

Session 3: Equity and distributive justice in non-metropolitan Australia

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Abstract

Access and equity are important considerations in the provision of health care services in Australia. Nonetheless, despite the best endeavours of governments, several population sub-groups - notably people from low socio-economic backgrounds, from rural or isolated areas, culturally and linguistically diverse populations, and Aboriginal and Torres Strait Islanders - are under-serviced by their access to appropriate health care. This relative disadvantage results in poorer health outcomes and exacerbates health status differentials, many of which are attributable to environmental, social, political, and economic policy differences which are arguably amenable to intervention and are therefore unnecessary and avoidable.

This paper outlines the nature of health care disadvantage experienced by residents of rural and remote Australia, focusing in particular on their health status, access to and utilisation of health services, and financing of services. The paper examines some of the major government programs that have been implemented specifically to overcome such rural health inequities.

While it is difficult to assess the extent to which health care inequities have changed over time, because reliable and detailed empirical evidence is either not available and/or because of changes in the way data are defined and delimited geographically, the paper concludes that recent government policies have exacerbated problems of vertical equity and increased horizontal inequity in relation to rural and remote Australians.

Introduction

Access and equity are important considerations in the provision of health care services in Australia. Nonetheless, despite the best endeavours of governments, several population sub-groups - notably people from low socio-economic backgrounds, from rural or isolated areas, culturally and linguistically diverse populations, and Aboriginal and Torres Strait Islanders - are under-serviced by their access to appropriate health care. This relative disadvantage results in poorer health outcomes (Wells, 2000) and exacerbates health status differentials.

Because word constraints preclude a comprehensive discussion of national inequalities and inequities in health, this paper focuses on the nature of health care disadvantage experienced by residents of rural and remote Australia, and examines some of the responses to and programs implemented specifically to overcome such inequities. Rural and remote areas provide a particularly suitable basis for this discussion because of the coincidence of social and geographic disadvantage. Unfortunately it is difficult to assess the extent to which health care access inequalities and inequities have changed over recent years, because reliable and detailed empirical evidence is either not available and/or because of changes in the way data are defined and delimited geographically.

Equity and access

At the outset a few definitional and terminological distinctions need to be made. Equity in health refers to the absence of systematic differences in one or more aspects of health status across socially, demographically, or geographically defined population groups (Starfield, 2001). Equity differs from equality in that “equity is primarily concerned with passing a value judgement on equal or unequal health status among individuals and groups, with a goal of promoting actualisation of optimal health for all given their health potentials” (Chang, 2002: 491). In the absence of biological differences to explain variations in health status, Chang argues that it is safe to attribute inequalities in health to environmental, social, political and economic policy differences, most of which are amenable to intervention, and are therefore unnecessary and avoidable.

The extent to which inequalities are unjust and unfair, and hence inequitable, is a function of breaching one or other of the principles of horizontal equity (equal treatment to equals) or vertical equity (unequal but fair treatment to unequal need) (Macinko & Starfield, 2002; Mooney & Jan, 1997). Distributive justice (the extent to which resources are fairly allocated

across diverse population groups) is a function of both the processes by which scarce resources are distributed and the total amount of resources available for allocation.

Access to health services (the subjective or objective assessment of the ease with which health services may be accessed in terms of location, time, cost and ease of approach) differs from accessibility (incorporating aspects of the structure of health services that enhance the ability of people to reach health care providers at a time of need). Inequity of access in health services therefore refers to differences in access to health services in the face of equal needs and/or the absence of enhanced access for socially, demographically, or geographically defined populations with greater health needs (Starfield, 2001)

Patterns of inequality, disadvantage and inequity in non-metropolitan Australia

Australia's population of only twenty million is spread across some 7.5 million square kilometres (almost exactly the same as the contiguous states of the USA), the majority of whom lives within fifty kilometres of the eastern seaboard, almost two-thirds of them in half a dozen capital cities. The 6-7 million non-metropolitan Australians are scattered widely across major regional centres (with generally fewer than 100,000 residents) small country towns, retirement and recreational resorts, isolated mining communities, pastoral stations and indigenous outstations. For the residents of these non-metropolitan communities, geographical distance and the issues of accessibility underpin economic activity, their lifestyles and the level of health and social wellbeing.

In 2001, the number of Aboriginal and Torres Strait Islanders was estimated to be some 458,500, representing 2.4 per cent of the Australian population. Of these, 30% live in major cities, 20% live in inner regional areas, 23% in outer regional areas, 9 % in remote areas, and 18% in very remote areas. New South Wales (29%) and Queensland (27%) have the largest numbers of Aboriginal and Torres Strait Islanders, but they comprise the greatest percentage of the population in the Northern Territory.

Central to the identification of patterns of rural-urban inequality and inequity is the geographical classification scheme used when examining differentials in health status, health needs, workforce availability or utilisation of health services. Two schemes are currently used (AIHW, 2004) – the *Rural Remote and Metropolitan Classification* (RRMA) and the *Accessibility/Remoteness Index of Australia* (ARIA) (see Table 1). Appendix 1 shows the distribution of the categories in each of these schemes.

Table 1: Comparison of the Rural, Remote and Metropolitan Areas (RRMA) and the Accessibility/Remoteness Index of Australia (ARIA) classifications

RRMA Classification	ARIA Categories
<p><i>Metropolitan zone</i></p> <ul style="list-style-type: none"> • RRMA 1 - Capital Cities • RRMA 2 - Other Metropolitan Centres (urban population >100,000) 	<ul style="list-style-type: none"> • Highly accessible (ARIA score, 0-1.84) – relatively unrestricted accessibility to a wide range of goods and services and opportunities for social interaction. • Accessible (ARIA score, 1.84-3.51) – some restrictions to accessibility of some goods, services and opportunities for social interaction • Moderately accessible (ARIA score, >3.51-5.80) – significantly restricted accessibility to goods, services and opportunities for social interaction • Remote (ARIA score, >5.80-9.08) – very restricted accessibility of goods, services and opportunities for social interaction • Very remote (ARIA score, >9.08-12) very little accessibility of goods, services and opportunities for social interaction
<p><i>Rural zone</i></p> <ul style="list-style-type: none"> • RRMA 3 – Large Rural Centre (urban centre population 25 000 – 99 000) • RRMA 4 – Small Rural Centre (urban centre population 10 000 – 24 999) • RRMA 5 – Other Rural Area (urban centre population < 10 000) 	
<p><i>Remote zone</i></p> <ul style="list-style-type: none"> • RRMA 6 – Remote centre (urban centre population 5000 or more) • RRMA 7 – Other remote area (urban centre population < 5000) 	

The RRMA classification, which was developed in 1994, uses Statistical Local Areas and is primarily based on population numbers and an index of remoteness. The ARIA classification uses geographic information systems technology and determines the degree of remoteness of a community by the level of accessibility to services measured along the existing road network (see AIHW, 2004).

Equity and health status in non-metropolitan Australia

It is well known that Australians living in rural and remote areas generally have worse health than those living in cities (AIHW, 1998, 2006; Glover *et al.*, 1999; Haberkorn *et al.*, 1999; Population Health Division, 2007). In particular they have higher cause specific morbidity and mortality rates and lower life expectancy, and higher hospitalisation rates for some causes of ill-health (AIHW, 1998). Elevated levels are most pronounced for injuries and road accidents and, to some extent, coronary heart disease. Evidence of clear urban-rural differentials in mental health is less conclusive (Fraser, Jackson *et al.*, 2005), although high rates of suicide in rural areas, especially among farmers, are a matter for grave and continuing concern (Fraser, Smith *et al.*, 2005; Page & Fragar, 2002).

The substantially higher proportion of Indigenous people living in remote areas contributes to the poorer health status of people in this zone. Indigenous Australians are characterised by significantly poorer health status, particularly infant mortality rates (2.5-3.0 times higher than for non-Indigenous Australians), poorer life expectancy (17 years lower than for non-Indigenous Australians), 10-20 times higher death rates from specific diseases such as diabetes, cervical cancer, and infectious, parasitic and respiratory diseases; and the shift in morbidity and mortality to chronic diseases, such as diabetes and heart failure, with circulatory disease 2.5-3.0 times higher than in the non-Indigenous population. Indigenous people typically experience greater levels of social and economic disadvantage, especially in remote areas (Commonwealth of Australia, 2002), the level of disadvantage increasing with

remoteness, with almost 80% of the most socio-economically disadvantaged indigenous people living in very remote Australia (see Table 2).

Table 2: Distribution of Indigenous population by remoteness and socioeconomic disadvantage

	Highly Accessible	Accessible	Moderately Accessible	Remote	Very Remote	Total
Number of Indigenous People						
Least disadvantaged	79,959	14,682	2,169	400	373	97,583
Less disadvantaged	62,304	30,378	8,288	7,901	1,188	110,059
More disadvantaged	13,435	21,760	20,873	13,218	13,606	82,892
Most disadvantaged	0	1,314	5,688	5,270	48,103	60,375
Total	155,698	68,134	37,018	26,789	63,270	350,909
Distribution of Indigenous Population (per cent)						
Least disadvantaged	22.79	4.18	0.62	0.11	0.11	27.81
Less disadvantaged	17.76	8.66	2.36	2.25	0.34	31.36
More disadvantaged	3.83	6.20	5.95	3.77	3.88	23.62
Most disadvantaged	0	0.37	1.62	1.50	13.71	17.21
Total	44.38	19.41	10.55	7.63	18.04	100.00

This table shows the level of socio-economic disadvantage of Indigenous people against the Accessibility/Remoteness Index of Australia (ARIA). ARIA categorises the remoteness of localities in terms of a location's road distance from different sized service centres. It should be noted that the information in this table is experimental, completely data-driven and does not recognise cultural factors or provide insights into causality.

Equity and access to, and utilisation of, health services in non-metropolitan Australia

Improvements in health outcomes are contingent upon access to health care services and interventions. AIHW data show that people living in rural and remote areas have poorer access to various forms of health care than other Australians, for example:

- the supply of GPs and pharmacists is much diminished;
- nurses provide a higher proportion of care;
- per capita number of specialists is substantially lower;
- nursing home and hostel accommodation provisions decrease sharply with increasing remoteness;
- rural and remote residents use fewer services than those living in cities; and
- hospitalisation rates are higher.

Accessibility is an important indicator of equity in health systems. While a rural location does not always translate into health disadvantage, equity differences tend to parallel accessibility differentials. For example, end-stage renal disease in Indigenous Australians is significantly higher in remote areas than urban regions, highlighting inequitable accessibility to treatment facilities for remote patients (Cass *et al.* 2001). Likewise, Coory & Baade's (2005) study of urban-rural differences in prostate cancer mortality showed that prostate-specific antigen testing is less common in rural areas than capital cities and that rates of radical prostatectomy are 29% lower. A recent study also highlighted inequity in the location and accessibility of chronic heart failure management programs and general practice services

relative to the geographic distribution of people with chronic heart failure (Clark *et al.*, 2007). A survey of 820 rural women also concluded that rural health disadvantage and a lack of attention to rural women's health is endemic, especially in relation to maternity services, mental health services, care and respite services, and domestic violence services (Alston *et al.*, 2006). Young and Dobson (2003) also identified significant geographical inequities in rural women's accessibility to bulk-billing and obstetric services, and increased out-of-pocket expenses relative to women in urban areas. In relation to dental services, equity has worsened considerably since the discontinuation of a public dental program targeting the aged and poor in 1996, such that there is now a crisis in dental care in rural and remote areas.

The problem of inequitable access to health care services is further highlighted by medical workforce figures for rural and remote areas. Stratigos (2002), for example, noted the geographical imbalance in the provision of GP services, with capital cities having 123 general practitioners per 100,000; provincial cities 108; large rural centres 111; small rural centres 93; other rural areas 77, and remote areas only 66. Estimates indicate a shortfall of up to 1,000 GPs in rural and remote areas of Australia (RDAA & Monash University School of Rural Health, 2003). As Lokuge *et al.* (2005) concluded, "The lack of convenient, affordable and timely access to general practitioners, specialists and after-hours care is widely accepted as a major problem for Australians living in regional areas".

Whatever the rural-urban classification used (Tables 3-5), the maldistribution of health and medical workforce is clear; moreover, access difficulties are worsening (Productivity Commission, 2005). The medical workforce shortage in rural and remote areas is exacerbated by the decline in the proportion of proceduralists (anaesthetists, obstetricians and surgeons), an increase female GPs working fewer hours, a decline in average clinical hours worked, and declining numbers in solo practice (Health Workforce Queensland & New South Wales Doctors Network, 2006).

Table 3: Medical practitioners by geographic location (ARIA) 2003

	Major Cities		Inner Regional		Outer Regional		Remote		Very Remote	
Population (%)	13.18m	(66.3)	4.15m	(20.9)	2.04m	(10.2)	0.33m	(1.6)	0.18m	(0.9)
FTE ⁽¹⁾ Medical Practitioners per 100,000										
	2000	2003	2000	2003	2000	2003	2000	2003	2000	2003
Primary Care	105	102	88	89	83	85	99	97	100	95
Specialists	108	115	51	55	34	36	17	26	n.p.	7
⁽¹⁾ FTE =The number of practitioners divided by the average weekly hours worked, divided by the number of hours in a 'standard' full-time working week.										

Source: Australian Institute of Health & Welfare 2005, *Medical Labour Force 2003*. AIHW Cat. No. HWL32, Canberra, AIHW

Table 4: Medical practitioners: characteristics by geographic location (RRMA) of main job 1999

Geographic location of main job							
	Capital city	Other metropolitan centre	Large rural centre	Small rural centre	Other rural area	Remote centres and areas	Total
Number	39,165	3,619	3,135	2,035	2,343	672	50,969
Practitioner distribution (%)	76.8	7.1	6.2	4.0	4.6	1.3	100.0
Population distribution (%)	63.9	7.6	6.0	6.5	13.2	2.7	100.0
Practitioners per 100,000 population	322	248	277	165	94	8	268
Type of medical practitioner							
Primary care practitioners	14,900	1,526	1,193	1,185	1,987	440	21,232
Hospital non-specialists	3,694	413	390	142	77	85	4,801
Specialists	13,903	1,207	1,306	599	203	89	17,306
Specialists in-training	4,179	334	128	27	11	14	4,694
Non-clinicians	2,489	139	118	81	66	44	2,937

Table 5: Indigenous and total health workforce 2001 in selected categories

Worker Category	Total number	Total Indigenous	%
Medical staff (including general practitioners, specialists, medical administrators, trainees)	46 804	151	0.3
Nurses (including registered and enrolled nurses and nursing assistants)	2444 419	1 916	0.8
AHW (Indigenous health worker)	915	853	93.2
Dentists and dental workers	25 052	155	0.6
Pharmacists	12 046	10	0.1
Allied health professional	38 645	133	0.3
Complementary therapies	6 926	24	0.3
Environmental health officer	3 302	114	3.5

Source: AIHW, 2003: *Health and Community Services Labour Force 2001*, AIHW, Canberra.

Other evidence comparing access to and use of health services by people living in metropolitan and non-metropolitan areas accentuates the role of geographical location-related disadvantage (Sadkowski *et al.*, 2001). As Tables 6-7 show, urban area populations have a higher per capita and per patient consumption of Medical Benefits Scheme and Pharmaceutical Benefits Scheme services than those living in the bush, and increasing remoteness is inversely related to annual health care costs with increases in hospital costs and average length of stay in hospital increasing with remoteness from services. Based on diminishing utilisation rates with increasing remoteness, health funding provided to remote (often the most needy) areas is significantly less than to more accessible areas. In contrast, reduced access to GPs results in more and longer hospitalisations, with patients presenting at hospitals with more severe or delayed conditions.

Table 6: General practitioner MBS payments, 1995-96

ARIA Index	Total population	No. of services	No of patients	Services per capita	\$ Benefits per capita	Services per patient	\$ Benefits per patient	Patients as a % of population
0	1,267,376	7,051,396	1,145,929	5.6	126	6.2	138	90.4
1	106,698	456,835	91,737	4.3	93	5.0	109	86.0
2	39,233	179,375	35,894	4.6	103	5.0	112	91.5
3	97,126	394,014	84,818	4.1	88	4.7	101	87.3
4	35,564	150,541	30,420	4.2	92	5.0	108	85.5
5	38,658	154,619	34,832	4.0	88	4.4	98	90.1
6-8	27,745	105,621	22,836	3.8	83	4.6	101	82.3
9	28,145	95,264	22,923	3.4	75	4.2	92	81.5
10	28,019	87,480	19,609	3.1	69	4.5	99	70.0
11	26,654	40,351	1,100	1.5	44	3.6	79	41.6
12	12,766	13,260	2,827	1.0	24	4.7	108	22.1
Totals	1,707,984	8,729,016	1,502,960	5.1	114	5.8	130	88.0

Table 7: Total cost of health services by patients identified in the linked data set, 1995-96

ARIA Index	No. of patients	Total cost to government	Total length of stay (days)	Average length of stay	\$ Average MBS benefit	\$ Average PBS benefit	\$ Average hospital costs
0	1,089,661	967,120,304	1,629,709	1.5	330	75	482
1	83,034	75,970,127	156,575	1.9	282	76	557
2	31,470	28,367,288	58,077	1.9	247	79	576
3	72,824	68,600,222	156,316	2.2	231	81	631
4	28,838	27,728,558	69,568	2.4	217	65	679
5	30,717	25,998,828	63,356	2.1	216	45	585
6-8	20,439	19,103,769	45,503	2.2	224	62	648
9	18,574	14,179,354	32,910	1.8	178	22	557
10	17,191	17,309,625	44,735	2.6	149	28	830
11	12,500	17,563,872	51,993	4.2	111	19	1,275
12	2,186	2,863,499	8,539	3.9	118	9	1,183
Totals	1,407,614	1,264,805,446					

Source: *Sadkowski et al., 2001.*

Equity and financing of services

The basic tenet underlying the Australian health care system is that of universal access to needed health care, regardless of ability to pay (Hall, 1999). Under *Medicare*, every Australian is entitled to free treatment as a public patient in a public hospital and 85% of the scheduled fees for treatments provided outside the public hospital system. The publicly funded *Medicare* system is predicated on five key supporting principles - universality, access, equity, efficiency and simplicity. Unfortunately, while “In one sense, equity of access is assured by the structure and universality of Medicare, ... this does not ensure the same ease of access and cost of use for everyone for all services. Equity of access for lower-income groups, populations in rural and remote areas, and indigenous peoples is a continuing concern” (Hall, 1999:109). Turrell *et al's* (2003, 2004) study of the relationship between

socio-economic status and GP use in ARIA defined non-metropolitan areas showed that while metropolitan residents with lower levels of morbidity are making greater use of GP services, socio-economically disadvantaged people living in remote areas who are most in need of GP services are not only least likely to receive them but also experience disproportionate difficulty in accessing them.

Where health care funding is tied to the provision of services, inequity can result from lack of accessibility to available services and is usually reflected in under-utilisation of health services in times of need. Despite the paucity of data comparing overall urban-rural financing levels, the available evidence suggests that despite their poorer health status and the higher costs associated with the delivery of services, rural area populations receive lower per-capita financing and expenditure on health than urban areas, although the data tend to vary widely (see Table 8). For example, the National Rural Health Alliance showed that in 1999-2000, *Medicare* benefits paid to urban dwellers were \$195.87 per capita, \$139.70 in rural areas, and only \$83.11 in remote areas. The Rural Doctors Association of Australia has also noted that rural people (30% of population) receive only about 20% of rebates for non-referred (general practice) consultations. Hence of the \$2.3 billion paid out in rebates, only \$460 million goes to rural and remote area residents – a shortfall of \$250 million against a ‘fair’ allocation. Worse, if the underspend on specialist services in rural areas is taken into account, the shortfall would climb even more. Mooney (2003) notes that “on average, Australians use Medicare-funded primary health care to the extent of just over \$530 per year. The people of Double Bay, a rich suburb in Sydney, use more than \$900. In the Kutjungka Region, in the Kimberly, the Aboriginal people are among the sickest in Australia. They use less than \$80 in Medicare primary health care funds per year, largely because of the non-availability of GPs”.

Table 8: Medicare transfers from rural and remote areas to urban areas, 1999-2000

RRMA Group	Population (million)	HIC (Medicare) Benefits
1 Capital cities	12.25	1,547.2m
2 Other metropolitan	1.47	176.0m
<i>Total urban</i>	<i>13.72</i>	<i>1,723.1m</i>
<i>% of total</i>	<i>72%</i>	<i>79%</i>
Per capita		\$125.59
3-5 Rural/regional	4.87	436.5m
6-7 Remote	0.56	24.9m
<i>Total rural and remote</i>	<i>5.43</i>	<i>461.3m</i>
<i>% of total</i>	<i>28%</i>	<i>21%</i>
Per capita		\$84.91
Total	19.15	2,184.4m
Per capita		\$114.05
Rural-urban transfer		\$221.0m
Per capita		\$40.68

Source: ABS population data as at end-June 2000. HIC special data request for benefits data.
RDAA, 2004: Federal budget submission: 2004-2005, Canberra.

During 2001-2002 total expenditure on Aboriginal and Torres Strait Islander health for all services and from all sources of funds was estimated to be \$1,788 million - \$3,901 per Indigenous Australian compared with \$3,309 for each non-Indigenous Australian, a marginal difference only, considering their health status and the higher cost of delivering services to remote areas (Commonwealth Department of Health and Ageing Factbook 2006). Yet Indigenous Australians still do not enjoy anything like equitable access to effective health care. Indigenous use of the Commonwealth's *Medicare* and Pharmaceutical Benefits Scheme (PBS) is much lower than that of the general population - 41% and 33% of the non-Indigenous per capita rates respectively – even without adjustment for their higher burden of disease, or recognition of the higher cost of delivery to small rural and remote communities. Indigenous Australians are also lower users of private sector hospitals, dental and other health professional services, and services for older people. In contrast, they have greater reliance on public hospitals and community health services, including Aboriginal Community Controlled Health Services.

Policies and program responses to address rural-urban health inequity

Urban-rural health differentials are multi-causal, reflecting geographical location, socio-economic disadvantage, health care provider shortfalls, poor access to health services, elevated risk factors associated with lifestyles (alcohol consumption and smoking), greater exposure to injury risks and poor health among Aboriginal people. (Population Health Division, 2007). For indigenous people in particular, barriers to accessing services include distance from services, lack of transport, financial difficulties and remoteness from culturally appropriate services (Commonwealth Department of Health and Ageing Factbook 2006). However, the contributions of various risk determinants to patterns of health are not always clear-cut. For instance, although Turrell *et al's* (2006) study in Tasmania identified a link between socio-economic disadvantage and mortality, it found little support for an association between mortality and social capital and geographic remoteness.

Factors instrumental in perpetuating rural health disadvantage that are amenable to program interventions fall broadly into three categories: environmental, including geographical access; socioeconomic; and policy related issues, including those impacting on the distribution of services, financing arrangements, and social policies (see Table 9).

Table 9: Selected policy/program responses

Pathways leading to & perpetuating inequity	Selected program responses (See http://www.health.gov.au/)	Ongoing barriers to success
<i>Environmental</i> <ul style="list-style-type: none"> • geographical access • social access • living conditions 	<i>Access initiatives</i> <ul style="list-style-type: none"> • Patient Assisted Transport Scheme • Royal Flying Doctor Service • Medical Specialist Outreach Access Program 	<ul style="list-style-type: none"> • Lack of agreed objectives despite policy frameworks such as <i>Healthy Horizons</i> • Inherently “wicked” problem • Commonwealth-State relations • Disadvantaged groups such as indigenous population do not speak with a common voice • Lack of a national economic regional development strategy • Inadequacy of current initiatives to foster self-reliant communities and regions. • Lack of adequate data at an appropriate scale to monitor and evaluate the impact of health service interventions
<i>Socio-economic</i>	<i>Educational initiatives</i> <ul style="list-style-type: none"> • University entry schemes & student selection • Student scholarships • Rural exposure and rural clinical schools 	
<i>Policy</i>	<i>Workforce initiatives</i>	
<ul style="list-style-type: none"> • workforce measures • distribution of services • financing arrangements • broad social and economic policies (including regional development) 	<ul style="list-style-type: none"> • Practice Incentives Program • Workforce support for rural GPs • Retention Grants • International Medical Graduates • Practice nurses and More Allied Health Services 	
	<i>Indigenous initiatives</i>	
	<i>Service provision initiatives</i> <ul style="list-style-type: none"> • Regional Health Strategy to increase primary health care services • After-hours triage and help lines • Tele-health and tele-medicine • Multipurpose Services, Co-ordinated Care Trials, Outreach specialists 	
	<i>Financing initiatives</i>	
	<ul style="list-style-type: none"> • Primary Health Care Access Program • Medicare safety net & bulkbilling • Private health insurance rebates • Rural Private Access program 	
	<i>Regional development initiatives</i>	
	<ul style="list-style-type: none"> • Community Development Employment Program • Regional Partnerships 	

Specific purpose initiatives

- i. *Geographical access*: To counter geographical disadvantage and facilitate equity of access, States and Territories have implemented patient travel and accommodation schemes to provide financial assistance to offset expenses for rural residents needing to travel long distances to access medical services. Mobile or visiting outreach services such as the Medical Specialist Outreach Assistance Program (MSOAP) and the long-established Royal Flying Doctor Service (RFDS) represent programs designed to bring services to people, thereby overcoming inequality of access to health care services. While

these initiatives undoubtedly increase equity of access to health care services at times of needs, it is nonetheless apparent that accessibility patterns are constantly changing as health authorities faced with fiscal constraints continue to rationalise and centralise rural health services. A notable case is obstetrics. In recent years, over 1000 birthing facilities in rural and remote areas have been deliberately closed, despite evidence of the destructive effect of such closures on local communities and increased risk to women and their babies (AHCRA, 2005).

- ii. *Educational initiatives*: Compounding disadvantage arising from remoteness from services, rural and remote area residents are characterised by generally lower socio-economic status than urban dwellers (Walmsley & Weinand, 1997; Humphreys, 1998). Indeed, currently twelve of the 20 least advantaged federal electoral divisions are classified as rural or remote (RDAA, 2005). This socio-economic disadvantage is reflected in many ways, but especially in educational participation. In 1996, for example, girls in rural areas were 5% less likely to complete school than urban girls, rural boys 11% less, remote area girls 19% less and remote area boys 16% less (Lamb, 1998). Unsurprisingly, rural and remote students are also under-represented in higher education participation in almost all fields and levels of study (Coates & Krause, 2005; James *et al.*, 2004). In 1997 only 19.15% of students attending university came from rural and remote areas compared with the equity reference point of 28.8% of the population living in rural areas (Durey *et al.*, 2003). Barriers to participation include lack of information, socio-economic circumstances and cost of tertiary education (including living away from home costs), social dislocation, and a perceived lack of support (Young, 2004; Jones *et al.*, 2005; James, 2001). The situation for indigenous students is far worse of course - In 2001, only 22 indigenous students commenced a course in general medicine, 35 in 2002, and 29 in 2006. In 2006, a total of 109 indigenous students were enrolled in all years of medicine across all universities (Drysdale *et al.*, 2006).

In response to such glaring disparities, the government has funded a variety of access and equity measures designed to improve student selection and participation. Rural Student Scholarships, for example, aim to increase the number of students from rural backgrounds to pursue careers in medicine and allied health professions; increased emphasis has been placed on medical school recruitment of rural origin students and improved student support; and recently a significant proportion of medical training has been devolved to Regional Clinical Schools in order to strengthen the rural focus in medical training and

encourage medical students to assume a career in rural clinical practice by providing long-term placements in rural areas during their clinical training years.

- iii. *Workforce initiatives*: Undoubtedly current limitations on the capacity of the workforce will remain a key limiting factor in ensuring inequity in the provision of health services for some time. A major boost was provided in the 2000-2001 Federal budget with the announcement of the *Regional Health Strategy: More Doctors, Better Services* strategy, an integrated package worth \$562 million designed to increase medical workforce supply and the availability and viability of rural health services. But it is still too early to assess the impact of this strategy. In 2005, the Productivity Commission Medical Workforce Enquiry provided added impetus to the need for further measures to redress the rural medical workforce crisis, arguing that although system-wide reforms should be 'first-line' for pursuing better workforce outcomes in rural and remote Australia, there was a clear and a continuing role for targeted workforce initiatives (Productivity Commission, 2005). Suggestions for achieving this goal range from more generous fringe benefits tax arrangements, improved superannuation, better practice support, alternative models of service delivery, changing scope of practice, improved education and training, modifications to funding mechanisms through improved geographic differentiation, regional development.

Many specific rural workforce measures are already in place, of course. For example, the *Practice Incentives Program* (PIP) payment is higher for practices in more rural and remote areas, in recognition of the difficulties of providing care, often with little professional support, in small country towns or isolated communities, while the *Rural Retention Program* is designed to reward long-serving general practitioners in rural and remote communities that may experience significant difficulties in retaining doctors. Other targeted initiatives include workforce support for rural doctors and the *More Allied Health Scheme* to increase the numbers of practice nurses and allied health professionals practising in rural and remote areas. Arguably the workforce program that most underpins the Commonwealth Government's quest to supply more medical practitioners in non-metropolitan areas is support for International Medical Graduates (Han & Humphreys, 2005; Hawthorne & Birrell, 2002). Although these specific workforce initiatives have been in place for some years, there is little evidence by which to evaluate their success.

- iv. *Health service provision initiatives*: Wells' (2000) presentation to the 5th International Medical Workforce Conference outlines the wide range of innovative health service models that have evolved in Australia in response to the need to ensure maximum access to appropriate primary care services for residents of small rural and remote communities. These include Multipurpose Services, Co-ordinated Care Trials, outreach specialists, fly-in, fly-out female GPs, after-hours triage and help lines, tele-health and tele-medicine, and the *Regional Health Strategy* designed to increase primary health care services (see also Wakerman *et al.*, 2006).
- v. *Financing initiatives*: Several changes in financing health care have been introduced to help overcome inequity of access to health care in rural and remote areas. In 2004 the Commonwealth Government announced *Strengthening Medicare*, involving new safety net measures designed to improve access (including affordability) to out-of-hospital medical services as well as incentive payments to GPs to encourage bulk-billing ('free care') to financially disadvantaged patients and children under 16 years, particularly in regional, rural, and remote areas. Under the safety net Medicare will now cover 80% of all out-of-pocket costs over and above the standard rebate once a threshold is reached in a calendar year. To date, though, it is apparent that residents of the most affluent parts of Australia have benefited disproportionately. For example, the 25 most socio-economically disadvantaged electorates have averaged payments so far about \$148,000, while, in contrast, the 25 most advantaged averaged payments of about \$448,000. Moreover, an increase in bulk-billing will not necessarily increase equity of access because it fails to address problems of geographic inaccessibility in rural and remote areas (Day *et al.*, 2005; Griggs & Atkins, 2004).

The *Primary Health Care Access Program* (PHCAP) evolved in response to the under-utilisation of Medicare and PBS funding in areas with impaired access to the medical workforce, especially indigenous communities where under-servicing and under-funding is an important contributory factor to poor health. PHCAP involves pooling Commonwealth and State/Territory resources for primary health care in a region. Commonwealth allocations are calculated on a weighted multiplier for average national Medicare usage, based on two elements relating to the increased cost of delivering services in remote areas and the increased morbidity suffered by the Aboriginal population (Rosewarne & Boffa, 2004). To date it is not clear whether the weightings in the funding formula are either sufficient or sophisticated enough to address the inequities

in access to primary health services, while PHCAP alone certainly doesn't address all aspects of vertical inequity of access.

- vi. *Regional development initiatives*: Sustainable health services depend on sustainable communities, the determinants of which include a broad range of policies affecting taxation, employment, education, housing, environment, transport, communication, infrastructure and social security. Although a number of specific targeted initiatives have been implemented, such as the *Rural Private Access Program* (designed to assist the viability of small rural private hospitals and increase the range of privately insurable health services available to rural and remote Australia) and the *Community Development Employment Program* (focusing on indigenous community development projects as the basis for enhancing individual work skills), broader ranging action is required across all areas if improvements to health status, particularly for indigenous populations, are to be achieved (Commonwealth of Australia, 2002; Dwyer *et al.*, 2004). Despite greater government emphasis on population health policies, to date relative expenditure has been low while targeted programs are limited in scope and constantly subject to review.

The concept of a national regional economic development strategy has not been strongly pursued by a federal government imbued with its neo-liberal philosophy. The *Stronger Regions, a Stronger Australia* framework that resulted from the 1999 Regional Australia Summit only emerged in response to the emergence of the 'One Nation' Party. The resultant *Regional Partnerships* program, which funds projects to support the development of self-reliant communities, has failed to impact significantly on improving equity of access to services, and has recently been the subject of criticism in parliament for failing to spend its budget. Most recently, the severe impact of drought, which has exacerbated social and economic difficulties confronting many non-metropolitan Australians, has provided the catalyst for recognition of the need for a non-partisan strategic approach to regional development.

Conclusion

Despite existing health inequalities and inequities, particularly with respect to Indigenous health, it is important to remember that by world standards Australia ranks highly in life expectancy, overall health system effectiveness, waiting times, access to and quality of care (Podger, 2006).

In a recent speech, the Commonwealth Minister for Health and Ageing stated that “Medicare has turned out to be a very good way to ensure that everyone has fair access to essential medical services.” (Abbott, 2007). In reality, however, the evidence to support such a claim is not strong as it relates to our rural and remote regions. Nor is there any objective benchmark against which to assess whether Australia is moving closer to, or further from, improved equity. A 1995 study of equity of health care in Australia suggested a favourable distribution of health care payments in relation to the distribution of income, but considerably less equity in terms of the delivery of health care services according to level of need (Lairson *et al.*, 1995). Arguably government policies over the past decade have exacerbated problems of vertical equity and increased horizontal inequity in relation to rural and remote Australians. What is clear is that the effect of specific programs targeting health disadvantages in rural and remote areas has been relatively insignificant when compared with the regional importance of mainstream health financing programs like Medicare, the Pharmaceutical Benefits Scheme, and private health insurance.

Australia has a high degree of vertical fiscal imbalance, necessitating a very high reliance by the States on transfers of revenue from the Commonwealth Government. At the highest level the Commonwealth Grants Commission, established in 1933 and still in place today, is charged with responsibility of advising on how best to ensure horizontal fiscal equalisation across States and Territory such that “each State should be given the capacity to provide the average standard of State-type public services, assuming it does so at an average level of operational efficiency and makes an average effort to raise revenue from its own sources” (McLean, 2004). It should be noted that this equalisation is designed to equalise States’ capacity to provide services, not their results. Historically, the problem of vertical imbalance was addressed by specific purpose grants, and more subject to political manipulation (Dollery & Worthington, 1996).

Many of the existing inequalities and inequities confronting disadvantaged populations in rural and remote Australia reflect the deleterious consequences of unfettered market dominance, increasing corporatisation and the rolling back of state activity. Health and education, public goods that were once the epitome of community as opposed to the individual, have now become the province of the market place which inevitably lead to geographical and social inequalities. As Kassak (2004) has noted, “The principal reason for the lack of adequate and equitable access to the health-care system, irrespective of where, is the political environment in which it is embedded”.

To achieve a more equitable health care system will require:

- *Political will and leadership:* Without political ‘champions’ to carry the social justice banner in the political arena and to resist the diminished willingness of western governments to publicly fund health care, the energy and advocacy of stakeholder groups will be insufficient to achieve policy and program changes.
- *Agreed vision and objectives:* A lasting solution to rural-urban health inequities requires measures that address the macro-level forces responsible for them. The current confusion that characterises Commonwealth-State relations and which compromises the need for health priorities and the means to achieve them must be replaced by a clear statement of agreed health goals to guide the provision of optimal health for all.
- *Alternative financing arrangements based on the value of equity:* “Fairness and compassion need to be once again the guiding principles of our leaders and democracy” (Henry *et al.*, 2004). Left to the marketplace, the perpetuation of existing inequities is inevitable. Increased local autonomy alone is incapable of resisting strong market forces. The attainment of equity necessarily requires inequalities, but those deriving from policies of positive discrimination and not those created by market forces. Over the past decade an increasing proportion of federal government health expenditure has been directed into Australia’s health care system via private health insurance subsidies in the form of tax rebates and penalties for higher income earners without private health insurance (Lokuge *et al.*, 2005). These policies have increased inequality in health funding by disproportionately benefiting high income households (Hall & Maynard, 2007; RDAA 2005; Colombo & Tapay, 2003) while disadvantaging rural and remote areas where average incomes are lower and private facilities less available. In short, policies that distort the market will be required if vertical and horizontal equity are to be achieved. As Mooney (1998, 2003) has argued, the Australian health system fails on equity (particularly for Aboriginal people but also for the poor more generally) but that “redeploying about 1% of the healthcare budget would increase spending on indigenous health services by about 50%”.
- *Better data:* The absence of comprehensive, comparable data at a suitable scale will continue to ensure that, no matter how strong the political rhetoric about equity, the monitoring and evaluation of the impact of environmental, social, political, and economic policies designed to alleviate problems confronting disadvantaged groups will remain inadequate and inconclusive. An agreed index of rurality is essential for guiding resource allocation, workforce and service delivery policies, and, most importantly, facilitating

better evaluation of the health outcomes attributable to the provision of health care services. At the same time, pursuit of an agreed delimitation of non-metropolitan areas should avoid the danger of becoming “besotted with the production of ever more refined empirical based formulas” to the detriment of focusing attention on the extent to which current patterns of expenditure are bringing about improved health outcomes in areas of need rather than just reinforcing socially produced inequalities (Sheldon, 1997).

- *More research* on the delimitation of disadvantaged groups and how best to tackle problems of inequity is required. Existing patterns of geographical differentiation in health status and workforce availability are limited by their failure to reflect health service need and inadequate measures of socio-economic differentiation (McCracken, 2001; McMillan & Western, 2000). “Simplistic measures such as GP: population ratios provide a distorted view of workforce variation across locations, as there is no recognition of the specific needs of the population in question or the capacity of practices to provide for those needs” (Pegram *et al.*, 2006: 27). Improved schema are needed that incorporate service availability, demographic and socio-economic measures as well as geography. Electronic patient records could facilitate in improved assessment of patient outcomes

Despite periods of Australia’s history when social justice issues were prominent, such as under the Prime Ministerships of Gough Whitlam (“Increasingly, a citizen’s real standard of living, the health of himself and his family ... are determined not by his income, not by the hours he works, but by where he lives”) and Bob Hawke (“By 1990, no child shall live in poverty”), Australia’s record of success in reducing social and geographical disadvantage is mixed at best. In the case of health, there is little doubt that strong ministerial leadership is needed to implement any significant budget re-allocations and reforms likely to increase equity in health. Given the current focus of federal government on economic issues, national security and most recently climatic change, the prospect of any dramatic move to implement a significant social justice blueprint is bleak.

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Appendices:

Figure 1: SLAs mapped by RRMA category

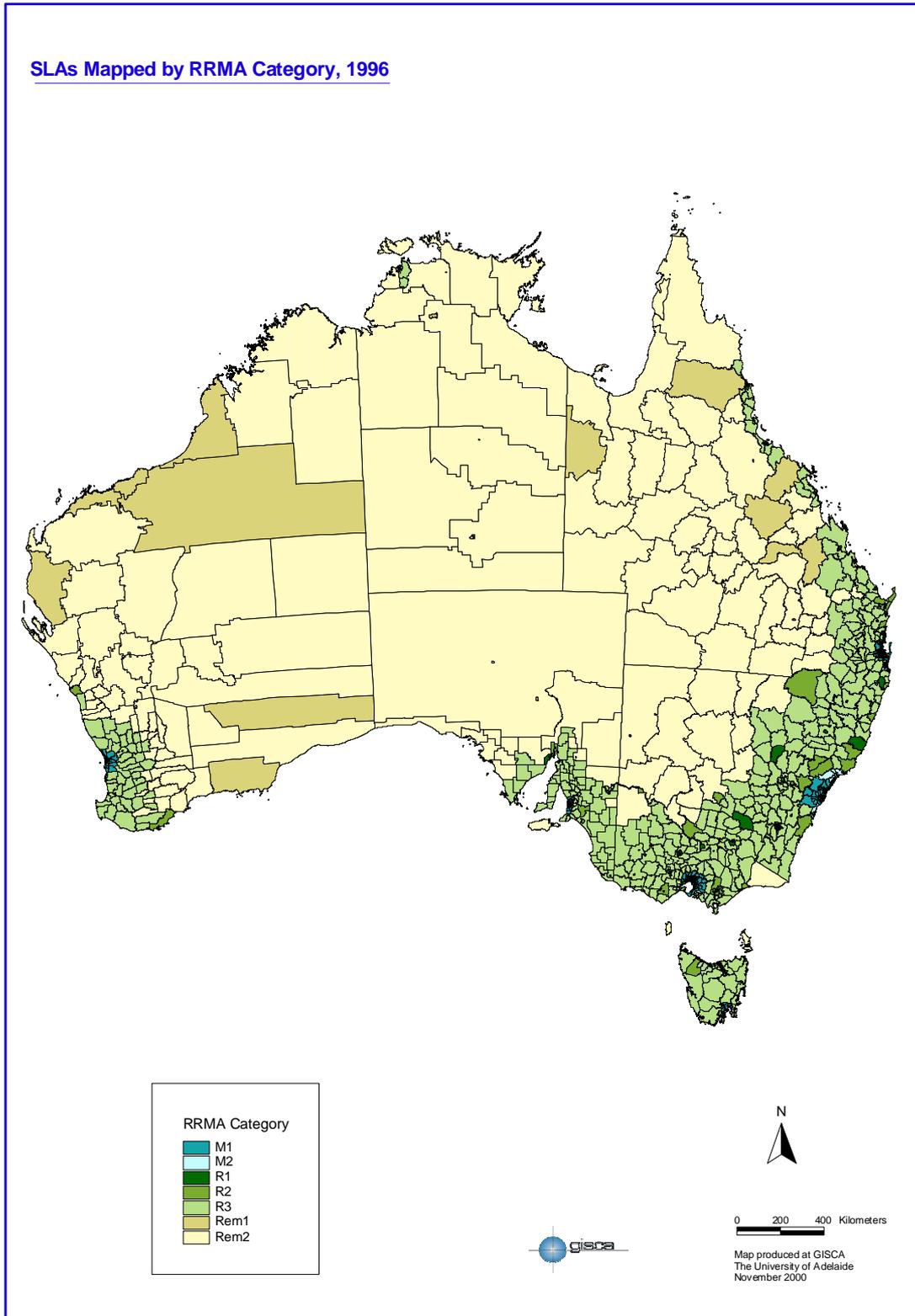


Figure 2: SLAs mapped by ARIA category

