NATIONAL RURAL HEALTH ALLIANCE INC.

Mr Paul Lindwall
Commissioner
Productivity Commission Inquiry into Transitioning Regional Economies
GPO Box 1428
CANBERRA ACT 2601

Dear Commissioner Lindwall

Transitioning Regional Economies

The National Rural Health Alliance (the Alliance) welcomes the opportunity to provide comments and suggestions for consideration by the Productivity Commission Inquiry into *Transitioning Regional Economies*.

The Alliance is comprised of 38 national member organisations covering more than 250,000 individual members. We are committed to improving the health and wellbeing of all people living in regional and remote Australia[1]. Our members include consumer groups, representation from the Aboriginal and Torres Strait Islander health sector, health professional organisations (representing doctors, nurses, midwives, allied health professionals, dentists, optometrists, paramedics and health service managers) and health service providers. A full list of Alliance members is at Attachment A.

The Alliance has identified that one of the most significant drivers to improve health and wellbeing in regional and remote communities is through unlocking the economic and social value of the 7 million people who live outside Australia's major cities. Transitioning to new economic bases will drive regional and remote innovation and productivity forward. The Alliance believes that it is vital for regional communities to identify and support new economic bases and it is key to improving health and wellbeing – particularly for people living in remote communities, who have some of the worst health outcomes of all Australians.

The ideal time to have planned for transition to new regional economies was at the height of the mining and resources boom. At that time, funding should have been set aside to plan and fund the development of emerging issues that could take root and become the next wave of development and growth once the resources wave had passed. This has not occurred and we are now seeing regional and remote communities facing significant concerns about their long-term sustainability and viability.

[1] Throughout this submission, references to remoteness are based on ASGC-RA, in which category 1 is Major cities, 2 is Inner regional areas, 3 Outer regional, 4 Remote and 5 Very remote. In the submission, references to "regional areas" mean Inner plus Outer regional; and references to "remote areas" mean Remote plus Very remote.

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Nevertheless, empowering communities to seek their future through embracing new locally-based opportunities is the only option for communities that are determined to maintain their connection to the people and place that is part of their very soul.

The Alliance supports the (re)development and growth of regional and remote communities as they seek to redefine a future that includes viable long-term jobs and opportunities for current and future generations. The Alliance also believes that these communities must be at the heart of this development activity with expert support to help them to identify, consider and prioritise their future options.

General comments

For communities and their expert support, considering the future direction of their communities, the single most vital need is for accurate, up to date information focussed on their local area. The Alliance believes that there is an urgent need for better access to data to support the development of policies and to plan for growth and development throughout regional and remote Australia.

In recognition of this need, the Alliance developed its *Little Book of Rural Health Numbers*, which was our attempt to bring together data from a myriad of providers into a single, accessible location.

The data required to understand the level of community need is diverse and from multiple sources. One of the major issues with much data collected through surveys, rather than through Census, is that the survey population often under-samples, or simply does not sample, remote communities. As the Alliance found in its recent work looking at the health impact of food insecurity in regional and remote communities, the data available significantly understates the degree of the problem because of this methodological issue (1). The lack of data, or poor quality of data, results in policy developed that does not adequately understand the level of local need. Issues that should be a priority are not identified because the data is simply not accurate. As a result, the issues that urgently need attention are not addressed.

Timeliness of data is also an issue: often the only data sets publicly available are up to five years old making recognition of trends or changes difficult or impossible. It is difficult to find public data that includes remoteness – for example employment data looks at major cities and the rest of the state/territory. This is particularly unhelpful if you are looking at trends in smaller remote communities and trying to explore linkages with socio-economic and health outcomes. Again, the lack of accurate data makes the recognition of areas facing significant issues difficult, as is accurate targeting of policy to address areas of specific need.

Finally, data needs to be local. National and jurisdictional data rarely provides the level of granularity required for local needs assessment, planning and decision-making. There is huge variation in access and outcomes for services between communities that may not be geographically far apart. Data on those variations at a local level is necessary to enable local responses to different local needs, including addressing their underlying causes.

These comments are as much accurate when one considers the economies of smaller regional and remote communities as they are when referring to health outcomes specifically.

Regional experiences of transition

Regional and remote communities have had differing experiences both through the resources boom and as that boom waned. Communities such as Karratha in the Pilbara attracted residents into the town and up to 5 years ago, housing prices were unsustainably high. As the mining boom wound down, people who paid almost $1 million for a three bedroom house then found that the value of that property more than halved.

Other communities, including those in the Galilee Basin in Queensland, had a very different experience of the resources boom. Many towns found that they did not attract residents from the fly-in-fly-out workers and thus did not expand to address growing needs.

Communities that are able to diversify their economic base during a resources boom will be best placed to address the challenge of transitioning once that boom ends. Where there are opportunities for tourism, education and agriculture, communities may be well placed to ride the transitional wave securely.

However, where communities have expanded to support the resources sector without seeking to diversify their economic base and where the opportunities for diversification are more limited, these communities are at risk of not only not transitioning well, but also of no longer being viable.

Identifying whether communities will transition well requires analysis of not only economic and social data, but consideration of the local environment and existing infrastructure.

Are there significant landmarks or National Parks that may be suitable to expand tourism options? Are the conditions suitable for different forms of agriculture? Does existing infrastructure provide a base for expanding educational options that could help to build a local workforce to meet changes in community needs? As the National Disability Insurance Scheme rolls out and the aged population expands the need for additional workforce will help drive expansion of local health and community services.

A detailed assessment of local demographics and analysis of local community needs over a ten year period may well identify opportunities for growth that can help communities retain their younger people and develop a self-sustaining cycle of community growth.

Health outcomes as a proxy for need

The Alliance has a long-standing interest in the broader causes of poor health outcomes in rural and remote Australia including access to social housing, lower income levels in regional and remote communities and the way in which complex health needs impact on the range of human services an individual and the carer and family may need to access. The Alliance believes that it is not possible to consider these issues separately due to the way in which each affects and impacts upon the others.

For example, poor access to social housing, and the current poor quality of much social housing stock in remote communities, leads to overcrowding, which in turn is reflected in poor hygiene, poor school attendance of children, higher levels of illness in children and adults and in long term poor health outcomes and poor compliance with treatment.

For this reason, examination of the health status of people in remote communities in particular, can be indicative of the broad level of unmet social need as well as the level of unmet health need. Similarly, the lesson for policy makers is that it is unrealistic to expect to see improvement in health outcomes in those communities without addressing the underlying causes of those poor health outcomes.

The prevalence of chronic diseases, particularly of people with multiple chronic diseases, is significantly higher outside the major cities. Some key facts comparing the prevalence of chronic diseases outside the major cities with major city prevalence:

- There are 10% fewer people with no chronic disease outside the major cities;
- There are similar numbers of people with one chronic disease;
- There are around 20% more people with two chronic diseases outside the major cities;
- There are around 50% more people with three or more chronic diseases in Inner regional communities; and
- There are around 30% more people with three or more chronic diseases in Outer regional communities[2].

At least some of the reasons for the differences above can be explained by the different age structure of regional and remote communities and by recognising that people with more complex care needs in remote communities move into regional centres as they age and need better access to care and social services. Compared with Major cities:

- Regional populations have proportionally more children, fewer young adults, fewer people of working age, more people in late working age approaching retirement, and more elderly people.
- Remote populations have proportionally more children, fewer young adults, slightly more people of working age, similar numbers of people in late working age approaching retirement, and substantially fewer elderly people.

For every ten working age adults aged 25-54 years, there are:

- three elderly (65+) people in Major cities,
- four elderly people in regional areas and
- two elderly people in remote areas

Further, mortality data indicates that the number of people who die with multiple chronic diseases is 20-30% higher in regional Australia than in major cities and lower in remote areas. It should also be recognised that older people would prefer to stay in their

[2] These data are drawn from crude rates that have not been age standardised. Source: http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4364.0.55.0012014-15?OpenDocument

community with their family and friends, and in exploring transitional options, meeting these aspirations may provide pointers to economic diversification. The delivery of services closer to the individual in need will lead to the generation of jobs and educational opportunities that at present do not exist and which need to be factored into any economic cost benefit analysis underpinning discussion of potential efficiencies.

Outreach services
Regional and remote Australia, and particularly the health sector, is reliant on the fly-in-fly-out/drive-in-drive-out and migrant workforce. Small communities do not have the population or therefore economic base to engage full time health professionals and the health sector has responded by developing a range of visiting support services that are successful in addressing community needs. However, they need careful coordination to ensure that those community members most in need are prioritised as well as being responsive to the specific needs of individual communities.

Successful service delivery in smaller remote communities is contingent upon providers taking the time to develop relationships with the community and to understand the community needs. Models of such service provision exist and should be transferable to other sectors of service provision.

Visiting eye health, medical specialists, dentists, general practitioners and nurses and allied health providers use a range of transport options to access even the most remote communities. Given the sparse population and distances between communities, the permanent location of practitioners in small communities is not viable. However, other options may be viable, including several communities combining together to engage regular visiting services that may be based in one of the communities or by communities working with the nearest larger centre to establish regular outreach services (the hub and spoke model).

The use of technology to support services is considered as the way of the future in small rural and remote communities, but is still dependant on broadband services that are accessible, reliable and affordable – which is not the current situation.

The changing nature of the rural and remote workforce
Increased professionalism is a growing feature across the delivery of human services nationally. In regional and remote communities, the growth of professionalism offers significant opportunities for current and future local employment growth. With access to appropriate education and training, growing local expertise to deliver professional human services, particularly in family and community services, child care, paramedical, health support and aged care should become the way of the future.

With regionally based universities now expanding their footprint to include smaller regional centres, the prospect of being able to train closer to home, with the possibility of training placements in local communities, seeking employment in the human services sector becomes more attractive to people who would previously have set aside these ambitions to remain within their community.

Universities need to be supported by a vibrant Technical and Further Education sector that offers increased access to quality education and training to enhance the growth in the human services workforce.

A further question for consideration is to what extent a range of support positions within the human services and other sectors could be appropriate for training through an accredited apprenticeship or mentoring system enabling portability of qualifications and offering a new supported stream of training and education to build the local workforce.

Planning for the future needs of communities should also consider the changing nature of the expectations of professionals providing the range of services the community needs.

For example, very few new doctors considering regional or remote practice are willing to buy into a general practice. This has resulted in development of different models of practice where an external community organisation, such as the local council or another organisation takes on the role of owning and managing the infrastructure, while the practitioner operates in a 'walk in- walk out' basis. For small communities, the cost of this form of operation may be considerable, although it also represents an investment in the long-term future of the community.

The need for fast, accessible broadband

Generally, there are greater vulnerabilities and challenges facing people living in regional and remote Australia. Poor access to adequate and affordable digital services only serves to deepen these vulnerabilities and challenges. In today's service delivery, internet access is almost mandatory, which places people in smaller regional and remote communities at a distinct disadvantage.

The Alliance believes that cost, access and proficiency are key issues in improving the delivery of first class health and human services in regional and remote Australia. The delivery of high quality telecommunication services offers potential gains for regional and remote communities in terms of improved access to education, health and business opportunities: but if the services available do not provide the quality and reliability required, such potential gains may be significantly diminished.

Kohen and Spandonide look at the way in which people in remote communities access telecommunication, noting that pre-paid services are the main source of access (2). They also note that charges are significantly higher in these communities, resulting in lower levels of access. With higher costs and poorer service quality, expecting the delivery of health services through apps and other mobile platforms will further disadvantage remote communities, particularly remote Aboriginal and Torres Strait Islander communities.

Lane et al undertook a case study of broadband access in rural Australia and their paper includes data on the limited availability of services, and greatly reduced download speeds, in rural and remote Australia (3). They indicate that the demand for data in rural and remote Australia is outstripping the capacity of current network services. While policies are in place to address these issues, Lane et al contend that the lag in delivery of those policies has resulted in efforts to address the inequality in service access being unsuccessful to date (3).

Lane indicates that affordability of broadband services decreases with remoteness as do the range of choices available to people seeking reliable, fast telecommunication and internet services with widely variable download speeds. They found that these limitations underlie significant dissatisfaction with the supply of broadband infrastructure in outer regional, remote and very remote households (3).

The need for improved telecommunication services in regional and remote Australia is urgent. If we are to address the need for greater professionalism and better access to information to empower human services users, then adequate and affordable technology and telecommunications must be available to meet the challenge. At present, they do not.

In conclusion
In supporting communities to transition from the resources boom to long-term growth and viability, communities will need support from a range of sources.

1. Data – Understanding the community and the options it may have available to explore transitional options relies upon quality, timely data.

2. Existing resources – having a detailed knowledge of resources currently available to the community and how the community uses its' existing resources

3. Needs – understanding community needs and aspirations will identify options for consideration.

4. Community buy in – without community support and ongoing engagement, it will not be possible to move to a more sustainable long-term economic base. Developing and maintaining a community plan to clearly articulate the way forward is vital.

5. Ongoing support – transition does not happen following a single intervention. It needs ongoing evaluation and support to ensure it is meeting community needs and addressing the issues identified through the analysis of needs, a community plan and regular feedback to the community.

6. Reporting and communication – dissemination of information about the process and its' outcomes not only acknowledges community activity, but provides models to other communities seeking to embark on similar journeys. Being open and honest about how the process was undertaken, what interventions were undertaken and how they were monitored and modified over time benefits all.

The National Rural Health Alliance is pleased to provide input for consideration by the Commission. Developing models to support the transition of regional and remote communities to a viable long-term economy is an issue we support strongly and will be happy to provide additional information and support as required.

Yours sincerely

David Butt
Chief Executive Officer
23 February 2017

References

1. National Rural Health Alliance. Food Security and Health in Rural and Remote Australia. Canberra: Rural Industries Research and Development Corporation; 2016 Oct.

2. Kohen A, Spandonide B. Switching on the remote: a new perspective on accessibility in remote Australia. Learn Communities. 2016 Apr;(19):76–97.

3. Lane MS, Tiwari S, Alam K. The Supply and Use of Broadband in Rural Australia: An Explanatory Case Study of the Western Downs Region. Australas J Inf Syst [Internet]. 2016 Oct 17 [cited 2017 Jan 16];20(0). Available from: http://journal.acs.org.au/index.php/ajis/article/view/1202

Attachment A

National Rural Health Alliance - Member Body Organisations
Australasian College for Emergency Medicine (Rural, Regional and Remote Committee)
Australasian College of Health Service Management (rural members)
Australian College of Midwives (Rural and Remote Advisory Committee)
Australian College of Nursing - Rural Nursing and Midwifery Community of Interest
Australian College of Rural and Remote Medicine
Australian General Practice Network
Australian Healthcare and Hospitals Association
Allied Health Professions Australia Rural and Remote
Australian Indigenous Doctors' Association
Australian Nursing and Midwifery Federation (rural nursing and midwifery members)
Australian Physiotherapy Association (Rural Members Network)
Australian Paediatric Society
Australian Psychological Society (Rural and Remote Psychology Interest Group)
Australian Rural Health Education Network
Council of Ambulance Authorities (Rural and Remote Group)
Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
CRANAplus
Country Women's Association of Australia
Exercise and Sports Science Australia (Rural and Remote Interest Group)
Federation of Rural Australian Medical Educators
Indigenous Allied Health Australia
Isolated Children's Parents' Association
National Aboriginal Community Controlled Health Organisation
National Aboriginal and Torres Strait Islander Health Worker Association
National Rural Health Student Network
Paramedics Australasia (Rural and Remote Special Interest Group)
Rural Special Interest Group of Pharmaceutical Society of Australia
RACGP Rural: The Royal Australian College of General Practitioners
Rural Doctors Association of Australia
Rural Dentists' Network of the Australian Dental Association
Royal Far West
Royal Flying Doctor Service
Rural Health Workforce Australia
Rural and Indigenous Health-interest Group of the Chiropractors' Association of Australia
Rural Optometry Group of Optometry Australia
Rural Pharmacists Australia
Services for Australian Rural and Remote Allied Health
Speech Pathology Australia (Rural and Remote Member Community)