

**AUSTRALIAN HEALTH MINISTERS  
COUNCIL**

**AUSTRALIAN HEALTH CARE  
AGREEMENTS**

**FINAL REPORT FROM THE  
'IMPROVING RURAL HEALTH'  
REFERENCE GROUP**

**September 2002**

## IMPROVING RURAL HEALTH

Rural, regional and remote (hereinafter referred to as rural) Australia is extremely diverse. It is a complex mosaic of activities and communities differentiated by geography, economic activity, environment, population characteristics and social organisation.

The health of Australians generally is better than most developed countries and the Australian health system is one of the best in the world. However, Australia is the world's most urbanised country and faces profound issues around access to health and aged care for residents of rural areas. Rural Australians' health status and access to health and aged care services continues to be poorer than that of their urban counterparts, despite efforts of governments to address this situation.

- Health inequalities are due to a complex interaction of multiple factors including poverty, behavioural factors, poor health literacy, poor social networks and discrimination because of poor health
- A recent study used nine indicators of social disadvantage to identify areas of social deprivation. Of 30 highest ranking areas based on disadvantage scores, only two were metropolitan areas, the rest were rural and outer metropolitan areas
- Rural populations have higher proportions of Indigenous people, appear to have lower levels of access to employment and services, and have poorer personal risk problems (e.g. people are more likely to smoke).
- Some of the major risk factors for poor health in rural areas are physical inactivity, overweight, smoking, hazardous or harmful alcohol consumption and high blood pressure.
- With greater prevalence of smoking, lower rates of physical activity and more restricted access to healthy food, people in rural and remote Australia are likely to be at greater risk of cardiovascular disease, the leading cause of death in Australia.

While access to adequate health and aged care services is a direct responsibility of government, the determinants of health in rural areas are a complex interaction between social, economic, cultural, industry and health service factors. Distance, lack of transport and other local infrastructure issues have an even greater influence on access to health care when an appropriate local workforce and health and aged care infrastructure is missing or inadequate.

Anomalies in funding mechanisms between the Commonwealth, the states/territories and the private sector further complicate and act against good health care delivery and achievement of positive health outcomes.

The current system is based on twenty-year-old assumptions of:

- Models of care
- Availability of workforce
- Lower technicality of treatment regimes
- Availability of and support from other community institutions such as industry, banks, air links and so on
- Central governance arrangements that exclude community involvement
- Community expectations of outcomes, safety, quality and system responsiveness
- Population demographics

In the last five years governments have dedicated significant funding to improve current rural health services and local infrastructure and to develop and trial integrated service provision, improve recruitment and retention, increase availability of specialists and allied health in rural centres (MSOAP and MAHS) and create rural clinical schools.

Despite these and other efforts, the rural health and aged care system continues to fall behind in providing access for local rural communities to comprehensive, appropriate health and aged care services. It is important to recognise that the situation is highly variable across rural Australia, with some areas doing well and many others doing very badly.

## **ADVICE TO MINISTERS**

### ***PRINCIPLES***

The Reference Group recommends to Ministers the following principles to guide action to improve health services and health outcomes in rural Australia:

- All Australians have the right to access the most appropriate, highest quality health care services in the most appropriate location delivered by skilled health professionals, **regardless of geographical location**
- All Australians have the right to be treated appropriately according to clinical need **regardless of geographical location**
- All Australians have the right to equal access to transport to health services and 'health related transport' (which provides access to the full range of services and facilities needed to maintain a healthy life in the community).
- All Australians are given a choice of provider whenever possible and this choice must be protected and enhanced when decisions are made about the distribution of services.
- Services are networked within regions, cities and states to meet community need.
- Community involvement is structured into the health services planning process and properly resourced. There is a clear timetable and opportunities for this involvement, and openness about options and costs
- The damaging impact of jurisdictional boundaries is limited through the development of bilateral agreements

### ***GOALS***

*Healthy Horizons* articulates seven underpinning goals for the improvement of health and wellbeing in rural communities

- Improve the highest health priorities first
- Improve the health of Aboriginal and Torres Strait Islander peoples living in rural Australia
- Undertake research and provide better information to rural Australians
- Develop flexible and coordinated services
- Maintain a skilled and responsive health workforce
- Develop needs-based flexible funding arrangements for rural Australia
- Achieve recognition of rural health as an important component of the Australian health system.

## **AREAS AND STRATEGIES FOR ACTION**

It will take a sustained, integrated and inclusive strategy that addresses health system, infrastructure and funding issues, to solve the significant health disparities between many rural communities and their urban counterparts and to implement equity of access to health and aged care services for rural Australians. A key challenge is to build upon current efforts, to integrate them and to make them work so that they deliver optimal impact in relation to health outcomes.

The new Australian Health Care Agreements provide a significant and timely opportunity to embark on a program to reform the rural health and aged care system to make it work better in the short and long term. For rural health and aged care to improve, governments have to refocus the Australian Health Care Agreements. The Agreements can no longer be solely a mechanism for compensating the states for lost revenue from private health insurance. The Agreements need to represent a funding partnership between the Commonwealth and states/territories to provide comprehensive health services for all Australians.

The goals and principles set out above form the basis for the following six specific areas that the Reference Group recommends to Ministers for action in the Australian Health Care Agreements:

- Workforce, including provision of an appropriate mix of health professionals
- Specialist services
- Aged care services
- Aboriginal health
- Transport
- Funding models

These areas are discussed in detail in the next section, together with specific strategies relating to each of the areas. The Reference Group recommends to Ministers the following six key actions, distilled from these specific strategies, that have the most potential for improving health and aged care services in rural Australia if targeted under the next Australian Health Care Agreements:

1. Provide additional funding for genuine incentives to increase the rural GP workforce
2. Create a critical mass of rural specialists using relevant recommendations from the Report on the Evaluation of Strategies to Support the Rural Specialist Workforce DHA 2002
3. Provide immediate resources to improve aged care services in rural communities and bring existing but non operational resources on-line
4. Undertake targeted increases in rural health expenditure on Aboriginal health services
5. Develop models for better use of existing private and community providers of transport in rural areas
6. Develop and implement community/regional based models for funding and governance that build the community's capacity to work with the Commonwealth, state and the private sector in planning comprehensive health and aged care services in their own communities and regions.

## **SPECIFIC STRATEGIES**

### **WORKFORCE**

Australians living in rural areas do not have adequate access to appropriate numbers and mix of health professionals.

- 30% of the Australian population live in rural areas, but only 15.6% of doctors work in rural areas.
- In 1998, small rural centres averaged 93 GPs per 100,000 population; other rural areas had 77 and remote areas 68.
- In the same year, all country areas were well below capital cities, which averaged 122 GPs per 100,000; other metropolitan areas and large rural centres averaged 107 and 110 respectively.
- Metropolitan Australia receives, on average \$392 in MBS benefits per capita. This is significantly more (29% or \$88 per head) than the benefit per capita of \$304 for non metropolitan areas.
- Rural Australia has access to only 73.5% of the level of GP services available to metropolitan Australia. In 1999, there were 121 primary medical care practitioners per 100,000 people in metropolitan areas and 89 per 100,000 people in rural and remote centres and regions.
- Availability of GP bulk billing and after hours care has fallen dramatically over the last five years – causing increasing numbers of people to seek care in public hospital emergency departments.
- Rural communities have limited access to a range of other health care professionals including allied health workers and pharmacists.

### **Recommended Strategies**

In order to recruit and retain an adequate health workforce, strategies must address the range of personal and professional reasons cited for not working in rural areas.

#### *Adequate remuneration for GPs*

1. Implement recommendations relating to rural disadvantage, shown in the Relative Value Study, for increased MBS reimbursement in rural areas.
2. Implement a grants system (like the remote area grants) for GPs to target areas of workforce need. These should be stepped according to urban, rural or remote locality. Practices, which receive these grants, should be required to commit to bulk billing of patients.
3. Re-examine the rural and remote classification systems to ensure all areas of need are appropriately classified.
4. Create opportunities for communities and/or regions to pool funds on a community/regional basis involving a cashing up and then cashing out of MBS/PBS payments and other appropriate Commonwealth and state funding.

#### *Improve the Nursing workforce*

5. Review the findings of the recent Senate Inquiry into Nursing and consider implementation of the recommendations which relate to nursing in rural areas.

#### *Train a local workforce*

6. Provide additional resources to train health professionals, especially nurses and allied health workers, in rural areas and develop re-entry and re-skilling programs for health professionals living in rural communities not currently working in health services.
7. Further develop rural clinical schools and university based medical, nursing and allied health professional courses in rural Australia to increase critical mass, local infrastructure and local skill mix.

8. Rebuild tertiary infrastructure in rural communities, particularly in education, health, law and business.

#### *Recruitment and retention*

9. Implement and evaluate alternate recruitment and retention programs for example:
  - o Minimum duration rural placements in return for priority access to specialist training places and urban practice placement.
  - o Employment packages that meet individual need (Visiting Medical Officer payment for hospital work; extra salary-packaged benefits such as car, office costs and child care support) and innovative employment arrangements (state/territory government Staff Specialist Scheme for GPs; pool of health professionals accepting responsibility for provision of services; job sharing).

#### *Numbers of Medical Practitioners*

10. Lift the cap on GP places for rural training in the training program.
11. Fund a national expansion of the current Commonwealth funded and ACRRM facilitated Rural Medical Intern Program.
12. Establish national minimum workforce benchmarks for rural areas to work towards over the next five years. Use the current national average of medical practitioners/specialists etc. per 1,000 population as the minimum workforce benchmark.

#### *Skill mix/ensuring an appropriate mix of health professionals*

13. Implement nurse practitioner positions in all rural and remote areas in line with existing models for services delivery, such as the Royal Flying Doctor Service program in Queensland. The role of nurses could include provision of “on call” support for rural or isolated practitioners.
14. Extend funding already provided for rural medical student training to nurses and allied health professionals.
15. Work with the Pharmacy Guild to develop and fund models of community pharmacy that substantially raise the quality use of medicines in rural Australia.

#### *Structural change*

16. Develop capacity for integrated service planning and delivery across networks. This would allow for the development and provision of the most appropriate services, be they primary care, allied health, nurse practitioner or specialist medical services which would assist in developing a critical mass.

#### *Evaluation*

17. As a matter of urgency, undertake research to investigate and build on strategies currently in place to promote recruitment and retention.

## **SPECIALIST SERVICES**

Rural Australian communities do not have reasonable access to high quality specialist services delivered in sustainable service centres.

- 29% of the Victorian population live in rural areas and are serviced by only 5.3% of Consultant Physicians
- Rural specialists identified six top unmet needs when interviewed in 2002 by the DHA:
  - The existence of a critical mass of rural specialists;
  - Opportunities for professional development, CME, and up skilling in tertiary teaching hospitals;
  - Adequate relief, locum support, and peer support;
  - Sufficient funding for trainee and rural specialist positions;
  - Family and spouse support/employment; and
  - Financial support

### **Recommended Strategies**

#### *Develop local service centres*

18. Provide funding to improve regional services and associated networks (that link city and country) based on community need.
19. Implement the AMWAC specialist/population ratios to assist in the development of a critical mass of specialists.
20. Ensure funding formulae account for capital and equipment replacement.
21. Develop and implement quality and safety standards appropriate to service provision in rural Australia.

#### *Improve the operation of Medical Services Outreach Assistance Program and similar programs*

22. Encourage use of state funded facilities.
23. Establish mechanisms that use the services of regional specialists to facilitate development of regional expertise.
24. Develop teaching and support roles in specialist areas such as anaesthetics.
25. Link to workforce issues involving recruitment and retention strategies.
26. Develop workforce benchmarks for a core set of specialists including general physicians, paediatricians, general surgeons, obstetricians and gynaecologists, psychiatrists, ophthalmologists, ear, nose and throat specialists, anaesthetists and emergency care specialists.

#### *Improve Allied Health Services*

27. Allocate funds to More Allied Health Service to cover all costs, such as land travel and accommodation, rather than salary and air travel alone.
28. Encourage allied health services to complement and work with state funded services.

#### *Remodel the workforce infrastructure*

29. Establish mechanisms which allow for up-skilling of rural specialists in tertiary teaching hospitals.
30. Increase the number of rural training posts and work with the Australian Medical Council to include minimum rural training/practice benchmarks in the accreditation of specialist Medical Colleges.

31. Investigate and implement a national specialist locum service.
32. Develop systems for IT support and training, especially to support telehealth.
33. Fund the creation of hospital training posts that allow rural GP trainees to conduct all or most of their training in the country rather than having to return to the city.

## **AGED CARE SERVICES**

Aged care services in some rural communities are inadequate and often do not meet the needs of the elderly or their communities.

- The expected growth rate from 2006 to 2016 for people aged 65 years and over is 2.9% pa compared to 0.8% pa for all ages.
- The proportion of the population aged 65 and over is projected to rise from around 12 per cent today to 18 per cent by the year 2021, reaching 25 per cent by the year 2051.
- In June 2001 there were approximately 600 older people in public hospital in rural NSW who should have been in residential aged care facilities.
- Approximately 16,000 residential aged care beds have been allocated but are not yet operating.
- Current and developing models of care for older people often do not readily apply in the rural sector.
- The volume and level of dependency of people of older people with chronic and complex care needs is increasing.
- It costs more to provide aged care services in rural areas.

### **Recommended Strategies**

#### *Increase resources for aged care:*

34. Either bring on line existing but non operational aged care places or allow states and territories to use non-operational aged care places and funding for transitional care services while residential aged care facilities are being commissioned.
35. Change funding formulae so that they accommodate the higher unit costs associated with providing aged care in rural areas and to meet the capital costs of building MPS.
36. Provide increased funding to integrated models such as MPS and Regional Health Services and for outreach services.
37. Increase funding for volunteers to assist with transport and care of the aged in small rural communities.

#### *Increase capacity to implement contemporary models of care*

38. Include a focus on cultural differences and diverse needs of consumers in all models of care.
39. Implement trials of innovative approaches that focus on integrated and coordinated care and develop funding mechanisms that allow for pooling of resources for integrated aged care and health services that allow for local flexibility, such as the development of regional models of aged care.
40. Introduce flexibility in number and location of residential aged care places for residential care.
41. Provide increased facilities of respite care for the aged.

#### *Enhance the aged care workforce*

42. In addition to the strategies recommended under the 'Workforce' section, introduce multidisciplinary, team-based care as part of core curricula and placements for professional training programs in aged care.

## **ABORIGINAL HEALTH**

The biggest single contributor to the differential in rural and urban health status in Australia is poor Aboriginal health status. This is due to the higher proportion of Aboriginal people living in rural areas and the very poor state of Aboriginal health.

- Aboriginal and Torres Strait Islander people are 20% of the rural population.
- Life expectancy is 20 years less than for non-Aboriginal Australians.
- Aboriginal boys born today have only a 45% chance of living to age 65 (85% for non-Aboriginal boys); Aboriginal girls have a 54% chance of living to age 65 (89% for non-Aboriginal girls).
- Over the last forty years, the Aboriginal infant mortality rate has declined (though it is still over three times the national average).
- Over the same period, adult mortality in the Aboriginal population has increased.

### **Recommended Strategies**

43. Require all rural health programs to be specifically accountable as to their impact on Aboriginal health.
44. Require all rural health programs to report on the access they provide for members of the Aboriginal community and their relationship with and impact upon Aboriginal community controlled health services.
45. Place a relative loading on all rural health expenditure for the Aboriginal population and Aboriginal community controlled health services in recognition of the extra need and workforce difficulties.

#### *Enhance the workforce available to Aboriginal health services*

46. Undertake further work to establish needs-based workforce requirements in rural areas with higher benchmarks for Aboriginal health services.
47. Apply higher workforce benchmarks to Aboriginal health services to counter the high burden of disease in the Aboriginal population. Recommended ratios for General Practitioners, Dentists, Nurses, Allied Health Professionals and Aboriginal Health Workers are 1:800, 1:1800, 1:400, 1:3,300 and 1:200 respectively for Aboriginal populations.

#### *Improve access to services*

48. Establish incentive programs for all mainstream health services to develop relationships with local Aboriginal health services in order to address poor service delivery to Aboriginal communities, including the provision of cultural safety/awareness programs to reduce the impact of institutionalised racism as well as necessary clinical training. These incentives could be extended to address poorer service delivery to people of low socio-economic status generally.
49. Collect data on Aboriginal and non-Aboriginal access to key tertiary endpoints including renal transplants, coronary angiography, cardiac surgery and access to radiotherapy.
50. Ensure full funding of the Primary Health Care Access Program in accordance with the current funding formula, based on early experience with the Primary Health Care Access Program.
51. Pilot the model of Aboriginal community controlled health services (provision of comprehensive primary health care using blended payments) in mainstream primary health care provision.

52. Expand the review of the impact of the mainstream health workforce programs on support, training, recruitment and retention of health professionals within Aboriginal primary health services to all rural programs.
53. Re-examine salaries and loadings for Aboriginal community controlled health services.

## **TRANSPORT**

Inadequate transport exists in much of rural Australia and this influences access to health services. The Reference Group has identified four major issues:

- A shortage or absence of public transport
- A shortage or absence of transport to health services
- Affordability
- Isolation

- Between 13 and 40% of health service users in different regions of NSW have difficulty in getting to health facilities.
- Trips of 4 - 5 hours to access health facilities in regional centres or cities are not uncommon with the increase in specialised service centres.
- Additional need for transport assistance to get to health facilities is likely to grow by about 16 - 20% over the next 5 years.
- People who have most difficulty getting to health facilities are those who do not drive or who do not have access to private transport.
- 61% of respondents surveyed by the Department of Primary Industry and Energy in rural Australia cited transport as the most important of all social services and 70% identified inadequate transport services as the main reason for a lower quality of life outside the major cities.

### **Recommended Strategies**

54. Establish nationally accepted guidelines for transport assistance provided to family members to support patients that need to travel.
55. Develop benchmarks for transport times and type of travel depending on size and remoteness of the community.
56. Provide funding for medical escorts for patients undergoing major procedures or facing life-threatening injuries.
57. Provide funding for patients to travel home when a health service has transferred them for further treatment.
58. Review and implement opportunities for using existing private and community providers of transport, such as multiple users of community buses and taxis, regional bus transport for outpatient services and the like.
59. Ensure that funding formulae accommodate the higher unit costs associated with servicing people in rural areas.
60. Undertake a review of the functioning of IPTAAS (or its equivalent) schemes.
61. Address, as a matter of the highest priority, transport difficulties for towns with populations of less than 7,500.

## **FUNDING MODELS**

There are two problems:

- Rural areas are significantly disadvantaged in terms of access to health resources.
- Some aspects of the current financial arrangements create barriers to the appropriate use of funding in rural areas and may inhibit the development and adoption of appropriate community-led models of care.

Where health services are undersupplied, communities may be unable to initiate alternative structures to provide care because of existing Commonwealth and state structural and funding arrangements.

Rural Australia needs an effective, appropriately resourced, rural health infrastructure that is typically quite different to that of urban Australia, which allows

- Effective regional based population health strategies
- Effective community participation
- Regions and communities to address emerging priorities as soon as possible
- Networking of services within regions, cities and states to meet community needs

- Commonwealth, state, territory and private sector funding arrangements mean that there are often more than a dozen different sources of funding for health and related services such as Aboriginal health and aged care.
- Good models of care exist but more often than not these are provided on a short-term pilot or trial basis.
- Communities may be prevented from brokering provision of integrated and comprehensive health care service locally because the Commonwealth funds community based care and the states and territories fund hospital care.

### **Recommended Strategies**

*Develop and implement customised funding models to create a viable rural health infrastructure*

62. Where significant improvements in the efficiency and effectiveness of rural health and aged care services can be expected, combine components of Commonwealth and state funding for rural health into rural health streams to allow greater flexibility in funding, to allow redirection of funds to areas of identified priority and to decrease onerous reporting requirements.

*Create adequately resourced community-inclusive governance structures*

63. Create community/region based, transparent planning processes involving all key groups (health professionals, managers and consumers) to support the provision of comprehensive health care, especially primary health care.

64. Encourage and resource community involvement and ownership and joint community/government/private sector planning capabilities.

*Research and evaluate current pilots and trials*

65. As a matter of urgency, evaluate various models of state and Commonwealth rural service delivery to assess their performance in relation to efficiency, effectiveness, community satisfaction and workforce recruitment and retention, to inform future extension of these services in the most appropriate manner.

*Undertake wider implementation of effective funding models*

66. Implement effective funding models, identified through research and evaluation, across the nation.

*Streamline performance reporting requirements*

67. Remove unnecessary performance reporting requirements that restrict the allocation/reallocation of funding within rural communities and thus increase the ability to address emerging priorities in a timely manner.

## ATTACHMENT 1

### REFERENCES

Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework May 2002, Australian Health Ministers' Advisory Council, Strategy 33.

AIHW *Health in Rural and Remote Australia* 1998:5

AIHW, Australia's Health 2002: The Eighth Biennial Health Report of the AIHW, Canberra, AIHW, 2002

Boffa, J. & Laughton, K. 1993, *The National Aboriginal Health Strategy & the National Rural Health Strategy in Dialogue - An Aboriginal Community Controlled Rural Health Training Unit in Central Australia*. Joint Keynote address at the 2nd National Rural Health Conference Armidale 12-14 February 1993. Published in Malko, K. (ed.). *2nd National Rural Health Conference Proceedings*. Armidale, The National Rural Health Alliance: 1993: 33-38.

Commonwealth Department of Health and Ageing, Report on the Evaluation of Strategies to Support the Rural Specialist Workforce, 2002

Commonwealth Government Electorate Profiles, Department of Health and Aged Care, June 2000

Cunningham J. Diagnostic and therapeutic procedures among Australian hospital patients identified as Indigenous. *Medical Journal of Australia*, Vol 176, 2002, 58-62.

Health Services in the City and the Bush: Measures of Access and Use Derived From Linked Administrative Data, Occasional Papers: New Series Number 13, Commonwealth Department of Health and Aged Care, September 2001

*Healthy Horizons: A Framework for Improving the Health of Rural, Regional and Remote Australians*, 1999, A Joint Development of the National Rural Health Policy Forum and the National Rural Health Alliance for the Australian Health Ministers' Conference

Healthy Horizons Progress Report to AHMAC, June 2002, pp 66-71

*"It's different in the bush" – A Comparison of General Practice Activity in Metropolitan and Rural areas of Australia 1998-2000*, Australian Institute of Health and Welfare, 2001

National Health Strategy (*Improving Australia's rural health and aged care services*) 1992

National Rural Health Strategy 1994

NSW Department of Health, Sinclair Report on Health Services in Smaller Towns, 2000

NSW Department of Health, Non-Emergency Health-Related Transport – Facilitating access to health services in NSW - Discussion Paper, December 2001

NSW Health Council Report, March 2000

Senate Inquiry into Public Hospital Funding, First Report, December 2000

Simmons D, Bolitho L, Phelps G, Ziffer R, & Disher G, 'Dispelling the myths about rural consultant physician practice: the Victorian Physicians Survey, *Medical Journal of Australia*, Vol 176, No 10, May 2002

WA Department of Health, Rural and Remote Allied Health Workforce Issues, Discussion paper, 2002

WA Department of Health, Allied Health Taskforce On Workforce Issues Initial Report - June 2002

## ATTACHMENT 2

### **HEALTHY HORIZONS: A Framework for Improving the Health of Rural, Regional and Remote Australians 1999 - 2002**

[Healthy Horizons 1999 - 2002 Click Here](#)