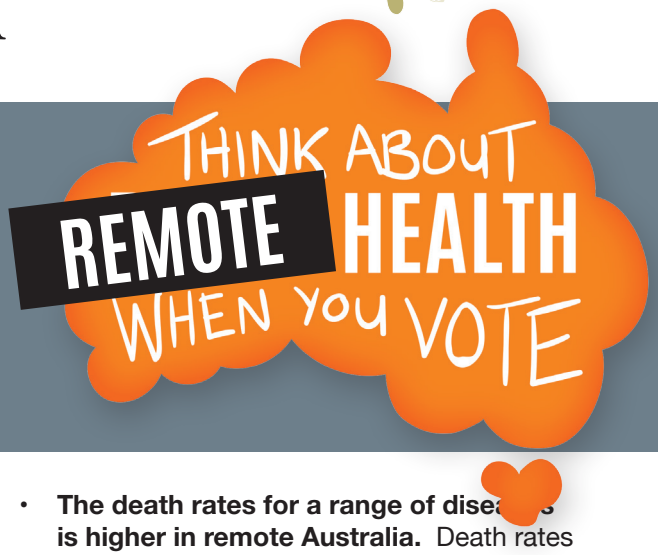
THE HEALTH OF PEOPLE LIVING IN REMOTE AUSTRALIA

NATIONAL RURAL HEALTH ALLIANCE INC.

Remote Australia is characterised by small, isolated communities with the highest rates of ill health. Despite their high needs, people in remote Australia have the lowest numbers of health professionals per population as well as poor access to health services which results in higher rates of hospitalisation and earlier death.



Demography

518,000 Australians live in remote areas which equates to 2.2 percent of the population[1]. The remote population varies over the year due to both fly-in-fly-out workers and travelling retirees, and can result in a doubling of the remote population in Northern Australia during the winter months. Despite the winter migration to remote Australia, there are substantially fewer older people living in remote communities, likely due largely to the lack of accessible health and community services for older people resulting in a net migration out of remote Australia.

Health Status

The health status of remote Australians is worse than both city and rural populations on almost every indicator.

- **Risk factors for poor health are higher in remote Australia.** A higher proportion of remote Australians smoke, drink to excess, are obese and are physically inactive when compared to the rest of Australia[2]. These factors are proven to contribute to ill health and the development of chronic diseases such as diabetes and heart disease, amongst others.
- **The proportion of remote living people with ill health is higher.** The most recent estimates on the prevalence of disease are from the 2015 AIHW Burden of Disease report. The report shows that 20% more people in remote areas are living with disease when compared with those living in major cities[3]. Remote Australians are also struggling to maintain good oral health with over more than one third (37%) of adults living with untreated decay compared with less than one quarter (23%) in major cities[4].
- **The death rates for a range of diseases is higher in remote Australia.** Death rates from the major causes of death in Australia are significantly higher in remote communities when compared with major cities:
  - » Land transport accidents – almost five times more deaths in remote Australia
  - » Diabetes - three times the number of deaths in remote Australia
  - » Suicide - twice the number of deaths due to suicide in remote Australia[5]
  - » Chronic obstructive pulmonary disease – 60% higher death rate in remote Australia
  - » Coronary heart disease – 40% more deaths in remote Australia
  - » Lung cancer – the rate is 40% more deaths in remote Australia.
- **People in remote Australia die around three years earlier than people in the city.** This is despite there being fewer older people living in remote communities.

Accessing health care

All of these indicators show that remote Australia has the highest health care needs. Unfortunately, remote Australia also has the lowest numbers of health professionals providing health services.

- *General practitioners* - General practitioners have a crucial role in the health care system, and access to a general practitioner is one of the services that people living in remote Australia value as vital to both their community and their health and wellbeing. Despite the high needs of the remote population, there is around 20% less Medicare funded GP activity[6] in remote Australia compared with the same population in the city.
- *Specialists* - Referrals to other medical practitioners can also be difficult with long waiting times while some specialists provide fly-in-fly-out and

1 www.abs.gov.au/AUSSTATS/abs@.nsf/mf/3101.0

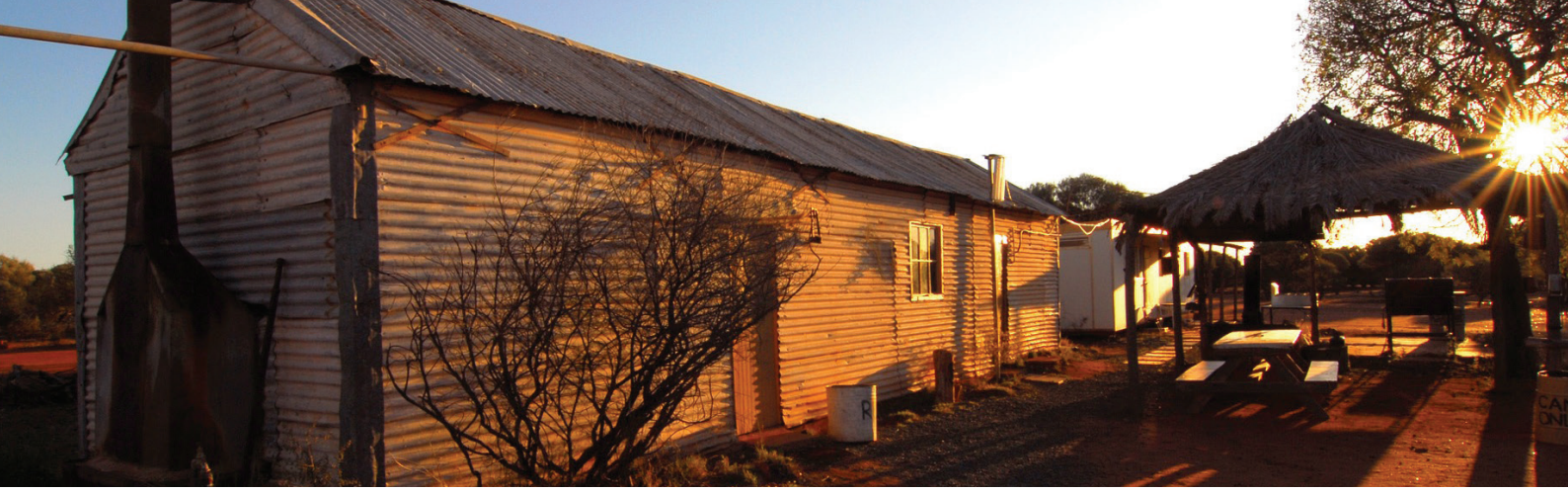
2 Statistics Chapter - Health risk factors. Available from: www.abs.gov.au/ausstats/abs@.nsf/Lookup/4364.0.55.003Chapter4002011-2012

3 www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129555476 Fatal and non-fatal burdens for remote areas have been derived by NRHA from the published AIHW estimates for remote and very remote areas.

4 Bishop, L.M. and Laverty, M.J. (2015), Filling the gap: Disparities in oral health access and outcomes between metropolitan and remote and rural Australia. Canberra: Royal Flying Doctor Service of Australia.

5 www.aihw.gov.au/publication-detail/?id=60129548021&tab=3

6 pandora.nla.gov.au/pan/146265/20140703-0935/www.coagreformcouncil.gov.au/reports.html



visiting services to remote Australia. There are 80% less Specialists in remote Australia when compared to the major cities. Where there are viable internet and mobile services, telehealth and video consultations can support treating non-specialists and general practitioners in both diagnosis and ongoing patient management.[7]

- *Dental workforce* - Dentists and the broader dental workforce, are in extremely short supply in remote Australia. Remote Australia has access to only one third of the number of dentists of major cities.[8]
- *Allied health professionals* - Access to allied health professionals is also an issue in remote Australia, particularly with regard to ongoing treatment and management of chronic diseases and for rehabilitation and recovery from significant illness or injury. Looking at the number of key health providers accessible in remote Australia per 100,000 population, there are 42% fewer pharmacists, less than half the number of psychologists (65% fewer), podiatrists (68% fewer), physiotherapists (51% fewer), optometrists (68% fewer) and occupational therapists (65% fewer).[9]
- *Nurses* – In contrast to the poor distribution of most health professionals in remote Australia, nurses are fairly evenly distributed across major cities, remote and very remote Australia. Indeed, in many small remote communities, nurses are the main provider of health services. Remote nurses can be sole practitioners, seeking input and advice to support the management of patients via mobile and internet based support systems, where those are available. Nurses and midwives living and working in remote settings frequently work long hours and often have to deal with a range of emergencies. This professional independence can at times also mean professional isolation, an extended scope of practise, and working and living in a different social and cultural setting.

The fact that people in remote communities have such difficulty accessing health professionals means delays in obtaining medical advice which can have serious consequences for health. Using diabetes as an example, we know that the role of allied health practitioners, particularly podiatrists, in preventing hospitalisations and amputations due to diabetes is critical. We also know that there are very few podiatrists in remote Australia (only 25 podiatrists to serve a dispersed population of half a million people). Remote Australian admissions to hospital for diabetes (which was preventable) are highest in remote (39 per 100,000) and very remote (58 per 100,000) Australia and lowest in major cities (23 per 100,000).[10]

Without access to health professionals, people in remote Australia may need lengthy stays away from home to access the services they need and may find self management of chronic conditions difficult. Poor access to health professionals may also jeopardise continuing recovery after returning home creating a vicious cycle of increasing ill health.

Per capita expenditure comparisons

The relatively low number of health practitioners in rural and remote Australia means that the relative spend per individual through the Medicare Benefits Schedule (MBS), is $910 in major cities and $536 in remote areas in 2014-15.[11] This equals an average of 17 MBS services annually per capita for people living in major cities against an average of 10 MBS services annually for people in remote Australia.[12]

If the difference in MBS spending between the major cities and remote communities was made available to remote health providers for service delivery, it would provide an additional $193.7 million per annum based on the 2015 population estimate. Such funding could be used to expand alternative models of health service delivery which have been implemented in remote communities.

7 *AIHW Medical Workforce data*

8 *Bishop, L.M. and Laverty, M.J. (2015), Filling the gap: Disparities in oral health access and outcomes between metropolitan and remote and rural Australia. Canberra: Royal Flying Doctor Service of Australia.*

9 *AIHW Medical workforce data*

10 *AIHW (2015), Admitted patient care 2013-2014: Australian hospital statistics. Canberra, AIHW*

11 *www.health.gov.au/internet/main/publishing.nsf/Content/Annual-Medicare-Statistics*

12 *Source: www.health.gov.au/internet/main/publishing.nsf/Content/Medicare+Statistics-1. Population data from http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3218.02012-13?OpenDocument*