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Inquiry into provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians

The provision of general practitioner (GP) and related primary health services to outer metropolitan, rural, and regional Australians, with particular reference to:

a. the current state of outer metropolitan, rural, and regional GPs and related services;
b. current state and former Government reforms to outer metropolitan, rural and regional GP services and their impact on GPs, including policies such as:
    i. the stronger Rural Health Strategy,
    ii. Distribution Priority Area and the Modified Monash Model (MMM) geographical classification system,
    iii. GP training reforms, and
    iv. Medicare rebate freeze;
c. the impact of the COVID-19 pandemic on doctor shortages in outer metropolitan, rural, and regional Australia; and
d. any other related matters impacting outer metropolitan, rural, and regional access to quality health services.

Thank you for the invitation to address the issues of the inquiry into the provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians.

CARPA Inc, the Central Australian Rural Practitioners Association supports remote health practitioners to deliver quality health care in unique and challenging remote settings. Our organisation was established 40 years ago, and is based in Alice Springs. We are involved in education, training and support of multidisciplinary Primary Health Care practitioners, and provide governance for the flagship CARPA Standard Treatment Manual.

CARPA has a multi-disciplinary focus, and the workforce issues of this inquiry are our core concern.

Our submission addresses the first and fourth terms of reference, namely current state of health care providers in rural and remote Australia, and other related matters. We make three general recommendations, and provide examples of how these could be implemented, and a fourth recommendation around climate change the major public health issue of our time. We would be pleased to follow up with an oral submission to the Inquiry.

Inverse care provision

50 years ago, British GP Julian Tudor Hart identified the inverse care law, which describes how the availability of health care varies inversely with the need (Hart, 1971). In 21st century Australia as in mid-20th century UK, the greater the need, the lower the access to health care (Australian Institute of Health and Welfare, 2019).

Hart notes that "A just and rational distribution of the resources of medical care would show parallel social and geographical differences according to need." However, in Australia health care resources and access decline with increasing need. For example, people in remote regions are six times more likely to report lack of access to a GP and ten times more likely to report lack of access to specialists compared with people in capital cities (Australian Institute of Health and Welfare, 2019). Hart described this distribution of health care resources as unjust and irrational (Hart, 1971).

There are many reasons for the inequitable distribution of health care services in Australia. Addressing it will require us to challenge the assumption that acting in enlightened self-interest achieves good social outcomes (Marmot, 2015). Marmot argues that this assumption is wrong: people acting in self-interest do not necessarily act as if enlightened, and good social outcomes do not arise from self-interest. He believes that the assumption that people act in enlightened self-interest is what has led to the current state of inequality and inefficiency in our societies. He proposes that we should aim for a "good society – one that brings wellbeing to all its members, reducing health inequalities and more positively, promoting health equity."

CARPA believes that Hart was correct, that the distribution of health care resources in Australia is unjust and irrational; and supports Marmot's proposal that health care providers should aim for a good society, one that brings wellbeing and reduced health inequality. To do this requires changes of assumptions, leading to changes of health system culture. Widespread reform is needed to address the inverse care law and focus on a vision of justice and rationality in health care distribution.

Recommendation 1: Australia's health care system must commit to widespread reform. Addressing the inverse care law through a vision of justice and rationality in health care distribution will require transformational change.

Commitment to healthcare reform to address the inverse care law could include:

- changing health care financing and funding so that resources are distributed according to need;
- reviewing the provision of Medicare in areas of lesser need, either through provider numbers, payments or access;
- overhauling Medicare altogether and funding health care provision according to population need rather than fee for service basis;
- increasing Medicare payments for health care services according to remoteness;
- increasing allocation to PATS (Patient Travel Assistance Scheme) services so that people have effective access to health care that are not available in remote locations, including essential dental care, allied health and other essential non-medical health care.

Health Research

In discussing the inverse care law, Hart further states that “Given the large social inequalities of mortality and morbidity … it is clearly not enough simply to improve care for everyone… Selective redistribution is needed.”

The deficit of health care in rural Australia is evidence of the applicability of the inverse care law in Australia. Despite our overall good quality research and health care, Australia has not effectively implemented research findings to improve health equity and population wide outcomes.

In Australia, much research is conducted through centres of research, and we acknowledge the need for excellence (NHMRC, 2021). However the centralised and competitive approach to health care research and optimising services needs to be balanced by considerations of health service distribution, health outcomes and human rights. Addressing the inverse care law would lead to an alternative approach to research and services based on needs and outcomes assessment. This may improve equity of service provision and overall health outcomes for the nation, which are currently dragged down by the poor health of the disadvantaged Australians of rural and remote regions.

Recommendation 2: For Australia’s health research funding to change focus from excellence to equity to improve overall health outcomes.

Commitment to equitable health care research could include:

- Prioritising research in areas of poor health outcomes, based on needs assessments
- Allocating funding to the implementation of research findings to improve health outcomes in rural and remote settings
- Building networks for culturally appropriate rural and remote-led research

Need for broad reform

Policies such as the Rural Health Strategy, Distribution Priority Areas and GP training reforms represent incremental change to improve service provision to rural and remote regions. Despite these policies, Australian health inequality is increasing because improvements in life expectancy are occurring disproportionately in metropolitan regions while rural and remote regions stagnate (Adair & Lopez, 2020). This shows how incremental changes in policy without changes in values and assumptions that underpin our health care system are inadequate. Major change is needed.

Australia implemented major changes to health care services early in the COVID-19 pandemic. These responses were based on strengthening collaboration, and striving to avoid situations like the outbreaks in other countries. Australia diverted resources from private health care to where it was needed to ensure a coordinated public health response (Duckett & Stobard, 2020). Leadership was transferred to First Nations Australians in their response to the pandemic, ensuring the safety of Aboriginal and Torres Strait Islander communities (Crooks, et al., 2020). As at September 2021, the COVID -19 pandemic continues and the situation in Australia is changing because of lack of clear leadership in uncertain situations. However we have shown that it is possible for Australia’s health system to respond rapidly, collaboratively and equitably. Such a response to the long established and

increasing relative health need in rural and remote Australia could have long lasting positive impacts on disadvantaged Australians, Australia's overall illness burden and our reputation as a global health leader.

Recommendation 3: Using the turbulent opportunity of COVID-19, work towards major change in the cultures of Australia's health care system, through changes in values and assumptions, away from centralisation and excellence and towards person centred care and equity.

This broad reform could begin with:

- Conclusion and implementation of this inquiry, with Australia's Minister for Health, who is in the national cabinet to lead response
- Meaningful collaboration with health care providers and community members in rural and remote areas to guide health system prioritisation and decision making
- Moving away from urban-centric policy, focus and management

Climate change

Climate change, not COVID-19 is the greatest health threat in Australia. Climate change has profound impact on Aboriginal communities was face existential suffering from loss of land and culture, and rural Australians especially those whose livelihoods depend on the environment. Climate change should be considered in all government policies, recognising the need to both reduce emissions and adapt to the changing climate. Like COVID-19, climate change will aggravate existing disadvantage and must be considered in every policy and program.

Recommendation 4:

For the Commonwealth Department of Health to acknowledge climate change as a significant factor in all health policy and planning. In the case of rural and remote health care climate change is likely to increase need and may reduce service capacity.

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