

The economics of delivering primary health care in rural and underserved areas—what works?

Dr Lesley Russell¹

¹Adj Assoc Professor, Menzies Centre for Health Policy, University of Sydney

Good health and local healthcare services contribute to the economic and social viability of rural communities. But at the same time, ensuring a community has the needed range of healthcare services and provides a supportive working and living environment for the people who deliver these services (and their families) requires thoughtful investments from all levels of government. We can learn what works, what doesn't, and why from international experiences and some innovative Australian programs.

I would like to acknowledge the peoples who are the Traditional Custodians of the Land on which we meet. I would also like to pay my respect to their Elders both past and present and extend that respect to other Indigenous Australians who are present today.

In April last year the fact that Australia rated seventh in the world in terms of life expectancy was headline news. But as everyone who lives and works in rural and remote Australia knows, behind that headline number are a series of sadder numbers that reflect the fact that the further Australians live from the major cities, the less their life expectancy and the poorer their health status.

Data from the [ABS in 2013](#) show that life expectancy at birth ranges from 82.1 years in major cities to 63.9 years in very remote areas. The picture is even grimmer from the perspective of [avoidable deaths](#): in a population of 100,000, there are 115 avoidable deaths in metropolitan areas compared to 171 in regional hubs and 244 in rural towns.

These numbers serve to highlight stories about limited access to healthcare services that may not be well-targeted to local needs, about ineffectual or non-existent health promotion programs, about a different set of social determinants of health, and about strategic plans for rural health that have languished unaddressed.

The National Rural Health Alliance said this in 1998; “Living and working in the country, especially the most remote parts of Australia, is a health hazard. The air may be cleaner than in the cities, the roads emptier, the noise levels lower, but the living is hazardous.”

This is not just an issue about fairness and equity and access to healthcare services, it's an economic issue that impacts on national, community and family budgets and life's opportunities for a significant number of Australians.

About 2.5 million Australians live in rural and remote areas. A fair go for this major segment of the population demands investments in the services and opportunities they need—and are entitled to. These investments will work best if health and healthcare services are integrated together with education, employment, housing, transport and business and social services and not delivered as isolated entities and siloed policies and programs. Yet the Turnbull Government's [development plan for Northern Australia](#) doesn't appear to mention health and healthcare services at all.

In today's political environment most of the debate centres around the sustainability of the cost of healthcare services to government budgets and there's a reluctance to view health and healthcare spending as an investment in future productivity and the national good.

We are inundated with reports about the economic burdens of failing to adequately address risk factors like obesity and smoking, chronic conditions like cancer, diabetes, asthma, and injuries, poisonings and mental health conditions (all of which are more prevalent in rural areas). What is largely ignored is the comprehensive and substantive impact of healthcare funding as an economic development driver. There are really no Australian studies to demonstrate this.

The most relevant examples of how to do this come from the United States, from the Community Health Centers which provide primary health care services in medically under-served areas. Data collected over their nearly 50 year history highlight that these centres don't just provide quality and culturally safe health, healthcare and related social services to vulnerable populations but they stimulate the economies of the communities in which they operate. There's a multiplier effect that extends beyond the employment of healthcare professionals and ancillary staff and beyond the walls of the clinics—for example, to local businesses that supply office needs, to tradesmen who provide services, and to people who are healthy enough to engage in work and community activities and consequently have pay cheques to spend. It is [estimated](#) that US\$11 is generated in total economic activity for every US\$1 invested in these health centres.

That Community Health Centres can be important economic drivers was highlighted by the fact that when President Obama first came to office in 2009 and confronted the US consequences of the global financial crisis, he asked the Congress to include additional funding for Community Health Centres in the American Recovery and Reinvestment Act.

When the Affordable Care Act (Obamacare) was enacted in 2010, it went further, with additional funding of \$11 billion for Community Health Centres. Five years on, in 2015, it was calculated that Community Health Centres were generating \$54 billion in economic activity. These dollars also translated into job retention and creation with over 457,000 jobs generated, including 284,000 as a direct result of the Affordable Care Act.

Recently there have been [a number of efforts](#) to look at the impact of other Obamacare funding as an economic development driver, especially in those areas that were previously had poor access to healthcare services, low employment rates and faltering economies. A [review](#) of state-based economic impact analyses for those states that undertook Medicaid expansion shows sustained job and economic activity growth in every state that conducted such a study. This is due to the fact that improved access to healthcare, including preventive services, means that healthier people look for work, remain in the workforce longer, and are more productive at work—all benefits that accrue to the state's economy and to individuals. In [California](#) it is calculated that working families now covered by Medi-Cal have an additional \$1.7 billion in personal income to spend every year.

Australia has shown little interest in these sorts of analyses and economic justifications for changes in health policy. For example, we have no idea what impact, if any, GP SuperClinics have had in their communities.

Aboriginal Community Controlled Health Organisations are very analogous to Community Health Centres and reflect the patient-centres medical home model that is now seen as best practice for primary care. I am sufficiently enamoured of the model to believe that every Australian should want their healthcare delivered through such an approach. It is very likely that, especially in rural areas,

ACCHOs make an important economic contribution. We do know that ACCHOs are the largest private employer industry for Aboriginal and Torres Strait Islander people, but I have seen no economic data beyond this.

It is clear however, that on the basis of healthcare costs alone, spending more money more wisely on rural and remote health could result in some significant savings. A [recent Australian study](#) from John Wakerman's group showed that investing \$1 in medium-level primary care (2-11 visits per year) for people with diabetes in remote Indigenous communities could save \$12.90 in hospitalisation costs.

If rural health needs are different than metropolitan needs, then what should the rural healthcare system or systems look like?

We know quite a lot about this, thanks to the work of the [Centre for Excellence for Accessible and Equitable Primary Health Care Service Provision in Rural and Remote Australia](#), which was funded and supported by the Australian Primary Health Care Research Institute (APHCRI) until the Turnbull Government 'forgot' to renew funding for primary health care research in 2015.

The Centre for Excellence, which was led by John Wakerman and colleagues, undertook some excellent ground work that should not be forgotten when it comes to rural and remote health. I worry however that this is increasingly the case.

The [National Strategic Framework for Rural and Remote Health](#) has not been updated since 2011, although there have been some roundtables on a range of topics. Rural health used to have its own outcome in the Department of Health Portfolio Budget Statements but is now lost in Outcome 2 where the only reference to rural health is under health workforce. It's now impossible to know from publicly available documents how much money is spent on rural health initiatives. A [Rural Health Commissioner](#) was an election promise that has yet to be delivered on.

John Wakerman, John Humphreys and colleagues recognised the need for agreement on a [core set of PHC services](#) that should be available to Australians living in rural and remote areas and the support functions necessary to ensure the sustainability of these services. Knowing what services should be available enables communities, health professionals and policy makers to work together to ensure they can be delivered in a way that is 'fit for (local) purpose' and that there are no gaps.

An examination of these essential services makes it plain that what is needed is something considerably beyond general practice—which is why I have been talking about primary health care. In particular, needed services include emergency care, obstetrics, mental health and counselling, dental health, rehabilitation, substance abuse, disability and aged care.

And of course, there is a range of necessary support functions. These include on-demand specialist back-up, telehealth and video conferencing, and the ability to evacuate seriously ill patients in a timely fashion. Most particularly, they include the need for specialised training. Data systems are just as important in the bush as they are in the cities.

Wakerman and colleagues have also looked at the [features of effective and sustainable PHC models](#) in rural and remote Australia. They identified three key "environmental enablers"—supportive policy, federal and state / territory relations; and community readiness—and five essential services requirements—governance; management and leadership; funding; linkages; infrastructure and workforce supply.

Which brings us to the inevitable question of how to recruit, structure and retain the primary health care team that is needed to deliver these services.

We know quite a lot about the [health care professionals](#) who are more likely to be attracted to the challenges of rural and remote medicine. But I think we need to move beyond a reliance on the rural pipeline to highlight the special professional opportunities that some find in rural and remote work.

Those who [love their work](#) in country areas talk about high levels of professional satisfaction, the challenging variety of the work and the professional autonomy, close relationships with other health professionals, and the sense of satisfaction from their patients.

But the isolation, the struggle with work-life balance, career advancement, schooling for children, jobs for spouses and difficulty finding locums to enable short 'escapes' for vacations and continuing medical education are [causes of dissatisfaction](#). It should be noted that such lists are common to all healthcare professionals—and likely also to those who work in other professions (such as teaching) in country areas.

Sometimes the solution to these problems must involve thinking outside the box. For example:

- Youth from rural areas who are interested in study medicine, dentistry, nursing or physiotherapy and then returning home to work in their communities will often need tutoring assistance to meet the required university standards, financial assistance to meet the cost of tertiary education, and mentoring assistance through training and beyond.
- If a husband and wife team share a practice in a rural area, who babysits the kids if they both get called out in the middle of the night?
- Are we making appropriate efforts to select out and train those individuals who will thrive in a rural healthcare position? Is there an appropriate focus on training and supporting procedural GPs, general surgeons and mental health professionals for rural areas?
- The rural health workforce should have no room for professional turf games; everyone should be working at full scope of practice, and there should be scope for physician assistants, nurse practitioners, community health workers, dental hygienists and paramedics to work alongside doctors, nurses and dentists.
- Can long-term links be established with urban practices to ensure back up support when needed and even regular locum relief?
- It's clear that most rural communities will not be able to support the full range of specialist care available in larger cities, but telemedicine, electronic consultations and fly-in, fly-out work should be arranged so that there is continuity of care.

Providing sustainable healthcare services in the bush is not an impossible task. There are many examples of where this is being done magnificently.

But where are the learnings? The evaluations and even the anecdotal evidence about what works?

Again, Australia performs poorly in this regard. For decades we have suffered from an epidemic of pilotitis, where short-term projects have disappeared—sometimes before they were even evaluated. Ongoing success stories are largely unsung and there is little appetite to learn from failures. The

basement of the Department of Health must be full of forgotten reports, analyses and commissioned studies.

One approach that would help fill this gap is something like CommunityCommons.org in the United States.

This website is operated by the University of Missouri with funding from Robert Wood Johnson Foundation. It has a range of data and information from fully implemented strategies to stories about what worked (and why) in just one small community.

It provides public access to thousands of meaningful data layers that allow mapping and reporting capabilities so that community health status and community health activities can be explored. It includes health, environment, food and social services information.

It is rightly described as “A place where data, tools, stories come together to inspire change and improve communities”.

Tackling the problems of financing delivering health and healthcare services in rural and remote areas—what is needed?

Recognition that rural and remote communities have varied needs.

Sheffield Tasmania, the Tiwi Islands and outback Queensland are very different. A one size fits all approach to rural health will not work.

Nothing can happen without the right workforce. This should look very different in training, composition and scope of practice to what is usually seen in metropolitan areas where the big university hospital is a few minutes away.

Telemedicine and skype consults will help fill the gaps, but they should not be seen as universal substitutes, for either patients or healthcare professionals. This is especially true given the current state of broadband technology in Australia.

Coordination of services should be a mantra everywhere—but especially in rural and remote areas. Transfers of care must ensure that patients do not slip through the gaps.

Quality and safety and best practice are just as important in rural and remote areas and must be facilitated.

Community involvement is essential for effective service implementation and sustainability. Ongoing accountability to the community also contributes to sustainability. Many rural and remote communities contribute financially and in-kind to their local healthcare services because they know that the viability of the community is intimately related to the presence of those services.

My theme for 2017 is to “mine the archives”. Too much important information and knowledge is locked away, unreleased or just forgotten. There is no point in reinventing the wheel and repeating previous studies and even previous mistakes.

Finally, we need leadership and long-term commitments from government, in accordance with agreed strategic approaches and evidence-based policy making. Resources are too precious to waste in ad hoc short-term funding for provisions that may or may not be part of a strategic plan. And for people

like me who track budget funding over the years—it would be nice to be able to do that for rural health once again. Actually, it would be nice to just see rural health listed in the budget papers as a priority.

Finally, you must spend money to save money. Short sighted budget cuts end up costing in the end. Expenditure on rural and remote health is a wise use of government resources because it focuses on what private markets are unable to do and delivers on outcomes that are measurable in the common currency of dollar benefits—as well as the social justice currency of a fair go for all Australians.

Presenter

Dr Lesley Russell is an Adjunct Associate Professor at the Menzies Centre for Health Policy (MCHP) at the University of Sydney. Her research interests include health care reform in Australia and the US, mental health, Indigenous health, addressing health disparities and health budget issues.

Dr Russell was previously a Senior Research Fellow and Visiting Fellow at the Australian Primary Health Care Research Institute at the Australian National University.

Dr Russell has substantial experience working in health policy in the United States and Australia, both in and out of government. In 2009-12 she worked in Washington DC on a range of issues around the enactment and implementation of President Obama's health care reforms, initially as a Visiting Fellow at the Center for American Progress and later as a Senior Advisor to the US Surgeon General in the Department of Health and Human Services.

From 2007-2010 she was the inaugural Menzies Foundation Fellow at the MCHP and a Research Associate at the US Studies Centre at the University of Sydney. Prior to that she was a health policy advisor to the Federal Australian Labor Party. She worked for seven years as health policy advisor on the Energy and Commerce Committee in the US House of Representatives.

Dr Russell holds a PhD in biochemistry from the John Curtin School of Medical Research at the ANU.