National Rural Health Alliance

A PROPOSAL FOR A NEW MODEL OF CARE FOR RURAL AND REMOTE AUSTRALIA PRIMARY HEALTH CARE

RURAL AREA COMMUNITY CONTROLLED HEALTH ORGANISATIONS (RACCHOs)

Australians living in rural and remote areas have shorter lives, higher levels of disease and injury and poorer access to and use of health services compared to people living in metropolitan areas. Governments have pursued a range of strategies to address these poorer health outcomes over many years. However, trend data reveal that these interventions are having limited success.

There are a range of drivers for the poor health outcomes for rural and remote Australians:

- difficulty in attracting and retaining health professionals to rural areas
- lack of access to services due to distance, lack of transport, income, health literacy and attitudinal barriers
- social determinants of health issues including low socio-economic status, lower education outcomes, higher levels of disability and chronic disease and older population.

What are the barriers to attracting and retaining a rural health workforce?

- Professional – career limitations, networking opportunities, clinical experiences, supervision, professional isolation and lack of support from peers, work life balance issues
- Financial – practice financial viability, need to work across multiple settings, multiple sources of funding both government and private, administrative burden, business acumen requirements
- Social – family and friendship networks, social isolation, cultural and recreational limitations, partner's concerns including careers and children's education.

Models of care which work for metropolitan areas do not work in rural Australia. The Alliance is proposing a locally-based model of health delivery aimed at addressing the key barriers to attracting a rural workforce.

RACCHOs are organisations that will employ a range of health care professionals including general practitioners, nurses and midwives, and allied health professionals such as physiotherapists, podiatrists, and psychologists. RACCHOs would also have close links with community pharmacies, infant health centres, dentists, paramedics, multipurpose services and local hospitals, and scope for visiting specialists.

RACCHOs would mean that health professionals would be part of a multi-disciplinary team which could provide professional support, secure, ongoing employment, and ready access to the local community.

RACCHOs would provide community based primary health services, in-reach services for residential aged care facilities, support for recipients of the NDIS, chronic disease management plans and DVA health care. RACCHOS would also work as training hubs for the full range of health professionals and would link to Universities and Colleges to facilitate rural placement and training opportunities.

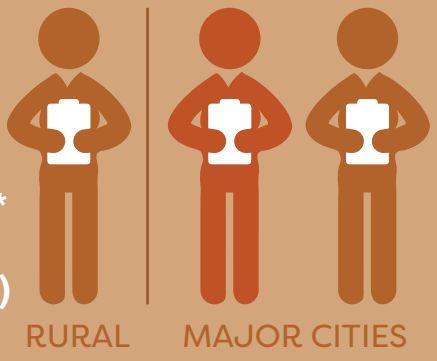
RACCHOs are a place-based model of healthcare. No two rural communities are the same and the circumstances and needs of each community are unique. Each jurisdiction has their own model of rural service delivery, so the RACCHO model is not prescriptive as it will need to be adaptable to suit the needs and circumstances of each community and the current model for rural health delivery in each state.

Noting the need for organisational and governance flexibility, a critical element for RACCHOs is the need for strong local governance, management and leadership with service planning based on local needs. Funding would rely on pooled existing Commonwealth, state and territory and local government funding sources, with some additional funding to assist with covering overheads including administrative and support staff, accommodation and recruitment. Some initial capital and infrastructure funding may be required to support establishment similar to that provided for the establishment of multi-purpose services.

THE CASE FOR BETTER HEALTH CARE:

The rural health deficit is estimated to be $4 billion today

Rural areas have up to 50% fewer health providers* than in major cities (per capita)



* E.g. GPs, physiotherapists, psychologists, dentists, pharmacists, optometrists, podiatrists

Rural doctors have lower bulk billing rates and are not catching up with major cities

Burden of disease increases with remoteness

Compared to major cities, remote areas have:

- **1.4x** total disease burden
- **2.5x** injury burden
- **1.8x** heart disease burden
- **3.6x** kidney disease burden

Compared to major cities, very remote areas have:

- **4x** deaths from diabetes
- **2.4x** deaths from kidney diease
- **2.2x** suicides
- **2.5x** avoidable hospitalisations
- **2.4x** deaths from lung disease

Life expectancy goes down with remoteness

North Sydney: 86.6 years vs Outback NT: 74.3 years

= 12.3 years

People in remote and very remote areas have lower rates of bowel, breast and cervical cancer screening

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