National Rural Health Alliance

Australian election 2022 rural health priorities

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About the National Rural Health Alliance

The National Rural Health Alliance (the Alliance) comprises 42 national organisations working together as a national catalyst for policy reform and innovation in rural, regional and remote (rural) health. Our Members include consumer groups, representation from the Aboriginal and Torres Strait Islander health sector, health professional organisations (representing doctors, nurses, midwives, dentists and allied health practitioners), health service administrators, and health educators and students.

We are a united voice for addressing the health needs of communities in rural Australia and strengthening the rural health workforce. Our goal is making rural health services more accessible, equitable, affordable and sustainable. We are a strong influencer of public policy, and we enable peer-reviewed rural health research and innovation. Through flagship conferences and events, and respected communication channels, we engage with a wide range of stakeholders interested in rural health.

National Rural Health Alliance

… healthy and sustainable rural, regional and remote communities

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Business case for rural health equity

This paper outlines priorities for the rural health sector in the 2022 federal election that could help close the gulf in health equity that exists between cities and our rural communities.

More than 7 million people live outside major cities, spread across 12,670 rural, regional and remote localities, spanning 99.3 per cent of Australia's land surface. Rural people underpin the nation's economic contribution, with around two-thirds of the nation's export earnings coming from tourism, retail, services and manufacturing, as well as $400 billion yearly in resources and agricultural exports.[1]

Rural people should be able to count on accessible, comprehensive, high-quality and affordable health care, reasonably close to home. But this fundamental expectation is frequently not met.

Rural areas have up to 50 per cent fewer health providers per capita than major cities. Lack of services means rural people utilise the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) at a much lower rate, which results in an expenditure shortfall in rural and remote areas. This is reflected in data on Medicare benefits claims per person, which are highest in major cities (6.4 per person), declining to around half that rate in very remote areas (3.6 per person).[2]

The Alliance estimates there is a spending shortfall of $4 billion in rural health annually – that's $4 billion in taxpayer funding that does not reach rural communities.

The lack of access to health services significantly contributes to the poorer health outcomes of rural people, including higher death rates, lower life expectancy and a greater burden of disease. Indeed, health outcomes for rural Australians have stagnated over recent years and, in some cases, are declining.

The Alliance believes the Australian Government (the Government) has a responsibility to address the commonly-felt status quo that poorer access to health care, 'goes with the territory' of living in a rural community.

Two rural health election priorities

The Alliance has two priorities for the 2022 federal election, which will help deepen the next Government's commitment to rural health, expand access to healthcare services and improve health outcomes for rural Australian communities:

- A new integrated National Rural Health Strategy (NRHS) and Implementation Plan to address the enduring workforce, access and affordability issues, and to include the rural health sector in responding to climate change and in local disaster planning and emergency management.
- A different model of primary health care called Rural Area Community Controlled Health Organisations (RACCHOs) – an evidence-based policy solution to build the rural primary healthcare workforce and improve access to affordable, high-quality, culturally safe health care when and where it is needed.

The pros and cons of life in rural Australia

People who live in rural Australia enjoy the benefits of living in smaller communities with a strong sense of community spirit, higher levels of life satisfaction, less congestion and, depending on location, more affordable housing.

However, they have poorer access to health services than other Australians. They may have to wait for long periods to get appointments with health professionals. They often incur additional financial costs associated with travelling long distances to access health services, including the cost of travel and accommodation, as well as loss of income due to time away from work.

An examination of the Australian Institute of Health and Welfare (AIHW) *Australia's health 2000*[3] and *Australia's health 2020*[2] reports show a consistent pattern over the past 20 years in health outcomes for rural and remote Australians.

There is no evidence over time of any significant reduction in the health workforce challenges confronting rural Australia.

Rural Australians are consistently over-represented in data on health risk factors, including having higher levels of alcohol consumption, higher rates of smoking, poorer diet choices, lower levels of physical activity and higher rates of overweight and obesity. Likewise, mortality, including from chronic diseases, remains higher in rural communities, increasing with remoteness.

There are still troubling and unacceptable health outcomes for rural, regional and remote Australians in 2020:

- Potentially preventable hospitalisations (PPH) – hospital admissions that could have been prevented by timely and adequate health care in the community – increase with remoteness and socioeconomic disadvantage, and the gap may be widening.[4]
- After adjusting for age, the total burden of disease increases with remoteness, with the total burden rate in remote and very remote areas 1.4 times higher than major cities.[5]
- For most disease groups, total burden rates increase with remoteness.[5] While there is some variation by disease, a clear trend of greater burden of disease with remoteness is seen for coronary heart disease, chronic kidney disease, chronic obstructive pulmonary disease, lung cancer, stroke, suicide and self-inflicted injuries, and type 2 diabetes.
- People living in rural and remote areas are more likely to die at a younger age than their counterparts in major cities.[5] They have higher mortality rates, higher rates of potentially avoidable deaths and lower life expectancy than those living in major cities.

The very poor health outcomes of Aboriginal and Torres Strait Islander Australians in remote and very remote Australia contributes to the poor health profile of these communities as a whole.[6]

Indigenous Australians have lower life expectancies, higher rates of chronic and preventable illness, poorer self-reported health issues, and a higher likelihood of being hospitalised than non-Indigenous Australians.[7]

The gulf in healthcare equity

Rural areas have up to 50 per cent fewer health providers than major cities, per capita. The number of health professionals, including nurses and midwives, allied health practitioners, general practitioners (GPs) and medical specialists, decreases as geographic isolation increases.

Lack of health care means that people living in rural communities are accessing services at a far lower rate than urban Australians. This results in the estimated annual deficit in government rural health spending of $4 billion.

This calculation takes into account, inter alia, the under-expenditure in MBS and PBS payments. The calculation also offsets these savings with the additional cost to governments of the over-representation of rural people in PPH rates (which increases with remoteness to be 2.5 times higher in remote areas than in major cities).

It is not acceptable that the savings to government from inequitable rural health spending should manifest in poorer health outcomes for these communities.

Opportunity to deepen Australian Government commitment

The current Government preference for supporting rural health is through programs and incentives grouped under the banner of the *Stronger Rural Health Strategy* (the Strategy). The Strategy focuses on gaps and inconsistencies in the workforce which, while critical, is only one element of addressing rural health outcomes.

The Stronger Rural Health Strategy is not fit for purpose as a strategic driver of rural health policy.

There was a *National Strategic Framework for Rural and Remote Health* (the Framework) a decade ago. However, it appears to be inactive and there has been no evaluation or any reporting on the effectiveness of the Framework. As with the limited scope of the current Strategy, the Framework was principally focused on the medical workforce, not multidisciplinary, and was not fit for purpose to address the rural health crisis from a nationally strategic level.

It is clear from examination of the trend data for rural health outcomes that there needs to be a renewed focus on addressing the gap in health outcomes for rural Australians.

Urban health care and rural health care are two vastly different markets. The current Medicare system, which is a fee-for-service model, rewards high-volume patient throughput. However, in smaller country towns there's rarely the critical mass of people necessary to sustain private GP practices. The situation is worse for allied health practitioners because there are so few MBS items that patients can claim that rural allied health practice is not financially viable and services becomes unaffordable for rural people.

There is a large unmet need for rural healthcare services.

ELECTION PRIORITY ONE

The case for a holistic National Rural Health Strategy

The Alliance is seeking a new integrated National Rural Health Strategy (NRHS) and Implementation Plan to address the enduring workforce, access and affordability issues, and to include the rural health sector in responding to climate change and in local disaster planning and emergency management.

The Government has an obligation to support the full spectrum of primary healthcare services throughout the country. Yet, the Government's current Framework and Strategy are not comprehensively fit for purpose. The emergence of significant new health challenges in recent years gives added impetus for the NRHS.

The health effects of climate change, including the frequency and intensity of bushfires, drought and floods, should be incorporated. This is particularly relevant for rural communities that are disproportionately affected by these extreme weather-related events.

The 2020 Royal Commission into National Natural Disaster Arrangements heard that, 'Primary care providers and [Primary Health Networks] PHNs are not systematically included in health emergency response and disaster management planning. The extent of their involvement is ad hoc and varies between local areas and jurisdictions, including in related plans and training and exercising processes. This results in roles and responsibilities of primary healthcare providers and PHNs not being clearly defined and can impede the delivery of services during and in the aftermath of disasters.'

Recommendation 15.2 Inclusion of primary care in disaster management – Australian, state and territory governments should develop arrangements that facilitate greater inclusion of primary healthcare providers in disaster management, including: representation on relevant disaster committees and plans and providing training, education and other supports. *Royal Commission into National Natural Disaster Arrangements Report 28 October 2020*

The Royal Commission found that, 'Natural disasters can hamper the ability of communities to access healthcare and medications' and 'can also exacerbate existing health disparities in local communities, particularly in regional, remote and isolated areas'.

Likewise, since the development of previous strategies and frameworks, the impact of the COVID-19 pandemic has exposed the vulnerability of rural Australians due to the lack of capacity in the rural health system to respond to health emergencies. Workforce shortages, the lack of appropriate facilities, and a higher proportion of older and vulnerable people all contribute to this risk. The way forward is the new, comprehensive and integrated NRHS to drive outcomes.

Robust assessment would be critical to the success of the NRHS. Measures should include agreed targets, regular reporting against those targets, an implementation plan and an evaluation.

The NRHS would need to incorporate elements of previous strategies and frameworks, as well as relevant aspects of wider health reform documents, including the recent work to develop the National Preventive Health Strategy and the Primary Health Care 10 Year Plan.

ELECTION PRIORITY TWO

The case for RACCHOs

Rural Area Community Controlled Health Organisations (RACCHOs) are a different model of primary health which provide an evidence-based policy solution to build the rural primary healthcare workforce and improve access to affordable, high-quality, culturally safe health care when and where it is needed.

There is a compelling case for greater direct Australian Government investment in primary health care in rural communities and the Alliance is seeking additional funding for the implementation of 30 RACCHOs across Australia.

RACCHOs are not-for-profit organisations that draw on the successful Aboriginal Community Controlled Health Organisations (ACCHOs) model. They are intended to build the rural primary healthcare workforce and improve access for rural people to affordable, high-quality, culturally safe care.

RACCHOs are necessary to help address the poorer health outcomes of rural people; the $4 billion rural health expenditure deficit; and the maldistribution of the health workforce, especially to overcome the professional, financial and social barriers to working rurally.

The four pillars of RACCHOs

1	2	3	4
Australian Government block funded	Community initiated, co-designed and locally governed	Salaried, multidisciplinary employment for health professionals	Patient-centred, culturally safe health care to meet local need

1. Australian Government block funded

RACCHOs are underpinned by Government block funding to ensure that rural health services that support (on average) older, sicker and more disadvantaged communities, can remain affordable and sustainable in thin rural markets.

Block funding enables the provision of comprehensive healthcare services where existing fee-for-service funding streams are limited. For example, the current MBS rewards high-volume patient throughput that does not work for smaller rural GP practices that don't have a critical volume of patients. The situation is also difficult for many private allied health services, as there are very few MBS items that patients can claim, reducing financial viability for practices and making those services unaffordable for many rural people.

This additional block funding would not preclude the use of existing funding streams such as the MBS, the National Disability Insurance Scheme (NDIS) or Department of Veterans' Affairs (DVA) funding.

The funding of primary health care should be no different to the block funding of rural hospitals, for the same reason that fee-for-service financing is not viable in rural areas.

The issues with lack of sustainability in primary health care are the same as in secondary and tertiary care. The current funding streams for rural practice are fragmented, complex and narrowly focused, and act as a workforce disincentive.

Dedicated, ongoing RACCHO funding assists in streamlining the cumbersome 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.

2. Community initiated, co-designed and locally governed

Rural communities initiate and drive the establishment of a RACCHO in their community. As no two communities are the same, RACCHOs are co-designed with local health consumers, providers and organisations to offer services that are better integrated across all sectors. The range of services and the mix of health practitioners they employ in their multidisciplinary team depends on local needs and circumstances.

When establishing RACCHOs, consideration is given to existing capacity and services that are working well and benefit the local community. RACCHOs are not intended to compete with existing health professionals in a community or threaten the viability of other existing services.

RACCHOs 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 practice. The RACCHO paradigm supports medical and allied health rural generalist models and pathways, including opportunities for structured supervision and support.

RACCHOs have transparent governance, structured to support high-quality accountability and service delivery. They address both clinical and strategic governance and ensure these priorities are responsive to, and inclusive of, community views and needs.

3. Salaried, multidisciplinary employment for health professionals

The key barriers to attracting and retaining a rural health workforce are:

- Professional – perceptions of limited networking opportunities, clinical experiences and supervision; professional isolation and lack of support from peers; and work–life balance issues.
- Financial – financial viability of practices, the need to work across multiple settings, multiple 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, and partner concerns including career and children's educational opportunities.

RACCHOs employ a range of primary healthcare professionals, including GPs, rural generalists, nurses and midwives, dentists and allied health professionals such as physiotherapists, podiatrists, psychologists, paramedics and pharmacists.

Rural health practitioners are not pressured to make the major commitment of establishing their own practice with the attendant responsibilities of operating a financially viable, standalone business, such as managing staff, administration and compliance.

RACCHOs overcome many of the barriers to attracting and retaining a workforce by providing a flexible employment framework. They offer 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.

RACCHOs make it easier for health professionals to take up rural positions, knowing they can focus on their clinical or professional practice without the stress of financing or managing a business.

RACCHOs support work–life balance, minimising social and professional isolation through peer support from a multidisciplinary team, and overcome related negative perceptions of rural practice. Employment conditions recognise and support continuous professional development and specific accreditation requirements and can provide the opportunity for training and research collaborations.

RACCHOs provide ready connection to the local community, with support and advice available regarding accommodation, employment opportunities for partners, education options for children, and social and recreational activities.

4. Patient-centred, culturally safe health care to meet local need

RACCHOs are aimed at supporting communities where there is a lack of primary health care and would be implemented to ensure existing services are enhanced. For example, for other community healthcare providers, including those who may not be directly employed by a RACCHO, there is the potential to work in close association, build relationships, establish referral pathways, maximise cooperation and efficiencies and, where appropriate, integrate services.

RACCHOs are not intended to compete with ACCHOs, but acknowledge the holistic, comprehensive and culturally appropriate health services provided by these distinct organisations.

Where appropriate, RACCHOs will work collaboratively with ACCHOs to ensure that all primary healthcare services, serving the full spectrum of community members, can thrive.

The rural health workforce shortage often means that older people and people with disabilities cannot access the support and interventions they need and are eligible for, across a range of settings: residential aged care facilities (RACF); NDIS benefits; and DVA.

There is the potential for RACCHOs 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 or similar care plans.

RACCHOs provide local access to a comprehensive range of primary healthcare services, meaning people do not have to travel extensive distances or experience long waiting times. RACCHOs provide permanent, team-based, continuous care focused on the health needs of the community, rather than a service reliant on locums or fly-in fly-out and drive-in drive-out health workers. RACCHOs can also provide a base for visiting medical specialists and other health professionals, as well as a location for supported patient-end services for telehealth. RACCHOs also support the rural generalist model.

Cost benefits of RACCHOs

A detailed costing for the introduction of the RACCHO model is provided below. It should be noted that the costing does not include possible offsets such as MBS rebates, nor the potential reduction in spending on the acute care sector due to improved utilisation of primary care.

A single RACCHO is estimated to cost $2.5 million for one year, or $10.5 million over the forward estimates. Given the significant unmet need in primary health care in rural areas, the Alliance believes that the Government should commit to the rollout of a significant number of RACCHOs to make a real impact on the lives and wellbeing of rural Australians. The costing therefore includes a figure for the rollout of 30 RACCHOs, estimated at $75 million for one year, or $313.8 million over the forward estimates.

As producers of $400 billion of the country's wealth, rural Australians deserve more from the government than a $4 billion void in rural health care services.

RACCHOs estimated* costings

1 RACCHO					
	2022–23	2023–24	2024–25	2025–26	Total
	$	$	$	$	$
Salaries and on costs	2,119,600	2,183,188	2,248,684	2,316,144	8,867,616
Administration	160,500	165,315	170,274	175,383	671,472
Rent and accommodation	86,500	89,095	91,768	94,521	361,884
Insurance, legal and audit – accounting	33,400	34,402	35,434	36,497	139,733
IT operational costs/software	40,000	41,200	42,436	43,709	167,345
Board expenses	10,000	10,300	10,609	10,927	41,836
Contingency fund	50,000	51,500	53,045	54,636	209,181
TOTAL	2,500,000	2,575,000	2,652,250	2,731,818	10,459,068

30 RACCHOs					
	2022–23	2023–24	2024–25	2025–26	Total
	$	$	$	$	$
Salaries and on costs	63,588,000	65,495,640	67,460,509	69,484,324	266,028,474
Administration	4,815,000	4,959,450	5,108,234	5,261,481	20,144,164
Rent and accommodation	2,595,000	2,672,850	2,753,036	2,835,627	10,856,512
Insurance, legal and audit – accounting	1,002,000	1,032,060	1,063,022	1,094,912	4,191,994
IT operational costs/software	1,200,000	1,236,000	1,273,080	1,311,272	5,020,352
Board expenses	300,000	309,000	318,270	327,818	1,255,088
Contingency fund	1,500,000	1,545,000	1,591,350	1,639,091	6,275,441
TOTAL	75,000,000	77,250,000	79,567,500	81,954,525	313,772,025

*Does not include possible offsets, for example MBS payments

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