NATIONAL RURAL HEALTH ALLIANCE INC.

Submission to the Standing Committee on Health and Ageing's Inquiry into Health Funding

July 2005

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Contents

This Submission is based on the views of the National Rural Health Alliance, but may not reflect the full or particular views of all of its Member Bodies.

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THE NATIONAL RURAL HEALTH ALLIANCE

The National Rural Health Alliance is the peak body for rural and remote health in Australia. Its 24 Member Bodies have a shared commitment to improving the health and well-being of people in rural and remote Australia and a common goal of equitable access to appropriate health services for all Australians, regardless of their geographical location. The Members are both consumer and provider organisations.

Some of the best examples of innovative health practice and teamwork are in rural and remote areas. Nevertheless, in aggregate, health status is poorer outside the capital cities, health risk factors are more common, and the range of services narrower and more costly to access.[1] There is evidence of worse health outcomes in remote and very remote areas, not all associated with the higher proportion of Indigenous population in remote areas. Other features of remoteness with financial implications are the small, mobile and dispersed population, as well as lack of public infrastructure such as sealed roads and public transport. These factors all result in higher costs, both to consumers out-of-pocket and to government, and so should result in higher unit allocations of resources to health services in remote areas.

The Alliance pursues a balanced line between the bad news and the good: there are certainly special health needs in rural and remote areas; but some of the existing services and many of the existing health professionals and workplace opportunities there are the best in the land.

One particular issue for the Alliance is the phenomenon captured by the phrase "No Doctor, No Medicare". The shortage of doctors and the current shape of Medicare mean that people who can't see a doctor are missing out – even though the better-off among them still pay taxes and the Medicare levy. It is essential that the contract relating to primary health care between government and the people represented by Medicare is met by other means where there are no doctors. This is a challenge for Australia's health funding system.

The Alliance takes a broad view of the determinants of health and when its Members have an agreed view it speaks out on issues like rural development, transport, socio-economic status and telecommunications. It is a rural and remote group but the Alliance recognises that health depends on strong partnerships that include metropolitan interests: partnerships among individuals, groups, organisations and governments in all parts of the nation.

The Alliance works with its Member Bodies:

- to identify priority needs in rural and remote health and promote appropriate action;
- to provide feedback on the impact of government policies in rural and remote communities;
- to collate information and develop knowledge on key issues in rural and remote health;

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[1] see *Rural, Regional and Remote Health: Indicators of Health*, AIHW, Canberra, May 2005.

- to disseminate information to those with an interest in rural and remote health; and
- to develop strategic alliances with other groups that have the potential to improve health outcomes.

The work of the NRHA is based on principles of social justice and the right of all Australians, wherever they live, to comprehensive, high quality, accessible and appropriate health services. The Alliance also works to help the diverse communities of rural and remote Australia to be healthy and health-promoting places in which to live and work.

It works in a way that involves consumers as partners with health care providers – doctors, allied health professionals, nurses, pharmacists, Aboriginal Health Workers, dentists, managers, hospitals and other facilities.

The Alliance was a co-signatory with Departments of Health to *Healthy Horizons - Outlook 2003-2007.* This is in effect the national strategy for improving the health of people in rural, regional and remote areas. The Alliance is manager of the biennial National Rural Health Conference and the Australian Journal of Rural Health. It is national manager of the Australian Government's Rural Australia Medical Undergraduate Scholarship Scheme (RAMUS).

THE ISSUES

The apparently simple title 'health funding' in fact connotes a number of separate and important considerations. For instance, it would be possible to have a re-distribution of existing health funds without any change in the total amount allocated nationally. If health funding is considered as a zero sum game then more on, say, programs for early intervention might mean less on acute care in tertiary institutions.[2]

The Alliance's priorities are the rural and remote dimensions of this complex matter. The particular factors of interest to us on which changes in 'health funding' may bear include the distribution of the health workforce, the distribution of health facilities, the nature and extent of special rural and remote programs, the shape of Medicare, the health capacity of local governments, some research questions and reform of the health care system.

DISTRIBUTION OF THE HEALTH WORKFORCE

Both the amount of funding available to the health sector and the way it is spent affect aspects of the health workforce: how many professionals there are, where they are distributed, how they are trained and supported, and how they are remunerated. It is well known that there are currently national shortages in all parts of Australia's health workforce. Wherever there are shortages, the worst of them are in rural and remote areas.

The Alliance has, over the years, emphasised not only the shortage of doctors in rural and remote areas (which is well known) but also the shortages of nurses, allied health professionals, dentists, pharmacists and managers – which are less well known and recognised.

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[2] One over-riding issue is the higher unit cost of providing health services in rural and remote areas.

These workforce shortages have serious impacts on health consumers and are powerfully described in two catch phrases:

> "No Doctor, No Medicare", and
> "No pharmacist, No subsidised pharmaceuticals."

There are a number of reasons for people not having access to doctors. Some people live in areas where there is no doctor; others cannot see a doctor either because the books are closed or they cannot afford it. Whatever the reason for their lack of access, such people are missing out on low-cost or no-cost access to the nation's most important primary care giver.

Several aspects of 'health funding' impact on such workforce shortages. First, it might be argued that the total amount of money being spent on health, and/or the proportion of GDP, is insufficient overall. Second, and more cogently, it is now clear that Australia is investing insufficient resources in the training of new professionals in many health sectors, notably medicine, nursing and allied health[3]. Thirdly, it is clear that the failure of the value of the Medicare rebate to keep pace with increases in the costs and complexity of rural practice results in a lack of incentive for GPs to practise in country areas. Fourthly, it may be argued that the continued maldistribution of the health workforce shows that insufficient resources are being devoted to special programs for recruitment and retention to rural and remote areas.

There is ample evidence of health workforce shortages and clearly several ways in which funding impacts on the situation. Each of the four circumstances listed above can be the focus of specific ameliorating activity: for example, more undergraduate places in health sciences and medicine can be allocated and funded; given the evidence that scholarships for undergraduate medicine for rural students help increase the supply of trained doctors to rural areas, such an approach can be extended to nursing, physiotherapy etc.[4]

DISTRIBUTION OF HEALTH FACILITIES

No-one expects people in small country towns or on pastoral properties to have immediate access to health infrastructure like dialysis machines, but it is accepted that people's lack of access to health facilities is a health risk factor. People with poor access have to pay higher costs when they make use of health services and sometimes the costs are so great that in effect they do not have access at all. What this means is that people in more remote areas tend to be diagnosed later and less comprehensively. This explains poorer survival rates for people in rural and remote areas with cancer and other cumulative diseases.

The absence of public transport and personal transport difficulties are pervasive factors inhibiting access to health services in many rural and remote areas.

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[3] In other documents and places the NRHA has argued strongly for Australia to move to the position in which it is making a net contribution to the world's supply of health professionals.
[4] The Alliance is currently promoting such extensions to allied health undergraduates.

As with the distribution of the health workforce, the volume and accessibility of health infrastructure is a function of both the total volume of resources allocated and the way they are distributed.

Taken together, the impact of health funding on both workforce and physical infrastructure for health underlines the obvious fact that the status of our health system is determined by (among other things) the amount of national income spent on it. Currently Australia spends around 9.5 per cent of its GDP on health[5]. There is nothing fixed or automatically correct about this figure, which in fact represents a lower proportion than in many other developed nations. If Australia's people want to have more than 9.5 per cent spent on health, they will only have to agree also on where public savings in other areas may be made and then move for this through political processes. After such decisions have been made it will follow that more money will be available for selected aspects of the health system. (The NRHA's challenge will then be to ensure that at least 30% of this extra is spent on the 30% who live in rural and remote areas.)

THE NATURE AND EXTENT OF SPECIAL RURAL AND REMOTE PROGRAMS

It is widely recognised that people in rural and remote areas have worse health status overall than people in the major cities. They also face a higher number of risk factors[6]. As already summarised above, people outside the major cities also experience the worst of the shortages of health professionals and facilities.

These circumstances combine to produce a 'rural and remote health deficit' which is recognised by governments. One of the results is that governments fund special health programs for rural and remote areas, including such things as General Practice Recruitment and Retention Initiatives, institutions like University Departments of Rural Health and Regional Clinical Schools, and programs in particular functional areas like allied health and mental health. There are such special programs as these at both national and State or Territory level, with the bulk of the associated expenditure coming from the Australian Government.

Despite this special attention, there is still a health differential between country and city people. Health funding systems must therefore continue to support the special rural and remote interventions and if the deficit persists there is an argument for their further augmentation.

The committee's attention has been drawn in an earlier submission to the relative amounts currently spent on special rural and remote programs and on the private

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[5] Spending on health accounted for 9.5% of GDP in 2002–03; up from 9.3% in the previous year; *Health expenditure Australia 2002–03*, Australian Institute of Health and Welfare, Canberra, September 2004; AIHW cat. no. HWE 27.

[6] The most recent and comprehensive evidence of these well-known facts appears in AIHW's Rural, Regional and Remote Health: Indicators of Health, May 2005.

health insurance rebate. Currently the former is running at $830 million over four years with the latter estimated to cost between $2.5 and $3.7 billion a year.[7]

THE SHAPE OF MEDICARE

Medicare is a major part of health funding and its shape determines much of the impact on health consumers of that funding. With some procedures being included under Medicare and others not, there is clearly differential access to services. The fact that Medicare affects the price of services may not matter to people who can afford to buy whatever services they need, but is a matter of the greatest significance to those who depend on subsidised care for their treatment.

The arbitrary nature of Medicare is illustrated with reference to the diabetic foot. This not uncommon concomitant of diabetes can be treated by amputation under Medicare but not treated in a prophylactic manner under Medicare by a podiatrist.

In submissions to the Senate Select Committee in June 2003 and December 2003, the NRHA has written extensively on its views about Medicare. The Alliance is concerned that some of the recent changes have reduced and endangered the program's principle of universality. It is also concerned that the amendments to Medicare have included much of the attention there has been on workforce issues. Medicare is not the best or only vehicle through which health workforce strategies can be implemented. There is still the need for a strategic national approach to the health workforce and this will hopefully be forthcoming from the work just commissioned through the Council of Australian Governments and through the Inquiry of the Productivity Commission.[8]

There have been some very encouraging recent changes in Medicare's shape including some new items for practice nurses and, in certain circumstances, for allied health and dentistry. The reasons for great caution with respect to Medicare's shape are clear; they stem from the potential impact on the health budget of major changes to its coverage. Nevertheless there can be few elements of greater importance to 'health funding' than the way Medicare is shaped and operated.

THE CAPACITY OF LOCAL GOVERNMENTS

Local government has an important but often understated role in relation to health. Especially in rural areas local authorities often provide incentives for practitioners to establish themselves and to remain in operation. The Rural Medical Infrastructure Fund is a welcome new program which will support such activities.

Perhaps of even greater importance is local government's role in creating and supporting communities that are healthy places in which to live. Through their provision of sports facilities, cycle ways, immunisation, health inspection, and their

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[7] The submission from the RDAA also points out that private health insurance, and so rebates related to it, are of relatively little value to rural and remote people because of the relative short supply of private health facilities.

[8] A summary of the need for health workforce reform, and some of the available options, is in the paper by Robert Wells to the 8th National Rural Health Conference; it can be accessed through the NRHA website.

capacity to support local public health programs, local authorities have a major role to play in health promotion and illness prevention. The question that arises, then, is whether local authorities in rural and remote areas have any differential capacity to be involved in such work. We do not have clear evidence on this but it is well known that rural councils have a smaller revenue base, fewer staff (including in health and community development departments), and face higher cost structures.

There is a very big variation in the capacity of councils to commit funds to health and health infrastructure. Small rural and remote councils do not have the capacity to employ persons with specific single roles, all available health dollars going to attracting and retaining doctors and in some instances aged housing. Some of these issues are accommodated in local government grants formulae but there must still be questions about the relative capacity of rural local authorities to be successfully involved in health promotion activity.

RESEARCH QUESTIONS

There is some important unfinished business in relation to health research and health funding issues. One of the perennial curiosities in health finance is the fact that the health/medical consumer price index (CPI) has for some time been running at twice the rate of normal CPI. This is presumably partly because the costs of procedures in private hospitals are higher than in the public sector. There is clearly an important issue here relating to costs and prices in the health sector and further research on the subject would reveal the causes, justifications and potential resolution.

It is commonly accepted that the best investment in a healthy life is in healthy pregnancies and the first three-five years of childhood. This is also the case in aggregate: a rebalancing of health funding to shift expenditures from life-extending interventions and technologies for older people to further investment in healthy pregnancies and young children would reap substantial returns. The general case of this is that health expenditures should be redirected so as to emphasise health promotion and early intervention as distinct from curative and life-extending procedures. Although this general case is already accepted it would be more likely for the necessary political decisions for such changes to be made if there was good research evidence about the quantity of national and patient benefits that would accrue.

A third question of particular interest to the NRHA relates to the out-of-pocket costs to consumers of accessing primary care. In its submissions on Medicare the Alliance has consistently argued that the level of out-of-pocket costs borne by consumers is a key determinant of their real access. The Alliance would like to see clearer evidence about the level of these costs in various areas and the impact of various levels on consumers' decisions about accessing primary care.

REFORM OF THE HEALTH CARE SYSTEM

Health funding is implicated in, and will be affected by, the current drive to reform the Australian health care system. The momentum for has been building for some time and has been given further weight by the decision of the Council of Australian Governments (COAG) made on 3 June 2005.

The NRHA is one of many organizations that sees great potential from further health care reform, notwithstanding the fact that our system and health status are of an internationally high standard overall. The key elements of health care reform agreed by COAG relate to:

- simplifying access to care services for the elderly, people with disabilities and people leaving hospital;
- helping public patients in hospital waiting for nursing home places;
- helping younger people with disabilities in nursing homes;
- improving the supply, flexibility and responsiveness of the health workforce;
- increasing the health system's focus on prevention and health promotion;
- accelerating work on a national electronic health records system;
- improving the integration of the health care system;
- continuing work on a National Health Call Centre Network; and
- addressing specific challenges of service delivery in rural and remote Australia.[9]

Because many of the worst impacts of the current deficiencies of the system are experienced in rural and remote areas, it follows that people in those areas stand to be disproportionately benefited through health care reform when it is achieved. The NRHA will therefore remain a strong supporter of the push for reform and will be keenly involved in it.

A FINAL WORD

This submission has described a number of the ways in which aspects of health funding impact on the health system and, through it, on the health and well-being of individuals. Our interest remains the specific elements of these issues that relate to people in rural and remote areas or to the health professionals or physical infrastructure in those areas.

The NRHA believes that there are spatial dimensions to all aspects of health funding: the quantum, the distribution, the special allocations for particular population groups, and the prospect of reform of the system. Health funding, and so the attention given to it, is not a unitary issue. The impact of amending each specific element needs to be assessed carefully for its effect on particular people. Those who live and work in rural and remote areas continue to deserve particular consideration.

[9] Council of Australian Governments Communiqué, 3 June 2005.