HEALTH EQUITY
FOR RURAL PEOPLE

RURAL COMMUNITY HUBS PROGRAM

HEALTHY
COMMUNITIES
FOUNDATION
AUSTRALIA

REGISTERED CHARITY
acnc.gov.au/charityregister

We live and work on the lands of the First Australians. We pay our respects to Elders past, present and emerging.

THE PROBLEM

Many people experience problems that affect their health that cannot be fixed by the healthcare system. Issues like poor quality housing, domestic violence, unemployment, lack of local economic opportunities, poor access to training and jobs etc have a major impact on people's health particularly in rural and remote towns.

Every day rural GPs spend time referring patients to NSW housing, child protection, community services and other social assistance programs to address problems that may be contributing to poor health. For example, a leaky roof that is causing childhood asthma.

On the other hand, social assistance organisations routinely refer their clients to local community health services for treatment and community development organisations seek input from local health services into priorities and needs.

Primary health and social assistance are two parts of one sector focussed on addressing the factors and conditions that impair the ability of people to live productive and healthy lives.

Together, their focus is on keeping people out of hospital, gaol, the child protection system and getting people into schools, training and jobs.

Despite the importance of integration and multidisciplinary coordination, primary health and social assistance services are often poorly integrated in rural and remote communities leading to fragmentation, declining access to local care, high levels of avoidable hospitalisation and a growing burden of disease.

Our focus on acute and emergency care (hospitals) means that hospitals consume ever-increasing proportions of our national and State budgets. Unless we shift strategy to health and wellbeing, that will mean less money for regional development, education, transport and other social services over time.

> [R]esidents in rural, regional and remote New South Wales have inferior access to health and hospital services, especially for those living in remote towns and locations and Indigenous communities, which has led to instances of patients receiving substandard levels of care.
>
> *NSW Inquiry into Health outcomes and access to health and hospital services in rural, regional and remote New South Wales (2021)*

This is likely to disproportionately impact rural and remote people if action is not taken to improve how we deliver services now.

The NSW Intergeneration Report 2022 concluded that a "focus on keeping people healthy ... is needed to reduce demand for hospital care and keep health spending sustainable, whilst improving health outcomes".

Improving access to local community and primary health care, and social assistance services, in rural and remote communities is now critical.

To do this, we need to bring together health and social assistance in rural and remote communities in a way that reflects the individual needs of different communities.

THE SOLUTION

Rural Community Hubs would work like ServiceNSW and similar one-stop-shop services in other States and Territories..

They would be a single integrated point of entry for rural and remote people to access local social support, primary and community health care, assistance with training and finding jobs, Centrelink services etc while also acting as a community development hub working with local communities to plan and deliver programs and services that contribute to economic development, employment and better health.

Rural Community Hubs would be established in rural and remote towns that are unable to financially sustain independent local social and community health care services.

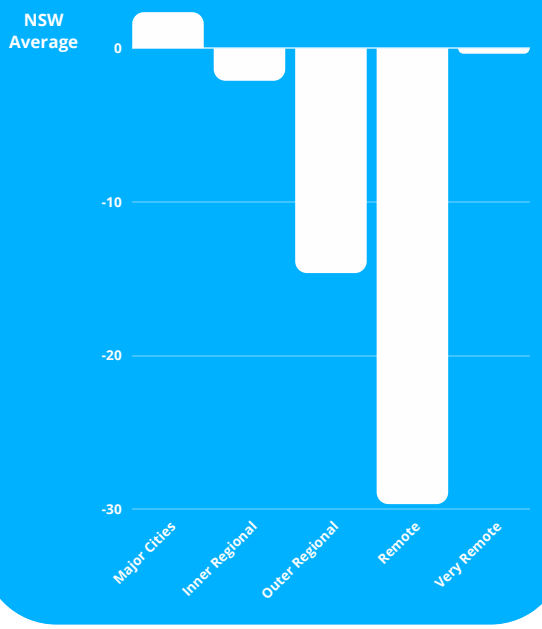
Services would primarily be delivered by locally employed staff with remote services accessible from the Hub at other times.

Each Hub would have a community board to establish a 10 year Community Plan and oversight performance. The Community Plan would address how the Hub would meet minimum performance standards set by each participating government and department.

To overcome the fragmentation of service delivery, and to allow for flexibility in employment models, community boards would contract non-government organisations to manage services on behalf of the local community. As the Hubs would be dealing with personal and private information about citizens, third party management would also be essential to instil confidence in the local community that their privacy will be respected and the Hubs are working to advance their interests.

Rural Community Hub Staffing Model

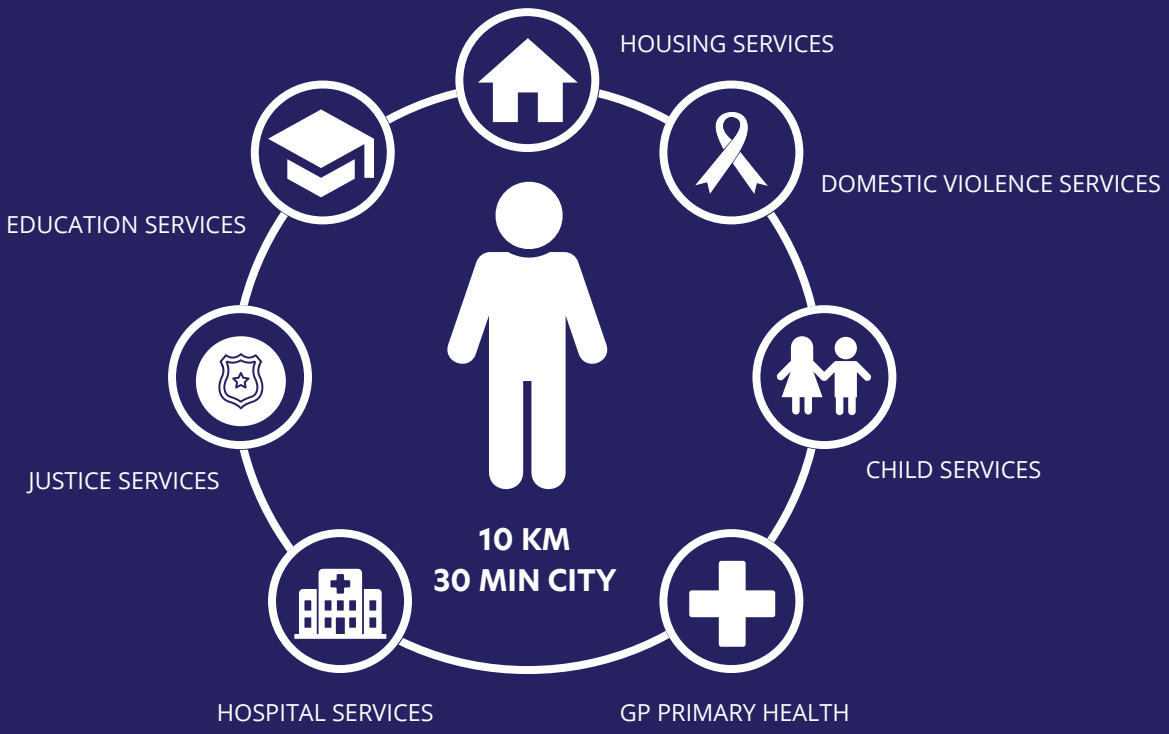
TABLE A - Trend in NSW-Based Public Administration Job Growth between 2006 and 2016 by Remoteness (Variance from the NSW Average)[10]



INEQUITY IN SERVICE ACCESS

30 Minute Cities envisage an environment in which jobs, services and recreational spaces are all accessible within 30 minutes of home.

MAJOR CITIES



While there will never be a 30 min rural or remote town, we can do things better to improve access for these vulnerable communities.

THE BUSH

RURAL COMMUNITY HUBS
EQUITY FOR THE BUSH

Having separate offices for multiple levels of government social assistance and community health functions in rural and remote towns is expensive. It increases the supervision costs for staff located at distance from departmental healthquarters. But delivering services from metropolitan and regional cities to rural and remote towns has contributed to increasing frustration with government due to a decline in understanding of the needs of individual communities which is contributing to fragmentation, duplication and waste.

Rural Community Hubs would create a one-stop-shop for consumer access to community health (health promotion, prevention, low acuity care, aged care and primary health) and social assistance services. Co-locating services in a central Hub in rural and remote towns would allow the cost of infrastructure and service delivery to be shared across multiple agencies and levels of government, bringing professional jobs back to rural and remote towns and making them more attractive places for doctors and others to work. A single employer model in each town would ensure all staff can be appropriately supported locally, and services better informed by local community priorities.

This colocation principle underpinning this model has proven successful in a number of other contexts.

For example, the Multi-Purpose Service Program combines funding for aged care services from the Australian Government with state and territory health services to ensure small regional and remote communities can offer flexible aged care services that meet the needs of their community.

The MPS Program aims to give regional and remote communities:

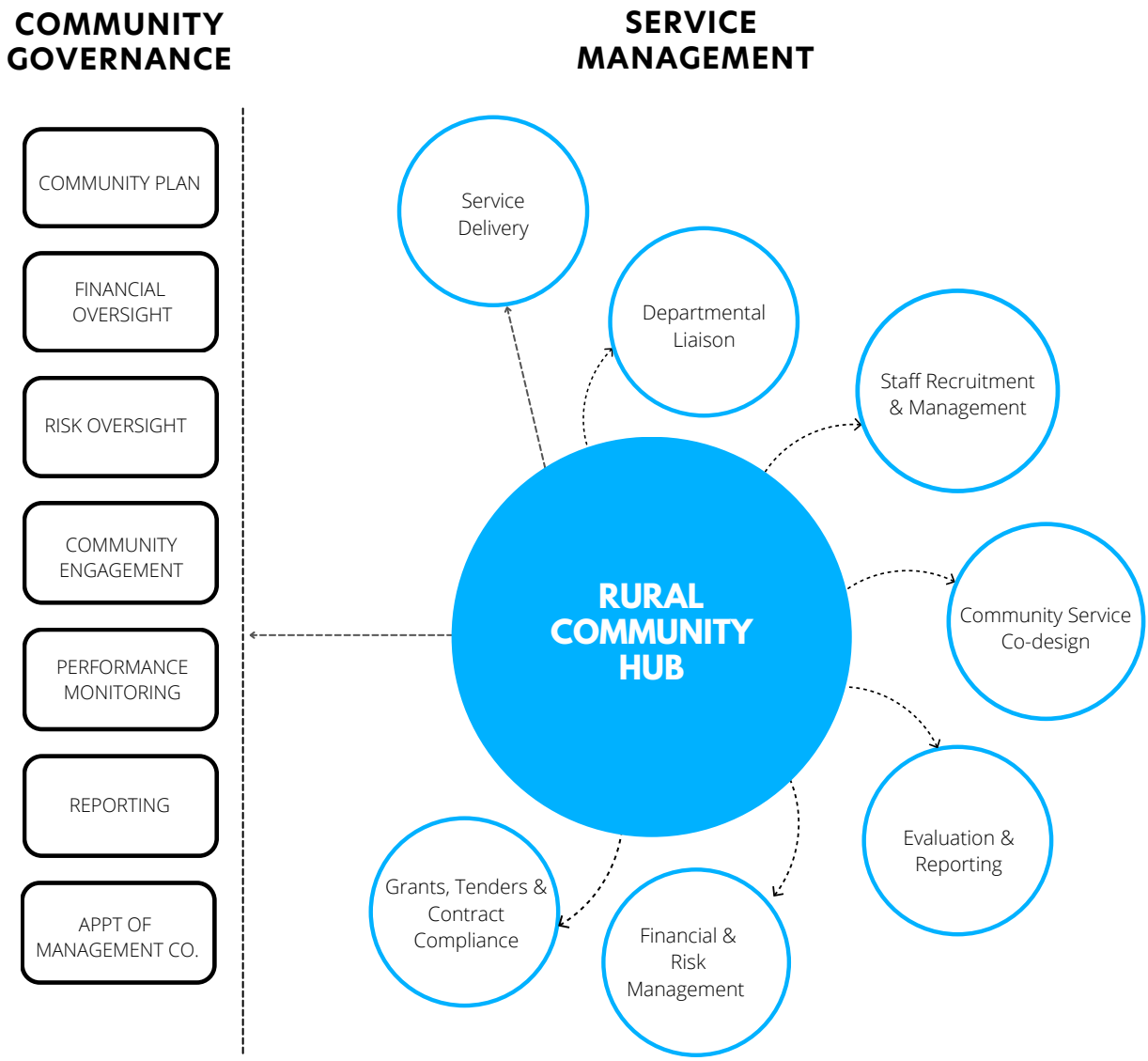
- improved access to a mix of health and aged care services that meet community needs
- more innovative, flexible and integrated service delivery
- flexible use of funding and/or resource infrastructure within integrated service planning
- improved quality of care for clients
- improved cost-effectiveness and long-term viability of services.

The Community Hubs model builds on these principles by

- extending the range of services well beyond aged care to include a wide range of health and social services
- strengthening community stewardship of the facilities and services.

A similar colocation model funded by the Commonwealth and State is used to support targeted health and social assistance programs for Aboriginal people through independent Aboriginal Community-Controlled Health Organisations.

There are a number of templates that already exist to inform the design and operation of Rural Community Hubs.



GOVERNANCE & MANAGEMENT

Local Government Authorities would be funded jointly by the Commonwealth and State governments for the construction of Rural Community Hubs and would receive annual funding for maintenance and repairs.

Management of the Rural Community Hubs would be tendered to a community not-for-profit corporation established by the LGA. The community corporation would have a board comprised of members of the local community, local government, community organisations (e.g. CWA, NFF, NGOs, LALC, local health provider, housing organisation etc), and at least 3 independent persons appointed with financial, compliance and discipline expertise (similar to the way in which government Audit & Risk Committee incorporate independent members).

The community corporation would be responsible for tendering for the supply of management services. Management service providers would be required to be not-for-profit organisations that have their main operations in the region they are supporting to ensure that funding is optimised for community benefit.

The community corporation responsible for the Hub would receive block funding to achieve Government determined performance targets. A key difference between government delivered services, and Hub delivered services, is that communities would be responsible for determining the most appropriate programs and approaches to achieve these targets rather than government officials located in metropolitan or regional cities.

A cap of 15% would be placed on management organisation fees to ensure funding is allocated to community outcomes rather than corporate overheads.

A central nationwide knowledge sharing centre would be established, possibly attached to a regional university, to collate case studies and conduct research, acting as a best-practice clearinghouse to inform local practices and contribute to success.

The Board of the community corporation could terminate the services of a management organisation under the contract for services if the organisation fails to achieve performance targets or deliver services locally. The Minister would have the power to place a Hub under Administration if the Minister formed the view that the community board had failed to exercise its responsibilities in the best interests of the community or for other governance failures.

THE BENEFITS

RURAL BENEFITS

The benefits of Rural Community Hubs include:

- local communities could engage directly in the co-design of local programs and services that reflect their needs and priorities, generating greater buy-in and ownership over goals and outcomes.
- there would be a stronger sense of shared accountability for outcomes between government and the community reducing the perception in rural and remote communities that decisions are being made in major cities without any understanding of the local circumstances.
- improved local coordination of programs and better alignment to the needs and priorities of individual communities would help reduce duplication, fragmentation and waste.
- team-based and multidisciplinary service delivery is better able to tackle the causes of poor health and life outcomes (a leaky roof, domestic violence, alcohol or drug use) before its becomes a bigger problem, rather than waiting to deal with the consequence.
- the model strongly aligns to evidence about preventing poor health and life outcomes (e.g. social prescribing, social determinants of health) compared to existing approaches.
- greater flexibility in configuring a local staffing profile that reflects the availability of skills in the local market and community needs.
- a single employer model would allow maintenance of entitlements.
- increase in the immediacy of access to health and social services locally.
- improve sustainability of social services and primary health care in rural and remote towns through the sharing of backend costs (rent, equipment, recruitment, ICT systems) increasing the range of services that could be made available locally.
- more local jobs contributing to improvements in educational participation and attainment (young people cannot aspire to careers they cannot see), reductions in poverty and improvements in health.
- rebuild professional networks that are essential to attracting in-demand professions such as doctors.
- more effective focus on prevention will lead to a reduction in chronic disease and significant savings in social support and avoidable hospitalisation costs for the State.

ECONOMIC BENEFITS

A study by the National Centre for Social and Economic Modelling (NATSEM) for Catholic Healthcare found that action to address the Social Determinants of Disadvantage in Australia would lead to:

- 500,000 Australians avoiding suffering a chronic illness;
- 170,000 extra Australians entering the workforce, generating $8 billion in extra earnings;
- Annual savings of $4 billion in welfare support payments;
- 60,000 fewer people needing admission to hospital annually, resulting in savings of $2.3 billion in hospital expenditure;
- 5.5 million fewer Medicare services would be needed each year, resulting in annual savings of $273 million;
- 5.3 million fewer Pharmaceutical Benefit Scheme scripts would be filled each year, resulting in annual savings of $184.5 million each year.

The World Health Organization has developed the Integrated People-Centred Care Framework arguing for better integration of health and social services to address the rapid increases in chronic disease Around the world.

PWC argues that governments need to do more to address the social determinants of health:

often ignored social factors such as employment; housing; income inequality; and level of access to clean water, education and transportation — undermine progress and can swamp the systems that ignore them. Because even the most advanced .. interventions are rendered ineffective when people struggle with social isolation, income inequality, poor nutrition and pollution.

CASE STUDY

Maarubaa Galariinbaraay-gu

COLLARENEBRI COMMUNITY HUB

The Collarenebri Community Hub, known in the Gamilaraay language as Maarubaa Galariinbaraay-gu (Healthy Collarenebri), is a joint initiative of the Healthy Communities Foundation Australia Ltd and the local Aboriginal and non-Aboriginal community. The shared aim was to build a facility that would enable the colocation of health and social assistance services to improve coordination and better address the social determinants of disadvantage.

Funded with a grant from the Murray Darling Basin Authority, the Hub is now home to:

1. Collarenebri Medical Centre (with full-time resident GP, Nurses and Aboriginal Health Workers);
2. Remote Integrated and Collaborative Health (RICH) Centre (which brings visiting allied health and specialist services to the community and deploys technology to maintain continuity of care);
3. the Dhirra-li Health Careers and Training Centre (providing work experience to students enrolled in TVET programs in health to increase school participation and progression to health careers);
4. the Waygal Art and Healing Circle (a program commencing in 2023 that will bring together Aboriginal people to learn art, create micro-businesses and discuss mental health and other issues of concern);
5. the National Rural and Remote Suicide Prevention Program (the headquarters of a Federally funded initiative to build awareness of mental health issues in rural and remote communities and to train first responders in a joint initiative with the NRL);
6. the Fetal Alcohol Spectrum Disorder Diagnostic Service (the headquarters for a Federally funded program to improve detection of FASD in children and referral to specialist services at the Sydney Children's Hospital in a collaboration with the University of Sydney).

In mid-2023 we will expand the centre to incorporate a clinical pharmacy centre to work collaboratively with our health staff to manage chronic diseases.

During 2022 the Foundation worked in collaboration with the Murdi Paaki Regional Assembly (Collarenebri) on the development of a new Community Plan. The Plan sets out a 10 year development agenda to address the social determinants of disadvantage, helping to contribute to a long-term decline in the incidence of chronic disease by promoting educational participation, training, career opportunities and economic development..

The design and delivery of the Hub was a joint initiative of the Walgett Shire Council, Country Women's Association, Collarenebri Local Aboriginal Land Corporation and Collarenebri Central School. It is an example of how rural and remote communities can work together for the common good, and achieve significant transformation, when they are supported to do so by government.

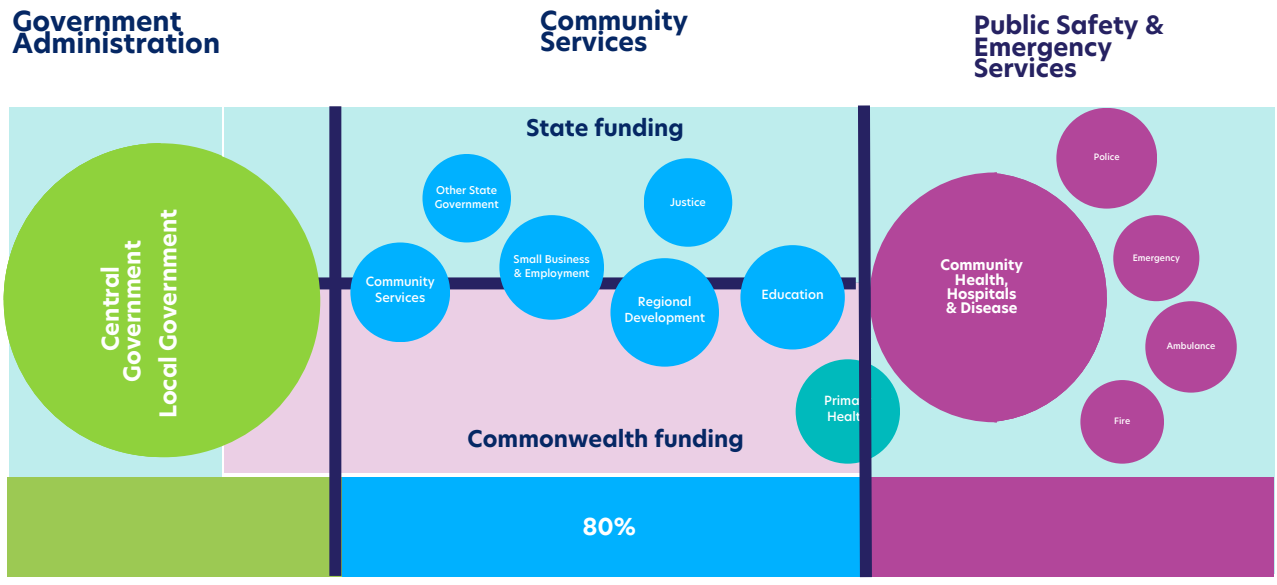
MACHINERY OF GOVERNMENT

The Rural Community Hub model is designed to support the World Health Organisation's Integrated People-Centred Health Framework in which the health of people (not just a patient or a person) drives decision making, and health and well-being is a core focus.

The model we are proposing differs from the Rural Area Community-Controlled Health Organisation and similar integrated primary health service delivery models because of its focus on health (bringing together health and social assistance professionals to prevent disease and address social determinants) rather than solely focussing on disease (bringing together health professionals to treat disease).

Our proposed model is superior as it aims to bring together a diverse and mutually-supportive professional network and distribute the cost of service delivery across a broader range of functions and levels of government making local service delivery more sustainable, and working rurally more attractive.

The Rural Community Hubs will enable the co-location of services that are designed to address the social determinants of health (housing, education, community services, domestic violence, public safety, employment, community development) with closely aligned primary health care and early intervention services (GPs, allied health, pharmacy, mental health etc). This represents a more holistic approach to health and wellbeing than existing models.



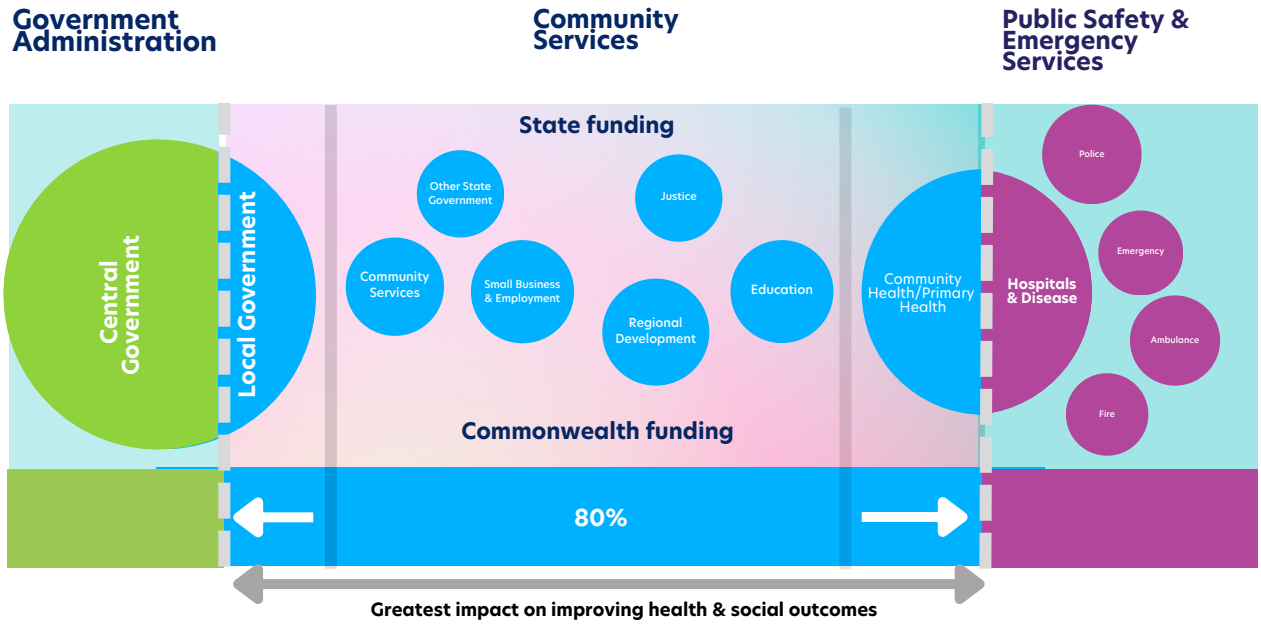
For too long governments have failed to recognise the significant resources deployed by all tiers of government to support community and individual health that sit outside the narrowly defined 'health system'. This has contributed to needless duplication (e.g. a Commonwealth Centrelink office in a seperate building to the NSW Housing Office and a local GP Clinic), despite these functions often engaging with the same clientele to address similar issues.

For example, we know that providing high quality education, training and employment opportunities for young people does more for the long-term health of an individual and community than a pill. We know that helping people to stop drinking or consuming drugs does more for that individual, and their long term economic outcomes, than treating the person once they become addicted. Yet too often the these functions are fragmented, or programs needlessly compete, reducing our ability to optimise resources and outcomes.

The major challenge for our health system today is not episodic and disconnected care. It is to address the growing burden of chronic disease and the complex needs of an expanding aged population as close to home as possible. To achieve this change, we need to think outside the traditional health system model which is dominated by the acute and emergency models of care.

We need to begin talking more about how we can better integrate the primary health and social assistance services at a local level to create a unified focus on keeping people healthy in their homes, rather than forcing primary care into a highly centralised and fragmented disease-centric model.

This is even more important in rural and remote towns where the distinction between primary, secondary and acute care are blurred. The replication of city-centric, fragmented models of care on these communities competes with the traditionally integrated approach to problem solving that occurs in rural and remote towns. Fragmentation has contributed to services being withdrawn from some of the most vulnerable communities in Australia because of cost, when better coordination and integration could have ensured that these services were sustainable within an innovative collocated delivery model.



RURAL COMMUNITY HUB STAFFING PROFILE

The Rural Community Hub model will use a single employer model to enable services to be locally delivered in rural and remote towns in a more integrated and responsive manner. The single employer model provides Hubs with greater flexibility to mix-and-match functions where appropriate around locally available skills and community priorities. For example, a 0.6FTE Women's Health Nurse could also be employed as a 0.4FTE Domestic Violence Support Officer, creating more meaningful and attractive employment opportunities in rural and remote towns (including spousal employment opportunities), while addressing the cost inefficiencies of remote and fractional appointments.

STAKEHOLDER MODEL

Rural Community Hubs would be designed from the start to be multi-jurisdictional service centres for rural and remote towns using a similar collaborative funding and governance framework that support Multi-Purpose Services and Aboriginal Medical Services.

The mix of functions and services would be bespoke to each location (place-based). In some rural and remote towns services such as aged care, community transport or Aboriginal health may be run by existing organisations. The model would be flexible enough to allow communities to decide whether a services is integrated (co-located) with other services, or becomes a partner provider of the Hub.

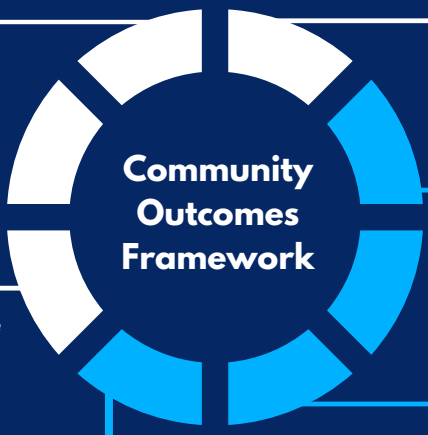
This would be an important feature of the new model. From time to time health and social service organisations cease to operate for a wide variety of reasons. The Hubs would be able to pick up service delivery to maintain continuity of care in these circumstances, rather than gaps arising in access to services.

A single Community Plan developed by the community, rather than multiple organisational plans developed outside the community, would ensure all programs and services are aligned to address the core issues driving poor health and life outcomes in a particular community.

INTEGRATED OR PARTNERED

- Child Services
- Community Transport
- Community Health
- Community Aged Care
- Aboriginal Health
- Housing
- Primary Health
- Universities
- TAFE
- Schools
- Human Services
- Police
- Business
- Community Organisations

COMMUNITY OUTCOME FRAMEWORK



Informed

Communities have access to plain language information about services and how to use them to improve their lives, make decisions and act on it.

Empowered

Communities are able to participate as a group and individually in decisions affecting their life and health and make informed choices.

Connected

Community are able to obtain coordinated access to an optimal mix of social, mental health, specialist and allied health services to address their needs.

Safe

Aboriginal and/or Torres Strait Islander, LGBTQIA+ and other vulnerable groups in our communities can access culturally safe services.

Accessible

Members of our communities can access the right Services, in the right place at the right time.

Improved

Members of the community are able to achieve positive improvement in their life and health outcomes.

Sustainable

Communities have access to health and social services that are sustainable and will contribute to local jobs and economic activity.

EVALUATION & IMPLEMENTATION PLAN

1

Rural Trial

3 trial sites in different remoteness areas

2023-2026

2

Model Development

Consult communities & stakeholders on development of a nationwide model and prepare feasibility & business case

2027

3

Stakeholder Agreement

Agreement between Local, State and Federal governments on roll-out plan, shared funding model & responsibilities.

2027-2028

4

Implementation

Roll-out to 10 sites per annum.

2029 -

THE FOUNDATION

The Board and management of the Healthy Communities Foundation Australia Ltd is comprised of experts in social determinants, social assistance, preventative health, health services and regional economic development. They have a combined track record of delivering initiatives to improve the alignment of services to community needs, and deliver improved efficiency in the provision of government services.

NSW

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MBA (UNewcastle) BComm (CSU)
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An Australian Health Charity since 2001

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CEO
MARK BURDACK
FGIA GAICD BA BLegS (Hons)
Aduncт Senior Lecturer, La Trobe University School of Rural Health

MANAGER, CORPORATE SERVICES
CROYDON DOWLEY
BFinAdmin (UNE) CA

MANAGER, HEALTHACCESS
TRACY HAIG
BBus DMM

CHIEF MEDICAL OFFICER
DR FREDDY CHAFOTA
MBBS FACRRM

Mark Burdack, CEO

THE HEALTHY COMMUNITIES FOUNDATION AUSTRALIA

Mark Burdack is the CEO of the Healthy Communities Foundation Australia. He worked with the NSW Government for a decade leading the establishment of LawAccess NSW, CaseLaw NSW and electronic court hearings. The Productivity Commission found that LawAccess NSW is a model that should be implemented in every jurisdiction. Relocating to the regions he was appointed a senior executive in the University sector, leading projects to address rural economic and social development including the successful establishment of a rural dental school, medical school and life sciences research hub. He wrote in collaboration with the community the ActivateOrange Strategy - a decadal plan for economic growth and social development in the central west of NSW. As CEO of the Foundation he led the creation of HealthAccess, a blended Telehealth model that is internationally recognised for enhancing patient experience and health outcomes, while also dramatically improving cost efficiencies in the delivery of rural hospital services. Mark has a proven track record of 'cutting-through' the noise, engaging with group-think by reframing assumptions that have limited consideration of alternatives and leading teams that are enthused by the opportunity to explore new ways of addressing old problems. A highly regarded executive and board director, he has been called by senior leaders around Australia a "visionary strategist", a person with "unique insights which enable him to get to the heart of issues", a "thorough researcher", "driven, with integrity and ethics", "highly collaborative", "creates and sustains stakeholder coalitions", "offers viewpoints not considered before", and able to "see the 'big picture' and make decisions based not just on what is in front of him, but a real consideration of outcomes and avoiding potential unforeseen consequences".

We believe in a world where every single person has local access to safe and high quality health and social services wherever they live