Improving Resource Allocation and Infrastructure

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Proceedings
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Introduction

Improving resource allocation is the final theme of the draft rural strategy document and there is some logic in it being the last theme. At the end of the day when the decisions have been made on what services will be provided, where and for whom it will be the quantity and form of resources provided which will determine the actual health services to be delivered.

A discussion of resource allocation should embrace the following issues: the quantum of the national resource put to health care; how do Governments decide this quantum and how does the community have a say in these decisions, how do we distribute the resource across the needs of metropolitan, rural and remote Australia, once resources are allocated at the micro level, how do we ensure they are converted efficiently and effectively to the health service needs of the community.

Any discussion of macro resource allocation seems to immediately raise the question of whether or not country Australians are receiving a fair go—this is in fact our conference theme. Rural and remote Australians are clearly concerned about their health services and have a perception that they are not being treated fairly. These concerns manifest themselves in statements such as:

- metropolitan services are much more comprehensive and expensive than country services;
- country services are under threat from government cutbacks and staff shortages;
- it is harder to get to services in the country.

Against this backdrop, the country is asking for a fair go. The question is; what is a fair level of resource allocation for rural and remote Australia and what can country people realistically expect from those resources.

What is Equity

Health Equity should mean a fair share of the burdens and benefits of the Australian health system.

Health Equity is not the same as Health Equality. Equality means the "same as" and can be measured in quite precise terms. Equity implies concepts of "fairness" and "justice" and is difficult to quantify.

National Health and Medical Research Council (NH&MRC) suggests; a person who has a need for health care should have equitable access to whatever effective care the society can reasonably afford.
The economic dimension in this statement needs to be emphasised. There is an economic dimension to health and gone are the days when we could hope to service every demand for health care wherever it arises. There are economies of scale (up to a point) in health care delivery and this means larger population groupings are more likely to be able to achieve more from a given quantum of health services. It means the centralisation of very expensive technology and services in the larger population centres, most likely the large provincial centres or the capital cities.

We cannot expect to ever be able to deliver, to every resident of country Australia, the services that are readily available in our capital cities. But we can and should pursue equity for rural and remote Australia; we can get essential health services widely distributed in rural and remote Australia.

There is a useful comment in the draft document about the distribution of health resources:

- the available resources should be fairly distributed between metropolitan and rural areas and between different rural/remote areas, i.e. that there is vertical equity in the distribution of resources;

- the services which are available are managed to ensure that localities with similar characteristics and needs are able to access similar services, i.e. that there is horizontal equity in the distribution of health resources.

Suggestions for Action

- **Objective 1**
  To describe the distribution of health resources between rural and metropolitan Australia and assess the feasibility of establishing a national reporting system to track annual changes in resource distribution.

  If the community doesn’t know the actual position on the macro allocation of resources, then it is likely that the general level of dissatisfaction will continue. Being “kept in the dark” is aggravating and will not foster good relationships between the bureaucracies and the community. An informed community may still want to argue the allocation decisions but there is at least the prospect of constructive debate.

  This objective seeks to inform the community on broad resource allocation and to keep them up to date through time.

- **Objective 2**
  To review funding mechanisms to ensure that any gross inequities in resource distribution are removed over a period of time
  
  - including inequities between metropolitan to country, and
  
  - from rural region to rural region

  It is unlikely that the historical funding procedures of the past have resulted in a pattern of resource distribution that is fair at the present time. However the correction of a maldistribution of resources will require courage at the political and state health administration level and will sorely test the commitment of the community to the equity principles, particularly those communities which have to bear a shifting out of resources.

  Funding mechanisms have to be devised which achieve broad equity in resource allocation. The Resource Allocation Formulae approach being used in a number of
Australian states is the logical way to progress, provided that the formulae are open to scrutiny and are applied consistently across the community.

- **Objective 3**
  For rural and remote Australians to have a clear idea of the scope of health services that they can reasonably expect to have, consistent with their geographical location.
  
  - This will require the development of service standards for the various “practise settings” in rural Australia.
  - Once in place these standards should be publicised within rural and remote communities.

  The practise settings might be based on “functional communities” such as mining towns, farming towns, rural service centres or it might be based on population thresholds and isolation factors. The AHMAC Rural Health Care Task Force has decided to engage a consultant to carry out a review of this question.

  Moving from the macro level to the micro, the organisation, planning and management of health services is an important issue.

- **Objective 4**
  To ensure the local management arrangements for health units are administratively efficient, are effective in terms of their responses to assessed need and bring the best skills available to bear on the management tasks of the health unit.

  Good management at the local level is an important issue:
  
  - funds that are locked up in unnecessary overheads are funds that cannot be made available for services and may represent a high opportunity cost;
  - a management that runs an inefficient service, say a food service, is a management that is wasting an opportunity for expanded health care within existing resources.

  We need to question whether our systems of individual Boards of management have served us well. Can we draw the range of management, legal, professional skills appropriate to the running of a complex human service organisation from small country towns? Is it sensible to have say twelve member boards for hospitals that might only have that number of beds?

  There is a view that management would be improved by health units cooperating across a wider geographical area. Area Health Boards have been proven in the metropolitan environment and should be investigated in the country.

- **Objective 5**
  To ensure effective planning arrangements for rural and remote health services which are responsive to:
  
  - community assessment of need
  - general practitioner experience in the area or region
  - input from other relevant health workers.

  Good planning is also fundamental to the effective allocation of resources and effective service delivery. Unfortunately, planning has been somewhat the prerogative of the health administrators, most of whom have been quite remote from the communities being
planned for. In my experience, the further the planning is from the community being served, the less relevant it is likely to be.

Community assessment of need is a major planning challenge; the “Healthy Cities” approach and the Health and Social Welfare approach should be further explored as possible solutions to this problem. Furthermore, mechanisms have to be found for involving general practitioners in the needs assessment of communities. General practitioners are well placed to observe the basic factors giving rise to ill health in their communities.

- **Objective 6**
  To remove hidden “rural subsidies” from rural health service budgets and replace with alternative funding sources; the objective should be to have the entire health budget dedicated to effective health care delivery.

  It is often said that the small country hospitals are there as much to preserve the viability of the small country town as they are to provide health services. A component of the health budget is therefore an undeclared subsidy to keep the community there. These hidden subsidies should not be tolerated if we are serious about good management and high quality performance in health service delivery. They should at least be identified and declared as such or preferably replaced by specific subsidies from outside of the health budget.

- **Objective 7**
  To explore innovative service delivery options so as to expand the service capacity of existing resources, consistent with the needs and circumstances of rural communities.

  There are many Australian hospitals which are trapped in the service delivery patterns and work practices of the past decades. This has to change if we are to survive in times of economic restraint and to continue to improve our services to rural communities. The agenda for innovative service delivery should challenge:

  - work practices
  - management improvement
  - productivity improvement
  - private sector participation
  - cooperative service arrangements between units.

  Innovation may well be the only way for some existing rural services to survive in the future and the Multi Disciplinary Centre may be an example of this.

- **Objective 8**
  Relocation of services provided for country people in metropolitan areas to rural health units, where practicable and appropriate. Given that the capacity of Governments to provide new resources is severely constrained and that maldistribution of services can be clearly demonstrated, we are probably at the time when we have to consider relocating actual services or programs to achieve equity.

  There would seem to be a clear case to do this in instances where metropolitan based units are servicing country residents but we should also look at relocating portions of programs that are provided in the city but not in the country, provided it is practical and appropriate to do so.
- **Objective 9**
  For new initiative funding to be targeted to sustainable solutions to the problems of recruiting, retaining and developing adequate numbers of rural health professional staff.

  Having talked about the need to establish equity and having realised the economic reality of not being able to attract new funds, it is clear that the essential area of health professional training is one where additional funding is going to have to be found, at least in the short term. The RHSET scheme might provide a valuable contribution but some further source of funds is likely to be needed for comprehensive and sustainable solutions.

- **Objective 10**
  To determine appropriate arrangements to ensure the coordination of Commonwealth, State, Local Government and public health initiatives and services so as to maximise the health status of the community.

  Perhaps the review of Commonwealth and State relations may result in the removal of one or more layers of administration in due course. Notwithstanding that, the different objectives, method of organisation, duplication of administration that is present in the current arrangements must be resolved.

  Turning now to infrastructure, let me say this is an area of the report where I would like to see some further ideas from the conference.

- **Objective 11**
  To ensure high quality emergency transport and retrieval systems and to devise more cost effective non-emergency transport options for health service access in rural Australia.

  Emergency transport services appear to be, or have recently been, the subject of review in a number of the States with the agenda having been the improvement of service responsiveness at cost effective service levels. Non-emergency transport appears to remain a problem of serious magnitude because of its impact on the accessibility of rural Australians to even basic health services particularly at a time of crisis for rural income.

- **Objective 12**
  To analyse the negative health impacts of deficiencies in infrastructure and to facilitate inter-sectoral responses to those deficiencies.

  There is wide acceptance of the need for an inter-sectoral approach to health but this will only be effective if the health services take the initiative in identifying where the deficiencies are and make representations to the appropriate authorities and agencies who can actually do something about resolving a problem.

**Conclusion**

Resource allocation questions have an image of being the preserve of the bureaucrats. In reality, the resolution of these questions is the most important determinant of actual service provision. The improvement of resource allocation processes and infrastructure issues is therefore deserving of the attention of all health care providers, health consumers and bureaucrats alike.