Submission by

Australian Healthcare & Hospitals Association

To the Senate 's
Community Affairs Legislation Committee

Inquiry into:
The factors affecting the supply of health services and medical professionals in rural areas.

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Summary

This submission is the Australian Healthcare & Hospitals Association's (AHHA) response to the Australian Senate Inquiry into: The factors affecting the supply of health services and medical professionals in rural areas.

The AHHA believes that this issue needs to be approached from a new perspective - one that focuses on National and State agreement to structural reform in rural health services. This new approach will facilitate more flexibility between, and integration of, primary, community and hospital services in order to encourage:

a) Local General Practitioners (GPs), other clinicians and community members to have a role and voice in planning the regional, specialist and tertiary health service networks that are clearly part of the extended and sustainable health services for rural areas;

b) Greater flexibility in governance arrangements across boundaries to support clinicians working in cross-boundary integrated teams as well as providing expanded opportunities for professional career pathways and peer mentoring;

c) Health services in rural and regional areas to utilise and develop more diverse roles for generalists, proceduralists, nurse practitioners and allied health professionals. This will attract and retain a workforce sufficient to provide needed services <u>and</u> guarantee quality, safety and sustainability of health services into the future; this may require health professionals and their representative groups to think beyond traditional boundaries and agree to changes for greater diversity of care settings for patients; and

d) Pooled funding models that facilitate the above and provide more flexibility for recruitment and changing workforce as needs of the communities change.

1. There have been multiple pilots, programs and funding schemes aimed at addressing factors that limit supply of health professionals to rural areas. The Commonwealth and States need to share knowledge of what works. The time for continued review and research must be replaced with action on the ground.

2. There needs to be a commitment to sustainable primary care practices in rural areas. This may be through establishing and supporting larger 'joined up' services and infrastructure resources, supporting general practitioners to develop sustainable practices with practice managers in place and supporting better utilisation of specialists, GPs, nurse practitioners and other health professionals in multi-disciplinary services. Providing more sustainable and joined up practices will better support rural health professionals.

3. Services and the health workforce need to be community focussed rather than simply focused on hospitals or the traditional medical model of care. Small hospitals and health services have been structured around traditional models that are more suitable to metropolitan healthcare. Multi-Purpose Services are examples of where Australia has successfully reformed health service delivery and more needs to be done to build on this model. Health professionals will be

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more supported and engaged in such structures as they focus on greater collaboration and team integration.

4. There needs to be a greater emphasis on more flexible generalist, proceduralist and nurse practitioner roles that suit the needs of rural health care settings. For example, Remote Area Health Corps and other recruitment strategies such as brokering supply for longer contracts should be considered where a permanent supply of specialist professional staff cannot be sustained.
5. Governments should undertake substantial new investment in education, training and support for medical, nursing and allied health professionals working in rural and remote health services. This will help them to manage the ongoing changes they are likely to experience in these locations and enhance their professional capabilities. These activities would ideally be undertaken in an interdisciplinary fashion, which is crossing traditional professional boundaries and enabling health professionals from different specialties to benefit from learning concurrently in teams and across disciplines of education.
6. It is vital that the Commonwealth Government's E-health strategy addresses rural needs and provides support for rural GPs and other health professionals. Technology should not replace rural communities' access to skilled health professionals but should support better ways of working and better connections between practices and health services. Like all innovation, change does not happen in a vacuum and investment needs to be provided.
7. Commonwealth and State governments need to ensure new funding provides incentives to deliver integrated care. This could be expedited through nationally consistent clinical practice guidelines to foster integrated care across Local Health Networks and Medicare Locals boundaries, resulting in patients being treated in more appropriate settings in the primary, community and secondary care services. This requires skilled health professionals who can effectively integrate care and work in a team effort across multiple services.
8. Innovation often comes at a cost. If governments really want to change the supply of rural health professionals there must be an investment in innovation, not simply ongoing incentive funding that does not contribute to real changes for people working in rural communities. This, combined with the lack of funding overall for rural health undermines the future positioning of the Australian health services to remain a world leader. If investment is to lead to results governments need to seize the opportunity and openly seek to be innovative and supportive of new ideas.
9. The *Australian Standard Geographical Classification – Remoteness Areas classification* methodology is not appropriate for rural areas and does not focus on health outcomes. Funding should be linked to population health needs while also addressing the needs of individuals and communities with respect to their health. There needs to be an alternative classification methodology for assessment and distribution of funds and resources for healthcare that uses a more robust population health model.

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1. Introduction

The AHHA believes that the Commonwealth Government's National Health Reform is delivering significant funding and structural changes for public hospitals and primary healthcare, and represents a strong and positive foundation for further reforms. Health system governance reforms, funding increases and a shift in clinical and financial decision-making closer to the community are commendable and long overdue.

Additional funding must, however, flow to the priority areas of the health system that need greater support to make substantial changes in the way healthcare is delivered, with an emphasis on access and equity for all communities. The health workforce in rural and remote areas is one for these priority areas. The factors affecting supply of health services and health professionals are widespread and despite ongoing research and program responses there has been minimal headway in finding solutions.

The AHHA believes that this issue needs to be approached from a new perspective - one that focuses on National and State agreement to structural reform in rural health services. This will facilitate more flexibility between, and integration of, primary, community and hospital services in order to encourage:

a) Local GPs, other clinicians and community members to have a role and voice in planning the regional, specialist and tertiary health service networks that are clearly part of the extended and sustainable health services for rural areas;

b) More flexible governance arrangements across professional and geographic boundaries to support clinicians working in integrated teams as well as providing expanded opportunities for professional career pathways and peer mentoring;

c) Health services in rural and regional areas to utilise and develop more diverse roles for generalists, proceduralists, nurse practitioners and allied health professionals. This will attract and retain a workforce sufficient to provide needed services and guarantee quality, safety and sustainability of health services into the future; this may require health professionals and their representative groups to think beyond traditional professional boundaries and agree to changes for greater diversity of care settings for patients;

d) Pooled funding models that facilitate the above and provide more flexibility for recruitment and changing workforce as needs of the community change.

Achieving these objectives will be vital to ensuring a more adequate and permanent supply of health professionals in rural areas in the future. Medical, nursing and allied health professionals will be more attracted to services that are dynamic and collaborative, meet community and population needs and provide a strong and sustainable workforce.

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1.1 AHHA role

The Australian Healthcare and Hospitals Association (AHHA) is the independent peak membership body and advocate for the Australian public and not-for-profit healthcare sectors and a national voice for universally accessible, high quality healthcare in Australia. The AHHA's core members are providers in the acute, community, primary and aged sectors as well as academic organisations. Our members include State and Territory health departments, regional health services (Local Hospital Networks), public and not-for-profit hospitals, community health and primary care services (Medicare Locals) and Universities.

The AHHA has a formal Rural and Remote Health Policy Network actively engaged in policy development and fostering communication between a wide range of stakeholders. Members of the Network are from national, state and local regional services as well as Universities.

The AHHA is also a formal member of the National Rural Health Alliance (NRHA).

The AHHA has expertise in coordinating the views of a wide range of stakeholders and is pleased to have the opportunity to provide this submission, which has been prepared in consultation with our Rural and Remote Health Policy Network members.

2. Factors limiting the supply of health services and medical, nursing and allied health professionals to small regional communities as compared with major regional and metropolitan centres.

The work of Health Workforce Australia in advancing a national program of health workforce innovation, developing new health workforce models and supporting innovative models of healthcare delivery is encouraging. However, ensuring an adequate supply of health services and health professionals in rural and regional Australia remains a problem, as it is in many OECD countries. The factors contributing to the short supply of health services and medical, nursing and allied health professionals are complex. Despite national and international research and effort, no country has found a long-term solution. To date, solutions have tended to focus on the workforce itself – that is, using incentives to attract and retain health professionals. The AHHA argues that it is time to look at health service and workforce structures, as well as funding and governance arrangements in order to address the important issues that previous attempts have overlooked.

2.1 The need for more action, not more research or review

In Australia, the major problem with the supply of health workforce in rural and regional areas is a maldistribution - some communities are able to access a range of services provided by skilled health professionals while others are missing out.

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- Multiple studies point to a range of complex factors that attract health professionals to small regional communities. Incentives identified as key to attracting professionals include:
  - Financial incentives;
  - Appropriate housing, transport and services;
  - Rewarding work and supportive colleagues in the workplace; and
  - Professional satisfaction and career opportunities.
- Smaller regional communities may not be able to offer choices of housing, convenience of shopping, community facilities or entertainment. Food and accommodation are often expensive.
- Other factors that may inhibit recruitment and retention of staff in rural areas are:
  - A rural position can sometimes be viewed as career limiting with little opportunity to join in professional development and learn from peers and others;
  - Professional isolation leading to long hours of work (including on-call) and pressures of being a lone practitioner with associated stress and fatigue plus the large distances making it difficult to attend meetings and educational activities;
  - The environmental extremes and geographic isolation with consequent separation from family, established relationships and social networks;
  - The difference in community expectations and pressures for health professionals to be actively engaged in the community and to be there for life long placement while also experiencing difficulties in becoming a "local";
  - The feeling of lack privacy in one's personal life;
  - The challenge of ensuring confidentiality in small rural towns – particularly where there is a high degree of access by local staff to information within a practice or hospital;
  - The issue of spousal career requirements in rural and regional environments; and
  - Lack of schooling and higher education for children, particularly access to high schools.

Recommendation

There have been multiple pilot programs, programs and funding schemes aimed at addressing factors that limit the supply of health professionals to rural areas .[1] There are multiple numbers of funded initiatives, recruitment incentives and scholarship programs conducted in each State/Territory by a range of agencies and

[1] Examples of programs: NSW Health Rural Preferential Rural Preferential Recruitment Program; NSW Health Area of Need program; Victoria's Extended Skills for GPs Program; Medicare Australia and the Australian College of Rural and Remote Medicine (ACRRM) Scholarships; Rural Health Workforce Australia relocation grants; Commonwealth Governments HECS Reimbursement Scheme; Scholarship programs; Prevocational General Practice Placements Program (PGPPP)

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departments. Commonwealth and States now need to implement some of the outcomes of these pilot programs and research and share knowledge of what works best. The time for continued review and research must be replaced with action on the ground.

2.2 Primary health care

There is overwhelming evidence at the macro level that countries with strong primary care services have better health outcomes at a lower cost.[2] In Australia, however, fewer GPs in a region means less GP visits and less early intervention and preventative care and often increased costs to the public health systems as a result.

- While rural GPs can now access some incentive funding available through grant programs, they must manage their own practice, or partner with other GPs, manage contractual services with local hospitals as well as provide out of hours services and on call. For smaller rural medical services the additional incentive grants require management components that larger metropolitan services can often aggregate.
- In the current system, primary care services are funded by the Commonwealth, while other services in the community are funded by States/Territories and therefore largely separated from GP services. Communities who fail to attract medical professionals depend on locum medical services that must be provided through the State public health services, which may also struggle to attract medical professionals.
- There is a need for primary health care services to provide a wider range of services at appropriate levels in rural areas including nurse led care by Nurse Practitioners, more allied health services and general community based services such as wound care, palliative care and chronic disease care. There are few incentives and multiple challenges to building such multi-disciplinary services in rural areas.
- Lack of access to general practitioners and other primary health care services is only part of the problem leading to unmet demand for services. Research shows that out of pocket costs (co-payments) for healthcare inhibit access, particularly for the disadvantaged. Research conducted by the Australian Bureau of Statistics in 2009 indicated that 7-8% of patients in rural Australia delayed their attendance due to costs.[3]
- Rural communities have a higher age profile and lower socio-economic profiles overall. Combined with declining populations in some communities, regional small practices will face greater sustainability challenges in future.
- In some parts of rural and regional Australian, geographic isolation, limited choice of services and social/cultural factors also lead to sub-optimal patterns of primary care utilisation.

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[2] Rawaf S. Maeseneer J. & Starfield B. *From Alma-Ata to Almaty: a new start for primary health care* , Comment on WHO Report on Lancet, Vol 372 October 18, 2008 World Health Organization (2008) Primary Health Care Now more than ever. http://www.who.int/whr/2008/whr08_en.pdf

[3] Australian Bureau of Statistics (2009). Health Services: Patient Experiences in Australia, 2009.

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- Financial incentives have not been sufficient to retain medical staff specialists in rural areas, as private income always exceeds public pay. Improving working conditions and providing other incentives, such as better housing options, are more likely to succeed.

Recommendation

There needs to be a commitment to sustainable primary care practices in rural areas. This may be through establishing and supporting larger 'joined up' services and infrastructure resources, supporting GPs to develop sustainable practices with practice managers in place, and supporting better utilisation of specialists, GPs, nurse practitioners and other health professionals in multi-disciplinary services. Ensuring rural practices are more sustainable is one key way of providing better support for rural health professionals.

2.3 Small health services and hospitals

Small hospitals and health services are increasingly under pressure in regional and rural communities. Changing population patterns and ageing rural populations mean many hospitals need to change the characteristics of their services to meet the needs of their communities, and therefore are required to change their structure and workforce skills profile. They also face increasing community, media and political pressure to be "all things to all people" in their communities.

- The structure of most small regional and rural hospitals and the funding models are historic and work continues to focus around professional silos and models based on similar structures to metropolitan service. Services are hospital focussed, not patient and 'population health need' focussed. Maintaining these 'mini' versions of metropolitan structures with doctors, nurses and allied health professionals working independently is resource intensive and inhibits staff from working easily across a range of services.
- On the other hand, the Multi-Purpose-Service model of health services is an excellent example of a multi-governmental pooled funding arrangement in rural communities. Multi-Purpose-Services provide services for acute and aged care with a flexible skilled health workforce and should continue to be utilised as a resource. This is a model that could be built on and expanded into other areas.
- Rural hospitals cannot and should not be expected to provide all services, only those that can be provided safely and appropriately in the local setting. However, few clinicians and managers are involved in decisions and activities about providing health services through the wider network of secondary and tertiary hospital and specialist hospitals. These decisions are often made at State or regional level. Communities do not understand the wider health service linkages that are provided for their town and region and so do not feel they have a stake or a voice in those networked services.

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- Rural and regional health services are frequently expected to fund additional recruitment incentives and relocation expenses from overly stretched local budgets.
- There is an opportunity to form amalgams of smaller rural stand-alone sites subject to national guidelines and support, providing high level local services and clinicians through aggregation of services. This model has not yet been tested in Australia. In Canada, where First Nation communities are self-governed in relation to healthcare, they have funded integrated service delivery structures by combining multiple government funded programs under one umbrella to meet the needs of communities. [4]

Recommendation

Services in rural areas need to be community focussed rather than focused overly on the hospital or medical model of care. The Health workforce should be organised to support this focus. Small hospitals and health services have been structured around traditional models that are more suitable to metropolitan healthcare. Multi-Purpose Services are examples of where Australia has successfully changed health services and more needs to be done to build on this type of model – one that is more sustainable and flexible for the future. Health professionals will be more supported and engaged in such structures as they focus on greater collaboration and team integration.

2.4 A renewed approach to workforce

Hospitals in regional areas must compete with other regional hospitals and metropolitan services to recruit and retain staff. More professionals choose to work in metropolitan areas and, in recent years, Australia has relied on international medical graduates and increasing numbers of overseas trained nurses and allied health professionals to work in rural health services.

- The qualifications of international health graduates, given the appropriate registration and credentialing, are not in question. What is questioned is the fairness of this system and whether it is merely masking inherent problems, therefore reducing the likelihood of finding solutions. International graduates new to the country are motivated by other factors in addition to career development, such as visa security. Those in rural and remote locations experience other major challenges and must often study by distance education as well as travel for obligatory college examinations. They are often not entirely happy with their situation; they just do not have a choice.[5]
- There has been limited exploration of alternative workforce options such as allowing health professionals to expand their scope of practice or to use different skills sets, as well as the greater use of information technologies and telemedicine.

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[4] Canada Health, Ten Years of Health Transfer First Nation and Inuit Control (2005) http://www.hc-sc.gc.ca/fniah-spnia/pubs/finance/_agree-accord/10_years_ans_trans/index-eng.php

[5] Refer to submissions from the Australian Government Inquiry into Registration Processes and Support for Overseas Trained Doctors 2011; Viewed 8 December 2011 http://www.aph.gov.au/house/committee/haa/overseasdoctors/subs.htm

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- There has been no take up of the Physician's Assistant model to date in Australia although pilots have shown good possibilities and there is a great deal of interest in this type of role.
- There has been limited public funding dedicated to exploring regional, state or national bureau like placement services such as the Remote Area Health Corps (RAHC) model. The Remote Area Health Corps (RAHC) has been established to attract urban-based health professionals to provide short-term staffing needs for remote Indigenous communities in the Northern Territory. This is a model that could be further developed.
- Long term management strategies may include offering time limited employment contracts to health professionals. This would allow for a brokered supply of services to communities and not be focussed on the person so allowing people to experience rural life styles without feeling trapped and giving comfort to rural communities that they have services.
- There is a greater need for generalist positions and roles for GPs that include more proceduralist work and attract GPs who want to undertake such procedural work regularly. For example, NSW has successfully trained many GPs to return to procedural work in rural areas in small surgery, obstetrics, emergency medicine and anaesthetics. Such training needs financial support. The work is also rewarding for those who are interested and contributes to attracting workforce to rural areas.
- There needs to be more options for ensuring MBS rebates are available for Nurse Practitioner services. This would make the Nurse Practitioners role more sustainable in rural and remote communities. For example, recent research by Curtin and Griffith Universities indicates nurse practitioners based in community pharmacies can ease the burden on primary care.[6]

Recommendation

a) There needs to be a greater emphasis on generalist, proceduralist and nurse practitioner roles that allow for greater flexibility, thus better suiting the needs of rural health care settings.
b) Remote Area Health Corps and other recruitment strategies such as brokering supply on longer contracts should be considered where permanent supply of specialist professional staff cannot be sustained.

2.5 Education and rural clinical schools

Providing rewarding work, career and professional development opportunities for staff in small hospitals and health services in rural areas is challenging.

- University Departments of Rural Health and Rural Clinical Schools have provided unique and positive contributions by exposing students to rural communities and supporting local and visiting health professionals in their education and

[6] http://news.curtin.edu.au/media-releases/nurse-practitioners-a-success-in-community-pharmacies/

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professional development. Such Departments also help build and sustain rural communities and keep them rich with knowledge and engagement.

- Professional bodies such as medical and nursing colleges and allied health associations are the backbone of professional development for many rural staff – they provide training and education with relatively limited resourcing. They also provide for all members, not just rural members.
- Rural and remote clinicians can feel very isolated because they miss out on peer interaction, learning and recognition. Education and professional development opportunities can overcome some of those concerns. Education and training is provided by a range of professional Colleges, Local Health Networks and GP Divisions/Medicare Locals; health professionals also undertake self-education independently and or through Universities to meet professional registration requirements for ongoing education points. Education is also essential to maintain standards of practice.
- Governments need to undertake region-by-region assessment and planning of education and training needs and associated infrastructure, and the provision of funding to support that clinical training.

Recommendation

Governments should undertake substantial new investment in education, training and support for medical, nursing and allied health professionals in rural and remote health services to promote professional excellence and help them manage the ongoing changes they are likely to experience. These activities would ideally be undertaken in an interdisciplinary framework.

2.6 Technology

Health professionals will increasingly face difficulties in small regional communities without significant improvement to technology. This is likely to be one of the greatest challenges in the future and health professionals will expect such technology to be available and accessible in small regional communities to facilitate their work. This includes rapid access to pathology, radiology and other diagnostic technologies as well as future access to Patient Controlled Electronic Health Records (PCEHRs).

- Access to technology is also the key to improving quality. Practitioners who are collecting data locally are well placed to also recognise the overall purpose for its collection and improve services for their rural populations. Similarly rural hospitals and small health facilities will need health professionals who can use technology and manage data.
- The roll out of such technology, including telehealth, is expensive and slow. Australia has been slow to adopt telehealth due to a lack of infrastructure to support videoconferencing and the high-speed transmission of data and

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images.[7] Medical practitioners have also been reluctant to adopt telehealth because of concerns that the technology is not as accurate as face to face diagnosis and may compromise standards of care.

Recommendation

The Commonwealth Government's E-health strategy needs to address specific rural needs and consider additional ways of providing support for rural GPs and other health professionals. Technology should not replace rural communities' access to skilled health professionals, but should support better ways of working and improved connections between practices and health services. Like all innovation, change does not happen in a vacuum and investment needs to be provided.

3. The effect of the introduction of Medicare Locals on the provision of medical services in rural areas.

The establishment of Medicare Locals (MLs) is in its early stages and it is difficult to judge the short and long term impacts on the provision of medical services.

- In a rural context there are concerns for potential fractionalisation of services when close contact between hospitals and primary care is an attraction to rural service placement and rewarding to both patients and the provider in giving one stop shop service.
- Better health care in rural and remote areas depends on people working together effectively. MLs currently being established in rural areas will require immediate support to build leadership capabilities and provide organisational improvement and governance support to assist cultural change in primary care services.
- MLs could, for example, create incentives for medical services to provide the right primary care at the right time by encouraging medical professionals to recruit, purchase or partner with a range of nursing and community health professionals. Experiences in Scotland[8] and New Zealand[9] have shown that networked primary care services co-located or working with or for GPs can facilitate access to healthcare services as well as home based care in small regional communities. This requires changes to models of care as well as changes to administration and structure of practices which will not be achieved without vision and support.
- Community based health professionals (including those providing in-reach services in hospitals) are well placed to enhance professional linking and should be empowered to do so. This requires medical professionals and other clinical professionals to lead service change and develop skills in new models of care including developing nationally consistent clinical practice guidelines.

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[7] Department of Health and Ageing (2011). Connecting Health Services with the future: Modernising medicare by providing rebates for online consultations: A discussion paper from the Australian Government. Viewed 14 December 2011. http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/256BA3C38B7EEA22CA2577EA006F7C42/$File/Telehealth%20discussion%20paper.pdf

[8] Department of Audit Scotland (2011) Report on the Review of Community Health Partnerships. Prepared for the Auditor General for Scotland and the Accounts Commission.

[9] Smith J. & Cumming J. (2009). *Where Next for Primary Health Care Organisations in New Zealand?* Victoria University of Wellington, School of Government Health Services Research Centre. Viewed 1 December 2011 http://www.health.govt.nz/publication/where-next-primary-health-care-organisations-new-zealand

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Recommendation

Commonwealth and State governments need to provide new funding to provide incentives to integrated care. This could be expedited through nationally consistent clinical practice guidelines to foster integrated care across Local Health Networks and Medicare Locals boundaries, resulting in patients being treated in more appropriate settings in the primary, community and secondary care services. This requires skilled health professionals who can effectively integrate care and work in a team effort across multiple services.

4. Current incentive programs for recruitment and retention of doctors and dentists, particularly in smaller rural communities, including: (i) their role, structure and effectiveness, (ii) the appropriateness of the delivery model

Current incentives focus on multiple numbers of small grants for a range of different circumstances. Doctors and dentists must apply, report and respond to numerous programs each with different requirements. Small, one or two person GP services or solo dental practices are at a disadvantage in this complex landscape of bureaucracy.

- It is difficult to assess in the short term the impact of new scaling incentives (e.g. Practice Improvement Program – PIP) and other initiatives without adequate data to see the impact on the maldistruibution of the health services in rural and region areas.
- Some increases in incentives for GPs (e.g. increases in the PIP Aged Care Access Incentive and the new PIP Indigenous Health Incentive) are yet to take effect and the impacts of these programs should be closely monitored, especially in relation to the attraction of new GPs.
- The Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) system is at the heart of most incentive programs and is flawed as it is geographic rather than population health based and has enshrined numerous anomalies in grouping small towns inappropriately.
- While progress has been made by Health Workforce Australia in increasing national support for clinical placement and supervision, and there have been increases in the numbers of graduates in some professions, maldistribution is likely to continue in rural areas[10]. Estimates suggest that only five per cent of medical graduates in NSW and Queensland are choosing rural (of urban) practice, and the reliance of rural and remote communities on international medical graduates has steadily increased.
- Overall, workforce shortages in rural and remote Australia, and in Aboriginal and Torres Strait Islander health professionals, constitute a first-order barrier

[10] AIHW 2010. Medical labour force 2008. AIHW bulletin no. 82. Cat. no. AUS 131. Canberra: AIHW. Viewed 15 December 2011 <http://www.aihw.gov.au/publication-detail/?id=6442468395>.

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to universality in access and equity in health outcomes and to Closing the Gap in Aboriginal health. The models of care which are known to work, and new approaches to service delivery that should be tested, may be simply impracticable if there is not the local workforce to deliver them.

Recommendation

Innovation often comes at a cost. If governments really want to change the supply of rural health professionals there must be an investment in innovation, not in a continued line of incentive funding that does not contribute to real changes for people working in rural communities. This, combined with the lack of funding overall for rural health undermines the future positioning of the Australian health services system to remain as a world leader. Investment will produce results but governments need to take hold of the opportunity and openly seek to be innovative and supportive of new ideas.

5. Whether the application of the current Australian Standard Geographical Classification – Remoteness Areas classification scheme ensures appropriate distribution of funds and delivers intended outcomes.

Socio-economic conditions are strong determinants of health status and disease. The weakness of using a geographic classification to assess population health needs is that it uses the characteristics of the area in which people live as the basis for calculating funding levels, not the attributes of individuals themselves.

- Socio-economic conditions, while determinants, cannot be considered on a wide regional basis as this is unlikely to be an accurate measure of individual health needs; those who are deprived and need additional health services are likely to be concentrated or dispersed differently within regions, or may indeed live outside such areas.

- The current system of using Australian Bureau of Statistics data is too broad and does not consider inter town and region differences. Towns can be within a short distance of each other and be classified unequally.

Recommendation

The *Australian Standard Geographical Classification – Remoteness Areas classification* methodology is not appropriate for rural areas and does not focus on health outcomes. Funding should be linked to population health needs and address the needs of individuals and communities with respect to their health. There needs to be an alternative classification methodology for assessment and distribution for funds and resources for healthcare using more robust population health models.

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