NATIONAL RURAL HEALTH ALLIANCE INC.

Submission to the Productivity Commission Inquiry into Human Services

August 2016

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.

Good health and wellbeing for rural and remote Australia

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INTRODUCTION

This submission has been developed to provide the Productivity Commission with information for consideration as part of its Inquiry into Human Services, including the delivery of health care services in rural and remote Australia.

The submission is presented in two sections:

1. A discussion of the terms of reference and key issues and questions identified in the Commission's discussion paper against the delivery of health and related human services in rural and remote Australia.
2. Discussion of models of health service delivery in rural and remote Australia, their success (or otherwise) and how the lessons learnt can be applied more broadly in consideration of greater competition and user choice as well as contestability in the delivery of health and other human services.

This submission is from the perspective of the Alliance as an organisation committed to improving the health and wellbeing of people living in rural and remote Australia[1]. In Australia some seven million people - one third of the population - live outside major cities. Key issues in rural and remote health care are:

- The health profile of people living in rural and remote Australia is worse to the health profile of people living in the major cities.
- The health profile of Aboriginal and Torres Strait Islander people living in rural and remote Australia is significantly worse than that of non-Indigenous people.
- Access to health care services in rural and remote Australia is significantly more limited than access to health services in major cities.
- There is a maldistribution of the health workforce in Australia strongly skewed in favour of the major cities.
- Travel distance to services and out of pocket costs are barriers to timely access to health services for people living in rural and remote Australia.

More information on rural and remote populations and their health care is provided at Attachment A.

The concepts of user choice, competition and contestability are not new to the health and human services sectors. Perhaps the most interesting of issues raised by the Review's Terms of Reference[2] is the question of whose outcomes we are seeking to optimise. If the outcomes are to be assessed in terms of the end user, in this instance the consumer or patient, the issues to be examined will be significantly different to those relevant for the funder or the service provider.

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[1] ABS 2014-15 Publication 3218.0 Regional Population Growth Australia
http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3218.02014-15?OpenDocument

[2] The Commission is requested to examine the application of competition and user choice to services within the human services sector and develop policy options to improve outcomes. These options should lead to improvement in the sector's efficiency and effectiveness and help to ensure all Australians can access timely, affordable and high quality services, which are appropriate to their needs, and are delivered in a cost-effective manner.

With the health and aged care sectors moving to place an emphasis on consumer directed care, which is not mentioned specifically in the discussion paper, the question of who the outcomes are for is a core issue and will greatly influence the approach taken in considering competition and user choice within those sectors.

For the purposes of this submission, the Alliance will be responding to the outcomes for the end user – the consumer. The Alliance believes that if consumer directed health care, including implementation of the health care home model of health service delivery, is to be successful, the outcomes must be considered primarily from the viewpoint of the health consumer.

This is not to say that the view of the funder or provider is not important. But if the aim of the change in health care delivery is to improve health outcomes in the long term and deliver health benefits into the future, consideration of costs need to be viewed in the same timeframe to ensure the potential for long term gains.

The National Rural Health Alliance is able to provide any further information that the Productivity Commission may find helpful in considering this important issue.

ADDRESSING THE TERMS OF REFERENCE

What represents improved human services with regard to health care?

When assessing health service provision and models of care, quality, equity, efficacy and responsiveness of services are paramount. Health care must be of the highest quality and informed by best practice.

Workforce maldistribution exists in all healthcare professions. Shortages are worst for specialised care and mean that health care that would be provided by specialists in the city is provided by the limited number of general practitioners and allied health providers in rural and remote Australia and through the use of new and developing technologies, including telehealth.

In some instances GPs and nurses are professionally and physically isolated providing solo care to patients with limited or no allied health or tertiary specialists for referral. In such situations, they may be stretched and/or have limited expertise in the specific field, needing to make use of available technology to seek advice and support.

Chronic health practitioner shortages in rural and remote Australia also result in patients having limited options to choose a practitioner that can best meet their needs or who they feel most able to relate to. This may be particularly relevant where women prefer a female GP but the only available GP is male and the patient therefore actively avoids some important screening examinations. Similarly, men may defer prostate examinations because they are only able to access a female GP.

The Rural Women's GP Service was established to ensure women living in rural and remote communities had access to a female GP. This program has been incorporated into the Rural Health Outreach Fund, which is one of the health programs identified in the 2016 Budget to be cut significantly in 2017-18. How these cuts will impact access to female GPs for women in rural and remote Australia is unknown.

The Alliance defines equity of service in this scenario as patients having the same access to services in rural and remote Australia as in major cities. There is inequity in the distribution of health services across Australia. That is, people living in major cities have far better access to a range of health services than their counterparts in rural and remote Australia.

Responsiveness of health services is difficult to achieve in rural and remote communities. The tyranny of distance to nearest health service may make timeliness in seeking management and treatment difficult, although fly in fly out emergency services can mitigate in emergency or life threatening situations.

With regard to chronic disease management and other long term illnesses, essential members of the health care team such as endocrinologists or podiatrists are often only available in regional centres or major cities and as such, patients can wait many weeks or even months before they are able to visit these centres – leaving behind family and community not to mention livelihood. Further, travel to these centres can be prohibitively expensive. The only alternative may be for patients to wait for visiting specialised care.

In major cities, there are a range of services available within close proximity of a patient's home and accessible within reasonable timeframes. Patients may have a choice of provider. No such responsiveness exists for patients in rural and remote areas. Similarly, there are also barriers arising from economies of scale and volume of business, and maintenance of skills for specialists, making specialist practice outside a major centre significantly more problematic.

Key issues for consideration

1. Quality, Equity, Efficacy and Responsiveness are pivotal in providing health care.
2. Health care is highly regulated to ensure the highest quality and standards of practice.
3. Patients in rural and remote Australia have limited options and may choose to defer treatment where it is not convenient to travel (Equity).
4. Permanent placement of specialists outside a major centre may be unviable in remote Australia and access is therefore dependent on outreach and other service modalities.
5. Waiting times to access services in rural and remote communities is significantly longer than in major cities (Responsiveness).

What are the roles and responsibilities of Governments in the delivery of rural and remote health services?

Commonwealth, State and Territory and Local Governments all fund a range of services directly and indirectly in addition to the provision of private services delivered by a range of health professionals.

The primary funding vehicle utilised by the Commonwealth Government is the universal system of Medicare which underpins the health system and financially supports patients to receive primary and specialist medical care.

The Alliance strongly supports Medicare as the Australian health financing system. However, access to Medicare funding is heavily dependent on access to health practitioners, which is difficult in rural and remote Australia. There are almost twice as many medical practitioners per 100,000 population in major cities than there are in rural and remote areas[3]. This is particularly telling when comparing the Medicare spend per person in rural and remote Australia with that in major cities. People living in major cities access twice as much Medicare funding as those living in very remote areas. This clearly shows that rural and remote patients are accessing far fewer Medicare health services than their city counterparts.

The Alliance recognises the limitations of Medicare in the provision of health services in rural and remote Australia and recommends the implementation of more flexible funding arrangements for health services that meet the needs of rural and remote communities.

Additionally, there are even fewer allied health and specialised care services to support patients in receiving the care they need. There are up to three times fewer allied health providers in rural and remote areas. This is particularly problematic given their critical role in the prevention of disease and management of the progression of disease and illness.

[3] http://ruralhealth.org.au/book/health-workforce-0

In addition to Medicare funded services, the Australian Government supports the delivery of health through funding:

- Aboriginal Medical Services and funding for health initiatives through *Closing the Gap*;
- A range of Outreach services funded through the Rural Health Outreach Fund
- Support for recruitment and retention of rural and remote health practitioners;
- MultiPurpose Services;
- Regional Health Services;
- Regional Cancer Services;
- The Royal Flying Doctor Service and
- State and Territory Governments to support health care *et. al*.

State and Territory Governments also provide and fund a range of vital services including public hospital services and direct health service delivery through health centres and outreach services to supplement those supported by the Commonwealth Government. In addition, State and Territory governments provide patient assisted travel subsidies for people needing to travel significant distances to access medical care.

The use of outreach and visiting services is how rural and remote communities access the wider range of health services needed. These programs are already subject to a range of contestability measures and one could argue that the tender process to fund outreach also represents opportunities for greater competition from potential service providers.

Good coordination may be the key to making the myriad services most effective. But good coordination is often the point at which the question of who funds the coordinator rises to the surface.

Private health providers are present in rural and remote communities in addition to government funded services, although their presence is limited to sustainability of the service model they use.

In rural and remote Australia, the role of government funding is vital to ensure access to a wide range of health services that would otherwise not be available due to a combination of factors including the lack of a critical mass of population combined with viability and sustainability issues.

Where private health providers have access to Medicare funding, they are more likely to be present, but the more remote the location, the less likely the community is to have access to a private health care provider. The lack of private providers and private hospitals also limits the range of services available, and is reflected in the very low take up of private health insurance in rural and remote Australia.

In the face of such barriers to private health provision, the role of governments is, and remains, the single most valuable lever to ensure the delivery of basic health services in rural and remote Australia.

Key issues for consideration

1. Governments play a vital role in funding and delivering health care services in rural and especially remote Australia.
2. Without government action, there would be no services in many rural and remote communities due to market failure.
3. Innovative service models have been developed in response to the challenges of health service delivery in rural and remote Australia but have not been evaluated to determine patient outcomes, efficiency or cost effectiveness.
4. There are few private health providers the more remote the community.

What is competition in the context of rural and remote health service delivery?

The Alliance believes that 'major policy levers', including competition policy, should be used where they improve quality of life and access to services in rural and remote areas. However, it is impossible to ignore the issue of market failure, or the absence of markets altogether, when considering how competition principles might apply with respect to the delivery of health services in rural and remote Australia.

There is clear, longstanding evidence that the market for health service delivery is weak or absent in many parts of rural and remote Australia. Despite the existence of various programs designed to encourage more health professionals to practise in rural and remote areas, for example recruitment and retention financial bonuses, persistent workforce shortages remain in many places.

One of the central tenets of competition policy – the ability to choose between providers – does not always apply when it comes to delivering human services in rural and remote locations. If there are no providers in the area, or only one, then people cannot exercise choice. At best, many rural people have the option of choosing the only service provider in town, or going without.

What is not mentioned in the discussion above is the level of health literacy in rural and remote Australia and how that also impacts the ability of individuals to exercise choice. People living in rural and remote Australia have lower levels of health literacy which not only compromises their ability to exercise informed choice, but exposes them to higher risks of adverse outcomes[4].

The degree to which competition exists in rural and remote Australia is strongly linked to the size of the main community and the surrounding population. In many cases a community can only support a single, or part of a single, general practitioner. In other rural communities,

[4] Australian Institute of Health and Welfare 2012. Australia's health 2012. Australia's health series no.13. Cat. no. AUS 156. Canberra: AIHW; at 182

where more than one general practitioner may be present, the only viable service model may be for cooperation and collocation.

Much of remote Australia is subject to market failure with regard to the provision of health services and thus reliant on government intervention to provide these vital services. There is simply no private provider able or willing, to provide services into small remote communities on a regular basis. This is the point at which government subsidy is vital to ensure access to basic services through outreach and other visiting services.

In very small remote communities, the only access to health care may be through a Remote Area Nurse, who is working with an expanded scope of practice. Health practitioners working to their maximum scope of practice can result in more locally available services for rural and remote Australians. However, currently there is a lack of ability for nurses, particularly nurse practitioners, midwives and allied health practitioners to be able to provide a full service or scope of practice due to the restrictions built into the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme.

Possible models for increased user choice may include collaboration between Commonwealth and State/Territory governments to pool funding for a range of services. In this situation, it may be possible to explore a range of private and state based service providers working together collaboratively to offer a wider suite of health services. These could be further supported by collocation of other community service providers in a community hub model that expands on the MPS model. This could include one MPS site providing additional services such as community care, family support and social welfare.

Increasing competition also comes with risks. For example, tendering for services may result in a large provider winning a contract and displacing a small local provider on the basis of lower cost. Once established, the service may then raise prices, which results simply in displacing one provider, with loss of employment through displacement of the original provider. Competition in small communities must be considered in the broader context of the benefit of a service to the whole community: do patients have access to high quality health services; does it build on or supplement existing services; does it provide local employment and is it affordable to the community now and into the future while remaining viable?

Key issues for consideration

1. The existence of competition and therefore, user choice, in the current health service market in rural and remote Australia is severely limited.
2. There are innovative models of service delivery that could be explored with the engagement and agreement of Commonwealth and State/Territory governments that would result in greater access to services.
3. It is vital to ensure that changes in scope of practice within one health care profession do not compromise services offered through other health care providers.
4. Additional competition should be of benefit to the community in the long term.

What framework should be used to consider increased competition and contestability in rural and remote service provision?

With regard to increasing competition, user choice and contestability in rural and remote communities, the most important issues are:

- What are the health needs of the people in the community?
- What services are being provided? Can these be improved?
- What health needs are not being met?
- What options may exist for addressing unmet need?
- What are the overall community benefits – will there be opportunities for greater employment or investment in community infrastructure?
- How will options address long term viability issues?

The Alliance is keen to ensure that the unique circumstances of rural and remote Australia are given special consideration when developing policy in the human services area. In particular, policymakers need to be aware that in many parts of rural and remote Australia there is no realistic prospect of establishing a viable and sustainable market for service delivery. In these cases, the role of government must be different to that in a market driven major city. There may be limited utility in investing time and resources into attempting to establish markets in areas where evidence points to a high likelihood of failure.

The role of government in areas where there is no prospect of establishing a market can take various forms. It may include providing funding for salaried health professionals who are employed by government owned and operated health facilities. It may include providing subsidies and grants to private sector operators who are willing to set up practices in rural areas (for example medical and allied health professionals, or pharmacists), or making some services provided in rural areas eligible for government benefits (such as Medicare) where they are not if provided in city locations.

Encouraging service providers to relocate to rural and remote areas is only part of the challenge of establishing markets in these places. Once providers are there, governments need to take an active role in keeping them there. To improve the retention of health care and related service providers in rural areas, governments need to invest adequately in continuing professional development and training programs for these health professionals. Currently, there are many government programs and services in place that work along these lines.

Commissioning human services in rural and remote areas
Expanding user choice and increasing contestability implies a process of commissioning additional health services.

The current extent of commissioning human services in rural and remote communities varies widely across sectors and jurisdictions. In some areas, for example mental health and employment services, governments routinely commission non-government organisations to provide services. In other areas, for example acute and primary care (which in a rural and remote setting may include GPs and nurses), governments have tended to play a more direct

role by funding the establishment and provision of services, or by providing benefits directly to patients who use health services.

Because of the difficulties of establishing viable markets in some rural and remote areas, commissioning services from private sector or non-government providers tends to happen less often in these areas than it does in major cities. If there is to be a shift in government policy to rely more on commissioning services, the Alliance believes that special consideration needs to be given to how, or if, the proposed services might operate in rural and remote areas and to account for the higher costs of delivering services in rural and remote areas.

When faced with the typical situation of a relatively high cost of delivering services in rural and remote areas, there may be a temptation to compromise on quality in order to save costs. This may take the form of engaging inexperienced staff, or curtailing expenditure on staff training, supervision or continuing professional development – resulting in diminished service quality and effectiveness in those areas.

To ensure that commissioning (where it is required and acceptable) has the best chance of working in rural and remote areas, governments need to ensure that additional resources are allocated to monitor the safety and quality of service delivery. Quality assurance systems that work in metropolitan areas will not necessarily work in rural areas. For example, additional investment may be required to support travel out to rural and remote locations to assess the quality of service delivery. Alternative models for complaints handling may also be needed in rural and remote areas where people may feel uncomfortable criticising service providers that they live and work alongside. For example, it may be necessary to fund assessors or complaints officers from communities outside the local area to ensure that people feel able to make complaints about services provided by local people.

If there is a shift to commissioning in some rural areas, governments may need to provide additional support to existing providers so that they are not forced out of the market in the early stages. This is particularly important because many existing providers have years of valuable experience and detailed knowledge of the area in which they operate. Because there is a real risk that some new entrants may come to the conclusion that they cannot sustain operations in rural markets, it is vital that governments support existing providers to remain in operation in them. If they do not, rural people may be faced with the prospect of poorer access to care under a market model than they were when governments provided or funded services directly.

Finally, governments need to be aware of the risks associated with establishing markets in some areas of human service delivery while continuing to also fund services directly. For example, in the area of health services for special needs children, state governments directly fund early intervention services for children with autism while the federal government has shifted to a competitive tendering model for similar services.

Some Alliance members have observed that in rural areas this has prompted some allied health professionals to resign from their positions in the public sector and set up private practices so that they can compete for federal government service delivery contracts. The result is that waiting times for public services have grown considerably as the workforce has not increased in size: it is the same providers working in both the public and private sectors. Whether this has improved outcomes remains to be seen.

These examples serve as a reminder of the challenges of shifting to a market-based model where the market does not, and cannot, operate effectively.

An issue of significant concern to the Alliance is the need to avoid a proliferation of new and separate service initiatives. GP Superclinics are a case in point. These are services that receive two or three year funding to startup and seek to recruit appropriate staff and commence operations, which can take 6-12 months depending on the salary and conditions offered. Once the service is commenced, 6-12 months of promotion of the service is vital to achieve solid growth to reach peak performance. At this point, the organisation has to reapply for funding to maintain the service and on current practice, this may result in 6-8 months of uncertainty during which vital staff may leave due to the need for certainty of employment. Service numbers collapse and recruitment cannot commence to replace the person until the organisation has funding certainty. The result is a loss of clientele and if no funding is provided, the service disappears leaving no footprint.

This type of funding not only results in the loss of service, but is demoralising to the existing local health workforce and the people who need the service most – the end users.

The Alliance would strongly recommend that new service funding for extended (5 year) periods (subject to meeting regular reporting requirements) be used to ensure services work in with existing service providers and are able to establish and remain viable and provide greater certainty in terms of delivery of new and additional services. It is difficult to attract staff to work in rural and remote communities. Greater funding certainty would greatly assist in recruitment and retention of staff, providing a stable basis for improved health service delivery.

If governments decide to pursue a greater number of market-based models for health service delivery in rural and remote areas, the Alliance stands ready and willing to assist in their design, implementation, management and appraisal.

Key issues for consideration

1. In some parts of rural and remote Australia it may never be possible to establish a sustainable, viable health care market.
2. Should commissioning be used to expand the range of health services to be made available, it is vital to ensure that there is no diminution of quality through relaxed standards of care.
3. Great care needs to be exercised to ensure any changes do not lead to perverse incentives – either for patients/users or for health care providers.
4. Consideration must be given to extended periods of funding for contracted rural and remote health care providers or not for profit providers.

MODELS OF SERVICE DELIVERY THAT HAVE BEEN TRIALLED IN RURAL AND REMOTE AUSTRALIA

Delivery of health services outside the major cities is different. Where access to services in the city is characterised by choice, access to health services in rural and remote Australia is based on what may be available, and the distance an individual may have to travel. Choice is largely a non-issue. This is in part due to issues relating to maldistribution of the health workforce, and in part due to the dispersal of the population.

Health service delivery in remote Australia is difficult, but this has served as a driver for great innovation across both the health and aged care sectors. The development of Multipurpose Services (MPSs) in the 1990s was a direct response to the challenge of delivering a range of hospital, medical, aged and community care needs in small communities and saw collaborative responses developed between the Commonwealth and State and Territory Governments. Importantly, the MPS model is driven by community consensus around agreed community needs[5].

Since the development of the MPS model, other flexible models of service delivery have evolved based around existing health infrastructure. The South Australian Centre for Rural and Remote Health developed a teaching general practice model of health care delivery which they term a Multi-professional health teaching practice with the aim of delivering integrated primary health care in small rural and remote communities. The model requires local agreements between existing service providers to provide integrated multidisciplinary care[6]. It is led by medical practitioners based on consultation with other private and State/Territory health practitioners. Unlike the MPS model, this model does not embed community consultation and consensus, but notes a high degree of community acceptance, although in the remote model this could simply be due to lack of choice.

In the 2003 study of the development of an outreach allied health service delivery model in remote Queensland, Battye and McTaggart describe the limitations on allied health professionals working in remote settings and developed a model for outreach service delivery that addresses the range of considerations that apply to successful service delivery in remote communities[7]. At the centre of their model was community consultation and advice on the most acceptable form of service delivery and the level of communication and coordination needed to ensure services achieved their optimal reach in the communities being visited.

In a 2008 systematic review, Wakerman et al examined the range of primary health care delivery models operating in rural and remote Australia. They discussed five key models of service delivery:

- Discrete primary care services sustained by one or more general practitioners, including different models of ownership of the practice
- Broader Integrated services providing a single point of entry to the general practitioner and a range of other health services

[5] Snowball K, Multipurpose Services – A Potential Solution for Rural Health and Aged Care, AJRH Vol 2, (4) 1994

[6] Taylor J, Blue I & Misan G, Approach to sustainable primary health care service delivery for rural and remote South Australia, AJRH, Vol 9 304-310, 2001

[7] Battye KM, McTaggart K, Development of a model for sustainable delivery of outreach allied health services to remote north-west Queensland Australia, Rural and Remote Health (3) no 194, 2003

- Comprehensive primary health care services, notably the model used in Aboriginal Community Controlled Health Services which aim to not only bring together a range of health services but also address underlying social determinants of health through offering educational and development programs to support the health services available
- Outreach models enable visiting services that may originate in a larger nearby centre or from a greater distance using fly-in-fly-out providers. Outreach services can enable access to a wider range of services that would not otherwise be sustainable in the local community.
- Telehealth and telemedicine, which may not be specifically a model of care, but nevertheless provides vital advice and support to remote health practitioners[8].

Wakerman et al conclude that successful comprehensive models of remote primary health care can be delivered based on a dispersed population of 2,000-3,000 people and that in smaller communities services can still be viable if carefully focused to meet identified local needs. Based on these findings, Wakerman et al developed a series of 'Environmental enablers' necessary to support successful remote service delivery.

Their key enablers are:

- Supportive policy that enables ideas to come up and be explored
- Federal and state/territory relations provide flexibility in developing sustainable funding models
- Community readiness through deep consultation and realistic expectations, supported by good communication between the community and health practitioners
- Realistic, practical service requirements that focus on prevention and share a single leadership vision for the model
- Adequate funding including a clear understanding of the roles and responsibilities of the project funders and accountability arrangements
- The development and maintenance of effective linkages between all participants and other local health providers and agencies
- Adequate infrastructure to support the delivery of the services to be delivered including internet and software systems appropriate to the range of services to be delivered
- A sustainable workforce must also include appropriate human maintenance services to ensure the health workforce does not feel isolated or unsupported[9].

Finally, Wakerman et al (2009) conclude that the missing vital ingredient is comprehensive evaluations of remote service delivery models. This is a notable issue, given that even MPSs, which have been operating for over 20 years, have not been evaluated at the time of writing.

The delivery of effective and comprehensive primary health care and allied health services in remote Australia is complex but models exist that demonstrate clearly that it can be done.

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[8] Wakerman J, Humphreys JS, Wells R, Kuipers P, Entwistle P, Jones JA, Primary health care delivery models in rural and remote Australia – a systematic review, BMC Health Services Research 2008 8:276

[9] Wakerman J, Humphreys JS, Wells R, Kuipers P, Jones JA, Entwistle P, Kinsman L, Features of effective primary health care models in rural and remote Australia: a case study analysis, MJA Vol 191 No 2, 2009 pp 88-91

Building a sustainable workforce in rural and remote communities is possible, but needs to have the buy in and support of:

- The local community;
- Local and visiting health providers;
- Commonwealth and state/territory health; and
- Coordination to ensure the best effect is gained for both the community and the health funder.

With the relevant enablers and support in place, communities can anticipate well focussed and sustainable services that meet community needs and expectations.

ATTACHMENT A

ABOUT THE NATIONAL RURAL HEALTH ALLIANCE

The National Rural Health Alliance (the Alliance) is comprised of 38 national organisations (see Attachment A). The Alliance is committed to improving the health and wellbeing of the more than 6.9 million people living in rural and remote Australia[10].

Alliance members include consumer groups (such as the Country Women's Association of Australia), representation from the Aboriginal and Torres Strait Islander health sector, health professional organisations (representing doctors, nurses and midwives, allied health professionals, dentists, pharmacists, optometrists, paramedics, health students, chiropractors and health service managers) and service providers (such as the Royal Flying Doctor Service).

The Alliance's vision is good health and wellbeing in rural and remote Australia. Our member organisations are committed to working towards equitable health care services and health outcomes in rural and remote Australia. The member bodies bring knowledge of specific priority areas across the different agencies.

The Alliance views health care as a universal right and works to ensure that all Australians can receive high quality, affordable health care within a reasonable distance of their home, their family and their community.

Member Bodies of the National Rural Health Alliance

ACEM-RRRC - Australasian College for Emergency Medicine's Rural, Regional and Remote Committee
ACHSM - Australasian College of Health Service Management (rural members)
ACM-RRAC - Australian College of Midwives Rural and Remote Advisory Committee
ACN-RN&MCI - Australian College of Nursing (Rural Nursing and Midwifery Community of Interest)
ACRRM - Australian College of Rural and Remote Medicine
AGPN - Australian General Practice Network
AHHA - Australian Healthcare and Hospitals Association
AHPARR - Allied Health Professions Australia Rural and Remote
AIDA - Australian Indigenous Doctors' Association
ANMF - Australian Nursing and Midwifery Federation (rural nursing and midwifery members)
APA (RMN) - Australian Physiotherapy Association (Rural Members Network)
APS - Australian Paediatric Society
APS (RRPIG) - Australian Psychological Society (Rural and Remote Psychology Interest Group)
ARHEN - Australian Rural Health Education Network Limited
CAA (RRG) - Council of Ambulance Authorities (Rural and Remote Group)
CATSINaM - Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
CRANAplus - the professional body for all remote health
CWAA - Country Women's Association of Australia
ESSA (RRIG) - Exercise and Sports Science Australia (Rural and Remote Interest Group)
FRAME - Federation of Rural Australian Medical Educators
HCRRA - Health Consumers of Rural and Remote Australia
IAHA - Indigenous Allied Health Australia

[10] ABS 2014-15 Publication 3218.0 Regional Population Growth Australia
http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3218.02014-15?OpenDocument

ICPA - Isolated Children's Parents' Association
NACCHO - National Aboriginal Community Controlled Health Organisation
NATSIHWA - National Aboriginal and Torres Strait Islander Health Worker Association
NRHSN - National Rural Health Students' Network
PA (RRSIG) - Paramedics Australasia (Rural and Remote Special Interest Group)
PSA (RSIG) - Rural Special Interest Group of Pharmaceutical Society of Australia
RACGP Rural: The Royal Australian College of General Practitioners
RDAA - Rural Doctors' Association of Australia
RDN of ADA - Rural Dentists' Network of the Australian Dental Association
RFDS - Australian Council of the Royal Flying Doctor Service
RHWA - Rural Health Workforce Australia
RIHG of CAA - Rural and Indigenous Health-interest Group of the Chiropractors' Association of Australia
ROG of OA - Rural Optometry Group of Optometry Australia
RPA - Rural Pharmacists Australia
SARRAH - Services for Australian Rural and Remote Allied Health
SPA-RRMC - Speech Pathology Australia - Rural and Remote Member Community

Rural and remote demography and socio-economic status

Using 2015 estimates, the Australian Bureau of Statistics estimates that in total, 70% of Australians live in major cities, while 30% - that is 6.9 million people – live in regional (including rural) or remote areas (27.5% of Australians live in regional areas, while 2.5% live in remote areas)[11].

Compared with major cities:

- Rural (including 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.

The geographic distribution of the Aboriginal and Torres Strait Islander population varies greatly from the non-Indigenous population. While only 1% of the population in major cities is Aboriginal or Torres Strait Islander, they make up 45% of the population in very remote areas[12]. Approximately 35% of Australia's Aboriginal and Torres Strait Islander people live in major cities, with 65% living in regional and remote areas. In comparison, 71% of Australia's non-Indigenous people live in major cities, and 29% live in regional or remote areas.

The Aboriginal and Torres Strait Islander population shows a young population with approximately 42 percent under working age and less than 50 percent of working age (aged 20-59) compared with an older profile in the non-Indigenous population with approximately 26 percent under working age and over 56 percent of working age (aged 20-59).

The social determinants of health

The Alliance undertakes its policy work within the framework of the social determinants of health, which are those underlying features of society and community that affect an individual's ability to achieve personal good health and wellbeing. For example, housing, education, access to healthy food, and employment. These underpin the essence of good health and wellbeing. Where these factors are not successfully addressed, good health and wellbeing may be difficult to attain.

The Alliance Fact Sheet on the social determinants of health and the way in which they influence health and wellbeing in rural and remote Australia is at http://ruralhealth.org.au/advocacy/current-focus-areas/social-determinants-health .

[11] ABS 2014-15 Publication 3218.0 Regional Population Growth Australia http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3218.02014-15?OpenDocument

[12] Throughout this submission references to remoteness areas 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. For methodological reasons (eg small numbers) Remote and Very remote are often reported jointly. In the submission, references to "regional areas" mean Inner plus Outer regional; and references to "remote areas" mean Remote plus Very remote.

Health in rural and remote Australia

The health of people living in rural and remote Australia is poor when compared with the health of people living in major urban centres[13].

On average, people who live in rural and remote Australia do not enjoy the same high standard of health and wellbeing as those who live in the cities, or the same access to health services and health-related infrastructure. The differentials are particularly stark for Aboriginal and Torres Strait Islander people. There are a range of issues involved and it is the rural and remote people themselves who are best placed to understand the issues and to generate and manage solutions.

Compared with major cities, the burden of disease is 9 per cent higher in rural areas and 26 per cent higher in remote areas[14]. The fatal health burden increases with remoteness by at least 50 per cent for Aboriginal and Torres Strait Islander Australians and by up to 20 per cent for non-Indigenous Australians[15]. Most chronic diseases have a higher prevalence in rural areas. For example, compared with the major cities:

- the prevalence of cardiovascular disease is approximately 7 per cent higher;[16]
- the incidence of bowel cancer and lung cancer in rural and remote areas is 15 per cent and 10 to 50 per cent higher respectively, while the incidence of melanoma is 20 per cent higher in rural areas[17];
- the incidence of end-stage kidney disease is roughly similar or slightly higher in rural areas, but much higher in remote areas, reflecting very high incidence among Aboriginal and Torres Strait Islander people;[18]
- the prevalence of type 2 diabetes in rural areas is roughly similar, or possibly slightly higher;
- the prevalence of arthritis is about 8 per cent higher in rural areas;[11]
- the prevalence of mental illness in rural areas is similar or slightly higher.[19]

In rural communities the health effects of the disadvantage is compounded by poor access to communications (such as high speed broadband and mobile phone coverage), public transport and environmental challenges (such as drought, floods and bushfire). Simply being unable to leave the family farm for a period to seek medical attention is a significant barrier to seeking

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[13] http://ruralhealth.org.au/book/health-status-and-outcomes
[14] AIHW, http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442459747
[15] AIHW, http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129550616
[16] PHIDU, http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-Australia-remoteness=areas
[17] http://pandora.nla.gov.au/pan/146265/20140703-0935/www.coagreformcouncil.gov.au/reports/healthcare/healthcare-australia-2012-13-five-years-performance.html
[18] http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129549614
[19] http://pandora.nla.gov.au/pan/146265/20140703-0935/www.coagreformcouncil.gov.au/reports/healthcare/healthcare-australia-2012-13-five-years-performance.html

timely health care, as are the distances that may need to be travelled, the out of pocket costs and the time away from the community[20,21].

Aboriginal and Torres Strait Islander health care and services

The prevalence of chronic disease among Aboriginal and Torres Strait Islander Australians is frequently greater than among non-Indigenous people, with the incidence of chronic disease increasing with remoteness.

- Aboriginal and Torres Strait Islander Australians in rural areas are about 25 per cent more likely to have diabetes, while those in remote areas are more than twice as likely (ie 100%) to have diabetes;[22] than in major cities and
- the incidence of end-stage kidney disease is twice as high amongst Aboriginal and Torres Strait Islander Australians from Outer regional areas, and about four times as high amongst Aboriginal and Torres Strait Islander Australians from remote areas than in major cities.[23]
- Aboriginal and Torres Strait Islander Australians in remote areas are also 60 per cent more likely to have circulatory disease compared with those in major city and rural areas.[24]

There is also evidence that the social determinants of health have a greater impact on Indigenous Australians as remoteness increases. Employment and incomes for Indigenous people tend to be lower in more remote areas than in major cities. Again, this impacts on the ability of Indigenous people to access health and other human services.

Health expenditure by remoteness

The AIHW report , *Australian health expenditure by remoteness* (2011) shows that people in rural and remote Australia have substantially less equitable access to health services. In particular, they have a low share of government outlays on primary care, diagnostic, specialist services and other out of hospital services; PBS scripts; and non-acute hospital care and same-day hospital services.

The one third of the population who live outside the major cities have the highest health care needs, but also the worst access to health services. The difficulty accessing health services means poorer management of illness. The result of this is increased rates of ill health, hospitalisation and premature death in our rural and remote population.

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[20] Barriers to accessing rural paediatric speech pathology services: Health care consumers' perspectives, Anna M. O'Callaghan*, Lindy McAllister and Linda Wilson, AJRH, 13: 3, pp162-171, June 2005

[21] Understanding barriers to health care: A review of disparities in health care services among Indigenous populations, Sonia Marrone, International Journal of Circumpolar Health 66:3 pp188-198, 2007

[22] http://www.dpmc.gov.au/indigenous-affairs/publication/aboriginal-and-torres-strait-islander-health-performance-framework-2014-report

[23] http://www.dpmc.gov.au/indigenous-affairs/publication/aboriginal-and-torres-strait-islander-health-performance-framework-2014-report

[24] http://www.dpmc.gov.au/indigenous-affairs/publication/aboriginal-and-torres-strait-islander-health-performance-framework-2014-report

There is a $2 billion deficit in Medicare expenditure in rural and remote Australia when compared with the same population in major cities. This is primarily attributable to the lack of services available to the population."

The Alliance has developed a Fact Sheet on this issue, which is available at http://ruralhealth.org.au/sites/default/files/publications/fact-sheet-27-election2016-13-may-2016.pdf .

Health workforce

At least in part, some of the reason for the $2 billion deficit on health expenditure in rural and remote Australia is due to health workforce shortages. Despite a range of government programs to attract general practitioners, dentists and other health practitioners to rural and remote practice over many years, the ongoing shortages represent a significant barrier to addressing the health inequalities present in rural and remote Australia.

According to data from the Australian Institute of Health and Welfare (AIHW), the number of full-time equivalent (FTE) medical practitioners per head declines substantially the further you travel away from major cities. There are, for example, 405 medical practitioners per 100,000 people in major cities, but only 275 in inner regional areas, 250 in outer regional areas, and 249 in remote and very remote areas.[25] Similar trends are seen in the supply of dental health professionals and allied health professionals (who include physiotherapists, psychologists and optometrists).[26] The supply of nurses and midwives per head is lower in regional areas than major cities, but is slightly higher in remote and very remote areas.[27]

[25] AIHW 2014.Medical Workforce 2012.National health workforce series no. 8. Cat. no. HWL 54. Canberra: AIHW.http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129546076

[26] AIHW 2014. Dental workforce 2012.National health workforce series no. 7. Cat. no. HWL 53. Canberra: AIHW.http://www.aihw.gov.au/publication-detail/?id=60129545961

Allied Health: AIHW 2013. Allied health workforce 2012.National health workforce series no. 5. Cat. no. HWL 51. Canberra: AIHW.
http://www.aihw.gov.au/publication-detail/?id=60129544591

[27] AIHW 2013. Nursing and midwifery workforce 2012.National Health Workforce Series no. 6. Cat. no. HWL 52. Canberra: AIHW.http://www.aihw.gov.au/publication-detail/?id=60129545333