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Discussion Paper for Council

COAG Reform Council: ***Healthcare 2011-12: Comparing performance across Australia***

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COAG's latest reports were released on Friday 24 May 2013 and can be accessed here: **http://www.coagreformcouncil.gov.au/reports/healthcare/healthcare-2011-12-comparing-performance-across-australia**

The structure of the main report is different this year, with its content separated into broader groupings along the lines of the indicators in the National Healthcare Agreement:

- health status of Australians;
- healthy habits and behaviours;
- health system at work; and
- progress against performance benchmarks and national partnerships.

This structure is useful as it provides a context for mentioning indicators not being reported on this year because, for instance, there is no new data or measures have not yet been agreed by governments. This means that such indicators - which might be among the most important to us - are less likely to fall off the radar.

The reports include several years of data for many of the indicators, since the baseline report was in 2008-09. This means that this year's reports start to provide some useful monitoring of performance over time.

The Alliance is very pleased that the Reform Council has again produced two Supplements: one comparing health outcomes by remoteness, the other by socio-economic status.

This year for the first time the Reform Council has reported on the combined effect of location and disadvantage, starting with three health risk factors (smoking, excess weight and at-risk alcohol consumption. This analysis is very important to working out how to target programs and activities that support health improvement for people with the worst health outcomes.

For instance, Figure 2.12 on page 37 shows that the combined effect of location and disadvantage varies with each risk factor. For example, in 2011–12, an adult living in a disadvantaged area:

- was much more likely to smoke if they lived in a disadvantaged area outside a major city (30.9%) than if they lived in a disadvantaged area inside a major city (21.9%);
- had a similar likelihood of being overweight or obese regardless of whether they lived in or outside a major city (66.5% compared to 69.3%); and
- interestingly, a person from a disadvantaged major city area, was significantly less likely to drink at risky levels (12.7%) than anyone else—with adults living in disadvantaged areas outside major cities having much higher rates (23.3%).

In the COAG Reform Council's media release, Sue Middleton (who spoke at the Conference in Adelaide) is quoted as saying:

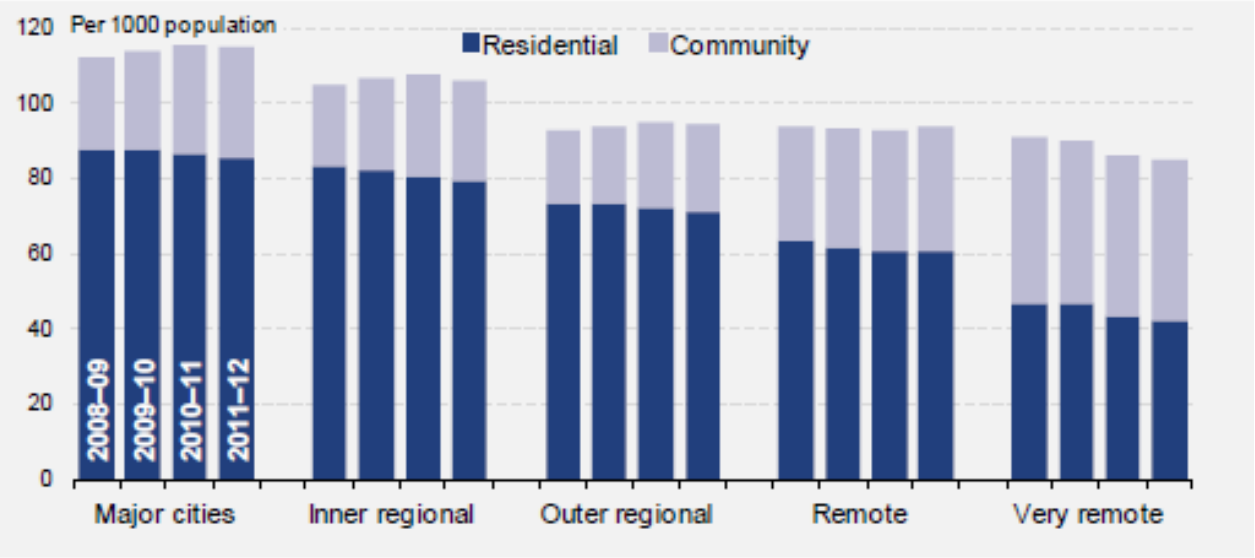
> "On the basis of measures like life expectancy and infant mortality we enjoy some of the best health and healthcare in the world. But this is not true for all Australians and, until it is, there is work to be done.
>
> "Australia's smoking rates for adults continue to fall and is now 16.5% down from 19.2% four years ago – but stubbornly high in rural and remote and disadvantaged areas.
>
> "In major cities, one in 10 people who live in higher socioeconomic areas smoke compared to one in five in the most disadvantaged city areas. But when you combine disadvantage with rural or remoteness, the figure is a shocking one in three."

Aged care

The Reform Council's Rural Supplement also provides some valuable insights - by rurality - into how the aged care system is working. In summary, the rural aged care deficit is stark, as the following facts show.

- People living outside major cities have lower rates of aged care places available and higher rates of hospital patient days waiting for residential aged care.
- The increase in aged care places – residential and community – has been mainly in the cities (see the full report).
- Once people are assessed for high level residential aged care (meaning they are people who really cannot look after themselves) only half the rate (26.2%) of those living in very remote areas entered care within one month of their assessment compared to 52.1% in cities. (This might be influenced by people not wanting to move away from their local community.)

Figure 3.16 Rates of aged care places per 1000 older Australians by area of remoteness



Source: Commonwealth Department of Health and Ageing (DoHA) Ageing and Aged Care data warehouse—see Appendix C.

Preventable hospitalisation

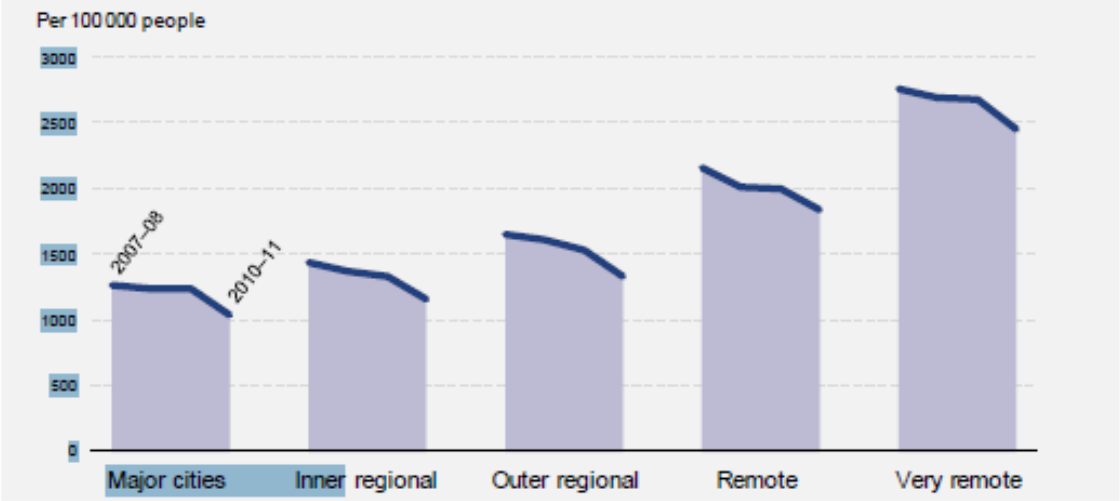
The new reports include findings relating to potentially preventable hospitalisations for chronic conditions (diabetes, asthma, angina, hypertension, congestive heart failure and chronic obstructive pulmonary disease). This does not include complications from diabetes such as renal failure, which is a separate diagnosis. This should be seen not only as an indicator of health status, but also as an indicator of the effectiveness of primary care.

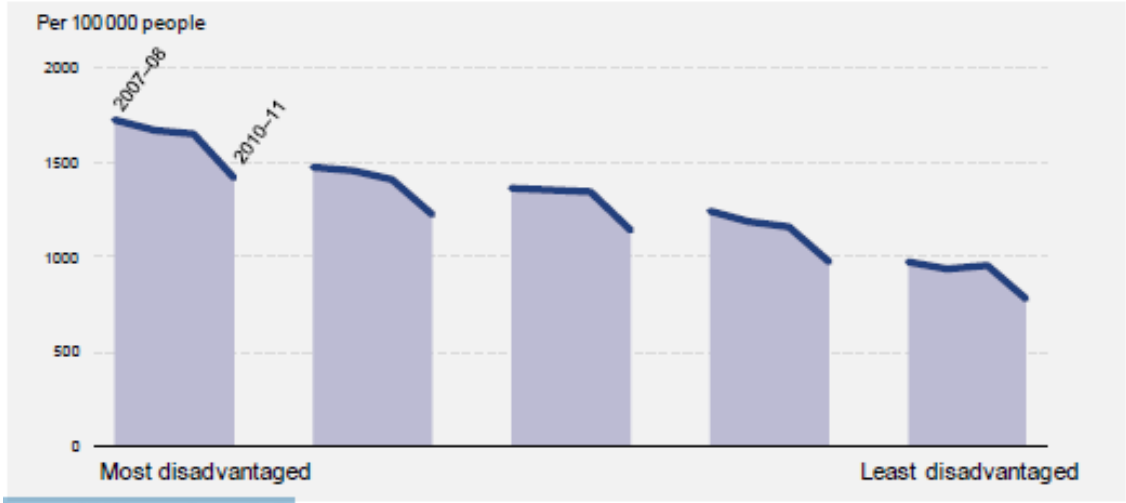
- Potentially preventable hospitalisations for chronic conditions are lowest in major cities (1,037 per 100,000 people), increasing to 2,457 per 100,000 people in very remote areas.
- The Council's main report focuses on how the rate has fallen across all remoteness areas and all socioeconomic groups from 2007-08 to 2010-11 (Figure 1.17 in the main report).
- It is not able to report on the target of reducing the proportion of potentially preventable hospital admissions to 8.5% of hospital admissions, because the data available are not comparable over time. (See p72 at bottom in Appendices to the main report.)
- The figures for people living in remote and very remote areas remain unacceptably high. It looks as though the rate for remote and very remote areas combined is at least double the rate in major cities and substantially higher than for the lowest socioeconomic groups.
- Apart from anything else, this is a reminder that there is still much to be done to improve primary care outside the cities. In this respect much is expected of Medicare Locals.
- While neither the main Report nor the Rural Supplement do so, the COAG Statistical Supplement compares rates of vaccine preventable hospital admissions and those for acute conditions in each of the remoteness areas.

Improvement occurred in all areas of remoteness, and all areas of disadvantage

The drop in potentially preventable hospitalisations due to chronic conditions occurred across all areas of socio-economic disadvantage, and all areas of remoteness (see Figure 1.17).

Figure 1.17 Potentially preventable hospitalisations due to chronic conditions by socio-economic area and location, 2007–08 to 2010–11





Source: AIHW—see Appendix C.

Other headline issues

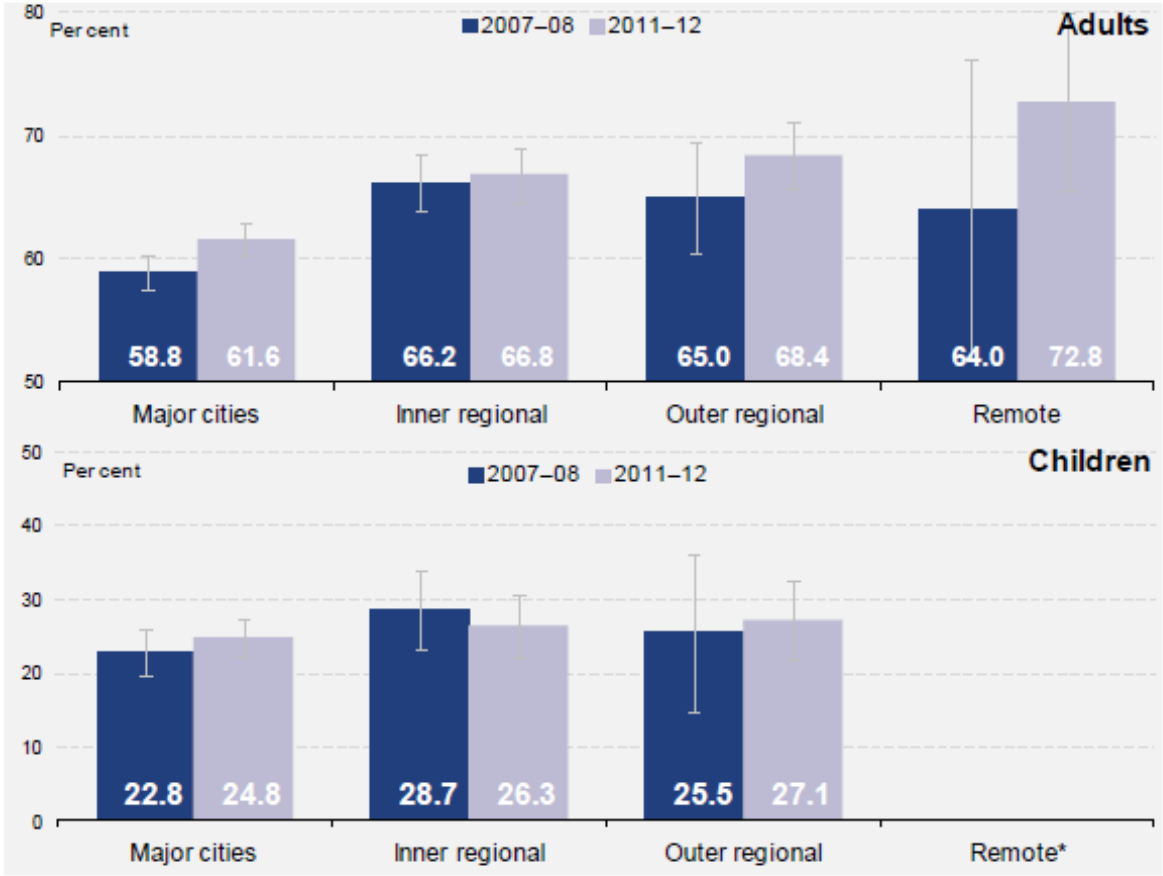
- The long term risks from alcohol consumption increase with remoteness, suggesting the situation may be similar to that for smoking. Between 2007-08 and 2011-12 the proportion of adults drinking at levels that increased their lifetime risk of harm from alcohol-related disease or injury significantly fell nationally from 20.9% to 19.4% - just below 1 in 5. However in remote areas it remains close to 1 in 3, having fallen from 32.1% to 31.4%. This is much higher than the "disadvantaged area outside major cities" figure of 23.3%.

- Nationally, rates of overweight/obesity increased significantly between 2007-08 and 2011-12 from 61.1% to 63.2% of Australian adults (aged 18 years and over), but rates outside the major cities are still much higher (67.5%) compared with the cities (61.6%).

The COAG Reform Council's supplementary report, *Healthcare 2011-12: Comparing health outcomes by remoteness* also identifies a pattern of increasing proportions of overweight/obese adults by remoteness, rising from 61.6% in major cities to 66.8% for inner regional areas, 68.4% for outer regional areas and 72.8% for remote areas (see the figure below).

Similarly, rates of childhood overweight or obesity showed a pattern of increasing by remoteness, from 24.8% in major cities to 26.3% in inner regional areas and 27.1% in outer regional areas in 2011-12. Nationally, childhood rates of overweight and obesity remained similar (25.3% in 2011-12) for children (aged 5–17 years).

Figure 2.1 Proportion of overweight or obese adults and children, by remoteness



Note: Figures for overweight/obese children in remote areas were not considered reliable for comparisons (RSE>25%)
Source: ABS—see Appendix C.

From COAG Reform Council, 2013.Healthcare 2011-12: Comparing health outcomes by remoteness.

The analysis by socioeconomic status showed that people living in disadvantaged areas have a similar likelihood of being overweight or obese regardless of whether they lived in or outside a major city (66.5% compared to 69.3%).

- Rates of psychological distress were similar in all (remoteness) areas, but there was a strong association with socioeconomic status — the higher the status, the lower the psychological distress.
- A higher proportion of people in rural and remote areas report deferring expenditure on dental care due to costs. A higher proportion of people from remote areas also report

waiting one year or more for a public dentist, although more country people are seen within two weeks. This needs further exploration and explanation. Access to dental care is one of the measures also considered in the *HealthyCommunities* report by Medicare Local area.

- Full time equivalent employed GPs per 100,000 population was not reported in the main report or the rural supplement, but was tucked away in the Statistical supplement. It shows increasing prevalence of GPs with remoteness, but decreasing full-time equivalents (ie GP work) with remoteness.
- The indicator related to unplanned hospital readmission rates shows dramatically (ten times) lower readmission rates for rural and remote people. It is possible that this is because rural people are likely to be admitted to a different hospital than the one where the procedure was performed initially. Either way, this indicator requires close scrutiny – either we are on the verge of a major medical breakthrough, or there is a problem with the comparison.
- Waiting times for elective surgery in peer group A, B and C hospitals were longer for Indigenous people and also for regional people (but not necessarily for remote people). One assumes that little elective surgery occurs in the other peer group hospitals (generally smaller rural hospitals).
- In the rural supplement, waiting times in Emergency Departments are reported as more likely to be within benchmarks. However, in the Statistical supplement it becomes clear that this relates only to peer group A and B hospitals (principal referral, women's and children's, and other large hospitals). This indicator should be interpreted with caution; perhaps it is best interpreted as a comparison of waiting times between the largest 30 rural hospitals and those in major cities; but it gives no sense of what is happening in the bulk of small to medium rural hospitals.
- It is difficult to make sense of the indicator related to the rate of potentially avoidable GP type presentations to emergency departments; these presentations relate to peer group A and B hospitals (as with the ED waiting time indicator discussed in the previous dot point). The indicator reports numbers of presentations only, probably because there is no clear denominator. What this means is that calculating a rate based on the IR, OR, R and VR populations is pointless because the presentations we are describing only relate to a subset of people in these areas: those who live close to the 30 or so large hospitals in rural and regional areas, and not close to the other 500 or so rural hospitals.
- The indicators related to deferring access because of financial barriers suffered from small numbers – ie the survey sample. However, this suite of indicators was capable of showing that 8.6% of people in rural areas delayed or didn't see a GP because of cost, compared with 6.6% of people in major cities.
- Unfortunately mortality again wasn't reported, because of ABS concerns that the migration of the frail aged to larger, less remote centres, could affect inter-regional comparisons. While we agree that this is will happen, we believe that the effect in regional areas will be small (but larger and potentially noticeable in remote areas). Its effect is to very slightly increase death rates in regional areas, and substantially reduce them in remote areas.

The future

The final chapter of the main health report deals with the Reform Council's recommendations on more timely, meaningful data.

The fact that the Reform Council's report is now against a reduced set of 33 performance indicators, rather than 70, makes the process sharper or more focused. They propose that the

focus should now be on more timely administrative data, particularly cancer incidence data; more frequent smoking and body weight data as Australia approaches target dates; and on the desirability of having more of the key indicators disaggregated by remoteness.

We intend to pick these issues up with staff at the Reform Council.

ADDENDUM

COAG Reform Council's report on disability services[1]

> "Disability is more common in regional and remote areas than major cities (AIHW 2008)"

The proportion of people living with a disability who use disability services delivered by State and Territory agencies increased nationally between 2008–09 and 2010–11. However, there is still a high degree of variation between individual jurisdictions. The lowest rate in 2010–11 was 22.2% in the Northern Territory and the highest rate was 53.2% in Tasmania.

Increases were smaller for people in older age groups (55–64 years), and negligible for people in outer regional and remote areas.

The use of disability services by people who need them is lower in outer regional/remote areas despite a higher proportion of service usage by Aboriginal and Torres Strait Islanders outside the major cities. There are graphs to support both of these findings in the text.

The Reform Council has also included a data supplement providing information about where and what data relating to disability analysed by remoteness is to be found.

[1]COAG Reform Council. Disability 2011-12: Comparing performance across Australia. 30 April 2013. http://www.coagreformcouncil.gov.au/reports/disability/disability-2011-12-comparing-performance-acrossaustralia