



Victorian Healthcare Association

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Lilian Topic
Executive Officer
Rural and Regional Committee
Parliament House
Spring Street
EAST MELBOURNE 3002

‘Place does matter for your health’

The Victorian Healthcare Association Submission on:

The Victorian Rural and Regional Committees’ Inquiry into the Extent and Nature of Disadvantage and Inequity in Rural and Regional Victoria

The Victorian Healthcare Association (VHA) welcomes the opportunity to provide a submission to the Victorian Rural and Regional Committee on the extent and nature of disadvantage and inequity in Rural and Regional Victoria.

The Victorian Healthcare Association

The Victorian Healthcare Association (VHA) is the major peak body representing the interests of the public healthcare sector in Victoria. The VHA promotes improvement of health outcomes for all Victorians from the perspective of its members that include public hospitals, rural and regional health services, community health services and aged care facilities. The majority of the VHA’s members are located within rural and regional Victoria.

Prefacing comments

Local solutions for local needs are vitally important to the health of rural Victorians. The VHA supports funding models and service structures that allow Victoria’s health services to plan, implement and evaluate services and programs that best meet the needs of the communities they serve.

Action to address the main determinants of inequities and disadvantage are primarily located outside the health sector. However, health services and the health sector more broadly, have an important role to play in this area. Health services are seeking opportunities to complement existing services with activities that may change the factors underlying inequity and disadvantage. To be effective, this action requires considerably more government support, particular, the system needs to provide incentives for collaboration and partnership. Overall the health system requires reorienting to focus on prevention, early intervention and a wellness approach to care – to make it possible to begin to address the health inequities that contribute to the burden of disease.

Service and demographic context

About 1.42 million Victorians (26.7 per cent) live in rural and regional areas, or one in four Victorians. In 2018, it is estimated that at least 1.5 million more people will reside in rural Victoria. This growth will be due, in part, to strong population growth on the metropolitan–rural fringe, regional centres and



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seachange/treechange lifestyle areas. Rural Victorians generally face a shortage of health services related to access, availability, affordability and appropriateness of services offered.

People who live in rural and remote Victoria tend to have higher rates of diseases and injury due to several, interlinking factors. They are exposed to greater physical risks; have less access to health services, particularly emergency services; and have less access to other health-benefiting determinants such as transport, education and employment. This is compounded by social isolation, conditions of economic decline and drought. People living in rural Victoria consequently have lower standards of health and a lower socioeconomic status than their metropolitan counterparts.

For example, the Victorian Burden of Disease Study found that the mortality burden is greater in rural Victoria than in metropolitan areas. It also found that rural Victoria has a lower health status than metropolitan Victoria, albeit with major differentials within rural and metropolitan areas. Rates of hospitalisation for preventable chronic diseases are higher in rural Victoria as are avoidable mortality rates for cardiovascular disease, cancer and road traffic injury. Some of this is due to the distance to care experienced by rural residents. However, rural health could be improved by increasing the provision of community-based preventative health measures.

The VHA encourages the committee to consider the impact of living in rural and regional Victoria on health outcomes, life expectancy, and socioeconomic opportunity. This reduced life expectancy for rural populations may be attributable to a combination of socioeconomic factors, health impacts of the long-running drought, accessibility of local services and timely access to life-saving treatment, such as resuscitation and surgery.

The Health Sector

Victoria's health system is comprised of, but not limited to, public hospitals, community health services and small rural health services. Sustaining the delivery of existing services to Victorians into the future requires major innovation in modes of service delivery, flexible models of care, and investment in preventative health strategies. Health services no longer operate merely to serve those that "walk in the door" seeking immediate medical care. Rather, their role has expanded and they have become a key stakeholder of community viability. A modern health service now actively targets a wide range of population groups within the community and across the socioeconomic spectrum, including those most vulnerable or at risk, through outreach and community development strategies.

Victoria's primary healthcare services –predominantly community health services – often work with the most vulnerable and disempowered members of our community. This well-established primary healthcare service system is unique to Victoria and should be nurtured. To ensure its continued viability, this sector requires flexible funding that supports innovation to design creative programs and further improvements in care coordination to integrate services across the care continuum. The focus of healthcare delivery needs to shift from treating individual illnesses to a holistic, person-centred approach that provides access to multidisciplinary teams of healthcare professionals, client management plans and a focus, where appropriate, on self-management of chronic illness. A stronger primary healthcare sector will enable a more effective health system overall and improving these services in rural Victoria would address disadvantage and inequity.

A key component of Victoria's health system is the provision of health services through a system of regional self sufficiency, which enables patients to access the care they require close to home. This is a model supported by the VHA. In order to sustain this "hub and spoke" model there needs to be greater recognition of the unique needs of many communities, better regional leadership and coordination, more flexibility in funding models as well as more clearly defined scope of practice.

Investment is needed in the regional "hubs" to ensure their capacity to provide the full range of services as outlined in *Rural Directions – for a stronger healthier Victoria*¹. There is also a need to strengthen the "spokes" through improved communication systems and transportation to ensure rural residents have reliable access to the "hubs", without incurring extra costs or delays. Governments must provide incentives to encourage innovation and collaboration between health services ,



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particularly partnerships between rural and larger regional and metropolitan services. A 2008 VHA survey of its small rural health service members found most felt they had adequate flexibility to allocate funding; yet very few believed this flexibility extended to being able to instigate major service change.

Responses to the Inquiry Terms of Reference

(a) examine current evidence of disadvantage in rural and regional Victoria with a view to identifying the social groups most affected by disadvantage;

Many rural Victorians with complex health needs seek specialist care from metropolitan or possibly regional specialists, but then lack the community sector health organisations to co-ordinate the continued care they require in their community. Primary healthcare services require bolstering in rural communities, to act as the mediator and facilitator in terms of care coordination and subsequently, higher quality of care.

Furthermore, only regional and sub-regional hospitals in rural and regional Victoria have state-funded emergency departments, where the community can receive free medical care 24 hours a day. In rural areas the local hospitals rely on local GPs and GP proceduralists to choose to work on-call with visiting rights to the local hospital to provide emergency care.

If the GP does not choose to bulk bill, the patient must pay a co-payment, unlike their metropolitan counterparts. The medications prescribed by the GP are funded by the Federal Government's Prescription Benefit Schedule (PBS), but if there is no access to a 24 hour pharmacy the patient must wait or the GP must procure them from the hospital stock (which it is not funded to provide). This is compounded by a lack of public transport in rural areas meaning that people living in smaller towns with a local hospital have no access to travel to a town with an emergency department.

Health promotion, illness prevention, early intervention and chronic disease management programs and initiatives are vital to targeting inequity and disadvantage in rural Victoria. However, these services in rural and regional areas lack resources, coordination and cohesion.

(b) identify any gaps and weaknesses in methods for measuring, recording and capturing information on disadvantage and inequity in rural and regional Victoria;

Meeting the health needs of our communities requires effective planning and, therefore, access to reliable and accessible data. There is significant potential for improved service planning by giving health services access to reliable sources of data. Currently, this data exists but is unavailable. This both impedes service planning and the capacity for benchmarking. The Victorian health system is currently failing to achieve these basic goals.

There are many measurement and recording issues associated with access to elective surgery. Currently, elective surgery waiting lists preoccupy public and media perceptions of health system performance. Elective surgery occurs at 63 public hospitals throughout Victoria. However, publically reported elective surgery waiting lists only apply to certain types of elective surgery included in the Elective Surgery Information System (ESIS) and performed at 29 ESIS participating hospitals: 22 metropolitan hospital sites, five regional health service sites, and two sub-regional health service sites.

Therefore, the omission of non-ESIS participating public hospitals, (many located within rural and regional Victoria) from elective surgery waiting list data means that the recorded waiting list data do not provide a full picture of the health system capacity or the population demand for elective surgery, particularly in rural areas.

Consequently, the current access data fail to reflect the needs of those living in rural and remote areas. The national data already show that people in remote and outer regional areas have longer



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waiting times for elective surgery than metropolitan residents², however access to specialist services is not measured.

Currently there is no access indicator to measure the time taken to access primary healthcare and specialist appointments from the first GP visit. This data is needed to accurately determine the true waiting times for elective surgery and the capacity of the system to meet increasing demand pressure³, and to ensure that rural communities are not further disadvantaged.

(c) identify the key factors of disadvantage and inequity in rural and regional Victoria, such as access to education, health care, employment opportunities, housing affordability and transport;

There is often a severe lack of access to after hours GP services and after hours pharmacy services in rural areas, as these are private businesses under no obligation to remain open 24-hours. Many rural hospitals are obliged to provide emergency resuscitation and stabilisation for adults and children at all times, but do not have sufficient access to GP services or medications (other than life saving) to relieve severe pain. In particular, rural residents who live greater than 30 minutes from a regional centre are at a severe disadvantage. They are often unable to access after-hours medical care and rural residents who are unable to drive are even further disadvantaged as there is no public transport access to after hours medical care. In contrast, a metropolitan resident can access a public hospital emergency department (potentially via public transport) 24 hours a day.

For example, the VHA notes the often difficult role that emergency services (police and ambulance services) play in the management and transport of patients with high-acuity or first onset of mental illness. Currently, dispatch priorities for the emergency transport of the psychiatrically unwell are out of sync with those who are transported for medical reasons. The VHA's members report situations where patients wait exceedingly long times for transport away from rural health services that are ill-equipped to manage acute mental illness. One factor the VHA has identified which compounds this issue is the requirement under the patient transport regulations that prevents mental health patients from being transported by private ambulance services.

In order to curb unnecessary hospital admissions, a better balance is needed between policies and local service delivery needs. Spending on health is increasing at unsustainable rates, making the reform mandate all the more urgent. The VHA encourages the committee to consider and advocate for further structural reform to ensure more effective and efficient use of finite resources.

(d) identify the geographical locations in rural and regional Victoria where disadvantage is most severe with a view to prioritising these areas for future action by Government;

Twenty-eight towns with a local hospital campus do not have an emergency department within a one hour drive. For example, residents of Mallacoota in Victoria's south east live more than three hours to the nearest emergency department. Many residents in fire affected areas in 2009 live greater than one hour to an emergency department, such as Kinglake and Flowerdale, and all the way up to Yea. These rural areas are becoming more suburban as blocks are sub-divided and the population grows.

Residents in Alpine regions are particularly disadvantaged, such as Mansfield, Bright, Mt Beauty and Omeo. More surprisingly, residents of the East Wimmera region from the Grampians region of Ararat through Maryborough, St. Arnaud, then up through the Southern Mallee region of Donald, Charlton, Wycheproof and Birchip also face impediments to emergency department access. The Northwest corner of Victoria is very isolated, including the towns of Rainbow, Kaniva, Ouyen and Robinvale. These are also the areas that have been hit hard economically and psychologically by the 13 year drought.



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Other areas that are affected by the distance to travel for emergency health services are the coastal areas around Phillip Island, the Great Ocean Road, Southern Gippsland, far eastern Gippsland and the coastline around Portland.

(e) identify rural and regional areas of significant disadvantage and inequity that may be masked by the comparative prosperity of surrounding areas;

There are many specific issues facing areas on the metropolitan-rural fringe, with many services facing rising demand for health services due to population growth and ageing. The main areas where there is disadvantage masked by comparative prosperity is on the urban fringe where population growth is putting health services under severe stress. The urban fringe across the north is increasing in population, and attracts people looking for low housing prices. These people often have a low socioeconomic backgrounds, as well as young families, which need ready access to a range of health services, particularly primary healthcare and emergency care.

(f) investigate the impact of social and economic trends on the future of rural and regional Victoria in the context of disadvantage;

To hold investment at the lower end of the projected range, the VHA estimates the health system will need in the period 2010-2021:

1. Investment in new infrastructure of at least \$6.2 billion
2. Investment in infrastructure renewal of \$4.7 billion
3. Investment in service growth of \$650 million per annum - this will require annual increases of \$885 million if the amount deducted to cover bureaucratic costs remains at 26.5 per cent of the funding total
4. Increased investment in Information and Communication Technologies (ICT) supporting the healthcare system of \$150 million per annum for the next four years

The VHA supports efforts to extract maximum efficiency from the state's public healthcare system. However, the VHA does not support the State Government's current policy of simply imposing efficiency and productivity and other like titled reductions on providers' operating budgets. This approach is illogical and fails to recognise the varying capacity of providers to reasonably achieve the expected outcome.

(g) examine current Government responses to rural and regional disadvantage;

Investment by the Victorian Government in health promotion interventions at a local level is vitally important to the health of all Victorians. Although high-quality hospitals and health services will remain a fundamental component of reducing disadvantage in rural Victoria, the VHA supports increased funding for illness prevention and health promotion. This shift is fundamental to deal with future challenges of an ageing population, widening social inequities, rising levels of demand and increasing rates of chronic disease.

Despite Victoria being a leader over recent decades, illness prevention and health promotion remain poorly funded relative to the total health budget. This level of funding is both disproportionate and inadequate to meet need, especially in rural Victoria. There is now clear and robust evidence that preventative health measures can yield social, economic and health benefits for the community. In addition, evidence demonstrates that comprehensive approaches to preventative health are the most effective approaches and can decrease subsequent costs to society, the health system and the individual.

The State Government has done a lot of work in the area of major trauma services. There is recognition that the rate of injuries through road trauma or the workplace is higher in rural areas, therefore major trauma patients are transported immediately to major trauma services.



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Currently the State Government's response to bringing services to rural and regional areas is in a "hub and spoke" model. In lay terms this means more complex services are provided at the regional "hubs" and the less complex services are provided further down the "spokes", or closer to the communities that they serve. The local communities are given more control over decisions about which health services are offered within a limited budget. Many innovative local solutions have resulted from this policy.

The State Government has also supported the community health services that provide free prevention and early intervention initiatives for people who cannot afford to pay for these services.

(h) identify priorities for action by Government to tackle key rural and regional disadvantage issues;

The State Government needs to ensure that all rural residents have access to health services within a reasonable timeframe. Travelling for a few hours for a once-off complex surgery is not unreasonable, but travelling two hours three times a week for dialysis, or chemotherapy, or psychological counselling will deter patients from continuing vital treatment. When the cost of services, whether it is financial or practical, is too great, then people fail to comply with treatments that may save their lives, or at least prevent them from needing further hospital treatment.

Rural communities are in dire need of capital investment in their health services. It is clear that many health services – primary healthcare, acute health and aged care – across Victoria are located in buildings "totally unsuited" to modern healthcare facilities". For many services, the most cost effective solution is a total rebuild, yet boards at these hospitals are faced with having to decide on whether or not to approve urgent repairs, such as upgrades of old air conditioning units, when the facility may be replaced entirely at some time in the near future. The level of uncertainty surrounding capital planning remains due to Victoria's lack of a long-term infrastructure plan. This causes inequity for both communities and health services.

For example, a health service may have a "master plan" to rebuild approved by the Department of Health, but have no idea which year they will win the "bidding war" as part of the budgetary process to fund this development. Consequently, these services, and communities, wait in limbo for years, missing out on smaller upgrade funding and doing "bandaid" repairs to a haemorrhaging wound.

This ageing infrastructure in areas of high need and socioeconomic disadvantage creates barriers to healthcare access and limits the capacity of services to conduct appropriate health promotion, community development and early intervention programs. Similarly, these depreciation and maintenance costs increase the costs of treating individual patients, erode productivity and contribute to ongoing difficulties these health services face in attracting key staff, further exacerbating inequities of access.

The VHA believes investment in community-based interventions that shape the health and wellbeing of rural Victorians are vital. As such, issues of drought, social isolation, access to services, transport, employment and population change and the supply of health practitioners cannot be overlooked. More integrated, multidisciplinary, community based teams acting on a population health model are needed to focus specifically on the demographics and needs of rural Victoria. Rural projects are often characterised by small staff proportions, which affect programme delivery. The VHA encourages continued investment to assist those living in drought affected Victoria. Drought has explicit correlations to mental health status, impacting on income, livelihood, self-esteem, purpose and opportunity.

(i) examine measures taken at a local level to combat problems of hardship and disadvantage; and

Population health planning is a strategic priority of the VHA.



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The steep acceleration in disadvantage and inequity (and its impact on health outcomes), and a greater understanding of the causes of health and disease over the past 20 years has necessitated a review of how we plan health and community services into the future. The VHA believes a population health approach to planning will ensure a rigorous analysis of the needs of populations, both today and into the future. This approach is based on gathering evidence-based data to measure local community needs, rather than what the service needs or has historically provided. This analysis then guides the evaluation of existing services, with the goal of changing the health system to meet the identified health needs of local populations.

Population health as an approach to planning, aims to improve the health and wellbeing of whole populations and to reduce inequities within and between specific population groups. Best practice population health planning is grounded in effective and meaningful community, inter-sectoral and whole-of-government engagement.

A joint project between the VHA and Monash University's School of Population Health aims to reduce misunderstandings of what constitutes population health by building Victoria's capacity to move towards population health approaches to planning from the ground up.

This project aims to:

1. Build a "shared definition" and evidence base for population health approaches to planning
2. Identify any skills deficit in the health workforce to improve training curricula to enable a move towards a population health approach
3. Design a toolbox to arm the health workforce with the knowledge to apply population health approaches in multiple settings and reduce the need to employ consultants
4. Establish processes within Victoria's healthcare system to enable population health approaches to planning. This includes documenting existing data sources, their relevance and how to access and utilise them
5. Support the improvement of population health standards within accreditation frameworks

Organisational commitment is fundamental to drive the change needed to plan and work from a population health approach. In order to support the realisation of population health in the Victorian community, the VHA recommends the following actions:

1. That the VHA working definition of population health and the VHA working definition of population health planning, including the four core components and eight best-practice principles are adopted by federal, state and local governments, as well as all health and community sector agencies
2. That there is investment in ongoing training in 'population health approaches to planning' for the workforce and boards of health and community sectors, and across government agencies
3. That health and community sector boards and senior management actively support the uptake of population health approaches across Victoria

(j) investigate approaches in other jurisdictions to combat rural and regional disadvantage.

The award winning Sustainable Farm Families Program initiated by the Western District Health Service, Hamilton, draws on health promotion, primary prevention and community development to address the health, wellbeing and safety of farm families. This is an example of an approach that targets specific disadvantage in communities.

- By improving both the living and working conditions - farms are homes and workplaces so 'double bang for the buck'
- Strengthening communities - all workshops are conducted in local communities and mix industry, health, and farmer groups together, as well as supporting local infrastructure and capacity
- Improved behavioural risk factors - which are evidence based and proven by the published evaluations and reports
- Improved social networks - due to the capacity building and cross sectoral collaboration in each community



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- Health service providers report improved engagement with farm families who have previously been recognised as hard to engage and stoic

The VHA believes reducing health inequalities both between and within populations and regions remains one of the most important challenges faced by society. The way to make inroads has varying causes and solutions and will require input from multiple stakeholders, including all levels of government.

Conclusion

The VHA welcomes the interest shown by the Rural and Regional Committee in improving the relationship between disadvantage and inequity in rural and regional areas across Victoria. The VHA strongly believes that health services are a key stakeholder in this process and need to be factored in to any discussions.

Please contact me for any more information regarding this response. We welcome the opportunity to represent the Victorian public healthcare sector throughout this or future inquiries.

Yours faithfully

A handwritten signature in black ink, appearing to read 'Trevor Carr', with a long horizontal flourish extending to the right.

Trevor Carr
Chief Executive

¹ Department of Health (2009) Rural Directions for a better state of health.

² Australian Institute of Health and Welfare (2008) Elective surgery in Australia: New measures of access.

³ Victorian Auditor-General (2009) Access to Public Hospitals: Measuring Performance