NATIONAL RURAL HEALTH ALLIANCE INC.

...good health and wellbeing in rural and remote Australia

Fact Sheet 23

Measuring the metropolitan-rural inequity

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There is an overwhelming case for greater equity to be provided for rural, regional and remote people through investments by the Australian Government in health, education, telecommunications and infrastructure.

Over the last two decades – a period when the Australian Government was benefiting from economic surpluses generated largely by the mining boom – investments in infrastructure and outlays on services in non-metropolitan areas have lagged dangerously behind those in the major cities. This has resulted in substantial inequities in vital areas like health, education, basic infrastructure and telecommunications.

Inequity in life expectancy

No measure of human existence is more serious than life expectancy. It has been estimated that overall life expectancy is up to four years lower in rural, regional and remote areas than it is in Australia's major cities. Put another way, this results in 4,600 premature deaths per year in rural and remote Australia. The Royal Australian College of Physicians estimated that a white man born in the Central Darling Shire in Far West New South Wales could expect 11 years less life than one born in Mosman in Sydney.

These differences are not due entirely to the higher proportion of Indigenous people in more remote areas. Living in more remote areas in Australia is itself a risk factor.

Inequity in access to Medicare-funded services

The table below shows clearly that access to and use of health-related services diminish with increasing remoteness.

Table 1: Services received by rurality, 2006-07 - as a proportion of services received in Major Cities

Service Type	Inner Regional	Outer Regional	Remote	Very Remote
MBS GP services	84%	79%	71%	54%
MBS Specialist services	74%	59%	38%	30%
MBS allied health services	75%	45%	24%	9%

Note: This table relates to the place of residence of those receiving service, so it overstates the number of MBS services actually received in rural and remote areas. There are many other services under-provided in rural areas, offset to some extent by basic hospital services and specially-targeted investments eg the Regional Health Services package.

Overall, there is an estimated Medicare deficit each year of about $1 billion, and growing, between major cities and rural, regional and remote areas. Cumulatively over the past decade, this shortfall in MBS funding alone equates to the prospective $10 billion in Government allocations and priorities for rural and remote Australia.

Three Country Independents consult with Jenny May (Chair) and full Council of the Alliance on rural issues during the week following the 2010 Federal Election.

Mental health and dental services are also very poor, with access to psychological services 25 per cent less than in major cities, while the ratio of dentists to people in rural areas is less than half the rate it is in the major cities.

Inequity in health workforce

There are shortages of health professionals of all types across rural, regional and remote areas. In general, the more remote the area, the more serious the shortages.

Although there are now greater numbers of students in medicine and nursing than ever before, the policy settings are still not in place to ensure that a fair proportion of them will choose to work in non-metropolitan areas after graduation. And despite the inventiveness and resilience of rural health workers, many of the service types that work well in rural areas cannot be established without the necessary workforce.

Inequity in health status and health risk factors

The Australian Institute of Health and Welfare has reported that, compared to their counterparts in Major Cities, people in Inner Regional, Outer Regional and Remote/Very Remote areas have:

- 20 per cent higher reported rates of only fair or poor health;
- 10 per cent higher levels of mortality;
- 24 per cent higher rates of smoking;
- 32 per cent higher rates of risky alcohol consumption;
- 20 per cent higher rates of injury and disability;

Table 2: Persons employed in health occupations, per 100,000 population, by Remoteness Areas, 2006

Occupation	Major cities	Inner regional	Outer regional	Remote	Very remote	Australia
Medical practitioners	324	184	148	136	70	275
Medical imaging workers	58	40	28	15	5	51
Dental workers	159	119	100	60	21	143
Nursing workers	1,058	1,177	1,016	857	665	1,073
Registered nurses	978	1,056	886	748	589	979
Enrolled nurses	80	121	129	109	76	94
Pharmacists	84	57	49	33	15	74
Allied health workers	354	256	201	161	64	315
Complementary therapists	82	82	62	40	11	79
Aboriginal and Torres Strait Islander health workers	1	4	10	50	190	5
Other health workers	624	584	524	447	320	602
Other health services managers	32	33	28	28	18	31
Total health workers	**2,777**	**2,536**	**2,166**	**1,827**	**1,379**	**2,649**

Source: ABS, Census of Population and Housing, 2006.

- 20-40 per cent higher reported levels of sedentary behaviour (for males);
- 10-70 per cent higher rates of perinatal deaths; and
- 15 per cent higher rate of overweight and obesity.

Australia's Health 2010 shows that the incidence of reported injury is 33 per cent higher outside Major Cities.

Inequity in the effectiveness of health promotion

It is widely understood that health is affected more by its social and economic determinants than by the health sector in the narrow sense. In aggregate, people in rural, regional and remote areas earn lower incomes and experience higher rates of cigarette smoking and excessive use of alcohol. There is a higher proportion of people in rural areas with disability than in the major cities. Rural communities are ageing at a faster rate than those in the major cities. All of this means that the burden of health risk is greater for country people.

In the decade to 2004-2005, rates of cigarette smoking fell in Major Cities to 17.6 per cent but did not fall or increased in other areas. Smoking rates remain at over 20 per cent in Inner Regional areas, over 25 per cent in Outer Regional and 27.3 per cent in Remote areas. This indicates that the suite of measures rolled out to reduce smoking has, for one reason or another, been less effective in more remote areas.

Inequity in survival rates – cancer as an example

A NSW study reported in the Medical Journal of Australia in 2004 found that people with cancer in regional areas were 35 per cent more likely to die within five years of diagnosis than patients in cities. The further from a metropolitan centre patients with cancer live, the more likely they are to die within five years of diagnosis. For some cancers, remote patients were up to three times more likely to die within five years of diagnosis.

These lower rates of survival are likely to be due to later diagnosis due largely to poorer access to specialised cancer services.

Inequity in education and educational outcomes

In 2006, 72 per cent of 19 year olds in Australia overall had completed Year 12 but the figure for 19-year-olds in Very Remote areas was less than 40 per cent. The proportion of young people who leave secondary school without completing Year 10 is also higher in Remote and Very Remote areas.

As a result of this, and because of the higher cost of access, people living in rural and remote areas are significantly under-represented in higher education. They comprise 32 per cent of Australia's population but only 18 per cent of tertiary students.

Only 12 per cent of tertiary education is provided in rural and regional areas, meaning that nearly half of rural and remote students have to live away from home to undertake tertiary studies. It has been estimated that the annual living cost for a regional student living away from home is between $15,000 and $20,000 – not including relocation and start-up costs of between $3,000 and $6,000.

To address some of these inequities, the Bradley Report on Higher Education recommended an additional allocation of $80 million per year to develop innovative, collaborative, local solutions to provision of higher education in regional and remote areas.

This deficit in access to higher education limits the capacity of rural areas to attract a skilled workforce, as rural origin is a key determinant of the preparedness of professionals to work in rural areas. There were very few students from rural and remote areas studying medicine until the establishment in 2000 of a special scholarship scheme for rural medical students, coupled with changes in medical school selection criteria and some quota arrangements. Recent evidence shows that the proportion of medical students with a rural background is still only 20 per cent, suggesting that new and better policies will still be required to attract one-third of Australian-trained doctors to rural and remote areas.


PHOTO: STEWART ROPER

Evidence from a few years ago showed there were almost no rural people studying dentistry. Since then three rural dental schools have given greater opportunities to rural students but they are almost certainly still under-represented.

The Commonwealth Government is progressively introducing reforms to government student income support from April 2010. Its stated purpose is to ensure that student income support is better targeted to those students who need it most, including rural students. It has estimated that the changes will improve access and lift the coverage of students receiving income support by 17 per cent. However, it will be some time before it will be possible to judge the impacts of these changes on rural students and whether the serious financial disincentives for rural students have been reduced.

Inequity in access to infrastructure

There is a range of measures of investment in infrastructure, with much of the recent focus having been on a major investments such as ports and rail associated with the mining sector.

Much of the local infrastructure more directly related to wellbeing and lifestyle is provided through local government. In the period from 1996-97 to 2008-09 – during which the Commonwealth government's revenues and surpluses grew very substantially – financial transfers through Financial Assistance Grants to local government fell from 1.01 per cent to 0.62 per cent of total Commonwealth taxation revenue. This was also a period in which the expectations of service provision through local government grew. Councils in rural and remote areas, in particular, are among those serving static or declining populations, reducing rate income and putting their financial sustainability at risk. Yet in contrast to cities, these country Councils are often required to incur substantial expenses to attract and sustain health services (including doctors) to their towns.

The provision of state-controlled rural health infrastructure also fell behind in the same period, caused in part by a reduction in the Australian Government's share of the funding of public hospitals from over 45 per cent to under 40 per cent.

Although it was not specifically related to rural and remote areas, a 2006 study of local government financial sustainability by PricewaterhouseCoopers identified a total backlog in local government infrastructure renewal work of some $14.5 billion, or an annual underspend of $1.1 billion. It found that the underspend by local government is resulting in deterioration in the condition of local infrastructure that binds communities together and fosters social inclusion, such as roads, libraries, community halls, galleries, museums, swimming pools, sports fields, drainage and sea walls.

Inequity in communications

The tyranny of distance has a pervasive influence on lifestyles in rural areas. The difficulties of physical and other forms of communication are well known. Telecommunications are poorer and more expensive in the bush. In 2006, 66 per cent of dwellings in major cities had access to the Internet and 46 per cent to broadband. The comparable rates for dwellings in Inner Regional, Outer Regional, Remote and Very Remote areas dropped off until for Very Remote areas they were 42 and 24 per cent respectively.

There is very little public transport in rural and remote areas, meaning that those who cannot afford to drive or cannot drive are isolated.

Good communications make a key contribution to quality of life. They are essential for business and commercial opportunity. They contribute to social capital. Human connectedness is directly related to health outcomes. Many people, particularly the young, regard good telecommunications as an essential prerequisite for lifestyle.

Inequity in cost of access to services

Research released in November 2009 entitled *Essential services in urban and regional Australia*, conducted by the National Institute of Industry and Economic Research, found that, on average, it costs rural residents two to ten times as much to access a range of essential services (including education and health services, and aged care) as it does metropolitan residents.

End note: *In all these circumstances, Government has an undeniable responsibility to improve access to services and support a base level of service delivery to people in rural, regional and remote areas. Potentially transformational infrastructure such as broadband, universally available at affordable prices, is an essential component of a new focus on rural, regional and remote Australia.*