NATIONAL RURAL HEALTH ALLIANCE INC.

Submission to the Treasurer

for

Budget 2008

Towards equal health by the year 2020

January 2008

National Rural Health Alliance
PO Box 280
DEAKIN WEST ACT 2600

Budget submission

January 2008

Towards equal health by the year 2020

The National Rural Health Alliance (NRHA)

The 27 national organisations in the National Rural Health Alliance represent consumers and providers of health services in rural, regional and remote areas. (A full list of its Members is included in Appendix 1.)

The Alliance's vision is equal health for all Australians by the year 2020. Achievement of this vision will require some changes in the way health services are delivered in rural and remote areas, some differential investments in health and related services in rural and remote areas to reduce inequities there in health status and access to services, and a confident national approach to the provision of economic and social infrastructure that accommodates the special needs of non-metropolitan areas.

The rural case

One third of Australia's people live in rural, regional and remote areas. As is well known, in aggregate their health is poorer, the range of locally available services is narrower and access to many services more costly and more difficult. In addition, they experience greater health risks: rural people have lower incomes and assets, face greater economic and climatic uncertainties, and have higher incidences of specific risk factors such as smoking, excessive drinking, and motor vehicle and occupational accidents.

Among other things, the Federal Budget should invest in what is required to make up these deficits - and not just because access to good health is a human right. Improving the health of people in rural, regional and remote areas will also make a substantial difference to the economic capacity and productivity of Australia.

At a time when the shortage of skilled workers is one of the first order constraints on national productivity and output, targeted expenditures on human health and wellbeing in country areas are good investments. Indeed, investments in improved health and wellbeing in country areas will meet several of the Treasurer’s stated priorities. They will help lift workforce participation and productivity, particularly in areas where the mineral, mining sector and agricultural industries are based. Also, meeting the rural and remote health challenges will require improved training, support and distribution of the health workforce, which is part of the overall skills base of the nation.

Most initiatives for improving rural health, including that of Aboriginal and Torres Strait Islander people, are not possible without a stable and productive workforce. Recruitment strategies to encourage a range of practitioners to rural areas and support for existing health professionals are two important elements in maintaining an effective rural health workforce. Rural health professionals need not only provide services to the community, but at the same time need to teach and support students and trainees. They need to be supported in this task in a variety of ways, including availability of adequate infrastructure, including housing.

The health of country people stands to gain very substantially from the Treasurer's commitment to deliver modern infrastructure and a world-class broadband network, and to ending the blame game between Federal and State Governments.

Given the recent sustained economic growth, now is a good time to invest in the nation's workforce, help protect country communities, point the way for health service and other interventions, and enable rural people to share in national prosperity.

A Budget to implement the Government's plans

As the Treasurer has indicated, the fundamental task of the Budget will be to make a major contribution to management of inflation and enhancement of the productive capacity of the economy. The Budget will also be expected to contribute to longer term plans related to climate change, water security and Australia's workforce.

At the same time, however, the 2008-09 Federal Budget will need to meet the expectations consequent upon the plans of the new Government that were announced in the lead-up to and during the election and which are to take immediate effect. Several of these plans relate specifically to health and wellbeing, including in rural and remote areas. The Alliance, like many other interest groups, is concerned to see that the promises for new programs are met while 'fiscal responsibility' is maintained and macro economic targets hit. The Alliance recognises that this balance is likely to place pressure on some existing programs, from which savings will be expected.

People in rural and remote areas will regard it as reasonable for evidence of effectiveness to be the chief criterion by which Budgetary savings are made. However, the point is made later in this submission that much of the required evidence base relating to rural and remote health interventions is still in poor shape. On behalf of those people - the Alliance's constituents - we will continue to advocate for the retention and expansion of targeted programs which can help make up the health and service deficits and which can provide rural and remote people with their 30 per cent fair share of benefit from program and policy attention.

Given its purpose and its constituency, the Alliance's Budget Submission focuses not on the macroeconomic issues but on the reasonable expectations of people in rural and remote areas where the May Budget and specific health measures are concerned. The submission will emphasise approaches that will bring a fair benefit to people in rural and remote Australia and, where appropriate, propose additional considerations that have not been dealt with elsewhere.

1 Indigenous health

The Alliance welcomes the Government's commitment to a reciprocal partnership with Indigenous Australians on economic development and health, and expects the 2008-09 Budget to provide the $460 million estimated by those associated with the *Close the Gap* campaign to be the necessary initial commitment to improve primary health care services for Aboriginal and Torres Strait Islander people. The purposes to which the money would be put include additional support for health-related infrastructure, developing the Indigenous health workforce, Indigenous community-controlled health services, and improving the accessibility of mainstream health services for Indigenous peoples.

While the Indigenous health challenge is a national issue, the Alliance has a particular interest because 70 per cent of Aboriginal and Torres Strait Island people live outside the major cities. The Alliance also bases its existence and its business on notions of social justice and equity, and it has therefore always regarded improving Indigenous health outcomes as the nation's number one health priority.

The Alliance asserts the need for a generation-long, 'whole-of-governments', collaborative and well-funded effort to bring equal health to Aboriginal and Torres Strait Islander people. Whatever view is taken of the detail of the Northern Territory intervention to date, it has provided a public focus and useful information about how a long-term national program should be implemented.

Improving Indigenous health must remain on COAG's agenda, because it will always require the collaboration of all governments at all levels.

2 The Australian Health Care Agreements

The Alliance welcomes the collaborative approach already indicated by the Rudd Government and the States and Territories to the next Australian Health Care Agreements (AHCAs). Public expectations for the new agreements are high. It is assumed that the Commonwealth will revive its commitment to paying 50 per cent of the cost of running public hospitals. There is also the expectation that the new round of AHCAs will be used as the opportunity for the Commonwealth and the States/Territories to agree formally on a number of other important matters relating to health services and health outcomes.

The Alliance hopes and expects that the AHCAs will include new Commonwealth-State agreements about the reporting of expenditures and outcomes in individual hospitals (including those in rural areas), as well as agreements on children's oral health services, mental health, Indigenous health, maternity services and patients' accommodation and travel schemes.

3 Patients' accommodation and travel schemes

The 2008-09 Federal Budget will be the first for many years to include allocations for and references to the patients' accommodation and travel schemes (PATS). During the election campaign the Government promised up to $10 million towards patient transport services for Tasmania, to include the purchase of community buses. The Alliance hopes and expects that this pilot will be successful and will result in similar schemes being rolled out soon in rural and remote areas in other jurisdictions.

The Alliance also hopes that general agreement on the PATS schemes will be reached by the Commonwealth and State/Territory in the context of the AHCAs. In future years, the Budget could be the means by which the Commonwealth provides incentives for all States and Territories in relation to their operation of those schemes. If this proves to be the case, it will be a very satisfactory outcome to the public policy conundrum of how a good national (Senate) PATS policy inquiry articulates with State-run schemes.

In the longer term it is the Alliance's hope that Governments will jointly consider including in PATS schemes a wide range of effective health interventions not available locally, including those related to illness prevention, early intervention or management (eg antenatal care) and dental emergency care as well as the emergency specialist treatments currently covered.

4 National Health and Hospitals Reform Commission

The Alliance expects the Budget to confirm the resources to be allocated to the new National Health and Hospitals Reform Commission for its important work, particularly the development of an explicit national health policy and plan.

The Alliance has already publicly expressed its expectations of the new Commission's potential to encompass the specific needs and requirements of rural and remote areas, and to impact positively in areas such as mental health, children's oral health services and other national health priority areas.

The Alliance expects the Commission to play the key role in developing a long-term national health reform plan, with an explicit long-term plan for improving the health services and the supply of health professionals in rural, regional and remote areas.

5 Replacement for Healthy Horizons 2003-07

The Alliance expects allocations to elements of a new rural health plan to be foreshadowed or included in the May Budget.

The Alliance has a particular interest in the Government's proposed development of an explicit health policy and plan for rural and remote areas. The Alliance assumes such a plan will emerge from the work of the new Commission and from the evaluation of *Healthy Horizons* (the previous national framework for rural and remote health) currently being undertaken by the health jurisdictions and the NRHA.

Healthy Horizons has been valued by rural and remote people and their health jurisdictions. However it has been a high level strategic framework and the new rural health plan should include more detailed and programmatic elements with Budgetary costs.

6 Improved oral health

The Alliance welcomes the commitments made by the Government to improved public oral health services, including for teenagers, and to the new dental school at Charles Sturt University and the proposed dental school at James Cook University.

The Alliance expects the Budget will include new allocations for this critically under-serviced area of the health sector, particularly for a workforce review and development of services to rural, remote and Indigenous communities.

The Alliance strongly recommends that oral health sections be funded in both the Federal Department of Health and Ageing and the Office of Aboriginal and Torres Strait Islander Health (OATSIH). There are many activities that require urgent attention and follow up by staff with oral health expertise. They include the expansion of dental services through Commonwealth funding, Commonwealth participation in the National Oral Health Plan, the COAG Health Working Group review of the health workforce, the identification of oral health as a critical Indigenous children's health issue in the Northern Territory, and oral and dental health aspects of work to reduce waiting lists.

7 The existing Rural Health Strategy

The existing Rural Health Strategy is the mainstay of the special programs provided for rural and remote health in the absence of an equal distribution of Medicare and PBS services. The Strategy comprises a dozen or so specific programs, including the Rural Clinical Schools, University Departments of Rural Health, More Allied Health Services and Regional Health Services programs, among others.

The Alliance understands that the Strategy currently provides around $270 million a year.

The Rural Health Strategy is due for renewal from 1 July 2008 and funds for it should be announced in full in the forthcoming Budget.

8 Nurses and allied health professionals

The commitments made during the election campaign to 9,250 extra nurses for the hospital system and to the new allied health scholarship scheme are warmly welcomed and the Alliance expects these to be confirmed by allocations in the 2008-09 Budget.

Nurses are the largest single profession in the health workforce, including in rural and remote areas. The shortage of nurses in rural and remote Australia is very serious.

A significant proportion of those trained as nurses within Australia are not in the nursing workforce (more than 30,000 according to election documents). This attests to relatively poor rates of pay in nursing, the difficulties and conditions of the work, and perhaps the perceived low esteem of the profession.

The Alliance urges the Government to give consideration to the particular shortages in rural and remote areas and how they might be overcome through targeted programs. Governments could collaborate to provide nurses in those areas with access to reliable information technology, as well as training and support for its use. Governments should also consider how to overcome the impact of the pay differential for nurses between the aged care and acute care sectors (see, for example, the paragraphs below on the aged care sector).

Little has been done to understand the extent, causes and impact of allied health workforce shortages. Some of the causes will be those shared with the medical and nursing workforces. The Alliance urges the Government to take steps to increase the allied health workforce, diversify its capabilities, and recognise and support it more widely as a necessary component of the health teams delivering services in rural and remote areas. The Alliance encourages research into the reasons for shortages and possible incentives to enhance career paths generally and rural practice in particular.

The workloads of doctors, nurses and allied health professionals – and how they relate to and intersect with each other – should also be explored in more depth.

While the Alliance welcomes the Government's commitment to additional John Flynn scholarships, it hopes further announcements (including those in future Budgets) will lead to the situation in which support for students in nursing, allied health, dental health, paramedicine, pharmacy and health service management is more nearly equivalent to that provided to trainee doctors.

9 Mental health services for rural and remote people

The government has clearly identified improved mental health as an important target. There can be no doubting the severity of mental health problems in rural and remote areas.

The Government has committed to an extension of the Access to Allied Psychological Services (ATAPS) program. This is enables GPs registered with the Better Outcomes in Mental Health Care program to refer consumers to allied health professionals who deliver focused psychological strategies (eg psychologists, social workers, mental health nurses, occupational therapists and Aboriginal and Torres Strait Islander health workers with specific mental health qualifications). However, many people in more remote areas do not have access to a GP, let alone one of the listed allied health professionals.

The Alliance sees the May Budget as an early opportunity for the Government to reallocate some of the $1.8 billion already earmarked for mental health services to specific programs for rural and remote areas.

Although access to the relevant data has so far been protected, many observers believe that the distribution of expenditure through the new Medicare item numbers for mental health professionals has been predominantly in metropolitan areas. Once the evidence base is available, the urgency of providing mental health services that work well in rural and remote areas will be more apparent.

10 Maternity services in rural areas

The Alliance supports the Government's commitment to national maternity services planning to ensure a range of birthing options and support services, such as community nurses and midwives, are available in rural, regional and remote areas. This commitment includes a promise to improve maternity services for rural communities through the next Australian Health Care Agreements. The promised expansion of the Specialist Obstetrician Locum Scheme will also be of considerable value.

The May Budget should include allocations to begin this maternity services planning work for rural areas. The work should focus on both maintaining small rural maternity services, investigating the practicability of reopening some of those that have closed and implementing new models of care.

These issues are of particular concern to people in rural and remote areas, where over 130 maternity services have closed in the last 10 years. The capacity for people to have their babies ‘close to home’ is of particular cultural, social and economic significance. When it is no longer possible it brings home many of the realities of rural health service disadvantage.

11 Broadband for the Bush

The Alliance is a strong supporter of the Government’s commitment to improved broadband. It will require sufficient resources to ensure that all people in rural and remote Australia have information and communications technology infrastructure that provides world-class speed, connectivity and coverage – and a start should be made with Budget 2008-09.

Developments in information and communication technology (ICT), such as broadband, have not brought the same gains to rural as to urban people. The necessary infrastructure is

generally first made available in capital cities, where population densities are higher and returns greater, before it is extended to rural and then remote areas.

Many aspects of ICT are potentially of extreme benefit to rural people in need of, or undergoing health care, and to their service providers. High speed internet connection would provide point-of-care linkages between local health care providers and specialists at a distance. Telehealth systems have the potential to improve health service efficiency and access and convenience for the consumer, thereby in some small measure, reducing inequities in service delivery to rural and remote areas. ICT systems are also important in providing access to evidence-based best practice and continuing professional development for professionals in more remote areas.

12 New expenditure on health promotion

The Alliance is pleased to see the Government's strong emphasis on illness prevention and health promotion, including its plans to develop a National Preventative Health Strategy to provide a blueprint for tackling chronic disease.

It is to be hoped that a start in these new directions will be made with the May Budget. Given the priorities already announced by the Government during the election campaign, the first programs to be emphasised should include those focusing on child and maternal health, obesity, diet, alcohol and other drugs, and smoking. Other priorities for rural people would include safety on the roads and in workplaces, including on farms, and interpersonal violence.

In the longer term there should be greater investment in programs encouraging self-care, including structured approaches for individuals and groups to follow.

By promoting wellbeing and preventing or delaying ill health, health promotion delivers personal, family, community and national benefits - the last in terms of cost savings in the national health care and disability systems, as well as improved productivity. Currently Australia spends a very small proportion of its health Budget on health promotion. As well as providing additional information and resources, successful health promotion campaigns can enable people to gain greater control over their own lives and thus over their health and wellbeing.

In rural and remote areas, the social and economic returns achievable through effective health promotion are high because there is great scope for action. . Rural and remote areas can benefit from improvements in basic infrastructure including, for example, unreliable energy supplies, poor water quality and waste management, and inadequate 'health hardware' (taps, toilets, stoves, washing machines, fridges etc). People in rural and remote areas have less access to appropriate health information and professional support and advice, which can lead to unhealthy attitudes, behaviours and cultures. Effective health promotion would address such environmental, cultural, attitudinal and behavioural risk factors..

13 The evidence base for rural and remote health

The Alliance welcomes the Government's commitment to ensuring its health policies and programs that are based on good evidence. Regrettably, the current evidence base on rural and remote health is deficient in many respects.

The Budget should therefore provide additional allocations to rural and remote health research.

Importantly, there should be augmentation of the Australian Institute of Health and Welfare's capacity to undertake its rural and remote health research stream.

Australia is now recognised as a world leader in rural and remote health education and training, but rural and remote health research here is still relatively piecemeal and generally consists of short-term projects based on limited short-term funding.

Improved health research infrastructure and quarantined funding would not only help to improve the evidence base and the research effort in rural and remote Australia but it would also help support the recruitment and retention of its clinicians. They would be better placed to maintain and develop appropriate attitudes, knowledge and skills. It would also foster a culture of enquiry and continual improvement that would encourage rural health services to adopt new models of care.

In particular, there should be a funded national strategic approach to rural and remote health research, building on the existing infrastructure in rural, regional and remote areas. The approach should encompass all institutions in which research and evaluation is undertaken, including academic bodies and service providers. The research should include participatory and action research, as well as more theoretical inquiry.

At the national level, rural and remote health research will continue to be led by the NHMRC and the Australian Institute of Health and Welfare.

An indicative list of potentially valuable new research activities in rural and remote health is in Appendix 2.

14 Aged care in the bush

Prior to the election the Labor Party highlighted the shortage of residential aged care places and the problems with management of the aged care system. It has also acknowledged the serious shortage of staff in the aged care sector, particularly in rural and remote areas.

The Budget must allow for the higher costs of providing aged care services in rural and remote areas. Because the capacity of rural facilities to generate revenue streams is much lower, even the proposed interest-free loan scheme may not work for building aged care capacity in rural and remote areas. Notwithstanding the fact that the Viability Supplement has been extended to community (cf institutional) aged care services in rural and regional areas, many facilities in more remote areas will still find it very difficult to be economically sustainable and to attract staff.

The May Budget should therefore include additional funds for capital grants to smaller communities in more remote areas so that facilities can be built and maintained which will meet appropriate certification requirements.

Where staff recruitment and retention are concerned, rural aged care facilities suffer the double whammy of competition with the acute care sector and the greater shortage of nurses in more remote areas.

The Government should therefore consider the establishment of a special staff recruitment, induction and professional development incentive support scheme for rural and remote aged care services, to include such as support for e-learning and distance education to enable aged care facilities to recruit and keep skilled staff.

15 Augmented network of University Departments of Rural Health

Some regions do not have the benefits of a University Department of Rural Health to assist with recruitment, training and support of health professionals across the board. The Alliance urges the Government to consider allocating resources to augment the network of UDRHs so that all regions can be serviced by them.

16 International medical graduates

Australia's dependence on international medical graduates (IMGs) is well known and is particularly strong in many rural and regional areas.

IMGs now account for over 25 per cent of the rural GP workforce, and over 50 per cent of rural GPs under 45 years old. There is a fear that the *Strengthening Medicare* program will result in loss of rural IMGs to urban Districts of Workforce Shortage. IMGs are an essential part of the rural health workforce but concerns have been expressed about assessment processes, cultural adaptation, the amount of support and assistance provided by Governments and the level of training, mentoring and supervision available from experienced rural GPs.

The Government should plan the introduction of a more intensive case-management approach to supporting individual IMGs and their families, to help ensure that they are successfully placed in rural and remote medical practice.

APPENDIX 1: Alliance member organisations

The 27 Member Bodies of the National Rural Health Alliance are:

ACHSE	Australian College of Health Service Executives
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AHHA	Australian Healthcare & Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association
ANF	Australian Nursing Federation (rural members)
APA (RMN)	Australian Physiotherapy Association Rural Member Network
ARHEN	Australian Rural Health Education Network Limited
ARNM	Australian Rural Nurses and Midwives
CAA (RRG)	Council of Ambulance Authorities - Rural and Remote Group
CRANA	Council of Remote Area Nurses of Australia Inc
CRHF	Catholic Rural Hospitals Forum of Catholic Health of Australia
CWAA	Country Women's Association of Australia
FS	Frontier Services of the Uniting Church in Australia
HCRRA	Health Consumers of Rural and Remote Australia
ICPA	Isolated Children's Parents' Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NRHN	National Rural Health Network
RACGP (NRF)	National Rural Faculty of the Royal Australian College of General Practitioners
RDAA	Rural Doctors' Association of Australia
RDN	Rural Dentists Network
RHWA	Rural Health Workforce Australia
RFDS	Royal Flying Doctor Service of Australia
RGPS	Regional and General Paediatric Society
RPA	Rural Pharmacists Australia—Rural Interest Group of the Pharmacy Guild of Australia, the Pharmaceutical Society of Australia and the Society of Hospital Pharmacists of Australia
SARRAH	Services for Australian Rural and Remote Allied Health

APPENDIX 2: Additional rural health research priorities

REGIONAL HEALTH DIFFERENCES

1. Health differences – coastal versus inland

Refine methodology and report on health inequalities and disparate death rates between coastal and inland residents (include variables such as Indigenous status, remoteness, SES/SEIFA).

2. Access to primary care

Investigation to provide regular snapshots of GP and other primary care services provided under the Medicare Benefits Schedule (could include multidisciplinary care per 'chronic disease' item numbers, home medicines review, utilisation rates of investigative medicine and other measures of access/uptake). This could include availability, cost, access and utilisation factors.

3. Health hardware and infrastructure

Investigate environmental health determinants including workforce and availability/adequacy/quality of water (supply and waste) and water fluoridation, food, housing, recreational and cultural facilities/space, workplace factors and occupational and environmental pollutants.

4. Prescriptions and access

Develop systems to better report on prescription medication use beyond PBS. (This includes hospital dispensing, dispensing GPs and s100 exempt providers.)

5. Information and Communications Technology access and research

a. Investigate bias in computer assisted telephone interview response rates (with decreasing levels of telephone access with increasingly remote residents).

b. Availability and utilisation factors in relation to broadband/high speed data modalities.

6. Build capacity

Develop and establish a website to detail statistical concordance between RRMA, ARIA and ASGC to support greater public understanding and use of the classifications, and to assist with evaluation and analysis that uses them.

HEALTH OUTCOMES

7. Common risk factor analysis

Investigate common risk factors (focussing on rural and remote populations) relating to oral health/dental diseases, obesity, cardiovascular disease and cancer; including physical activity, diet, smoking and other 'lifestyle' factors (eg drivers for inactivity – television and computers).

8. Specific risk factor analysis - Cardiovascular Disease (CVD)

Focussed investigation of coronary heart disease in rural and remote areas, where CVD is the main cause of death.

9. Cancer care

Focussed investigation of cancer with regard to diagnosis, acute management and after-care, including aspects of survival rates.

10. Cancer: risk factor exposure

Analysis of the differential exposure to cancer risk factors for rural people.

11. Injury: incidence and outcome
Detailed review of rural injury statistics (for which there is significant rural: metropolitan disparity, second only to CVD). This could encompass workers' compensation rates and outcomes.

HEALTH INPUTS

12. Detailed analysis of factors contributing to health determinants
Multivariate analyses to explore factors contributing to health determinants, including socio-economic status, occupation, remoteness, Indigenous status, service access, and environmental factors.

13. Rural health programs
Inputs to evaluation of existing rural health programs that focuses on impacts and outcomes, as distinct from compliance and inputs evaluation.

14. Health access information
Support more timely reporting of MBS data.

15. Ambulance retrieval times
Develop methodology and investigate ambulance/emergency service retrieval times, and their impact on health outcomes.

16. Child and maternal health outcomes

a. Development of methodology and use of data available in existing datasets to collate and map the distribution of birthing women by their residence (SLA or SD) and existing birthing services, in a way that enables identification of areas where demand justifies additional maternity services.

b. Research the relationship between the closure of maternity services and both attitudes to planning for families and numbers of births in areas affected. The research could also investigate the relationship between the need to birth a long distance from home and adverse maternal and family indicators (eg postnatal depression).

HEALTH DRIVERS

17. Health and ageing people
Investigate the validity of the 'migration of the frail aged' hypothesis. This suggests that increasingly frail elderly return to urban environments where higher care is available, contributing to lower death rates in rural settings.

18. Education and health
Investigate the impact on ultimate vocation and work location of various educational pathways for both rural and urban people.

19. Primary care models
Evaluate models of primary care to identify superior models.

20. Chronic disease managed self-care
Investigate the appropriateness of various methods of managed self-care for people in rural and remote areas.