemented by fortnightly meetings of the CIs held by teleconference. These regular meetings and communication maintained the success of the collaboration and enabled the successful completion of joint projects, as well as training and supervision for research students across institutions. In addition to the central management and
operational functioning of the CRERRPHC, individual roles were assigned to CIs in order to ensure the efficient and effective functioning at each of its nodes.

**Academic leadership**

As with any successful organisation, strong academic leadership was required to ensure that the CRERRPHC met its goals. Individual CIs shouldered this responsibility.

- CI McGrail and CI Humphreys co-led the Stream 1 ‘Mapping access to PHC and service utilisation’ project;
- CI Wakeman led the Stream 2 ‘Developing an appropriate PHC evaluation framework for service access and equity’ project;
- CI Lyle took responsibility for researcher capacity building activity, particularly with higher research degree students, and co-led the Stream 3 ‘Developing and evaluating sustainable PHC service models to improve access’ project with CI Perkins.

Staff of the Poche Centre for Indigenous Health in Alice Springs (Flinders University) contributed to the research program, but the original intention of the Poche Centre taking leadership of the Indigenous health literacy and health services research was not fully realised for reasons beyond the control of the CRERRPHC.

Fortnightly academic teleconferences were held to review academic progress across the CRERRPHC research program, and these were complemented by annual face-to-face gatherings and presentations. In addition, there were regular teleconferences of individual CIs and researchers at various stages of the projects.

**Project Manager**

In addition to the organisational and academic leadership, a key role in any successful research organisation is that provided by the Project Manager. The exceptional performance of Lisa Lavey in fulfilling this role was a critical component of the success of the CRERRPHC. Initially, Lisa Lavey occupied this role half-time, but for the latter three years of the CRERRPHC she assumed the role full-time because of the onerous work-load and diverse nature of its national activities. The task of the project manager included:

- Organising meetings and conference attendance;
- Interfacing with stakeholders, universities, governments, health authorities and professional bodies;
- Meeting all reporting and contractual requirements;
> Developing and maintaining the CRERRPHC website;
> Establishing and managing the CRERRPHC Twitter page;
> Preparation of the CRERRPHC newsletter and other publicity for the CRERRPHC;
> Developing and maintaining a database for monitoring the impact of the CRERRPHC;
> Finalising and desk-topping all reports and publications;
> Liaising with APHRCRI and the broader CRE Network;
> Being responsible for finances and all fiscal reporting; and
> Managing an extensive range of extraneous duties that evolved during the course of the CRERRPHC.

In addition, the Project Manager, in conjunction with the Project Manager from the Centre for Obesity Management and Prevention Research Excellence in Primary Health Care (COMPaRE-PHC), and the Research Manager at APHCR, developed a “Tips for New Players” document to assist in the establishment and management of multi-institutional centres of research excellence. This draft document was presented at Australia’s 2013 Primary Health Care Research Conference and subsequently formed the basis for a $20,000 grant in 2015 to further develop and validate this important tool. The findings of this study were presented to the CRE Network Meeting in Canberra (April 2015), and the 2015 Primary Health Care Research Conference in Adelaide (July 2015). The final document entitled “Establishment and Management of a Multi-Institutional Centre of Research Excellence: Tips for New Players” was presented by Lisa Lavey at the 2015 Australasian Research Management Society Conference in Singapore (October 2015) and is available on the APHRCRI website: http://aphcri.anu.edu.au/resources/researchers.

**Chief investigator meetings**

Chief Investigators met regularly each fortnight by teleconference to discuss all aspects of the performance of the CRERRPHC. This important and, at times, onerous responsibility ensured the efficient functioning of the centre, facilitated and enabled strategic forward planning, and maintained a strong focus on relevant, rigorous and high-quality academic research.

**Research Stream meetings**

Central to the academic success of the CRERRPHC is the full engagement of all staff, thereby ensuring shared communication and understanding of the requirements of the CRERRPC and strong guidance and supervision of early-career researchers and postgraduate students. To that end, Stream Leaders and all academic staff linked by teleconference each alternate fortnight to report and discuss progress with projects.

**Linkage with end-users**

With PHC research, the engagement of end users (including health authorities, service providers, policymakers and consumers) is vital to the effective planning, implementation and take-up of outcomes. The CRERRPHC research program incorporated a comprehensive strategy to ensure regular and effective communication and widespread dissemination of its activities so that end-users are aware of, and informed by, the research program, in order to maximise take-up and implementation.

**Role of the Advisory Committee**

The CRERRPHC established a National Advisory Committee (NAC) made up of key remote, rural and Indigenous policymakers, consumers, service providers and advocacy groups. The National Advisory Committee included representation of key rural groups such as the Health Consumers of Rural and Remote Australia Inc (HCRRA) and peak Indigenous organisations such as the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT). Details of members, terms of reference and meeting dates are shown in Appendix 2. While the composition changed over the five-year period, every attempt was made to ensure widespread organisational and geographic representation.
Governments and bureaucrats

Staff from the CRERRPHC maintained regular contact with policymakers and staff from the Australian Department of Health, both through face-to-face meetings and teleconferences. The CRERRPHC conducted and led several seminars, roundtables and meetings over the five years, details of which are shown in Appendix 3. Evaluation feedback from such meetings showed that these were highly valued and provided a useful avenue for informing staff from across a wide spectrum of government (see Appendix 4).

APHCRI

CIs from the CRERRPHC maintained regular contact with APHCRI, including face-to-face meetings, attendance at CRE network meetings, regular interaction with APHCRI Directors, and in relation to ongoing reporting requirements. Staff from the CRERRPHC were actively engaged with the APHCRI interest group in geo-spatial analysis and spatial epidemiology, participating in forums and as a member of its advisory group.

Health services, professional organisations and consumers

The CRERRPHC approach to PHC research was very much aligned to the principles and processes that underpin the Canadian Institutes of Health Research Citizen Engagement framework. To that extent, our team employed processes whereby consumers were engaged as a member of the NAC or reference groups associated with the actual research activity, as in the cases of the Elmore Primary Health Service research or the evaluation studies in Aboriginal communities by Wakeman and his staff.

Research outcomes were always translated in a form suitable to meeting the needs of different audiences, including the mass media (both print and radio); brochures and presentations for diverse lay audiences; in culturally appropriate forms for Indigenous communities and ethnic groups; in 1:3:25 format reports for politicians and bureaucrats; in peer-reviewed publications; and in social media and electronic format on our websites and associated links. Staff also presented at numerous conferences and scientific meetings to inform their constituency about the most current evidence relating to rural, remote and Indigenous health services research.

In summary, the CRERRPHC staff maintained excellent and regular interaction with its diverse population of stakeholders, ensuring that good communication channels facilitated dissemination and take-up of the outcomes of the centre.

Academic research & knowledge generation methods

The CRERRPHC team brought together extensive research methodological expertise, including sophisticated geographical information system (GIS) and regression modelling, analysis of large data sets, longitudinal survey and program evaluation skills, systematic review skills, health economics expertise, detailed case-study and qualitative expertise, and importantly, the research skills required to work closely with Indigenous communities. Each research stream adopted methods most appropriate to its investigations. All research activities were usually preceded by an extensive review of the relevant literature to guide the study. In addition, a major 2½ day research methods workshop (together with a comprehensive manual) was held in Adelaide for early-career researchers within the CRERRPHC.

Specific methods underpinning the activities of each stream are provided in detail in the publications listed at Appendix 8. In summary these generally comprised:

Stream 1

Wherever possible, researchers drew on existing secondary data available at the national level, and only collected primary data where necessary. A systematic assessment was undertaken of existing (secondary) primary care workforce datasets. Researchers drew on data available at the national level or specific state-level data, but remained limited by the aggregated nature of most
secondary datasets. Notable exceptions of usable small-area workforce datasets were Medicare Australia and the Australian Medical Publishing Company (AMPCo), both enabling full-time equivalence data of rural general practitioners at the town or community geographical level. Datasets from state-level Rural Workforce Agencies were additionally used for subprojects relating to rural workforce retention and turnover modelling.

In the absence of any empirical secondary data relating to health service utilisation behaviour of rural residents, primary data were sought. An extensive delivery-and-collection survey of residents from five small rural communities across two states 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, notably of ‘distance-decay’ (propensity to travel larger distances for health care) and most important access dimensions (when deciding to utilise health care) using multivariate regression models and paired-comparison methods. The survey instrument is shown in Appendix 5.

In developing the Index of Access, sophisticated Geographical Information System (GIS) techniques using road network analysis methods within the ArcView software were employed. Floating catchments were then used as the framework for calculating accessibility. Recognising that residents in more sparsely populated areas are prepared to travel further to access healthcare, five catchment size levels were used. Service availability measures used included the volume of general practitioner (GP) services according to the Australian Government’s Medicare Benefits Schedule and the Australasian Medical Publishing Company. Resident locations, population size and surrogate variables for health needs were sourced from ABS 2011 census data. A composite health needs measure was calculated using weightings for socio-economic status, Indigenous population % counts and age. A full description of the methods underpinning the Index of Access are contained in our Discussion Paper and the Geospatial Health journal paper (See Appendix 8: papers 11, 83).

In 2015, the Index of Access was validated by key rural health workforce and policy stakeholders targeting expert individuals (see Appendix 12 for the reported outcomes).

Stream 2

The complex nature of the benchmarking research required both qualitative and quantitative methods. First, a systematic review of international peer-reviewed literature was undertaken as the basis for determining what is known about core primary health care services. Building on this evidence, a comprehensive Delphi study comprising experienced rural and remote experts from across Australia was conducted, and the results formed the basis for a face-to-face focus group meeting held in Adelaide.

A complex methodology was used to develop a sample of high performing PHC services in rural and remote Australia for primary data collection. Data for potential primary care practices were accessed with permission through the Improvement Foundation Australia (IFA) based on the Australian Primary Care Collaboratives. Staff from the CRE in Primary Health Care Microsystems: researchers at the Greater Green Triangle University Department of Rural Health, Flinders and Deakin Universities assisted this process. Practice quality scores were based on improvement measures over one year, for type 2 diabetes mellitus and coronary heart disease. Additional data included ABS census data (used to assign a population to the communities where the primary care practice was located), and an ASGC-RA 1-5 rating applied to each community. Eligible practices were sorted according to 12 population groups. Following ethics approval from the Central Australian Human Research Ethics Committee (HREC-12-57), practices from four States and one Territory were approached to participate in the ‘benchmarking’ study. The survey instrument is shown in Appendix 6. The timing of the data collection was dependent on the availability of practice staff. Face-to-face, on-site visits were conducted by at least two members of the CRERRPHC, and data collected were supplemented by the provision by each practice of additional detailed financial and workforce data.
Whilst remote services approached were willing to participate, logistical, organisational and capacity issues resulted in extended timeframes. Extension of the CRERRPHC was welcome to enable us to complete this fieldwork. Both quantitative and qualitative analyses were employed to examine the data.

Stream 3

Because the range of PHC service models varies greatly across rural and remote areas, a key aspect of the methodology was to review the vast extant literature in order to identify gaps with existing knowledge. A wide range of stakeholders, practitioners, service providers and health organisations from diverse rural and remote areas worked closely with the research team to facilitate both primary and secondary data collection, and the maintenance of these relationships was vital in contributing to the success of the research activity. A range of both qualitative and multivariate quantitative methods were used for data analysis, with specific details provided in each of the peer-reviewed publications listed in the next section.

During the 2015 extension of the CRERRPHC a narrative synthesis was undertaken of key findings from seven PHC service evaluations in rural and remote Australia, in order to better understand how context influences what made these models work, where they worked and why. All the PHC service reforms were successfully implemented to provide access to health care that was previously not available to residents. The analysis involved a shift in focus from delineating key barriers and enablers for effective implementation to consider how those factors interact in real world settings to enable the dissemination of evidence based PHC services and programs. Fifteen papers reporting on seven CRE service evaluations published between 2012 and 2015 were included.

Capacity building

A key goal of the CRERRPHC was building the next generation of rural health researchers. The CRERRPHC research capacity building programs sought both to increase the quantum of experienced post-doctoral researchers ready to lead future research efforts, and also to deliver a cohort of competent researchers who have completed PhDs in rural and remote centres. The CRERRPHC also sought to engage rural health policymakers, service providers and consumers in the research process.

Part of its strategy to achieve this was through providing supervisors and mentors from multiple sites across rural and remote Australia, assisted by using information technology to overcome the isolation of small groups of research students in rural and remote locations. The supervision team brought together considerable multi-method expertise in applied epidemiological, bio-statistical and health economics skills (using large data sets and sophisticated econometric modelling); rural health workforce, services and policy; and indigenous health. The extensive research training expertise and experience provided by the CIs was complemented by that of Associate Investigators and international partners.

Two broad strategies were used to build research capacity:
Internal – ‘Growing PhD and Post-Doctoral Researchers’

The CRERRPHC provided PhD scholarships and post-doctoral positions in Bendigo, Alice Springs and Broken Hill, supported by high level research supervision from across institutions. Five PhD students were supported. Post-doctoral researchers were supported to gain CI status on nationally competitive grants, as a means of ensuring future research leadership and sustained PHC research activity in rural areas. These early career researchers were also given significant exposure to the process of knowledge translation through their participation in meetings with high-level policymakers in government.

As part of a strategy to help break down research isolation resulting from the tyranny of distance characterising rural and remote areas, the CRERRPHC made extensive use of interactive technology to maximise research support. Supervisors, mentors, higher-degree students and post-doctoral researchers operating from widely dispersed sites, engaged in several training programs, including journal clubs, virtual methods training workshops, research forums, and seminars on topical health service reform issues and policy debates.

External – ‘Building research skills of rural health practitioners’

The CRERRPHC provided funding support to release staff from PHC services for one day a week for a period of two years. Expressions of interest from rural health practitioners working in all CRERRPHC catchment areas were sought, detailing potential projects, the nature of support from their practice or employer, and their interest and experience in undertaking research. These were reviewed and short-listed, potential candidates interviewed, and 9 offers were made.

Following their induction, site supervisors worked closely with these early career researchers to fashion their projects in accord with the aims of the CRERRPHC and to ensure they were feasible. All successful candidates were funded to attend a 2½ day face-to-face methods workshop held in Adelaide early in their program. Regular teleconferences were held between site supervisors and students to discuss problems and as a means to share ideas and discuss their research.

Each student selected a research topic relevant to the interests and needs of their practice and community, and was expected to complete a peer-reviewed publication at the conclusion of their ‘internship’.

Knowledge transfer

Knowledge transfer was an integral part of the CRERRPHC program. To that end, staff from the CRERRPHC adopted a multi-faceted knowledge translation strategy that maximised dissemination of research outcomes and the likelihood of knowledge take-up by effectively engaging and targeting likely end-users.  

Dissemination of research outcomes – Website and Newsletters

Effective communication with all stakeholder groups is vital to knowledge translation and the uptake of evidence into policy and practice. Our current knowledge dissemination has national reach to the most remote Australians. Given the diversity of media and the plural nature of its intended audience and interested organisations, the CRERRPHC adopted a broad-ranging dissemination strategy that spanned peer-reviewed publications, conference and workshop presentations, newsletters, media presentations, use of twitter, and a web-site (See appendices 6, 7, 8 and 9).

Tracking knowledge impact and uptake

The ability of research to influence the PHC sector depends on the quality, relevance and timeliness of the evidence generated, and a robust communication strategy that engages with the diverse stakeholder population. An important aspect of evaluating the research undertaken by the CRERRPHC was ensuring that there existed a comprehensive framework against which its impact could be assessed. A particularly important aspect of this was ascertaining which
audiences were being impacted and the nature of the impact. For this reason, CRERRPHC staff invested considerable time in reviewing current literature on knowledge transfer as the basis for developing a fit-for-purpose research impact framework. This resulted in an important publication. See Appendix 8 (Paper 57).

This research impact conceptualisation formed the basis for constructing an impact monitoring database for the purpose of harnessing all measures of the research impact. Led by CRERRPHC Project Manager, Lisa Lavey, together with assistance provided by Dr Matthew McGrail, the database was developed using Microsoft Access to handle complex data. Underpinned by the research impact framework, the impact indicators are organised by who is affected by the research (academics, policymakers, service delivery providers and society at large), and whether the impacts were initiated by the producer or by the user of the research.

Knowledge translation strategies

A key aspect of the CRERRPHC mandate was the translation of knowledge generated into PHC policies and practice. Given that uptake of evidence depends more on factors related to the behaviour of researchers and the receptivity of decision-makers and practitioners than on the attributes of the research itself, the CRERRPHC worked closely with leading stakeholders, consumers and policymakers to ensure that the research was based on user needs and accorded with the right predisposition or political and material conditions. Evidence was contextualised within the environment in which it was to be used. Good use was made of the NAC, meetings with APHCRI and the DoH, reference groups which included representation of key stakeholders from all State, Territory and national government health departments, key organisations such as the National Rural Health Alliance, Colleges of General Practice and Rural Medicine, Indigenous organisations, nursing and allied health organisations, and consumers.

Part of the CRERRPHC knowledge translation strategy was to help build capacity for uptake by decision-makers. The CIs have been extensively involved with national policymakers and decision-makers through presentations, workshops, meetings and targeted distribution of its publications. Working closely with, and providing evidence directly to, these networks and ‘communities of practice’ has been shown to be one of the most effective means of knowledge dissemination and take-up.

An additional requirement of the CRERRPHC was to respond to government requests for evidence. The CRERRPHC has built on its existing very strong track record to respond to requests from government and health authorities to provide advice and undertake timely research relevant to their immediate policy needs and imperatives. This was exemplified especially well in the work undertaken by staff from the CRERRPHC in developing an improved classification to overcome existing problems with use of the ASGC-RA scheme to underpin rural and remote programs by the Department of Health. More details on the construction and adoption of the ‘Modified Monash Model’ are outlined in the next section.
SECTION 3 - RESULTS

Knowledge generation

The Stream 1 research program was led by Dr Matthew McGrail. What follows is a very brief resume of key outputs, because a significant amount of this activity has already been disseminated in the peer-reviewed literature (see Appendix 8).

Stream 1: the geography of access and equity:

Stream 1 has generated important new evidence relating specifically to three vitally important aspects of access and equity:

(i) The development of a national Index of Access based on service availability, need for care, and their ability to access services;

Unlike existing measures of access, this index integrates population health needs within its measurement, thereby measuring ‘equity of access’ and not just rurality or remoteness. Using available secondary data, the Index of Access is sensitive to small area differences and longitudinal changes in services, and adaptable for measuring access to PHC services in rural, remote and outer-metropolitan areas. This improved measure of access can be used to inform the optimal delimitation of integrated PHC services into regional networks at different geographical scales (such as Medicare Locals/Primary Health Networks) or changes in access with new services (such as GP Superclinics).

A key publication is noted Appendix 8 (Paper 28).

In 2015, the Index of Access was published in a peer-reviewed academic paper, and its development was described in an accompanying technical Discussion Paper. The results of the external validation are contained Appendix 12. In general, there was strong support for the value of the new Index of Access and its potential application within rural health service planning and resource allocation decision-making. Key recommendations were:

> Utilisation of the Index of Access is supported by rural health workforce stakeholders and policymakers and should be explored further in 2016.
> The Index of Access should be viewed as a health service planning tool to complement current use of the Modified Monash classification.
> The Index of Access will be most useful as a decision tool if it is updated annually.
> Data holders should make available their key workforce datasets across the range of primary health care providers in order to improve the value of the Index of Access.
> Further research may be required to improve suitability of the Index of Access for planning health services in remote areas.

In 2015, an additional paper was developed to demonstrate the importance of how access is measured, describing implications for health service planning. Publications completed during the 2015 extension are noted in Appendix 8 (Papers 4, 11 & 83).

(ii) New empirical information of patterns of utilisation of health services;

For purposes of health service planning, it is vital to know the ease with which patients can access an appropriate service at times of need. In a country as large and diverse as Australia, patterns of service utilisation differ. Many factors affect this, but unfortunately there has been a dearth of empirical research to identify how different factors facilitate or impede service use, and how these vary across geography.

Staff from Stream 1 of the CRERRPHC undertook a survey of 5 small communities varying in geographical location which ascertained their usual behaviour with respect to use of primary care
health services and gathered information about the distances they would be prepared to travel to obtain PHC at times of need. The results gained from these empirical data were vitally important in informing the parameters of the Index of Access model, thereby assuring it of greater construct validity. Key publications are noted in Appendix 8 (Papers 12 & 37).

(iii) The development of a ‘fit-for-purpose’ classification to guide the allocation of workforce incentives.

Given the CRERRPHC mandate of being responsive to the needs of government, and recognising the long-standing inequities and problems associated with continued use of the ASGC-RA classification to guide rural and remote incentives programs, staff from the CRERRPHC combined their collective expertise with data from the Medicine in Australia: Balancing Employment and Life (MABEL) project (of which Humphreys and McGrail were CIs) to generate a new improved classification scheme which is based on what rural doctors actually do and the differing geographical contexts in which they practise. The outcomes of this research were published in a peer-reviewed journal and received widespread acclaim from government and professional organisations for their practical application (leading to the Modified Monash Model – MMM). The policy significance and process by which it has become applied is outlined in the following Discussion and Policy Option section. A key publication is noted in Appendix 8 (Paper 60).

During 2015, the MMM was first implemented by the Department of Health for rural GP retention incentives policies, with negotiations continuing for its expanded application to other rural workforce programs. Feedback from the Index of Access evaluation, and a public seminar run by the National Rural Health Alliance on the MMM, also supported the need for multiple ‘fit-for-purpose’ classifications, including both the MMM and Index of Access.

Case Study: Matthew McGrail and Robert Graham Centre Visiting Fellowship

Dr Matthew McGrail was awarded the 2014 Australian Primary Health Care Research Institute (APHCRI) Robert Graham Center Visiting Fellowship to further investigate how GIS and large datasets can be efficiently and effectively utilised to underpin rural primary health care policies relating to workforce planning and service delivery.

Matthew’s Fellowship enabled him to travel to the Robert Graham Center (RGC) in Washington DC for five weeks in October and November 2014 where he worked with geospatial and health services researchers on two new projects, the first investigating how ‘rurality’ and other geographical characteristics relate to retention of rural primary care doctors in the USA; and secondly on spatial accessibility outcomes in both Australia and the USA.

In 2015, Matthew developed a new paper evaluating the role of community amenity and other population dynamics on rural and remote patterns of workforce availability (see Appendix 8: Paper 5).

Matthew travelled to the Northern Illinois University, in DeKalb, Illinois, where he discussed the 2-step floating catchment area method with Professor Wei Luo and conducted a one-hour research colloquium to postgraduate students in the Department of Geography. Matthew also visited Dr Don Pathman and Professor Tom Rickets, both world leaders of rural workforce retention and mobility research, at the Sheps Centre for Health Services Research in North Carolina. He also joined 1,000 attendees from 15 countries at the North American Primary Care Research Group (NAPCRG) Annual Meeting in New York.
Stream 2: Benchmarking the impact of rural and remote context on primary care practice:

It has been recognised for some time that “a critical component of monitoring and strengthening the performance of national health systems is the identification of a set of benchmarks and indicators – and the means for their measurement – for monitoring the health workforce.” Led by John Wakerman, Stream 2 research staff undertook landmark research investigating the generation of benchmarks for primary health care services in differing geographical contexts.

The first stage was a comprehensive systematic review of extant (national and international) literature, in order to ascertain what PHC services were considered optimal in order to ensure equitable access to health care in varying communities differing in size and geographical location. The resultant publication was so timely and significant that it achieved ‘highly accessed’ status almost immediately.

Stage two involved a comprehensive Delphi study of experts from across rural and remote Australia, and defined what core PHC services rural and remote residents should reasonably expect to access. A key aspect of this research was identifying their availability for communities differing in population size and geographical location.

The third stage of the work involved primary data collection from exemplary PHC services stratified by size and geographical location. This extensive fieldwork required the cooperation of selected PHC services in providing detailed workforce, financial and service data relating to their practice. At the end of 2014, this work was still in progress. However, two key messages were emerging from early data:

> the need for an efficient methodology to collect comprehensively the quantitative data associated with the costs of providing PHC in different settings, and

> the immense value and insight gained from the qualitative data provided by existing PHC workers about what they actually do in their communities and the support they require to deliver comprehensive PHC.

Key publications are noted in Appendix 8 (Papers 34 & 44).

During 2015 financial, workforce and service delivery data for 7 rural and 11 remote PHC centres were collected and analysed to identify potential workforce and funding benchmarks.

Rural practices exhibited wide variability in costs across population groups. Workforce constituted the greatest proportion of expenditure. Several issues emerged that would need to be addressed in order to develop benchmarks, define the scope of services provided and characteristics of the population catchment, categorise service models, and ensure comprehensive collection of cost data. Nonetheless, benchmarks are important if governments are to ensure equity of access to PHC for all Australians regardless of where they live.

Data for remote services show more promising results. The discrete nature of remote health services has offered a more reliable population denominator, while the more consistent nature of remote service types has simplified comparison. Despite lengthy delays to obtain community approval and work through travel logistics, a larger sample was achieved. Early observations include significant correlations between population and per capita costs, workable variances in costs per consult, and a relationship with cost estimations reported in other studies. Work is currently underway to include the cost of visiting services to ensure that estimates include the full cost of remote primary health care. Results will be published in 2016. Key publications with detailed results published or submitted during 2015 are noted in Appendix 8 (Paper 6, 17).
Stream 3: Primary health care models:

Research undertaken in Stream 3 specifically targeted improved equity in health outcomes associated with improved access to integrated models of care, especially mental health and aged care. This focus on mental health and aged care, particularly as they apply in Indigenous populations, reflects the importance of these national priority areas for rural and remote communities currently experiencing the most inequitable access to services.

A detailed examination of one innovative model of care for mental health (which built on extensive work investigating rural emergency mental health access utilising telehealth, integrated models of care, and with the Royal Flying Doctor Service and rural GPs) was conducted by staff from the Broken Hill node of the CRERRPHC led by PhD student, Emily Saurman and her supervisors Professor David Lyle and Dr Sue Kirby, with a number of significant publications emerging. These are noted in Appendix 8 (Papers 29, 30, 31 & 32).

Key publications published during 2015 are also noted in Appendix 8 (Papers 9, 16 & 84).

Important research was also undertaken in relation to mental health and aged care, where a key factor in health system reform is to connect health and aged care services for people over the course of their lives. Accordingly, in line with priorities identified by practitioners and consumers in remote areas, this research sought to ensure streamlined, consistent assessment of eligibility for care across all aged care programs, and coordinated service provision with the broader system of care. The significant unmet need associated with access to community and residential care services, particularly for Indigenous populations, people with dementia and other mental health problems, financially disadvantaged people, and people living in remote areas is widely recognised. Importantly, CRERRPHC research also examined the important issue of acceptability of PHC services to Indigenous patients and community participation. Staff from the Alice Springs node of the CRERRPHC, including Professor Tim Carey, Postdoctoral Research Fellow Associate Professor Melissa Lindeman, and PhD student Jessamy Bath led important work in this area.

Key publications are noted in Appendix 8 (Papers 21, 39, 40, 42, 43, 47, 48, 49, 54, 55, 64, 65, 66, 70, 73 & 74).

Further publications published during 2015 are noted in Appendix 8 (Paper 18).

The analysis of studies undertaken in Stream 3 in 2015 generated several key themes associated with improving access and sustainability of primary health care. These included the importance of:

> Community consultation, engagement and ownership.
> Community capacity to articulate their health needs and negotiate with health services and government agencies, including supporting the development of leadership skills for local community members.
> Funding.
> Collaboration or integration with key health providers including the clarification of roles and responsibilities.
> Establishment of governance and operational procedures.
> Ongoing feedback, monitoring and assessment against performance indicators including the ability to adapt and respond as needed.

Detailed results are contained in a Synthesis paper as noted in Appendix 8 (Paper 3).
Rural area case study 1 – The Elmore Primary Health Service study

The CRERRPHC was awarded further funding from the Commonwealth Department of Health to continue its Elmore Primary Health Service (EPHS) longitudinal study. Working closely in partnership with staff from the EPHS, the project is:

> Evaluating the performance and sustainability of the service, and
> Monitoring the quality of care, changes in health outcomes of residents using the service, and the impact of the service on community viability and satisfaction.

Numerous benefits have accrued from this collaboration, including peer-reviewed publications, quality improvement in the service, research capacity building of local rural health professionals, and knowledge translation to many other small rural and remote health services. Testimony to the value of embedding research closely with service delivery was EPHS’s success in receiving the 2015 Victorian ‘Rural General Practice Award’ from more than 120 nominations.

Key publications are noted in Appendix 8 (Papers 33, 36, 56 & 76).

During 2015, this research involved staff from the Elmore Primary Health Service (EPHS) and Monash University in the ongoing audit of clinical data and a qualitative investigation of how the service had been able to expand successfully to nearby towns to provide primary health services across a wider region.

Clinical data collection: An annual audit of clinical data relating to previously identified sentinel indicators was undertaken in 2015. Review of these data indicates that it is time to begin the longitudinal summary of patterns and trends in these indicators. Accordingly, these data are being transferred to a format suitable for analysis within a statistical software package, so that the pattern and trend analysis required for the final report can commence, and the outcomes evaluated.

Service expansion: In 2015 a detailed qualitative analysis of how the Elmore Primary Health Service has expanded to 8 nearby rural towns was undertaken. Staff across all sites were interviewed and completed a questionnaire on service expansion.

While community engagement was important throughout, service expansion comprised 5 broad stages, viz: initiative, consultation, roll-out, evaluation and consolidation, as indicated in the conceptual model included in the resulting article. The full range of previously identified key environmental enablers and essential service requirements were very important for successful expansion, particularly during roll-out and consolidation stages. Individual services benefitted from a regionally ‘networked’ PHC model through the assistance that could be provided to meet essential service requirements in rapidly changing circumstances.

This important study is soon to be published in Open Access format in the academic journal Rural and Remote Health so that it is widely available for interested stakeholders (Appendix 8: paper 7).

Capacity building: The data collection and writing up of a short research note highlighting the research capacity building that occurred and its benefits is well under way and will be completed within the allotted time frame.

In summary, this important collaborative research has continued successfully throughout 2015, and generated important results that have been broadly disseminated. As the Elmore Study reaches the end of its funding, preparation of the final report is already in train.
Remote area case study 2 – The Fitzroy Crossing study.

There is increasing evidence that strengthening primary health care is the key pathway to reducing health inequities in disadvantaged populations. The caveat, however, is that it must be comprehensive and involve community participation to ensure needs are met in a manner that is acceptable to the community. In order to have any long term effects on health outcomes, it must also be sustainable as well as addressing the social determinants of health. An example of these principles in action is the evolution of health services in the Fitzroy Valley in the Kimberley region of northern Western Australia. Led by Carole Reeve, staff from the CRERRPHC have had the privilege of observing and studying their journey over the past few years.

The personal impact of the mortality due to chronic disease and underlying socioeconomic disadvantage was the catalyst for community-initiated changes in health service delivery. Over a 10-year period involving two extensive 18-month-long periods of community consultation, a Community Controlled Health Service was established and a formal partnership with the State Health Service established. The result was a unique partnership enabling a comprehensive approach to primary health care.

The Community Controlled Health Service provides health promotion, environmental health services, and Cultural Guardianship, and has had a significant impact on health in the Fitzroy Valley through alcohol restrictions and addressing the social determinants of health. Through the Partnership, it has also had a significant impact on reorienting health service delivery. The shared vision with the State Health Service to make illness prevention a priority was made possible through the policy changes embodied in the National Health Reform.

The changes in health service delivery resulting from this reorientation included a systematic approach to screening for chronic disease and implementing interdisciplinary care as cases were identified, in addition to dealing with the presenting complaint.

Understanding how this innovative primary health care service evolved, and the factors instrumental in bringing about significant reorientation to a comprehensive primary health care service relevant to the local context, provides important insight into the requirements for effective health service change and sustainability, thereby informing policy and service development for other small disadvantaged communities. This case study highlights what is possible and necessary to deliver appropriate and accessible primary health care in communities seeking to align services with local needs. Publications resulting from this work are noted in Appendix 8 (Paper 15).

In 2016, Dr Carole Reeve completed her PhD by publication. Further publications with detailed results are noted in Appendix 8 (Papers 10, 13 & 15).

Capacity building

Internal program

The CRERRPHC has achieved considerable success in the training and development of early career researchers, a function of close engagement of staff on core research projects within our individual centres. The capacity building program was complex, partly due to the time and resources required to train researchers with different interests from different backgrounds working in different environments, and because of the long time period required to ensure rigorous training appropriate to the needs of the researcher. Nonetheless, considerable success was achieved, as exemplified by the following case-study of one of the five PhD students.
PhD Case study – Deborah Russell

Dr Deborah Russell exemplifies the successful research capacity building undertaken by the CRERRPHC. Deborah undertook important research on the critical issue of PHC workforce retention in rural and remote areas. Her PhD thesis, ‘The patterns, determinants and measurement of rural and remote primary health care workforce turnover and retention’ has provided important new empirical evidence to guide rural health workforce retention policies.

Deborah received her testamur at a graduation ceremony in December 2014, at the Monash University Clayton campus.

Deborah’s PhD publications are noted in Appendix 8 (Papers 51, 52, 53, 68, 69 & 75).

Noteworthy too has been the extent to which involvement with the CRERRPHC research program has assisted career development of many staff, several of whom have risen to senior academic positions in universities. The promotions include:

- Matthew McGrail promoted to Senior Research Fellow, Monash University
- John Wakerman promoted to Associate Dean, Flinders Northern Territory
- Tim Carey promoted to Professor, Flinders University
- Melissa Lindeman promoted to Associate Professor, Flinders University
- Mike Jones promoted to Professor, Macquarie University
- David Perkins promoted to Professor, University of Newcastle
- Leigh Kinsman promoted to Professor, University of Tasmania
- Penny Buykx, Senior Research Fellow, University of Sheffield
- John Humphreys, Emeritus Professor status, Monash University
- Susan Thomas, Postdoctoral Research Fellow, University of Newcastle

The 2015 funding provided continued support for two PhD completions (Saurman and Reeve) with a further two due to submit in the near future (Chisholm & Tyrrell).

External program:

The comprehensive methodology that was devised to meet the needs of the external early career researchers has already been described. Much credit for the program must be attributed to the diligence, expertise, and commitment of the three supervisors – Dr Sue Kirby, Dr Bernadette Ward and Dr Susan Thomas – who spent countless hours working in close conjunction with their individual students.

In addition, considerable gain was made from conducting group workshops throughout the CRERRPHC program, as exemplified in the following case-study.
The process of knowledge translation is complex, as testified by the vast literature on this topic. In order to ensure that the research undertaken by the CRERRPHC achieved maximum impact and take-up, the team adopted a very strategic approach. Building on its acknowledgement of the need to research issues that were topical and timely for governments, health authorities, rural and remote health services and communities, staff focused on three priority areas:

- Ensuring that its target audiences were fully conversant with the research being undertaken and the outcomes achieved;
- Monitoring the impact of the research in terms of which audiences were adopting research findings and how they were being accessed; and
- Carefully translating the research through many avenues in order to ensure that they achieved the maximum likelihood of take-up.

### Research dissemination – Newsletters and Website:

The CRERRPHC was energetic and vigilant in ensuring that every possible avenue was used for the dissemination of information relating to the research being undertaken. This ranged from maintaining a website, regular newsletters that were circulated in both print form and electronically to key stakeholders, social media, conference and workshop presentations, as well as circulars and media releases for the lay person. Considerable success was achieved through the website, with the added advantage that it was regularly accessed internationally (see Appendix 8). A measure of its impact is that more than 17,000 unique visitors hit the site in excess of 385,000 times. Similarly, feedback from the readership of the CRERRPHC Newsletter (Appendix 9) was extremely positive, with many readers following up with both written and verbal requests for further information. It was clear that the CRERRPHC has managed to capture an extremely comprehensive set of readers and followers. CRE Website: [www.crerrphc.org.au](http://www.crerrphc.org.au)

During 2015, the CRERRPHC web site had more than 5,000 additional unique visitors and more than 48,000 total additional visits. This takes the total unique visitors to more than 22,000 and total visits to over 433,000 for the duration of the CRERRPHC.
Conceptualising a research impact framework:
In order to formally assess whether the work undertaken by the CRERRPHC has been “making a difference”, staff developed a strategic framework for monitoring which target population was most affected by what type of activity, and the form in which this was being impacted – see Appendix 8 (Paper 57)
Indeed, the framework developed has been widely adopted by a diversity of research organisations, some of whom have further modified it for their own purposes. Importantly, this framework formed the basis for developing a database for recording the many ways in which the research activities were impacting on the policies and practices of rural and remote health stakeholders.

Constructing an impact monitoring database:

Traditional methods for monitoring research often don’t show the scope of influence and impact of research. To assist the CRERRPHC in monitoring the impact of its research and related activities, staff from the CRERRPHC have developed a database to capture information on all research activities across all institutions including evidence of uptake or use of research. As Figure 4 demonstrates, this database can record a vast amount of detail for an individual, project or program of research. It includes journal articles, books and book chapters, conference and stakeholder presentations, media exposure, evidence of uptake or use of the project’s research, and much more. Research projects can be across multiple institutions or individual institutions.

To maximise the value of this new database as a tool for measuring knowledge transfer and impact, the database template is available free of charge to organisations that need to measure the impact of their work from the CRERRPHC under a licence agreement with Monash University. So far, 21 institutions, both nationally and internationally, have begun to use the database under separate licence agreements.

Table 1: Summary chart of research impacts

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<th>Broad area of impact</th>
<th>Specific areas of impact</th>
<th>Key audience Stakeholders</th>
<th>Evidence</th>
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<tr>
<td>Research-related impact</td>
<td>New knowledge - Capacity building</td>
<td>- Researchers - Educators - Media</td>
<td>- 89 publications - 79 related-publications - 54 Conference presentations - 26 Related conference presentations - 5 media coverage - 17 successful Grants - 5 PhDs - 17 Invited Visitors</td>
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<tr>
<td>Broad area of impact</td>
<td>Specific areas of impact</td>
<td>Key audience</td>
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<td>‘Informing decision making’</td>
<td>Evidence base</td>
<td>Policy makers</td>
<td>- 2 policy briefs</td>
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<td>- Influence in decision-making</td>
<td>Politicians</td>
<td>- 12 stakeholder presentations</td>
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<td><strong>Service impact</strong></td>
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<td>‘Improving health &amp; health systems’</td>
<td>Evidence-based practice</td>
<td>Managers</td>
<td>- Evaluation reports</td>
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<td>- Quality &amp; safety</td>
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<td>- Practice guidelines</td>
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<td><strong>Societal impact</strong></td>
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<td>‘Creating broad social &amp; economic benefit’</td>
<td>Health literacy</td>
<td>Consumers</td>
<td>- 29 media coverage</td>
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<td>Advocates</td>
<td>- 4 Media interviews</td>
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<td></td>
<td>- Health status</td>
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<td>- Evidence of changes</td>
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**Case-study of research into policy – The ‘Modified Monash Model’:**

The extent to which research outcomes contribute to policy is often difficult to measure. Few governments or organisations readily “attribute” success to researchers, seeking rather to draw on their expertise indirectly in order to demonstrate that it is in fact the government or authority that is initiating the innovative policy or practice! Moreover, the process from awareness to take-up is invariably long and complicated, and frequently fraught with obstacles and reasons not to adopt evidence-based outcomes because often their implementation is economically or politically too risky.

Nonetheless, the CRERRPHC has achieved considerable success in initiating research to address a long-standing problem in rural health, identify a feasible solution, and (over a three and a half year period) work with government to assist the adoption of research recommendations into policy. A brief resume follows:
Case-study of knowledge translation into policy

The policy problem:
In response to problems of recruitment and retention of doctors in rural areas, the Australian Government implemented retention incentive payments. However, the distribution of these payments was based on the ASGC-RA classification that demonstrably resulted in perverse and highly inequitable outcomes. For nearly five years, the Rural Doctors Association led the charge in demanding a fairer basis for the allocation of retention payments.

The research response:
Staff from the CRERRPHC developed a new scheme that was not just based on geography, but rather incorporated an understanding of what doctors actually do and the extent to which their practice location impacted upon the complexity of their work. Using both professional indicators (Total hours worked; Undertakes work in a public hospital setting; On-call for 2+ patients; Difficulty in taking time off) and nonprofessional indicators (Partner employment opportunities; Adequate choice of schools), a new taxonomy was developed. The proposed new scale was shown to be both far more sensitive to important differences, and a better basis for equitable resource allocation based on what doctors do and the impact of the geographical setting on work and life.

The knowledge transfer process:
Despite its acknowledged merit, the process of implementing the research recommendation was extremely complex and extended over three years. CRERRPHC staff made innumerable presentations to Government and professional organisations, drafted a major submission to a Senate Enquiry into Rural Workforce Issues, conducted many telephone discussions and held meetings with bureaucrats in Canberra. The CRERRPHC submission received endorsement from several favourable independent review reports to government:

> “The committee was impressed with the comprehensive nature of the model….and.....is supportive of the methodology and data utilised” (Australian Government Senate Enquiry, 2012)

> “The enhancement.....is a valuable one.....based on reasonable evidence derived from data generated through the MABEL Study….A modification to the “model” is recommended as the approach most likely to provide positive enhancements to current systems.” (Mason Review, 2012)

> “The model provides a sound and practical basis on which to move forward, and the RDAA has joined other stakeholders – including United General Practice Australia – in supporting this model in-principle.” (RDAA, 2013)

This advocacy was paralleled by ongoing agitation by rural doctors, and ultimately resulted in the Assistant Minister of Health announcing the adoption of a “Modified Monash model” and the formation of an Independent Expert Committee to examine the roll-out of the Rural Retention Grant program on the basis of the new improved classification.

The policy outcome:
The IEC’s report was accepted by the Minister and formed input into the 2015 Budget process. There is early evidence that this research is making a difference in the policy arena to bring about improved equity. For example, the Assistant Minister for Health, Fiona Nash, commented that the new classification.”...will allow support and resources to be focused on areas where there is the most need – in small rural and remote communities”.

In 2015, uptake of the MMM by the DoH into GP rural retention policy began. The CRERRPHC continues to provide expert advice in relation to expanding use of the MMM for other rural workforce programs and policies.
SECTION 4 - DISCUSSION AND POLICY IMPLICATIONS

This section discusses the implications of the CRERRPHC research for PHC policy and practice. Working in a complex environment characterised by increasing need for PHC associated with an ageing population and within severe fiscal constraint, health authorities are faced with many challenges. Nonetheless, a key plank of the national health reform agenda is increasing equity in health outcomes, nowhere more so than for disadvantaged rural and remote communities. The research undertaken within the CRERRPHC provides for the first time a significant evidence base highlighting the health impact of inequitable access to PHC health services, and will assist health authorities in planning PHC service delivery to small, difficult-to-service communities.

Particularly important too is the work done in developing an evaluation framework using sentinel measures by which to monitor progress in health outcome improvements associated with the provision of sustainable PHC services, the value of which is shown in the Fitzroy Valley case-study. Undoubtedly this new knowledge helps to inform policymakers with the criteria that enable them to plan, monitor and evaluate the equitable provision of health care for all Australians.

Policy implications – Research Streams

Stream 1

Research in stream 1 focused on providing empirical evidence to improve our understanding of how access affects the utilisation of health services in rural and remote Australia and as the basis for modelling improved provision of PHC services to areas that currently are characterised by inequitable access to care at times of need. Key policy implications include:

> The need for scarce resources to be allocated on the basis of greatest need, based on evidence-based programs targeting the specific PHC needs of rural and remote areas. Equitable resource allocation will inevitably involve inequalities, but will generate the greatest improvement in population health outcomes based on improved access to appropriate PHC health services and improved health literacy resulting from access to appropriate care.

> Measures of access need to be modified to take greater account of health needs, patients abilities to access care, and the availability of appropriate PHC services. Geography alone is an insufficient criterion to guide PHC service planning, and crude indicators (such as provider-to-population ratios) are inadequate measures of access.

> Researchers require improved access to existing unit record and small-area health data in order to work closely with policy-makers in generating improved measures to guide the provision of appropriate PHC services and underpin specific rural and remote health incentive and program funding.

Stream 2

The goal of the complex and ambitious research undertaken in stream 2 was to ascertain the feasibility of ‘benchmarking’ the workforce and funding requirements necessary to ensure the availability of high-quality, sustainable PHC services in different rural and remote contexts. Comprehensive data and evidence on this issue are largely non-existent and long-overdue if health service planners, policymakers and funders are to be informed in their decision-making by rigorous evidence about core PHC service requirements of small rural and remote communities. Key policy implications include:

> Indicators and benchmarks are essential for monitoring the provision of PHC services and evaluating national policies designed to provide effective and equitable health care to all Australians regardless of their place of residence.

> Significantly more research is required to develop an efficient methodology to collect comprehensively the quantitative data associated with the costs of providing PHC in different
sized communities located in different geographical settings in order to develop benchmarks for core PHC services.

- Improved access to existing administrative data sources is also required.
- Quantitative analyses of what constitutes a high-performing and sustainable rural and remote PHC service should be complemented by qualitative data provided by existing PHC workers about what they actually do in their communities and the support they require to deliver comprehensive PHC.
- Evidence collected throughout the Stream 2 research validated previous research highlighting important environmental enablers and PHC service requirements necessary to ensure accessible and equitable provision of PHC services.

The 2015 work identified a number of limiting factors which need to be addressed in future research. These include sample size, denominator population, enumeration and heterogeneity of services provided.

**Stream 3**

Stream 3 sought to identify and evaluate innovative PHC service models meeting previously unmet needs as the basis for providing a comprehensive evaluation framework that takes account of the significantly different needs and contexts associated with the provision of comprehensive, appropriate, high-quality and sustainable health care. Key policy implications include:

- While significant commonality exists in the challenges facing PHC services and workers throughout rural and remote areas, models need to be fit-for-purpose, something that is best achieved by policy-makers 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 fewer workforce supply issues, improved access to and utilisation of services, better health literacy, and significantly improved population health outcomes.

**Policy implications – Research capacity building**

Research capacity building is not dissimilar to the gestation period of elephants! – long and slow, but in the end extremely rewarding. To be effective, such activity needs to include a diversity of stakeholders – career academics (through PhD, Post-doctoral and early career mentoring support), health practitioners from across the health spectrum, policy-makers and funders, and consumers – ideally working in close co-operation and collaboration. While the ultimate academic goal might be some peer-reviewed publication adding new knowledge, the actual value of the learning experience should not be under-estimated. Indeed, as with many life experiences, the journey is often more valuable than the end-point. The research capacity building activities undertaken by staff from the CRERRPHC provided a most valuable experience for both the providers and the recipients. Key policy insights include:

- Strategic monitoring of rural and remote PHC services and workforce issues is vital if governments are to meet their avowed goal of accessible, equitable, effective and sustainable high quality PHC for all Australians, regardless of where they live. To undertake this activity, rural and remote health services require the assistance at the local level of staff with well-developed research and evaluation skills.
- As with rural and remote PHC service provision, research capacity building programs should not be delivered according to a “one-coat-fits-all” model, but rather should be tailored to meet the interests of the participants, the needs and contexts of their services, and the types of research and evaluation skills perceived to be most valuable by the service.
The most effective policies clearly emerge from health authorities well versed with matching evidence against community needs and behaviour. Invariably, a sound understanding of, and involvement with, the research generation process assist with efficient and effective formulation and implementation of policy and program responses in meeting the needs for appropriate and effective PHC services. Engagement of policy-makers in research capacity building programs, such as was funded and conducted by the Canadian Health Services foundation, should be encouraged.

Ideally, ongoing research collaborations of academic researchers, health workers, consumer and policy-makers should be maintained, with input from each participant at all stages of the research in order to ensure that it is feasible and multi-disciplinary, and that the outcomes are relevant and implementable.
SECTION 5 - CONCLUSION

In summary, the CRERRPHC research program has generated significant systematic evidence using objective criteria relating to the numerous issues (including the nature, volume, and distribution of the resources required to overcome problems of poor access to PHC services) impacting on the goal of delivering equitable health outcomes for residents of rural and remote Australia.

The CRERRPHC has also modelled the complex array of strategies required to effect policy and practice change. Moreover, it has developed a tool for monitoring impact and then demonstrated, with the Modified Monash Model, the effectiveness of its strategies and monitoring process.

Although much more research is required, the CRERRPHC has made significant advances in linking inputs to outputs and outcomes identified in Watson’s Logic Model\textsuperscript{13} (see Figure 2). Based on this new evidence, policy makers charged with the task of providing appropriate and effective PHC services are better placed to counter ineffective historical, political and ‘squeaky-wheel’ programs that have done little to effect change with evidence that demonstrates significant advance in access, equity and improvements in health outcomes.
APPENDICES

Appendix 1 –References


2. World Health Organisation. Increasing access to health workers in remote and rural areas through improved retention: Global policy recommendations 2010; Geneva, WHO.


Appendix 2: National Advisory Group: Terms of Reference and membership

NATIONAL ADVISORY COMMITTEE

Terms of Reference

1. To advise on the conceptualisation, methods and implementation of the CRE research program;
2. To act as a source of expert advice on rural, remote and Indigenous health priorities, strategies and policies relevant to the research program;
3. To assist the research team with identification of, and access to, relevant statistical data and publications;
4. To work with the research team to develop and implement a research transfer strategy;
5. To facilitate communication with government and non-government organisations and their employees;
6. To comment on project outputs.

Membership 2011-2014

<table>
<thead>
<tr>
<th>Name</th>
<th>Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lou Andreatta</td>
<td>• Grant Service Division, Department of Health</td>
</tr>
<tr>
<td>Mark Booth</td>
<td>• Primary &amp; Mental Health Care Division, Department of Health</td>
</tr>
<tr>
<td>Margaret Brown</td>
<td>• Health Consumers of Rural and Remote Australia Inc.</td>
</tr>
<tr>
<td>Ian Cameron</td>
<td>• NSW Rural Doctors Network</td>
</tr>
<tr>
<td>Adam Catchpole</td>
<td>• Mapping and Online Services, Workforce Distribution Branch, Department of Health</td>
</tr>
<tr>
<td>Linda Cutler</td>
<td>• CETI Rural Division</td>
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<td>• Royal Flying Doctor Service</td>
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<tr>
<td>Nicholas Duell</td>
<td>• Rural and Regional Health Australia, Department of Health</td>
</tr>
<tr>
<td>Kirsty Faichney</td>
<td>• Department of Health</td>
</tr>
<tr>
<td>Terry Findlay</td>
<td>• Australian Primary Health Care Research Institute</td>
</tr>
<tr>
<td>Vicki Gordon</td>
<td>• Aboriginal Medical Services Alliance Northern Territory</td>
</tr>
<tr>
<td>Gordon Gregory</td>
<td>• National Rural Health Alliance Inc</td>
</tr>
<tr>
<td>Anthony Hobbs</td>
<td>• GP &amp; Chair, External Reference Group developing Australia’s first National Primary Health Care Strategy and Therapeutic Goods Administration, Department of Health</td>
</tr>
<tr>
<td>Kerri Kellett</td>
<td>• Australian Primary Health Care Research Institute</td>
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<tr>
<td>James Lyons</td>
<td>• Rural and Regional Health Australia, Department of Health</td>
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<tr>
<td>Chips Mackinolty</td>
<td>• Aboriginal Medical Services Alliance Northern Territory</td>
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<tr>
<td>Lisa McGlynn</td>
<td>• Australian Institute of Health and Welfare</td>
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<tr>
<td>Peter McInnes</td>
<td>• Australian Primary Health Care Research Institute</td>
</tr>
<tr>
<td>Meredith Taylor</td>
<td>• Rural and Regional Health Australia, Department of Health</td>
</tr>
<tr>
<td>Robert Wells</td>
<td>• Australian Primary Health Care Research Institute</td>
</tr>
<tr>
<td>Mark Wenitong</td>
<td>• Apunipima Cape York Health Council</td>
</tr>
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Meeting Dates of the National Advisory Committee

Meetings of the National Advisory Committee were held as follows:

- Tuesday, 31 May 2011
- Tuesday, 22 November 2011
- Tuesday, 14 August 2012
- Tuesday, 14 May 2013
- Wednesday, 13 August 2014
Appendix 3: List of stakeholder meetings and presentations, including Reference Group and round-tables

2014


3. Humphreys JS (2014). Why rural communities should be concerned about their health, and how best to ensure timely and equitable access to appropriate health care at times of need? Presentation to the Shepparton Community, 6 August 2014.


2013


22. Lindeman MA (2013). Contribution to workshop on prevalence of common conditions in old age such as dementia, falls, depression, chronic pain and incontinence. Presentation to Broome and Kununurra Indigenous communities and health professionals, Broome/Kununurra, 18 September 2013.


2012


**2011**


Appendix 4: Evaluation feedback from presentations

Evaluation feedback from Department of Health and Ageing Roundtable, 12 August 2014, 2.00-3.30pm - What works to improve access to primary health care in rural and remote Australia (Professors John Humphreys & John Wakeman).

(Number of attendees: 16; Number of responses: 7; Response rate: 44%)

1. I had **good general knowledge** of the topic before attending this roundtable

<table>
<thead>
<tr>
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2. The content of this roundtable confirmed my existing knowledge on the topic

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3. The content of this roundtable **broadened my knowledge** of the topic

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4. The content of this roundtable **stimulated my thinking** on the topic

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5. I may be able to use knowledge gained from this roundtable in my job

<table>
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6. The content of this roundtable is directly applicable to my job

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**Evaluation feedback from Department of Health and Ageing Seminar**, 12 August 2014, 12.30-1.30pm - Access and equity in the provision of primary health care in rural and remote Australia (Professors John Humphreys & John Wakerman).
(Number of attendees: 46; Number of responses: 35; Response rate: 76%)

1. I had good general knowledge of the topic before attending this seminar

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2. The content of this seminar confirmed my existing knowledge on the topic

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3. The content of this seminar *broadened my knowledge* of the topic

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4. The content of this seminar *stimulated my thinking* on the topic

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5. I may be able to *use knowledge gained* from this seminar in my job

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6. The content of this seminar *is directly applicable* to my job

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<tr>
<td><strong>Grand Total</strong></td>
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</table>
Appendix 5: Final survey – Health Care Access

Access to Health Care in Small Rural Communities

This survey is seeking information about access to, and the use of, doctors (general practitioners) by people in your community. The study is being conducted by staff from the Centre of Research Excellence in Rural and Remote Primary Health Care (CRE) at Monash University School of Rural Health in Bendigo.

This questionnaire will only take 10 – 15 minutes to complete. Your participation in this survey is entirely voluntary. Please complete only one questionnaire per household.

All information you provide will be treated confidentially. Survey responses will be analysed and presented so that it will not be possible to identify any individual responses. The results of the survey will be available on the CRE website (www.crrphc.org.au) in 2013.

If you have any queries relating to this survey, please do not hesitate to contact Dr Bernadette Ward on telephone (03) 5440 9064 or 0427 059 205. Thank you for your time.

SECTION 1 – YOUR HEALTH

1. In general, would you say that your health is: (please tick one)

   - Excellent
   - Very Good
   - Good
   - Fair
   - Poor

SECTION 2 – VISITS TO A DOCTOR

2. When was the last time you visited a doctor (GP) about your own health? (please tick one)

   - During the last month
   - Between 1 and 3 months ago
   - Between 3 and 12 months ago
   - More than 12 months ago
   - Don’t know

3. a. How far do you normally travel to visit a doctor (GP)?

   [Distance in kilometres]

   b. How long does it normally take you to travel to visit a doctor (GP)?

   [Time in minutes]
4. a. Do you have a usual doctor (GP) who you visit?
   - Yes  Go to question 4b
   - No    Go to question 5

   b. If yes, what is the name of the town where your usual GP is located?
   Name of Town of usual GP

5. Is the GP you visit the closest one to your home?
   - Yes  Go to question 7
   - No    Go to question 6
   - Don’t know  Go to question 7

6. If you travel to a GP who is not the closest one to your home, what is the reason for travelling further? (please tick all that apply)
   - Combine appointment with other activity (e.g. shopping, visiting friends or family)
   - Convenient to my work location
   - Like the doctor
   - Doctor knows my medical history
   - Easy to get appointment
   - Large practice that includes other health professionals
   - Cost of consultation
   - Other factor (Please specify)

7. How do you usually travel to your GP? (please tick one)
   - Private vehicle is always available when needed
   - Private vehicle driven by some other family member, neighbour or friend
   - Public transport (train, bus service including school bus)
   - Walk
   - Other (please specify)

SECTION 3 – ACCESS TO A DOCTOR FOR A NON-EMERGENCY CONSULTATION

8. If you need to see a GP for something that wasn’t an emergency, what is the maximum time that you are prepared to travel to get there?
   Maximum time in minutes
9. Thinking about yourself, which factor in each pair is the most important when you decide to visit a doctor for a non-emergency consultation?

   (FOR EACH PAIR, TICK WHICH ONE OF THE TWO ALTERNATIVES YOU THINK IS MORE IMPORTANT)

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<th>OR</th>
<th>Cost to visit a GP</th>
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<td>Seeing a GP you prefer</td>
<td>OR</td>
<td>Availability of a GP</td>
</tr>
<tr>
<td>Cost to visit a GP</td>
<td>OR</td>
<td>Distance to travel to a GP</td>
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<tr>
<td>Availability of a GP</td>
<td>OR</td>
<td>Distance to travel to a GP</td>
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<td>Seeing a GP you prefer</td>
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<tr>
<td>Distance to travel to a GP</td>
<td>OR</td>
<td>Seeing a GP you prefer</td>
</tr>
</tbody>
</table>

10. a. Is accessing a GP ever a problem for you?
    
    | Yes | Go to question 10b |
    | No | Go to question 11 |

    b. What is the problem?
    
    
    
    11. In the last 12 months, have you ever put off seeing a GP because you could not get an appointment?
    
    | Yes |
    | No |

SECTION 4 – ABOUT YOU

12. Are you male or female? (please tick one)
    
    | Male |
    | Female |

13. How old are you? (please tick one)
    
    | 18-24 |
    | 25-34 |
    | 35-44 |
    | 45-54 |
    | 55-64 |
    | 65-74 |
    | 75+ |
14. Your place of residence:
   a. If you live in a town, please indicate its name and its postcode
      ____________________________________________________________  Name of town
      ____________________________________________________________  Postcode of town
   b. If you live outside of a town, please indicate how many kilometres from the nearest town and the name of that town
      ____________________________________________________________  Kilometres from nearest town
      ____________________________________________________________  Name of nearest town

15. How many years have you lived at your current address?  ____________________________________________________________  Years

16. How many registered motor vehicles are garaged at this address? (Exclude motorbikes, scooters, tractors etc)
   ____________________________________________________________

17. How many people live at this address?
   ____________________________________________________________  Adults
   ____________________________________________________________  Children under the age of 18

18. What is your current occupation?  ____________________________________________________________

19. Is there anything else you would like to tell us about accessing a doctor or other health service?
   ____________________________________________________________
   ____________________________________________________________

That concludes this survey. Thank you very much for your participation.

If you would be willing to participate in a follow-up telephone interview to provide more detailed information about your use of health services, please write your name and telephone number below.
Name: ____________________________  Telephone: ____________________________

Please place the completed survey in the postage-paid envelope and return it to:
Dr Bernadette Ward
Monash University School of Rural Health
PO Box 666
Bendigo  Vic  3552
Appendix 6: Benchmarking survey instrument

**Survey**

Equity of Access to Primary Health Care Services in Rural and Remote Australia: Developing funding benchmarks to ensure sustainable, high quality rural and remote practices

A study by the Centre of Research Excellence in Rural and Remote Primary Health Care

John Wakeman, Susan Thomas, John Humphreys

2014

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**Type of Service:**
- Solo GP
- Group GP
- ACCOS
- Multi-Purpose Service (MPS)
- Other

**Model of Service:**
- Discrete (walk-in/walk-out)
- Integrated (shared care, primary health care services, multi-purpose services)
- Comprehensive PC (CCHS)
- Outreach (hub-and-spoke, visiting service, FPC/UCC)

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**Practice Details**

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<thead>
<tr>
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<tbody>
<tr>
<td>Address:</td>
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<td>Phone:</td>
</tr>
<tr>
<td>Email:</td>
</tr>
</tbody>
</table>

| Hours of operation: |
| Monday - Friday | From: | To: |
| Saturday | From: | To: |
| Public Holidays | From: | To: |

**Service functions:**
- Please tick all applicable:
  - Outreach (such as to other smaller communities in your catchment)
  - Home visiting
  - On-call (outside of normal hours)

**Service utilisation:**
- How many patients are currently registered with this practice?
- How many patients have attended this practice at least once in the last financial year ending 30 June 2023?
- What was the total number of consultations received in the last financial year ending 30 June 2023?
Questions for Practice Principal

1. We would like to begin by validating the key information provided on the questionnaire:
   - Staffing
   - Costs (per those from-tax documents, payroll, estimates)
   - Number of patients registered and number of consultations in the last year
   - Services provided, not provided

2. We would like to know the population size that your practice serves:
   - What is the population covered by this primary health care service?
   - What is the geographical centroid area of this practice? Include the names of other communities served by this practice.
   - Are there any specific needs in your catchment area that affect the cost of providing primary care services? (financial needs, stability, socioeconomic, cultural, other needs)

3. Your practice has been identified as one that provides high-quality care to patients. What are the essential requirements for ensuring your practice continues to maintain a high level of quality care?

4. What barriers has this practice faced in providing a high quality service and how have you addressed them?

5. Any other comments you would like to make in relation to providing high-quality, sustainable primary health care services in this area?

Thank you for your participation.
Appendix 7: List of conference presentations

2015


2014


2013


42. Lindeman MA, Dingwall KM, Bell D (2013). “If you don’t have that knowledge you don’t ask that question”: Staff readiness for conducting assessments in remote Indigenous community contexts. Oral presentation at the 10th National Allied Health Conference, Brisbane, 16-18 October 2013.


2012


71. **Humphreys JS** (2011). *Sustaining rural health services and improving community well-being through research: lessons from Elmore*, Keynote Address at the Rural Health Research Colloquium – Sustaining Rural Health through Research’, 12th October, Dubbo, NSW.


Appendix 8: List of peer-reviewed And Other publications

**CRERRPHC journal articles submitted for review:**

1. **Carey TA**, Tai SJ & Lampshire D (Submitted for review). Improving access to psychological services in remote Australia with a patient-led clinic, *BMC Research Notes*.
2. **Chisholm M & Ward B** (Submitted for review) Older men’s experiences of accessing general practitioner services in rural areas, *Australian Journal of Rural Health*.
4. **McGrail MR, Russell DJ & Humphreys JS** (submitted for review) Rural health service planning: The importance of how 'access' to primary health care is measured, *Australian Health Review*.
6. **Thomas SL, Humphreys JS & Wakeman J** (Submitted for review) What does it cost to provide equity of access to high-quality, comprehensive primary health care in rural Australia? A pilot study. *Rural and Remote Health*.

**CRERRPHC journal articles accepted for publication:**

7. **Russell D & Humphreys JS** (Accepted for Publication). Meeting the primary health care needs of small rural communities: Lessons for health service planners (Elmore longitudinal study), *Rural and Remote Health*.

**2016:**


**2015:**


2014


http://dx.doi.org/10.1016/j.apgeog.2014.08.005


2013


2012


2011


Book/Book chapters


81. Humphreys JS (2012). From a Broom Cupboard: Twenty years of Rural Health at Monash University, Chapter: Research: Community relevance

Reports

86. Lindeman MA, Flouris A & Lopes J (2013). Youth programs in remote Central Australian Aboriginal Communities, Publisher: Centre for Remote Health.

Conference Proceedings (refereed)

Appendix 9: Website details and frontispiece

Website address:  www.crerrphc.org.au
Appendix 10: Newsletters
Newslette of the Centre of Research Excellence in Rural and Remote Primary Health Care

Editorial

“A sincere and thank you”
This is the final newsletter of the Centre of Research Excellence in Rural and Remote Primary Health Care. We would like to take this opportunity to reflect on the achievements of the Centre and thank all those who have supported us during our funding cycle.

The Centre of Research Excellence in Rural and Remote Primary Health Care (CREE) has been supported by the Australian Government through the National Health and Medical Research Council (NH&MRC). This support has allowed us to undertake high-quality research on the health needs of rural and remote populations and to build capacity in this field.

The Centre has been able to deliver a range of outcomes, including the development of new research initiatives, the training of researchers and the dissemination of research findings.

In future, the Centre will continue to support research in rural and remote areas, with a focus on improving health outcomes for these populations.

Thank you to all those who have supported the Centre, and we look forward to continuing our work in the future.

Professor John Roseman
Director of the Centre of Research Excellence in Rural and Remote Primary Health Care

Funded by the Australian Primary Health Care Research Institute

www.aphcri.org.au
Appendix 11: Summary Report: Evaluation of the CRERRPHC’s new national Index of Access in Australia

January 2016

Introduction

To date, health service planning and resource allocation decisions of rural and remote health workforce have relied predominantly on geographical classifications defined by relative population size and/or remoteness – the Rural Remote and Metropolitan Areas Classification (RRMA), the Accessibility/Remoteness Index of Australia (ARIA), the Australian Standard Geographical Classification - Remoteness Area (ASGC-RA) and the recent Modified Monash Model (MMM) scale. These classifications were based largely on geography, with little regard for any meaningful measure of ‘access’ to health care services, an important concept which fundamentally determines the ease with which a household can obtain health care at times of need. One exception has been the use of District of Workforce Shortage (which uses actual health service data), but which has also been strongly criticised as being a crude measure of ‘access’ for a population.

In response, during its existence, the CRERRPHC developed a ‘fit-for-purpose’ classification for primary health workforce planning which measures population access - the Index of Access. This was specifically designed to provide an improved empirical basis for rural health service planning and resource allocation decisions. In 2015, the CRERRPHC undertook to evaluate and validate the Index of Access with feedback sought from key workforce and policy stakeholders and targeted expert individuals.

Evaluation method

Evaluation and validation of the Index of Access comes from both the internal CRERRPHC experts not associated with its development and key external stakeholders, with a focus on both the overall Index of Access and specific remote aspects within the Index of Access.

Whilst formulation of the Index of Access has evolved with regular assessment and feedback since its origin in 2005 to its completion in 2015, there remained concerns with some design aspects with the Index of Access because of the complexity of operationalising such an important concept across diverse geographical environments. Some of these are outlined within the CRERRPHC’s Discussion Paper1 and the main refereed paper in the Geospatial Health journal.2

Copies of the Discussion Paper, Geospatial Health paper and high quality maps were circulated to 20 targeted stakeholders or leaders of policy, with an additional 7 individuals who had specific expertise in remote areas. All material was distributed initially as printed documents, with follow-up emails where appropriate. Feedback was collected through follow-up phone discussions, email responses and formal written submissions.

At the time of this report, feedback had been received from 12/20 key stakeholders and 4/7 remote experts. Many stakeholders also indicated their intention to continue to provide feedback with the CRERRPHC members through 2016, as they begin to test its real-world policy and planning application.

Notably, Rural Health Workforce Australia and the seven state and territory workforce agencies combined to submit a 12-page response paper, attached as Appendix 11 to this report. The time and resources to producing this feedback demonstrates the importance attributed to our research for their organisation.

Key findings

Overall, stakeholders were impressed by the Index of Access and could see merit in its usage in more refined policy and planning decisions for rural health workforce resource allocation. There was solid support for the improvements of using a 2-state floating catchment methodology over existing methodologies, and in particular its ability to measure access with finer geographical granularity. The workforce agencies also agree that there is a strong role for a nationally consistent and reliable measure of access - the “innovative” Index of Access - to aid their decision making.

A common concern expressed was that the Index of Access should not be considered as the sole tool for guiding all service planning knowledge and resource decisions. Instead, it must be recognised that the Index of Access complements ‘local’ expertise (e.g. Primary Health Networks, local Rural Workforce Agencies), and that it is not intended to replace general classifications, such as the MMM, across all policies. A clearer statement of how the Index of Access complements other classifications like the MMM would also help.

There was both positive and negative acknowledgement of the complexity in the Index of Access methodology. Some stakeholders questioned the dynamic nature of the data, noting that there is significant cost required to update the Index of Access, and it is not clear how often data inputs need to be updated for it to be maintained as a useful long-term tool. Our recommendation is that 12 months would be the ideal balance between cost/effort whilst maintaining a useful and current tool.

Inclusion of health needs within the Index of Access is seen as a positive step, but there was recognition of the difficulty in defining needs. There was general support for the current approach used for measuring need within the Index of Access; however, this may not be appropriate nationally. Some NT stakeholders expressed concerns when applied to remote and high-Indigenous communities.

The AIHW, an organisation which has also utilised the 2SFCA method for some of its projects (but not exactly the same method as per the Index of Access), was concerned about whether the use of different catchment sizes by remoteness and applying a varying distance-decay function was appropriate. However, recent international literature supports the use of dynamic catchments that change in size relative to the volume of nearby alternative access options.

Remote-specific issues

A key drawback of the Index of Access in its current form is its reliance on Medicare Benefits Schedule (MBS) billing for measuring service availability. In particular, remote area nurses and other General Practitioners (GPs) employed directly by organisations (outside of MBS billing) are critical to ensure a more accurate representation of all services provided to a location. GPs are not the first primary care provider for many remote communities, where remote areas nurses and allied health clinicians are common as well as the role of visiting providers including Royal Flying Doctor Services. There was wide acknowledgement that this issue is not easily addressed given that reliable and appropriate national datasets are not currently available.

One weakness of the Index of Access is its reliance on the road network and an assumption of car travel. Currently it does not capture the impact of poorer travel conditions across Australia, including: the impact of the ‘wet’ season in northern Australia leading to closure of roads and dependence on aircraft or helicopter travel, significant variations in the quality and nature of existing roads, increased dangers of wildlife and night travel, and the omission of public transport services.

Moreover, a higher volume of GP services in remote communities does not necessarily equate with increased primary health care access, because these GPs often provide non-PHC services that would elsewhere be filled by other specialists. Remote towns without access to specialist care can place a high burden on the resident GPs who deliver comprehensive medical care. Also, Indigenous health utilisation behaviour does not necessarily equate to having access where services are available. Many travel to alternative centres from the nearest service for a number of reasons. A high access score in small remote areas can
dramatically change – thus it is important to understand the potential vulnerability of access for a population, not just their current access surface.

The concept of access includes several dimensions which are often difficult to capture. Remote access is commonly poorer due to higher staff turnover which leads to reduced continuity of care. This issue is currently not captured by the Index of Access which can only measure access at one point in time. Additionally, service models may be more limited by a reduced range of services being offered or limited after-hours services. Affordability is not included in the Index of Access nor are provider characteristics like gender; these omissions are potentially more critical in remote areas due to populations often having limited alternative options.

Potential future research

Most concerns of the Index of Access that may require further research evidence relate to its suitability for remote access measurement. In no particular order, access in remote areas is likely different for a number of reasons, most notably:

- Remote PHC services are delivered by a much wider range of clinicians and health professionals using a wider range of service models, which are often delivered ‘regionally’ rather than to a single town.
- Geography barriers for remote populations can vary, including, roads cut off by floods, poorer road conditions and lack of alternative transport.
- Indigenous populations may place different emphasis on access aspects, such as provider characteristics, service characteristics as well as their own health literacy.
- Remote populations are more itinerant, and many services are only intermittent or are delivered by a high turnover workforce.

Recommendations

1. Utilisation of the Index of Access is supported by rural health workforce stakeholders and policymakers and should be explored further in 2016.
2. The Index of Access should be viewed as a health service planning tool to complement current use of the Modified Monash classification.
3. The Index of Access will be most useful as a decision tool if it is updated annually.
4. Data holders should make available their key workforce datasets across the range of primary health care providers in order to improve the value of the Index of Access.
5. Further research may be required to improve suitability of the Index of Access for planning health services in remote communities.
Appendix 12: 12-page response paper by Rural Health Workforce Australia and the seven state and territory workforce agencies

See attached.
Development of a National Index of Access for Primary Health Care in Australia

Response to Discussion Paper

January 2016
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1. RURAL HEALTH WORKFORCE AUSTRALIA AND RURAL WORKFORCE AGENCIES

Rural Health Workforce Australia (RHWA) and the state and territory Rural Workforce Agencies (RWAs) are committed to making healthcare more accessible for the people of regional, rural and remote Australia by providing and retaining a skilled workforce that meets communities’ health care needs. RHWA and RWAs are independent, not-for-profit organisations with extensive knowledge of and experience in supporting Australia’s rural health workforce.

- Rural Health Workforce Australia
- NSW Rural Doctors Network
- Rural Workforce Agency Victoria
- Health Workforce Queensland
- Rural Doctors Workforce Agency (South Australia)
- Rural Health West (Western Australia)
- Northern Territory PHN
- Health Recruitment Plus (Tasmania)

RHWA and RWAs provide a wide range of services to regional, rural and remote health professionals, their practices, Aboriginal and Torres Strait Islander health services, dental and primary care services, including:

- attraction of a new workforce, marketing and the promotion of rural careers;
- recruitment;
- locum support;
- training and continuing professional development;
- personal and family support services for healthcare professionals;
- practice support services;
- community and health service development;
- research and policy advice; and
- communications and advocacy.
2. BACKGROUND

2.1. Development of a National Index of Access for Primary Health Care in Australia

To date, health authorities and organisations implementing rural and remote health workforce policies in Australia have predominantly based health service planning and resource allocation decisions on geographical classification systems. The three key classification systems that have been used are:

- Rural, Remote and Metropolitan Area (RRMA);
- Accessibility/Remoteness Index of Australia (ARIA) classification; and
- Australian Standard Geographical Classification – Remoteness Area (ASGC-RA).

In response to criticism over many years that the use of these systems can lead to inequitable resource allocation and workforce planning decisions, the Centre for Research Excellence in Rural and Remote Primary Health Care (CRERRPHC) has developed a 'fit-for-purpose' classification system.

This new National Index of Access for Primary Health Care in Australia is a function of 3 core components:

- Availability – the availability of primary healthcare services to a community
- Proximity – the distance the community needs to travel to access primary healthcare services (a ‘distance-decay function’ has been included in the model to account for large, sparsely populated areas, i.e. remote)
- Health needs – the required volume of services of the community

(Following extensive analysis, health needs is determined in the model as a function of population size adjusted for the community’s socioeconomic status (50% weighting), Indigenous population (25% weighting), and proportion of young (0-4 years) and old (65+ years) people in the community (25% weighting)

The Index of Access has been developed to provide a summary measure of access to primary health care from the patient’s perspective, based on their place of residence, and provides a tool that can be used to guide service planning and resource allocation in order to increase equity of rural health outcomes.

It is noted that in 2015, the Department of Health adopted a new classification system - the Modified Monash Model - for use with many of its workforce programs, commencing with the General Practice Rural Incentives Program. Like other classifications systems such as RRMA,
ARIA or ASGC-RA, the MMM provides a summary measure from the provider's perspective – (“how rural or remote is the community where I work?”). Such systems are appropriate for directing workforce support and retention incentives, however the Index of Access is broader, also looking at the community’s need and current levels of access to primary healthcare services.

2.2. Request for Feedback

The CRERRPHC is seeking stakeholder input into a proposed National Index of Access for Primary Health Care in Australia and RHWA appreciates the opportunity to respond to the Discussion Paper.

Specifically, the CRERRPHC has requested feedback on the following:

1) What are your first thoughts about the Index of Access?
2) Is it useful - if so, how?
3) What are its limitations or problems?
4) Do you see scope for its improvement?

In the following pages we detail our response to each of these in turn.

This submission has been prepared in response to a request from the CRERRPHC with regards to a proposed National Index of Access for Primary Health Care in Australia and represents the views and opinions of RHWA and Northern Territory PHN.

Should you require any further information in relation to this submission please contact Mr Greg Mundy, Chief Executive Officer via email at greg.mundy@rhwa.org.au or by telephone on 03 9860 4700.
3. RESPONSE TO THE DISCUSSION PAPER

3.1. First thoughts about the Index of Access

Overall, we concur that there is a role for a nationally consistent, reliable measure of access to primary health care to aid workforce planning and target resource allocation. The national Index of Access outlined in the Discussion Paper is acknowledged as the first 'fit-for-purpose' tool and is more appropriate for planning and prioritising resources than existing measures which focus on population size and/ or distance from larger centres.

In particular, the process by which the Index takes into account the community's level of health needs is innovative. Identifying and quantifying health needs in a consistent way is challenging and hence the considerable work in evaluating the impact of different measures discussed in the Discussion Paper makes a valuable contribution. The weighted formula proposed to comprise the 'health needs' component of the Index (50% socioeconomic status, 25% Indigenous population, 25% young/ old population) provides a relatively straightforward measure of the concept.

A further innovative component of the Index is the use of the two-step floating catchment area methodology and the inclusion of a distance-decay function to measure access to primary healthcare. This overcomes issues with some other measures of access which are not well suited to Australia’s sparsely populated rural and remote communities where catchment areas for health services can be very large.

We are naturally supportive of any work that aims to improve workforce planning and the targeting of healthcare resources in rural and remote areas and believe the Index of Access is a major step forward in this area. It represents a move away from purely geographical classification systems through its inclusion of both health needs and current service provision levels. The Index is well-researched, utilises accurate and nationally consistent Australian data, and has been specifically developed with rural and remote communities in mind.

The major drawback of the Index of Access at present is in the way in which it accounts for the availability of current primary health care services. In essence, access to primary health care services is measured solely through GPs’ Medicare-billed services (and some Remote Area Nurse services in remote locations). While the reasons for this are well-explained and it is acknowledged that reliable national datasets for other healthcare professionals are at present unavailable, this issue limits the potential usefulness of the Index as a workforce planning and resource allocation tool.
To this end, it is noted that the Discussion Paper does not include a definition of primary health care, the addition of which may assist in defining the parameters of health care service access that the Index is measuring.

3.2. Is the Index of Access useful?

The Index of Access is of potential value for organisations such as ours in

(1) planning services;

(2) targeting services and incentives; and

(3) measuring the impact of interventions over time.

Given its limitations however (discussed below at 3.3), the Index would at this stage only be of value as a 'starting reference point' in the planning or targeting of services. For example, the Index could be used to identify potential communities of higher need, however this would then be reviewed by Rural Workforce Agencies who have detailed 'on-the-ground' knowledge of the communities within their jurisdiction.

As the Discussion Paper acknowledges, it would of course be preferable that the Index of Access take account of all the primary health care services available to a community – including non-GP medical specialists, nurses and allied health practitioners.

At present we would not support the use of the Index of Access as the sole determinant of a community's need for health care services or as the only consideration in prioritising resources. As will be demonstrated, there are examples of communities in the Discussion Paper that have a relatively high Index of Access 'score'; however this is due primarily to the way in which the Index assesses access rather than the community not having a need for primary health care services.

The Northern Territory PHN indicated that they have already undertaken a comprehensive needs assessment for their jurisdiction, triangulating data from surveys, stakeholder consultations and existing population demographic and health statistics. Northern Territory PHN use this analysis as the foundation for their workforce planning and resource prioritisation.

With regards to using the Index of Access to measure the impact of interventions over time, it is assumed that changes in the Index would most likely reflect increases in GP Medicare-billed
services (in the absence of any major demographic changes in the community). In this context, it would be useful to know:

- the ease with which the Index can be updated;
- how often the Index would be updated; and
- who would be responsible for updating it (and the associated cost).

3.3. What are the limitations of/ problems with the Index of Access?

3.3.1. Measuring current service provision by GP Medicare billings

As has been noted, the key limitation of the Index of Access is that the availability of primary health care services is measured only from the perspective of GP Medicare billings. While it is acknowledged that this represents the only reliable, accurate and nationally consistent data-set at present, this relatively narrow definition of primary health care is problematic for a variety of reasons.

GP Medicare billings data does not take account of primary health services provided by:

- medical practitioners (including GPs) outside of Medicare (such as the Royal Flying Doctors Service, Visiting Medical Officers at regional hospitals or doctors employed by state government health services); or
- non-GP medical specialists, nurses and allied health professionals.

This is a particularly relevant issue for rural and remote areas where a nurse or allied health professional is often the first point of contact. Northern Territory PHIN advise that nurses and Aboriginal Health Workers play a large role in primary care in rural and remote Northern Territory communities. In this instance, the Index of Access may potentially under-estimate a community’s level of current service provision due to a low level of GP Medicare billing.

On the other hand, the Index of Access could potentially over-estimate a community’s level of service provision where there is a relatively high level of GP Medicare billings. For example, in many rural and remote communities GPs often provide other medical specialist care because there is relatively limited access to other specialists (such as geriatricians or oncologists). Hence a town may have high a relative high level of GP Medicare billings but this is because GPs are doing things that other medical specialists would be doing in larger centres, including additional roles in public health and linkages between community based primary health care and hospital services.
Although non-GP medical specialists do not usually provide primary care services, their absence in a community can impact on the access to primary care from GPs and others. Northern Territory PHN provided the example of East Arnhem Land to illustrate this point. In the Discussion Paper, Nhulunbuy receives a relatively high Index of Access (6.86E-04) – the highest of the 10 Northern Territory community examples in the paper.

However, Northern Territory PHN believe that contributing factors to this score may include limited access to specialists in East Arnhem Land, with GPs providing many of the services that would be provided by specialists such as dermatologists in urban and larger regional areas. Despite a relatively high Index of Access score, Northern Territory PHN's needs analysis and other data highlights that the people of Nhulunbuy and East Arnhem Land have identified gaps to accessing primary health care services.

3.3.2. Measuring access at a single point in time

A further issue, common to any measure of access taken at a single point in time, is that circumstances can change quickly - particularly in a community with only one or two GPs. For example, a GP can become seriously ill or take unplanned extended leave – suddenly reducing current service provision. Alternatively, a community's health needs may suddenly increase due to a natural disaster such as bushfire, as was the case in many small Victorian communities after the 2009 Black Saturday bushfires.

As such, it is envisaged that any measure of access used for workforce planning and health service resource allocation must be incorporated into a flexible process that permits:

- frequent and ongoing review of communities’ needs and levels of service provision; and
- the ability to recognise and respond promptly to sudden and unexpected changes in either levels of service provision or health needs.

3.3.3. Issues relating to the calculation of health needs

With regards to the weighted formula that comprises the 'health needs' component of the Index, the following issues are noted:

- socioeconomic status at postcode level can mask significant variations with a community – there can be very wealthy and very poor people living in the same postcode and as such people with very high health needs will not be highlighted in an overall 'well-off' community
in taking into account the proportion of a population aged over 65 years, it should be recognised that the Indigenous population is dramatically under-represented in this age group

3.4. Scope for improvements to the Index of Access

The key improvement suggested for the Index of Access is to broaden the way in which current primary care health service is imputed into the model, recognising of course that at present the only primary health care services for which reliable and consistent national data are available are those provided by GPs.

In time however, it is hoped that data for other medical specialists, nurses and the 11 AHPRA-registered allied health professions could be incorporated. Ways of accounting for services provided by GPs that are not billed to Medicare could also be investigated. Potential sources of data may include:

- hospitals/ hospital networks;
- state and local government health services;
- ambulance services;
- Royal Flying Doctor Service; and
- district nursing services.

We note that some previous work in the development of the Index of Access was undertaken in Victoria and recommend that further trialling of this tool be undertaken in conjunction with Rural Workforce Agencies and/ or Primary Health Networks in other jurisdictions regarding its utility and value in each of the three core envisaged usages of:

- workforce planning;
- targeting and allocation of resources and incentives; and
- assessing the impact of interventions and incentives.
3.5. Conclusion

Overall, the Index of Access represents a significant advance on existing classification systems used as the basis of current rural and remote health workforce planning and resource/incentive allocation decisions. The Index has been developed through thorough research and offers the specific benefits of:

- the use of the two-step floating catchment area methodology and inclusion of a distance-decay function; and
- the incorporation of a community's health needs in the determination of an overall access 'score'.

At present it is recognised that in determining a community's present level of primary health care service provision, the only reliable and consistent national data are for services provided by GPs. Naturally however, primary health care services, particularly in rural and remote areas, are often provided by health professionals other than GPs.

As such, the Index would not be of use as the sole measure of a community's need for primary health care services or as the only consideration in targeting resources or incentives. However, current workforce planning is rarely based on a single measure or classification system and the Index of Access is likely to offer an improvement over other classification systems currently used (principally ASGC-RA).

We look forward to continuing discussions with the CRERRPHC to explore how the Index of Access can be used (and potentially trialled) in workforce planning and how it compares with currently used geographic classification systems as a component of multi-faceted planning and resource allocation processes.