National Rural Health Alliance

RURAL AREA COMMUNITY CONTROLLED HEALTH ORGANISATIONS*

WHAT PROBLEMS WILL BE SOLVED?

People living in rural and remote Australia have poorer access to health services than other Australians. The number of health professionals decreases as geographic isolation increases and many communities have very limited access to health services. In fact, per capita, rural areas have up to 50 per cent fewer health providers than major cities.

Limited access to health services means people living in rural and remote areas have shorter lives and higher levels of disease and injury.

The shortage of health professionals in rural areas means that people are not accessing health services or claiming Medicare benefits at the same rate as people in major cities. This results in an underspend on health services in rural Australia. The National Rural Health Alliance has estimated that this rural health expenditure deficit is $4 billion every year.

This means that $4 billion that governments should be spending on health services for rural communities is not being spent where it should be. This saving to government comes at the expense of optimal health outcomes for rural communities.

There are a range of government programs and initiatives seeking to address these shortfalls. However, these initiatives are fragmented and, while some may have enjoyed a level of success, there is no evidence over time of any significant systemic improvement.

A new model of rural health care is needed to address the poorer health outcomes, rural health expenditure deficit and maldistribution of the health workforce affecting rural Australia. The new model of care, rural area community controlled health organisations, overcomes the barriers to attracting and retaining a rural health workforce. These barriers can be classified as:

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

WHAT ARE RURAL AREA COMMUNITY CONTROLLED HEALTH ORGANISATIONS?

Rural area community controlled health organisations offer a comprehensive and affordable range of primary healthcare services. They are not-for-profit organisations funded by government, designed and established by local communities to meet their primary healthcare needs in flexible and responsive ways.

Rural area community controlled health organisations employ a range of primary healthcare professionals – including general practitioners, nurses and midwives, dentists, allied health professionals (such as physiotherapists, podiatrists, psychologists, paramedics and pharmacists), as well as opportunities for rural generalists – to provide comprehensive continuity of care for rural communities according to need and local circumstances. They also employ a practice manager and other administrative staff, supported by integrated information technology systems, to ensure a high standard of support that allows clinical staff to focus on clinical practise.

The model is designed to:

- overcome many of the barriers to attracting and retaining a workforce by providing secure, ongoing employment with a single or primary employer, with attractive conditions including leave provisions (holiday, personal, parental and long service leave) and certainty of employment and income
- release practitioners from the major commitment of establishing their own practices with the attendant responsibilities of operating a financially viable, standalone business, such as managing staff, administration and compliance in what are often thin rural markets. This employment model makes it easier for health professionals to take up a rural position, knowing they can focus on their professional practise without the stress of establishing, purchasing or managing a practice. They can also easily change their mind if circumstances change
- support work–life balance, minimising social and professional isolation through peer support from a multidisciplinary team and overcoming negative perceptions of rural practice. Employment conditions recognise and support continuous professional development and specific accreditation requirements

- provide a ready connection to the local community, with support and advice available regarding accommodation, professional education, employment opportunities for partners, education options for children, and social and recreational activities
- embed a flexible employment model, adaptable to professional and community needs, which works with existing services (hospital, multipurpose service, general practice or other health providers) and with scope for conjoint appointment
- promote a transparent governance model structured to support high-quality accountability and service delivery, addressing both clinical and strategic governance and ensuring these priorities are responsive to community views and needs
- utilise government funding from dedicated, additional and ongoing mechanisms to ensure their sustainability in thin rural markets. Rural hospitals receive block funding in acknowledgement that activity-based funding is not sufficient to support sustainable services in rural areas. The funding of primary health care should be no different. Dedicated, ongoing funding assists in streamlining the fragmented and complex funding streams currently available to encourage and support rural practice. Streamlined funding also significantly reduces the administrative burden of reporting and accountability requirements for multiple funding streams. Block funding, in recognition of the increased costs of delivering health services in rural and remote areas, helps ensure the accessibility of primary health care for all community members, noting that rural doctors currently have lower bulk-billing rates than those in major cities.

WHAT RURAL AREA COMMUNITY CONTROLLED HEALTH ORGANISATIONS ARE NOT

On the other hand, the model is:

- not 'one-size-fits-all', but rather a ground-up, tailored model designed to meet the specific primary healthcare needs of individual rural communities
- never imposed on any rural community. They would only be established at the request of communities. They must be initiated, developed and co-designed by local communities, including any existing health services
- never established in competition with existing health professionals in a community or threaten the viability of existing services. They are intended to support communities where there is a lack of primary health care and would be implemented to ensure opportunities for any existing services are enhanced
- not intended to compete with Aboriginal Community Controlled Health Organisations (ACCHOs). Where appropriate, they work collaboratively to ensure that all primary healthcare services, serving the full spectrum of community members, can thrive. They would always acknowledge the holistic, comprehensive and culturally appropriate health services provided by these distinct organisations.

WHAT ARE THE BENEFITS FOR ME?

HEALTH PROFESSIONALS

For health professionals considering rural practise, the rural area community controlled health organisation model provides an opportunity to work rurally without the requirement of establishing a practice or relying on short-term, insecure contracts and practise as part of a multidisciplinary team, as well as the professional satisfaction of providing continuity of care in a supportive community. Employment conditions support work–life balance as well as providing for professional development and skill enhancement.

OTHER COMMUNITY HEALTHCARE PROVIDERS

For other community healthcare providers, there is the potential to work in close association with rural area community controlled health organisations to build relationships, establish referral pathways, maximise cooperation and efficiencies and, where appropriate, integrate services.

Services such as community pharmacies benefit from community access to general practice and allied health services, as people are less likely to bypass their local services in favour of larger service centres.

RURAL COMMUNITIES

The rural area community controlled health organisation model provides local access to a comprehensive range of primary healthcare services, meaning people do not have to travel extensive distances or experience long waiting times. It provides permanent, team-based continuous care focused on the health needs of the community, rather than a service reliant on locums or FIFO/DIDO health workers.

The model can also provide a base for visiting medical specialists, other visiting health professionals and a location for supported patient-end services for telehealth.

UNIVERSITIES AND STUDENTS

Rural area community controlled health organisations provide an accessible environment to support undergraduate and graduate student training placements across the scope of health professions in a multidisciplinary team environment. They also provide a primary point of contact for University Departments of Rural Health to support health education, training and research.

LOCAL GOVERNMENT

Lack of access to quality primary health care is a major barrier to attracting and retaining a rural population base. This is particularly important for attracting younger families to rural Australia and to ensure that older people do not need to leave their communities to access primary health care.

If people do not need to leave their community to access health services, in both the short and long term there are flow-on benefits to the entire community, including all retail and service providers, ensuring community members shop and seek advice locally rather than in major centres.

The benefits of having access to comprehensive and affordable primary health care also has the potential to make communities more attractive for business investment. Rural area community controlled health organisations have the capacity to be a catalyst to improve viability of local businesses and can be highlighted by local government as a key benefit of the local area.

A further benefit for local government is that the model can be scaled up in times of natural disaster or other events, such as COVID-19, as a foundation to support additional health and welfare requirements, including mental health and trauma support.

AUSTRALIAN, STATE AND TERRITORY GOVERNMENTS

The rural area community controlled health organisation model provides the opportunity for the Australian Government to provide targeted, high-profile funding to rural communities to address the $4 billion rural health expenditure deficit.

The model comprehensively addresses the ambitions outlined in the 2020–25 Addendum to the National Health Reform Agreement, including the following requirements:

- joint planning and funding at a local level
- exploring innovative models of care in the national funding model
- identifying rural and remote areas where there is limited access to health and related services, with a view to developing new models of care that address equity of access and improve outcomes
- reorienting the health system around individuals and communities, and improving patient outcomes and experiences while considering the impacts on patients, carers and their families
- addressing workforce matters, including capability gaps for effective health service commissioning, and exploration of innovative workforce models and potential new roles to support better care coordination.

Providing people living in rural Australia with better access to primary health care will reduce the over-representation of rural Australians in potentially preventable hospitalisations (PPH). PPH can be addressed through the provision of appropriate individualised preventative health interventions and early disease management, usually delivered in primary health care and community-based settings.

The model is consistent with, and fundamental to, the implementation of proposed primary healthcare reforms incorporating voluntary patient enrolment (VPE). The benefits of VPE can only be actualised for those who have access to a continuity of primary health care.

It also provides a key point of contact for Primary Health Networks, Rural Workforce Agencies, and Local Health and Hospital Networks.

AGED-CARE, NDIS, DVA PROVIDERS AND RECIPIENTS

The health workforce shortages in rural Australia often mean that older people cannot access the support and interventions they need and are eligible for, including residential aged care facilities (RACF), National Disability Insurance Scheme (NDIS) benefits and support through the Department of Veterans' Affairs (DVA). Rural area community controlled health organisations have the potential to provide in-reach services for RACF, NDIS and DVA recipients, as well as for rural people with chronic disease, including those with chronic disease management plans.

**The Alliance is proposing a different model of rural health care, currently called rural area community controlled health organisations. The model is an evidence-based policy solution that aims to overcome the professional, financial and social barriers to working rurally. It is therefore intended to build the rural primary healthcare workforce, improving access to affordable, high-quality, culturally safe care when and where it is needed.*

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