NATIONAL RURAL HEALTH ALLIANCE INC.

Specific priority actions for rural and remote health

1. ***Rural Health Australia*** **and a National Rural Health Plan**
   - The Alliance supports the proposed establishment of *Rural Health Australia* in the Department of Health and Ageing. It will chair an inter-departmental Board to advise Government on rural health and will be accountable through a report to Federal Parliament.
   - The core of *Rural Health Australia's* work will be implementation of a new Rural Health Plan to be agreed with the States/Territories and rural health consumer groups.

2. **Oral health**
   - A permanent National Advisory Council on Dental Health should be established with representation from all appropriate sectors.
   - Following abolition of the Chronic Disease Dental Health Program, $750million per year should be allocated to a Commonwealth oral health program to focus on those most in need, including people in rural and remote areas; and a new early childhood and school oral health service established.
   - A range of workforce support programs like those provided to rural and remote medical students and graduates should be available to rural and remote students of oral health.

3. **Broadband solutions in more remote areas**
   - There should be a special grants program to ensure that 'difficult to access' homes, businesses and services can take advantage of the rollout of high speed broadband.

4. **Publicly funded primary health care models for rural communities**
   - Where private fee-for-service models of health care are not viable or do not meet need, the Federal Government, with the States and Territories, should fund comprehensive health care services using salaried staff or innovative business models.

5. **Improving rural educational outcomes**
   - Tertiary educational institutions should be required to set, meet and report on targets for the number and proportion of their students who are Indigenous and of rural/remote origin.
   - To optimise tertiary education enrolments and completion rates, new support programs should be funded as part of 'an educational pathway' for Indigenous and rural students.

6. **Aged care**
   - Aged care subsidies for rural areas must be set at rates which reflect the true costs of delivering community and residential aged care in those areas.

7. **Rural placements for health professionals**
   - Government should establish a collaborative rural placement scheme for health undergrads, providing greater equivalence of support for all professional groups (medical v other).

8. **Mental health**
   - The National Mental Health Commission must give attention to how mental health services translate to areas where staff are not available, and the National Report Card on Mental Health and Suicide Prevention must include a report by remoteness.

9. **Integrated primary care in rural areas**
   - The Alliance seeks bipartisan commitment to local control and integration of health care, with the delivery of health services undertaken on the basis of relatively small areas which reflect communities of interest.

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General priorities for action on *rural and remote*[1] health

Detailed report from Council of the National Rural Health Alliance

Introduction

Council of the National Rural Health Alliance has just completed its annual face-to-face meeting in Canberra. At the meeting, the 32 national bodies in the Alliance agreed on immediate priorities for action to improve the health and wellbeing of people in rural Australia, to move towards the vision of equal health by the year 2020.

The Alliance confirmed its belief that, in a prosperous nation such as Australia, it is unacceptable that one third of the population (the seven million people in rural and remote Australia) live with poorer health outcomes and significantly less access to health services. Members of Council agreed that the organisation will redouble its efforts to seek additional investment in rural health services as early as the May 2012 Federal Budget.

The Alliance does not accept that the current fiscal circumstances in which the Federal Government finds itself are a valid reason for failing to provide the urgent additional investment needed. Extra expenditure on rural health services should be seen as an investment in the ongoing capacity of rural areas to continue their production of food, wealth and exports - not as a cost to the Federal budget. This is particularly the case given the medium-term savings which would be generated through the sort of healthcare which will keep people out of hospital, including comprehensive primary health care, equitable access to GPs and other primary care providers, and a greater focus on health promotion and illness prevention.

Now that significant progress has been made with hospital reform, the next priority should be rural health. The Alliance will be arguing for a national 'royalties for regions' type of approach by the Federal Government in its Budget considerations, especially given the fact that there is an annual underspend of over $2 billion on primary care services to rural areas.

Achieving a national Budget surplus seems to have become the Holy Grail for both sides of politics; the Alliance does not accept this view, especially in an environment in which individual women are putting at risk their own lives and the lives of their babies by intentionally avoiding the maternity system which provides them with no option but to spend up to two months away from home and family.

The Alliance has major expectations of the new National Maternity Services Plan which includes a significant focus on rural areas and which may be seen as a model for planning and accountability for the whole of Australia's rural health system.

As the peak non-government organisation for rural health, the Alliance welcomes the regional focus of the Gillard Government and, in particular, those elements of it which relate specifically to reform of the health system in rural, regional and remote areas. The Alliance has reaffirmed its determination to see major advances made in the Australian Government's capacity to deliver a whole-of-government approach to rural health services. Among the keys to this development are genuine commitment to

[1] hereinafter 'rural'

localisation of the funding and control of health services, better local integration of primary and hospital care, and programs to ensure that 'physical and learning infrastructures' for the rural health workforce are made available.

In the medium term consideration should be given to a single national funder for the health system.

The Alliance sees the availability of 'fit for purpose' high-speed broadband across every part of rural Australia as a key facilitator of community sustainability, business and recreational opportunities, and the health services of the future in those areas.

The administrative centrepiece of continued rural health reform will be a new body, *Rural Health Australia*, which will lead the Government's work across relevant departments and meet the commitment made by the Gillard Government to the regional independents. This new entity will play a leading role, in consultation with people in rural areas and organisations like the NRHA, in developing a national rural health plan that is agreed by all health jurisdictions. The plan will serve as the roadmap for national development in rural health services, and will lift the accountability of government at all levels for their work on rural health to a level equivalent to that planned for public hospitals.

The personal reflections of members of Council of the Alliance illustrated a significant level of concern with a range of issue in rural and remote Australia relating to the environment. The Alliance remains concerned about the potential impact of climate change on health in rural and remote areas and is seeking opportunities to work collaboratively with other organisations to promote action on the matter. The Alliance's ongoing interest in the sustainability of rural communities means that it is vitally concerned with the various implications of climate change, including the significant economic opportunities it may offer to people in rural and remote areas.

1. *Rural Health Australia* and a National Rural Health Plan

The Alliance stands ready to welcome the announcement of *Rural Health Australia* - which it will expect to have the following characteristics.

a) It will be a senior and authoritative entity within the Department of Health and Ageing with a cross-government Board and rural stakeholder representation and engagement.
b) It will provide an annual report to Federal Parliament.
c) The core of its operational plan will be a new Rural Health Plan.
d) The Agency will require funding to play its leadership role in developing the Plan.
e) The new national Plan will be negotiated collaboratively through and with Commonwealth, State and Territory Departments and stakeholders.
f) The Plan will harmonise and define 'minimum service obligations' for places of particular sizes and be grounded in research, data and modelling, as is the case with the National Maternity Services Plan. The new Rural Health Plan will also include a Forward Expenditure Plan for rural health, and be compatible with the existing planning documents of State and Territory Departments of Health.
g) To enable *Rural Health Australia* to report against the performance measures in the Plan, the entity will have ongoing access to evidence from a range of other plans and strategies (COAG, Physical Activity, Close the Gap, National Mental Health Plan etc), as such evidence emerges, and augmented where necessary by additional analysis by rurality commissioned from the AIHW.
h) *Rural Health Australia* will chair a board that collaborates with the Departments of Prime Minister and Cabinet, Regional Development, FaHCSIA, DAFF, Finance and Treasury, and other federal agencies as necessary, to coordinate rural health-related work. There will be direct stakeholder representation on the Board and collaboration with rural stakeholders will be an ongoing part of the work of the Board. This work will constitute a welcome effort to apply a whole-of-government approach to the social and economic determinants of health in rural areas.

2. Oral health

Building on the existing RePAIR plan advocated by the National Oral Health Alliance of which it is a member, the Alliance proposes:

a) that a permanent National Advisory Council on Dental Health (or its equivalent) be established and that it include appropriate representation of rural, Indigenous and other special needs groups;
b) that the Australian National Preventive Health Agency include oral health promotion and illness prevention in its Second Operational Plan (2012-13) or soon thereafter;
c) that when the Chronic Disease Dental Health Program (CDDHP) is terminated, an equivalent amount of money (ie $750 million a year) be allocated to a new targeted Commonwealth oral health program (by whatever name). This new program would provide new infrastructure and operational support to deliver services on a 'worst first' basis to people in rural areas, starting with special needs groups, including rural Health Care Card holders and Aboriginal and Torres Strait Islander people.
d) that, to improve the availability of oral health professionals to people in rural areas, and in addition to the Foundation Year currently being developed for dental graduates, incentives be provided to encourage and support rural students to study dentistry, and to attract new graduates and city-based private practitioners to rural areas by subsidising the use of the public and private practice workforce;
e) that a new early childhood and school (4-18 years) oral health system be established to expand the work of the existing School Dental Services and the Teen Dental Scheme; and
f) that priority be given in the work of the Australian Health Practitioner Regulation Agency and Health Workforce Australia to the collection and publication of data on the oral health workforce in rural areas and its scopes of practice.

3. Ensuring 'fit for purpose' broadband solutions in more remote areas

The Alliance re-affirms its position that, by whatever means, 'fit for purpose' high speed broadband must be made available to all parts of rural Australia.

Such 'fit for purpose' services are essential for connecting the people of rural Australia with the health system through current and future telehealth applications and for the sharing of health information. The current and future rural health workforce will rely more and more on high speed broadband connections for aspects of their training and education, ongoing professional development and intra- and inter-professional advice and mentoring. These connections need to go beyond the current public health system networks so that they are available to private and isolated practitioners. High speed broadband connections will also underpin business opportunities outside health and the overall sustainability of rural communities.

The Alliance proposes a special grants program to ensure that 'difficult to access' customers (homes, businesses, health professionals) will be able to take advantage of the national roll out of high speed broadband and can be prioritised for early coverage.

Current plans include fibre connections, to be complemented by wireless and satellite solutions in more remote settings, yet residual doubts remain about whether the isolated and remote communities that are most in need of health connections and support will be covered in a timely way and whether the proposed connections will be adequate for health applications.

The Alliance also seeks ongoing attention to the ultimate cost of services for consumers, businesses and health professionals; and cost structures relating to ISPs and consumers that will work and be affordable beyond the competitive markets that exist in the major cities and regional centres.

4. Publicly funded primary health care

The Alliance believes that services provided by the Aboriginal Community Controlled Health Sector and the RFDS provide models of integrated primary health care in many parts of rural Australia and for many population groups. The public funding of such services in areas where private fee-for-service models of

care are not viable or are not providing satisfactory outcomes will include cashing out MBS and PBS entitlements, with loadings reflecting the cost of service delivery (the more remote, the higher the cost).

This program would in effect be an extension of what happened in the Northern Territory prior to the intervention. The characteristics of such block-funded primary health care services include:

- the block funding consists of monies cashed up to national averages, not cashed out at existing useage levels;
- a weighting is applied to the block funding, reflecting increasing costs with increasing remoteness;
- the more widespread use of salaried health professionals, to support and complement those in private practice;
- co-location of members of the healthcare team, with high level access via fast internet to support in larger less remote centres;
- comprehensive primary health care, with services provided perhaps including health education; counselling; engagement as necessary with police, prisons, Centrelink etc; support for traineeships; and householder support; and
- cultural appropriateness - not just for Aboriginal and Torres Strait Islander people, but for refugees, prisoners and people of non-English speaking backgrounds.

We request that Federal Government, in collaboration with State Governments, support demonstration models of such entities in areas not currently covered by the Aboriginal Community Controlled Health Sector and the RFDS. The performance of such entities should be carefully assessed.

5. Improving rural educational outcomes

Attempts to avoid the looming workforce shortage identified by the Productivity Commission must embrace the one third of Australian school students who either live in rural/remote Australia, or are Indigenous.

A concerted national effort is urgently needed to widen the curriculums of rural high schools and improve high school completion rates for rural, remote and Indigenous students as well as access to tertiary and vocational training. High school completion alone will improve health outcomes for these young people. It will also reduce the difficulty they have in accessing higher education. Developing a specially-designed pathway for rural students to and through tertiary education will help to add value and efficiency to our future workforce and reduce the need to import labour – and contribute in a major way to the rural health workforce.

The Alliance asks that:

1. as part of their funding agreements with the Commonwealth Government, tertiary educational institutions and the VET sector be required to meet and report on targets set (in conjunction with the Department of Education) relating to the number and proportion of their students who are of Indigenous origin and rural/remote origin, including in nursing and allied health disciplines;

2. additional programs of support for Indigenous and rural/remote students should be provided during secondary school and tertiary studies, in order to optimise tertiary enrolment and completion rates, including:
    - improvement of the quality and breadth of the educational experience though grasping the educational opportunities offered by high speed internet and better valuing quality teachers for these students in both primary and secondary school; and
    - providing financial support to enable Indigenous and rural/remote youth to live away from home so that they can attend school and access tertiary education.

The Education Revolution should not only be available for youth from major cities and in those regional centres where university campuses exist.

Educational aspiration does not develop in a vacuum. Students' aspirations develop through contacts with role-models and are also shaped by perceived opportunities in the workforce. Their educational aspirations will be enhanced through the development of sustainable rural, remote and Indigenous communities, with economies that need a diverse workforce – including those with technical and professional skills. These aspirations will develop further when young people live in an environment presided over by accountable and local governance, in which high speed internet is available, and as part of a decentralised economy which is taking advantage of renewable energy and 21st century green technology.

6. Aged care

The Alliance welcomes the current focus on healthy ageing in the Productivity Commission report which recommends a better range of choices and surety as people age. These benefits must also apply to the 32+ per cent of older Australians who live outside major cities. For this to occur, consideration must be given to the true costs of delivering community and residential aged care in more challenging circumstances including the costs for staff, travel, housing, freight, goods and services, flying and accommodating agency staff, and training and backfill.

These cost imposts should be recognised by the proposed Australian Aged Care Commission (AACC) which will have a role in monitoring, reporting and assessing costs and recommending a scheduled set of prices, subsidies and a rate of indexation for approved aged care services. Healthy ageing close to home will assist in reducing preventable hospital admissions but all elderly people must have regular access to primary care and support systems (including transport) in the country. In rural areas it is impractical and inefficient to separate aged care and health care. Flexible funding models that are developed with the community to make the best use of the health and aged care facilities and health professionals living locally have already shown their worth and should continue to be expanded. Block funding may be required where thin markets mean that private practice and not-for-profit services are not viable.

7. Rural placements for health professionals

Positive experiences in rural practice for students and new graduates strongly influence health professionals to choose to work in rural areas. A strong rural pathway which allows students with an interest in rural careers to have an opportunity and, once graduated, to stay rural is essential to maximising every opportunity to attract and retain members of the future rural health workforce. Graduates from UDRHs and Rural Clinical Schools are starting to constitute the intern intake in large regional hospitals.

There are two major issues: to ensure equity of opportunity for students in all health professions when it comes to rural placements; and to ensure an integrated scheme of rural placements for all health graduates.

The first requires the establishment of a collaborative system engaging universities, TAFEs, clinical practices and clinicians, and health and related sector organisations in rural areas to provide undergraduate rural placements on an equitable basis across the professions and between universities. Such a scheme should include:

- identification and funding to address infrastructure deficits, eg teaching facilities and accommodation;
- extension to allied health and nursing of short-term scholarships for familiarising students with rural areas with appropriate funding for travel, accommodation and living expenses; and
- support (including remuneration) for the preceptors and mentors supervising students.

The second proposal - for integrated graduate rural placements - requires a rapid expansion of Health Workforce Australia's program and particularly its Integrated Regional Training Networks. The Alliance stands ready to work with Health Workforce Australia and other interested parties to develop systems for collaborative vocational placements for health graduates in rural areas that recognise and build on the work of agencies already demonstrating success in the area.

In both of these schemes, students and graduates who have demonstrated a commitment to rural practice or who are of rural origin should be given preferential entry and more opportunities for pursuing a rural training pathway.

This will help bridge the current gap in the rural pathway from university graduation to future work where potential rural health workers may be lost to the city if rural areas do not have the capacity and resources to support them.

8. Mental health

The Alliance welcomes the current focus on improving mental health services, but is concerned about the extent to which the various new initiatives proposed will improve mental health outcomes in the bush. The higher rates of completed suicide in regional and remote areas, especially the existence of known suicide hot-spots, attest to continued unmet need.

The Alliance welcomes the establishment of a National Mental Health Commission as an executive agency within the Department of Prime Minister and Cabinet portfolio to ensure quality, accountability and innovation in mental health services. Access to high quality mental health care is the right of all Australians including those who live in the bush.

We call on the Prime Minister to ensure that this Commission investigates, plans for and analyses mental health services for their impact on the unmet mental health care needs of the people who live in rural communities. The National Report Card on Mental Health and Suicide Prevention must include a report on mental health outcomes by remoteness. It must monitor the effectiveness of new and existing programs in reaching people in rural communities over time. Ongoing or emerging shortfalls in mental health care and outcomes for rural people must be promptly referred for action by State and Commonwealth Governments.

It is of great concern to the Alliance that the shortage of GPs and mental health professionals across the disciplines in rural areas means that Medicare programs cannot meet rural mental health needs. Even flexible funding programs such as local coordination of care for people with severe, persistent mental illness and complex care needs, as outlined in the Federal Budget 2010-11, will be challenging to implement in many under-served rural communities.

Increasing numbers of regional specialist centres for mental health (such as EPPIC and *headspace*) will make a welcome contribution to mental health service capacity in the region, especially if outreach services such as visiting medical and allied health specialists and telehealth are possible. However, best practice will still involve consultations with health professionals on the ground, complemented by online support with consultations and ongoing care. Local health professionals such as practice nurses and community workers will continue to provide frontline mental health in many rural communities, and they will need mental health care education and support to be effective.

The Alliance welcomes additional funding to boost the support available through crisis hotlines, helplines for men and ‘Mental Health First Aid’ training provided in the 2010-2011 Federal Budget. The commitment to expand community mental health services through more personal helpers and mentors and respite services in 2012 also has the potential to provide for better local level mental health support.

The key contributor to lower access to mental health services for the third of the Australian population who live in rural areas is the relative scarcity of psychologists. The success of the Government’s drive to increase the number of doctors outside major cities by assisting students of rural origin to study medicine suggests a model that may be able to be replicated to increase the number of psychologists in regional and remote areas.

Wherever specific scholarships or similar investments are made for rural mental health, the recipients should be eligible for mental health courses that are relevant to rural practice, participate in rural

placements and supported where desired in pursuing a career and related activities in rural areas and/or on rural topics.

9. Local control of integrated primary care in rural areas

The Alliance re-affirms its support for greater local control and integration of health care, based on relatively small areas which reflect communities of interest. Sectors which must be involved include aged care and primary and community care funded by both the Commonwealth and the States/Territories. The Alliance continues to advocate for primary care and hospital (acute and subacute) care to be very closely aligned in rural areas, with the boundaries of such systems matching whenever possible. The body responsible for the local management of primary care in each area must have adequate funding to enable it to plan services, identify service gaps, address workforce shortages and engage in direct service delivery when appropriate.

Even the more remote areas which have a small number of health, aged care and social service personnel are within the boundaries of various State, national and professional networks: local authorities, Medicare Locals, LHNs, Regional Training Providers, Regional Development Australia (RDAs) etc. These boundaries should be aligned wherever possible through national and jurisdictional partnerships. This will encourage collaboration among such entities, and ensure that the small number of professionals available locally are not 'burned out' by liaison with and contribution to such organisations. One of the existing networks should be given responsibility to take the lead role in organising collaboration among local agencies.

The governance of local health entities must engage community leadership, including local government and RDA committees. The Alliance proposes that the Minister for Regional Development should require all RDA committees to be involved in improving health outcomes and health-related services in their area. This could lead to collaboration across regions and States and to the delivery of potentially valuable regionalised health initiatives through the RDA.