National Rural Health Alliance

Productivity Commission –

Inquiry into the effectiveness of Part 3 of the *Future Drought Fund Act 2019*

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Healthy and
sustainable rural,
regional and remote
communities
across Australia.

National
Rural Health
Alliance

Postal address:	PO Box 280 Deakin West ACT 2600
Address:	10 Campion St Deakin ACT 2600
Phone:	02 6285 4660
Email:	nrha@ruralhealth.org.au

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The National Rural Health Alliance (the Alliance) is pleased to provide a submission for consideration to the Inquiry into the effectiveness of Part 3 of the *Future Drought Fund Act* 2019. The Alliance is the peak body for rural and remote health in Australia. We represent 45 national Members (see www.ruralhealth.org.au/about/memberbodies) and our vision is for healthy and sustainable rural, regional and remote (rural) communities across Australia.

The Alliance recognises the importance of initiatives funded through the Future Drought Fund and understands that more initiatives will need to be supported and funded through this or other similar funds to support rural communities that bear the brunt of the impact of drought. In this submission, we are taking the opportunity to bring to your attention a range of issues and initiatives that the Alliance believes will support rural communities preparing for, and impacted by, drought and provide this information in the context of your term of reference to:

- Provide specific and practical advice to inform the development of a new Funding Plan; the development, delivery, monitoring and evaluation of future programs, arrangements and grants; and the processes and systems to administer the Fund.

Background

Rural Australia is not only home to more than seven million Australians, it also contributes the majority of the nation's economic worth, with around two-thirds of Australia's export earnings coming from regional industries such as agriculture, tourism, retail, services and manufacturing.[1] Add mining and resources to this equation and it becomes stark that rural Australia is producing the great majority of Australia's exports with the Reserve Bank noting that resources alone are 62.8 per cent of Australia's exports.[2]

Farmers produce about $60 billion worth of goods each year. The agriculture supply chain supports **1.6 million jobs**. More than 99 per cent of Australia's agricultural businesses are wholly Australian owned, the majority are family owned and operated.[3]

Despite the enormous contribution made by rural Australia to the general prosperity, resilience and wellbeing of the whole country, people living in rural Australia have poorer access to health services than other Australians, with the number of health professionals (including nurses and midwives, allied health practitioners, general practitioners, medical specialists and other health providers) decreasing as geographic isolation increases. Per capita, rural areas have up to 50 per cent fewer health providers than major cities. As a result, Australians living in rural areas have, on average, shorter lives, higher levels of disease and injury and poorer access to and use of health services, compared with people living in metropolitan areas.[4]

Despite a high level of awareness of the significant disparities in health outcomes between urban and rural Australia, health outcomes for rural Australians have not been considered a priority, beyond disaster support, with health outcomes stagnating and, in many instances, declining.

The Alliance advocates that all Australians, wherever they live, should have access to comprehensive, high-quality, accessible and appropriate health services, and the opportunity for equitable health outcomes. The Alliance does not consider that poor health or premature death should be an accepted outcome of living in rural Australia, especially when Australians as a whole rely on and benefit from the primary industry, mining, tourism and service export and supply income from this 30 per cent of the population.

Long-term impact of drought on mental health and wellbeing

Drought has an impact on people who work on the land or are involved in associated industries, along with their communities. It has been associated with accumulated mental health exposure for people living in rural areas.[5] Drought can cause stress, and this is more likely in farmers who are younger, both live and work on a farm, experience financial hardship or are isolated geographically.[6]

The impact of drought on mental health is thought to be modulated by the characteristics of the drought and the remoteness of the resident. People living in areas with a population of fewer than 1000 who experience a cumulative long period of drought, coupled with a recent prolonged unbroken dry period (long and constant), reported higher levels of psychological distress on a Kessler-10 (K10) scale.[5] Their levels of distress are in the sub-clinical range of moderate distress, putting them at increased risk of developing a mental health disorder.

An association has also been found between drought severity and suicide in rural males aged 30 to 49 years. In a retrospective study, there was a 15 per cent increase in the relative risk of suicide in this demographic group when the drought index rose.[7] A link has been proposed between background levels of psychological distress (to which drought contributes) and suicide.[8] The disease burden due to suicide and self-inflicted injuries increases with remoteness and in remote areas is 2.2 times that of major cities.[9]

This population group already faces barriers to help-seeking and accessing care due to sociocultural factors, availability of health services, and structural barriers such as travel and cost.[8,10] These drivers of inequity are an important consideration for mitigating against some of the mental health impacts of drought.

Mental health support for people in rural Australia

While the above outlines that drought has a major impact on mental health for people in rural communities, with particular concern for farmers, the availability of mental health services does not match this need. As outlined in the Alliance's *Mental health in rural and remote Australia* fact sheet (July 2021), in relation to mental health services, the rate of service reduces with increasing remoteness in each professional category except 'other allied health'. The highest rate of service in each remoteness category is provided by general practitioners (GPs), yet GP mental health specific services reduce significantly in Remote and Very Remote areas. Services provided by a psychiatrist reduce dramatically once outside of Major Cities, as do those provided by clinical psychologists.[11]

Rural Australians are less likely to access MBS-funded primary mental health care services than their city counterparts, yet more likely to utilise state and territory community health services. They are also more likely to present to an emergency department with a mental health concern and more likely to be admitted to hospital for a mental health problem in Remote and Very Remote areas. When rural Australians access hospital-based mental health care, they are less likely to receive specialised psychiatric services.[11]

The livelihood of many rural people relies on the land and associated industries, making them more exposed to the effects of extreme weather events and climate change, including drought, bushfires and floods. In the broader context of lower incomes, lower educational attainment and higher rates of unemployment, rural people face the challenge of cumulative and ongoing adversity, with its subsequent impact on mental health and wellbeing. When combined with inadequate health workforce to meet population need and barriers to accessing services – geographic distance, cost, waiting times, privacy concerns, attitudinal factors and digital barriers – it is evident that there is significant unmet need.

Structural barriers such as the need to travel vast distances to access care, and costs related to travel, accommodation and time away from work are also a significant concern. While access to digital carer and support services may ameliorate some of these barriers, reduced digital literacy in consumers and health professionals, lack of access to digital infrastructure (including reliable and affordable internet and mobile phone connectivity, hardware and interoperable software), presents challenges to equitable access outside of major cities, where the potential for benefits is large.

Though digital health care reduces barriers due to geographical distance, might be more accessible for people who lack flexibility in their work and family commitments, and provides the benefit of privacy for those living in smaller communities where this is a concern, its uptake might be limited by reduced digital literacy and lack of universal access to a reliable, affordable internet connection, There is also the risk that a generic online program, or one supported by a clinician from another geographic location, will miss the contextual nuances a clinician embedded within a community would be aware of. Though there are many potential benefits, it may also be that people who have overcome barriers to seek help need human connection, particularly in the context of the COVID-19 pandemic. Hence, we continue to advocate for improved provision of appropriate face-to-face services in local communities, in addition to increased access to high-quality online services.

Primary care – the backbone of health care for drought-affected communities

The Alliance believes that further support needs to be given for primary care in rural communities. This is needed for communities generally but also to support people and communities affected by the impact of drought.

The current Medicare Benefits Schedule (MBS) universal health system rewards high-volume, single-health-issue patients. It does not provide enough access or support for patients of smaller rural general practices without a critical volume of patients, where those patients cannot make a co-payment. The situation is also difficult for many private allied health, nursing and paramedic services, as there are very few MBS items that patients can claim. This reduces financial viability for practices and makes those services unaffordable for many rural people.

When rural primary care practices recruit professionals, they are not able to compete with the salaried government conditions, flexibility and moveability offered under a single-employer paid model that allows for a minimum five-year contract, support and security.

A new approach is needed to address the poorer health outcomes, rural health deficit and maldistribution of the health workforce experienced by rural communities. A new model of rural health care is needed to overcome the barriers to attracting and retaining a rural health workforce, which are:

- Professional – limited networking opportunities, clinical experiences and supervision; professional isolation and lack of support from peers; and work–life balance issues, such as long on-call rosters.
- Financial – practice financial viability; cost of infrastructure purchase, maintenance and potential subsequent sale in a thin market; the need to work across multiple settings; multiple sources of both government and private funding; administrative burden; and business acumen requirements.
- Social – lack of family and friendship networks; social isolation; cultural and recreational limitations; and partner concerns including careers and children's education.

Models of care that work for metropolitan areas do not work in rural Australia. Supporting people in droughts and other climate disasters is a fundamental component of health care provision in rural communities. The Alliance has developed a model of primary care which we believe should be supported and funded in rural Australia. The model is known as Primary care Rural Integrated Multidisciplinary Health Services (PRIM-HS).

More details about the Alliance PRIM-HS model and associated costings can be found in our 2023-2024 pre-Budget submission

What are PRIM-HS?

PRIM-HS will be community-based organisations that offer a comprehensive and affordable range of primary healthcare services. They should be not-for-profit organisations funded by government, designed and established by local communities to meet their primary healthcare needs in flexible and responsive ways.

PRIM-HS will employ a range of primary healthcare providers including rural generalists, nurses and midwives, dentists and allied health professionals. The mix of practitioners employed will depend on the needs and circumstances of individual communities, with consideration of existing healthcare providers. Health practitioners will be supported by administrative staff (including practice managers), to ensure that clinical staff can focus on clinical practice. The PRIM-HS paradigm supports medical and allied health rural generalist models and pathways, including opportunities for structured supervision and support.

PRIM-HS overcome the barriers to attracting and retaining a rural health workforce. They provide secure, ongoing employment with a single or primary employer, attractive conditions including leave provisions (holiday, personal, parental and long service leave) and certainty of employment and income.

Most importantly, PRIM-HS are not an urban-based corporate entity, 'cherry picking' the profit out of rural communities. The Alliance believes that Australia has a social and economic contract to build regions, not just to take the best from them. This requires support to determine need and investment at the grassroots, in local people, local services and regions. A funded PRIM-HS would be ideally placed to help communities prepare for drought including building resilience and offer services that can help address health needs of people affected by drought.

PRIM-HS do not rely on health practitioners committing to establish their own practice, with the attendant responsibilities of operating a financially viable, standalone business (managing staff, administration and compliance), in what are generally thin markets. This employment model makes it easier for health practitioners to take up a rural position, knowing they can focus on their professional practice without the stress of establishing, purchasing or running a practice in a thin or failed market.

PRIM-HS support work–life balance, minimising social and professional isolation through peer support from a multidisciplinary team and overcoming related negative perceptions of rural practice. Employment conditions recognise and support continuous professional development and specific accreditation requirements and can provide the opportunity for training and research collaborations. PRIM-HS provide ready connection to the local community, with support and advice available regarding accommodation, employment opportunities for partners, education options for children, and social and recreational activities.

The health workforce shortage in rural Australia often means that older people or people with disabilities cannot access the support and interventions they need and are eligible for, including medical, nursing, allied health, dental and pharmacy, across a range of settings: residential aged care facilities (RACF); National Disability Insurance Scheme (NDIS) benefits; and support through the

Department of Veteran's Affairs (DVA). PRIM-HS has the potential to provide in-reach services for RACF, NDIS and DVA recipients, as well as for rural people with chronic disease, including those with chronic disease management or other similar care plans.

PRIM-HS are not intended to compete with Aboriginal Community Controlled Health Organisations (ACCHOs). Where appropriate, PRIM-HS will work collaboratively to ensure that all primary healthcare services, serving the full spectrum of community members, can thrive. PRIM-HS acknowledge the holistic, comprehensive and culturally appropriate health services provided by these distinct organisations.

PRIM-HS are also not intended to compete with existing health professionals in a community or threaten the viability of existing services. PRIM-HS are aimed at supporting communities where there is a lack of primary health care and would be implemented to ensure existing services are enhanced. Hence, PRIM-HS will be co-designed with local health consumers, providers and organisations to address local needs, offering a range of services that are better integrated across all sectors.

The Alliance has been working with various stakeholders that have driven this proposal. This has included specifically working with primary care organisations (PHNs, local government, RFDS, private practice, community organisations) to develop the model. These organisations have been based in New South Wales, Queensland, South Australia and Tasmania where the market has already or just about failed. The Alliance proposes that the model is relevant for primary care organisations based in MM3–7 locations.

The PRIM-HS model requires government funding from dedicated, additional and ongoing mechanisms to ensure their sustainability in thin and failing rural markets that serve, on average, older, sicker and more disadvantaged communities including communities affected by drought and those which have often not received the access they require.

Rural hospitals and ACCHOs receive block funding in acknowledgement that activity-based funding is not sufficient to support sustainable services in rural areas. The funding of primary health care should be no different. The issues with lack of sustainability in primary care are the same as in secondary and tertiary care.

The current funding streams for rural practice are fragmented, complex and narrowly focused, and act as a disincentive to rural practice and the establishment of multidisciplinary teams. These teams should include an appropriate mix of medical, nursing and midwifery, allied and other health practitioners.

A single PRIM-HS (using a population of 3,000 as an example, noting that the population will vary) is estimated to cost, starting in the first year, $3,361,600 ($2,361,600 taking into account Medicare billing income of $1 million). Given the significant unmet need in primary health care in rural areas, the Alliance believes that the Government should commit to the roll out of a significant number of PRIM-HS in order to make a real impact on the lives and wellbeing of rural Australians.

National Rural Health Strategy and Implementation Plan

The Alliance is seeking an integrated National Rural Health Strategy and Implementation Plan to address enduring healthcare workforce, access and affordability issues, and to include the rural health sector in responding to climate change and in local disaster planning including drought and emergency management. Drought has a greater impact on people in rural Australia and a National Rural Health Strategy would go a long way to strategically planning for the health needs of people in drought affected communities.

The Government has an obligation to support the full spectrum of primary healthcare services throughout the country. The emergence of significant new health challenges in recent years gives added impetus for a new and current National Rural Health Strategy.

A commitment from all levels of government to support a National Rural Health Strategy will be critical to its success and capacity to drive reform and structural change. Support for the objectives of the Strategy, as well as collaboration and action across governments, will be key drivers required to achieve the aims of improved accessibility, equity and rural health outcomes. In particular, a commitment is required from governments to additional funding to support rural access to the full spectrum of health professionals, including medical, nursing, allied health, dental, paramedicine and pharmacy.

A new National Rural Health Strategy should acknowledge that rural and remote communities are different to metropolitan communities and that each rural or remote community has particular circumstances and needs. Any new Strategy must address the lack of progress in improving the health outcomes for those living in rural Australia. It should consider the barriers and incentives for attracting and retaining a rural health workforce, how to incentivise and provide greater investment in preventive health as well as acute care, and how to fund and administer models of care that are flexible and responsive to local needs. It will also address the need to mitigate the impacts of climate change, drought and other disasters in respect to health access and outcomes for people in rural areas.

Considering they represent 30 per cent of the population, there is an urgent need for a health strategy for the seven million people living in rural Australia.

Recommendations

- Ensure access to health services for people in drought-affected areas is a priority for the Future Drought Fund.
- Introduce and fund Primary care Rural Integrated Multidisciplinary Health Services (PRIM-HS). This is a model proposed by the Alliance of comprehensive, multidisciplinary primary health care for rural Australia that would address the barriers to recruitment and retention of a rural health workforce, in order to increase its size and improve its distribution, therefore enabling improved access to high-quality, culturally safe health care in rural Australia. This model requires block funding, enables a flexible employment model, creates a multidisciplinary team and is locally designed and led, ensuring close links between the service and the community it serves. The PRIM-HS model has the potential to be a key mechanism in the provision of universal primary health care to people experiencing disadvantage in rural Australia.
- That the Australian Government commit to developing an integrated National Rural Health Strategy and Implementation Plan to address (not limited to) workforce, access and affordability issues, climate change, drought, food security and health promotion and prevention in rural locations.
- Prioritise ongoing investment into communications infrastructure in rural Australia in order to improve coverage, reliability and speed, as well as reduce cost, to improve equity in digital inclusion by geography. This is essential for accessing health services and health information, particularly in times of vulnerability such as drought.

Conclusion

While the Alliance supports remedial funding to support drought-affected communities, there is an urgent need to address the additional and inequitable issues faced by rural communities through a long-term shortage and maldistribution of primary and other health care providers which has developed over the past few decades. These communities have sustained Australia with food production and our valuable exports and GDP contribution. Yet these same communities do not have access to equitable health care.

Governments should be taking a whole of system approach to addressing the impact of drought, fire, floods and other disasters which take a greater toll on rural and remote Australia. To do otherwise, will not keep Australia in the economic prosperity and status it has come to enjoy and rely so heavily upon.

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