Can technology fix the failure of Medicare for rural and remote Australians

Kim Snowball
Healthfix Consulting

Introduction

It seems strange that those in Australia who are sickest and with the highest health risks have the least access to Medicare, simply because of where they live. This was once excusable on the basis that it was difficult to get General Practitioners into the remote and small rural communities.

That excuse has now gone with access to technology.

This paper will examine whether access to Medicare funded GP services in rural Australia has improved since the former Federal Health Minister Dr Michael Wooldridge famously declared that Medicare had failed rural Australians.

So has technology been the saviour of rural communities or is Medicare still failing rural Australians?

To answer this question we examined the Medicare data (non-referred attendances NRA-effectively GP consultations) across the Australian Standard Geographic Classification which allows for quantitative comparisons between 'City' and 'Country'.

The approach quantified the per capita share of Medicare across very remote, remote and outer regional and compared it to Major Cities. This showed whether Medicare access for rural Australians has improved or continues to be a failure.

The difference in access is described in dollar terms for each of the geographic classifications.

We then overlay the burden of disease, preventable deaths and the higher health risks faced by those living in these areas. These health issues are all preventable and treatable with early access, response and advocacy by primary health care services.

To assess the health outcomes we focused on hospitalisation rates per 1000, Median age at death for each statistical region and finally age standardised, potentially avoidable, death rates.

What the data tells us

The source of the data was from two commonwealth government agencies.

The per capita Medicare access was drawn from the Australian government department of health, General Practice Statistics, GP workforce statistics—national, state and remoteness area 2016/17. Viewed August 2018. See <http//www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1>

The assessment of hospitalisation, median age at death and age standardised potentially avoidable death rates were drawn from Australian Institute of Health and Welfare publication, Australia's health 2018, Australia's health series no 16.AUS 221 Canberra:AIHW.

While not perfect science this approach allows the use of the same data source over time to consider changes over the past ten years and to see if things have changed for the better or worse.

Table 1 Per capita Medicare access (Non referred attendances)—effectively GP Service

	Major City	Inner Regional	Outer regional	Remote	Very remote	
Estimate Resident Population (ERP)	14,209,000	3,828,000	1,927,000	304,000	183,000	2006/07
	17,159,000	4,358,000	2,091,000	319,000	202,000	2016/17
NRA Benefit Per person	$208	$166.50	$146.50	$126.50	$90.70	2006/07
	$314.80	$292.60	$260.30	$207.20	$161.90	2016/17
NRA Service per person	5.3	4.3	3.8	3.1	2.0	2006/07
	6.2	5.8	5.2	3.8	2.6	2016/17
2015/16 Hospitalisation per 1000	409.6	415.5	415.4	479.4	745.8	
2015 Median age at death	82	81	79	76	67	
2015 Age Standardised potentially avoidable death rate	96	120	140	170	256	

Based on this analysis, clearly the level of access to Medicare for those living in rural and remote Australia, while improved, has not improved as quickly as the major cities.

One very telling piece of evidence is that those living in very remote Australia have the highest burden of disease, live the shortest lives and suffer from the highest rates of hospitalisation and preventable death and yet have the absolute poorest access to Medicare.

On average a person living in a major city access a Medicare funded GP type service 6.2 times per year yet someone in remote accesses 3.8 times and very remote only accesses just 2.6 or less than half the city rate.

In financial terms, in the past ten years to 2016/17, people living in major cities have seen an increase of $106.80 per person compared to just $71.20 in very remote areas. So in the last ten years the disadvantage for people living in very remote parts of Australia has worsened.

And this is at a time when Medicare is being promoted as universal health care, available to all Australians regardless of where they live.

So the bare reality is that Australia's investment in primary health care is directly inverse to health need. The more remote you live, the sicker you are and the less access to Medicare funded primary health care.

And in the past ten years this has worsened.

What a joke!

It's time this preventable disadvantage for Australians living in rural and remote Australia was fixed.

Using telehealth to deliver Medicare funded GP services

The Australian Health system is underpinned by Medicare, the universal public health insurance scheme. It enables Australian citizens, fee free treatment at public hospitals and it provides a rebate for medical services, procedures and prescriptions.

Primary care is usually the first point of contact people have with the health system and over 85% of Australians had seen a GP in the past 12 months (2014/15).

The health of people living in rural and remote Australia would be transformed by a simple act of allowing all Medicare funded services, through telehealth. This could lift access to general practice and primary health care to levels enjoyed by other Australians

Patients of specialists of all types including FACEMS, Radiologists, Psychiatrists already enjoy Medicare rebates for telehealth consultations. This shows safety and quality is not a barrier to using technology.

Already, the MBS Review GP and Primary Care Clinical Committee phase 2 report - January 2019 makes clear that the requirement for telehealth services to take place with specialists/consultations limits patient access to telehealth items and the addition of GP's as eligible telehealth providers will increase patient access to GP's, particularly in remote areas where GP access is more limited.

The Australian digital health strategy agreed by all States and Territories through COAG in 2017 included seven strategic priorities and states. 'Maximum use is made of digital technology to improve accessibility, quality, safety and efficiency of care'.

The following table shows the projected cost to Medicare of providing the same access to Medicare NRA services as City based Australians.

Very Remote	202,000 ERP	$30,885,800 per annum
Remote	319,000 ERP	$34,324,400 per annum
Outer regional	2,091,000 ERP	$113,959,500 per annum
Total	**2,410,000 ERP**	**$179,169,700 per annum**

This action would mean that 2,410,000 Australians living in rural and remote Australia would receive access to the GP services they need at a rate enjoyed by those living in major cities.

This investment by the Australian government would finally remove one of the most appalling areas of disadvantage and unfairness experienced by Australians in rural and remote areas.

If introduced, the gross cost of the lift in access to Medicare would be reduced by fewer preventable deaths, fewer preventable hospital admissions, fewer emergency evacuations by RFDS, less social and economic cost of poorly managed chronic health conditions, but above all improved health outcomes and a fairer deal and a fairer share for rural Australians.

Importantly, The telehealth access to Medicare items should not be constrained in any way, people should be able to choose their practitioner and their service. We have already seen calls from various interest groups that telehealth should only be available to the patients' own local GP. This becomes a form of capitation that no other Australians are forced to experience.

Choice of access to primary health care should be left to the patient not professional associations.

Recommendation

Given the facts and evidence and the clear way forward, the author calls on the National Rural Health Alliance and its partners to advocate for unrestricted Medicare rebates using telehealth for those living in outer regional, remote and very remote areas of Australia.

References

Medicare Data: Australian government department of health, General Practice Statistics, GP workforce statistics—national, state and remoteness area 2016/17. Viewed August 2018. See <**http//www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1**>

Hospitalisation, median age at death and age standardised potentially avoidable death rate: Australian Institute of Health and Welfare publication, Australia's health 2018, Australia's health series no 16.AUS 221 Canberra: AIHW.

Presenter

Kim Snowball has worked in senior health roles in both the public and private health sectors for over 30 years. He has managed and run rural public and private hospitals, led corporate reform of financial and health workforce functions and led the WA Health system as Director General for over three years. In broader national roles, Mr Snowball was appointed Chair of the Australian Health Ministers' Advisory Council (AHMAC) for two years, a body providing advice and support to Health Ministers and the Australian Health Workforce Ministerial Council (AHWMC). In 2014 Mr Snowball was asked to undertake an independent review of the National Registration and Accreditation Scheme for over 600,000 health professionals for the Australian Health Ministers. A final report was finalised and released by Health Ministers in August 2015. Mr Snowball has a proven track record in the public and private health sector at the senior most levels. He has a deep understanding of the Australian health system and most recently has focused his attention and effort towards innovative clinical service approaches and workforce reform initiatives that will position the Australian health system to better meet the emerging health and service challenges.