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Tantalus and the Tyranny of Territory: Pursuing the dream of parity in rural and metropolitan population health outcomes through primary health care programs

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Many health professionals and rural health academics are motivated by the challenge of achieving equitable access to health care in rural communities with the implicit vision that fairer access to services might ultimately lead to more equitable health outcomes for people living in rural and remote settings. The purpose of this paper is to put the issue of rural and urban health outcome parity into perspective and assess recent progress towards achieving the ultimate goal of improving rural health status. I will also explore ways in which rural communities might increase their access to and use of primary health care revenue in the future to improve community health outcomes. While some improvements have been achieved across the rural health system in recent times, the fundamental problem of maintaining infrastructure to service community needs in rural areas remains as daunting as ever. Extensive evidence has now been assembled to show that rural people generally enjoy a much lower standard of health care, health outcomes and life expectancy than their urban cousins. The question underlying all of this evidence, however, is...must this always be so? Is it possible to redress the current inequities between rural and urban populations and could new primary health care initiatives, such as the Enhanced Primary Care (EPC) program, be vehicles for achieving more equitable health care arrangements and health outcomes for people living in rural communities?

Key words: Rural health, Isolation, Equity, Primary health care, Economics

Extensive evidence has now been assembled to argue that people living in rural communities experience broad-based disadvantage. They are poorer, work physically harder and in more dangerous occupations, have higher mortality rates, lower education standards, have more road accidents, smoke and drink more and generally enjoy a much lower standard of health care, health outcomes and life expectancy than their urban cousins (Anderson & Thomson, 2002; Simmons & Hsu-Hage, 2002; Wakerman & Lenthal, 2002). Indeed, the very creation of new approaches to training and retention of health professionals in rural areas is predicated on the knowledge that not only are rural people disadvantaged in the main in regard to health service access and wellbeing, but also that we now have positive strategies that can be adopted to redress inequity and improve population health outcomes for rural people in Australia (Hays, 2002).

The fundamental question remains, however: can rural people living in small and remote communities realistically expect to enjoy access to services and infrastructure, including schools, hospitals, health care, food and nutrition, comparable with the level of access offered in larger rural centres and major cities? Are the dreams for the future of rural health (Walker, 2001) achievable and should people in all communities, as suggested by Smith, have "fair and equal access to services and resources and freedom and choice to decide how we as Australians want to live our lives, irrespective of where we live" (Smith, 2004, p.49)?

At the heart of this question, and the issue of rural and remote health outcome parity with metropolitan residents, is the age-old divide between the city and the country, based essentially on economic differences between the two cultures and the different perceptions that rural people tend to have of themselves in relation to their lives and their health, compared with city people:

> *Rural people see themselves as different from city people. It is from this perceived difference that rural people have developed what is termed a "'sense of country mindedness", or their ideology or "truth" about being rural people,* (Smith, 2004, p.12)

Smith also argues that rural people are more focussed on health care as "curative rather than preventive". That is, rural people tend to access care when they are in need of curative intervention or acute care and do not see health care in the context of "wellness management" or "illness prevention" to the same extent as city people. Such a view of health has significant implications for the management of chronic diseases, for example, and for the way we deal with conditions such as depression and mental health problems, especially given that access to end-point acute services contribute only fractionally to the overall maintenance of community health and wellbeing (Smith, 2004, p.131). Many other social support structures and institutions contribute to the maintenance of wellbeing in communities apart from direct health care services.

These other key determinants of health and wellbeing are social structures, income, education and lifestyle choices (McMurray, 1999, p.5-14). As Smith observes, "...the key factors that make for better health are funded from other government departments—housing, education and employment —outside the health department" (Smith, 2004, p.73). Therefore, focusing disproportionately on clinical and acute interventions in terms of how they conceive of "health care", along with a lack of recognition of or participation in other important primary health, education and preventive health care programs, may further disadvantage rural communities .

This situation, coupled with a different "rural health care ideology" means that the overall quality of life and wellbeing of traditional rural populations is poorer than for urban populations, and this quality declines—especially in relation to Indigenous communities—in proportion to the degree of remoteness experienced in these communities (Strong, Trickett, Titulaer, & Bhatia, 1998). Rural people are therefore "probably poorer, and certainly less healthy, especially if (they) are also Indigenous" (Smith, 2004, p.65).

To further characterise rural living, Smith argues that the "sense of country-mindedness" or rural ideology is characterised by a kind of rural mythology through which rural production is seen to underpin overall prosperity for all Australians. Paradoxically, power resides in the cities; rural communities are disadvantaged by politics and policies that emanate from an urban rather than a rural culture. Examples of this perception are wages and employment arbitration systems that appear to... "protect the wages of city people at the expense of those who live in the country" (Smith, 2004, p.13) and which contribute to the perception among rural people that they are both different and vulnerable (Lockie, 2000).

Health funding and rural disadvantage

It is often argued that the rural/city community divide is accentuated by the failure of mainstream funding mechanisms to support flexible and creative service provision in rural areas (Humphreys, 2002, p.289) and that rural and remote communities should be able to pool resources from a range of sources to provide more integrated and efficient service delivery across the various sectors of the system according to their local needs; a key premise of the Council of Australian Governments (COAG) trials (Commonwealth of Australia, 1999a; Podger, 1999). However, whereas healthy competition can exist across these sectors in larger communities, smaller communities lack the people and the economies of scale to operate in such a natural market environment.

Numerous researchers involved in rural health service provision have identified key issues associated with the normal conditions of rural living that serve to reduce the access to services and quality of life of many rural people. These may be summarised as:

- lack of funding flexibility to address short-term and changing needs in rural areas (this is being addressed in part through the Commonwealth Regional Health Service program)
- a pre-occupation with fee-for-service provision rather than with outcome-based approaches to funding (Harvey, 2001, p.71)
- a disease focus rather than a preventive primary care focus; resources geared to dealing with crises rather than prevention (Harvey, 1996)
- poor coordination of the various strands of the services resulting in duplication and inefficiencies (Commonwealth of Australia, 1999b)
- workforce issues, shortages of staff, lack of peer support and an inability to build and maintain capacity within rural communities and health services. (Veitch & Grant, 2004)

Productivity and economic determinism

The declining economic wealth of rural communities is a well-recognised phenomenon. Many rural communities have "declining populations, declining incomes, declining services and declining quality of life (Pritchard & McManus, 2000; Smith, 2004, p.142). As Flannery notes (Flannery, 1994), along with Humphreys (Rolley & Humphreys, 1993), the rural contribution to GDP has declined markedly since the Second World War. So, unless compensation to rural communities in decline can be sustained or even increased as a kind of affirmative action, the wealth that those communities will have with which to purchase their quality of life will continue to decline, and the dream of parity and equity in health outcomes between rural and city communities will drift further out of reach—Tantalus in the stream!

In his book "The Future Eaters", dealing with the state of Australia's population and economy, Flannery writes: "It is almost certain that the social inequality that has increasingly begun to characterise Australian society will grow" (Flannery, 1994, p.370). Flannery is concerned that the Australian economy in general will no longer be able to support the standard of living to which Australians have become accustomed. Recent trends in economic rationalism suggest the same scenario, but for rural populations the difficulties are compounded. The wealth they are able to generate is diminishing and the pre-eminence of rural production over other export earners has declined:

> *Until the early 1980s agricultural products were the single most important income earners for Australia. Since then, a rapid growth in mineral exports has superseded agriculture, so that today mining earns Australia more than 29 billion dollars, while agriculture earns only 16 billion dollars. All other export earnings (including all manufacturing) earns around 11 billion dollars.* (Flannery, 1994, p.372)

The reduced capital being generated for community use will inevitably mean that the distribution of wealth, in the form of money and social services, will be affected adversely. In such situations, those who lack economic security and power will have access to lower standard services and support structures. Rural communities have already experienced significant changes in their population demographics and this decline in rural infrastructure can only serve to continue the trend of younger people seeking opportunities elsewhere, leaving behind an ageing, dwindling population with a smaller capital base and a reduced income potential (Harvey, 1996).

This being the case, the only way of maintaining living standards and equity of outcomes in these populations is if increased revenue flows in other forms to these communities in order to support rural lifestyles. Primary health care programs may be one effective avenue through which this kind of funding support might flow.

Integrated funding and local self-determination

Many public funding models applied to rural communities have been developed for larger communities, but don't really meet the operational needs of smaller and isolated rural communities. For hospital and health service funding, for example, funds are allocated for a unit service, whether this is for "Equiseps" (a standard hospital admission benchmark) in the hospital Casemix funding model, or fee-for-service for a visit to the general practitioner (GP). However, in smaller communities, the casemix funding model is not really functional, resulting in smaller health units being unable to generate the necessary quantum of activity to justify their required funding and therefore needing additional state government funding each year to survive. In addition, small, "minimum funded" hospitals cannot generate enough revenue through the Casemix model to pay for capital development or refurbishment programs, and each year the funding problems are compounded.

Similarly, the Medical Benefits Scheme (MBS) system pays GPs to consult with patients, yet GPs in rural communities usually have more patients to treat than their counterparts in the cities. Consequently, rural GPs, although they can generate more revenue in rural communities by virtue of the number of overall patients they care for and the work they do, see individual patients less often, on average, than do GPs working in larger populations (Smith, 2004, p.76). This results in the per-capita payment of MBS funds to rural communities being significantly less than is the case in the cities.

This situation is even worse for people living in more isolated and remote rural communities.

Although Indigenous people are "twice as likely to be hospitalised and much more likely to live further from a range of health services and facilities", they receive only 20% more per capita health funding than is allocated for the population as a whole (Smith, 2004, p.107). Such situations prompt the exploration of population-based "cash pooling" approaches in these communities as a way of guaranteeing more equitable access to health care resources for isolated groups in proportion to the real needs of these communities and the actual cost of delivering services.

The COAG coordinated care trials attempted to pool resources for MBS, the Pharmaceutical Benefits Scheme (PBS), hospital and allied health services to manage the health service needs of patients with chronic and complex illness (Commonwealth Department of Health and Ageing, 2002d; Commonwealth of Australia, 1999a, 1999b, 2001). This mechanism was seen as a way of increasing health funding opportunities for rural areas through highlighting existing shortfalls in service provision and exploring potentially new population-based funding models (Harvey, 2001).

Since then further coordinated care trials (round 2) have been implemented along with the Enhanced Primary Care (EPC) program for aged health assessment and care planning for patients with chronic conditions (Commonwealth Department of Health and Ageing, 2002a, 2002b). Integrated Commonwealth Regional Health Service programs have also been established to amalgamate small rural health units in order to improve their overall capacity to deliver effective preventive and acute care services, as modelled in the first round of trials.

These strategies are all designed to make health service delivery more effective and efficient in rural communities by building capacity for program flexibility at the local level. In addition, efforts are being made to improve the relevance of training for rural health professionals through the new University Departments of Rural Health (UDRH) which have been established to build "a more accessible educational infrastructure in both rural and remote areas" (Lyle, 2001, p.268).

The way forward

As outlined above, numerous programs have been and are being implemented in rural communities to attempt to redress the imbalance between rural and metropolitan communities in relation to health service access and delivery, health outcomes and resultant quality of life. At the same time, more work needs to be done to assess the benefits of this major investment in terms of achieving the desired outcome of a more equitable rural health care system. For example, research into the long-term impacts of the UDRH program for rural practitioners and overall community wellbeing will be essential if these programs are to be sustained. Given that determinants of health and wellbeing have more to do with social and economic factors than direct health care delivery, it is significant for rural communities that broader-based primary health care initiatives such as education and preventative care programs are being expanded.

These innovations mean that rural people can have better access to health-related information, preventive care and early intervention programs instead—as has been the case historically—of their conception of health remaining couched in terms of end point, acute intervention and hospital-based care. Also, it is anticipated that the new wave of health professionals trained in multi-disciplinary formats in rural communities will be able to work more effectively and over longer periods of time in contributing to improvements in wellbeing of the rural populations they serve by responding to local needs (Lyle, 2001, p.270). In addition, given the documented disadvantage confronted by people living in rural and remote communities, new primary health care initiatives may provide a mechanism for redressing what Smith characterises as the "limited access to health care and transport, shortages of health facilities and professionals and poor coordination of government processes" (Smith, 2004, p.79) faced daily by rural people.

Perhaps by organising health systems to access the Enhanced Primary Care program funding more effectively for all eligible rural people, for example, rural populations might begin to enjoy considerably more health benefits than they do at present. The funds are available, but generally have been under-utilised to date because rural GPs, as the gate-keepers of the funds, are far too busy dealing with acute demand to devote additional time to health assessments and care planning:

> *...while uptake (of EPC items) has been variable across Australia, and while the quality of use is not yet optimal, a fundamental shift has occurred in general practice. Patience and persistence will be needed as fundamental change inevitably takes time, but the basics and the current platform are right.* (Wilkinson et al., 2003, p.6).

Further recent innovations in health assessments for younger Indigenous people (Commonwealth of Australia, 2004a) and new funding to support allied health professionals to contribute to the care of patients who have EPC care plans, offer additional incentives to communities to access these resources (Commonwealth of Australia, 2004b). Clearly opportunities exist for rural communities, as outlined by Veitch and Grant (2004) to organise themselves and their health professionals more effectively in order to access and utilise integrated primary health care funding packages such as the EPC program.

To bring in the primary health care crop efficiently, however, the "farmers"—in this case the wider primary health care networks and teams—must link their harvesting machinery into a more functional cooperative! At present each of the provider groups owns and operates their own small and inefficient system with too much capital (human and economic) committed to unproductive activity. A primary care cooperative arrangement would therefore seem a sensible way through which community health teams might work to maximise primary health care revenue. The sticking point, however, is that the creation of such a cooperative model would mean breaking down the historical distinctions that have existed between privately run general practice, the public community health sector, hospital systems and other providers through collaboration and cooperation to increase activity in and revenue from primary care initiatives.

Endnote

Tantalus was condemned to a life of eternal damnation in a stream of crystal clear water with luxurious fruits growing on branches above his head. However, as he reached for water or food these things would recede from him...the water and food remained tantalisingly out of reach.

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