Caring for Older Australians
Productivity Commission
PO Box 1428
CANBERRA CITY ACT 2601

19 July 2010

Dear Commission

Thank you for the opportunity to comment on the *Caring for Older Australians* issues paper.

Older Australians who live in rural and remote areas have the same right to quality health services as their counterparts who live in metropolitan centres. Sadly, the reality is that older Australians living in country areas access health services at very much lower rates than metropolitan residents and have significantly worse health outcomes. They are also more likely to have lower incomes and lower levels of private health insurance than their urban counterparts, and have limited access to transport, and residential and community care.

All of these factors have implications for the planning of a future aged care system if the system intends to deliver timely access to appropriate care and support services to older Australians, no matter where they live.

With the ageing of the population being more prominent in rural areas than in urban areas, the time has come to develop long-term strategies that invest in aged care services which are flexible enough to respond to the unique challenges associated with delivering such services in the bush.

The RDAA urges the Productivity Commission and the Government to consult extensively to ensure that options for a future aged care system are underpinned by an understanding of rural health and rural communities, and are capable of strengthening, rather than undermining, existing services. These options must also acknowledge the real cost of providing aged care services in the bush. It costs more to provide residential care services in rural, regional and remote areas, as such services cannot generally benefit from economies of scale.

The RDAA notes that the National Rural Health Alliance has prepared a detailed submission in response to the issues papers. The RDAA's submission at **Attachment 1** only focuses on four issues - the rural health workforce, rural proofing, Multi-purpose Services (MPS) program and patient transport and travel.

Please do not hesitate to contact me on if you require any further information.

Yours sincerely

Steve Sant
Chief Executive Officer

Caring for older Australians

RDAA submission to the Productivity Commission Issues Paper

Introduction

Older Australians who live in rural and remote areas are significantly disadvantaged in their access to health services. As a result, their health outcomes continue to lag well behind older Australians who live in metropolitan areas and they have significantly shorter life expectancy. Many older rural people are unable to access even the most basic primary care medical services in their local communities, and have to travel significant distances just to see a GP for a basic consultation, or have to wait many weeks to be seen close to where they live.

The RDAA's position is that older Australians should have timely access to quality health services and the choice of ageing within their own community. They should receive the assistance they need to maintain and strengthen their health, avoid preventable illnesses and manage unavoidable illnesses and disabilities effectively. They should also be supported to maintain their independence as long as possible and, where independence is not longer feasible, have options for care which maintain their well-being, keep them safe and offer a good quality of life.

The RDAA has welcomed the Australian Government's recent announcement that it will be taking over funding and regulatory responsibility for aged care services. We have also welcomed the announcement of more funding and support for aged and community care services, and strategies designed to ensure the availability of an appropriately skilled aged care workforce.

However, it remains to be seen whether the forthcoming changes will make a real difference for older Australians living in rural and remote areas. While a greater investment in aged care infrastructure, primary care services, community care services and training for health professionals is required, funding reform and the roll-out of new programs will only redress the disadvantage experienced by older people living in the bush if doctors, nurses and other health professionals are available on the ground to deliver the health care. Targeted strategies for *attracting* and *retaining* a sufficient rural health workforce are long overdue.

The RDAA urges the Productivity Commission to consult extensively with rural and remote communities as part of developing options for restructuring Australia's aged care system. This must include detailed consultation with rural GPs to find out what will actually help them to improve the level of care they provide to older Australians. The RDAA also urges the Commission to engage in *rural proofing* - that is, to assess the full impact of any options for restructuring Australia's aged care system on rural health services.

Rural proofing is a process that requires government policy makers to consider the needs of people living in rural and remote areas. In the context of health policy, the aim of rural proofing would be to ensure that health care services are rurally sensitive and do not produce inequities in access to care. To be effective, rural proofing must be entrenched within key corporate and policy making processes[1].

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[1] Brian Wilson Associates and Rural Innovation (2008) "Rural Proofing Literature Review: A report to the Commission for Rural Communities", United Kingdom.

There are numerous health programs and policies that have had an unintended or adverse impact on rural communities because policy makers simply do not understand how clinical services are delivered in the rural setting.

General practices operate in the bush as small businesses and struggle to remain economically viable. Any new policies and programs that threaten to diminish or undermine the income of rural GPs can result in the withdrawal of GP services from a community and will contribute more generally to making the option of a career in rural medicine even less attractive to medical graduates, exacerbating the rural medical workforce shortage.

The design of a future aged care system for Australia must therefore take into account the enormity of the challenge involved in attracting doctors and other health professionals to work in aged care in the bush and be underpinned by an understanding of the business of providing health care in the bush and the dynamics of rural health care.

A rural health workforce for older Australians living in rural and remote areas

The challenges associated with ensuring the availability of an appropriately skilled aged care workforce are accentuated in rural and remote Australia where there is a depleted and declining rural health workforce.

Rural doctors are multi-skilled professionals that provide a diverse range of health care services from the cradle to the grave. Unlike their city counterparts most rural GPs or rural generalists provide additional services at their local public hospital, these services range from treating road trauma victims in the emergency department through to providing obstetrics, surgery and anaesthetic services. They also have to provide services to their local communities with little or no on the ground support from specialists who are mainly based in the city and large regional centres.

Rural doctors shoulder the burden of providing medical care to rural communities 24 hours a day, seven days a week. They usually earn less than their urban counterparts but are more likely to work longer hours (around 40% work over 60 hours per week compared to 26% of metropolitan doctors working over 60 hours per week). They are an ageing population, with the average age of rural doctors in Australia nearing 55 years and the average age of rural GP proceduralists (i.e. rural GP anaesthetists, rural GP obstetricians and rural GP surgeons) nearing 60 years.

At least 1800 doctors are needed immediately in rural and remote Australia to ensure even basic medical coverage in the bush. The influx of overseas trained doctors is the only reason that medical workforce numbers in rural areas are not in complete free fall. Close to 50% of rural doctors are overseas trained and in many areas 100% of services are being provided by overseas trained doctors, well above the national average of 25%.

Evidence shows that increasing the supply of health graduates alone will not improve the rural health workforce situation. Strategies are required which include realistic measures to entice health professionals to move to the bush once they have graduated and remain there.

The RDAA is disappointed that the most significant health reforms of recent times do not involve the funding of the much-needed Rural Rescue Package called for by RDAA, the Australian Medical Association and the Australian Medical Students Association. The Rural Rescue Package rewards those doctors that choose to support rural communities and who provide essential hospital-based

services and involves paying higher Medicare rebates to people who live in the bush. The Rural Rescue Package is specifically designed to entice more doctors to the bush, better support rural practices as the small businesses that they are, and recognise the nature and diversity of the work performed by rural doctors.

In the absence of realistic measures to entice doctors to move to the bush once they have graduated, the Australian Government's proposed investment of $98.6 million over four years to improve access to primary care services for older Australians, and the proposal to provide an extra 105,000 GP services in aged care homes, will have little impact in rural and remote areas, as the health workforce will simply not be available to deliver the services.

A key challenge is to attract GPs to *work* and *live* in rural communities where there is a small community hospital or MPS that primarily deliver aged care services. Rural communities often lose a resident GP/s when their local hospital is downgraded, no longer provides acute care services and evolves into a facility which predominantly has aged care beds. This has a number of implications for continuity of care, as patients have to rely on visiting GPs and must be transported elsewhere for emergency care and specialist care, such as palliative care.

MPS Program

The Australian Government has announced that it will invest $122.0 million to build more than 280 sub-acute beds under the MPS program to improve care for people in rural and remote areas.

The RDAA considers that MPS should be available for older Australian waiting for an aged care place to become available, as well as for older Australians making the transition back to living at home. However, the RDAA also considers that the location of MPS in rural and remote areas should be carefully considered to ensure that they do not undermine the viability of existing health services. Consultation should therefore occur with rural communities before determining locations of MPS to ensure they will complement existing services.

The availability of an appropriately trained health workforce to support the functioning of rural MPS should also be a key consideration. Some GPs in smaller rural communities will simply not have the capacity to provide medical care to patients in MPS in addition to their current workload.

Patient transport and travel assistance schemes

A well funded and equitable national patient transport and travel assistance scheme would help older Australians living in rural communities to have better access to healthcare services and improve their health outcomes by promoting earlier treatment of medical conditions and better management of chronic illnesses.

In many States we are seeing an increasing centralisation of services, with rural hospitals and specialist units either being closed or downgraded. This means that rural patients can no longer access the services they require in or close to their local communities.

Most of the patient transport and travel schemes now in place in the States are under-funded, overly bureaucratic and unfairly restrictive. The schemes appear to be process driven and centred around bureaucratic control and management, rather being patient centred and focused on ensuring that Australians living in rural and remote areas have the same access to treatment services as their city counterparts. Because the schemes are underfunded, patients who must

travel for treatment are often faced with significant financial hardship, particularly when they require frequent and/or longer term treatments for conditions such as cancer and chronic illnesses.

Older Australians who need to travel to access health care services or treatments will generally have a lower tolerance of travel because of their age and illness. Such travel will also isolate them from their family and community support. In some cases, the RDAA is aware that patients have been reluctant or unable to travel for treatment because of the financial and other circumstances, such as family responsibilities, which ultimately leads to poorer health outcomes. For older Australians, poorer health outcomes can lead to an earlier transition from independent living arrangements to service integrated housing, and avoidable premature death.

We need a range of policies and program funding for improved transport services and facilities for older people in country areas to facilitate access to health services. This should include assisted transport. The provision of a good transport and travel assistance scheme would help to address health inequities experienced older Australians living in rural and remote areas and reduce the additional costs to the health system incurred in both Federal and State funded areas due to the late treatment of conditions and the increased costs to the community associated with an increased burden of illness.