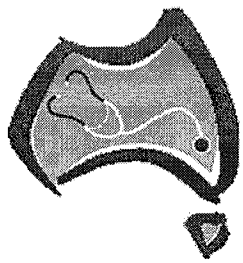
Standing Committee on Health and Ageing

Inquiry into Health Funding

May 2005



RURAL DOCTORS
ASSOCIATION
OF AUSTRALIA
Caring for the Country

Submission by the Rural Doctors Association of Australia

This submission is based on the right of all Australians to a fair share of the resources needed to support their health derived from funding systems designed to achieve and equitable distribution of these resources.

Recommendations

1. The Australian Government must *take a leading role in improving the efficient and effective delivery of highest quality health care to all Australians* through funding systems that facilitate addressing the inequities in health care between rural and urban Australia and Indigenous and non-Indigenous people as a matter of urgency.

2. Additional resources must be directed to rural communities to provide greater access to affordable health care for the third of the Australian population that lives and to redress the current inequitable distribution of federal health funding due to the Medicare underspend due to less access to services and the lower uptake of private health insurance by rural Australians.

3. RDAA contends that higher Medicare reimbursement for rural patients, combined with an appropriate indexation mechanism, is the best way to address the declining rate of bulk billing in country areas and at the same time to remove one of the barriers to viable rural medical practice.

4. Funding and service delivery mechanisms should centre the health care system around the primary health care sector, where more than 80% of health care is delivered, rather than tacking primary care on to the expensive, high-tech, 'heroic' hospital sector.

5. Fee-for-service must be maintained as the basic mechanism for remunerating medical care, but this must be augmented by:
   - incentives for the provision of timely health promotion, prevention and early intervention by primary health care providers
   - funding that facilitates the structured management of chronic diseases
   - models that may be needed to ensure the delivery of quality health care to specific areas or populations
   - support for structures which accommodate the preference for salaried positions in some sections of the medical workforce

6. Coordination of care must be supported by effective information and communications technology and management systems that provide all health practitioners and care givers with access to accurate and timely information about an individual's treatment and support the delivery of structured, proactive care for patients with chronic illnesses.

7. Initiatives that aim to support and improve the health of those who live in the bush must include components to encourage the recruitment and retention of an adequate health workforce.

8. The additional costs, both financial and in human resources, faced by rural practices in meeting the requirements for CPD and accreditation must be recognised and recompensed.

9. Broader health funding systems must be constructed to incorporate collaborative, community partnership based models of local needs assessment and prioritization as a means of more effective resource allocation

1. The Rural Doctors Association of Australia

The Rural Doctors Association of Australia (RDAA) was formed in 1991 to give rural doctors a national voice.

The RDAA is a federal body with seven constituent members - the Rural Doctors Associations (RDAs) of all States and the Northern Territory. Every RDA is represented on the RDAA Committee of Management which meets monthly by teleconference. The autonomous State/Territory associations work and negotiate with relevant bodies in their jurisdictions, while the RDAA Committee of Management, supported by a small national secretariat in Canberra, has overall responsibility for negotiations with the Commonwealth and working with national bodies and decision makers.

In keeping with the overall demographic profile of the rural medical workforce, most RDA members are general practitioners (GPs) and most are men. However, the Association takes steps to ensure that the interests and perspectives of smaller groups within the rural medical workforce are incorporated into its advocacy and negotiations. This has led to the establishment of special interest groups for female doctors and rural specialists, both of which meet regularly to discuss specific and generic rural workforce and health service policy matters. RDAA also works closely with relevant agencies to support the interests of the Overseas Trained Doctors (OTDs) who now make up over 30% of the rural medical workforce generally and closer to 50% of it in some States.

The RDAA has a primary focus on industrial issues and seeks to promote the maintenance and expansion of a highly skilled and motivated medical workforce to provide quality care to the people of rural and remote Australia. Much of its activity therefore concentrates on recruitment and retention issues and the viability of rural medical practice. However, it also works on particular health and health service issues including Indigenous health, rural birthing services, small rural hospitals and rural and remote nursing practice.

As the only advocacy body with a specific mission to support the provision of medical services to rural and remote communities, RDAA has a particular responsibility to ensure that the needs and perspectives of people who live in the bush are heard by decision makers and incorporated into the design and implementation of national policies and programs.

In accordance with RDAA's role as a member-based organisation, this submission focuses predominantly on the role of medical practitioners in rural and remote Australia and the impact of various health policies on rural communities. This means that some of the Terms of Reference for the Inquiry are covered in more depth than others.

2. Background

Research and public opinion surveys spanning many years have shown that Australians have a strong belief in health care as a public good for which responsibility is shared across the community, and in the universality of Medicare as public health insurance coverage for all Australians, paid for proportionately by all taxpayers through the taxation system. However, in the current libertarian policy environment, the idea that *publicly financed health care is essentially a welfare provision*[1] seems to be increasing.

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. And this is despite the demonstrably greater need for health care in rural and remote Australia.

As RDAA has repeatedly pointed out, the diverse and complex physical and professional contexts of health care delivery in rural Australia mean that blunt, untargeted mechanisms for system wide reform will not achieve their stated objectives for a substantial proportion of the population, a contention supported by a growing body of research. Much of this research properly focuses on health outcomes, though increasing attention is being paid to the inequitable distribution of public funding through mechanisms which inadvertently favour those on higher incomes and those who live in urban centres over those who do not. As yet, there is relatively little research that deals specifically with the maldistribution of health resources through publicly subsidized private health insurance and its potential impact on the health status of those in lower socio-economic groups and those who live in rural and remote

[1] McAuley I (2003)- Funding health care – taxes, insurance or markets? Paper for Health Insurance Summit, Sydney, June 2003 p 4

areas. Those studies that have done so all suggest that this impact will be significant and negative.[2]

Approximately a third of Australians live in rural areas.[3] The Australian Institute of Health and Welfare (AIHW) has summarized the widely acknowledged disparities in health status and health risk between the urban and rural populations of Australia:

> *...those who live outside Major Cities* [population > 250,000] *tend to have higher levels of health risk factors and somewhat higher mortality rates than those in the cities...compared with people in Major Cities, those living elsewhere are more likely to be smokers; to drink alcohol in hazardous quantities; to be overweight or obese; to be physically inactive; to have lower levels of education; and to have poorer access to work, particularly skilled work. They also have less access to specialist medical services and a range of other health services. In addition, numerous rural occupations (for example farming, forestry, fishing and mining) are physically risky, and traveling on country roads can be more dangerous because of factors such as higher speeds, fatigue and animals on the road.*[4]

Standardised mortality data show death rates in Australia increasing 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.*[5]

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[2] Dennis R (2003) – *Health spending in the bush: an analysis of the geographic distribution of private health insurance rebate*. Canberra, The Australia Institute; Dennis R (2005) – *Who benefits from private health insurance in Australia?* Canberra, The Australia Institute; Lokuge B, Dennis R & Faunce TA (2005) – Private health insurance and regional Australia. *Medical Journal of Australia* **182:6**;Walker A, Percival R, Thurecht L & Pearse J (2005)- Distributional impact of recent changes in private health insurance policies. *Australian Health Review* **29:2**

[3] Australian Institute of Health & Welfare (AIHW) (2003) - *Rural, regional and remote health: a study on mortality.* [PHE 45] Canberra, AIHW

[4] AIHW (2004) - Australia's health 2004: the ninth report of the AIHW. Canberra, AIHW [AUS44] p 208

While the causes of these disparities between urban and rural health status are complex and diverse, a common factor is that rural Australians are among the poorest groups in the population. Domestic and international evidence linking socioeconomic status – measured by income, employment and educational levels – and health outcomes is unequivocal: people in lower socioeconomic groups experience higher rates of morbidity and premature mortality, on average, than those materially more fortunate. The ABS Index of Relative Socio-Economic Disadvantage shows that non-Metropolitan Australia scores lower on the Socio-Economic Index for Areas (SEIFA) than urban areas. Non-Metropolitan households are more likely to be in receipt of government income support and, in spite of the confounding effect of mining areas, mean annual taxable incomes are lower. The proportion of 16-year olds in full-time education is substantially lower.[7]

Aboriginal and Torres Islander peoples, who constitute approximately 12 percent of the population of remote areas and 45 percent of the population of very remote areas, continue to experience a much heavier burden of preventable disease and mortality at an earlier age than other Australians, including age-standardized mortality rates which are triple those of the non-Indigenous population and so substantially lower life expectancy. [8]

Less access to medical care because of the shortfall of doctors also contributes to lower health status in rural areas.[9] Access to multidisciplinary health care is similarly limited by workforce and funding shortages, particularly in the areas of public health education and gender specific and sexual health services. In other words, the range of health care professionals and 'substitutable' services accessible in cities is simply not available in rural Australia. Private medical practice apart, there is very little private sector investment in hospital or other healthcare services outside major centres.

Yet despite their higher health needs and equal right to Medicare as our universal health insurance system, the 30 percent of the population that lives in rural and remote Australia

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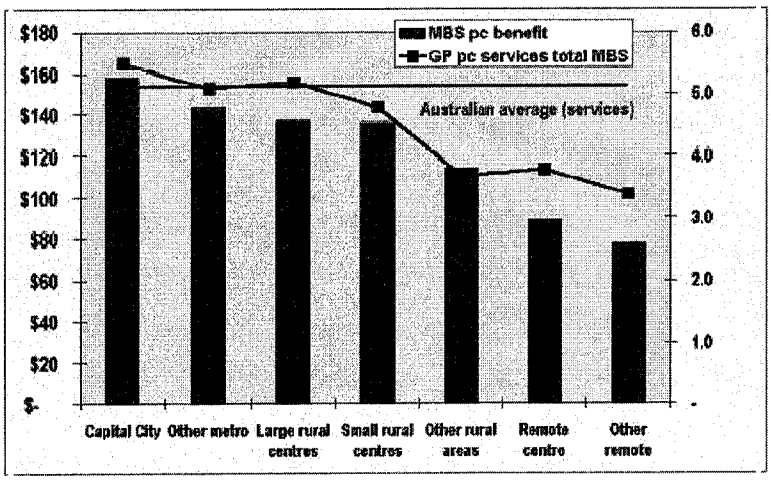
[5] *Ibid.*
[7] Bureau of Rural Sciences (BRS) & Rural Industries Research and Development Corporation (RIDC) (2003) – *Country matters: social atlas of rural and regional Australia.* Canberra, BRS [RIDC 03/015]
[8] AIHW (2003) *op cit*
[9] National Rural Health Alliance (2003), A more effective Medicare for country Australians. Canberra: NRHA, February 2003: 41. www.ruralhealth.org.au/nrhapublic/publicdocs/CD-ROM/data/papers/position_papers_2003.pdf, accessed 28/4/05.

accesses only 21 percent of Medicare-funded GP services. On the basis of population and HIC figures for 1999-2000, it has been estimated that the average per capita Medicare benefit paid in metropolitan areas was $125.59, compared to $84.91 in other parts of Australia. This suggests that approximately $221,009,162 of the Medicare levy collected in non-urban areas flowed back to subsidise metropolitan services.[10]

Figure 1 illustrates differences in the number of Medicare subsidized GP services provided in different parts of the country by RRMA (Rural, Remote and Metropolitan Area) classification. In 2001-02, this ranged from 5.5 in capital cities to 3.4 in remote areas. Figure 1 also shows that MBS billing per person falls steadily by RRMA category: in 2001-02 MBS spending was nearly $160 per person in capital cities, while it was less than half that – under $80 per person – in Other Remote areas.

Figure 1: Services & MBS benefits per capita, by RRMA, 2001-02



Source: DHA (2003) and AMWAC (2000) extrapolated to 2001-02

RDAA believes that the Australian Government must *take a leading role in improving the efficient and effective delivery of highest quality health care to all Australians* by addressing these inequities in health care between urban and rural Australia as a matter of urgency.

3. The need for reform

[10] Wagga Wagga City Council (2003) - Medical services in rural, regional and outer metropolitan areas in Australia. Unpublished.

It is it generally acknowledged that the complexity of the Australian health care system, with different services and providers funded by different levels of government, results in waste, duplication, and cost and blame shifting. Estimates of the cost of these inefficiencies to the Australian economy range up to $1.1 billion per annum in the health sector alone.[11]

Various proposals have been put forward to address these issues. Media reports suggest that the recent Podger review, which has not yet been released to stakeholders, canvasses the establishment of clear funder-purchaser-provider roles that would see regional purchasing bodies 'competing' for health care resources and contracting providers to deliver the necessary services for their prescribed population.[12]

The concept is not new, and while there is strong resistance in Australia to high profile United States models, developments in other countries including New Zealand and the United Kingdom may offer more acceptable interpretations of this approach and it concomitant mix of public and private sector financing and service delivery.

Changes in New Zealand's health funding system in the 1990s widened the potential pool of providers which had previously consisted mainly of public sector or specific professional entities. Relatively large numbers (people speak of a ten-fold increase)[13] of new providers emerged, including a significant proportion that set out specifically to offer services tailored to the health needs of indigenous New Zealanders. In this way, publicly funded services were extended and employment/career opportunities increased for some healthcare professionals.

In the United Kingdom, the massive investment in new and redeveloped hospitals for the NHS will be largely funded through a Private Finance Initiative.

The competition which is both a strategy and an objective of similar paradigms can also be encouraged by changing from annual budgeting systems, which are often based on historical patterns and highly dependent on the negotiating skills of the parties concerned, to service-

11 Davis M (2005) - Federal system wastes $2.4 bn. *Australian Financial Review* 14/3/05.
12 Uren D (2005) - States out in health shake up. *The Australian* 6/04/05.
13 SP, *pers.comm.* May 2005

based funding systems which can underpin purchasing from a plurality of providers and greater flexibility in health care delivery. [14]

Whether any of these models would work in rural and remote Australia is problematic. Private sector investment is not easily attracted to sparsely populated areas of relatively low socio-economic status. A competition based system would inevitably be focused on urban areas where market forces operate, to the potential detriment of the sole public sector provider in areas where they do not. And, as one rural doctor put it:

> *A competitive purchaser provider model is not an option where the existence of any services at all is under question.*[15]

RDAA therefore contends that 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 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. The power of larger, metropolitan authorities with greater access to such resources would place rural areas at increased disadvantage and could lead to further siphoning of resources away from them. It could also exacerbate the imbalance in the system between large city-based institutional health services and low-tech primary health care delivered in the communities where people live.

The difficulties of maintaining an adequate health workforce of both clinicians and administrators in rural areas frequently results in the closure or downgrading of local hospital services in favour of transfers to regional centres. These decisions are usually made without community involvement, and they are not necessarily in the community's best interest. They often seem to be made on the basis of budgetary or workforce considerations rather than health outcomes. For every service provided at a distant site there is a cohort of people who

[14] UK Dept of Health (2002) – *Reforming NHS financial flow introducing payment by results*. London, Dept of Health; Kirby MJL & Keon W (2004) – Why competition is essential in the delivery of publicly funded healthcare services. *Policy Matters* **5:8**

do not access that service because they are unable or unwilling to travel to it. For some people, difficulties or delays in reaching the service will deliver unacceptable outcomes.

One of the fundamental causes of much of the waste in the Australian health care system is the lack of emphasis on primary health care. The more that services are moved from the rural community setting to hospitals and services in regional centres, the more the attention of federal and State governments and the community is directed towards the provision of highly technological and expensive acute care services. While different levels of government may gain short-term advantages through cost-shifting, the overall cost of health services increases and appropriate coordination of locally provided primary health care services declines.

5. Appropriate funding arrangements

The overriding tension in the Australian health care system is that no one level of government takes responsibility for the delivery of essential health care services. Moreover, most commentators would agree that the current health care system

> *has little or no rationality. Some services, such as those offered by public hospitals, are free. Some, such as prescription pharmaceuticals, are subject to co-payments, but these are capped. Some, such as ambulatory services, are subject to open-ended co-payments where the consumer bears the risk. And some important services, such as dentistry and physiotherapy, receive no public insurance cover at all.*'[16]

Current funding arrangements create artificial barriers between primary, acute and aged care services. This is particularly absurd in rural Australia where the distinction between hospital and community, public and private, acute and aged care services, is largely academic. Doctors practising privately in rural areas are in many places the same doctors who are contracted as Visiting Medical Officers in the local public hospital. Under the joint Federal/State Multi-Purpose Services program, rural hospital beds can also function as long term aged care beds for elderly residents who do not have access to alternative care arrangements.

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[15] RM, *pers. comm.* 9 May 2005
[16] McAuley (2003) *op cit.* p 14

Change in health care delivery is needed to deal with the changing needs of the population as it ages. New, complementary funding mechanisms must reflect the new models of care that are emerging in response to the changing demographics and particular disease profiles. The Primary Health Care Access Program for Indigenous communities in northern Australia which pools contributions from both federal and State-funded services and is managed at the community level to address specific local needs is a good example of this.

RDAA believe that a fee for service system must the basic mechanism of remuneration for medical services. However, it acknowledges the need to provide other blended payments which reward or recognize particular factors. Some of these payments, for example Rural Retention Payments, are a major factor in supporting the rural workforce and must be maintained. They should also be extended to shore up rural practice through adequate on call and relief arrangements. However, some circumstances, for example in remote areas, where other models like funds pooling may be needed.

RDAA believes that additional dedicated funding is needed to support the coordination of care through multidisciplinary teams of health care providers. Given that *consulting a doctor is the most common action related to health care taken by Australians* [17] clustering these teams around general practice is likely to increase access, enhance service sustainability and generate efficiencies in a thinly stretched health workforce. A reformed health funding system must support this approach and the infrastructure needed to maintain it and it must support cross-disciplinary education and team skills training. It must also provide incentives for the provision of timely health promotion, prevention and early intervention by primary health care providers and facilitate the structured collaborative management of chronic diseases. Aligning funding to parallel a patient's journey through the system would have a significant impact on both health outcomes and overall health system costs.

There is general agreement in the literature about the key areas where health systems can achieve greater efficiency, quality and equity. These include better coordination of care, prevention and early intervention, access to care and affordability.

i. *Better coordination of care*

[17] AIHW (2004) *op cit.* p 394

Coordination between general practice, other community-based services and hospitals is haphazard and largely reliant on individual relationships among providers and services. Relatively recent policy initiatives, including the establishment of Divisions of General Practice, the More Allied Health Services program and the Enhanced Primary Care MBS items, have attempted to address this lack of integration. However these initiatives do not deal with the underlying systemic fragmentation and competition among sectors for scarce resources (but the same patients!) that characterise the Australian health care system.

For example, the new MBS dental and allied health items provide Medicare access for multidisciplinary primary care services, but are restricted to those patients with complex care needs being treated under an Enhanced Primary Care Multidisciplinary Care Plan. As Lokuge *et al* note:

> *While targeted programs can act as short-term boosters to regional health services, their effect is relatively insignificant compared with the regional importance of mainstream health financing policies and programs: Medicare, the Pharmaceutical Benefits Scheme, and private health insurance (PHI) rebates.*[18]

Coordination of care must be supported by effective information and communications technology and management systems that provide all health practitioners and care givers with access to accurate and timely information about an individual's treatment and support the delivery of structured, proactive care for patients with chronic illnesses. The health system has been relatively slow to adopt the benefits of information technology; current initiatives to achieve greater integration and flow of information among health care providers are welcome, but further research is needed on the drivers of technology uptake in health care, particularly in private medicine, and additional incentives to increase uptake based on relevant strategies.

ii. Prevention and early intervention

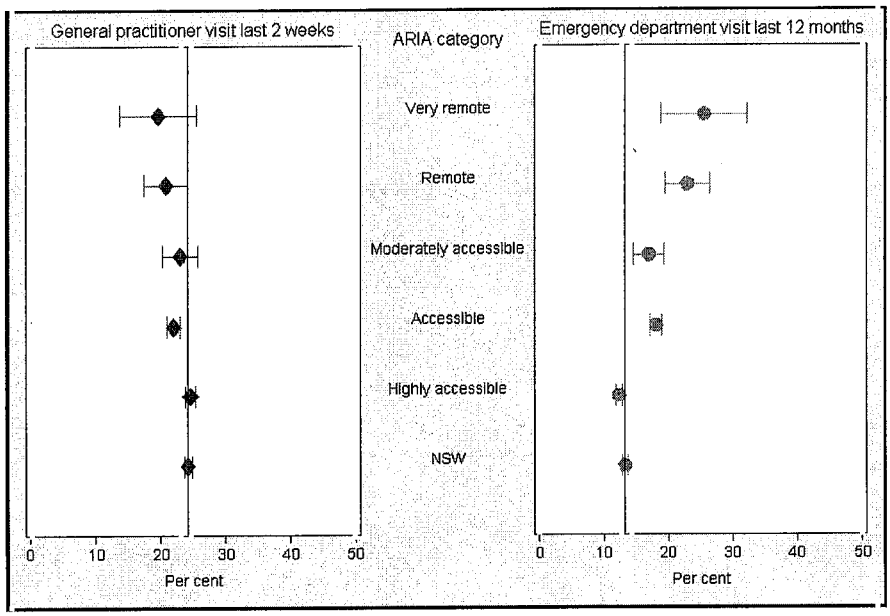
RDAA strongly supports the Minister for Health and Ageing's strong emphasis on health promotion and disease prevention. The changing burden of disease, with chronic and co-morbid illnesses comprising a greater proportion of health needs and costs, means that the

[18] Lokuge B, Denniss R and Faunce TA (2005), Private health insurance and regional Australia, *Medical Journal of Australia*, **182: 6**

delivery of care must also change. Given that many of these conditions are largely preventable, greater emphasis must be given to addressing their common risk factors and intervening earlier in the disease path.

General practitioners are 'the hub in the wheel' of primary health care and play a significant role in prevention and early intervention and the avoidance of unnecessary hospitalisations. Data suggests that where general practice services are limited, hospital admissions are correspondingly higher.[20]

Figure 2: GP and emergency department visits by accessibility/remoteness, person aged 16 years and over, NSW 1997 and 1998 [21]



Rural doctors are increasingly expected to play a role in public health and population medicine, but as a leading commentator on health reform wrote recently:

> *Primary care physicians [are] naturally expected to play a major role in [these areas] but current remuneration packages make it very difficult for our general*

[20] NSWHealth (2004) – *The health of the people of New South Wales: report of the Chief Health Officer 2004.* Sydney, NSWHealth p 151

[21] NSWHealth (2002) – *The health of the people of New South Wales: report of the Chief health Officer, 2002.* Sydney, NSW Health p 132

practitioners to give an appropriate amount of time to address lifestyle issues with those who most need that advice.[22]

McAuley suggests that:

Reforming hospital funding, to bring more competitive neutrality to private and public hospitals, is an important aspect in health finance reform, but it should be only one step in integrating all health care services, including preventative, ambulatory and pharmaceutical care. Many episodes of expensive (and risky) hospitalisation could be eliminated through better-resources preventative and primary care programs.[23]

iii. Access to care

Lokuge *et al* note that *the lack of convenient, affordable and timely access to general practitioners, specialists and after-hours care is widely accepted as a major problem for Australians living in regional areas.*[24]

A case in point is rural obstetric services. The safety and continuity of care provided by small rural maternity services, staffed by rural GP obstetricians and midwives, has been demonstrated in Australian and international studies. However, recent policy changes apparently based on urban paradigms (or myths?) have seen the closure of over 120 maternity units in numerous rural areas over the last decade. There is no evidence of improved obstetric outcomes, but increasing media reports of unfortunate incidents including roadside births as women are forced to travel greater distances from their homes to seek birthing care.

Denniss argues that:

Increasing access to health care facilities and allied health professionals in regional areas is critical to improving the health outcomes of people in rural and remote areas compared to those in metropolitan areas... Regional hospitals have

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[22] Dwyer J (2003) - Opinion piece. *Australian Financial Review* June 12 2003

[23] McAuley I (2004) - Stress on public hospitals – why private insurance has made it worse. A discussion paper for the Australian Consumers' Association and the Australian Healthcare Association. January 2004 p 19

[24] Lokuge et al (2005), *op cit.* p 290

[26] Denniss R (2003) - Health spending in the bush: an analysis of the geographic distribution of the private health insurance rebate.
http://www.google.com.au/search?hl=en&q=rural%2C+private+health+insurance&btnG=Google+Search&meta=cr%3DcountryAU, accessed 28/4/05 p 2

traditionally supported GPs and substituted for specialist care in regional areas... However, the shortage of GPs persists.[26]

Estimates of the general practice workforce vary widely, but recent research suggests that there is a shortfall of approximately 16% - 18% in rural and remote areas. Nearly half (44%) of the rural population lives in an area of severe shortfall.[27,28]

The concentration of medical practitioners in metropolitan areas results in inequitable access to services elsewhere and as a consequence, the Medicare rebate which is repatriated to non-metropolitan areas is significantly less...In short, the Medicare levy which is collected from all Australians ...regardless of where they live is not repatriated to all Australians equally.[29]

Initiatives that aim to support and improve the health of those who live in the bush must therefore include components that encourage the recruitment and retention of an adequate health workforce, particularly general practitioners. International evidence has shown that the number of primary care physicians is positively correlated with national health outcomes and health care cost containment.

iv. Affordability

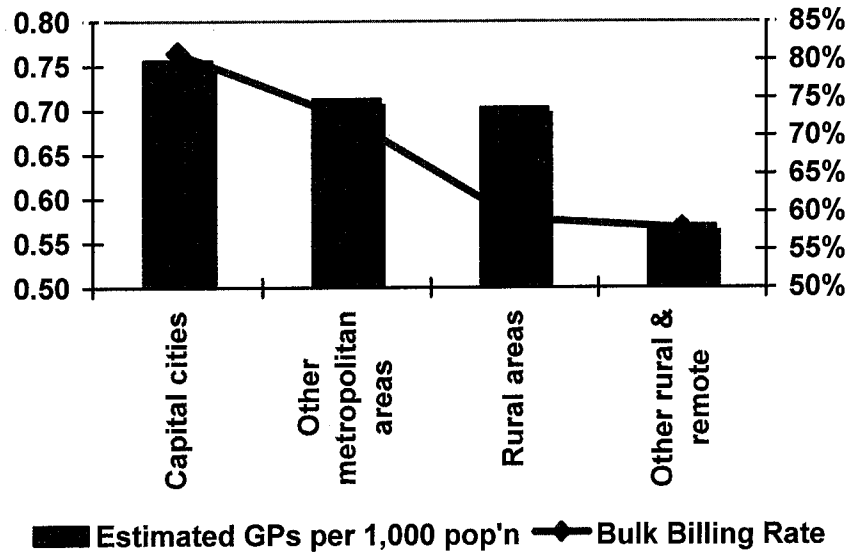
Finding ways to simplify and streamline the health care system must take into account the generally lower socioeconomic status of people in most rural and remote areas. Twelve of the 20 least advantaged federal electoral divisions are classified as rural or remote. Thirty-six of the 40 poorest areas of Australia are rural or remote. Analysis using the Socio-Economic Indexes for Areas (SEIFA) shows that whether measured by indexes of advantage and disadvantage, economic resources or education and occupation, people who live in the cities are generally better off than those who live elsewhere.

The lower rates of bulk billing in rural areas reflect the higher costs of supplying medical services outside major centres. That they are not related to workforce shortfalls can be seen in

[27] Access Economics (2002) - An analysis of the widening gap between community need and the availability of GP services. A report to the Australian Medical Association. Canberra, AMA
[28] Australian Medical Workforce Advisory Committee (AMWAC) (2000) - The general practice workforce in Australia: supply and requirements - 1999-2010. Sydney, AMWAC
[29] Wagga Wagga City Council (2003), *op cit.*

Figure 3 below by comparing the different rates of bulkbilling in Other Metropolitan and Rural Areas where the patient-doctor ratios are very much the same.

Figure 3: Bulkbilling rates by area [30]



Thus halting and reversing the bulk billing decline in rural Australia can only be achieved through strategies that respond to the higher cost structures there. RDAA's *Viable Models of Rural and Remote Practice* identified economic issues ("adequate rewards for the skills, responsibility and workload of rural and remote doctors") as a major factor in the sustainability of rural medicine. [31] The rural market for medical services is relatively inelastic in terms of both supply and demand. Therefore the most effective leverage will be achieved by enhancing the attraction and viability of rural general practice through a higher rebate in these areas.

International evidence suggests that adequate funding will also help to address workforce shortages, particularly if this is part of wider support for rural areas:

> *...increasing physician numbers does not change their geographical distribution, but educational, regulatory and financial policies may be*

[30] Department of Health and Ageing (2003)
[31] RDAA & Monash University (2003) – *Viable models of rural and remote practice: Stage 1 and Stage 2 Reports*. Canberra, RDAA

effective...To attract more physicians to rural areas, these supply side policies may need to be accompanied by policies that sustain the economic and social viability of rural communities.[32]

RDAA has been advocating for some years for a differential Medicare rebate for rural Australians to redress the inequity in health funding between metropolitan and rural areas due to both the higher rate of socioeconomic disadvantage and the higher cost of delivering medical services in rural and remote Australia.[33] A differential rebate on socioeconomic grounds (as a proxy for lower health status) alone would be very difficult to apply nationally, however, the application of a rebate based on existing geographic classifications of rurality and remoteness would be manageable and help to address the needs of almost one third of Australians whose lower health status is aggravated by lower access to affordable medical services.

Further, general medical practice varies according to its setting and population intake and country practice is different from urban practice in a number of ways:

Rural doctors carry a higher level of clinical responsibility and provide a wider range of services in relative isolation... Certainly rural doctors live and work in a different world from their urban counterparts. The psychology and sociology of rural communities are markedly different from the cities. Also the spectrum of illness and injuries with which rural doctors have to cope is specific to rural areas, and the structure and process of health services in the country are quite different.[34]

The 2003 study of viable models of rural practice also confirmed that rural and remote general practice is more complex and requires a higher level of skills, responsibility and related cost, for example continuing professional development and essential equipment that would otherwise not be available to patients.[35] Furthermore, most rural doctors spend a proportion of their working time (ranging from 10% to 70%) providing acute care in the local

[32] Simoens S (2004) - Experiences of Organization for Economic Cooperation and Development countries with recruiting and retaining physicians in rural areas. *Australian Journal of Rural Health* **12:3**
[33] RDAA (1999) - *RDAA responses to Regional Australia Summit. Theme 3: Health.* Canberra: RDAA.
[34] Strasser R (1995) - Rural general practice: is it a distinct discipline? *Australian Family Physician,* **24;5**
[35] RDAA (2003) - *Viable models of rural and remote practice: Stage 1 and Stage 2 Reports.* Canberra, RDAA

hospital.[36] This responsibility does not apply in urban areas where hospitals carry their own staff and other health care services are available to complement the range of care – acute, routine and preventive - which the country doctor has to provide without local backup.

The cost and complexity of rural medical practice needs to be recognised and rewarded in the remuneration accessed by rural doctors through the MBS. This could be done through the establishment of a Rural Consultation Item Number (RCIN) or a complexity loading on relevant services. This strategy is advocated by RDAA based on current research and the practical experience of rural doctors across the country.[37] It would address both the complexity of rural medicine and the higher costs of service provision in rural and remote areas. It would also create a financial incentive that will assist in recruiting and retaining rural doctors and improving health outcomes in rural and remote areas.

In addition, use of the WCI5 index for Medicare indexation (or half WCI5 as it was for some years), has resulted in an erosion of MBS rebates in real terms as well as an erosion of real incomes of GPs. While the WC15 is a useful Department of Finance tool in other areas of economic policy, it does not cover costs specific to medical practice and therefore results in fee increases that do not keep pace with growth in practice costs. Moreover, while data demonstrates that larger practices can achieve economic efficiencies of scale which enhance their sustainability, areas of low population density cannot support larger practices and many small centres cannot only sustain a solo practice. The viability of smaller rural practices must therefore depend on a more equitable funding system.

One alternative worth noting is the indexed financial support scheme in the RDANSW Rural Doctors Settlement Package. This contract negotiated with the NSW government by the Rural Doctors Association incorporates the AWOTE index and a number of other key determinates of the cost of rural practice. Since its inception in 1987, its scheduled fees have gradually risen from 85 to 130 percent of the MBS fee. The success of the scheme in attracting and retaining doctors to work in rural hospitals (the average length of stay in rural NSW is 16 years, compared to a national average of 9 years) indicates that agreed conditions and appropriately indexed financial support works well when it guarantees adequate

[36] Mildenhall D, Mara P, Chater B, Rosenthal D, Maxfield N, Boots A, Humphreys J, Jones, J & Jones M (2003) - Sustaining healthy rural communities through viable rural medical practices. Paper presented at the 7th National Rural Health Conference, Hobart.

remuneration and recognises the value of services provided. The adoption of similar models in other states would help to minimise their workforce deficits.

RDAA contends that higher Medicare reimbursement for rural patients, combined with an appropriate indexation mechanism, is the best way to address the declining rate of bulk billing in country areas, to remove one of the barriers to viable rural medical practice and to help address workforce shortfalls.

> *At the end of the day we run a small business, we charge for our services and Medicare provides a method of reimbursing patients for those services. If the rebate was set at a level that allowed medical practices to be financially sustainable, then the bulk billing rate would increase. After all this is what happened when Medicare was introduced. It is only in the last few years as the Medicare rebate fell below any reasonable indexation and cost basis that GP's have had to raise their fees to remain viable.*[38]

6. Quality and accountability

Australia has significant safety and accountability mechanisms in place for general medical services. General practitioners who wish to work unsupervised are required to undertake several years of postgraduate education to obtain Fellowship of the Royal Australian College of General Practitioners (FRACGP). The vocational recognition which enables access to higher Medicare rebates is available to FRACGP holders and also to other doctors practising in designated areas of workforce shortage who undertake continuing professional development. Many rural doctors acquire additional skills through training specific to rural medicine, particularly the Fellowship of the Australian College of Rural and Remote Medicine (ACRRM), the RACGP Graduate Diploma in Rural Health or a variety of separate modules, for example relative to advanced emergency skills and procedural medicine delivered by the specialist colleges and some universities. However these additional skills receive no financial assistance once registrar training is completed, nor ongoing financial recognition as would be provided by a merit based system.

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[37] RDAA (2001) - *Rural Consultation Item Numbers Information Pack 2001*. Canberra, RDAA
[38] GS, *pers. comm.* June 2003

In addition, practices that wish to access the federal government's Practice Incentive Payments (PIP) scheme, which now represent around 20% of remuneration, must maintain practice accreditation against the RACGP minimum standards for practices. In addition, some elements of the PIP (such as the Mental Health incentives) require additional training in mental health. The disease specific items all follow evidence-based care protocols.

RDAA supports these initiatives to maintain and enhance the quality of care being provided to the Australian community. However, the additional costs, both financial and in human resources, faced by rural practices in meeting the requirements for accreditation must be recognised and compensated. Solo and small practices in rural towns that cannot sustain larger services, and Aboriginal Medical Services in particular, are severely constrained by a lack of resources and lack of capacity to instigate accreditation processes, which means they are further disadvantaged by not being able to access the payments available through the PIP.

7. Private health insurance

There is good international evidence that heavy reliance on private sector funding of health services results in higher overall public expenditure on health,[39] although one author, from a study commissioned by a private health fund, has argued that *it would cost the government more to allow PHI to dwindle than to continue to support it.* [40]

In Australia, the recent policies supporting uptake of private health insurance have been extremely costly, but alternative methods of subsidising private hospital services, other than indirectly through the private health funds, have not been considered. For example, it has been suggested that government could directly fund the current level of private hospital services for approximately the same amount as the 30% insurance rebate. Furthermore, private *insurance* (as distinct from private health *services)* is relatively inefficient compared with public insurance of health services, with 11.3% of precious health care resources diverted to administration in 2001-02 (compared to approximately 4.8% administrative costs for Medicare, including taxation collection costs).[41]

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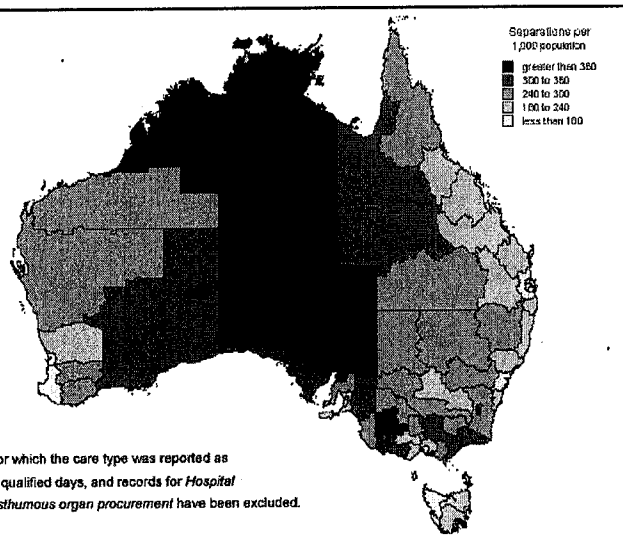
[39] McAuley (2004), *op cit.* p 15
[40] Harper IR (2003) - Health sense: when spending money saves money. *Policy* Spring www.cis.org.u/policy/spr03/polspr03-3.htm, accessed 21/04/05
[41] McAuley (2004), *op cit.* p 13

It has also been suggested that the redirection of (financial) resources into the private hospital system has meant that doctors are spending less time providing services in public hospitals where remuneration is generally lower and this is why waiting lists for public hospital services have seen little relief despite the increase in private hospital service provision.[42]

> *In health care, particularly hospital care, which is intensive in skilled labour, the most crucial resources are in constrained supply. There are shortages of both medical practitioners and nurses, and any replenishment of supply will take many years. When more money is directed at one sector (i.e. at private hospitals through the private health insurance subsidy), then there is no subsequent increase in resources in the system as a whole. Unless there are productivity improvements available, the inevitable result is some combination of movement of skilled staff from one sector to the other, or a rise in the payment necessary to retain the services of skilled staff.* [43]

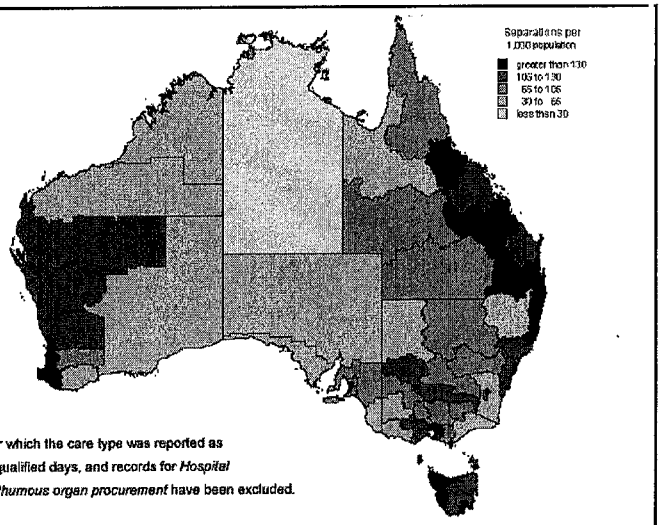
This potentially affects rural areas even more acutely. Private hospitals tend to be concentrated in metropolitan regions.[44]



(a) Separations for which the care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

Figure 7.8: Separations(a) per 1,000 population by Statistical Division of usual residence, public hospitals, Australia, 2002-03

[42] Duckett SJ (2005) - Private care and public waiting. *Australian Health Review* **29:1**
[43] McAuley (2004), *op cit.*
[44] AIHW (2004 - *Australian Hospital Statistics 2002-03.* Canberra, AIHW, [HSE 32] p 173



(a) Separations for which the care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

Figure 7.9: Separations(a) per 1,000 population by Statistical Division of usual residence, private hospitals, Australia, 2002-03

Private hospital beds account for 34 percent of total hospital beds in capital cities, but for only 17 percent in small regional centres and 6 percent in other rural and remote areas.[45]

One of the main benefits of private health insurance cover is to have access to private hospitals.[46] Private hospitals make location decisions primarily on financial criteria based on projected numbers of users. Therefore people living in rural and remote areas of Australia are highly unlikely to have the same level of access to private hospitals as those living in metropolitan areas. Furthermore, *the indirect nature of the private health insurance rebate means that the Government is unable to influence the regional distribution of private health services.*[47] People living in rural and regional areas are missing out on both public and private health services.

RDAA believes that the unique conditions of health service delivery in rural areas must be explicitly considered in any initiatives designed to improve *relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in various levels of government.* In fact, rural Australia has led the way in developing innovative and collaborative models of care involving private general

[45] Strong K, Trickett P, Titulaer I & Bhatia K (1998) - *Health in rural and remote Australia.* AIHW, Canberra, cited in Denniss (2003), *op cit.*
[46] Denniss (2003), *op cit.*
[47] *Ibid.*

practitioners, outreach medical specialists, allied health and hospital services, local governments and the community. These moves must be fostered and resources made available to communities to facilitate similar initiatives focused on their particular local needs and circumstances. Innovative models such as 'place based health planning' should be fostered as a means of more effective health resource allocation.[48]

Given income levels are lower in rural and regional areas compared to the national average, private insurance, and the considerable gap fees that accompany use of private services, will also be more unaffordable for a higher proportion of the population in these areas.

Because people who live in rural Australia have less access to private hospitals, those with incomes above $50,000 (the level at which the tax penalty kicks in) are doubly disadvantaged by being forced to carry private insurance, even though it carries no benefit. If they do not carry it, they may suffer the Lifetime Health Cover penalty for taking out private insurance after age 30 if their circumstances change and they can or need to access private sector services. The private health insurance rebate thus exacerbates the existing health inequalities between metropolitan and regional Australia.

Denniss has suggested that: *Due to their lower rate of private health insurance coverage, rural and regional areas receive an estimated $100 million less of the Government's private health insurance rebate than they would if funds were allocated on a per capita basis.*[49] Further, it has been estimated by the National Rural Health Alliance that rural and remote Australians pay $43 million more in out of pocket costs on a proportional basis for their health services than those living in urban areas, due to higher average out-of-pocket expenses relating to gap payments for GP and pharmacy services and travelling costs.

The 2004-05 Federal Budget, provided funding of $830.2 million over 4 years for the Rural Health Strategy, which includes the Regional Health Services, Medical Specialist Outreach Assistance and More Allied Health Services programs, GP and Registrar recruitment and retention programs, rural medical scholarships and the rural private access initiative.[50] In contrast, the private health insurance rebate is estimated to cost anywhere from $2.5 to $3.7

[48] Yeboah DA (2004) A framework for place based health planning. *Australian Health Review,* 29; 1: 30-36.
[49] Denniss (2003), *op cit.*
[50] Australian Government Department of Health and Ageing (2004). Budget 2004-2005 Fact Sheet Health 4.

billion *per annum*, which, it has been shown, is distributed inequitably between urban and rural areas.

Additional resources must be directed to rural communities to provide greater access to affordable health care for the almost one third of Australians who reside there, and to redress the inequitable distribution of federal health funding due to lower uptake of private health insurance by rural Australians.

7. Conclusion

The one third of Australians who live in rural and remote areas carry a higher disease burden than other Australians, yet they do not have equal access to either public or private health services. Workforce shortages of health professionals in the country compound the lower socioeconomic status of rural Australians. The inequitable distribution of government funding through policies such as the private health insurance rebate means that rural Australians, despite their demonstrably greater needs, are subsidising the health care of people who live in urban areas.

RDAA believes that any reforms to the health system must explicitly consider the needs of Australians who live in rural and remote areas and Aboriginal and Torres Strait Islander peoples as they bear the greatest morbidity and mortality burden. This means that policies and programs must be designed to achieve an equitable, rather than equal, distribution of health resources among the population, based on differential needs and ability to access care whether provided by public or private health services.