FACT SHEET

THE EXTENT OF THE RURAL HEALTH DEFICIT

NATIONAL RURAL HEALTH ALLIANCE INC.

There is a total health deficit in rural and remote areas of at least $2.1 billion a year. This equates to a shortage of 25 million services, and it includes the rural Medicare deficit which has now reached $1 billion a year.

Research from the National Rural Health Alliance and the Australian Institute of Health and Welfare* has demonstrated the size of the rural and remote health deficit – both in terms of dollar figures and service occasions lacking.

The AIHW report deals with the 56 per cent of recurrent health expenditure that can at present be allocated according to rurality. The NRHA's complementary report reviews the likely deficits in the 44 per cent of expenditure that could not be so classified.

Between them the reports show an annual shortfall in services for country people of more than 25 million services and a primary care deficit in regional and remote areas of at least $2.1 billion in 2006-07 – the latest year for which data on expenditure by rurality are available. The rurality category related to where the person lives, not where the service occurred. This underspend on primary care (doctors, dentists, pharmacies) contributed to the need for an extra $830 million to be spent on acute (hospital) care for people from rural and remote areas. The Alliance estimates this to represent some 60,000 extra acute care hospital episodes.

A fairer share of public expenditure on health promotion, primary care and early intervention in rural areas would reduce acute care episodes and keep people out of hospital.

The following table summarises the best estimates for 2006-07 of what the Alliance calls the rural and remote health and aged care deficit. In that year there was a total Medicare deficit of $811 million. This translates to a total of 12.6 million fewer services that year for the people of regional and remote areas. To this may be added a pharmacy deficit of $850 million and an 'other primary care' deficit of at least $800 million – this last largely attributable to less access for people from regional and remote areas to allied health and oral and dental care. The pharmacy deficit means that rural Australians had around 11 million fewer scripts that year than would have been the case if the Major Cities rate had applied.

Adding the Medicare, PBS and 'other primary care' deficits results in a conservative estimate of $2.46 billion for the rural primary care deficit for the year 2006-07. The lower levels of Medicare and PBS expenditure can be largely attributable to poorer access to health professionals. The Alliance also estimates a rural and remote aged care deficit of

Table 1: Summary of overall rural health deficit 2006-07

Item	$ million
MBS – primary and related care deficit	661
MBS – in-hospital deficit	150
Total Medicare deficit	**811**
PBS deficit	500
Other pharmaceuticals deficit	350
Total pharmacy deficit	**850**
Oral/dental care deficit	340-500
Allied health services deficit	260-345
Aids and appliances deficit	200
Total other primary care deficit	**800-1045**
Total primary care and related deficit	**2,461-2,707**
Aged care deficit	500
Public hospital 'overspend'	1,381
Private hospital 'underspend'	552
Net hospital 'overspend'	**829**
Estimated total 'rural health deficit'	**2,132-2,378**
For more information on the source of these figures see below*	

* The AIHW report, *Australian health expenditure by remoteness*, was commissioned by the Alliance. It is available on the AIHW website at **www.aihw.gov.au**. The Alliance's report, *Australia's health system needs re-balancing: a report on the shortage of primary care services in rural and remote areas*, is at **www.ruralhealth.org.au** (go to Advocacy and Policy>Key Rural Health Documents...)

There is currently a

$2 BILLION

deficit for rural & remote health every year.

some $500 million. For this, one of the key assumptions is that Aboriginal and Torres Strait Islander people over the age of 50 need equivalent 'ageing and aged care' services as non-Indigenous people over the age of 70.

The total rural primary and aged care deficit is therefore likely to be around $3.0 billion.

One of the results is a hospital overspend on people from rural and remote areas of some $829 million. The Alliance's case is that extra investment in primary care and aged care for rural areas would be offset by savings in expenditures on acute care episodes in hospital. Many of these extra acute care episodes and the longer hospital stays that characterise rural people would be avoidable with an improved focus in the rural health care system on primary, diagnostic and early intervention services. Ironically, it is for acute care services that rural people are most likely to have to travel to Inner Regional base hospitals or Major Cities, which adds to the burden of their acute care needs.

To put it simply, hospitals are providing rural people with the primary and aged care that is often not available in many of their home areas. The Alliance estimates that, overall, country people experienced an extra 60,000 episodes of acute care in 2006-2007, and about 190,000 more episodes of overnight hospital stay than would have been the case at Major Cities rates.

Critically, the AIHW report shows that, for the 56 per cent of total health expenditure it analysed, between 2001-02 and 2006-07 the relative disadvantage of residents of regional and remote areas worsened by about 10 per cent. Despite recent investments in rural health, the lack of overall improvement in the distribution of health care professionals and in the incidence of health risk factors in rural and remote areas suggests that this rural health deficit would now be at least as large in dollar terms today, particularly given the increased population and the increases in prices.

Based on these findings, the NRHA concludes that:

1. there is a very strong case for Federal and State governments to boost both proportionate and total expenditure on primary care, diagnostics, specialist care and access to PBS for residents of regional and remote areas;
2. such an increased focus on rural and remote heath would provide strong support for governments' progress towards national health goals. (The Government's COAG goals are very unlikely to be met without improvements in rural and remote areas, with the current status in those areas pulling down national figures. The stronger focus would require both better access in country areas to primary care as well as development of healthy economic, educational and physical environments.);
3. a more equitable distribution of all health professionals should be a key health policy objective of all governments;
4. Governments and their agencies should move to augment data collections on health services and costs to enable the complete picture of health and aged care provision in regional and remote Australia to be assessed;
5. the public hospital 'overspend' on people from regional and remote areas be further investigated. (For instance, what is the true extent of lower levels of access to aged care in these areas, and what are the other functions of regional and remote hospitals not addressed by Major Cities hospitals?);
6. there should be further investigation of the means by which people from regional and remote areas can be given better access to same-day acute care services. (Overnight admissions are more expensive than same day admissions. If rural people are not able to access day surgery, this places them at both a financial and health disadvantage);
7. a better understanding of the geographic distribution of private hospitals be developed and how they can be made more accessible to residents of regional and remote areas;
8. it is important to properly assess the magnitude of aged care under-servicing, especially taking into account the needs of Aboriginal peoples and the consequent need for regional and remote hospitals to fill the gap;
9. there should be a better understanding of the contribution of the health sector to the economic activity and sustainability of regional and remote communities; and
10. reflecting the importance of the broad determinants of health, a comprehensive analysis by region of government expenditures related to health would include expenditure on vital areas such as secondary and tertiary education, housing, employment support and infrastructure.

It is true that some substantial investments in rural health have been made since the data in these reports were collected, but there is no evidence that the deficit has actually reduced.

Key areas that continue to require urgent attention include mental health, dental health and the funding of Medicare Locals at a level that will allow them to operate effectively in rural and remote areas. Aged care and Indigenous health are two other areas that consistently merit targeted new expenditures in rural and remote areas.

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