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Budget Submission

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EQUITY IN HEALTH FOR THE PEOPLE OF RURAL, REGIONAL AND REMOTE AUSTRALIA

Overview

The National Rural Health Alliance (the Alliance) recognises the significant fiscal constraints imposed on the Government by the global financial crisis and compounded by recent natural disasters. As the Government completes its work on the 2011-12 Budget, the people of rural and remote Australia draw some reassurance from its recent commitments to regional areas. These areas will continue to be a very significant source of Australia's export income and have borne the brunt of the natural disasters of the last few months.

The Government's focus on regional areas has already resulted in a range of commitments, including some in the health sector such as the current regional round of allocations under the Health and Hospitals Fund.

In the context of this overall regional emphasis, the health priorities chosen by the Government for inclusion in the 2011-2012 Budget should be those that ensure improved equity in access to the infrastructure and services necessary for good health in rural Australia.

This will require analysis of new policy proposals to ensure a fair geographic distribution of benefits between the Major Cities and the rest of Australia. Programs and implementation plans need to be designed and scrutinised to ensure their accessibility and relevance in rural and remote areas. In many program areas, improving equity will require 'catch-up' elements for rural Australia, rather than just the one-third share that should be standard on the basis of population distribution.

In the health sector narrowly defined, the Alliance believes there are four key Budget priorities:

1. strong financial support for the Medicare Locals in rural and remote areas, with funding allocation that is flexible and commensurate with responsibilities and local need;

2. a package of mental health measures to provide locally for the needs of people in smaller towns and communities;

3. new investment in aged care services in rural and remote communities; and

4. action on better oral health and dental care, especially through workforce initiatives.

Background

Inequities in Rural Health Service Provision

The seven million people of rural and remote Australia experience significantly worse health risk factors, higher rates of mortality and morbidity and substantially less access to health services than those in major cities. In rural and remote areas there are fewer health professionals – both in absolute number and proportionally. The mal-distribution of doctors and other health professionals whose services are eligible for Medicare rebates results in rural and remote Australia suffering a deficit in MBS funding of at least $1 billion a year and an excess mortality rate of 4,600 deaths per year.

This substantial and unacceptable discrimination against residents of country Australia is further aggravated by:

- the need for those outside major regional centres to travel long distances for many more complex and acute health and specialist services;
- a very serious mal-distribution of dentists, other oral health professionals and many allied health professionals and specialists, including psychologists and psychiatrists, resulting in poorer access to dental, rehabilitation and mental health services; and
- similar skewing of private hospital facilities and services towards Major Cities, meaning that people in rural Australia do not get their fair share of the government subsidy for private health insurance.

The rural inequities in access to vital health services were confirmed and quantified by a recent AIHW Report: *Australian health expenditure by remoteness: a comparison of remote, regional and city health expenditure (AIHW, 2011).*

The Report, coupled with additional analysis by the Alliance, shows that people in rural and remote Australia have substantially less equitable access to health services and do not get their fair share of government outlays on:

- primary care, diagnostic, specialist services and other out of hospital services;
- PBS scripts; and
- non-acute hospital care and same-day hospital services.

Table 1 below identifies these deficiencies by remoteness, while Table 2 shows that (notwithstanding significant variation in the figures for Very Remote areas) the gaps in recurrent health expenditure per head between Major Cities and regional and remote areas actually grew wider in the five years to 2006-07.

Table 1 Service shortfall by region and types of service compared to Major Cities rates, 2006-07; (AIHW, 2011)

SERVICE TYPE	Inner Regional	Outer Regional	Remote	Very Remote	TOTAL 'RURAL'
MBS services shortfall *(no. of services):*					
GP and other primary care	3,568,895	2,187,338	509,639	392,834	6,658,706
% shortfall cf Major Cities (MC) rate	16%	20%	30%	44%	
Specialist services	992,779	747,330	179,072	106,618	2,025,800
% below MC rate	36%	41%	62%	70%	
Pathology services	1,592,816	1,195,848	284,833	136,625	3,210,123
% below MC rate	10%	15%	23%	21%	
Imaging services	341,641	266,734	81,946	64,027	754,348
% below MC rate	11%	18%	35%	53%	
Total MBS shortfall (no. of services)	6,496,131	4,397,250	1,055,490	700,104	12,648,975
% below MC rate	14%	21%	31%	41%	
PBS Scripts* shortfall (no. of scripts)	5,220,000	3,810,000	1,400,000	740,000	11,000,000
Allied health services shortfall (NRHA estimate)	20%+	35%+	40%+	50%+	
Oral health services shortfall (NRHA estimate)	20%+	30%+	40%+	40%+	

*Estimated, having adjusted for substantially higher levels of concession cardholders in rural Australia.

Table 2 Percentage change in age standardised expenditure per person, adjusted to 2006-07 prices, 2001-02 to 2006-07

	MC	IR	OR	Remote	Very Remote	Australia
Hospitals	19.5	9.8	7.5	8.2	5.2	15.3
GPs	4.9	-4.1	-3.8	-0.3	13.5	2.5
Specialists	-6.6	-13.9	-17.3	-20.6	-9.3	-8.6
Pathology	4.1	-5.8	-6.2	-11.5	0.7	1.1
Imaging	2.8	-6.3	-6.7	-2.8	40.4	0.2

Because people in regional and remote areas had less access to primary care and specialist and diagnostic services in 2006-2007 than the people who lived in Major Cities, they had in total 12.6 million fewer primary care services, and government MBS outlays on them were over $660 million less than if the Major Cities rate had applied.

The same people who experienced this deficit in primary care also had around 11 million less PBS scripts compared with Major Cities usage, taking into account the higher number of concession card holders in regional Australia (45 per cent compared with 30 per cent in Major Cities).

Government outlays for these combined MBS services and scripts were an estimated $1.21 billion less in 2006-07 than they would have been if Major Cities rates of expenditure had applied.

MBS payments for in-hospital services in rural areas also fell short by over $150 million, bringing the total MBS shortfall in 2006-2007 to over $810m which, taking four years' price and population changes into account, would be in excess of $1 billion today.

Country people also had slightly less access to non-acute hospital services such as rehabilitation, palliative care, geriatric and newborn care.

Regrettably, but not surprisingly, the only area of higher service usage for people in rural and remote Australia was in acute care hospital admission rates. Overall, country people experienced an extra 60,000 episodes of acute care in 2006-2007, costing the government an extra $829 million.

Many of these extra acute care episodes would be avoidable with an improved focus in the rural health care system on primary, diagnostic and early intervention services. Ironically, it is for acute care services that rural people are most likely to have to travel to Inner Regional base hospitals, or to Major Cities. This adds to the burden of their acute care needs.

Budget Proposals

1. Support for the work of rural Medicare Locals to fill urgent local primary care gaps

The first tranche of Medicare Locals should include at least a proportionate number (1/3) in rural and remote Australia. Funding allocated to them should be commensurate with the greater task such rural organisations will face in fulfilling their responsibilities to meet gaps in service provision. In particular, the rural and remote Medicare Locals must be funded and developed in such a way as to contribute to Closing the Gap in health for Aboriginal people, including through their relationships with Aboriginal Community Controlled Health Organisations.

Medicare Locals are to have the primary role in the identification of the health needs of local areas and in the development of services, in improving the patient journey through developing integrated and coordinated services, and in providing support to clinicians and other service providers.

These responsibilities are much greater for rural Medicare Locals than for those in urban areas. In rural areas there are fewer primary care providers per capita, more pressures upon them, larger distances to travel for giving and receiving service, greater health needs, more

gaps in services and greater complexity in integrating care because of the lack of local specialists, allied health professionals and many acute services. People in rural and remote areas will not consider Medicare Locals to be valuable unless they can quickly begin to fill urgent gaps in primary care services.

The resourcing of Medicare Locals based in rural and remote areas must be commensurate with these greater responsibilities, and in particular take account of the serious deficiencies in health workforce, Medicare funding, public transport and health infrastructure. The Alliance believes that rural/remote Medicare Locals should be allocated substantially more than the average funding provision, and should have some flexible funding to provide additional services that target locally-identified priority service gaps.

Seventy per cent of Aboriginal people live outside the Major Cities. In its response on the National Health and Hospital Reform Commission report, the Government acknowledged that Aboriginal Community Controlled Health services (ACCHS) provide an effective model of culturally appropriate primary care services and that they will continue to play an important role into the future.

The establishment of Medicare Locals and their relationship with the ACCHS must contribute to the Council of Australian Government (COAG) commitment to a partnership between all levels of government to work with Aboriginal and Torres Strait Islander communities to achieve the target of "Closing the Gap in Indigenous disadvantage". In addition, Medicare Locals should be involved with cultural safety training programs, endorsed by the ACCHS sector, to provide culturally secure services for Aboriginal and Torres Strait Islander people from mainstream health care.

2. Mental health measures to provide locally for people in smaller communities

A package of mental health measures that provides locally for the needs of people in smaller towns and communities should include:
- additional programs to build 'problem solving' capacity for people at high risk of suicide, including Aboriginal people and those exposed to natural disasters;
- extension of current primary care programs for mental health to better reach people in regional and remote areas;
- further expansion of centre-based initiatives to include expanded outreach capacity; and
- specific tasking of Medicare Locals to work with Local Hospital Networks on integrated patient pathways for people with mental illness including acute mental health care needs.

The prevalence of mental illness in rural and remote Australia is estimated to be broadly equivalent to the levels in Australia's Major Cities. However, the AIHW estimates that rates of completed suicide in regional and remote areas are 1.2 to 2.4 times higher than those in Major Cities. Recent natural disasters will also have contributed to mental illnesses and have a direct impact on income and wellbeing for rural Australians. There are known 'mental health hotspots' in some more remote areas, including in some Aboriginal communities.

Despite these needs and risks, people in rural and remote areas have lower levels of access to specialised mental health services. For instance in 2008 the Mental Health Council Australia report on the MBS-based Better Access to Mental Health program identified that usage in regional areas was 43-91 per cent of that in Major Cities; and in remote areas it was 10-34 per cent of the rate in Major Cities, probably reflecting workforce distributions for clinical psychologists, psychologists and GPs. It is estimated that men access mental health services

provided by GPs at only 50 per cent of the rate of women. Local access to psychiatrists is very poor for people in rural and remote areas, with 91 per cent of psychiatrists having their main practice in metropolitan areas.

People in rural and remote Australia need and deserve at least equitable access to the range of primary, specialist and community mental health care services that are available in Major Cities.

A package of mental health measures that can be well-distributed throughout Australia and provide locally for the needs of people in smaller towns and communities should include the following.

Targeted suicide prevention: Additional programs to build 'problem solving' capacity for people at high risk of suicide, including in Aboriginal communities and for the country towns and communities devastated by the recent floods; (these approaches must be culturally appropriate for Aboriginal communities and build community capacity).

Capacity building in the primary care system: Strengthening the capacity of the primary care system to provide mental health care for those with mild to moderate needs, to address the range of health needs - including co-morbidities[1] - and as an entry point for those with more specialised needs. This should include at least the expansion of current mental health and related workforce initiatives to people in regional and remote areas:

- expanded funding for mental health nurses, with a particular focus on rural and remote Australia;
- further expansion of the Access to Allied Psychological Services program (ATAPS) which has delivered about 45 per cent of its services in rural areas; (unlike the MBS-funded Better Access scheme, which has had substantial negative equity impacts);
- further expansion of the Personal Helpers and Mentors Service program;
- continuation of the various telephone help and counselling services; and
- expansion of the visiting specialist scheme for psychiatrists to include the capacity to fund psychologists working with rural primary care teams, including in ACCHOs, in a mentoring and support role as well as to provide direct client services.

- Similarly, the involvement of psychologists and social workers in primary mental health care through existing MBS telepsychiatry items should be updated in association with the new MBS telehealth initiative for online consultations with specialists, to include consultations with patients facilitated through the range of primary health professionals working locally in rural and remote communities including remote area nurses, nurse practitioners and Aboriginal Health Workers, especially where there is no GP available locally.

Centre-based expansion including outreach: There should be further expansion of centre-based initiatives such as HEADSpace and EPPIC, emphasising the capacity of regional centres to reach out to people in their broader catchment areas and to provide clinical support to rural generalists in these catchments. (The need to avoid too much reliance on single services in central places is illustrated by the fact that there are more than 1400 towns of 200 to 5000 people and about 140 in the range 5000-18,000 who will have the same need for these types of services as people in the Major Cities.)

[1] data from the US indicate that, on average, a person with depression also has three other chronic conditions.

Tasking of Medicare Locals to develop integrated patient pathways with acute mental health care: Medicare Locals should be specifically tasked to work with Local Hospital Networks to develop integrated patient pathways including for those with more acute mental health needs.

There will be a critical need for coordination between Local Hospital Networks and Medicare Locals to develop flexible patient pathways for people with mental illness, to reduce the need for hospitalisation for such people, and to ensure well-managed discharge of acute patients back into community and primary care.

3. Further investment in aged care in rural and remote communities

Both community and residential aged care services in rural and remote areas struggle to address the growing need and the higher costs they face. The Budget should invest in this growing area of need through support for rural aged care services to recruit and retain staff, adopt new technology and meet increasing standards of safety and quality. The measures should include a Rural and Remote Aged Care Infrastructure Grant to expand the range of services provided and upgrade residential and community aged care facilities in areas of need.

A 2010 report from the AIHW, *Residential aged care in Australia 2008-09,* showed that country regions other than Very Remote had a shortfall compared with Major Cities of at least 2 per cent in the provision of aged care places. If adjusted for Aboriginal aged care needs for people age 50-69, the provision of aged care places falls short nationally by an additional 2.9 per cent. Given that 70 per cent of Aboriginal people reside in rural and remote Australia, it can be concluded that most of this additional shortfall would also be in rural areas. With government aged care outlays of $10 billion in 2008-2009, the Alliance considers that aged care provision in regional rural and remote areas could be short by close to $500 million per annum, even before considering the higher costs of providing aged care services in rural and remote areas.

The viability of aged care services for people in rural and remote communities - and thereby their choice and access - is affected by the higher cost of goods and services, due both to their freight component and the relatively small volumes. In addition, smaller rural populations do not provide opportunities for the economies of scale in services that are available to major city services. Further, rural services will generally have higher costs for attraction and retention of staff, with the need in some communities to provide suitable accommodation.

In addition, people in rural areas have generally higher health needs, poorer health services provision and lower socio-economic status - all of which contribute to higher per capita need for aged care support, on top of the needs of larger proportions of Aboriginal people. Any co-contribution scheme for aged care in rural and remote communities, now or in the future, must be adjusted for capacity of the clients to pay.

For these reasons rural aged care services have less potential for raising the capital through accommodation bonds to pay for new technologies, extend the services they provide and keep up with increasing standards of safety and quality. For example, building or upgrading treatment and training rooms in rural and remote aged care facilities that would enable them to accommodate allied health and medical specialist outreach visits, may well be beyond reach. There may well be insufficient capital available for establishing video-conferencing facilities to better link local aged care professionals and their clients with multidisciplinary

care teams in regional centres, for example through the roll-out of new telehealth initiatives. Services in rural and remote areas also struggle to keep up with their urban counterparts with such things as the purchase and installation of infrastructure for new technology and the associated costs of staff training and technical support.

One service model that has demonstrated its capacity to overcome natural challenges to aged care in rural and remote communities is the Multi-Purpose Service (MPS). The Alliance supports further development of this approach. With Commonwealth funding for aged care pooled with State funding for acute care and some Home and Community Care and other funding, MPSs have the capacity for economies of size and scale.

The deficiencies and challenges for healthy ageing and aged care in rural and remote communities warrant immediate attention which should include:

- improved reporting by remoteness classification on the delivery of aged care services, taking account of the Aboriginal population aged 50-69 years of age, and through Medicare Locals' Healthy Community reports on the relationship between the availability of aged care services and avoidable or prolonged hospitalisations;
- 'catch-up' aged care places: rural and regional Australia should get priority in further allocations of aged care places to allow catch-up to Major Cities rates of service provision;
- further refinement of the aged care Viability Supplement to offset the higher cost of providing both community and residential aged care places in rural and remote communities through adjustments for catch up and then maintenance of the actual costs of providing the services;
- strengthening and further expansion of the Multi-Purpose Service (MPS) program by accelerating the roll-out of extra aged care beds in existing MPSs; further expanding the number of MPSs to cover towns of up to 12,000 population in the catchment; and recognising increasing costs of daily care for clients with ageing-in-place; and
- having a targeted National Rural and Remote Aged Care Infrastructure Grant round, complementary to Primary Care Infrastructure Grants and the National Health and Hospitals Fund regional funding round, to expand and upgrade the services that aged care facilities offer to rural and remote communities and to improve the safety and quality of caring for older people.

4. Oral and dental health

Immediate measures to overcome the severe oral health workforce shortage in rural and remote communities should be coupled with the establishment of a new Commonwealth Dental Health Program.

The ABS Census of Population and Housing 2006 reported the distribution of oral health workers as follows:

Dental workers employed, per100,000 population, by remoteness, 2006

Major cities	Inner regional	Outer regional	Remote	Very remote
159	119	100	60	21

The oral health outcomes of people in rural and remote Australia are substantially worse than those of urban people, with surveys showing that rural people aged 25-44 were only half as

likely to visit a dentist as city dwellers in the same age group. About 40 per cent of Aboriginal and Torres Strait Islander people avoided some foods because of dental problems, and child dental health was significantly worse with increasing remoteness from Major Cities, with the lack of access to fluoridated water being one contributing factor. Despite the greater need for care, a 2005 AIHW study of the dental health workforce showed that rural and remote Australians enjoy less than half the access to dental health services of their urban counterparts. This pattern of greater need shows that any oral health plan must have clear and effective distributional measures.

The Alliance supports the establishment of a new Commonwealth Dental Health Program, with a particular condition that it specifically focus on improving equity of access to people in rural and remote areas, including Aboriginal communities, and is able to report annually on the actual distribution of such services. Special arrangements for service provision may be necessary, such as visiting dentist and other oral health worker services, and contracting of service provision to existing private providers in rural and remote areas, coupled with a greater emphasis on oral health in rural health infrastructure programs.

The unacceptable disparities in workforce distribution must be addressed as a matter of urgency to ensure that people in rural and remote areas benefit proportionately from the new CDHP and other services. Immediate measures to improve access to the oral health workforce should include phasing in - over 5-10 years – of a foundation year for graduate dentists as infrastructure and professional mentoring and support is developed. Incentives such as scholarships for rural students of dentistry and oral health sciences and HECS debt reductions for rural practice should be introduced and scaled for remoteness, along with locum relief services.

Conclusion

The 2011-12 Federal Budget provides an opportunity to continue to address the $2.1billion rural health deficit recently confirmed by the NRHA. At a time of considerable fiscal constraint, the emphasis in funded new policy proposals should be on programs that will both meet the Government’s current commitment to regional areas and result in reduced inequity in access to good health and good health services.

Attachment

Member Bodies of the National Rural Health Alliance

ACAP (RRSIG)	Australian College of Ambulance Professionals (Rural and Remote Special Interest Group
ACHSM	Australasian College of Health Service Management
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AHHA	Australian Healthcare & Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association
ANF	Australian Nursing Federation (rural members)
APA (RMN)	Australian Physiotherapy Association Rural Member Network
APS	Australian Paediatric Society
ARHEN	Australian Rural Health Education Network Limited
CAA (RRG)	CRANAplus – the professional body for all remote health
CHA	Catholic Health Australia (rural members)
CRANAplus	Council of Remote Area Nurses of Australia Inc
CWAA	Country Women's Association of Australia
FS	Frontier Services of the Uniting Church in Australia
HCRRA	Health Consumers of Rural and Remote Australia
ICPA	Isolated Children's Parents' Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NRHSN	National Rural Health Students' Network
RACGP (NRF)	National Rural Faculty of the Royal Australian College of General Practitioners
RDAA	Rural Doctors' Association of Australia
RDN	Rural Dentists Network
RHWA	Rural Health Workforce Australia
RFDS	Royal Flying Doctor Service of Australia
RHEF	Rural Health Education Foundation
RIHG (CAA)	Rural Indigenous and Health-interest Group of the Chiropractors' Association of Australia
RNMF (RCNA)	Rural Nursing and Midwifery Faculty of the Royal College of Nursing Australia
ROG (OAA)	Rural Optometry Group of the Australian Optometrists Association
RPA	Rural Pharmacists Australia—Rural Interest Group of the Pharmacy Guild of Australia, the Pharmaceutical Society of Australia and the Society of Hospital Pharmacists of Australia
SARRAH	Services for Australian Rural and Remote Allied Health