NATIONAL RURAL HEALTH ALLIANCE INC.

ABN: 68 480 848 412

PO Box 280 Deakin West ACT 2600
Phone: (02) 6285 4660 • Fax: (02) 6285 4670
Web: www.ruralhealth.org.au • Email: nrha@ruralhealth.org.au

Budget Submission
January 2010

Introduction

The National Rural Health Alliance is the peak non-government organisation working to improve health and wellbeing in rural and remote Australia. It is comprised of 29 Member Bodies, being health service provider and consumer organisations, and health professional bodies.

In response to the Treasurer's general invitation received late last year, the Alliance is pleased to submit its views about the specific New Policy Proposals it believes should be included in the 2010-11 Budget. This submission also includes reference to priority areas in which the Alliance will be pleased to see continued spending.

The Alliance's proposals focus on some of the areas of greatest current need in rural and remote health, and build on the strengths of existing health services wherever practicable. Particularly at a time of fiscal restraint, all health initiatives in the Budget should pass the tests of improving equity in access to services and targeting those most in need. We believe the following proposals meet these tests, are practicable and urgent, and are compatible with the more strategic health reform developments that may occur in the longer term.

While the Alliance supports the development of a blueprint for health reform in Australia, it is strongly of the belief that much-needed early improvements in the health of people in rural and remote areas should not be postponed while such strategic reform is completed. To this end, the Commonwealth should lead a clinical services audit to inform the minimum service standards that can be expected for country communities. This would then facilitate the development of inter-related infrastructure, workforce and operational plans, brought together under the new national strategic framework currently being developed.

Most urgent is the need for continued government investment at higher levels and across portfolios in closing the gap in the health and wellbeing of Australia's Aboriginal and Torres Strait Islander peoples. This should continue in the 2010-11 Budget. The Prime Minister has established important targets relating to the Close the Gap campaign. Meeting these targets will require continued new investment in Indigenous education, early childhood, health and welfare.

The Alliance's other proposals are for:

- strategic investment at three levels in high need areas: in service hubs in rural regions, multipurpose nodes in smaller towns, and supported networks between those places and still smaller communities;
- an improved patients' assisted travel scheme;
- further investment in rural/remote health workforce measures; in particular, a package of measures to improve the rural oral health workforce;
- a 'Broadband for all' initiative which will ensure equal access for those who cannot be serviced by fibre-to-the-home/office;
- further allocations to the illness prevention agenda;
- re-investment in maternity services in rural and regional areas; and
- a modest allocation from existing resources for a dedicated rural/remote health research stream.

Integrated Regional Health Services

Health outlays in the 2010-11 Budget should be geared to addressing the poorer health of people in rural and remote areas and their much more limited access to health services.

The Alliance proposes a four-level system that:

1. recognises the role and importance of the **tertiary and specialised services** provided only from capital cities and a limited number of major centres;
2. builds the capacity of selected **regional hubs** to relieve the pressure on urban hospitals and provide support for the extension of outreach services to medium and smaller towns;
3. further develops **multipurpose service nodes** through extending existing initiatives such as the MultiPurpose Service and Regional Health Service programs, to provide support for rural health infrastructure in medium sized towns (with populations of perhaps 2,000 to 12,000 people); and
4. creates **networks of primary health care services** covering whole rural regions, based on the hubs and nodes, and which are the rural and regional version of the comprehensive primary health care services envisaged for urban areas.

The provision of fair, safe and comprehensive services to people in these regions depends on both the *capacities* of the services in places at the four levels, and the *relationships* between the services at those four levels.

The Alliance is calling on the Government to invest in the regional hubs (level 2) and in a greater number of multi-purpose service nodes (level 3), beginning with the 2010-11 Budget. These investments will result in more coordinated and integrated health services, and capacity for a greater emphasis on health care prevention, early intervention and chronic conditions.

The location of both the regional hubs and the multi-purpose service nodes should be determined on the basis of regional demography, health status and transport systems/flows. Over time this would result in the regional health service system of the kind envisaged by the National Health and Hospitals Reform Commission (NHHRC) and others.

Regional hubs must receive their fair share of all health system investments. This should include a proportion of current allocations for reduction of elective surgery waiting lists in hospitals and for future investments to address emergency, subacute, mental health, cancer care, palliative care, rehabilitation and other critical health sector enhancements. These larger regional health hubs must also have capacity for outreach services to the medium-sized and smaller communities in the region (eg by specialists, a rehabilitation team, autism assessment, mental health and palliative care/end-of-life care services).

In some of the medium-sized towns there are already Multi-Purpose Services and/or Regional Health Service programs. These two programs could be amalgamated and their number should be at least doubled from the current 250 to perhaps 500 multipurpose service nodes. Their resourcing should be increased to enable more competitive staff recruitment, and to give them the capacity to provide, in collaboration with local general practices and other private sector services (eg those of allied health professionals), a range of multi-disciplinary services, including for improved mental health, maternal and child health and oral health.

The regional hubs and the multipurpose service nodes will provide support as necessary for primary care in the smaller communities in their area. As recommended by the NHHRC, these smaller communities also need support for linking local primary care services into cooperative networks, such as through shared multidisciplinary teams, emergency and after-hours services, and 24-hour on-call telephone and internet support. These local primary care services should also have capacity for linking to regional hubs and multi-purpose services towns, including facilities (including rooms/space) and equipment for visiting specialist, nursing and allied health professionals.

The allocation of new resources at three levels (regional hubs, multipurpose service nodes and their relationships with primary care in smaller communities) can be seen as meeting the NHHRC proposal for providing under-served areas with 'equivalence funding'. This will give concrete effect to the principle of universality of access to health care services on which much of Australia's health policy is based.

Overall, the enhanced regional health service program should provide:

- capital for infrastructure: for example, for high quality equipment such as for point-of-service testing, dental health facilities, and communications and other infrastructure for outreach and service integration;

- increased recurrent funding to provide more equitable access for people in the region to public health services, and to permit a greater focus on prevention, early intervention and people with chronic conditions; and

- increased funding to engage a well-balanced multidisciplinary workforce and to provide the clinical leadership, mentoring and professional and career development required to retain staff in regional areas.

The new investment in these regional hubs, multipurpose service towns and comprehensive primary care services in smaller communities and the relationships between them, should build upon existing structures and practices. Dental services must be seen as a standard part of a comprehensive primary care system, even if they are only operated periodically by visiting dentists.

Enhancing the quality and resourcing of these regional hubs and multipurpose service towns will play an important role in attracting and retaining health professionals, including doctors, to rural, regional and remote areas. It will also help to relieve the pressure on tertiary and specialist services, through using rural services to best effect. Health investment in major cities without equivalence payments to regional and rural areas would inevitably aggravate the current maldistribution of health professionals and increase still further the differential between health outcomes in city and country. This would not only be inequitable but would be a visible liability for current governments and require even more expensive and inefficient policy responses down the track.

Patients' Assisted Travel Schemes (PATS)

Given the urgency and fundamental importance of PATS, the Alliance believes the Commonwealth should now provide some direct investment in the schemes. Key purposes of such funding should include more realistic levels of payment for travel and accommodation, easier ways to apply for the money, provision for better carer support and assistance, a broader scope of eligible health services, and more consistent conditions of accessibility. A form which could be generated by the doctor's software system and be signed at the time of making the referral would help reduce red tape.

The Alliance's proposal is that the Budget commits new money to be used as incentive payments to the States and Territories, to be matched by those jurisdictions, and subject to national standards and performance reporting under COAG's National Partnership Agreements.

Workforce Distribution

The Alliance believes that the substantial investment in the regional hubs and smaller town nodes described above will give rural, regional and remote areas greater capacity to bid for and win the services of health professionals who are currently in short supply in those areas.

In addition, the Budget should announce new investment in some new programs to improve the health workforce distribution. This has become the emblematic issue in rural and remote health: the one on which so many of the perceptions and health service realities depend.

A crucial first step is to increase the proportion of clinical training and placements for health professions that is carried out in rural and remote areas. Governments are funding large increases in the overall number of clinical training places over the next four years and it is essential that a significant proportion of them are in rural, regional and remote areas. This will attract more health professions to rural and remote areas after their training.

This should be accompanied by a substantial increase in the number of scholarships available for rural people to study health sciences, especially those related to priorities like mental health, oral health, remote areas nursing, midwifery, and child and aged care. These scholarships would help extend to designated other health professions the range of incentives available to GPs.

A greater emphasis on retention, as distinct from recruitment, requires accommodation assistance, still more locum support, IT availability and other incentives for continuing professional development. There could be financial incentives to existing practitioners for providing mentoring and support to medical, nursing and allied health students, and further investments in the careers of Indigenous health science students.

The rural oral health workforce

The 2010-11 Budget should announce new investments in the oral and dental health workforce.

The Alliance proposes a package of measures:

- a voluntary 'foundation year' for graduate dentists, oral health therapists and hygienists, to be undertaken whenever possible in rural and remote areas;
- incorporating oral and dental health staff and facilities in the selected regional service hubs to be built up, with professional support provided by the University Departments of Rural Health;
- until numbers of rural dentists increase, outreach and travel services such as visiting dentists, therapists and eligibility for PATS should be extended to allow rural and remote Australians better access to dental services;
- a greater emphasis on oral health in health service infrastructure programs; and
- the full package of incentives (rural undergraduate scholarship scheme, HECS relief, rural and remote incentives for attraction and retention, and locum relief services) being available to dentists and oral health therapists and hygienists.

'Broadband for all'

The Budget should target some of the resources earmarked for the National Broadband Network to a 'Broadband for all' initiative for those who are unlikely for technical and logistical reasons to be connected by fibre-to-the-home or business.

This is a key recommendation of the National Health and Hospitals Reform Commission and fundamental to improving access and safety and quality of health care in the most remote and disadvantaged communities in Australia. Internet access for patients could be provided as part of the attraction of attending the local health clinic.

Providing fast and upgradeable broadband for remote families and businesses will require commercial grade satellite or other high speed connection capacity to be made available to them at an affordable price. This will require a full assessment of the technological requirements and costs of the alternatives to fibre, and specific plans to meet the electronic information and communication needs of more remote Australians.

Improved connectivity will support health care and e-health as well as commerce and lifestyles, with citizens and their health professionals having easier access to information held in different parts of the system, and to information available through the internet.

Illness prevention

Australia should invest more and more effectively in health promotion and illness prevention. The proposed National Preventive Health Agency must be set up to lead such work. The Alliance wants to see this Agency progressed with urgency to implement specially targeted preventive programs for 'at risk' groups, including people in rural and remote communities. Among other things the programs should build the capacity of rural and remote communities to address health risks in locally meaningful ways.

The Budget should reconfirm the Government's commitment to allocate funds to the new national body and for its work.

People in rural and remote areas have higher rates of smoking, excessive alcohol consumption and obesity, and higher incidence of injury. They also have lower levels of health literacy and of access to resources to address these risk factors. There is great scope for illness prevention work to contribute to improvements in health outcomes for rural people.

However illness prevention is time-consuming work done by nurses and doctors and is not reimbursed realistically under the MBS. MBS item numbers need to accommodate the examination of a body part for 'illness prevention' so that the work can be appropriately remunerated.

Re-investing in maternity services

The new national maternity services plan, being developed with the States and the NT, must lead to *reinvestment* in maternity services in some of the rural centres that have lost such services. The 2010-11 Budget should include allocations for this important purpose. More midwives are needed in rural and regional areas.

Such investment in maternity services yields high returns for individuals, families and the nation and should be an important part of the national maternity services plan. We support the philosophy that women be assisted to feel 'in control' not only in pregnancy, but in childbirth and during the postnatal stage. Healthy pregnancy, a birth that is managed with appropriate care and an optimum beginning to life are key determinants of the long-term health of every individual. Poor prenatal and birthing experiences are likely to impose costs for life and involve health care beyond the costs of re-establishing and maintaining rural maternity services.

A widespread network of maternity services would help to sustain country hospitals as well as the rural, regional and remote communities that depend on their services.

Other things required for improved birthing in the bush include greater support for the health professions involved in maternity services, antenatal and postnatal care, replication of collaborative birthing services that have already been shown to work well, electronic retention of routine data collected during pregnancy, birth and in the first five years of life, and a no-fault insurance scheme to reduce the cost to clinicians and taxpayers in the event of adverse outcomes.

The national partnership agreement on prevention has a focus, inter alia, on child care centres, pre-schools, children and family centres and breastfeeding support. These are important contributors to health for young children, and are programs which will yield positive returns on investments made.

Rural and remote health research

Recognising the complexity of the health workforce challenges faced by rural and remote communities and their impact on health reform programs, the National Health and Hospitals Reform Commission recommended a stronger remote and rural health research program. Rural health research is also required to systematically identify best practice in rural health provision, and to better link research and policy and program development. Rather than competing in the research mainstream, there is a strong case for a separate program of research on rural and remote health in Australia.

The 2010-11 Budget should provide $500,000 per annum to the Australian Institute of Health and Welfare (AIHW) and an increased allocation to the NHMRC for a dedicated rural/remote stream within that body's work.

The new allocation to the AIHW is critical because it currently has no such dedicated resource base. It would permit a broader range of analysis of workforce issues, more timely results, and more detailed analysis to reveal particular rural areas where access, health risks, health status or health outcome measures are lower.

The Alliance supports a dedicated rural/remote stream in the NHMRC's work. Such a stream has many precedents, including the Primary Health Research, Evaluation and Development Strategy(PHRED), the 5 per cent allocation to Aboriginal Health of NHMRC funding, the NHMRC Partnership Projects, targeted to achieve a more effective integration of evidence into health policy and service delivery, and the Centres of Clinical Research Excellence. While all of these programs, as well as the mainstream NHMRC project grants, research enabling grants, and career and fellowship grants are in theory equally available for remote and rural research purposes, the outcomes do not show any reasonable allocation to remote and rural research. For example, of the approximately 60 NHMRC Partnership Project grants and Centre for Clinical Research grants that have been awarded, none have a specific rural focus. Part of the difficulty is that grants are awarded on the basis of past performance and in some cases require substantial resource contributions from the host and partner research bodies, all of which favours more established and resource rich institutions.

A dedicated remote and rural research program is crucial to reverse this situation and enhance the evidence base. A $20 million per annum program would represent less than 2.8 per cent of the existing NHMRC research funding allocation in 2009-2010, and could readily be accommodated within the $100 million to $200 million per annum increase in NHMRC funding over the period to 2012-2013 ie only 10 per cent of the increase by 2012-2013.

A comprehensive remote and rural research and development program would comprise:

- research enabling grants, career development, research fellowship grants and infrastructure to build research capacity and the resource base in rural institutions in which research and evaluation is undertaken, including academic bodies and service providers;
- project grants to address the many clinical and service delivery challenges of particular relevance to remote and rural Australia;
- partnership grants to support collaborations between researchers and policy or practice agencies to facilitate the application of research into policy and service delivery; and
- a mechanism to provide support in the area of dissemination and knowledge-exchange, similar to the Primary Health Care Research and Information Service (PHCRIS) element of the Primary Health Care Research, Evaluation and Development (PHCRED) Strategy.