NATIONAL RURAL HEALTH ALLIANCE INC.

# Section 1

# RURAL HEALTH - 30% FAIR SHARE

**This Position Paper represents the agreed position of the twenty-two Member Bodies of the National Rural Health Alliance but not necessarily the entire view of all individual Member Bodies.**

# RURAL HEALTH - A 30% FAIR SHARE

## As at December 2000

The **National Rural Health Alliance**, the peak non-government rural and remote health organisation, **notes** that:

1. The health status of people in rural and remote areas is generally poorer than that of people in metropolitan areas, with higher incidences of cardio-vascular disease, preventable accidents, mental illness, cancer and diabetes. Health status declines along a continuum as one moves away from metropolitan centres to rural and remote locations.

   Death rates in the remote zone are the highest with rates among males and females in 'other remote areas' 22% and 32% higher respectively than males and females in capital cities (AIHW 1998)[1].

2. Key factors contributing to this poorer status include lower socio-economic and employment levels, risky behaviours, occupational and environmental hazards, and a lack of access to health services.

   Thirty three of the poorest electorates in Australia are rural electorates, with the average weekly earnings of families and individuals in these areas considerably lower than the national average.[2]

   Critical shortages of health professionals combined with the lack of public transport networks in rural and regional areas make access to health services very difficult for the financially disadvantaged, the aged, disabled and people who do not drive.

   The Australian Consumers' Association (1998)[3] states that people in rural and remote areas, including those on Health Cards, have considerably less access than urban dwellers to General Practitioners (GPs) who bulk-bill.

3. Australia's Aboriginal Peoples and Torres Strait Islanders continue to experience poorer health than the general Australian population. The life expectancy for indigenous people is 20% lower than for the general community. Life expectancy for indigenous males is 56.9 years compared to 75.2 years for the total male population and 61.7 years for indigenous females compared to 81.1years for the total female population. [4]

4. The profile of Australia's rural population is ageing, placing increasing demands on the health and community services in rural and remote areas. The older population of rural communities is not homogeneous but includes people on farms, properties, stations, mines, fishing and tourism areas, retired manual and farm workers, people from different cultural and linguistic backgrounds, retirees from urban areas and Aboriginal Peoples and Torres Strait Islanders.

   Evidence presented at the National Rural Public Health Forum in 1997 showed that rural older people use health services more frequently than younger people, with twice as many General Practitioner consultations and three times more hospital admissions.

5. The National Rural Health Alliance defines 'rural' as all areas of Australia except the capital cities and Townsville, the Gold Coast, Newcastle, Gosford-Wyong, Wollongong and Geelong. Based on the 1996 Census figures, 69.63% or 13 028 900 people live in these areas. The remaining 30.37% of Australia's 18.7m people live in rural, regional or remote areas.

6. Lack of access to GP services is a major risk factor for the health of people in rural and remote communities. Even though 30% of the Australian population lives in rural areas as defined, only 22% of male GPs and 17% of female GPs practise there. The result is a rural GP shortage of 500-750, with critical shortages in the specialties of psychiatry, obstetrics and anaesthesia.

   A lack of other health professionals is also undermining the delivery of health services to people in rural and remote areas. These include nurses and midwives, dentists and members of the allied health professions.

7. Cost-shifting and buck-passing between the Federal and State/Territory governments on health responsibility compromise the development and operation of appropriate services in rural and remote areas.

   In addition, policies of economic rationalism and the centralisation of health services in the name of efficiency and deficit reduction have impacted most heavily on small rural and remote communities.

   The closure or partial closure of smaller rural hospitals has meant that rural people must travel considerable distances for minor procedures and routine operations as well as the delivery of their babies.

8. The Commonwealth provides funding for medical services provided by private practitioners through the Medical Benefits Schedule (MBS) and for medicines provided by privately owned community pharmacies through the Pharmaceutical Benefits Scheme (PBS). Together, these programs account for 48% of the Commonwealth's health budget.[6] The table below outlines the financial contribution of the main players in the healthcare system.

9. Recurrent health Expenditure[1], 1997-98

| Area of Health | Government sector | | Non-Government sector | | | |
|---|---|---|---|---|---|---|
| | Commonwealth | State & Local | Health insurance funds | Individuals | Other[2] | Total Non-Govt |
| | ($m) | ($m) | ($m) | ($m) | ($m) | ($m) |
| Medical | 6970 | - | 217 | 897 | 419 | 1533 |
| Pharmaceuticals | 2785 | 16 | 34 | 2463 | 37 | 2534 |
| Public hospitals[3] | 5793 | 6437 | 311 | 97 | 602 | 1010 |
| Private hospitals | 550 | - | 2295 | 321 | 493 | 3109 |
| Nursing homes | 2575 | 1437 | - | 608 | - | 608 |
| Administration, public health, dental services | 1380 | 2086 | 1080 | 1611 | 8 | 2699 |
| Research | 427 | 96 | - | - | 129 | 129 |
| Other professionals | 219 | - | 214 | 1046 | 173 | 1433 |
| Other[4] | 438 | 281 | 283 | 564 | 76 | 923 |
| **Total each sector** | **21137** | **9053** | **4434** | **7607** | **1937** | **31.6** |
| **% each sector** | **47.8** | **20.5** | | | **13978** | |

Source: 6, p 13

[1] Not adjusted for personal income tax rebate for net medical expenses

[2] Includes Workers' Compensation and Motor Vehicle Third Party insurers

[3] Includes acute, repatriation and psychiatric hospitals

[4] Includes ambulances, aids and appliances and other institutional expenditure

10. The backbone of the Australian health system is the publicly funded Medicare program. While eligibility for Medicare is unaffected by location of residency, difficulty recruiting a full range of health professions, in combination with long distances, means that access to the services provided through Medicare can sometimes be more difficult in rural and remote areas.[6]

11. On average, people in rural communities receive only $92 per year in Medicare services compared with $145 in urban areas. The difference is even starker in remote areas. According to the AIHW (1998)[1] the rate of GP consultations in 'other remote areas' was less than 50% of the rate in 'capital cities'. For example, in NSW, the average person has access to $363 of Medicare benefits per year, whereas someone in the Kimberley or Pilbara, is accessing only $66 per year.

    Some of this gap may be offset by the increased use of other services in rural and remote areas, such as hospital services, salaried community medical services (including the Aboriginal Medical Services) and other primary care providers such as Aboriginal Health Workers and remote area nurses. However, the use and availability of non-Medicare services does not fully compensate for the discrepancy between rural/remote and urban benefits from Medicare.

12. Based on the 92:145 ratio, rural people are $250m worse off in terms of Medicare rebates for GP services. Lack of access to a GP is the most significant factor explaining this difference.

    Rural people receive $460m (19.6%) of the total $2.3b of Medicare rebates for non-referred consultations. $250m in additional Medicare funds would achieve the "30% fair share" for rural people on this measure alone.

13. Low income and lack of access to or choice of medical practitioner or hospital in rural and remote areas are also major reasons for the low take-up of private health insurance. There is a major debate about the rebate to private health insurance. Whatever the view on this debate it is certain that rural and remote people have less to gain from the rebate, and from the private health system, than people in the major cities.

14. The changed administrative arrangements within the Department of Health and Aged Care provide for the better co-ordination of rural health issues. In particular, the establishment of the Office of Rural Health and the significant new allocation to rural general practice in budget 2000 is welcomed by the Alliance.

## The **National Rural Health Alliance affirms** that:

15 Access to affordable health care is a basic human right that should not depend on a person's socio-economic status, religion, gender, sexual preference, ethnic background or geographical location.

16. Health status is closely linked to socio-economic and employment status, social and geographic location and education level. It is therefore impossible to consider health in isolation from other social and economic factors. Rural and remote areas need their 30% fair share of allocations to physical and human infrastructure, as well as a loading to reflect the higher cost of infrastructure development and its poorer status. The most important parts of this infrastructure are education, transport and telecommunications.

17. The poor health status of our Indigenous population is a national disgrace. The principle of 'worst first' should therefore be pursued in addressing the health problems of rural and remote areas. This requires a commitment to increase health resources to Indigenous communities. Currently only 23 cents per head is spent on Indigenous health for every one dollar per head spent on non-Indigenous health.

18. The loss of a range of health, social welfare, retail and other services from small rural communities has impacted negatively on the physical and mental well-being of people in these communities.

19. The maintenance of a publicly funded universal health insurance scheme is critical to the provision of affordable and accessible health care to all Australians.

20. Member Bodies support the principles of Healthy Horizons and work by the Commonwealth States and Territories to implement them. The Member Bodies themselves will continue to monitor their own developments with the goals of Healthy Horizons.

21. The lack of health and medical services in rural and remote communities is a critical risk factor affecting the health status of rural and remote people.

22. There is a need for more funding to address the shortages of health professionals in rural and remote locations. In addition to its initiatives to improve the recruitment and retention of GPs and pharmacists to rural and remote areas, the Federal Government should accept greater responsibility for providing incentives and support for Aboriginal Health Workers, nurses and allied health professionals working in rural and remote areas. These could include scholarships and other support for undergraduate and post-graduate training as well as support for existing workforce.

23. Member Bodies will seek from governments across the board a commitment to a '30% fair share' of the overall health dollar for the 30% of the Australian population that lives in rural and remote areas. The funding for rural and remote people should be spent in rural and remote areas.

24. The development of integrated and flexible regional public transport networks is critical to improving access to health services in rural areas.

25. Community consultation must be an integral part of the planning, development and organisational phases for a Regional Health Services facility. The process of community consultation must not be hurried but allow for all stakeholders to have their views, both positive and negative, considered in a non-threatening manner. The termination of acute care service should not be seen as a trade-off for the development of a Regional Health Services facility.

## The **National Rural Health Alliance resolves** to:

26. Work with the Federal and State and Territory Health Departments for implementation and evaluation of the principles and actions of 'Healthy Horizons'.

27. Strongly support initiatives and funding to improve the health status of Australia's Indigenous population.

28. Continue to lobby Federal and State Governments for flexible health and aged care services that suit rural and remote communities,

29. Continue to lobby Federal and State Governments for funding of integrated and flexible regional public transport networks to improve access to health services in rural areas.

30. Seek a commitment from the Federal, State and Territory Governments to a "30% Fair Share" of the overall health dollar for the 30% of Australians that live outside the metropolitan centres.

31. Maintain the close working relationship with the Office of the Minister for Health and Aged Care, the Office of Rural Health and other Departmental staff to highlight the issues of concern for rural and remote people and health practitioners in rural and remote locations.
32. Support widespread consultation in implementation of the Regional Health Service program to ensure that the services provided are flexible and suit local conditions.
33. Seek additional funding from the Federal Government to provide incentives and support for the recruitment, retention and support of nurses and allied health professionals to rural and remote areas.
34. Continue its support for the development and application of models of service delivery that include outreach, mobile teams, and hub and spoke approaches.
35. Push for further consideration of the relative costs of general practice and its complexity as between metropolitan and rural/remote areas. Among other things, the results of such further study would inform the debate about whether Medicare in rural and remote areas should provide differential rebates for different areas or different types of practice. The argument for a higher rebate in rural and remote areas includes the assertion that it would result in the attraction of more general practitioners and that it would lead to a higher rate of bulk billing.
36. The bilateral Medicare agreements between Commonwealth and States must provide that at least 30% of State's health budget is expended in rural and remote areas of the States and mandate the measurement and monitoring of this principle.

## References:


1. Australian Institute of Health and Welfare 1998, Health in Rural and Remote Australia, AIHW Cat. No. PHE 6, AIHW, Canberra.
2. Human Rights & Equal Opportunity Commision (HREOC), Sydney.
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4. ABS & AIHW, 1999, The health and welfare Australia's Aboriginal and Torres Strait islander peoples, ABS Cat No. 4704.0. AIHW Cat No. IHW 3, ABS & AIHW, Canberra.
5. Australian Institute of Health and Welfare 2000, Australia's Health 2000, AIHW, Canberra.
6. DH&AC & NRHA, 2000, Health Financing in Rural and Remote Australia- a background paper, Canberra.


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