

## CHAPTER 2

### HEALTH SERVICE DELIVERY: REGIONAL, RURAL AND REMOTE AUSTRALIA

2.1 It was clear from the evidence received that the operation and effectiveness of the travel schemes can only be understood within the broader context of health service delivery in rural and remote Australia. A number of supply and demand issues were presented to the Committee, which impact on the efficacy of the current travel schemes and present future challenges for health service delivery in rural and remote areas.

#### **Regional, rural, remote: demography**

2.2 There are three principal systems for defining non-metropolitan areas (areas with less than 100,000 inhabitants) in Australia: the Australian Standard Geographical Classification (ASGC), which defines an area's 'urbanness/ruralness'; the Accessibility/Remoteness Index of Australia (ARIA), which defines an area's level of accessibility to goods and services; and the Rural, Remote and Metropolitan Areas (RRMA) classification.<sup>1</sup>

2.3 The ASGC system was established by the Australian Bureau of Statistics. Sections of the States and Territories are classified as follows:

- Major Urban: urban areas with a population of 100,000 and over
- Other Urban: urban areas with a population of 1000 to 99,999
- Bounded rural locality: rural areas with a population of 200 to 999
- Rural balance: the remainder of the states and territories
- Migratory: areas composed of offshore, shipping, and migratory collection districts.<sup>2</sup>

2.4 The ARIA system was developed by the National Key Centre for Social Applications of Geographical Information Systems (GISCA) at the University of Adelaide. It has been summarised as follows:

Highly accessible: locations with relatively unrestricted accessibility to a wide range of goods, services and opportunities for social interaction.

Accessible: locations with some restrictions of some goods, services and opportunities for social interaction.

Moderately accessible: locations with significantly restricted accessibility of goods, services and opportunities for social interaction.

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1 Hugo, G., 'Australia's Changing Non-metropolitan population', in Wilkinson, D. & Blue, I. (eds.) *The New Rural Health*, Oxford University Press, Melbourne, 2002, p.13.

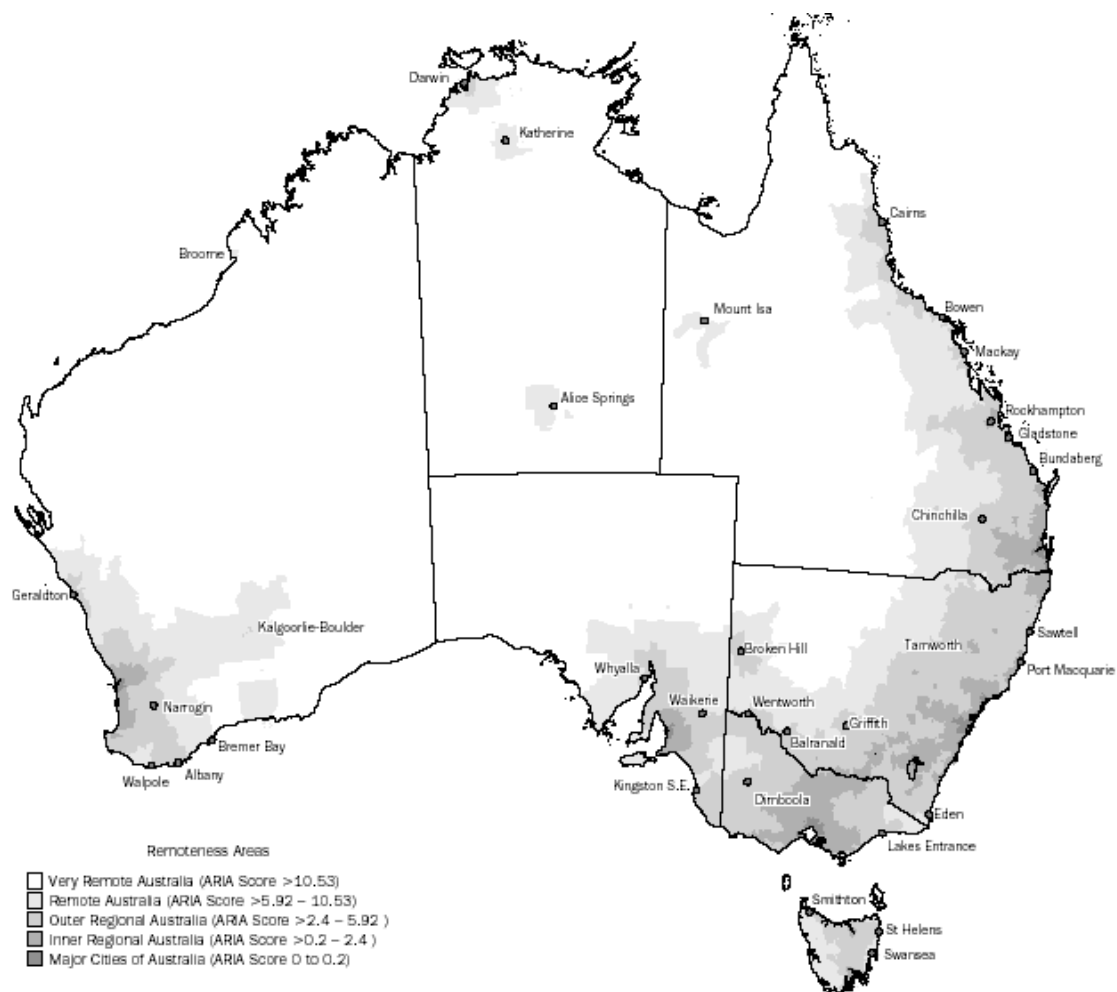
2 Hugo, G., 'Australia's Changing Non-metropolitan population', in Wilkinson, D. & Blue, I. (eds.) *The New Rural Health*, Oxford University Press, Melbourne, 2002, p.13.

Remote: locations with very restricted accessibility of goods, services and opportunities for social interaction.

Very remote: locations with very little accessibility of goods, services and opportunities for social interaction.<sup>3</sup>

2.5 The following discussion draws extensively on publications by the Australian Institute of Health and Welfare (AIHW), which uses the ASGC categories of Major Cities, Inner Regional, Outer Regional, Remote and Very Remote. The following map shows these classifications.

**Figure 2.1: Australian Remoteness Areas**



Source: <http://www.abs.gov.au> [accessed 31.8.07]

2.6 The regions outside Major Cities encompass an extremely diverse area ranging from coastal or inland areas within commuting distance of Major Cities to the sparsely populated, hot and dry outback. Many areas outside Major Cities, predominantly on the coast, attract older people in retirement. A significant proportion

3 Hugo, G., 'Australia's Changing Non-metropolitan population', in Wilkinson, D. & Blue, I. (eds.) *The New Rural Health*, Oxford University Press, Melbourne, 2002, p.14.

of the occupations in regional and remote areas (for example mining, transport, forestry, commercial fishing and farming) entail higher levels of risk than other occupations. One in ten people in the non-metropolitan workforce is engaged in agriculture.

2.7 In Australia, two-thirds of the total population live in Major Cities, with 21 per cent, 11 per cent, 2 per cent and 1 per cent living in Inner Regional, Outer Regional, Remote and Very Remote areas respectively. The Indigenous population of Major Cities is only 1 per cent (representing 30 per cent of the total Indigenous population), increasing to 2 per cent and 5 per cent in Inner and Outer Regional areas (43 per cent of the total Indigenous population), 12 per cent in Remote areas and 45 per cent in Very Remote areas (27 per cent of the total Indigenous population).<sup>4</sup>

2.8 Males outnumber females in almost all age groups in the more remote areas. This is largely influenced by the non-Indigenous population. The number of Indigenous males in each area is similar to the number of females.

2.9 Remote area populations tend to have proportionally more children and working age males, and fewer elderly people than other areas. Regional areas have proportionally lower numbers of people aged 25-44 years, higher numbers of people aged 45-74 years and similar or slightly lower numbers of people older than 75 years than other areas. In regional areas, children make up a higher proportion than in Major Cities, but lower than in remote areas.<sup>5</sup>

### **Measures of health status in rural and remote areas**

2.10 People in rural and remote areas generally do worse than other Australians on a range of health status measures. There are higher mortality rates, poorer dental health and higher levels of mental health concerns. This is likely to be a result of a mix of behavioural, socioeconomic factors and poorer access to health services.

2.11 The following is a brief overview of the findings of the AIHW's 2005 report *Rural, regional and remote health – Indicators of health* which includes measures of both health status and the determinants of health.<sup>6</sup>

2.12 The AIHW reported the following indicators of rural and remote health status:

- Chronic disease: overall there was no significant difference between the prevalence of self reported chronic diseases in regional areas and Major Cities;

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4 AIHW, *Australia's Health 2006*, p.240.

5 AIHW, 2003. *Rural, regional and remote health: a study on mortality*. AIHW cat. no. PHE 45. Canberra: AIHW (Rural Health Series no. 2), p.5.

6 AIHW, 2005, *Rural, regional and remote health – Indicators of health*. AIHW Cat. No. PHE 59. Canberra: AIHW (Rural Health Series no. 5).

- Injury: people in regional areas were 1.2 times more likely to self-report a recent injury and more likely to self-report a long-term condition due to injury;
- Mental health: depression was more prevalent in regional areas;
- Dental health: children had more decayed, missing or filled teeth in regional/remote areas;
- Communicable diseases: the rates of communicable disease notification tend to increase with remoteness;
- Birthweight: very low birthweight babies were more prevalent compared to Major Cities;
- Disability: disability was more prevalent compared to Major Cities;
- Reduced activity because of illness: the average number of days of reduced activity because of illness was greater in regional areas than in Major Cities;
- Life expectancy: life expectancy was highest in Major Cities and lowest in Very Remote areas likely due to the much lower Indigenous life expectancy;
- Overall mortality: compared with their counterparts in Major Cities males and females from regional and especially remote areas had higher rates of death and death rates rose with increasing remoteness – this is about 3,300 additional deaths annually;
- Perinatal mortality: compared with their counterparts in Major Cities rates of foetal and neonatal death were higher in regional and especially remote areas which is at least partly a reflection of Indigenous population distribution; and
- Causes of death: the leading causes of the higher death rates experienced in regional and remote areas are mainly circulatory diseases (42 per cent of the excess deaths) and injury (24 per cent) with respiratory disease and cancers contributing about 10 per cent of the 'excess' deaths each.<sup>7</sup>

2.13 The AIHW also noted that rural and regional areas had poorer determinants of health including less access to fluoridated water (only 30-40 per cent of those in regional and Remote areas, and 25 per cent of those in Very Remote areas have access to fluoridated water). Other determinants highlighted by the AIHW included:

- higher unemployment rates in regional and remote areas compared to Major Cities;
- lower after-tax household incomes in regional areas;
- the main sources of employment are agriculture, forestry, fishing and mining with less employment in manufacturing;

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7 AIHW, 2005, *Rural, regional and remote health – Indicators of health*. AIHW Cat. No. PHE 59. Canberra: AIHW (Rural Health Series no. 5), pp.8-12.

- the three indexes of relative socioeconomic disadvantage (economic resources, and education and occupation) outcomes were better in Major Cities than in regional and remote areas;
- birth rates were higher for women in regional and remote areas than for those in Major Cities, and increased with increasing remoteness;
- homicide death rates were substantially higher in Remote and Very Remote areas (although the actual numbers of deaths were relatively small);
- there is more household crowding in Very Remote areas;
- food prices increased with remoteness – food prices in Very Remote areas were between 14 per cent and 19 per cent higher than in the Australian capital cities;
- fuel prices also increased with remoteness; and
- the cost of housing decreased with remoteness.

2.14 People in regional areas are more likely to smoke and more likely to engage in risky alcohol consumption. Illicit drug use is more prevalent in regional areas. The situation in remote areas is unclear. People in regional areas are more likely to be sedentary and more likely to be overweight.<sup>8</sup>

2.15 The AIHW noted that people who live away from Major Cities and for whom access to health services is restricted may be disadvantaged because of different access to:

- preventive services such as immunisation and information allowing healthy life choices;
- health management and monitoring;
- specialist surgery and medical care;
- emergency care, for example ambulance;
- rehabilitation services after medical or surgical intervention; and
- aged care services.<sup>9</sup>

2.16 Evidence received by the Committee also emphasised the variation of health outcomes in regional and remote Australia.<sup>10</sup>

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8 AIHW, 2005, *Rural, regional and remote health – Indicators of health*. AIHW Cat. No. PHE 59. Canberra: AIHW (Rural Health Series no. 5), pp.12-19.

9 AIHW, 2003. *Rural, regional and remote health: a study on mortality*. AIHW cat. no. PHE 45. Canberra: AIHW (Rural Health Series no. 2), pp.3-4.

10 See for example, *Submission 55*, p.2 (NRHA) and *Submission 47*, p.5 (AMA).

2.17 The Australian Rural and Remote Workforce Agencies Group (ARRWAG) cited the following statement from J. Dade-Smith in *Australia's Rural and Remote Health. A social justice perspective*:

Australians living in rural areas have unique health concerns that relate directly to their living conditions, social isolation, socioeconomic disadvantage and distance from health services. They have death rates that are double the urban rate due to injury, triple due to road accidents and double due to falls in the aged. Hospital admission rates due to diabetes are four times the urban admission rate. Yet rural people have lower access to health care compared with their metropolitan counterparts because of distance, time factors, costs and transport availability.<sup>11</sup>

2.18 Focusing specifically on breast cancer, a study commissioned by the pharmaceutical company GlaxoSmithKline revealed that the higher mortality rate of rural and remote women with breast cancer was due, in part, to 'later diagnosis and less access to cancer screening and treatment services in regional areas'.<sup>12</sup> Other witnesses also noted that rural women are significantly more likely to undergo mastectomy rather than breast-conserving therapy unlike urban women. It was argued that rural women were less likely to travel to have breast-conserving surgery at an urban treatment centre for adjuvant therapy.<sup>13</sup>

2.19 The Cancer Council Australia also pointed to poor outcomes for cancer patients in rural and remote areas:

There is growing epidemiological evidence that cancer mortality rates increase significantly in step with geographic isolation. A study published in the *Medical Journal of Australia* in 2004 showed that people with cancer in regional NSW were 35% more likely to die within five years of diagnosis than patients in cities. Mortality rates increased with remoteness. For some cancers, remote patients were up to 300% more likely to die within five years of diagnosis.

A study published by COSA [Clinical Oncological Society of Australia] in 2006 and editorialised in the *Medical Journal of Australia* mapped the provision of rural/remote oncology services across Australia. The study was the first national analysis to statistically demonstrate what has long been assumed: that access to essential cancer care in all disciplines decreases nationwide as communities became more isolated.<sup>14</sup>

2.20 There is also evidence on differences in the rate at which people from major cities, regional and remote areas were admitted to hospital for a range of surgical procedures in 2002–03. For example, rates of coronary artery bypass graft and

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11 *Submission* 136, p.2 (ARRWAG).

12 *Submission* 60, p.3 (GlaxoSmithKline).

13 *Submission* 136, p.8 (ARRWAG).

14 *Submission* 109, p.11 (Cancer Council Australia).

coronary angioplasty were lower among people from regional and especially remote areas (and at odds with the pattern of death rates due to coronary heart disease). Compared with residents of Major Cities, rates of:

- diagnostic gastrointestinal endoscopy and myringotomy were also lower for residents of regional and especially remote areas;
- appendectomy and lens insertion were higher for residents of regional and remote areas; and
- cholecystectomy, hip replacement, revision of hip replacement, knee replacement, hysterectomy, tonsillectomy and arthroscopic procedures were typically higher for residents of regional areas and lower for residents of remote areas.<sup>15</sup>

2.21 The Australian Medical Association (AMA) concluded that:

A driving factor behind these poorer health outcomes is the difficulty people in regional and remote areas face in accessing specialist and primary health care. Isolation and lack of services make it complicated for these patients to receive preventive services and manage chronic diseases. Consumers needing to travel long distances to access services can face considerable disruption and personal financial cost.<sup>16</sup>

### **Access to services**

2.22 Limited access to health services is a significant issue for people living in rural and remote Australia. An inadequate supply of hospital and other health services and workforce shortages in these areas were identified as key factors.

#### ***Supply of hospital services***

2.23 The provision of hospitals and hospital beds are concentrated in Major Cities and regional areas. Some 22 per cent of public hospitals (but only 4.8 per cent of the available beds) are located in remote and very remote areas (compared with 6 per cent of the population).<sup>17</sup> Most hospitals in remote areas are public hospitals. However, hospitals are less likely to be accredited in regional and remote areas.

2.24 Most smaller rural hospitals are not equipped to provide the full range of specialised services and people must be transferred to larger regional or metropolitan centres. Some smaller hospitals operate as Multi-purpose Services (MPSs) and provide a range of services such as emergency triage, hospital care and aged and community care.

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15 AIHW, 2005, *Rural, regional and remote health – Indicators of health*. AIHW Cat. No. PHE 59. Canberra: AIHW (Rural Health Series no. 5), pp.19-20.

16 *Submission 47*, p.5 (AMA).

17 *Submission 157*, pp.10-11 (DoHA).

### *Workforce shortages*

2.25 The supply of health workers in regional areas has long been an issue. The AIHW reported that the supply of health workers declines with remoteness. Table 2.1 shows the number of employed medical practitioners in 2003 by type of practitioner and remoteness area.

**Table 2.1: Employed medical practitioners, by type of practitioner and remoteness areas**

	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote	Total <sup>[a]</sup>
<b>Type of medical practitioner</b>						
Clinicians	39,389	7,074	2,948	468	212	51,819
Primary care practitioners	15,132	3,901	1,740	301	152	21,919
Hospital non-specialists	4,561	659	359	69	42	5,915
Specialists	14,580	2,164	665	79	15	18,093
Specialists-in-training	5,116	350	185	20	3	5,892
Non-clinicians	3,621	372	205	30	18	4,388
<b>Total</b>	<b>43,010</b>	<b>7,446</b>	<b>3,154</b>	<b>498</b>	<b>230</b>	<b>56,207</b>
No. per 100,000 population	326	179	155	154	130	283
Percentage female	32.6	27.4	30.3	31.5	35.0	31.9
Average age (years)	45.7	46.8	45.1	44.7	43.4	45.9
Average hours worked per week	44.2	44.8	46.2	47.8	50.0	44.4

<sup>[a]</sup> Includes 1,870 medical practitioners who did not provide information on the location of their main job.

Source: Australian Institute of Health and Welfare, *Australia's Health 2006*, p.325.

2.26 The AIHW noted that to some extent, the decrease in supply of medical practitioners was countered by patterns of average hours worked by medical practitioners which increased from 44.2 hours per week in Major Cities to 50.0 hours per week in Very Remote areas. The AIHW also noted that, consistent with the placement of the large teaching hospitals near population centres, Major Cities and Inner Regional areas together accounted for 84.3 per cent of specialists and 92.8 per cent of specialists in training.

2.27 ARRWAG commented on access to primary health care providers, particularly GPs and noted that in 1998 the Australian Medical Workforce Advisory Committee (AMWAC) estimated the shortage to be in the region of 1240 GPs. Four years later, in 2002, the AMA commissioned a report from Access Economics which



estimated that there was a shortage of between 700 and 800 full time equivalent GPs in rural and remote areas.<sup>18</sup>

2.28 The nursing workforce is more evenly distributed across regions than medical practitioners, and shows a smaller variation in number per 100,000 population. Nurses in regional and remote Australia are older than in Major Cities and tended to work longer hours per week in Remote and Very Remote areas. Table 2.2 show employed registered and enrolled nurses in 2003.

**Table 2.2: Employed registered and enrolled nurses, by remoteness areas of main job, 2003**

	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote	Total <sup>[a]</sup>
Number	147,670	48,440	22,719	3,870	1,936	236,645
No. per 100, 000	1,120	1,167	1,115	1,193	1,095	1,191
Percentage female	91.2	90.9	93.9	93.3	89.7	91.4
Percentage registered	83.3	75.0	71.5	73.4	79.1	79.9
Average age (years)	42.5	44.2	44.3	44.2	44.3	43.1
Average hours worked per week	32.8	31.7	32.3	34.1	37.8	32.5

<sup>[a]</sup> Includes 12,009 nurses who did not provide information on the location of their main job.

Source: Australian Institute of Health and Welfare, *Australia's Health 2006*, p.327.

2.29 The distribution of dentists in Major Cities is more than three times that in Remote and Very Remote areas with the rate dropping from 57.6 to 18.1 per 100,000 population.<sup>19</sup>

2.30 The Rural Doctors Association of Australia (RDAA) also commented on the discrepancy between the levels of ill health that people in rural and remote areas and the health dollars spent in those areas:

Even though rural and remote Australia has a more aged and a 'sicker' population there is less spent on their health needs compared to their city counterparts. Medicare figures provided by the Department of Health and Ageing also show that if you lived in a capital city that the average general practitioner benefit paid per capita was \$195 but if you lived in a remote area of Australia that this figure falls to \$120...Many specialist services are also not available or viable in rural areas either because of workforce shortages, low concentrations of patients or because they require the facilities of a large hospital.<sup>20</sup>

18 *Submission 136*, p.3 (ARRWAG).

19 AIHW, 2006, *Australia's Health 2006*, AIHW Cat. No. AUS73, Canberra: AIHW, p.328.

20 *Submission 90*, p.2 (RDAA); see also *Submission 47*, p.4 (AMA).

2.31 While the analysis of rural services and workforce gives an indication of the general limits to access, there are differences between jurisdictions and within regions. The Australian Rural Nurses and Midwives (ARNM) explained:

There are considerable differences between states with regard to the geographical spread of services. Remoteness factor cannot only be measured by geographical location or distance; regional health services for example are in much greater numbers in rural New South Wales, Victoria and Queensland as opposed to Western Australia and South Australia. As such specialist services in these states are only available in the capital cities.<sup>21</sup>

### *Diminishing services in regional, rural and remote areas*

2.32 Many witnesses noted that there has been a continuing diminution of services in rural and remote areas with a decline in GP numbers and a downgrading of hospital services. The Country Women's Association of NSW stated that:

With the down-grading of country and regional hospitals it is now necessary for patients to travel greater distances. In the past it was not unusual for specialists to regularly visit country and regional hospitals which meant that patients were able to access locally many of the services for which they now need to travel vast distances.<sup>22</sup>

2.33 The Shire of Sandstone provided an example of the decrease in access to general practitioners:

In Mount Magnet the situation has become quite dire, in that, from having a full-time general practitioner a couple of years ago, the town of 700 people is now serviced once a month by a visiting medical practitioner from Geraldton who sees between 60 and 70 clients for one day a month. The nursing posts have gone down from four nurses to one. It is a town which is experiencing significant social and health problems in terms of drug and alcohol abuse, which of course precedes child abuse.<sup>23</sup>

2.34 The Australian Nurses Federation (ANF) raised concerns about access to obstetric services:

Access to health care also means access to services to assist with normal life events, such as maternity and birthing services; the ANF is very concerned that people in rural and remote Australia are being denied access to birthing services with over 130 birthing services in country areas closed in the last decade.<sup>24</sup>

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21 *Submission 45*, p.3 (ARNM).

22 *Submission 5*, p.2 (Social Issues Committee – Country Women's Association of NSW).

23 *Committee Hansard*, 13.7.07, p.67 (Mr W Atkinson, Shire of Sandstone).

24 *Submission 96*, p.2 (ANF).

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2.35 The RDAA also commented that half of the obstetric services had closed in the last 10 years which meant 'that many GP obstetricians and obstetrician gynaecologists who want to provide services are unable to provide those services in their community'.<sup>25</sup>

2.36 ARRWAG also reported a reduction in services being offered by GPs:

...there has been a decline in the proportion of GPs providing procedural services – down from 24% in 2002 to 21.5% in 2005. Rural GPs have traditionally been more likely to undertake procedures than their urban counterparts because of a lack of specialists in rural and remote areas. A decline in GPs undertaking this work may be a major factor in people living in rural and remote areas having to travel to visit a medical specialist in addition to an on-going decline in proceduralist GPs.<sup>26</sup>

2.37 WA Country Health Services indicated that workforce issues were impacting on the delivery of services to the extent that a regional 'hub and spoke' model had been introduced in an attempt to maintain service delivery levels:

Obstetric services are becoming harder to deliver. Anaesthetic services are harder to deliver. General surgeons are in scarce supply; they threw away the mould and they are not making generalist positions. Procedural trained GPs that are willing to go out into the bush, which are the backbone of our country hospital system, are not being made any more. I would contend, that is just going to be the way the rural health service delivery is going to be. That is why we have introduced a regional hub-and-spoke model because it is the only way we think that you can try and maintain at least some services in a region in the face of those workforce difficulties.<sup>27</sup>

2.38 However, witnesses commented that the hub and spoke model does not always take into account the transport problems of the area. The Shire of Ashburton WA stated:

The issues are: hub and spoke does not work because there is no spoke in the sense that there is no public transport; there is no commercial link or integration of any type whatsoever between any town in the Pilbara at the air level; there is absolutely no land service of a commercial public nature; and, all interaction is through private travel. We are talking about extremely long distances and times. Most one way distances are 400 to 500 kilometres or more. This puts great pressure on patients because, the way the system works, carers do not get a great deal of support through the PATS system. Also, the road systems, the distances travelled, the safety risks from animals on the road, the sheer heat and such types of things mean that it is a test for

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25 *Committee Hansard*, 22.6.07, p.5 (Mr S Sant, RDAA).

26 *Submission* 136, p.5 (ARRWAG).

27 *Committee Hansard*, 13.7.07, p.15 (Mrs C O'Farrell, WA Country Health Service).

an able-bodied, healthy person, let alone someone who is suffering an illness.<sup>28</sup>

2.39 The Department of Health and Ageing (DoHA) cited two reasons for the centralisation of services. Firstly, evidence shows that sufficient patient 'throughput' is required to achieve 'safe and appropriate clinical outcomes'. To put it simply, specialists need the opportunity to practice. Secondly, advances in medical technology have resulted in the development of sophisticated procedures and (often highly expensive) medical equipment. Due to the cost and degree of specialisation, treatments are restricted to a few health centres:

Because of the needs for cost effective utilisation of expensive equipment and/or to achieve and maintain clinical competence in complex and costly procedures, it may be feasible to have only a limited number of health-care establishments, such as hospitals, providing certain specialised health services.<sup>29</sup>

2.40 Haematology services in Western Australia are an example of centralised services:

Throughout regional Western Australia there are extremely limited haematology services available. There is limited low level care available in Bunbury and in Albany. These treatment areas provide only simple administration of chemotherapy. They are not resourced for admissions of an un-well immunised compromised patient.

No haematology patient diagnosed within regional WA would be able to avoid multiple trips to Perth as is evidenced by the following list of diagnostics and treatment that are not available elsewhere:

- all haematologist appointments.
- scanning and radiology appointments.
- any nuclear medicine scans.
- chemotherapy regimes – either preformed as inpatient or outpatient.
- admission to treat neutropenia infections post chemotherapy.
- access to specialised physio; dietetics; rehabilitation and psychological health professionals.<sup>30</sup>

2.41 While there may be sound reasons for centralisation, the lack of services places greater pressure on rural GPs to provide more specialised services and manage more highly complex cases:

Clearly, if patients do not have access to specialist care in their community and they do not have access to, say, the Alfred or Prince of Wales hospital,

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28 *Committee Hansard*, 13.7.07, p.66 (Mr K Pearson, Shire of Ashburton).

29 AIHW cited in *Submission 157*, p. 12 (DoHA); see also *Submission 136*, p.7 (ARRWAG).

30 *Submission 54*, p.3 (Leukaemia Foundation WA).

those patients end up being managed by the GP in their community often without being able to get support from their specialist colleagues. There are some money issues involved, but it is broader than that. There are training issues as well. I think that we really have to make it attractive for GPs to train in procedural specialties, that is, anaesthetics, obstetrics.<sup>31</sup>

ARRWAG also concurred that work intensity was a problem with attracting and retaining rural GPs.<sup>32</sup>

### **An increasing demand for PATS**

2.42 Witnesses argued that the demand for PATS will continue to increase over time as services in regional, rural and remote areas continue to decline, the population ages and other issues such as more sophisticated and more expensive medical technologies are introduced.

#### ***Future pressures on PATS***

2.43 DoHA identified 'future pressures' that could impact on patient transport, with more patients needing to travel to receive treatment:

- increased health needs of the ageing population;
- increase in the number of patients with chronic conditions and, consequently, complex health needs;
- advances in medical technology:
  - patient expectations of treatment available to them grows as treatment becomes more effective and previously untreatable conditions become treatable;
  - highly specialised and expensive equipment is provided in limited hospitals/specialist centres requiring patients to travel for treatment; and
- possible rationalisation of hospital and health services by State and Territory governments.<sup>33</sup>

2.44 State and Territory Governments concurred with the majority of DoHA's observations,<sup>34</sup> with the impact of the drought also identified as increasing demand. The Victorian Government commented that the lack of access to Commonwealth-funded medical and allied health services was also contributing to demand pressures, while South Australia argued that 'the level of growth [in demand for PATS] is

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31 *Committee Hansard*, 22.6.07, p.6 (Mr S Sant, RDAA).

32 *Submission* 136, pp.3-4 (ARRWAG).

33 *Submission* 157, pp.15-16 (Department of Health and Ageing).

34 *Submissions* 150, p.1 (ACT Government); 164, p.8 (NT Government); 165, p.6 (SA Government); 182, p.2 (Victorian Government); 184, p.2 (Queensland Health).

causing increasing pressure on SA resources while the Australian Government contribution has grown more slowly'.<sup>35</sup>

2.45 The Rural Doctors Association of Australia similarly noted that the ageing population will impact on demand:

Chronic disease (conditions likely to persist for at least six months) constitutes about 80% of the burden of disease in Australia today, a figure which will rise with demographic ageing.<sup>36</sup>

2.46 At the same time, the ageing population is impacting on the medical workforce with more than 50 per cent of the GP workforce in rural and remote Australia aged over 45 years.<sup>37</sup> As demographic ageing continues, there will be a relatively smaller pool of professionals to attract to rural and remote areas.<sup>38</sup>

### *A changed operating environment*

2.47 Witnesses argued that PATS as it was envisioned in the 1980s is no longer sustainable. The environment in which PATS operates has changed significantly. As discussed above, people in regional, rural and remote areas have poorer health status than other Australians; there are significant workforce shortages which are exacerbated by the need to centralise services due to cost and technology imperatives; and ageing is impacting on both the general population and the medical professional population. The WA Country Health Service commented:

The difficulty I think for us is that we are losing ground. We have had quite a lot of success in recent years but we are losing ground with that strategy at the moment because the workforce shortages that we forecast five years ago are now with us and they are getting worse. So we have lots of vacancies, we have lots of services where the skills mix is skewed and out of plumb; we have lots of services that are completely failed and we have some that are so fragile they work some days and not on others. The Pilbara region is absolutely in tremendous difficulty at the moment with fragile services. We have enormous numbers of overseas trained doctors who are not familiar with the Western Australian system and who have varying skills mix, so our services have never been so challenged.<sup>39</sup>

2.48 The WA Country Health Service went on to comment that to try and operate PATS in the same old way, 'where the services that would ordinarily be available

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35 *Submissions* 182, p.5 (Victorian Government); 165, p.2 (SA Government).

36 *Submission* 90, Additional information, 26.6.07 (RDAA).

37 *Submission* 136, p.5 (ARRWAG).

38 *Committee Hansard*, 22.6.07, p.6 (Mr G Gregory, NRHA).

39 *Committee Hansard*, 13.7.07, p.15 (Mrs C O'Farrell, WA Country Health Service).

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locally are sometimes there and sometimes not, is starting to create some more tension'.<sup>40</sup>

2.49 The South Australian Government also commented on the changes in health care delivery since the introduction of patient assisted travel schemes:

The schemes started from a base where they focused on access to medical specialist services. Health care delivery has changed over the last 20 years and it is critical that PATS look towards expanding to include access to primary and allied health care services. The cost implications of expanding need to be considered and the Australian Government needs to provide its fair share of funding support.<sup>41</sup>

2.50 In addition, the schemes have not evolved as advances in treatments and care have evolved. A case in point is the treatment of cancer where access to a multidisciplinary team increases survival rates and decreases adverse outcomes. The NRHA stated that:

Complete cancer care often includes care coordination and planning between medical, surgical and other cancer care specialists, specialist investigative procedures, surgery, radiation therapy and chemotherapy, with a range of frequencies and intensities, and monitoring requirements. This is necessary for some conditions, in order to match a subsequent therapy with the patient's response to an earlier treatment. Often, acute side-effects are debilitating for the patient. A secure home-like environment, whilst experiencing unpleasant side effects of some treatments away from home, with support from relevant carer/s, will assist treatment compliance and maximise benefit. The failure of the schemes to genuinely cover essential care for many cancer patients probably contributes to poorer survival rates in cancer among people in rural and remote areas.<sup>42</sup>

2.51 Other examples include access to coordinated treatment and support for chronic conditions such as epilepsy, kidney disease and Parkinson's disease where access to a range of allied health services can decrease the adverse impact of the disease through physiotherapy, specialised nursing care and occupational therapy.

2.52 At the same time, witnesses commented that it was short-sighted for governments not to provide adequate access to health services as in the long-term costs incurred were greater through health complications and economic loss and could, in fact, undermine other health initiatives.

2.53 The RDAA argued that there was a 'compelling case' for increasing the level of benefits because country people are 'just not getting the access that they used to get'. Not providing good transport assistance schemes is a false economy as the likely

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40 *Committee Hansard*, 13.7.07, p.15 (Mrs C O'Farrell, WA Country Health Service).

41 *Submission* 165, p.15 (SA Government).

42 *Submission* 55, p.6 (NRHA).

outcome will be additional health system costs being incurred in both Federal and State funded areas. This is due to late treatment of conditions and increased costs to the community associated with an increased burden of illness and even avoidable and premature death.

In the long run, one would think, one would achieve better outcomes. But it would be a lot less expensive for the Commonwealth in the long run...if we were able to assist people to access preventive care and screening in antenatal care and so on, thus saving money on acute healthcare in the long run.<sup>43</sup>

2.54 The RDAA also noted that other initiatives could be undermined by the lack of patient transport. For example, the Commonwealth Bowel Cancer Screening Program – which enables people in any part of the country to be screened – is not coordinated with follow-on care. People in rural and remote areas with a positive test result still face enormous access issues in securing further tests and treatment. RDAA research showed that following a positive screening test a rural patient may have to wait six months or more to get a colonoscopy which is 'a disaster for those people'.<sup>44</sup>

2.55 Dr Eduard Roos of the Southern Queensland Rural Division of General Practice concluded that 'prevention is better than cure' and told the Committee that:

...there is a cost saving if we can get the patient to see the specialist sooner rather than later. So for us it is very important to make sure that our patients can access the services.<sup>45</sup>

2.56 However, NSW Health argued that other factors such as 'access to carers for children' and 'potential loss of income' impact on people's decisions about how, when and if to travel to receive health care, as well as the adequacy of the travel schemes. As such, NSW Health concluded:

[I]t would be extremely difficult to draw solid connections between improved travel and accommodation support and clinical outcomes for patients given the number of variables that affect a patient's clinical outcomes.<sup>46</sup>

## Conclusion

2.57 The health outcomes of people living in rural, regional and remote communities are poorer than those in major cities in Australia. As discussed above,

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43 *Committee Hansard*, 22.6.07, p.16 (Ms S Stratigos, RDAA); see also *Submission 157*, Answers to questions on notice, p.2 (DoHA) for information on research on the cost effectiveness of early and appropriate intervention.

44 *Committee Hansard*, 22.6.07, p.5 (Ms S Stratigos, RDAA).

45 *Committee Hansard*, 6.8.07, p.3 (Dr E Roos, Southern Queensland Rural Division of General Practice).

46 *Submission 188*, p.23 (NSW Health); see also *Submission 183*, p.6 (Tasmanian Government).



the reasons for this are multifaceted and include a range of socioeconomic and behavioural factors.

2.58 It is evident that rural, regional and remote communities are facing considerable disadvantage in accessing services that those in major cities take for granted. While the Committee acknowledges that many factors contribute to decisions to travel (or not to) for treatment, the schemes that have been put in place to assist with access should not themselves form a barrier to that access.

2.59 The Committee considers that, although there are considerable challenges in providing services to a dispersed population, it is imperative that access to services be improved. The failure to do so means health priorities are undermined; costs to government may increase in the long term and most importantly, the health status of those living in rural, regional and remote communities will not be improved.

