5

Rural and regional health services

Equity and efficiency are touted as fundamental attributes of our health system. In practice, however, major inequities and inefficiencies in the distribution of resources, services and funding, particularly between urban and rural areas, make a mockery of these principles.[1]

5.1 People living in regional, rural and remote parts of Australia are generally at a disadvantage in accessing health care services compared to their city counterparts.

5.2 This chapter examines some of the factors that contribute to reduced access for communities outside of the major urban areas and considers some funding options for governments to address the major inequities.

5.3 As noted in chapter 4, health workforce shortages are more pronounced the greater the distance from urban areas. High quality health care services cannot be delivered without an appropriate number and mix of skilled health professionals. Health workforce training and funding arrangements need to support an equitable distribution of health carers so some communities do not miss out on the health care they need.

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1 Rural Doctors Association of Australia, sub 31, p 5.

Regional, rural and remote disadvantage

5.4 Approximately 34 per cent of Australians live outside major urban areas.[2] There are clear, measurable differences in health outcomes and health risk factors between Australia's urban and rural populations (figure 5.1). The National Rural Health Alliance noted that:

> in aggregate, health status is poorer outside the capital cities, health risk factors are more common, and the range of services narrower and more costly to access. There is evidence of worse health outcomes in remote and very remote areas, not all associated with the higher proportion of Indigenous population in remote areas.[3]

Figure 5.1 Selected health indicators, by remoteness area

	Major City	Inner Regional	Outer Regional	Remote	Very Remote
			Standardised ratio		
Males <65 years with profound/severe activity restriction (1998)[(a)]	1.00	1.57	1.46	n.a.	n.a.
Females <65 years with profound/severe activity restriction (1998)[(a)]	1.00	1.27	1.03	n.a.	n.a.
Pertussis notifications (2001)	1.00	*1.31	*1.88	*1.90[(b)]	*1.90[(b)]
Ross River virus notifications (2001)	1.00	*3.15	*4.85	*8.71[(b)]	*8.71[(b)]
Perinatal deaths (1999–2001)	1.00	*1.13	*1.28	*1.43	*2.42
Deaths (all ages, 1997–1999)	1.00	*1.06	*1.10	*1.13	*1.50
Deaths, non-Indigenous (all ages, 1997–1999)	1.00	*1.05	*1.08	*1.03	0.95
Death >74 years, non-Indigenous (1997–1999)	1.00	*1.03	*1.04	*0.93	0.71
Death <65 years, non-Indigenous (1997–1999)	1.00	*1.11	*1.15	*1.13	*1.21
			Number		
Average DMFT teeth in 6 year olds (1998)[(a)(c)]	1.45	1.93	1.87	1.71	1.88
Average DMFT teeth in 12 year olds (1998)[(a)(c)]	0.84	0.98	0.85	1.02	1.09

(a) Statistical significance is not available for these results.

(b) These ratios are not specific to Remote or Very Remote areas, but are averages for remote areas generally.

(c) Decayed, missing and filled permanent teeth. See Chapter 2.

Notes

1. Reported standardised ratios are indirectly age-standardised using Major Cities age-specific rates. The ratios are a way of comparing the levels of health in various areas with that in a reference area, in this case Major Cities. A ratio of 1.5 for mortality, for example, indicates that there were 1.5 times as many deaths as expected had the age-specific rates for Major Cities been applied to the population in that area.
2. Ratios that are statistically different to 1.00 are marked with an asterisk (except for activity restriction and DMFT teeth, for which information on statistical significance was not available).

Source *Australian Institute of Health and Welfare, Australia's health 2006 (2006), p 243.*

2 Australian Institute of Health and Welfare, *Australia's health 2006* (2006), p 241.

3 National Rural Health Alliance, sub 59, p 3.

5.5 The Rural Doctors Association noted that standardised mortality data show death rates in Australia increase with rurality:

> Australians living in regional, rural and remote areas are 10% more likely to die of all causes than those in major cities, and 50% more likely to do so if they live in very remote areas. Life expectancy also declines as rurality increases: from 77.9 to 72.2 for males and 83.9 to 78.5 for females. The main specific causes of higher death rates outside Major Cities include ischaemic heart disease and 'other circulatory diseases', chronic obstructive pulmonary disease, motor vehicle accidents, diabetes, suicide, other injuries and prostate, colorectal and lung cancer, many of which are largely preventable.[4]

5.6 Access largely depends on the presence of appropriate numbers of skilled health professionals, the availability of infrastructure such as a hospital or community medical centre and the affordability of services.

5.7 In general terms, there are fewer health professionals per capita and people often live great distances away from town centres. The more chronic or urgent the problem, then the more difficulty in accessing the specialist treatments required. The Productivity Commission noted that:

> For patients, access to primary and emergency care services can be many hours away, potentially impacting on health outcomes. And access to more specialised services, only available in major population centres, involves even longer travel times, and greater financial costs and disruption to family life and work.[5]

5.8 While access to medical specialists may be limited in more sparsely settled areas, the geographic spread of nursing professionals is relatively even (table 5.1).

4 Rural Doctors Association of Australia, sub 31, p 6.

5 Productivity Commission, *Australia's Health Workforce* (2005), p 203.

Table 5.1 Health workforce — Persons employed in selected health occupations per 100,000 population, by remoteness areas, 2003

Occupation	Major cities	Inner regional	Outer regional	Remote	Very remote	Total
Medical practitioners	**326**	**179**	**155**	**154**	**130**	**283**
NSW	327	179	107	76	66	327
Victoria	338	173	132	211	. .	338
Queensland	296	157	154	71	78	296
South Australia	387	135	133	130	87	387
Western Australia	279	114	128	145	168	279
Tasmania	. .	354	138	111	121	. .
Northern Territory	. .	. .	537	460	170	. .
ACT	n.p.	n.p.	. .	. .	. .	n.p.
Nurses (a)	**1,120**	**1,166**	**1,115**	**1,193**	**1,082**	**1,120**
NSW	1,010	1,180	1,044	1,044	1,305	1,115
Victoria	1,246	1,387	1,497	1,350	. .	1,355
Queensland	1,013	981	967	891	1,164	1,038
South Australia	1,434	784	1,251	1,281	1,238	1,434
Western Australia	1,068	755	1,144	1,083	1,195	1,076
Tasmania	. .	1,520	875	706	1,726	1,331
Northern Territory	. .	. .	1,541	2,236	813	1,575
ACT	n.p.	n.p.	. .	. .	. .	1,182
Dentists	**57.6**	**34.5**	**27.7**	**18.1 (b)**		**48.7**

Note *(a) Includes registered and enrolled nurses.*

(b) Combined average for remote and very remote areas.

n.p. not published. . . not applicable. Regional rates for medical practitioners exclude 1,870 practitioners who did not report the region in which they worked, whereas the total includes these practitioners.

Some practitioners make regular visits outside their place of residence and therefore lower numbers of medical practitioners per 100,000 populations may understate the number of people providing health services to people living in remote areas.

Source *Australian Institute of Health and Welfare (AIHW), Australia's health 2006 (2006), pp 325–329; AIHW, Medical labour force 2003 (2005), Table 2.8; AIHW, Nursing and midwifery labour force 2003 (2005), Table 12; Australian Institute of Health and Welfare, Australia's health 2004 (2004), p 262.*

Sustainable regional and rural health workforce

5.9 As discussed in chapter 4, there are a number of broad issues that need to be addressed to provide for an increased number of well trained health professionals. Inquiry participants also noted a range of health workforce issues that specifically related to attracting and

retaining health professionals outside of the major capital cities including:

- the availability of appropriate infrastructure to support the required broad range of health services and provide a supportive and stimulating environment for health professionals to work and train;[6]
- providing appropriate financial and other incentives to ensure that sufficient numbers of health professionals are attracted and retained in regional and rural areas;[7] and
- the need to support different models of care and provide specific training and assistance for regional and rural health professionals.[8]

5.10 The committee notes that as part of the COAG's health workforce response in July 2006, the Australian Health Ministers' Conference will ensure that all broad institutional health workforce frameworks make explicit provision to consider the particular requirements of rural and remote areas.[9]

5.11 The committee also noted that COAG has asked that health ministers to undertake work and provide proposals, involving both Commonwealth and state government programs, to COAG by mid-2007 on ways to improve rural and remote health service delivery.[10]

5.12 The committee supports these developments, and considers that the health ministers should address some of the particular concerns outlined by inquiry participants below.

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6 Dr Ross Cartmill, sub 107, p 4; National Rural Health Alliance, sub 59, p 3; Australian Institute of Medical Scientists, sub 12, p 2; Clout T, Hunter New England Health, transcript, 20 July 2006, p 22.

7 Kidd M, Royal Australian College of General Practitioners, transcript, 5 July 2005, p 58; Clout T, Hunter New England Health, transcript, 20 July 2006, p 11; Marion O'Shea, sub 89, p 3; Dr Vladimir Vizec, sub 73, p 2; Local Government Association of NSW and Shires Association of NSW, sub 18, p 9.

8 Chater B, Australian College of Rural and Remote Medicine, transcript, 16 March 2006, p 30; O' Reilly B, Australian Dental Association, transcript, 5 July 2005, p 6; Western Australian Local Government Association, sub 34, p 8.

9 Council of Australian Governments, *Communique*, 14 July 2006.

10 Council of Australian Governments, *Communique*, 14 July 2006.

Infrastructure and training opportunity support

5.13 Several inquiry participants pointed to clear evidence that training of the health workforce in regional and rural areas was more likely to lead to trainees working in these areas sometime in the future.[11] Professor Wronksi noted the example of recent graduates from James Cook University in Townsville:

> We have had one graduation of medical students. Thirty-seven of the incoming cohort of medical students came from North Queensland and seven were from interstate. In terms of internship positions, 51 of 58 have stayed in Queensland, 31 are working in North Queensland and seven have gone interstate. There is no doubt that rural origin as well as where you train are the most significant predictors of where you are likely to work.[12]

5.14 Health workforce trainees can also benefit from spending parts of their training in regional and rural areas. The Australian College of Rural and Remote Medicine told the committee that:

> There is often a concept that you need to do extra things in rural practice; in fact, those extra things are rural practice, and we need to acknowledge that. It is not just city based practice with a bit added on. You really need to understand what it means to treat somebody with a snakebite or with a heart attack in your town. You cannot learn that at the Royal Brisbane Hospital; you have to learn it in practice.[13]

5.15 The Commonwealth and the states have significantly increased their support for training to be conducted in regional and rural areas, with the establishment of over 10 rural clinical schools and new medical schools in regional areas in recent years.[14] Opportunities for more health workforce trainees to spent time in regional areas should increase significantly as rising numbers of trainees enter the training pipeline in the next few years (see chapter 4).

5.16 The committee considers that it is important that funding arrangements for training recognise the value of training in regional

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11 National Rural Health Alliance, sub 59, p 5; Wronski I, transcript, 16 March 2006, p 19; Aboriginal Medical Services Alliance NT, sub 149, attachment A, p 4.

12 Wronski I, transcript, 16 March 2006, p 19.

13 Chater B, transcript, 16 March 2006, p 30.

14 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Tamworth to become a medical training centre*, 14 February 2006.

and rural areas and provide the appropriate funding to conduct high quality training outside of the major urban areas.

5.17 While on the one hand there are opportunities being created to train the future health workforce in regional and rural areas, the committee also noted that there were significant concerns about the impact of the closure of smaller country hospitals on access to health services, the quality of care and training opportunities.[15] The Rural Doctors Association of Australian noted that:

> …the problem … is that the Commonwealth gives the money to the states, (which) … then use their own judgment and discretion subject to their own political pressures, to distribute it. This means that many small rural hospitals are starved of funds, they are downgraded and they close.[16]

5.18 The provision of health services in regional, rural and remote areas needs to take account of how treatment can be best delivered to the patient. In some cases, this may mean that patients in regional, rural and remote areas need to be transported to other areas. The Australian Health Insurance Association noted that:

> We have a community psyche that seems to think a hospital is a place where you go for whatever treatment you need in one facility. All the evidence and all the science which I have read indicates to me that is no longer relevant. It is much safer to go to a hospital which specialises in the sorts of treatments that you need. It is a particular problem in regional Australia where again there is a view that every town must have its own hospital to provide services to the community. That, in fact, is no longer necessarily in the best interests of the patient.[17]

5.19 The Australian Medical Association (AMA) has proposed that a broader 'public interest test' should be applied when governments are looking at closing country hospitals which would consider:

- the impact on the maintenance of skills of the local medical workforce;
- the impact on the health needs of the local community;

15 Rural Doctors Association of Australia, sub 30, p 15; Leishman J, Caboolture Shire Council (Qld), transcript, 17 March 2006, pp 13–14; Western Australian Local Government Association, sub 34, p 8.

16 Stratigos S, Rural Doctors Association of Australia, transcript, 28 June 2005, p 17.

17 Schneider R, Australian Health Insurance Association, transcript, 23 August 2005, p 26.

- the social and employment impacts on the local community; and
- the availability and proximity of alternative resources.[18]

5.20 The committee broadly supports the AMA's proposal, which should lead to governments making more informed decisions about the impact of closing public hospitals or reducing the services they provide.

5.21 The committee considers that the Commonwealth should further examine this proposal as part of its negotiations with the states over the next five-year public hospital funding agreements (see chapter 7). The national health agenda, proposed by the committee in chapter 3, also provides an opportunity for governments to provide communities with a clearer expectation about the standards of service that they will receive.

Incentives

5.22 There are a range of incentives offered by governments for health workforce professionals to work in regional, rural and remote areas. While many health professionals willingly work in these areas without financial and other incentives, there appears to be broad agreement that incentives need to be in place to ensure that access to health professionals is reasonably equitable — particularly in times of workforce shortage.

5.23 Hunter New England Health emphasised that the non-financial elements were also important to attract and retain skilled health professionals:

> … salaries are only one component of things that allow you to attract and retain. For senior clinicians—be they doctors, nurses or allied health staff—sustainability of their capacity to teach, having a range of services that they can provide so that their professional skills are retained and having confidence in the quality of the services that will be provided, being able to be involved in research and having a range of services in which they can ply their trade are also significant parts of the package.
>
> Another package in rural and remote areas is: what is available for the partner? What is their profession? What is

18 Australian Medical Association, media release, *Country Hospitals Must be Kept Viable – AMA*, 25 July 2006.

> available for them in employment? Another issue is: what is available for education of children? How can I do that? What is the package available in relation to that? What are the issues around accommodation? Is it possible to find someone to act in a locum capacity when I want to go on leave? There is absolutely no point in just looking at salaries and wages; you have to look at the whole package. For some people, the driver is salary until you get to a certain level, and then those other things kick in.[19]

5.24 Incentives offered by the Australian Government to attract and retain health workforce in regional areas in recent years include:

- higher payments for selected Medicare Benefits Schedule items to general practitioners providing services in regional and rural areas. For example, doctors in country Australia and Tasmania can claim an extra payment every time they bulk bill a child under 16 or a person with a concession card;[20]
- supporting the continuation of selected specialist services. For example, from November 2006, GPs providing obstetric services in rural and remote areas who deliver 20 or more babies a year will be eligible for a procedural payment of $17,000 per year.[21]
- supporting locum and training for rural health professionals. For example, a recent $500,000 pilot locum relief service for rural specialist obstetricians provided subsidised locum support to 20 rural obstetricians.[22]

5.25 There are also incentives for health workforce trainees and overseas trained doctors migrating to Australia to work in regional and rural areas. For many overseas trained doctors, agreeing to work in an area of workforce shortage is a requirement of their visa and their entitlement to receive Medicare benefits on behalf of their patients.

5.26 Some health workforce trainees are also given incentives to work in regional and rural areas through conditions attached to their training arrangements. For example, the medical bonded rural scholarships

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19 Clout T, Hunter New England Health, transcript, 20 July 2006, pp 6–7.

20 Hon John Howard MP, Prime Minister of Australia, media release, *Medicare plus: Protecting and strengthening Medicare*, 18 November 2003.

21 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Increased support for GP obstetricians in rural Australia*, 8 September 2006.

22 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Pilot project to provide locum relief for rural obstetricians*, 4 July 2006.

program provides an annual scholarship of around $22,300 in return for a requirement that students agree to practice in rural areas of Australia for six years upon completion of their basic medical and postgraduate training.[23]

5.27 Getting the right mix and level of incentives is important. Governments need timely information about the quantity and quality of services delivered in targeted areas and services to ensure that incentives are having the desired effect.

Models of care and support

5.28 Many inquiry participants noted that the delivery of health services in regional and rural areas was generally structured in a more flexible way, allowing for greater degree of task substitution, multidisciplinary approaches to health care and a broader range of roles for general practitioners.[24] While funding arrangements may underpin some of this flexibility, the use of different models of care is also related to health workforce issues.[25]

5.29 Flexible service delivery arrangements are more likely to meet the needs of local communities and be more accepted. The Australian College of Rural and Remote Medicine noted that:

> …immunisations, dressings, smear tests and midwifery. They have been accepted wholeheartedly by the rural groups.
>
> …In my practice I have nurses, visiting psychologists, a social worker and a diabetic educator. All of those people within my practice. They do that very well. They are well accepted by the community and they take a lot of load off.[26]

5.30 As noted in chapter 3, the committee does not generally consider that introducing greater substitutability and flexibility in care models in regional and rural areas is necessarily the best response to providing health services in instances of workforce shortage. The preferred

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23 Department of Health and Ageing, Medical Rural Bonded (MRB) Scholarships, viewed on 19 October 2006 at www.health.gov.au/mrbscholarships.

24 Carnel K, Australian Divisions of General Practice, transcript, 30 May 2005, p 30; Lambert J, Hospital Reform Group, transcript, 29 March 2006, p 9; Australian Physiotherapy Association, sub 118, p 10; Royal Australian College of General Practitioners, sub 66, p 10.

25 Kidd M, Royal Australian College of General Practitioners, transcript, 5 July 2005, p 58.

26 Chater B, Australian College of Rural and Remote Medicine, transcript, 16 March 2006, p 33.

response would be increasing the number of health professionals to the required level to match the community's needs.

5.31 The remaining part of this chapter considers a range of different funding models for the provision of health services to regional and rural areas.

Alternative funding models

5.32 The availability of health workforce in rural and regional areas acts as a cap on what would otherwise be broad access under Medicare to subsidised pharmaceuticals and medical services. Hunter New England Health told the committee that:

> It is also true that if we do not have the workforce in our area health service for the services we provide, people cannot access them. I think that is a problem. I think it is rural and remote communities that are missing out. It is not the sole challenge, but one of the significant challenges for us as a society and for governments in general is how to overcome and change the system of funding we have got at the moment, which causes that perversion, because it is based, at the Commonwealth funding end, on an uncapped model that is dependent upon the workforce.[27]

5.33 The marked variation for selected population centres was highlighted to the committee by the Hunter Urban Division of General Practice, who noted differences between funding levels per person for GP services under the Medicare from $66 per person in northern Queensland to $243 per person in inner Sydney.[28]

5.34 While the Rural Doctors Association supported fee for service arrangements as the basic mechanism for remunerating medical care in regional and rural areas, they also considered that other funding options needed to be examined:

> … introducing further contestability into health care funding arrangements will not deal with the inequitable distribution of health care resources between urban and rural areas. The lack of services and providers means there is little

27 Clout T, Hunter New England Health, transcript, 20 July 2006, p 9.

28 Sprogis A, Hunter Urban Division of General Practice, transcript, 20 July 2006, p 52.

> competition in rural areas, so that traditional market constructs, which are in any case always difficult to apply to health care, are not applicable. Furthermore, a competitive purchaser-provider system would place heavy and perhaps unachievable demands on the skills and capacity of regional purchasing authorities to compete for both human and financial resources.[29]

5.35 The Commonwealth and the states are involved in a range of fund pooling programs, such as the Coordinated Care Trials and the Multi-Purpose Services (MPS) Program.[30] The MPS Program brings the health services in a rural community come together under one management structure, receiving Commonwealth funding for flexible aged care places and state funding for a range of health services. There are currently 94 operational MPSs nationally, with most in New South Wales (34), Western Australia (29) and Queensland (16).[31]

5.36 The committee accepts that workforce shortages do affect access to health services outside of major urban areas under current funding arrangements. While there will be a significant rise in the number of health professionals in the next 5–10 years, it is likely that there will continue to be a need to support funding arrangements that target the particular health care needs of people living in regional, rural and remote areas.

5.37 Inquiry participants nominated a range of proposals to modify funding arrangements to address health care issues for regional, rural and remote areas:

- fund pooling between governments to provide for a more flexible allocation of existing health resources across the target population. There are existing examples, such as the MPS program where governments have pooled funds to provide health services to specific communities.[32] As part of a 2005-06 budget initiative, the Commonwealth and states agreed to consolidate their respective funding for nominated health programs in certain agreed rural and remote communities with populations of less than 7,000;[33]

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29 Rural Doctors Association of Australia, sub 31, p 10.

30 Department of Health and Ageing, sub 142, p 30.

31 Department of Health and Ageing, sub 142, p 24.

32 Department of Health and Ageing, sub 142, pp 24–25.

33 Hon Tony Abbott MP, Minister for Health and Ageing, media release, *Developing the health workforce to meet community needs*, 9 May 2006.

- the provision of 'top up' funding to regional areas that is notionally underfunded under Medicare, the pharmaceutical benefits scheme and the private health insurance rebate. These funds could be allocated by fund-holding bodies such as local governments or Divisions of General Practice to purchase appropriate services on behalf of their local community;[34]
- building on the existing fee-for-service arrangements with higher reimbursement for rural patients, combined with an appropriate indexation mechanism;[35]
- the employment of more salaried doctors in areas of doctor shortage;[36]
- capitation (ie: population-based) payments adjusted for relative disadvantage to fund-holding bodies that purchase the full range of health services for their target population, building in incentives for patient care and appropriate targeted incentive schemes;[37] and
- allocating regionally-based provider numbers that give doctors access to Medicare rebates in specific areas.[38]

5.38 Some of the funding models developed in chapter 3 also have relevance for regional and rural areas. The proposal that the Commonwealth be the single funder of around 30 regionally-based purchasers of health services appears to offer a greater focus on regional health needs than other models, such as fund pooling by governments at a high level.[39]

5.39 As previously stated, the committee supports the work of health ministers in developing options for COAG by mid-2007 on proposals to improve rural and remote health service delivery.

5.40 As part of the national health agenda recommended by the committee in chapter 3, there should be clear standards developed about the delivery of health services in regional, rural and remote areas. Clearer service standards should then guide the use of the mix of funding models to meet these standards.

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34 Sprogis A, Hunter Urban Division of General Practice, transcript, 20 July 2006, p 53

35 Rural Doctors Association of Australia, sub 31, p 20.

36 Western Australian Local Government Association, sub 34, p 7.

37 Redcliffe-Bribie-Division of General Practice, sub 81, p 22; Piterman, L, 'No place for fee-for-service in future health system', *Australian Doctor*, 25 August 2006, p 22.

38 Dr Vladimir Vizec, sub 73, p 1; Local Government Association of NSW and Shires Association of NSW, sub 18, p 9;

39 Podger A, *Inaugural Menzies Health Policy Lecture : 3 March 2006* (2006), exhibit 27.

Recommendation 11

5.41 **The Minister for Health and Ageing, in consultation with state and territory health ministers and as part of the national health agenda (see recommendation no. 1), develop standards for the delivery of health services in regional, rural and remote areas.**

5.42 The committee also considers that the delivery of health services by public hospitals in regional, rural and remote areas should be considered as part of the renegotiation of the next Australian Health Care Agreements (described in chapter 7).