

# Health Reform - Note 6

October 2009

## Rural equivalence funding

### What is equivalence funding?

Equivalence or 'top-up' funding is a term for the extra financial resources that could be provided by the Australian Government for health services to people who are not receiving the same (or 'equivalent') amount as other people through the Medicare Benefits Schedule (MBS) and other means.

The main reason for people not having their fair share of MBS expenditure is that they do not have access to a general practitioner. This situation is summed up in the rhetorical phrase "No Doctor: No Medicare". There is widespread acceptance of the notion of a 'Medicare deficit' and it has been estimated by the NHHRC at \$143 million a year for people missing out on the services of GPs and not including deficits in other areas. Were the figure to include money spent through the MBS on other medical practitioners (mainly specialists), pathology and optometrists, the Medicare deficit would be substantially greater.

Whatever the actual size of this deficit, two things are clear. First, acceptance of this deficit is one of the main reasons for the Australian Government allocating substantial resources to targeted programs for remote areas, such as those included within the *Rural Health Strategy* [1]. Secondly, where health services are concerned, people in rural and remote areas experience deficits in areas other than the MBS. For example, notwithstanding the success of the s100 provisions, people living in an area without a pharmacist make less demands on the Pharmaceutical Benefits Scheme (PBS) than others, while the tyranny of distance means that access to many acute services such as hospitals, cancer care and palliative care is also less than urban levels.

The general notion of equivalence funding may be seen as one of the means by which a fair share of health resources could be made available to people in more remote areas.

### The current proposal

In recognition of the fact that the concept of universal entitlement to the MBS and PBS does not hold where there are GP and other workforce shortages, the National Health and Hospitals Commission has recommended:

“‘top-up’ funding equivalent to national average medical benefits and primary health care service costs, appropriately adjusted for remoteness and health status, be made available for local service provision where populations are otherwise under-served.”

In estimating the shortfall on MBS funding for GPs alone at \$143 million per annum, the NHHRC noted that figures are not available on state-funded programs and it did not include non-GP MBS shortfall, PBS shortfalls, program and incentive shortfalls, and the additional costs of getting workforce into rural and remote areas.

The Commission also proposed additional funding for the development of networks of primary care services, for expansion of specialist outreach and telehealth support, and for a better-funded Patients Assisted Travel Scheme (PATS).

## **The Alliance position so far**

The Alliance welcomes the general principle of equivalence, especially in relation to access to primary care services at the local level in rural and remote Australia. However it is critical that, as suggested by the NHHRC in its Final Report, the calculation of equivalence funding provided to under-served rural and remote areas should take into account the worse health status and higher costs of service delivery in those areas. (Remoteness and the proportion of Indigenous people are sometimes seen as proxies for both higher costs and worse health.)

With comprehensive and weighted equivalence payments in place, distribution of funds in the health system would be more closely aligned to the distribution of health care needs. To ensure that the system moves further in that direction, the Alliance believes that all proposals flowing from the three health reform reports [2] should be critically examined for their distributional effects. The principle of equivalence in access to primary care services for rural and remote communities should be built into the new models of care and new funding arrangements. Otherwise, despite catch-up funding based on present Medicare payments, rural and remote people will be left further and further behind.

For example, should proposals for capital investment in the establishment of networks of comprehensive primary health care services go ahead, these should include targeted investment in areas of high need in rural and remote communities, sufficiently flexible to meet the general principle of equivalence of access, not simply on a dollar basis. New funding proposals to complement Medicare and provide better continuity of care, such as access to allied health care for people who voluntarily enrol with a practice or network of services, would need to be designed to ensure that their access was not at the expense of others in smaller rural communities.

Rural equity *in toto* and, in particular, for population groups most in need, should be used as a guiding principle in implementing health policy decisions. Many of the proposals currently being considered, such as funding for elective surgery and subacute services, have the potential to improve access in more urban areas where these services are delivered, while leaving rural and remote areas further behind.

Even with the increased resources that equivalence funding would bring to rural and remote areas, it will still not be possible or desirable to provide all health services locally. The Alliance therefore continues as a strong advocate for outreach models of care and for an improved Patients Assisted Travel Scheme.

## Your input is invited

The Alliance views comprehensive equivalence funding as a good measure to boost local access to some services that can be acquired in the short term and to build the base for the longer term.

However, there can be no substitute for attracting the right mix of workforce to an area and the provision of a wide range of services locally. Equivalence funding should be seen as a means by which local services can be built up and staff attracted to local areas – not as an excuse for giving up on building local service capacity.

The Alliance would like to see further work to estimate the total rural and remote health service shortfall - expressed as a dollar figure if possible. (See the table below on MBS/PBS shortfall by jurisdiction compared to the NSW average.) A proper estimate would recognise different health status in different locations and disparate expenditures on primary care by the various State and Territory Governments.

**Table 8: Per capita MBS and PBS funding by state and territory 2007/2008**

<b>Jurisdiction</b>	<b>MBS and PBS per capita</b>	<b>Per capita difference from national average</b>
NSW	\$1,010	\$80
SA	\$957	\$27
VIC	\$941	\$11
TAS	\$909	-\$21
QLD	\$892	\$38
WA	\$787	\$143
ACT	\$739	\$191
NT	\$423	\$508
<b>Australia</b>	<b>\$930</b>	<b>\$0</b>

<b>Jurisdiction</b>	<b>\$ required to increase MBS and PBS to NSW level</b>	<b>% increase</b>
NSW	\$0	0%
SA	\$84,125,206	5.5%
VIC	\$359,910,356	7.3%
TAS	\$49,767,845	11.0%
QLD	\$496,545,915	13.2%
WA	\$473,919,055	28.2%
ACT	\$92,209,318	36.6%
NT	\$127,777,533	139.0%
<b>Australia</b>	<b>\$1,686,577,811</b>	<b>8.6%</b>

If you have a comment, let us know at [nrha@ruralhealth.org.au](mailto:nrha@ruralhealth.org.au) or by mail to NRHA, PO Box 280, Deakin West, ACT 2600.

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*[1] This is a portmanteau term for a group of around a dozen targeted Federal programs for rural and remote health, including the Rural Clinical Schools, University Departments of Rural Health, More Allied Health Services and Regional Health Services.*

*[2] The final reports from the NHHRC, the Preventive Health Taskforce and the Primary Care Strategy Taskforce*