Adoption, implementation and prioritization of specialist outreach policy in Australia: a national perspective

Belinda G O'Sullivan,[a] Catherine M Joyce[b] & Matthew R McGrail[c]

Abstract The World Health Organization has endorsed the use of outreach to promote: efficient redeployment of the health-care workforce; continuity of care at the local level; and professional support for local, rural, health-care workers. Australia is the only country that has had, since 2000, a sustained national policy on outreach for subsidizing medical specialist outreach to rural areas. This paper describes the adoption, implementation and prioritization of a national specialist outreach policy in Australia. Adoption of the national policy followed a long history of successful outreach, largely driven by the professional interest and personal commitment of the workforce. Initially the policy supported only new outreach services but concerns about the sustainability of existing services resulted in eligibility for funding being extended to all specialist services. The costs of travel, travel time, accommodation, professional support, staff relief at specialists' primary practices and equipment hire were subsidized. Over time, a national political commitment to the equitable treatment of indigenous people resulted in more targeted support for outreach in remote areas. Current priorities are: (i) establishing team-based outreach services; (ii) improving local staff's skills; (iii) achieving local coordination; and (iv) conducting a nationally consistent needs assessment. The absence of subsidies for specialists' clinical work can discourage private specialists from providing services in remote areas where clinical throughput is low. To be successful, outreach policy must harmonize with the interests of the workforce and support professional autonomy. Internationally, the development of outreach policy must take account of the local pay and practice conditions of health workers.

Abstracts in عربي, 中文, Français, Русский and Español at the end of each article.

Introduction

The World Health Organization (WHO) recognizes the need for policies designed to overcome the chronic undersupply of health workers in rural areas in both developed and developing countries.[1] In February 2009, following international calls for action, WHO launched a programme that aimed to increase access to health workers in rural and remote areas by improving staff retention.[2] The programme involved an evidence-based appraisal of policies that could influence retention through education, regulation, financial incentives or professional support.[3] Outreach was endorsed as an effective strategy because it enables: efficient redeployment of the workforce; continuity of care at the local level; and professional support and education for local workers, which could improve retention.[1] WHO defines outreach as, "any type of health service that mobilizes health workers to provide services to the population or to other health workers away from the location where they usually work and live".[1] In Australia, outreach involves planned, regular visits to each community.[4]

Australia is the only country that has had, since 2000, a sustained, national policy on outreach that subsidizes medical specialist outreach to rural areas. The country has a low population density, vast stretches of uninhabited land and several urban centres distributed sparsely along the coastal fringe.[5] Inequalities in the social determinants of health between metropolitan and rural populations influence the need for health care.[4,6] Although it is a developed country, Australia continues to have problems addressing the high rate of preventable disease, particularly in remote communities where the proportion of indigenous people is high and where geographical distances are extremely large.[4] For example, the rates of trachoma,[7] otitis media[8] and rheumatic heart disease[9] in these communities remain high relative to global expectations.

In rural and remote communities, a lack of local services and low utilization of hospitals results in higher mortality than is found in large cities.[10] The medical evacuation of patients who require specialist care in a large hospital is important for these communities but a substantial number need to be retrieved and the cost is high.[5,11] Thus, more efficient and effective community-based approaches are needed. Access to comprehensive primary health care involving specialists is considered ideal for the early and ongoing management of illness in rural areas.[12] However, only 15% of Australian specialists have their main practice outside metropolitan areas, whereas 30% of Australians reside in nonmetropolitan areas.[13] Rural specialist outreach services could help overcome complex barriers to service access,[4,6] which are mainly due to language and cultural differences,[5,14] and help avoid the cost and effort of seeking care away from home.[15] Visiting specialists can meet many of the health service needs of rural areas[16] and, since they are less exposed to some of the negative effects of full-time rural specialist practice, it may be easier to recruit them.[17,18] In addition, visiting specialists can also provide periodic procedural support for rural generalists, thereby increasing their confidence clinically and reducing their professional isolation.[19,20]

All medical specialists in Australia must complete advanced medical training and become fellows of a specialist college. Specialist care is normally accessed by referral from a general practitioner and is partly or wholly subsidized by a universal health insurance scheme – the Medicare Benefits Schedule[21] – which is funded by the Commonwealth of Australia (i.e. the national or federal government). Self-employed

[a] School of Rural Health, Monash University, 26 Mercy Street (Level 3), PO Box 666, Bendigo, Victoria, 3550, Australia.
[b] Department of Epidemiology and Preventive Medicine, Monash University, Melbourne, Australia.
[c] Monash University Gippsland Medical School, Churchill, Australia.
Correspondence to Belinda G O'Sullivan (email: Belinda.osullivan@monash.edu).
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and hospital specialists with a right to private practice, who together account for 73% of all Australian specialists,[21] have the discretion to set their fees at or above the Medicare funding level, which has an effect on the level of co-payment, if any, required from patients. Overall, 47% of specialists work in mixed public and private practice, 33% work in public practice only and 20% work in private practice only.[22] Furthermore, 49% of those working only in public practice have a right to a private practice.[22]

Globally there is a lack of information on outreach strategies that can help guide policy.[1] The aim of this paper, therefore, was to describe the adoption, implementation and prioritization of a national specialist outreach policy in Australia to provide a reference for other countries.

Specialist outreach

The early history of specialist outreach in Australia includes many examples of individual "champions" who, despite various barriers and logistical challenges, pioneered outreach services at a local and national level.[23–25] There are numerous examples of specialists whose practice was adapted to complement local health services, which highlights the importance of professional autonomy and local design.[9,14,26] The provision of specialist outreach through a "bottom-up" approach has continued to result in accessible, safe and relatively sustained (i.e. for more than 5 years) services in different parts of the nation and across a range of specialties.[6,8,27] Evaluations have shown that specialist outreach in remote settings improves early interventions and the coordination of care and reduces the hospitalization rate.[6] Moreover, integrated services have a higher clinic throughput and lower costs.[28] However, such services require time and patience to develop and must be based on local relationships and respect for local culture.[9,14] In Australia, specialist outreach has been fostered by the interest and investment of state and territory governments.[4,27]

The funding arrangements for locally initiated outreach services tend to be patchy: funding has often developed relatively opportunistically and its distribution may be inequitable. Some specialists do not receive subsidies for travel associated with outreach,[27] whereas others are subsidized by mixed funding – for example, by short-term Commonwealth funding coupled to longer-term state funding – or directly through the health services. Nevertheless, inequitable funding does not necessarily deter professionals from being interested in or having a commitment to outreach. However, with "self-funded" services, in which specialists independently fund their own transport and accommodation, outreach is likely to be restricted to easily reached locations and the time dedicated to professional support is likely to be limited.[27]

Although the proportion of specialists providing outreach services to rural areas in Australia is unknown, it appears to be substantial and is increasing. Surveys carried out in the late 1990s indicated that 29% of otolaryngologists and 41% of dermatologists based in metropolitan areas provided outreach to rural communities.[29,30] The factors that motivated specialists to participate in outreach were the variety of the work professionally, the needs of the rural community and loyalty to rural staff.[29,30] Although specialists were willing to provide outreach services for a smaller financial reward than they would receive in metropolitan areas,[31] adequate remuneration for clinical services (at least at the level provided by Medicare) was considered important for sustainability.[27] Bridging the gap in remuneration between specialists' main practices and their outreach work is vital, particularly for outreach to remote areas.[32]

A national outreach policy

In 1998, following the establishment of national structures for providing policy advice on medical workforce planning three years earlier,[33] a discussion paper on sustainable specialist services in Australia was submitted to the Australian Health Minister's Advisory Council.[34] It advocated outreach as the only means through which many rural communities could obtain access to regular specialist care. The estimated size of the catchment area population that was large enough to ensure that outreach work was viable varied from 14 000 to 30 000 people, smaller than that necessary for residential practice (i.e. 20 000 to over 80 000). Moreover, the desirable population size was similar for different specialties. The main barriers to outreach identified were: (i) the specialist's travel and accommodation costs and the time needed; (ii) the local clinical infrastructure; and (iii) the availability of staff.[34]

In May 2000, the Medical Specialist Outreach Assistance Program (MSOAP-*Core*), a national initiative of the Commonwealth Government, commenced with an allocated annual budget of approximately 20 million Australian dollars (Aus$), which was equivalent to 12 million United States dollars (US$) at the exchange rate on 3 July 2000. The initial aim was to promote the supply of new rural outreach services by subsidizing costs.[31] Initially, services that were operating before 2000 – including those that were already receiving funding from, for example, individual specialists or state or territory governments – were not eligible for funding. In practice, MSOAP-*Core* complemented other Commonwealth Government programmes. For example, it helped ensure that ophthalmologists were available for the new Eye Health Program.[35] In addition, MSOAP-*Core* provided systematic support for travel, the travel time needed by non-salaried specialists, accommodation and the hire of equipment and facilities. It was well received by specialists contemplating rural service.[36] Proposals for new outreach services usually originated at the local level and MSOAP-*Core* ensured that service delivery was flexible. Table 1 gives a broad outline of the administrative steps involved in implementing national specialist outreach policy. Subsidies were also provided for meals, cultural training for specialists, back-filling for the specialist's primary practice (i.e. short-term staff relief for salaried specialists) and improvement of skills (i.e. sharing knowledge with or providing educational support for local staff).[37] However, clinical services were not subsidized, which provided an incentive for specialists to achieve a reasonable clinical load. Specialists had the discretion to set charges for services.

After the first four years of MSOAP-*Core*, the Commonwealth Government commissioned an evaluation of the sustainability of outreach services that were not eligible for MSOAP-*Core* funding in 2000. Despite the lack of Commonwealth Government funding, outreach services had been operating for more than five years in six of eight case studies, principally because of personal investment by specialists and the clear willingness of the community to pay.[27] To ensure that these services would be sustainable, the Commonwealth

Table 1. **Administration of national specialist outreach policy, Australia, 2000–present**[37,38]

Administrative step	Associated action
A specialist or a rural health organization submits a proposal to the fund holder (i.e. the operational agency in the state or territory government responsible for national specialist outreach policy).	The specialist or rural health organization: • proposes a location and commencement date for the service; • describes how the proposed service meets needs; • estimates the size of the visiting team, including students; • describes the proposed clinical services and the actions that will be taken to improve skills; • describes how cultural awareness training will be carried out; • confirms worker registration and indemnity insurance have been arranged; and • proposes a billing method and reports funding from other sources.
The fund holder reviews the submission in the context of a regional needs assessment and the regional service plan.	The fund holder: • verifies there is a substantial need in the community for the care provided by the specialist; • ensures the proposal is consistent with national policy priorities; • ensures the local workforce and facilities can support and integrate with the proposed service; and • verifies that the proposed service provides value for money.
The State or Territory Advisory Forum, which is an impartial representative of the state or territory government, endorses the proposal.	The State or Territory Advisory Forum holds regular meetings with the fund holder.
The Commonwealth Government approves the proposal and contracts a specialist provider via the fund holder.	• A deed of agreement is signed by the Commonwealth Government and the specialist or rural health organization.
The fund holder pays the specialist on submission of a bimonthly service report.	The specialist reports: • the number of specialist visits completed; • the number of patients seen; • the proportion of patients from indigenous communities; and • the skills improved and the personnel involved.
The fund holder reports annually to the Commonwealth Government.	The fund holder: • submits an annual report; and • renews contracts for services that were performed well.

Government expanded eligibility for MSOAP-*Core* funding to existing services in May 2004 with the hope that state and territory governments would continue their current levels of investment in outreach services.[31]

In 2008, after an incoming government renewed its commitment to improve the health of indigenous people as a political commitment to equity, a National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes was signed between the Commonwealth Government and State and Territory Governments. As part of this Agreement, the Commonwealth Government provided an additional stream of funding for outreach in 2009 and 2010 through the MSOAP Indigenous Chronic Disease (MSOAP-*ICD*) programme. This programme had the same annual budget as MSOAP-*Core* (i.e. US$ 16 million at the Aus$ exchange rate on 1 July 2009) and targeted remote communities or communities with a high proportion of Aboriginal people, who have high rates of diabetes, cardiovascular disease, chronic respiratory disease, chronic renal disease and cancer. It funded outreach services based on multidisciplinary teams that included specialists, general practitioners and allied health workers;[39] placed a greater emphasis on collaborative and sustained care; supported the local workforce and encouraged improvements in their skills; and encouraged self-management by patients. Subsequently, two further streams of MSOAP funding were introduced: one for ophthalmology in 2011 (MSOAP-*Ophthalmology*) and one for maternity services in 2012 (MSOAP-*Maternity*).

In 2011, an independent national evaluation of all streams of MSOAP funding was commissioned because it was not possible to judge the value of the programme using only self-reported data submitted in bimonthly specialist service reports (Table 1). The evaluation showed that MSOAP was strongly supported by policy-makers, fund-holders, service providers and local staff. In addition, the evaluation identified the need for improvements in: (i) the national framework for assessing the local need for specialists; (ii) the systematic provision of local outreach coordinators; and (iii) national monitoring of specialist outreach.[31] Although improving local staff's skills was also considered important, it may not have occurred in practice because of competing demands on specialists' time during short visits.[31]

The relative effect of MSOAP on improving access to specialist services was assessed using Medicare data and estimates of billing practices in remote areas based on consultations with stakeholders. It was estimated that MSOAP contributed 0.7% to 3.0% of specialist services in inner and outer regional areas, 4.2% in remote areas and 28.7% in very remote areas.[31] Geographical areas were defined according to the Australian Standard Geographical Classification Remoteness Structure as either metropolitan, inner regional, outer regional, remote or very remote.[40] Case studies in seven local areas showed that, whereas most visiting specialist services in remote areas were provided through MSOAP, a large number in regional areas operated independently.[41] This highlighted the need for strong local coordination of outreach services supported by MSOAP and of those operating independently of national policy, principally in regional centres.

The evaluation of MSOAP included a provider survey of 233 specialists. It showed that 59% intended to provide outreach for an additional five years or more. Moreover, 57% of specialists involved in MSOAP normally worked in the private sector: 42% had mixed public and private practices and 15% had private practices only. In addition, 41% were from public hospitals and had a right to private practice in 67% of the cases.[42]

The estimated annual cost of administration in 2010 and 2011 for state and territory governments was US$ 1.8 million (at the Aus$ exchange rate valid on 1 July 2010) for MSOAP-*Core* and US$ 1.3 million (at the Aus$ exchange rate valid on 1 July 2010) for MSOAP-*ICD*. The total annual cost to the Commonwealth Government was around US$ 0.84 million (at the Aus$ exchange rate valid on 1 July 2010).[31] Most costs were staff costs.

In July 2012, as a result of the MSOAP evaluation, a streamlined Rural Health Outreach Fund was created to consolidate the funding for outreach provided by MSOAP-*Core*, MSOAP-*Ophthalmology* and MSOAP-*Maternity*. The fund had a value of US$ 28 million per year (at the Aus$ exchange rate valid on 2 January 2014) and funding was separate from that for MSOAP-*ICD*. However, as with MSOAP-*ICD*, the priorities of the Rural Health Outreach Fund were aligned with other health-care priorities (e.g. on chronic disease, maternal and paediatric health, mental health and ophthalmology) and a team-based approach to outreach, which included a service coordinator, was adopted.[38] The principles underlying the administration of the Rural Health Outreach Fund are similar to those listed in Table 1 but place greater emphasis on performing nationally consistent assessments of needs via fund holders.

In 2012 and 2013, in response to the growth of fly-in-fly-out work practices in the mining industry in Australia, a national parliamentary inquiry was conducted into the fly-in-fly-out workforce.[43] The findings confirmed that outreach services were important for rural health care in Australia, particularly as a complement to residential services in primary health care. The inquiry concluded that a comprehensive national public health policy on outreach was required to tackle the need for: (i) infrastructure, such as staff accommodation and clinical facilities; (ii) streamlined and supported local coordination; (iii) realistic funding that takes into account the true cost of service provision; and (iv) explicit regional planning that incorporates the outreach workforce.

Discussion

The two broad aims of national specialist outreach policy in Australia are to support the provision of outreach and to ensure its sustainability. The specific policy aims are: (i) to counter strong market forces that reinforce the centralization of specialists; (ii) to ensure that remote areas are equitably served by outreach; (iii) to sustain outreach practice by ensuring its financial viability; and (iv) to influence practice by providing incentives that support the integration of specialist outreach services with local health services and the provision of professional assistance for local workers. The policy affects specialists who would otherwise fund outreach themselves and who would encounter financial disincentives to providing outreach in remote areas and to improving the skills of local workers. Back-filling support for salaried specialists also fosters outreach by hospital-based specialists.

The extent to which specialist outreach services can be provided independently of national policy – for example, by specialists or rural health organizations – has not been explored systematically. Consequently, the influence of national policy on the distribution and practice of outreach has not been evaluated in comparative studies. It is likely that the professional autonomy and personal investment of specialists will remain important for initiating and ensuring the continuity of outreach services.

Current national policy, by default, encourages the supply of outreach to areas where there is a legitimate clinical demand because it does not subsidise payment for clinical services. However, although fee-for-service billing arrangements improve the efficiency of outreach services, providing specialists with a regular salary or a fixed payment for clinical services in remote and sparsely populated areas might help counterbalance any loss of income due to poor attendance or low throughput at clinics in these areas.[28] Funding for outreach services is based on proposals from specialists or health organizations and a strong assessment framework is needed to ensure that these proposals address legitimate needs. The establishment of a national outreach service register might help identify where there is an oversupply or undersupply of services. Local outreach service coordinators can help reduce costs and improve the efficiency of services by organizing what can be a complex array of interrelated outreach services.[28] In addition, coordinators can act as cultural intermediaries who ensure that outreach services are accessed according to need.[44]

Outreach has been described as a low-cost, health-care option for resource-constrained countries[45] but has also been seen as essential for ensuring universal access to health care.[44] International attempts to replicate Australia's experience with adaptable and regular outreach have highlighted the need to take into account local patterns of illness, the characteristics of the local community and the capacity of the local workforce.[46] In addition, national policy must consider: political stability; the structure and funding of the health system; the size of the health-care workforce; remuneration patterns; local transportation and options for retrieving patients; and the level of poverty in the local community. The structure and funding of the health services in a country will influence the autonomy of the workforce and hence the ability of workforce members to participate in outreach and their payment for participating. Dual-practice health-care systems, like Australia's, are common internationally.[47] However, the cost of the outreach policy in Australia is small relative to the national health budget and outreach is made possible by the existence of Medicare.[48] In countries with high levels of poverty and high health-care needs that lack universal health insurance, outreach policy may be based on salaried or volunteer workers, a low level of subsidy or mandatory participation. Moreover, the implementation of outreach in resource-constrained nations may require the support of partner nations for technical knowledge and help with equipment, training and mentorship, monitoring and funding.[45] International alliances can work well if they address programmes at a systemic level, engage with local staff and are responsive to local circumstances.[49] For example, the Fred Hollows Foundation in Australia, a not-for-profit agency, has promoted outreach internationally by offering leadership, providing strong collaboration and focusing on capacity building.[50] Globally, such alliances often benefit outreach workers, many of whom practice under extremely difficult conditions.[45]

In Australia, national policy supports the supply of specialist outreach services and helps ensure their sustainability while making sure that they are aligned with national health-care priorities. The policy's success is underpinned by interested specialists who, given the right support, may initiate and sustain outreach. It is essential that outreach policy be coupled to the systematic assessment of local health-care needs, take into account local health-care organization and funding, and be implemented in accordance with the interests of the workforce. ■

Competing interests: None declared.

ملخص

اعتماد سياسة تواصل الأخصائيين في أستراليا وتنفيذها وتحديد أولوياتها: منظور وطني

اعتمدت منظمة الصحة العالمية استخدام التواصل لتعزيز ما يلي: إعادة نشر القوى العاملة في مجال الرعاية الصحية بكفاءة؛ واستمرارية الرعاية على الصعيد المحلي؛ والدعم المهني للعاملين في مجال الرعاية الصحية على الصعيدين المحلي والريفي. وتعد أستراليا البلد الوحيد الذي توجد لديه، منذ عام 2000، سياسة وطنية مستدامة بشأن التواصل تهدف إلى دعم تواصل الأخصائيين الطبيين مع المناطق الريفية. وتصف هذه الورقة اعتماد سياسة وطنية لتواصل الأخصائيين في أستراليا وتنفيذها وتحديد أولوياتها. وكان اعتماد السياسة الوطنية نتاج تاريخ طويل من التواصل الناجح، الذي نتج بشكل رئيسي عن الاهتمام المهني والالتزام الشخصي للقوى العاملة. وفي البداية، دعمت السياسة خدمات التواصل الجديدة فقط غير أن المخاوف بشأن استدامة الخدمات القائمة نتج عنها توسيع نطاق أهلية التمويل ليشمل جميع خدمات الأخصائيين. وتم دعم تكاليف السفر ووقت السفر والإقامة والدعم المهني وراحة العاملين في عيادات الأخصائيين الأولية واستئجار المعدات. وبمرور الوقت، نتج عن الالتزام السياسي الوطني بتحري الإنصاف في علاج السكان الأصليين زيادة الدعم المستهدف للتواصل في المناطق النائية. وتتمثل الأولويات الراهنة فيما يلي: (1) إنشاء خدمات التواصل المستندة على الفرق؛ (2) تحسين مهارات الفريق المحلي؛ (3) تحقيق التنسيق المحلي؛ (4) إجراء تقييم للاحتياجات على نحو متسق وطنياً. ومن الممكن أن يؤدي غياب الإعانات المقدمة للعمل السريري الذي يقوم به الأخصائيون إلى إثناء الأخصائيين في القطاع الخاص عن تقديم الخدمات في المناطق النائية التي ينخفض فيها إجمالي الإنفاق السريري. ولضمان نجاحها، يجب أن تتسق سياسة التواصل مع اهتمامات القوى العاملة ودعم الاستقلال المهني. وعلى الصعيد الدولي، يجب أن يأخذ وضع سياسة التواصل في الحسبان الرواتب المحلية للعاملين الصحيين وظروف الممارسة.

摘要

澳大利亚专科医生外展政策的采用、实施和优先落实：国家视角

世界卫生组织一直都支持使用外展以便推进：医疗劳动力的有效调动；护理在地方层面上的连续性；对地方、农村卫生医护人员的专业支持。澳大利亚是唯一自 2000 年以来一直提供可持续外展政策的国家，该政策为在农村地区开展外展服务的专科医生提供补贴。本文描述澳大利亚国家专科医生外展政策的采用、实施和优先落实。采用国家政策之后，外展取得长期的成功，这在很大程度上是由工作人员的职业兴趣和个人奉献驱动的。最初，政策只支持新的外展服务，但因为考虑到现有服务的可持续性，资助资格扩展至所有专科医生服务。对差旅、差旅时间、住宿、专业支持、专科医生的主要工作的员工助济和设备租用的费用进行补贴。久而久之，公平对待原住民的全国性政治承诺促进了偏远地区更有针对性的外展支持。当前的优先顺序是：(i) 建立基于团队的外展服务；(ii) 提高当地工作人员技能；(iii) 实现当地协调；(iv) 执行全国一致的需求评估。如果专科医生临床工作无补贴，则会打击私人专科医生在临床产出较低的偏远地区提供服务的积极性。要想取得成功，外展政策必须与工作人员利益相协调，并对专业自主权提供支持。在国际上，外展政策的制定必须考虑卫生工作人员的当地工资和实践条件。

Résumé

Adoption, mise en œuvre et priorisation de la politique de proximité spécialisée en Australie: un point de vue national

L'Organisation mondiale de la Santé a approuvé l'utilisation de services de proximité pour promouvoir: le redéploiement efficace du personnel des soins de santé; la continuité des soins au niveau local; et le support professionnel au personnel de santé local et rural. L'Australie est le seul pays qui possède, depuis l'an 2000, une politique nationale soutenue de services de proximité afin de subventionner la présence de médecins spécialistes dans les zones rurales. Cet article décrit l'adoption, la mise en œuvre et la priorisation d'une politique nationale de proximité spécialisée en Australie. L'adoption de cette politique nationale a fait suite à une longue histoire de services de proximité dont la réussite est largement attribuable à l'intérêt professionnel et à l'engagement personnel des professionnels de santé. À l'origine, cette politique soutenait seulement les nouveaux services de proximité, mais les préoccupations concernant la durabilité des services existants ont abouti à l'extension de l'admissibilité au financement à tous les services spécialisés. Les coûts des déplacements, des temps de déplacement, d'hébergement, du soutien professionnel, de personnel de remplacement dans les cabinets primaires des médecins spécialistes et de la location d'équipement ont été subventionnés. Au fil du temps, l'engagement politique national pour le traitement équitable des populations autochtones a entraîné un soutien plus ciblé pour acheminer les services de médecine mobile dans les zones reculées. Les priorités actuelles sont: (i) l'établissement de services de proximité en équipe; (ii) l'amélioration des compétences des professionnels locaux; (iii) la réalisation de la coordination locale; et (iv) la conduite d'une évaluation cohérente des besoins à l'échelle nationale. L'absence de subventions pour le travail clinique des médecins spécialistes peut décourager les médecins spécialistes privés de venir soigner dans les zones éloignées où le rendement clinique est faible. Pour qu'elle réussisse, la politique de proximité doit s'harmoniser avec les intérêts des professionnels de santé et soutenir l'autonomie professionnelle. À l'échelle internationale, le développement de politiques de proximité doit tenir compte du salaire local et des conditions d'exercice des professionnels de la santé.

Резюме

Принятие, осуществление и определение приоритетов политики выездного обслуживания специалистами в Австралии: национальная перспектива

Всемирная организация здравоохранения одобрила использование выездного обслуживания для способствования эффективному перераспределению медицинских кадров, преемственности оказания медицинской помощи на местном уровне, а также для профессиональной поддержки местных и сельских медицинских работников. Австралия — это единственная страна, в которой с 2000 года проводится национальная политика выездного обслуживания с целью субсидирования выездного обслуживания медицинскими специалистами сельских районов. В данной статье описывается принятие, осуществление и определение приоритетов в национальной политике выездного обслуживания специалистами в Австралии. Национальная политика была принята после длительного периода осуществления выездного обслуживания, успех которого в значительной степени был обусловлен профессиональным интересом и личной приверженностью работников. Изначально в рамках политики поддержка оказывалась только новым видам выездного обслуживания, но опасения относительно развития существующих услуг привело к распространению права на финансирование всех видов услуг специалистов. Осуществлялось субсидирование затрат на проезд, время в пути, проживание, профессиональное обслуживание, высвобождение персонала в первичных учреждениях практикующих врачей-специалистов и аренду оборудования. Со временем национальная политическая приверженность принципу равного отношения к коренным народам привела к более адресной поддержке выездного обслуживания в отдаленных районах. В настоящее время приоритетами являются: (i) введение услуг выездного обслуживания коллективом специалистов; (ii) повышение квалификации местного персонала; (iii) осуществление координации на местном уровне и (iv) проведение последовательной оценки потребностей на национальном уровне. Отсутствие субсидий для поддержки клинической работы специалистов может препятствовать предоставлению услуг частными специалистами в отдаленных районах с низкой клинической пропускной способностью. Для обеспечения успешности политики выездного обслуживания она должна согласовываться с интересами работников и поддерживать профессиональную автономию. На международном уровне при развитии политики выездного обслуживания необходимо учитывать уровень оплаты труда на местах и условия практической работы медицинского персонала.

Resumen

La adopción, implementación y prioridad de una política de difusión de especialistas en Australia: una perspectiva nacional

La Organización Mundial de la Salud ha aprobado el uso de la difusión con el objetivo de promover la reasignación eficiente del personal sanitario, la continuidad de la atención a nivel local y el apoyo profesional para el personal sanitario a nivel local y rural. Australia es el único país que ha mantenido, desde el año 2000, una política nacional continuada en materia de subvención de la difusión de especialistas médicos en las zonas rurales. Este artículo describe la adopción, implementación y prioridad de la política de difusión de especialistas en dicho país. La adopción de la política nacional obedeció a un largo historial de difusión con buenos resultados, impulsado en gran parte por el interés profesional y el compromiso personal de los trabajadores. En un principio, la política apoyaba únicamente los servicios de difusión nuevos, pero la preocupación acerca de la sostenibilidad de los servicios existentes auspició una ampliación de la financiación a la totalidad de los servicios especializados. Se subvencionaron los costes y el tiempo de viaje, el alojamiento, el apoyo profesional, la asistencia al personal en los consultorios principales de los especialistas y el alquiler de equipos. Con el tiempo, el compromiso político nacional respecto al trato equitativo de los pueblos indígenas se tradujo en un apoyo más específico para la difusión en las áreas más alejadas. Las prioridades actuales son: (i) establecer servicios periféricos por equipos, (ii) mejorar las capacidades del personal local, (iii) lograr la coordinación local y (iv) llevar a cabo una evaluación cohesiva de las necesidades a nivel nacional. La ausencia de subsidios para el trabajo clínico de los especialistas puede disuadir a los especialistas privados de prestar servicios en zonas remotas, en las que el rendimiento clínico es bajo. Para resultar satisfactoria, la política de difusión debe armonizar los intereses del personal y apoyar la autonomía profesional. A nivel internacional, el desarrollo de una política de divulgación debe tener en cuenta los salarios y las condiciones locales de los miembros del personal sanitario.

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