Discussion Paper

Why we need a new rural and remote health strategy

June 2017

This paper has been prepared to stimulate discussion on an issue of importance to rural and remote health. The views and opinions in the paper do not necessarily represent those of the National Rural Health Alliance or any of its Member Bodies.

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Background

The *National Strategic Framework for Rural and Remote Health* (the Framework) was developed through the Rural Health Standing Committee, a committee of the Australian Health Ministers' Advisory Council, and agreed by the Standing Council on Health, the committee of Ministers of Health, in late 2011. It was launched in 2012. The Framework was developed through a consultative process that included significant input from the National Rural Health Alliance (the Alliance) and other rural and remote health stakeholders, including State and Territory governments.

While the Framework can be accessed through the Department of Health website, it is not in use. No reporting has ever been undertaken to present an update on progress, recognition of the range of policies and programs implemented by Commonwealth, State or Territory Governments to address the goals of the Framework, or to examine the effectiveness of the Framework in addressing those goals.

Further, the health workforce strategy developed as a companion document to the Framework – *National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015* – is also no longer in use, having been archived when the Health Workforce Agency was disbanded in 2014.

At the time, the Alliance called for a National Rural and Remote Health Plan to be developed to operationalise the Framework, but this never eventuated.

The role of a comprehensive Framework to guide and direct better health outcomes in rural and remote communities is critical. Where players from communities, jurisdictional and private health providers and federally-funded organisations come together to meet the challenges of delivering health services in rural and remote communities, it must be through a shared understanding of the issues and a clear vision for the future.

At the outset, the Framework acknowledged that the people who live in rural and remote Australia "tend to have lower life expectancy, higher rates of disease and injury, and poorer access to and use of health services than people living in Major cities".

Drawing on the Australian Institute of Health and Welfare publication *Australia's Health 2010*, the Framework identified key areas of concern with regard to the health of people in rural and remote communities, particularly:

- higher mortality rates and lower life expectancy;
- higher road injury and fatality rates;
- higher reported rates of high blood pressure, diabetes, and obesity;
- higher death rates from chronic disease;
- higher prevalence of mental health problems;
- higher rates of alcohol abuse and smoking;
- poorer dental health;
- higher incidence of poor ante-natal and post-natal health; and
- higher incidence of babies born with low birth weight to mothers (in very remote areas).

The Framework does not include data quantifying these concerns. In referring back to *Australia's Health 2010*, the data used to describe the health of people in rural and remote Australia is from 2004-2006 – it was already up to six years old at the time the Framework based on it was launched. It is very difficult to plan appropriately to address inequality when data is this out of date.

Perhaps the biggest gap in the Framework is that it does not link the inequities it identifies in rural and remote health generally to the five goals it develops. While this is largely due to a lack of narrative, what this lack of narrative does is lose the unifying rationale for the five goals and how they will work together to make a difference to the inequities identified in the Framework. If this was simply a lack of a coherent narrative to drive the needed policy responses, it may be excusable. But unfortunately, the lack of this coherent narrative has resulted in:

- lack of recognition of the need for baseline indicators against which progress can be measured and reviewed;
- loss of the connectedness of the goals – at the Commonwealth level we now see rural health reduced to workforce policy responses without a clear understanding of how those responses will actually lead to improvements in health outcomes and the range of health inequities in rural and remote communities; and
- undermining one of the most crucial needs underpinning the Framework as a whole – the need for quality and TIMELY data. The lack of good quality, current, data is apparent as soon as you begin to seek answers to the question "what has the Framework achieved?"

In developing this Discussion paper, the Alliance is seeking to undertake a high level, selective assessment using publicly available data to ascertain to what extent progress is being made in addressing health concerns and inequities in rural and remote Australia, referencing back to the goals and outcomes set out in the Framework.

Where related specific programs stemming from the Framework can be identified and their outcomes assessed, this will be included in the discussion. Given there are nine specific issues identified in the Framework and set out in dot point format above, the Alliance will seek information on only three to discuss whether any change in outcomes following the implementation of the Framework can be assessed accurately, and if so, what outcomes were achieved.

## What has the Framework achieved?

The most recent iteration of Australia's Health – *Australia's Health 2016* – acknowledges that "Australians living in rural and remote areas tend to have lower life expectancy, higher rates of disease and injury, and poorer access to and use of health services than people living in Major cities" (p 248). This is word for word the same as the statement from the 2010 edition of *Australia's Health,* quoted at the outset of the Framework, and suggests that perhaps there has been little change in the intervening six years.

The dataset against which health status is considered in the 2016 edition dates from 2009-2011 – that is prior to the implementation of the Framework. It is, therefore, impossible to assess what, if any, changes have been observed in health status for those who live outside the major cities since the adoption of the Framework in 2012, given the data is so out of date.

This becomes apparent quickly when you seek to determine what progress has been made against three of the issues that the Framework identified – higher mortality rates, higher road fatality rates and higher rates of chronic disease (this paper will look at only diabetes, cardiovascular disease and lung cancer).

Mortality rates

The Mortality over Regions and Time (MORT) 'books' at the Australian Institute of Health and Welfare (AIHW) include mortality data by remoteness to 2014. These data span the period of the implementation of the Framework and clearly show the extent of the differential in age standardised mortality rates across remoteness areas. There is a clear gradient of increasing mortality rates as you move from Major cities through to Very remote communities, with a significant difference between major cities and very remote communities. Very remote communities report rates in excess of 50% higher than Major cities in 2012, reducing to in excess of 25% higher by 2014. The general trend in other remoteness areas is downwards over the period.

Source: MORT Books, AIHW http://aihw.gov.au/deaths/mort/
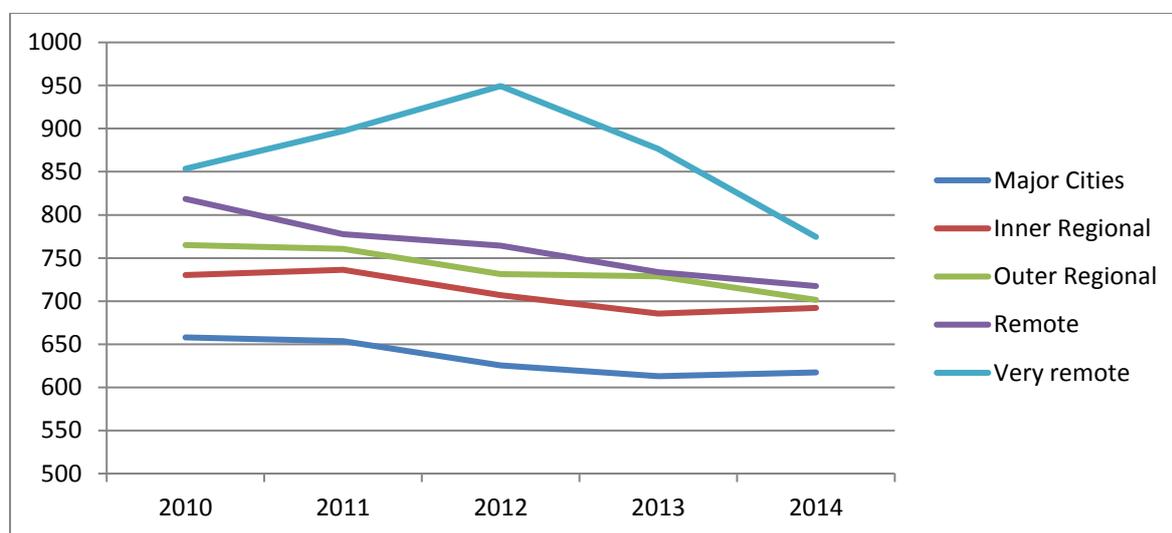
While the higher proportion of Aboriginal and Torres Strait Islander people in very remote communities, with their higher levels of poor health and mortality, explains a significant proportion of the higher result for very remote communities, it does not explain it all. The MORT books do not explore the reasons for the differences, and we need to look more broadly to find these.

Data available for Aboriginal and Torres Strait Islander age standardised mortality rates are not for the same period as those above for the whole population – although there is some overlap. The AIHW publication *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2015* includes data for the period 2008-12. While this data is broken down by jurisdiction, it is not available by remoteness area, making real comparisons impossible at this time. The data indicate that:

- Two-thirds (65%) of deaths among Indigenous people occurred before the age of 65, compared with 19% of deaths among non-Indigenous people during the 5-year period 2008–2012.

- The mortality rate for Indigenous people was 1.6 times that of non-Indigenous people in 2008–2012 (age-standardised rates of 981 and 596 deaths per 100,000 population, respectively).
- The largest difference between Indigenous and non-Indigenous mortality rates in 2008–2012 was for people aged 35–44, with male and female Indigenous death rates 3.9 and 4.5 times the non-Indigenous rates, respectively (p110).

With regard to being able to assess whether the Framework has achieved progress in reducing the inequity between age standardised death rates by remoteness, the evidence from mortality statistics suggests that progress has been made but as to why is not discernible.

Road fatalities

The raw data indicates that the overwhelming <u>numbers</u> of road fatalities in Australia occur in the Major cities. However, we need to examine the <u>rate</u> by population to ascertain the real extent of the impact in regional and remote communities. The first table below is the raw data, but the following table converts the number of fatal accidents to a rate per 100,000 population. The difference is stark.

Fatal crashes by Remoteness

	Major cities	Inner regional	Outer regional	Remote	Very remote
2008	522	404	273	53	83
2009	485	412	315	76	56
2010	420	415	262	67	68
2011	404	381	247	67	52
2012	430	413	255	43	50
2013	395	367	217	70	50
2014	365	355	222	59	54

Source: https://bitre.gov.au/publications/ongoing/files/Road_trauma_Australia_2015.pdf (Table 3.8)

The raw data is sufficient to indicate a need to address better road behaviours and education measures to reduce the overwhelming number of fatalities. Converting these data into a population rate enables us to gain a different perspective and see the scope of the problem in regional and remote Australia – where the smaller number of fatalities masks the impact that fatalities have in small communities.

Fatal crashes by Remoteness per 100,000 population

	Major cities	Inner regional	Outer regional	Remote	Very remote
2008	3.52	10.25	13.85	17.25	43.39
2009	3.19	10.29	15.78	24.49	28.58
2010	2.72	10.22	13.01	21.44	34.01
2011	2.58	9.27	12.19	21.02	25.57
2012	2.69	9.92	12.45	13.49	24.19
2013	2.42	8.71	10.50	21.71	23.91
2014	2.20	8.33	10.68	18.34	26.04

Sources: https://bitre.gov.au/publications/ongoing/files/Road_trauma_Australia_2015.pdf (Table 3.8) and Australian Bureau of Statistics 3218.0 - Regional Population Growth, Australia, 2015-16
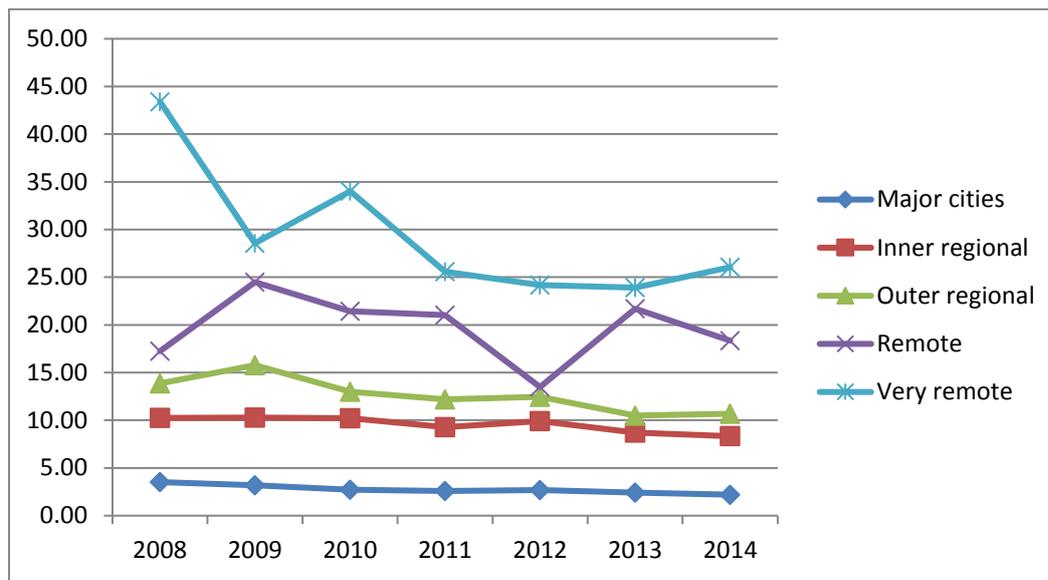
Nationally, progress is clearly being made in reducing road fatalities in Major cities, Inner regional and Outer regional locations, but the situation in Remote and Very remote locations is significantly more volatile. And while some of the road fatalities in these more remote communities are undoubtedly due to tourists who are unfamiliar with the roads, this does not explain the significant difference in the rates. Certainly, following evidence presented to the 2015-16 Senate Inquiry into Aspects of Road Safety in Australia, the Senate considered a range of reasons for such high rates including poor driver behaviours, poor roads or road conditions, the need for better driver education and the time for help to arrive – which in remote Australia can be considerable.

In 2011, Siskind et al argued that a combination of excessive speed, alcohol and failure to wear a seatbelt were significant contributing factors to the higher relative risk of fatality and injury in rural and remote accidents, compounded by poor road conditions and design and weather hazards.

Dinh et al, writing in 2016, found that there had been a statistically significant improvement in rural and remote fatality rates over the period 2009-2014, which was at least in part attributable to improved ambulance transfer protocols and improved access to regional trauma centres in rural and remote NSW communities. While this is not national data and does not cover the full span of the Framework, it is indicative of improvement in one of the identified key indicators of rural inequality.

The impact of road accidents cannot be understated. Not only is the individual affected, but their family and wider community is drawn in. And the injury has significant health system impacts. Recovery following a severe road accident requires sometimes months of hospitalisation and multiple surgeries followed by rehabilitation and may leave the individual with lifelong deficits requiring access to ongoing care, treatment and support. In smaller rural and remote communities, it may be impossible to support that person in the community and the options are stark – admission to an aged care facility for the remainder of their life, or leaving the community to be closer to the support and care they need, at the cost of severing lifelong ties of family and friendship.

But should road fatalities and injuries be considered within a rural and remote health framework? The causes of road accidents are clearly non-health related, but dealing with the outcomes is very much a health issue: access to health and rehabilitation services, access to disability services and support and the impact on daily health inequalities in rural and remote communities are all issues that would fit within a broad rural health strategy. The same issues occur in considering recovery from stroke and heart attack and many other conditions requiring a lengthy recovery following surgical intervention.

Chronic diseases

Rather than explore the full range of chronic diseases, this discussion will focus on only three – cardiovascular disease (which includes ischaemic heart disease (IHD)), Type-2 diabetes and lung cancer. These three conditions share a range of risk factors relating to smoking and diet, and thus represent a reasonable proxy for considering the success of the Framework in addressing those risk factors and the impact of chronic diseases in regional and remote communities.

Chronic disease prevalence is generally higher in rural and remote areas of Australia than in Major cities. Based on self-reported data from the 2014–15 National Health Survey (NHS) (ABS 2015), compared with people living in major cities, people living in inner regional and in outer regional/remote areas of Australia had higher rates of:

	Major cities	**Inner regional**	**Outer regional & remote**
Diabetes	4.7%	6.0%	6.7%
CVD	4.7%	6.7%	5.8%
Cancers (including lung cancers)	1.6%	1.7%	1.8%

Notes
1. '%' represents prevalence of chronic diseases in each region (excluding Very remote areas of Australia).
2. Proportions are not age-standardised, and in some instances higher prevalence may reflect the older age profiles in Inner regional and Outer regional/Remote areas.
3. 'CVD' refers to heart, stroke and vascular disease.

While rates of prevalence are only slightly higher between the regions, death rates from these conditions are markedly higher between the same regions. The charts below show the gradient across remoteness areas – age standardised – for all three causes of death over 2010-2014.

Coronary heart disease - mortality 2010-2014

ASMR per 100,000

(x-axis: Major cities, Inner regional, Outer regional, Remote, Very remote)
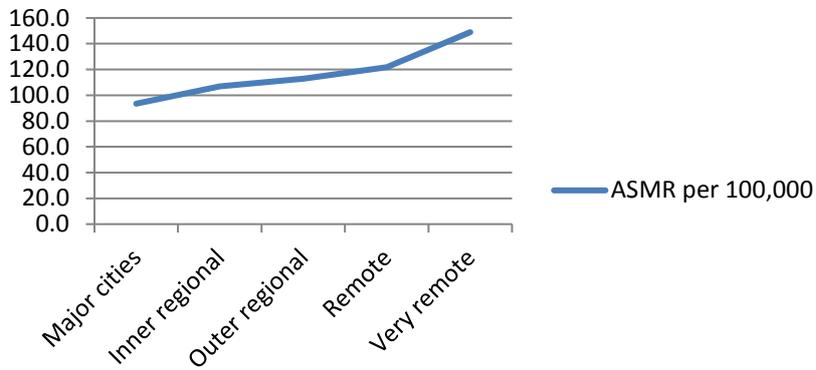
Diabetes - mortality 2010-2014

ASMR per 100,000

(x-axis: Major cities, Inner regional, Outer regional, Remote, Very remote)
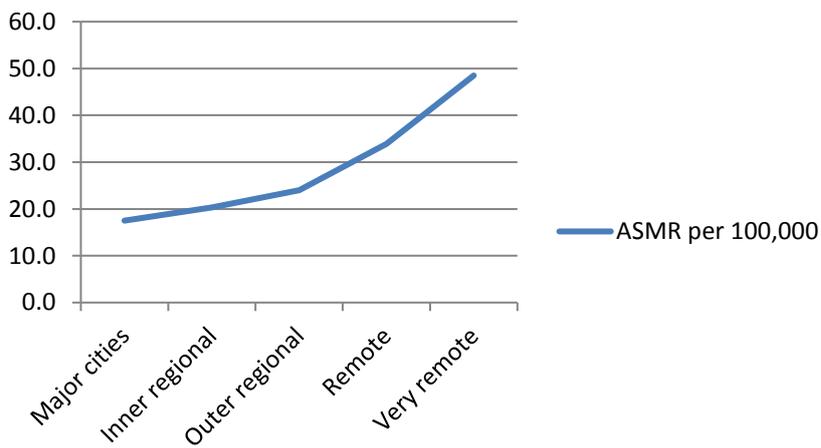
Lung cancer mortality 2010-2014

ASMR per 100,000

(x-axis: Major cities, Inner regional, Outer regional, Remote, Very remote)
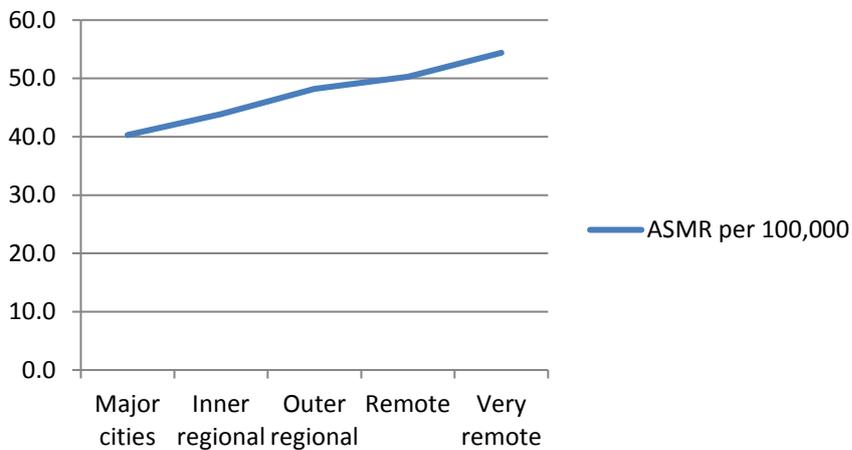
A remoteness gradient exists across all three causes of death with there being an increase across the remoteness gradient of 59.4% for Coronary heart disease, 177.1% for diabetes and 35% for lung cancer. It should be clarified that diabetes is rarely the sole cause of death, but is a growing contributing cause.

In the recently published review by Alston et al examining inequalities in outcomes between people with ischaemic heart disease (IHD) in rural and remote communities and their major city based peers, the authors found that:

> *Populations outside of major cities in Australia bear a disproportionately high burden of ill health due to IHD, yet the majority of the rural populations are yet to be investigated in terms of burden of disease outcomes from IHD. Remoteness is a key determinant of IHD burden in Australia. The reasons for increased IHD burden in rural compared to metropolitan communities of Australia are poorly understood, which has implications for the design of targeted interventions to reduce geographical inequalities.*

In particular, when discussing the 30 and 365 day follow up outcomes for people who were treated in metropolitan and non-metropolitan hospitals, the authors reported significantly higher mortality in people treated in non-metropolitan hospitals at both points of follow up - including that patients had 90% higher odds of dying in a non-metropolitan hospital (p125).

Alston et al also note that despite reviewing about 20 studies dating from 1990-2014, the lack of consistent data and outcome measures means it is still difficult to identify both the reasons for inequalities between rural and remote and metropolitan treated patients and which factors make the greatest contribution to those differences.

The same team, reviewing interventions targeting IHD in rural and remote Australia in BMC Public Health in 2016, found

> *Few interventions were identified that exclusively focussed on IHD prevention in rural communities, despite these populations being at increased risk of IHD in Australia, and this is consistent with comparable countries, internationally. Although limited, available evidence shows that primary and secondary interventions targeted at IHD and related risk factors can be effective in a rural setting.*

Further, they found most studies included in their review were at least 8 years old. There is very little current evidence on the effectiveness of modern treatment and prevention protocols in rural and remote settings, rendering it impossible to make any assessment of programs to address the risk factors and poor outcomes of people in rural and remote communities with IHD during the period since the implementation of the Framework.

The AIHW has a number of fact sheets about diabetes and from self reported data:
- around 1 in 17 adults (ie almost 6% of adults) in Australia have diabetes;
- death and hospitalisation rates in remote and very remote communities are double those in major cities; and
- diabetes is an associated or underlying cause in 10% of deaths nationally.

In discussing the impact of diabetes outside the major cities using 2012-14 data, the AIHW notes that death rates from diabetes (all forms) are:

- Twice as high in *remote and very remote* areas compared with *major cities* (101 compared with 52 per 100,000 population in 2012–14). The gap in these death rates was higher for females than males—2.3 times as high in *remote and very remote* areas than in *major cities* for females (97 compared with 41 per 100,000) and 1.6 times as high for males (107 compared with 66 per 100,000) (see figure below);
- Twice as high in the lowest socioeconomic group compared with the highest socioeconomic group (75 compared with 37 per 100,000 in 2014). This gap was similar for males and females (see figure below); and
- 4 times as high among Indigenous Australians compared with non-Indigenous Australians (234 compared with 55 deaths per 100,000, in 2012–14). This gap in death rates was higher for females than males—6 times as high for Indigenous females (236 compared with 43 per 100,000) and 3 times as high for Indigenous males (233 compared with 70 per 100,000) (see figure below).

Source: http://www.aihw.gov.au/diabetes/deaths/
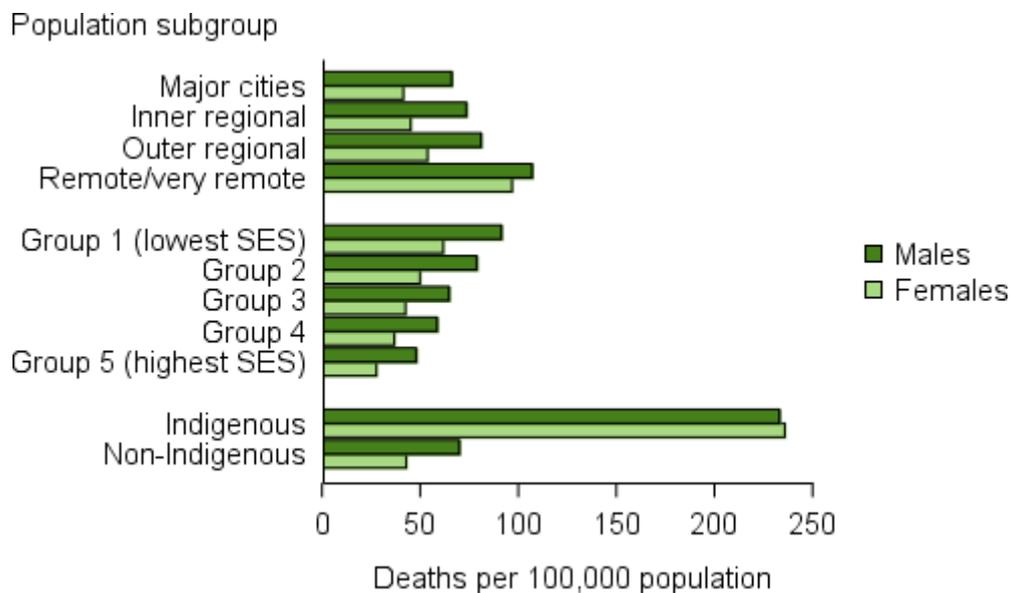
While the Framework does not focus on specific diseases, it draws on the range of poor health outcomes for people living in rural and remote Australia to develop a set of five goals for actions to turn around these poor outcomes. But it does not link those goals back to the health outcomes through reporting and evaluation requirements. Effectively, the outcomes for people have been lost.

Reviewing the Framework (and replacing it with a dedicated strategy and plan) provides the opportunity to reflect on these shortcomings and to look at redirecting effort through identifying specific goals and setting indicators that measure and reflect the health needs of people in rural and remote communities and, from there, to develop specific strategies to address those needs. The five goals that will be discussed below in many ways would morph into strategies to support the identified health needs of the key goals and indicators. An example of such a revised Goal is described below. It is intended purely as illustrative and is not in any way meant as a definitive approach.

Box 1: An example of a revised goal, indicator and strategic approach

Goal

To reduce the poor health outcomes and health inequality of people diagnosed with diabetes in rural and remote communities.

Indicator

To reduce both the incidence of diabetes and poor outcomes following diabetes diagnosis by 50% over five years for each of the regional and remote ASGC remoteness areas.

Strategies

Prevention strategies

- Culturally appropriate early childhood health and ongoing health and education support to build 'diabetes-proof' children and young adults
- Comprehensive screening in early childhood with community follow up (eg. Child and family nurses) of those at risk
- Access to sustainable, affordable, healthy, culturally appropriate diet and lifestyles across the whole of life
- Culturally appropriate obesity and healthy lifestyle interventions to reduce the burden of poor health in people at risk of obesity or who are obese.

Better management strategies

- Well-coordinated care to ensure people get access to the appropriate care they need in the form that best meets their needs as close to community as possible.
- Outreach services to be utilised to meet remote diabetes care needs.
- Culturally appropriate education and information on how to manage diabetes, with storage of and access to medication addressed appropriately.

Research strategies

- What are the barriers to effective treatment and management of diabetes in rural and remote communities?
- Different models of care in different settings: what local strategies work best and in what conditions?
- Does identifying hot spots for urgent action assist in tailoring responses and in reducing the impact of diabetes?

Evaluation strategies

- Baseline measures agreed, taken at implementation of the measure and reported to central point of contact
- Regular reporting to central point of contact to enable annual reporting against the goal and strategies.

The Framework's Five Goals

The Framework included five goals to support the vision statement that 'people in rural and remote Australia are as healthy as other Australians'. At the heart of this vision is recognising and addressing the impact that inequity is having on the health and health outcomes of people living in rural and remote Australia. The five goals are:

1. Improved access to appropriate and comprehensive health care.
2. Effective, appropriate and sustainable health care service delivery
3. Appropriately skilled and well-supported workforce
4. Collaborative health service planning and policy development
5. Strong leadership, governance, transparency and accountability.

These five Goals were developed into five Outcome areas, against which initiatives would be implemented:

Outcome area 1: Access
Outcome area 2: Service models and models of care
Outcome area 3: Health workforce
Outcome area 4: Collaborative partnerships and planning at the local level
Outcome area 5: Strong leadership, governance, transparency and performance.

Under each outcome area there are objectives and strategies. In discussing the need for outcome measures, the Framework acknowledges that implementing any measures will create issues for service providers.

> "Recognising the more limited resources and capacity of rural and remote health services to provide service data, it is imperative that any reporting and monitoring arrangements:
>
> - are appropriate and relevant to rural and remote settings;
> - provide meaningful, timely and useful data;
> - do not increase unnecessary administrative burden on services; and
> - feed back to services to support further quality improvement and recognise achievements."

Ideally, the Framework should build a narrative showing how the poor outcomes for people will be addressed through these five outcome areas. The narrative then would become the bridge, acknowledging how poor outcomes will transform into outcomes to measure needs across the range of underlying contributing factors to achieve better results. Over time, these need to be evidence based, with increasing evidence (of what works and what doesn't) being generated by implementation of the Framework.

In presenting the evidence, it should also be possible to state the current level and set a goal level to aim for. But to do this it is vital to have access to quality, up to date, data. If access is the first outcome, we need to know the current level of access. We also need to have this data available at lower levels than merely nationally or by jurisdiction.

In considering the outcome areas, publicly available data has been used to determine whether the outcome has achieved its objectives.

Outcome area 1: Access

The Framework notes that access is about more than simply being able to find a medical practitioner to meet the individual's needs. The Framework also lists potential barriers to accessing health services, including:

- travel distance to relevant health services, including the availability of transport and the cost of travel;
- uncertainty about how to use and access services, including the availability of emergency care and retrieval services;
- cultural and language barriers; and
- poorer understanding of health issues and how to access health services.

Since the Framework was launched in 2012, a number of significant policy changes have affected the way in which the strategies under this Outcome are achieved. Prior to 2011-12, Divisions of General Practice were in place to drive improved access to general practitioners through the Primary Health Care system with a focus on:

- Supporting GPs and practices within a changing primary care environment;
- Improving access (to GP services):
- Encouraging integration and multidisciplinary care;
- Prevention and early interventions;
- Better managing chronic conditions;
- Supporting quality and evidence-based care: and
- A growing consumer focus[1].

From 2011-12, the existing 111 Divisions were gradually replaced by 61 Medicare Locals. The role of the Medicare Local was to:

- Maintain GPs at the centre of primary health care, responsible for individual patient care.
- Develop strategies to meet the overall primary health care needs of communities. They were to ensure the primary health care services needed by their communities worked effectively for patients, through developing collaborative arrangements between health service providers in their area. They were also tasked with planning and supporting local after hours face-to-face GP services.
- Work closely with Local Hospital Networks and aged care to deliver better integration and smoother transitions for patients across the entire health care system.
- Support a stronger primary health care system by joint planning with states and territories and other Medicare Locals to improve the delivery of primary health care services in the local community[2].

Medicare Locals were able to bid for program funding and run programs to support local community needs. Following the change of government in 2013, the incoming Government announced a review of Medicare Locals and the 2014-15 Budget announced that all 61 Medicare Locals were to be abolished and replaced by 31 Primary Health Networks (PHNs).

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[1] http://aphcri.anu.edu.au/files/primary_care_and_general_practice_update_may_2013.pdf p14
[2] http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/First%20Interim%20Report/c04
Paragraph 4.10

The new PHNs would not deliver services, but would be able to commission services, and where appropriate, Medicare Local services were novated over to the replacement PHN.

This prolonged policy turbidity makes it virtually impossible to determine the impact of any of the three primary health care models on the access to services for people living in rural and remote Australia. The main sources of public data are through the Australian Health Practitioner Registration Agency (AHPRA), which does not provide remoteness analysis for the data it collects, and the Australian Institute of Health and Welfare (AIHW).

Employed medical practitioners: FTE per 100,000 population[a] **by remoteness area**[b]**, 2012 to 2015**[c][3]

Year	Remoteness area				Australia[e]
	Major cities	Inner regional	Outer regional	Remote/Very remote[d]	
2012	417.2	275.2	262.8	256.3	**373.8**
2013	425.8	282.8	258.0	256.8	**382.0**
2014	429.7	289.1	270.4	264.0	**387.6**
2015	441.6	297.5	278.7	262.8	**392.3**

(a)   Full-time equivalent (FTE) number per 100,000 population. FTE number is based on total weekly hours worked. Standard working week is 40 hours.

(b)   Derived from remoteness area of main job where available; otherwise, remoteness area of principal practice is used as a proxy.
If remoteness area details are unavailable, remoteness area of residence is used. Records with no information on all three locations are coded to 'Not stated'.

(c)   From 2012, data exclude provisional registrants.

(d)   Includes 'Migratory' areas.

(e)   Data include employed medical practitioners who did not state or adequately describe their remoteness area and employed medical practitioners who reside overseas.

Source: NHWDS: medical practitioners, 2011–2015

From the data, we can see that there has been an increase in the number of full-time equivalent (FTE) medical practitioners across all remoteness areas. However, when we examine the percentage increase across each remoteness area, we see that there has been a 5.85% increase in major cities, an 8.1% increase in inner regional communities, a 6.05% increase in outer regional but only a 2.54% increase in remote (including very remote) communities. So while there has been an overall increase in the number of GPs over the period 2012 to 2015, we have also seen an increase in the inequity of access for those living in remote and very remote communities.

One of the problems with publicly available data is that it may not be available at sufficient specificity. For example, the Australian Health Practitioner Regulation Agency (AHPRA) provides regular data on the number of health practitioners registered in Australia. It does not, however, provide any analysis by remoteness areas. If we are to examine inequality of access to health care professionals in rural and remote Australia, we cannot do so without access to data analysed by jurisdiction and by remoteness.

One of the activities that has been undertaken that can clearly be linked to the Framework, is work by the AIHW examining the spatial distribution of the health workforce in relation to

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[3] http://aihw.gov.au/workforce/medical/additional/ Supplementary Table 23

the distribution of the Aboriginal and Torres Strait Islander population. Released in late 2016, this analysis identifies areas of workforce challenge to enable better policy responses. The report identifies that a higher percentage of the Indigenous population, compared with the non-Indigenous population, lives in areas with relatively more workforce supply challenges (p67), which is indicative of the greater level of disadvantage and inequity that exists in rural and remote Indigenous communities. It is too early to determine how effective this work has been in developing policy to address workforce mal-distribution.

A number of jurisdictions have examined, or are examining, the role and effectiveness of patient assisted travel schemes in supporting better access to health care. However, to date this has not resulted in any move to standardise support schemes, and it is possible this sector could become more fractured, with one potential national policy response being to include travel as an allowable item through private health insurance.

Digital health solutions are becoming more accessible to some rural and remote communities, but are still hampered by significant internet access issues. While this is obviously an issue in more remote communities, it also affects some regional communities, including many, for example, in the NSW Central and North Coast.

Medicare Locals and now PHNs are working more closely with jurisdictional local area health services to support better integration and care coordination, but also encounter issues relating to different software platforms that do not enable the easy transfer of information. One of the key barriers to better communication and coordination of care is the investment different sectors and jurisdictions have made in IT infrastructure tailored for their own needs. Until all across the health sector are using software that can adequately deal with the differences and enable these barriers to be overcome, the future scope of information sharing will be limited.

Greater consumer engagement is occurring, although it is not yet at an optimal level. The inclusion of consumers and carers in co-design and implementation of policies and programs is a particularly important area for improvement, including enabling better access to educational and information materials that are appropriate to local needs, cultures and demographics.

Outcome area 2: Service models and models of care

This is an area of the Framework where there has been significant activity in the area of developing and enhancing service models and innovative models of care to improve aspects of health care treatment and management in rural and remote communities.

Multipurpose services (MPSs), acknowledged in the Framework for the contribution this innovate response to service needs in small remote communities makes in addressing the wide range of health and aged care needs, continue to lead the way in flexibly funded combined service delivery models. The MPS program continues to expand, with new MPS sites announced in January 2017 for Bamaga and Richmond in Queensland together with expanded funding and additional places for several rural and remote communities.

Significant service-based research has been undertaken within the rural health sector examining models of service and their capacity to deliver better health outcomes in differing situations. Efforts are being made to improve coordination of services, particularly to coordinate outreach services to ensure communities are able to make the best use of services

that visit periodically and are vital to support chronic diseases. Undoubtedly further activity can be undertaken to support better coordination. However, without data it is impossible to do anything other than surmise that on the balance of probabilities, better coordination is being delivered and is making a difference.

Perhaps the area where there is significant ability to improve health outcomes is through disease prevention activities. Many activities are being undertaken with differing degrees of success to address chronic disease and its causes. These would benefit from nationally agreed goals and indicators and regular reporting to enable assessment of progress.

Of major importance (and potential impact) in this area is the role of PHNs. PHNs have been established to provide regionally tailored solutions to local problems – place based approaches. They are contracted to undertake population health planning and needs assessments, and to commission services to best meet the highest priorities they have identified (albeit with much of their funding not yet that flexible and tied to particular health priorities and models of service).

Of particular design importance for PHNs has been their establishment as regional entities, associated with Local Hospital Networks (or their equivalents) which likewise operate at a regional level (albeit with differing levels of local authority and autonomy between jurisdictions). This provides the opportunity to overcome some of the Commonwealth/state/territory divide issues which have hindered integration of services around the needs of individuals and communities.

Many PHNs have begun to respond to these opportunities through working with LHNs to develop integrated models of care which are jointly planned and funded by PHNs and LHNs, including integrated care pathways which focus on continuity of care for individuals to navigate through an often difficult health system.

PHNs have received relatively significant increases in funding in some areas, for example in mental health, suicide prevention, and alcohol and drug services. However these amounts are relatively modest when compared with funds held by the state and territory hospital sectors and, while there are some flexible funds, much of the funding remains tied. These funds therefore need to be used as levers for change, rather than being seen as yet enabling significant expansion of services.

Over time significant existing and future funds should be channelled through PHNs (less tied and greater flexibility) to give them the capacity to build on this encouraging beginning.

It is relatively early days for PHNs and they need to be supported and encouraged to develop place based responses to need, developed in partnership with consumers and communities, LHNs and other service providers.

However, significantly, while the role of Medicare Locals was recognised to some extent in the Framework, PHNs did not exist at that time.

Outcome area 3: Health workforce

Health workforce is another area where there has been considerable progress. But the impact of that progress on rural and remote communities is highly variable.

As discussed above, Australia is now producing sufficient numbers of medical graduates to meet national needs – at least notionally. The problem is that overwhelmingly these graduates prefer to live and work in major cities. This is not a new phenomenon.

To counter the resulting mal-distribution of the medical and health workforce, a range of programs has been implemented over many years to encourage practice outside the major cities. These programs target students through scholarships and access to bonded places, early practice and specialist training through prevocational and rural and remote health placements and by return of service obligations and established practitioners through a range of incentive programs.

These programs are having limited effect, most particularly in Inner and Outer regional communities, which have seen an increase in the number of medical practitioners in those locations over the period 2012-2015. The table below shows the increase in the number of FTE GPs in remoteness areas as the difference between the number in 2012 and the number in 2015. The largest percentage increase is in Inner regional, which has seen an 8.1% increase, but the smallest increase of all - 2.65% - is in remote and very remote. As discussed earlier, while the number have indeed increased, the inequity in access between major cities and remote and very remote communities has also increased.

Difference over 2012-2015 FTE per 100,000

Major cities	Inner regional	Outer regional	Remote/Very remote[d]	Australia[e]
24.4	22.3	15.9	6.5	18.5

Source: NHWDS Medical practitioners 2012-2015 – derived from Table 23

Examining the average number of hours worked also indicates that medical practitioners work longer hours in remote and very remote communities.

Employed medical practitioners: average weekly hours worked by remoteness area[a], 2012 and 2015

Sex	Remoteness area				Australia[c]
	Major cities	Inner regional	Outer regional	Remote/Very remote[b]	
2012					
Persons	*42.4*	*42.7*	*44.6*	*46.2*	*42.7*
2015					
Persons	*42.2*	*42.3*	*43.8*	*45.7*	*42.4*

(a) Derived from remoteness area of main job where available; otherwise, remoteness area of principal practice is used as a proxy. If remoteness area details are unavailable, remoteness area of residence is used. Records with no information on all three locations are coded to 'Not stated'.

(b) Includes 'Migratory' areas.

(c) Data include employed medical practitioners who did not state or adequately describe their remoteness area, and employed medical practitioners who reside overseas.

Source: NHWDS: medical practitioners, 2012 and 2015, Table 10

The Rural Generalist Pathway is the Queensland response to training and supporting doctors working in rural and remote communities, proving a pathway to both vocational registration and recognition as a specialist holding advanced skills. While there is no publicly available data showing the impact of trained rural generalists in Queensland, the Queensland Health

[Minister](), speaking in 2015, indicated that 400 graduates were expected to be working in Queensland by 2019.

Following appointment of the first National Rural Health Commissioner, expected later in 2017, the Rural Generalist Pathway will be developed into a national program to promote rural and remote practice and develop the advanced skills that are vital to practice in these communities.

One of the key issues in addressing the health needs of people living in rural and remote communities is to remember that addressing workforce issues alone is not solving the problems resulting from poor health outcomes in these communities. The strategies developed against the health workforce objectives are more substantial than all other outcome areas. But a workforce approach that is not based on community needs and linked to improving health outcomes is not delivering to the community it is meant to serve.

Outcome area 4: Collaborative partnerships and planning

This outcome is highly focused on bringing together the range of local health bureaucracies and local consumer representatives to develop local health initiatives based on local needs and priorities. This is an area where progress is being made as PHNs have been tasked with much of the coordination and analysis work that underpins the strategies within this outcome area.

What is not available is an overarching report that brings together the initiatives undertaken within each PHN and the degree to which they are making effective use of consumer input. Each PHN is required to publish detailed information about the analysis they have undertaken, the level of services currently available in their area and their proposed responses to meet the needs identified through this process.

What is needed is a national overview that brings together this data, identifies key issues by remoteness areas and jurisdictions and then discusses the different approaches and how the information derived can be shared to promote more effective and efficient services and policies.

Outcome area 5: Strong leadership, governance, transparency and performance

This is undoubtedly the weakest area of the Framework in terms of response and outcomes. There has been no reporting on performance against the Framework and transparency is difficult to assess without access to timely and quality data. That the Framework is largely in abeyance is reflective of the lack of leadership and governance generally.

PHNs now have access to a range of data to support their planning and monitoring. Of the range of strategies and objectives included in the Framework against this outcome area, this is perhaps the most positive achievement, and should be acknowledged.

Efforts to develop national reporting measures have not progressed and ideally, outcome measures should have been developed and implemented at the outset of the Framework.

A new strategy and plan

There is no point in continuing to reference a Framework that is not in use and that is deeply flawed. Whatever document replaces the Framework, it must include outcome measures and set indicators to measure progress against the most pressing needs. And there must be annual

reporting against those outcomes to enable jurisdictions to consider how they are progressing and fine tune their responses as necessary.

Ideally, a new National Rural and Remote Health Strategy should be developed with stakeholder input and introduced with a fully funded Implementation and Evaluation plan. This should include, but not be restricted to, a rural and remote workforce plan – as pointed out throughout this report, the solutions needed to bridge the divide in the health and wellbeing of the city and the bush deserves and requires far more. We need concrete, on-the-ground actions, which make a positive difference in the lives of individuals, families and communities in rural and remote Australia.

The Alliance has been an active participant and co-signatory in the development of previous strategies and plans, and stands ready to fulfil that role again.

We must learn from the past and strive to address the inequity of health outcomes that are experienced by the seven million people living outside Australia's major cities.