NATIONAL RURAL HEALTH ALLIANCE INC.

ABN: 68 480 848 412

National Rural Health Conference
Australian Journal of Rural Health

PO Box 280 Deakin West ACT 2600
Phone: (02) 6285 4660 • **Fax:** (02) 6285 4670
Web: www.ruralhealth.org.au • **Email:** nrha@ruralhealth.org.au

Submission

to

National Commission of Audit

December 2013

This Submission is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies.

The need for Government engagement in health

The Australian health sector encompasses one of the functional areas of governance in which the Commonwealth, State/Territory and local government all have legitimate functions. Efforts have been made in the past decade, usually under the rubric of 'national health reform', to effect some rationalisation, particularly where the functions and services of the Commonwealth and State/Territory governments are concerned.

With respect to the health sector it is therefore timely for the Commission of Audit to review the activities of the Commonwealth Government to: ensure taxpayers are receiving value-for-money from each dollar spent; eliminate wasteful spending; identify areas of unnecessary duplication between the activities of the Commonwealth and other levels of government; identify areas of programs where Commonwealth involvement is inappropriate, no longer needed or blurs lines of accountability; and improve the overall efficiency and effectiveness with which government services and policy advice are delivered.

One of the principles guiding the Commission's work is that "government should do for people what they cannot do, or cannot do efficiently, for themselves, but no more."

In order to determine what adherence to this principle would mean for health there must be an understanding of the extent to which there is market failure in the delivery of health services – exemplified in many rural and remote communities. There is wide variation in the extent to which individuals and particular population groups have information about their own health and about health and health-related services. A substantial proportion of the total costs of providing health services are borne by individuals, meaning that those with limited financial means miss out on even fundamental health services such as access to a GP. There are severe and ongoing mal-distributions of health professionals given critical mass issues for both public and private sector services, making access harder and more costly for people in rural and more remote areas.

All of this means that the capacity of people to care for themselves where health services are concerned depends, among other things, on location as well as financial means.

However the unequal capacity of individuals to be and to remain healthy goes further than this; it goes to early childhood development, educational attainment, access to and capacity for work and income, housing circumstance. Differences in such variables as these mean that various individuals and families have quite distinct prospects for good health. Those who do not have the opportunity to become or remain healthy in a free market situation are more likely than others to pass poor health to their next-generation.

Governments should intervene to support the provision of services related to health and wellbeing to ensure a fair go for people who bear the brunt of market failure in relation to health and health-related services.

Which Government(s)?

One of the main questions being considered by the Commission is which level/s of government should be involved, where there is duplication and where there is a case for the direct involvement of the Commonwealth.

Given the relative power of its purse and without fundamental changes in taxation arrangements, the Commonwealth will have to remain the principal player in health financially, even where the States already have or might be given the primary responsibility for the delivery of services. This, coupled with the right and proper interest of the funder in how the money is spent, is perhaps the most "compelling case" for the Commonwealth to remain directly involved with the health sector.

The Commonwealth Government is responsible for the two national subsidy schemes, Medicare and the Pharmaceutical Benefits Scheme. It has shared responsibility for the funding of public hospital services, for subsidising private health insurance, funding for some public health programs and for aged care; for the national health research effort; the health of Veterans; Indigenous health; primary health; and regulation such as for the safety and quality of pharmaceuticals.

State and Territory Governments contribute funding for and deliver a range of health care services, including shared responsibility with the Commonwealth for public hospitals; community health services (including services specifically for Indigenous people); ambulance services; public health programs such as infectious disease control and health promotion campaigns; public dental and mental health programs; palliative care; and the licensing and registration of private hospitals, medical practitioners and other health professionals.

The financial bickering and cost shifting that these complex arrangements result in are better known in the health sector than in any other sphere of governance. State-funded public hospitals can refer discharged patients for care to their Commonwealth-subsidised GP instead of providing post-hospital services directly. Conversely, if patients have difficulty in accessing GP services (for example, in more remote areas where there are no GPs; or after hours in other places), they may attend State-funded hospitals for primary care.

Specific agreements between the Commonwealth and the States and Territories have from time to time been struck in an attempt to effect reform in such areas as the interface between hospitals, primary care and aged care; and continuity in cancer care and mental health services.

Intra-government

There are also many challenges relating to collaboration and effectiveness across Departments or areas within each level of government. Anything that can be done to reduce the disjunction between the various health-related responsibilities across the Commonwealth Government will be welcomed and applauded by health interest groups. It has long been realised that a 'whole of government' or 'joined up government' approach to health will save substantial costs by keeping people healthy for longer and out of hospital.

The National Rural Health Alliance is a strong supporter of 'regional impact statements' (or their equivalent), developed in consultation with stakeholders as a means of applying a transparent rural lens to the decisions of agencies whose policies and programs might have particular impact (or much less impact than expected) because of the characteristics of rural and remote communities.

Some jurisdictions overseas and a couple in Australia have what is called a 'health in all policies' approach to the considerations and decisions of agencies whose work has the

capacity to affect health outcomes, such as social services, infrastructure and regional development, communications, education and more.

Regional impact statements and a 'health in all policies' framework can be used both defensively – to protect rural and remote areas from the unintended consequences of new policies and programs – and positively, to try to maximise the beneficial outcomes from particular policies that are enacted.

Adoption of new technologies in service delivery and within government

The NRHA is a strong supporter of new technologies as one means through which the tyranny of distance can be mitigated. Good examples are telehealth and the Personally Controlled Electronic Health Record, both of which have the potential to be particularly beneficial for people in rural and remote areas.

However the rapid move to digital and online communications is another area in which there is substantial market failure in more remote areas. For one thing, access depends on the availability (including cost) of high speed broadband and mobile telephony. Too often there is a focus on the 93 per cent of Australians or Australian homes and businesses that can be provided relatively simply with high-speed broadband, and insufficient thought given to the 7 per cent for whom the technical and financial challenges are greater – where investment may translate more readily into gains in health service delivery.

As new technologies in service delivery and within government are increasingly adopted, special consideration should be given to people for whom connectivity is still a problem.

The fiscal challenge

We note and understand the emphasis given in the National Commission of Audit's Terms of Reference to the integrity of Australia's budget position.

The NRHA welcomes the focus on efficiency and effectiveness of government expenditure through improvements to productivity, service quality and value for money across the public sector, including better delivery of services to the regions. The danger, given that the Commission is not considering government revenues (taxation), is that too much weight might be attached or be seen to be attached to cuts in Commonwealth Government services and in special-purpose payments to other governments, as distinct from an appropriate balance between savings and revenue measures.

It should be remembered that cuts to essential services (i.e. those concerned with unavoidable challenges such as illness or foundational services such as education) impact most heavily on people who are already vulnerable. Progressive taxation, on the other hand, does not. And in aggregate, Australia's vulnerable people include those who live in rural and remote areas. They have less years of completed education and higher costs of accessing tertiary study. People in rural and remote areas are older and a greater proportion of them are living with a disability compared with their city cousins. Services are less readily available to them and often more costly to access. Targeted programs to reduce health risk factors such as smoking, dangerous use of alcohol, and overweight and obesity are less likely to reach them although risk rates are higher. Basic infrastructure, such as for transport and telecommunications, is inferior in rural and remote areas.

These are vital considerations affecting the more than 6.7 million people who live in rural and remote areas of Australia. The NRHA would like to see the Commission's recommendations acknowledge the value and importance of effective health and health-related programs which are targeted at or especially beneficial for individuals, communities and businesses in rural and remote areas in its considerations of the rationalisation and savings to be effected.

Specific health programs

A number of reviews in the health area have already been announced or begun, sensitising interest groups such as the Alliance to the possibilities relating to them.

Medicare Locals

The Alliance is a strong supporter of the concept of Medicare Locals. The expectations of them are considerable, including for such things as filling service gaps and being involved in local workforce recruitment and retention, as well as the tasks set all 61 of them including after-hours primary care and the provision of mental health services.

Some of the 61 Medicare Locals are only a little over one-year-old. All of them are still finding their feet and developing along lines compatible with both the uniform requirements set for them and the flexibility necessary to be fit for purpose in their particular area.

The most important principle in the early stages of their work is for Medicare Locals to bring together all contributors to primary care in health, recognising the centrality of general practice, and providing an element of local engagement for consumers, managers and the full range of practitioners. Aboriginal community controlled health services must also be supported as effective means of meeting local health needs in rural and remote areas - mainly (but not exclusively) for Aboriginal and Torres Strait Islander people.

Given sufficient resources and unequivocal support for them, Medicare Locals will be in a good position to meet expectations of them and collaborate closely with local hospital and health service networks. They need to be provided with growing revenue streams diverted as appropriate from other channels. Over time a greater proportion of Medicare Locals' total income will be untied, enabling them to be more responsive to the needs of the people of their area.

It is to be hoped that eventually Medicare Locals will be able to lead on broad primary health care, through such things as health promotion in schools, targeted support for the wellbeing of population groups like the long term unemployed, those living with a disability and prisoners. Through such work Medicare Locals will be one of the main means through which health expenditure is distributed according to health need. In the medium term this will improve the health of local people, starting with those in greatest need, and reduce the number of avoidable hospitalisations.

Illness prevention and health promotion

Australia currently directs a very small proportion (estimated to be around 3 per cent) of total health expenditure to illness prevention and health promotion. The Alliance is a strong supporter of the work of the Australian National Preventive Health Agency (ANPHA) focused as it is in the early life of that organisation on smoking, alcohol misuse and overweight and obesity. The issue of the differential success Australia has had in reducing the proportion of its people who are daily smokers as between major city areas and rural and remote areas is a matter of the gravest concern. ANPHA is demonstrating capacity to be

effective in relation to such things as anti-smoking campaigns that better target the specific challenges for rural and remote areas.

The work of ANPHA needs to be visible to the public as a separate stream of activity with messages that are clearly based on the best evidence available rather than government-derived, unencumbered by the rigidity of a larger organisation, but still directly accountable to the government of the day for its efficiency and effectiveness.

Health data and evidence

Given its vision and its mode of operation, the Alliance is naturally a keen user of data and evidence relating to health status and the effectiveness of health services in Australia. The Alliance is engaged with, and impressed by, the work of the National Health Performance Authority and the Independent Hospitals Pricing Authority. Both have demonstrated effectiveness in developing baseline measures for health differentials affecting people who live outside the major cities to ensure that the effectiveness of health program implementation and development can be monitored and held to account.

The Alliance is grateful for the work of the ABS, the Australian Institute of Health and Welfare and the COAG Reform Council in terms of the special reporting by rurality they have undertaken or enabled. The Alliance is aware of the difficulty the AIHW has in sustaining a rural and remote focus in the work that it does and is on the record as calling for a new allocation of resources to the AIHW for rural and remote staff capacity.

Mental health

The Alliance has a particular interest in mental illness and mental health services in rural and remote areas. It looks forward to making a submission to the Mental Health Commission for consideration as part of the Commission's review.

Block funding of smaller hospitals

The Alliance has been and remains engaged with the Independent Hospitals Pricing Authority, with the Alliance's particular interest being the way in which smaller hospitals are funded. The principle that smaller hospitals will be funded on the basis of block grants rather than activity is critical to their continued capacity and existence. The Alliance also has a special interest in the Multi-Purpose Service model which sees pooling of State/Territory funds with those from the Commonwealth and provides good examples of the intergovernmental flexibility in funding that is so important, particularly in rural and remote areas.

Conclusion

This brief submission has hopefully given the staff of the National Commission of Audit some understanding of the areas of particular interest and activity of the National Rural Health Alliance. We trust that, armed with such knowledge, the Commission will seek any further information it needs from the Alliance about the particular challenges of Commonwealth Government service delivery in rural and remote Australia.

Member Bodies of the National Rural Health Alliance

ACEM (RRRC)	Australasian College of Emergency Medicine (Rural, Regional and Remote Committee)
ACM (RRAC)	Australian College of Midwives (Rural and Remote Advisory Committee)
ACHSM	Australasian College of Health Service Management
ACM (RRAC)	Australian College of Midwives (Rural and Remote Advisory Committee)
ACN (RNMCI)	Australian College of Nursing (Rural Nursing and Midwifery Community of Interest)
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AHHA	Australian Healthcare and Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association
ANMF	Australian Nursing and Midwifery Federation (rural members)
APA (RMN)	Australian Physiotherapy Association Rural Member Network
APS	Australian Paediatric Society
APS (RRPIG)	Australian Psychological Society (Rural and Remote Psychology Interest Group)
ARHEN	Australian Rural Health Education Network Limited
CAA (RRG)	Council of Ambulance Authorities (Rural and Remote Group)
CHA	Catholic Health Australia (rural members)
CRANAplus	CRANAplus – the professional body for all remote health
CWAA	Country Women's Association of Australia
ESSA (NRRC)	Exercise and Sports Science Australia (National Rural and Remote Committee)
FRAME	Federation of Rural Australian Medical Educators
FS	Frontier Services of the Uniting Church in Australia
HCRRA	Health Consumers of Rural and Remote Australia
IAHA	Indigenous Allied Health Australia
ICPA	Isolated Children's Parents' Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NRF of RACGP	National Rural Faculty of the Royal Australian College of General Practitioners
NRHSN	National Rural Health Students' Network
PA (RRSIG)	Paramedics Australasia (Rural and Remote Special Interest Group
PSA (RSIG)	Rural Special Interest Group of the Pharmaceutical Society of Australia
RDAA	Rural Doctors Association of Australia
RDN of ADA	Rural Dentists' Network of the Australian Dental Association
RFDS	Royal Flying Doctor Service
RHEF	Rural Health Education Foundation
RHWA	Rural Health Workforce Australia
RIHG of CAA	Rural Indigenous and Health-interest Group of the Chiropractors' Association of Australia
ROG of OAA	Rural Optometry Group of the Australian Optometrists Association
RPA	Rural Pharmacists Australia
SARRAH	Services for Australian Rural and Remote Allied Health
SPA (RRMC)	Speech Pathology Australia (Rural and Remote Member Community)