



Rural and remote implications of a new structure for Australia's health system

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Background

I have spoken elsewhere about the challenges for Australia's health system, the case for reform and a proposal for the Australian Government to take full financial responsibility for the system as a precondition for longer-term and affordable improvements.

In summary, as set out in the following table, we have a pretty good system, with universal access to services, generally excellent health outcomes in terms of life expectancy and healthy life expectancy, and costs – while rising – that are only marginally above the OECD average. Our most serious blot concerns Indigenous health, where life expectancy is 17 years less than for other Australians, a larger gap than exists between Indigenous and non-Indigenous peoples in NZ, Canada or the US.

Indicators of performance

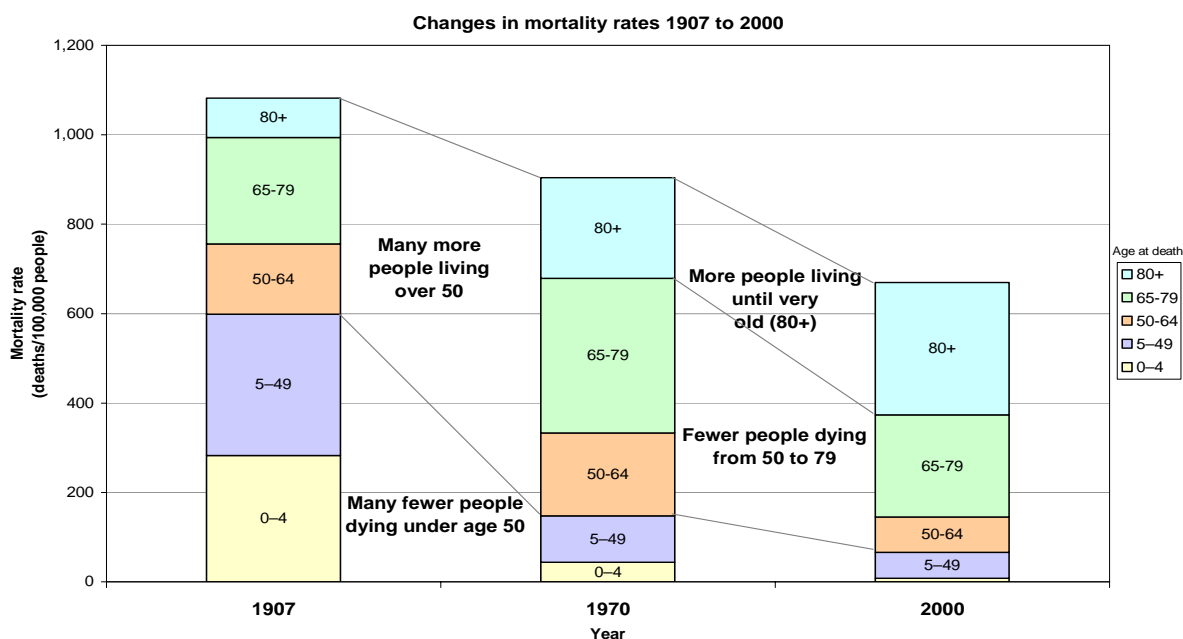
Australia ranks third amongst comparable OECD countries for life expectancy, sixth for healthy life expectancy and third in overall health system effectiveness;

- relative to Canada, the UK and the US, a higher proportion of Australians see a doctor promptly when they need to, and rate their care as very good or excellent;
- waiting times for emergency departments are shorter than for the US, Canada and the UK;
- waiting times for elective surgery are shorter than for Canada, NZ and the UK; **but**
- life expectancy of Indigenous Australians is about 17 years below that of non-Indigenous Australians.

We also face continuing challenges to deliver services in rural and remote regions. I am not aware of evidence that these are significantly greater, or that we are managing them significantly more poorly, than other nations with long distances and remote communities such as Canada. But let me return to this shortly because I suspect the structure of our health system does exacerbate the problems of health service delivery in rural and remote areas in this country.

Apart from Indigenous health, the major national challenge we now face is in large part the consequence of our success – the continuing improvement in life expectancy since around 1970 is primarily because people who reach age 50 are living a lot longer.

Changes in mortality rates 1907 to 2000



As a result, we have many more frail aged and people with chronic illnesses who have survived the onset of heart disease or cancer or other incidents that previously led more often to early death. Chronic illness according to AIHW now represents 80 per cent of the burden of disease in Australia.

Why is this so important? Because our reliance on separate programs that ensure high quality but distinct services, no longer delivers what an increasing number of patients needs: continuity of care, with seamless boundaries and a care management focus on them right across the system rather than a management focus on the different types of providers—GPs, hospitals, specialists, community care providers and residential aged care providers. Moreover, there is reason to believe we are not getting the value for money we could, as the allocation of resources through separate programs is unlikely to deliver the most effective allocation of resources between programs.

Successive governments have been addressing these concerns through sensible incremental changes, and further incremental reforms will undoubtedly help. These include the measures to enhance primary care, including in the bush and amongst Indigenous Australians, to broaden services for the mentally ill and others with chronic diseases, and the steady improvement in community aged care services.

But until we address the underlying fragmentation of our system, where program boundaries are reinforced by separate funding responsibilities, we will fall short of what we could achieve, and spend more money than necessary in the attempt to find a solution.

Sometime, whether in the short term or the longer term, we need the Australian Government to take full financial responsibility, and to establish a framework where service providers in regions and communities are able to deliver integrated services focused on the patients in their communities. I do not rule out entirely the option of a pooled arrangement between the Commonwealth and the states with a shared arrangement for regional purchasing of services from the pooled funds, but my strong feeling is that a Commonwealth take-over would be simpler and more effective, at least in the longer term given our history and the underlying forces demanding reform.



Rural and remote factors

Every large country faces additional challenges in delivering health, or other, services to rural and remote communities. Distance itself restricts access, the costs of delivery are higher and attracting and retaining skilled service providers is difficult. While technology is helping in some ways through improved communications and transport to large population centres with specialist services, those same influences are contributing to the population drift to capital cities and regional centres, and to workforce problems in more remote areas. Solutions require not only adequate remuneration for service providers, but career employment opportunities for spouses and non-wage benefits that compensate for such problems as limited school and other social and business services.

Moreover, advances in medical technology and the demand for high quality and safe treatment present a dilemma: what trade-off would remote communities themselves accept between local access and safety and quality?

What is evident in remote and rural communities is their greater reliance on a flexible and integrated approach that essentially ignores program boundaries and centrally determined administrative rules to get the most from the resources they have. More limited access to specialist services also demands an even wider role for primary care than in the cities whether through breaking into traditional specialist areas or through drawing on non-medical professionals to deliver care.

As with the broader health system, there have been many useful incremental reforms that have improved services in many communities. The Commonwealth has introduced a range of incentives to attract and retain general practitioners in rural and regional Australia, both through direct monetary rewards and through the conditions placed on many of the increased places for GP training. States, and local governments, have frequently complemented these by tailored packages involving for example housing and education support.

The Commonwealth has also introduced more generous and flexible arrangements for funding primary care services in rural areas and, in co-operation with the states, has established many multi-purpose health services giving a new lease of life to some rural hospitals no longer able to provide specialist care. These services include both primary care and aged and community care. The More Allied Health Services Program (MAHS) is another example of a recent initiative aimed at offering more flexibility to fund a wider range of services in rural areas.

Despite the improvements such initiatives have delivered, or at least ameliorating some of the problems associated with population drift, the boundary problems evident in the wider health system can be particularly counter-productive in smaller communities. The typical country hospital relies heavily on local GPs as well as its own staff, and artificial constraints to avoid spending beyond program boundaries are not only more obvious but also more directly frustrating. Similarly, of course, artificial boundaries limiting the role of nurse practitioners and other allied health professionals are also more obvious and frustrating.

While some of the Commonwealth initiatives involve considerable flexibility at the local level for local service providers to manage, others involve centrally determined rules and entitlements that inevitably lead to either overgenerous or inadequate support, and/or to inappropriate support.

And there is the question of the total resources available. At present, no-one produces comprehensive or reliable data on health and aged care spending on the services delivered to a population from wherever that service is located. Nevertheless, it is probably safe to say that lower MBS and PBS spending on rural and remote Australians reflects lower total health and aged care spending on such people relative to their health needs, in large part because of fewer health care providers (doctors, nurses, pharmacists, allied health professionals) in those areas.

Certainly, there is evidence that Indigenous communities receive primary health care funding below the national average, and well below the average for people with similar health needs, particularly taking into account the additional costs of delivery. Some action has been taken to address this concern, but far more is needed. The fact that spending by the states on Indigenous people, mostly via hospital

services, is over twice the per capita rate for other Australians partly reflects our under-investment in primary care services.

System change proposals and rural and remote Australia

While incremental reforms are delivering benefits, and most are heading in the right direction, I believe it is time to consider systemic reform. If this does no more than clarify the direction for more incremental reform, it may avoid the ad hocism that incremental reform can represent, and make future systemic reform easier.

The diagram on the following page summarises the model I have proposed for a system that is fully funded by the Commonwealth.

The rows represent where the responsibilities would be managed – nationally, regionally or locally. The columns represent the types of responsibilities – funder, purchaser or provider.

The system would not be managed entirely from Canberra, but would have regional purchasers with the responsibility and flexibility to purchase the mix of services most appropriate to the region. They would be required to work closely with local community leaders and providers such as the GP Divisions. They would, however, work within the policy framework established nationally. Most services would be provided locally with a considerable degree of professional independence; services such as public hospitals would have management boards or trusts.

Geographically large regions would need to have sub-regional planning structures and associated flexibility to allocate resources within the local area.

The potential benefits of such an arrangement are probably clearer for rural and remote communities than for urban communities:

- firstly, there would be transparency over the allocation of resources across regions, and the ability to highlight regions receiving significantly less than their population needs deserve (relative to other regions)
- secondly, there would be greater flexibility to find local solutions to regional problems, blurring the current boundaries in particular between hospitals, general practice and other forms of primary health care, and between medical services and aged care services
- thirdly, there would be room for informed choice by communities about services to be provided locally, and those to be accessed from specialist providers outside the area – making the trade-off, for example, between access and quality.

The model I propose would take some time to implement and there are many details open to debate and refinement. Moreover, there will be costs and risks in the transition. Accordingly, it is sensible to keep pursuing incremental changes in parallel with exploring the systemic change options.

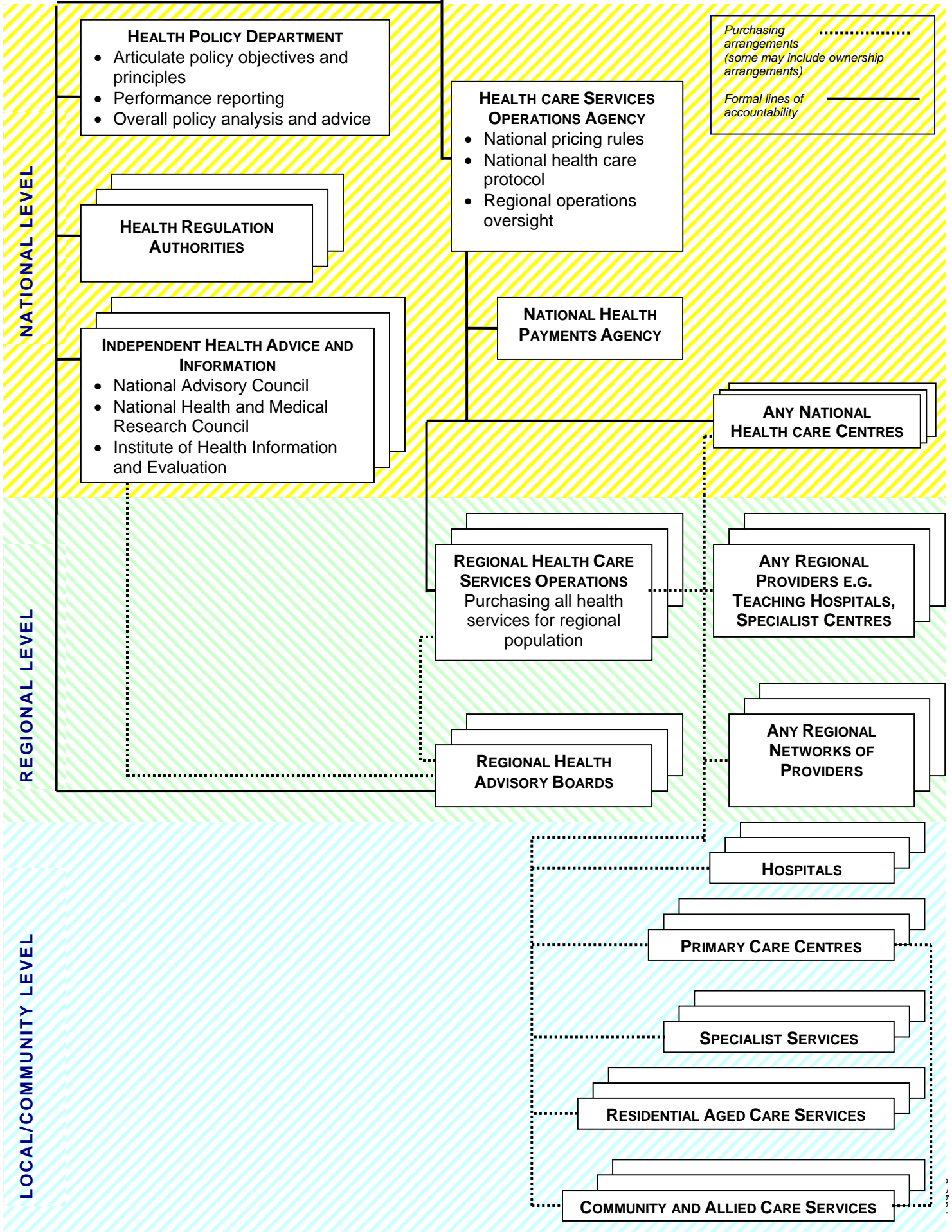


NATIONAL HEALTH MINISTER

FUNDER RESPONSIBILITIES

PURCHASER RESPONSIBILITIES

PROVIDER RESPONSIBILITIES



But the incremental changes must be in the right direction. Amongst the ones I would press first are:

- to have AIHW prepare independent regional health reports, identifying population health, service utilisation and total government spending, to support regional co-operation and consultation, and to inform governments and the public on the regional distribution of resources
- to increase Australian Government funding for primary care and preventive health, particularly in regions with lower than average health spending relative to need, and to provide the additional funding in a very flexible way
- to make a firm long-term commitment to steadily increase funding for primary care in Indigenous communities to finance services at the level available to other Australians with similar needs
- to use the additional primary care funding to promote closer co-operation between the Commonwealth and the states in regional primary health care planning, in consultation in particular with GP Divisions
- to have the Commonwealth take over full financial responsibility for all non-acute aged care services
- to continue investing in integrated information systems that might support continuity of care across service providers.

I have also proposed elsewhere changes to the Australian Health Care Agreements and PHI arrangements to promote more even competition amongst funds and amongst hospitals for the care of public and private patients. This reform might have more limited benefits to rural and remote communities than the other incremental measures I have identified.

Conclusion

Obviously many aspects of my proposals, particularly for systemic reform, are open to informed debate. I am not wedded to every detail and many details are yet to be worked through. Moreover, I am acutely aware that systemic reforms do not automatically reap tangible benefits but they do always present risks. To be successful, they must be complemented by practical measures that deliver early, tangible benefits for priority clients and communities and they must be well managed.

Nonetheless, I believe we should not be satisfied with incremental reforms, particularly if they smack of political ad hocery rather than reflect a clear and coherent longer term strategy that might make systemic reform easier in the future.

Systemic reform along the lines I propose, and incremental measures in that direction, have the potential to be of particular benefit to rural and remote communities – so long as the system genuinely allows greater flexibility at the regional and local level in response to regional and local requirements, and there is a more equitable share of resources across regions.

References

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(Detailed references on the information in this paper are contained in the above publications.)





Presenter

Andrew Podger AO is National President of the Institute of Public Administration Australia and Adjunct Professor in public administration at both the ANU and Griffith University. He is also a consultant on health policy and public sector governance.

Before his retirement from the Australian Public Service in 2005, he chaired a task force for the Prime Minister on the delivery of health services in Australia.

Prior to that, he was the Public Service Commissioner for three years following six years as Secretary to the Department of Health and Aged Care. He has also headed the Departments of Housing and Regional Development and Administrative Services.

Originally a mathematician, Andrew has had a long career in social policy and financial management. Apart from the Public Service Commission and the departments he has headed, he has worked in the departments of Finance, Prime Minister and Cabinet, Social Security and Defence and the Australian Bureau of Statistics.

