National Rural Health Alliance

2021–22 Pre-Budget Submission

29 January 2021

… healthy and
sustainable rural,
regional and remote
communities

National
Rural Health
Alliance

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... healthy and sustainable rural, regional and remote communities

29 January 2021

The Hon Josh Frydenberg MP
Treasurer
Parliament House
CANBERRA ACT 2600

Dear Treasurer

National Rural Health Alliance—2021–22 Pre-Budget Submission

The National Rural Health Alliance (the Alliance) is pleased to provide a submission for the 2021–22 Federal Budget. The Alliance is the peak body for rural and remote health in Australia. We represent 44 member bodies (see Appendix 1), and our vision is for healthy and sustainable rural, regional and remote (rural) communities.

OVERVIEW

Rural, regional and remote Australia is not only home to more than seven million Australians, it is also the source of much of the nation's economic contribution with around two thirds of Australia's export earnings come from regional industries such as agriculture, tourism, retail, services and manufacturing[1].

The Australians who live in rural, regional and remote Australia enjoy the benefits of living in smaller communities with a strong sense of community spirit, less congestion and, depending on location, more affordable housing. The Household, Income and Labour Dynamics in Australia (HILDA) survey found that Australians living in towns with fewer than 1,000 people generally experienced higher levels of life satisfaction than those in urban areas and major cities.[2]

A major disadvantage to rural living is, however, reduced access to services and in particular access to health services. On average, 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 with people living in metropolitan areas.[3] Despite there being a high level of awareness of the often significant disparities in health outcomes between urban and rural Australia, health outcomes for rural Australians have not been consistently improving over time, but rather are stagnating or, in some instances, declining.

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Rural and remote Australians recognise that they cannot always have ready access to the level of service that metropolitan Australians enjoy, but they should have access to quality and affordable health care which does not compromise the standard of care they receive or their health outcomes.

The National Rural Health Alliance believes that all Australians, wherever they live, should have access to comprehensive, high-quality, accessible and appropriate health services, and the opportunity for equitable health outcomes. The Alliance does not consider that poor health or premature death should be an accepted outcome of living in rural, regional and remote Australia.

The Alliance has three overarching 2021-22 Pre-Budget proposals targeting rural, regional and remote Australian communities, each with a number of proposed initiatives underneath them. The first overarching proposal is for the development of a new National Rural Health Strategy and Implementation Plan. The second proposal is for a focus on alternative funding for innovative models of care. The third proposal involves strengthening health system access and telehealth in the bush.

A summary of the Alliance's proposals and expected costs over the forward estimates are found on the following page. Further details of each proposals can be found at Appendix 2.

Yours sincerely

Dr Gabrielle O'Kane
Chief Executive Officer

References:

[1] Australian Government Department of Infrastructure, Transport, Regional Development and Communications https://www.regional.gov.au/regional/

[2] Wilkins R 2015. The Household, Income and Labour Dynamics in Australia Survey: selected findings from waves 1 to 12. Melbourne: Melbourne Institute of Applied Economic and Social Research.

[3] Australian Institute of Health and Welfare 2019. Rural & remote health. Cat. no. PHE 255. Canberra: AIHW. Viewed 22 December 2020, https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health

SUMMARY OF PROPOSALS – PRE-BUDGET SUBMISSION 2021-22

Objectives	Why this matters	Proposed work elements	Resources
1. NATIONAL RURAL HEALTH STRATEGY			
(A) Development of Strategy and Implementation Plan	Continued disparity in health outcomes by remoteness Lack of overarching Commonwealth framework to address this inequity	Lead development of the Strategy and Implementation Plan with wide consultations Develop a set of goals, priorities and enablers for reform over the short, medium and long term	$1,525,820
(B) Launch of Strategy and Implementation Plan	Need for definitive actions to achieve rural health targets Systems approach to enable optimal resource allocation and usage	Promote awareness of Strategy and Implementation Plan	$381,340
(C) Ongoing review and evaluation	Accountability against measurable targets Efficient use of finite resources	Annual review and reporting Five- and ten-yearly evaluation	$586,500[a]
2. Funding models for rural, regional and remote areas			
(A) Alternative funding for innovative models of care	Current funding models: - incentivise acute care - constrain flexibility of employment and scope of practice - limit team-based care - present barriers to rural and remote practice	Conduct trials of alternative models of funding in self-selected rural and remote communities Build community partnerships and local capacity	$2,500,000
(B) Facilitate effective change management towards alternative funding models in general practices	Authentic co-design essential to develop local funding solutions and harness the voice and leadership of rural and remote primary care	Conduct a series of workshop-based stakeholder engagement activities in areas of identified need Report on how to implement alternative funding models rurally	$311,880
(C) Continue funding Section 19(2) Exemptions	Section 19(2) Exemptions fund the improvement of primary care services in rural communities Ongoing funding will strengthen viability of primary care and improve patient access	Extend the Memoranda of Understanding under the Section 19(2) Exemptions program to December 2023	(Indeterminate)[b]
3. Health system access and telehealth in the bush			
(A) Create robust patient end-services	Telehealth has huge potential to increase access to healthcare in rural Australia MBS funding enables specialist care via telehealth, with support from a local clinician This model has potential for expansion	Lead a rapid review to explore the current utilisation of patient end-services and opportunities for expansion	$45,250
(B) Rural recruit-assist	Rural health professionals often need to manage recruitment, training and retention of new staff but lack these skills Support for small private businesses could support an increase in recruitment and retention of rural health workforce	Recruit-assist employee funded for two years to assist rural health businesses recruit, train and retain new staff	$121,900

a. This would cost $293,250 per annum over the Forward Estimates – ongoing for the life of the Strategy; b. The cost of extending the Section 19(2) Exemptions is excluded due to lack of historical figures for accurate estimates

PROJECTED FUNDING REQUIREMENT OVER THE FORWARD ESTIMATES (2021-22 TO 2024-25)

Proposed elements	2021-22	2022-23	2023-24	2024-25	Total
1. National Rural Health Strategy					
(A) Development of Strategy	$880,900	$644,920	-	-	$1,525,820
(B) Launch of Strategy	-	$381,340	-	-	$381,340
(C) Ongoing review and evaluation	-	-	$293,250	$293,250	$586,500
2. Funding models for rural and remote areas					
(A) Alternative funding for innovative models	$1,250,000	$1,250,000	-	-	$2,500,000
(B) Facilitate change management	-	-	$155,940	$155,940	$311,880
(C) Extend Section 19(2) Exemptions	-	-	-	-	(Indeterminate)
3. Health system access					
(A) Patient end-services review	$45,250	-	-	-	$45,250
(B) Rural recruit-assist	$121,900	$121,900	-	-	$243,800
Total	$2,298,050	$2,398,160	$449,190	$449,190	$5,594,590[a]

a. This excludes the cost of extending the Section 19(2) Exemptions due to lack of historical figures for accurate estimates.

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APPENDIX 1: MEMBER BODIES

National Rural Health Alliance 2021

44 organisations with an interest in rural and remote health and representing service providers and consumers:

Allied Health Professions Australia Rural and Remote	Federation of Rural Australian Medical Educators
Australasian College for Emergency Medicine (Rural, Regional and Remote Committee)	Isolated Children's Parents' Association
Australasian College of Health Service Management (rural members)	National Aboriginal Community Controlled Health Organisation
Australasian College of Paramedicine	National Aboriginal and Torres Strait Islander Health Worker Association
Australian College of Midwives (Rural and Remote Advisory Committee)	National Rural Health Student Network
Australian College of Nursing - Rural Nursing and Midwifery Community of Interest	Pharmaceutical Society of Australia Rural Special Interest Group
Australian Chiropractors Association Aboriginal and Torres Strait Islander Rural Remote Practitioner Network.	RACGP Rural: The Royal Australian College of General Practitioners
Australian College of Rural and Remote Medicine	Regional Medical Specialists Association
Australian General Practice Accreditation Limited	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Australian Healthcare and Hospitals Association	Royal Australian and New Zealand College of Psychiatrists
Australian Indigenous Doctors' Association	Royal Australasian College of Medical Administrators
Australian Nursing and Midwifery Federation (rural nursing and midwifery members)	Royal Australasian College of Surgeons Rural Surgery Section
Australian Physiotherapy Association (Rural Advisory Council)	Royal Far West
Australian Paediatric Society	Royal Flying Doctor Service
Australian Psychological Society (Rural and Remote Psychology Interest Group)	Rural Doctors Association of Australia
Australian Rural Health Education Network	Rural Dentists' Network of the Australian Dental Association
Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine	Rural Health Workforce Australia
Congress of Aboriginal and Torres Strait Islander Nurses and Midwives	Rural Optometry Group of Optometry Australia
Council of Ambulance Authorities (Rural and Remote Group)	Rural Pharmacists Australia
CRANAplus	Services for Australian Rural and Remote Allied Health
Country Women's Association of Australia	Society of Hospital Pharmacists
Exercise and Sports Science Australia (Rural and Remote Interest Group)	Speech Pathology Australia (Rural and Remote Member Community)

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APPENDIX 2: ADDITIONAL INFORMATION

Contents

Proposal 1 – National Rural Health Strategy

The National Rural Health Alliance is calling for the development of a new National Rural Health Strategy and Implementation Plan. The Strategy would build on previous Strategies and Frameworks for rural health. Significantly, the proposed Strategy would include outcomes measures and targets with a requirement for annual reviews and reporting. A critical element missing from previous frameworks has been an implementation plan that includes specific targets and an evaluation schedule at five and ten year intervals. Consideration could be given to the development of minimum service access standards for rural and remote Australia as part of the Strategy.

A new strategy for rural and remote health is also needed to respond to the significant health challenges which have emerged in recent years. The health effects of climate change, in particular the frequency and intensity of bushfires, drought, temperature extremes and other weather events should be incorporated as a focus of any new health strategy. This is particularly relevant for rural and remote Australians who are disproportionately affected by these events.

Likewise, since the development of previous strategies and frameworks, the impact of the COVID-19 pandemic has exposed the potential vulnerability of rural and remote Australians where there is a lack of capacity in the health system to respond to events such as pandemics, including through workforce shortages and appropriate facilities.

The National Rural Health Alliance is proposing that the Alliance be engaged to develop the Strategy and Implementation Plan over the 2021-22 financial year with completion at the end of 2022. The Alliance would also be responsible for the annual reporting on the delivery of the Strategy and Implementation Plan over the forward estimates and into the future and five yearly and ten yearly evaluations beyond the scope of the forward estimates.

Noting that responsibility for the public funding of health in Australia is shared between the Australian Government and state and territory governments, endorsement of the Strategy by the Health Council would be desirable.

Full details of the imperative for and key issues to be addressed in the Strategy and Plan are outlined further in this submission. A fully costed budget would be dependent on the nature of the organisation developing the Strategy, the timeframe and the agreed scope and frequency and location of consultations. The National Rural Health Alliance estimates that the cost of development of the Strategy and Implementation Plan would be in the vicinity of $2.5 million.

Background

The first National Rural Health Strategy was released in 1994. There have been various updates and revisions of the Strategy over the ensuing years, with the last being the National Strategic Framework for Rural and Remote Health, endorsed by Health Ministers in November 2011. The Framework was developed through a consultative process that included significant input from the Alliance and other rural and remote health stakeholders.

While the Framework can still be accessed through the Department of Health website, it is not being utilised as a strategic driver of health policy. No reporting has been undertaken against the goals of the Strategy nor has an evaluation of the effectiveness of the Framework in addressing its goals been undertaken. At the time, the Alliance called for a National Rural and Remote Health Plan to be developed to operationalise the goals set out in the Framework, but this key driver for outcomes was not implemented. Therefore, the 2011 Framework has not been actioned in a consistent or

comprehensive way. Nor are there any national reports on progress against the Framework, and no action has been taken to update it. The current Framework is also principally focused on the medical workforce and there is a pressing need to invest in and support the nursing and allied health workforce.

There is also currently a range of programs and incentives grouped under the banner of the Stronger Rural Health Strategy. The Strategy focuses on the rural health workforce, which while critical, is only one element of addressing rural health outcomes. Further, this Strategy while seeking to meet some workforce needs, is not a comprehensive or integrated policy approach, but rather demonstrates gaps and inconsistencies in addressing rural and remote workforce needs.

The Case for a National Rural Health Strategy

As noted, on average, 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 with people living in metropolitan areas.[4] In considering the need for a new National Rural Health Strategy, the Alliance has looked at the health data for Australians living in rural, regional and remote Australia twenty years ago and today for any evidence of significant improvement in the health outcomes of rural and remote Australians.

The Australian Institute of Health and Welfare (AIHW) produces annual reports on Australia's health. Examining the AIHW *Australia's Health 2000*[5] and AIHW *Australia's Health 2020*[6], while often not directly comparable in terms of data reported, the reports show a consistent pattern in health outcomes for rural and remote Australians.

Rural Australians are consistently overrepresented in data on health risk factors including as 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, increased mortality including from chronic diseases remains higher in rural communities, increasing with increasing remoteness.

Despite the release of the first National Rural Health Strategy in 1994, there are still troubling and unacceptable health outcomes for rural, regional and remote Australians in 2020.

- Potentially Preventable Hospitalisations (PPH) - PPH are specific hospital admissions that potentially could have been prevented by timely and adequate health care in the community. PPH rates increase with increasing remoteness and socioeconomic disadvantage, and the gaps may be widening7.
- After adjusting for age, the total burden of disease increases with increasing remoteness with the total burden rate in remote and very remote areas 1.4 times as high as major cities. This pattern was mostly driven by fatal burden (years of life lost due to premature death). In remote and very remote areas, rates were 1.7 times as high as major cities, while the non-fatal burden was 1.2 times as high.8
- For most disease groups, total burden rates increase with increasing remoteness[9]. Whilst there is some variation by disease, a clear trend of greater burden rates can be seen with increasing remoteness 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[10]. 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.[11] Indigenous Australians have lower life expectancies, higher rates of chronic and preventable illnesses, poorer self-reported health, and a higher likelihood of being hospitalised than non-Indigenous Australians[12]. Any Strategy will need to consider the particular needs of Aboriginal and Torres Strait Islander Australians, including addressing the other determinants of health including social, commercial and cultural.

Access to health care

People living in rural Australia and particularly in remote and very remote areas have poorer access to health services than people in major cities. They may have to wait for long periods of time and travel long distances to access health professionals. Rural and remote Australians often incur additional financial costs associated with travelling to access health services including the cost of travel and accommodation as well as loss of income due to time away from work. Costs can also include the social and emotional costs of being away from friends, family and community which can increase stress and contribute to poorer health outcomes. The range of services they have access to is also more limited, along with choice of practitioner. 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)[13]. Increased access to and use of telehealth can mitigate some of the challenges in accessing healthcare for rural and remote Australians, but should not be seen as the ultimate panacea for inadequate access to health care. Telehealth should always be a supplement, not a substitute for quality, accessible healthcare.

Workforce

Despite a range of initiatives and programs being in place over the last two decades, there are still significant issues with attracting and retaining a health workforce for rural and remote Australia. For nearly all types of health professions there is a marked decline in the rate of clinical full-time equivalent (FTE) practitioners per 100,000 population once outside major cities. This includes other health professionals including dentists, occupational therapists, optometrists, pharmacists, podiatrists and psychologists. Similar to 2000[14], the FTE rate for nurses and midwives is higher in remote and very remote areas compared with major cities, inner regional and outer regional areas reflecting that many health services in remote areas are undertaken by nurses[15].

In 2018, there were more registered clinical FTE health professionals in major cities than in all regional and remote areas of Australia combined (more than 347,000 FTE clinicians working in major cities compared with 115,000 in all other remoteness areas).[16]

The Rural Doctors Association of Australia note that the difficulties attracting health professionals to rural and remote areas are not new and there have been many programs over decades seeking to address the problem, concluding that “Nurses shouldn’t be left unsupported, country hospitals shouldn’t be left without doctors, and ambulances shouldn’t have to take critical patients to hospitals without doctors”.[17]

National Rural Health Strategy and Implementation Plan

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 health. The current strategies and frameworks are not comprehensively fit for purpose. Critical to the success of a future strategy will be robust accountability measures such as the inclusion of agreed targets, regular reporting against those targets, an implementation plan and evaluation.

In an article published online by the Medical Journal of Australia, Professor John Wakerman, Associate Dean of Flinders Northern Territory in Darwin and Emeritus Professor John Humphreys, from Monash University's School of Rural Health, wrote that the lack of progress in improving rural and remote health outcomes was largely due to a lack of an overarching strategy that draws on available evidence to guide its development, implementation and evaluation. They argue that while we know what works in rural and remote communities, the lack of a national strategic framework has led to a patchwork of responses without any evaluation of their effectiveness.[18]

A new National Rural Health Strategy should acknowledge that rural and remote communities are different to metropolitan communities and that each rural or remote community has particular circumstances and needs. Any new Strategy must address the lack of progress in improving the health outcomes for Australians living in rural, regional and remote Australia. It should consider the barriers and incentives for attracting and retaining a rural health workforce, how to incentivise preventive health as well as acute care and how to fund and administer models of care that are flexible and responsive to local needs.

A new National Rural Health Strategy will also need to incorporate elements of previous strategies and frameworks addressing rural health, as well as relevant aspects of wider health Strategy documents with a focus on particular groups or health priorities.

The Department of Health is currently engaged in the development of the National Preventive Health Strategy, the Primary Health Care 10 Year Plan, has oversight of Stronger Rural Health Strategy, and the Australian Government is a major funder of health in Australia.[19] However, due to the shared responsibility for health funding in Australia between the Australian Government, state/territory governments, consumers, private health insurers and non-government organisations, buy-in to the Strategy by these stakeholders will be important for its success.

A new National Rural Health Strategy would also provide the structure and guidance for governments to align, prioritise and optimise future policies and investments in rural health.

Conclusion

The longstanding gap in access to services and poorer health outcomes for rural, regional and remote Australians should not be an accepted consequence in living in rural Australia. It is widely acknowledged that across a range of key indicators the health outcomes for rural and remote Australians continue to be poorer than for Australians living in major cities. This is not acceptable, and governments at all levels in Australia should be working together to overcome this disadvantage.

To this end, the National Rural Health Alliance is proposing the development of a National Rural Health Strategy which addresses the actions required to improve the health outcomes for rural and remote Australians, including outcome measures and targets, developing an implementation and evaluation plan and annual reviews and reporting.

The National Rural Health Alliance is well-placed to develop the Strategy and has extensive links to the rural health sector through its Alliance members, Friends of the Alliance, universities and other research bodies and other key rural and regional stakeholders. The Alliance can leverage off these sector connections to ensure broad consultation from grass-roots through to peak bodies. The Alliance is a non-government body with a capacity to be innovative and can operate without the constraints of being a government agency. Development by the Alliance would support the perception of the rural health sector having ownership of the Strategy, rather than it being a government document.

It will be important that there is close engagement with the National Rural Health Commissioner, Aboriginal and Torres Strait Islander health care providers and health professionals and professional bodies, educators, funders, researchers and consumers.

It is important to acknowledge the work currently underway in developing the Primary Health Care 10 Year Plan and other relevant reports and initiatives including reports by the previous National Rural Health Commissioner Professor Paul Worley. Close engagement with the current National Rural Health Commissioner will also be a key element of the development of a new Strategy.

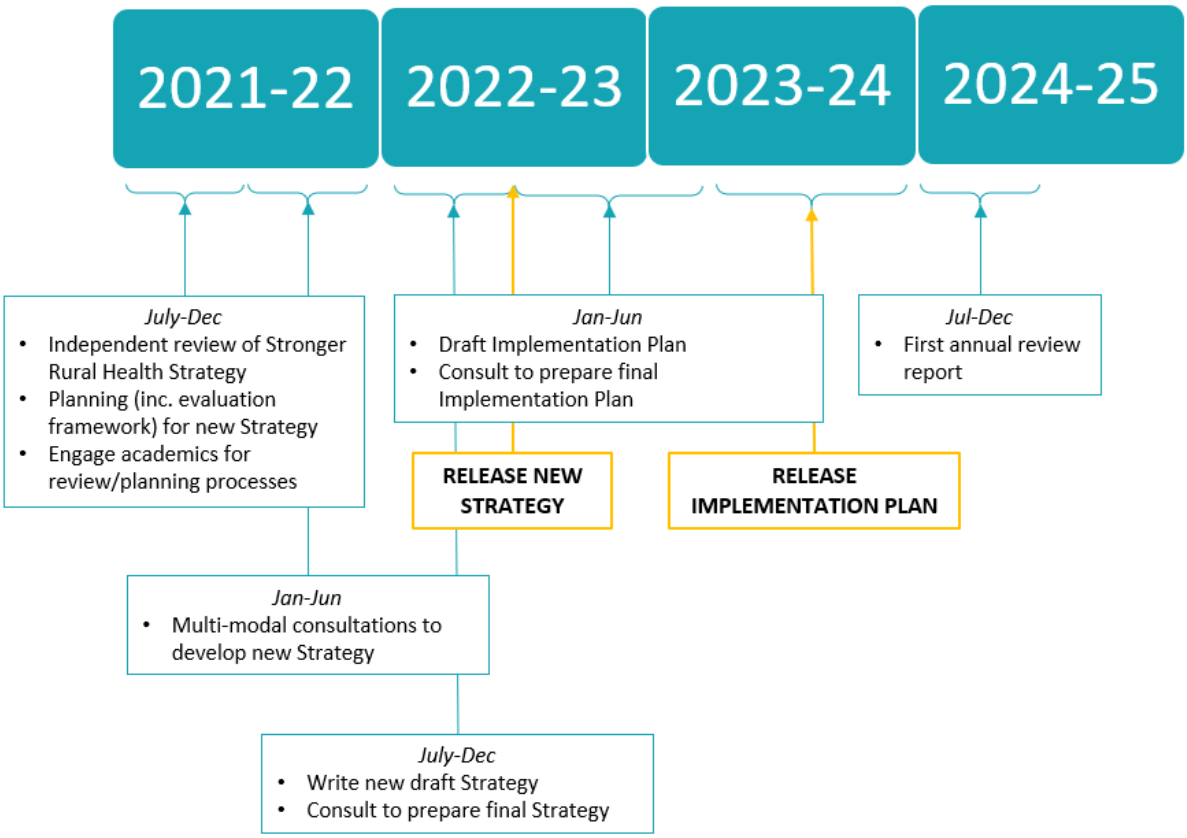
As noted above, due to the shared responsibility for health funding in Australia between the Australian Government, state/territory governments, consumers, private health insurers and non-government organisations, buy-in to the Strategy by these stakeholders and accountability for its delivery by government will be important for its success.

Timeframe

The National Rural Health Alliance is proposing that the development of the Strategy and Implementation Plan be developed over the 2021-22 financial year with completion by the end of 2022. There would then be scope for the Government to consider how the Strategy and Plan could be endorsed by governments and an official launch.

Consultation on the development of the Strategy would commence following the appropriation of funding in the 2021-22 Budget and the passage of the enabling legislation. It is anticipated that a draft Strategy and Implementation Plan be available for consultation by June 2022, with the Final Strategy and Implementation Plan finalised by the end of 2022 (noting that this timeframe may be affected by circumstances including the ongoing effect of the global pandemic or Federal or state elections).

Further information on the proposed timeline is outlined on the following page.



Budget

The budget for the development of the Strategy and Implementation Plan will be dependent on a range of variables including:

- the nature and number of consultations i.e., whether consultation is conducted face-to-face or virtually and whether there are two rounds of consultation i.e., initial consultation and another round of consultation on a draft Strategy and Implementation Plan;
- the number of stakeholders consulted and whether the consultation costs of stakeholders or selected stakeholders would be met by the Government;
- additional staffing would be required to develop the Strategy and Implementation Plan including organising consultations, drafting and editing, promotion and publicity and launch and liaison with government,
- if there was an identified need to commission specific research or conduct surveys,
- costs incurred across different organisations such as any Departmental costs or official launch costs.

The Alliance estimates that, subject to the caveats outlined above, a National Rural Health Strategy and Implementation and Evaluation Plan could cost in the vicinity of $2.5 million.

A detailed costing is provided on the following pages (8-9).

Budget	2021-22	2022-23	2023-24	2024-25
Item	**Amount ($)**			
Development of Strategy and Implementation Plan				
2.0 FTE research officers, $100 000 pro rata, two years • **workshops: research locations, produce briefings/agendas, collate outcomes** • **public consultations: prepare stimulus material, collate responses** • **individual consultations: prepare briefing material/agendas** • **analyse qualitative data from Round 1 and Round 2 consultations** • **prepare draft and final Strategy and Implementation Plan** • **ongoing review and evaluation of Strategy**	200 000	200 000		
Research officers – personnel on-costs (20% of salary)	40 000	40 000		
University consultation regarding research and review methodology	10 000	10 000		
2.0 FTE event officers, $90 000 pro rata, 1 year • **manage workshop logistics (inc. travel, accommodation, venue hire, audio-visual, catering, speakers, facilitators)** • **manage consultations with council organisations, consumer groups, individual experts**	180 000			
Event officers – personnel on-costs (20% of salary)	36 000			
0.2 FTE IT/design officer, $90 000 pro rata, 6 months • **design Strategy** • **publish digital communication material** • **manage public consultation website**		9 000		
IT officer – personnel on-costs (20% of salary)		1 800		
Round 1 consultation (incl. travel, facilitator, venue, catering)	300 000			
Round 2 consultation (incl. travel, accommodation, facilitator, venue, catering)		300 000		

Budget	2021-22	2022-23	2023-24	2024-25
Launch of Strategy and Implementation Plan				
Launch event (travel, accommodation, speakers, catering, venue, comms)		200 000		
0.8 FTE event officer, $90 000 pro rata, 3 months		18 000		
Event officer – personnel on-costs (20% of salary)		3 600		
Promotion of Strategy (comms material, printing)		80 000		
1.0 FTE media officer, $100 000 pro rata, 3 months		25 000		
Media officer – personnel on-costs (20% of salary)		5 000		
Ongoing review and evaluation				
2.0 FTE research officer, $100 000 pro rata, two years			200 000	200 000
Personnel on-costs (20% of salary)			20 000	20 000
University consultation regarding research and evaluation methodology			10 000	10 000
Broad consultation informing review and evaluation			25 000	25 000
Overarching costs	766 000	892 400	255 000	255 000
NRHA administrative cost (15% total costs)	114 900	133 860	38 250	38 250
Total	**880 900**	**1 026 260**	**293 250**	**293 250**
Grand Total	**2 493 660**			

Proposal 2 – Funding Models for Rural, Regional and Remote Areas

PROPOSAL 2(A) – A Focus on Alternative Funding for Innovative Models of Care

Background

In August 2019, the Minister for Health, the Hon Greg Hunt MP, announced Australia's Long Term National Health Plan for health system reform. This included the development of the Primary Health Care 10 Year Plan as an important piece of work to deliver the flexible care model of Voluntary Patient Enrolment.

The 2020-21 Federal Budget provided funding to the National Rural Health Commissioner to develop local, integrated, multidisciplinary models of primary care through a co-design process with local rural and remote communities. The Primary Care Rural Innovative Multidisciplinary Models (PRIMM) grant will design and consult on feasible solutions to address specific primary health care service issues within local rural communities and regions.

The National Rural Health Alliance supports the projects to develop new models of primary care, including new approaches to service design, consultation, data analysis and financial model design. However, the Alliance believes that to achieve more comprehensive and structural change to models of care, there needs to be a stronger focus on alternative models of funding.

The Case for Alternative Models of Funding

The current funding arrangements, particularly the funding responsibilities split between the Australian Government and state and territory governments, incentivise acute care to the detriment of primary care. Further, the current funding arrangements constrain flexibility in terms of employment and scope of practice, limit the capacity for team-based models of care and present financial and professional barriers to health professionals seeking to practice in rural, regional and remote Australia.

The Alliance is proposing that the number and scope of the projects be enhanced to incorporate trials of alternative models of funding to address the current barriers to innovative models of care. Options which could be trialled to reduce the health system's reliance on fee-for-service models include: modified fee-for-service; incentive programs; activity-based funding and bundled payments; capitation; blended funding; or pooled funding.

While the focus of the PRIMM grants is welcomed and supported by the Alliance, genuinely innovative and meaningful reform will be difficult without changes to the way health funding is delivered in rural and remote communities. Expanding the number and scope of the PRIMM grants or developing a separate program of trial sites would provide an opportunity to trial alternative funding arrangements in a range of rural and remote settings.

Conclusion

While the Australian Government's support for projects to trial new models of primary care is acknowledged and appreciated, the National Rural Health Alliance considers that the current scope of these projects could be expanded. The Alliance is seeking additional Australian Government

funding to support trials of innovative models of primary care which incorporate alternative funding approaches. The Alliance considers that meaningful reform to overcome the current disincentives to team based care and rural health care practice will not be possible without incorporating changes to funding arrangements. The trials of new models of primary care presents an opportunity to trial not only innovative approaches to governance and program management, but also for alternative approaches to funding.

Budget and Timeframe

The current budget for the PRIMM grants is $2.4 million. It is proposed that a similar amount, $2.5 million, be allocated to additional trials of alternative funding models for delivery of healthcare to rural and remote Australians over the two years of 2021-22 and 2022-23.

Proposal 2(B) – Change Management Facilitation

Background

Improving the health outcomes of people outside Australia's major cities is desperately needed. Attracting and retaining a range of health professionals (including allied health providers) in these areas will help address this challenge by ensuring greater access to a broad range of health services.

In rural, regional and remote Australia, the fee-for-service model puts the health workforce at risk due to market economics driving fewer services and less income than in major cities. Health providers in these communities may be resilient and focussed on the contribution they make to their patients. However, being viable as a business is often difficult.

Due to the way rural and remote workforce funding is currently structured, rural health professionals can draw upon a multiplicity of funding sources in addition to Medicare fee-for-service payments. This includes the Workforce Incentive Program, Practice Incentive Program and other Commonwealth funding sources, as well as state-based funding. While the Alliance welcomes all of this funding, the complexity in its provision makes it difficult for rural health professionals to utilise the various payments as effectively as possible. Furthermore, attracting and retaining students to rural areas is made more difficult by the large number of seemingly disconnected educational scholarships, placements and training pathways.

The Case for Change Management

Alternative models of funding could reduce the complexity of funding and make it easier for health professionals to work rurally. An example is to pool funding together from the various Commonwealth and state-based funding streams for practising health professionals. This type of change would help rural practitioners who need to work across different sectors to earn a living, such as private practice, non-government organisations and hospital-based practice. For these practitioners, pooled funding would enable more streamlined access to funding from private health insurance, compensable patient sources, the National Disability Insurance Scheme and the aged care system.

Alternative funding models may also reduce the administrative burden on health providers and their businesses, as well as shift away from incentivising the number and type of services provided. Alternative funding models open the door to new, innovative models of care that are multidisciplinary, team-based, and which deliver continuity of care for the patient.

Yet, changing the way that health providers view funding is difficult, largely due to the way the predominant, fee-for-service model is embedded. Additionally, all communities have different demographics and health needs, which requires the funding and service delivery model to be sufficiently adaptable to avoid a 'one-size-fits-all' approach to health care in rural and remote communities.

Proposal to Catalyse Change

To catalyse a shift in the way health professionals in rural Australia think about alternative funding models, the Alliance proposes commencing the change-management process at the grass-roots level with a program of community engagement activities. Such engagement would connect health-sector funders, service providers and local stakeholders in several rural locations. Participants might include: federal and state or territory government departments of health, primary health networks, local hospital networks, Aboriginal community-controlled health services, local governments, non-government organisations, general practitioners, other privately practising health professionals (e.g., allied health), and health consumers.

The engagement would be delivered in a workshop format, administered and facilitated by the Alliance (in consultation with partners as required), and follow principles of co-design.
The workshops would generate qualitative information on potential opportunities and local solutions to the provision of sustainable healthcare in rural Australia utilising alternative models of funding. We also anticipate an exploration of barriers and challenges to progress. The activity would build community linkages, partnerships and aid local capacity building.

This project is anticipated to cost $311,880 over the 2021-22 and 2022-23 financial years, taking into account the following project components:

- research and data analysis to ensure evidence-informed choice of workshop locations and adequate briefing of workshop attendees;
- delivery of six workshops in a mixed face-to-face/virtual format by 30 December 2022;
- partnership with university staff to maximise impact of qualitative workshop data; and
- production of a research report and associated summary document by 30 June 2023.

Budget	**2021-22**	**2022-23**
Item	**Amount ($)**	
Research and planning		
0.4 FTE research officer, $100 000 pro rata, two years • **research workshop locations** • **produce workshop briefing papers** • **collate workshop data into research report** • **write summary document**	20 000	20 000
0.2FTE events officer, $90 000 pro rata, two years	18 000	18 000
Personnel on-costs (20% of salary)	7 600	7 600
University consultation regarding research methodology	10 000	10 000

Budget	2021-22	2022-23
Workshop delivery		
Workshop consultation costs (inc. facilitator, venue, catering, audio-visual, travel, accommodation)	80 000	80 000
Overarching costs	135 600	135 600
NRHA administrative cost (15% total costs)	20 340	20 340
Total	155 940	155 940
Grand Total	311 880	

Proposal 2(C) Extending the Section 19(2) Exemptions Initiative

Section 19(2) of the *Health Insurance Act 1973* prohibits payment of Medicare benefits where other government funding is provided for that service. Under the 2006-07 Budget, the Council of Australian Governments introduced the s19(2) Exemptions Initiative (the Initiative) to improve access to primary health care in rural and remote areas.

Many rural and remote patients have limited access to primary health care services due to the lack of private practices. To address this, many rural and remote public hospitals have employed medical officers, practice nurses and allied health professionals to deliver non-admitted, non-referred services. The Initiative allows exempted sites to claim Medicare Benefits for these services, which would otherwise be funded through another mechanism (such as the National Health Funding Pool).

As of 25 November 2020, 118 active sites across New South Wales, Queensland, Western Australia and the Northern Territory have been approved under the Initiative. These states, as well as South Australia, participate in the Initiative through a bilateral Memorandum of Understanding with the Commonwealth. At present, these MoUs are active until 31 December 2021.

Hospitals, health services, community health centres and multi-purpose services across rural and remote Australia often face difficulty providing adequate primary health care services in their community. In recognition of the funding challenges for primary health care services in rural and remote areas, the longevity of their funding under their MoUs needs to be extended. The Alliance recommends that the active period for public health sites under this Initiative be extended out to 31 December 2023, to enable an additional two years of funding through the Initiative.

The Commonwealth Government's expenditure under the s19(2) Exemptions Initiative in not publicly available. Therefore, the Alliance is unable to determine the amount required over the proposed two-year extension period from 1 January 2022 to 31 December 2023.

Proposal 3 – Health System Access and Telehealth

Proposal 3(A) Trial of Expansion of Patient-End Support Services

Telehealth has enormous potential to improve access to healthcare for rural Australians and huge strides have been made to this end in response to the COVID-19 pandemic. Telephone and video consultations are now provided by many health professionals across the spectrum of care. A series of telehealth Medicare Benefits Schedule (MBS) item numbers exist to enable medical professionals, midwives, and nurse practitioners to provide clinical support to their patients during video

consultations with specialists, consultant physicians or consultant psychiatrists.[20] These are termed patient-end support services and allow access to secondary and tertiary level care where there are geographical barriers.

There is evidence in the research literature that other health professionals can provide specialty care in a similar way. Clients in rural locations have been supported by local clinicians while care is provided via videoconference from a metropolitan area.[21] Alternatively, care has been provided locally with the support of a more specialised clinician in a metropolitan area.[22]

These models increase access to care that would otherwise require outreach, significant travel, or disruption to the patient journey. This is in the context of workforce shortages and difficulty recruiting to specialty positions in rural areas. They are also proposed as a mechanism to build capacity in rural health professionals via professional development and mentoring opportunities.[23] These are key factors in retention of the rural health workforce.[24]

The Alliance proposes that the potential for multi-practitioner telehealth consultations to increase access to healthcare, act as a health workforce recruitment and retention strategy, and enhance continuity and integration of care be further explored. We seek funds to perform a rapid review to assess:

- Uptake and experience of the concept in its current form
- Feasibility of expanding patient-end support services to other health professions
- How this might be achieved in rural primary care (compared with hospital care)
- Potential for use in multi-disciplinary case-conferencing.

Project details:

- Output: rapid review as detailed above
- Completion of the review by 30 June 2022.

Budget	**2021-22**
Item	**Amount ($)**
0.5FTE research officer, $100 000 pro rata, six months	25 000
Personnel oncosts (20% of salary)	5 000
University consultation regarding research methodology	10 000
NRHA administrative cost (15% total costs)	5 250
Total	**45 250**

Proposal 3(B) Rural Recruit-Assist

Government policy and funding focusses on actioning the research that indicates training health professionals in rural locations results in them being more likely to work rurally during their careers. This is evidenced by ongoing funding of the Rural Health Multidisciplinary Training Program (RHMTP), as per the 2020-2021 budget.[25] The recently released independent evaluation of the RHMTP[26], to which the government is yet to comprehensively respond, proposes a future outcome of "increased opportunities for nursing, allied health and medical graduates to work in areas of rural and remote workforce need"[27(p34)], with workforce transition objectives of facilitating "the transition of allied health and nursing graduates (PGY1-4) to rural and remote practice"[28(p35)].

Anecdotally, the Alliance is aware of the difficulties rural health professionals and small business owners face when recruiting to vacancies and attempting to retain staff within their organisations, particularly in primary care. This highlights the importance of ensuring there is congruence between rurally trained and interested health professionals and existing vacancies in areas of rural workforce need. Hence, the Alliance proposes partnering with a Rural Clinical School and/or University Department of Rural Health, along with professional bodies and Primary Health Networks as appropriate, to design a pilot project focussed on recruitment of health professionals to primary care outside of major cities.

Research suggests that employment prospects for the partners of health professionals, and educational opportunities for their children, are important barriers to the recruitment of rural doctors.[29] Evidence also indicates that health professionals possess concerns about isolation and career development opportunities.[30] This project would seek to address the implications of this research.

The project would also consider Cosgrave's "Whole-of-person retention improvement framework"[31]. Her framework highlights the importance of workplace, organisation, role and career factors. These include relationships, access to professional development, supervision, mentoring, networking and opportunities for career progression. Her framework also emphasises community and place-based factors, enabling the development of a sense of place, place attachment and belonging-in-place.

This project seeks to translate research findings into practice to improve the recruitment and retention of rural health professionals. The primary aim is to improve connectivity between small health businesses and suitable workforce candidates. The professions of focus would depend on local need. It is anticipated the outcomes of this project, if positive, might then be scalable for use by the state and territory based on rural health workforce agencies.

This pilot would complement the work of Services for Rural and Remote Allied Health, led by Dr Cath Cosgrave, on the "Attract, Connect, Stay Rural Health Workforce Coordinator Project". This existing work focusses on the community and place components of rural workforce retention and is based on a model successfully implemented in Marathon, Ontario, Canada.[32]

Project components:

- Two years, in a defined geographical area
- Fund an employee to deliver program, working directly with health professionals and health businesses on the ground
- Fund an employee at NRHA to plan and set-up the project, develop program materials, manage it prospectively and evaluate
- Develop materials to allow evidence-informed assistance of small businesses to recruit to their vacancies and embed evidence-informed systems and processes to enable retention
- Travel: recruit-assist employee at partner organisation would need to be able to travel to meet with clients face-to-face, with potential overnight stays depending on nature of the geographical region
- Goal: assist businesses to design their advertisements, create positions, develop supports and benefit packages that are evidence informed to assist with recruitment and retention of staff to increase the health workforce in areas of regional, rural and remote workforce need.

Budget	2021-22	2022-23
Item	**Amount ($)**	
0.6 FTE recruit-assist employee at partner organisation, $100 000 pro rata, two years • **Health professional and business liaison** • **Research, data collection and reporting** • **Collaboration with NRHA and RCS/UDRH where relevant**	60 000	60 000
0.2 FTE research officer at NRHA, $100 000 pro rata, two years • **Project planning** • **Research and development of materials** • **Media and communications** • **Evaluation**	20 000	20 000
Personnel oncosts (20% of total salaries)	16 000	16 000
Travel for recruit-assist employee to meet with health professionals and businesses	10 000	10 000
NRHA administrative cost (15% total costs)	15 900	15 900
Total	**121 900**	**121 900**
Grand total (whole project)	**243 800**	

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