National Rural Health Alliance

2023–24 Pre-Budget Submission

27 January 2023

Healthy and
sustainable rural,
regional and remote
communities
across Australia.

National
Rural Health
Alliance

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National Rural Health Alliance

Healthy and sustainable rural, regional and remote communities across Australia.

27 January 2023

The Hon Dr Jim Chalmers MP
Treasurer
Parliament House
CANBERRA ACT 2600

The Hon Emma McBride MP
Minister for Regional Health
Parliament House
CANBERRA ACT 2600

Dear Treasurer and Minister

National Rural Health Alliance – 2023–24 Pre-Budget Submission

The National Rural Health Alliance (the Alliance) is pleased to provide a submission for consideration in the 2023–24 Federal Budget. The Alliance is the peak body for rural and remote health in Australia. We represent 45 national Members (see www.ruralhealth.org.au/about/memberbodies) and our vision is for healthy and sustainable rural, regional and remote (rural) communities across Australia.

Rural Australia is not only home to more than seven million Australians, it also contributes the majority of the nation's economic worth, with around two-thirds of Australia's export earnings coming from regional industries such as agriculture, mining, tourism, retail, services and manufacturing.[1]

Despite the enormous contribution made by rural Australia to the general prosperity, resilience and wellbeing of the whole country, people living in rural Australia have poorer access to health services than other Australians, with the number of health professionals (including nurses and midwives, allied health practitioners, general practitioners, medical specialists and other health providers) decreasing as geographic isolation increases. Per capita, rural areas have up to 50 per cent fewer health providers than major cities. As a result, Australians living in rural areas have, on average, shorter lives, higher levels of disease and injury and poorer access to and use of health services, compared with people living in metropolitan areas.[2]

We urge this Government to correct the problems of market failure associated with healthcare access for rural Australian communities.

Despite a high level of awareness of the significant disparities in health outcomes between urban and rural Australia, health outcomes for rural Australians have not been considered a priority, beyond disaster support, with health outcomes stagnating and, in many instances, declining.

The Alliance advocates 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 Australia, especially when Australians as a whole rely on and benefit from the primary industry, mining, tourism and service export and supply income from this 30 per cent of the population.

Data shows that people living in rural and remote areas have higher rates of hospitalisation, mortality and injury, but poorer access to and use of primary healthcare services, compared with those living in metropolitan areas.[2]

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Further, people living in rural Australia are more likely to be affected by the negative impacts of climate change, in addition to their already challenging status quo. Further investment, as well as a willingness to look to communities for innovative solutions and mitigation measures, will be needed to support rising health needs resulting from the existing situation combined with the impacts of a changing climate. Rural Australia is most impacted by the consequences of climate change via:

- extreme weather events
- food insecurity
- vector-borne disease.

Further information on these issues can be found in our comprehensive position paper: *Rural health policy in a changing climate – three key issues*.

In addition, there is a huge economic and social impact of rebuilding after extreme weather events in locations that are already at crisis point. Weather events have impacted significant and crucial infrastructure, for example major damage to buildings and roads. This is on top of the shock of three years of COVID-19, which has had a multiplier effect on the already stressed health sector in rural Australia.

The Alliance believes the Government has a social and economic responsibility, or social contract, to address the commonly held assumptions that poorer access to health care 'goes with the territory' and 'people choose where to live'. Government's role is to work when markets fail. Clearly, changes are required to address the inequity in the current funding and policy settings.

The Alliance has three 2023–24 pre-Budget proposals that support strategies and initiatives to expand access to health care and improve health outcomes for rural Australian communities.

The three key proposals are:

1. Primary care Rural Integrated Multidisciplinary Health Services (PRIM-HS). Several regions are shovel-ready to implement this initiative, starting in the second half of 2023: $16,577,376 per site for five years (of which Medicare offset is calculated at $5,000,000 over five years). The indicative budget is based on a population of 3,000 people; however, this will need to be region and site specific and have a Medicare offset according to where the clinic is in its life cycle.
2. The inter-site governance support, process and outcome evaluation of the PRIM-HS sites across Australia: $3,565,000 (of which Department of Health and Aged Care staff costings are $600,000) over four years.
3. Commitment to a National Rural Health Strategy and Implementation Plan: $3,200,000 (of which Department of Health and Aged Care staff costings are $1,300,000) over four years.

In addition, we have outlined an enabling recommendation:

4. To support improved analysis, reporting and publication – across the spectrum – of measures related to health outcomes, health services and health workforce by geographical classification, in particular reporting on health expenditure in rural Australia.

Further information on these proposals is provided below. I can be contacted for further information and to clarify and elaborate on any aspect of this pre-Budget submission.

Yours sincerely

Susanne Tegen
Chief Executive

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NATIONAL RURAL HEALTH ALLIANCE PRIORITIES FOR BUDGET 2023–24

Proposal 1 – Primary care Rural Integrated Multidisciplinary Health Services (PRIM-HS)

Every week, the National Rural Health Alliance (the Alliance) receives phone calls or correspondence from medical and health practitioners, local government, concerned citizens and rural accountants to advise us about, and seek help for, the market failure of primary care in rural Australia. We are advised about general practices and allied health providers that can no longer stay financially viable and are unable to attract and retain the necessary health professionals to sustain their practices. They cannot keep up with urban, major regional and jurisdictional wages nor relieve some of the excessive workload in communities where there are high needs but thin markets for health providers to operate.

It is well documented that something needs to change. The Alliance has been working with rural stakeholders on a community model of care that will build up and support primary care in rural communities to provide improved healthcare access to people living in rural Australia. The model was previously referred to as rural area community-controlled health organisations, based on the successful Aboriginal Community Controlled Health Organisations (ACCHOs). The Alliance has now named this model Primary care Rural Integrated Multidisciplinary Health Services or, for ease, PRIM-HS.

Since the Labor Government has come into power, the Alliance has held meetings and a workshop for seven communities from a range of geographic areas. These seven communities are developing, or have developed and led, their primary care services with varying models of ownership – including primary health networks (PHNs), local government, private general practice, the Royal Flying Doctor Service (RFDS) and community organisations. However, the market in those regions fails, in particular due to employment challenges, Medicare fee-for-service funding, high costs of running a business, and infrastructure and maintenance costs.

All seven communities, of varied backgrounds, share the same overarching motivation – a new funding model is needed to sustain primary care in areas where the market has failed. The inability to support employment of the necessary professionals – due to fee-for-service payment models and the lack of single-employer options across medical and health care – is not giving rural people, who are taxpayers adding significantly to the Australian economy, the same basic access as their urban counterparts. These seven communities are reflective of many other rural communities battling the same issues.

There are a range of government programs and initiatives seeking to address the maldistribution of the health workforce across Australia. However, these initiatives are fragmented, often adding more complexity and benefiting urban and major centres. There is little evidence of their success in improving the health outcomes or workforce challenges in rural Australia.

The Alliance also notes that changes to the Distribution Priority Areas (DPA) classification system, which now provides DPA classification to regional centres classified as Modified Monash (MM) 2, add a further barrier for attracting general practitioners to rural areas (MM3–7). The incentives will certainly have an impact, as doctors who have moved to rural areas may now establish themselves in larger regional centres.

The current Medicare Benefits Schedule (MBS) universal health system rewards high-volume, single-health-issue patients. It does not provide enough access or support for patients of smaller rural general

practices without a critical volume of patients, where those patients cannot make a co-payment. The situation is also difficult for many private allied health, nursing and paramedic services, as there are very few MBS items that patients can claim. This reduces financial viability for practices and makes those services unaffordable for many rural people.

When rural primary care practices recruit professionals, they are not able to compete with the salaried government conditions, flexibility and moveability offered under a single-employer paid model that allows for a minimum five year contract, support and security.

A new approach is needed to address the poorer health outcomes, rural health deficit and maldistribution of the health workforce experienced by rural communities. A new model of rural health care is needed to overcome the barriers to attracting and retaining a rural health workforce, which are:

- Professional – limited networking opportunities, clinical experiences and supervision; professional isolation and lack of support from peers; and work–life balance issues, such as long on-call rosters.
- Financial – practice financial viability; cost of infrastructure purchase, maintenance and potential subsequent sale in a thin market; the need to work across multiple settings; multiple sources of both government and private funding; administrative burden; and business acumen requirements.
- Social – lack of family and friendship networks; social isolation; cultural and recreational limitations; and partner concerns including careers and children's education.

Models of care that work for metropolitan areas do not work in rural Australia. PRIM-HS are a new model of care specifically designed with the community and stakeholders to address the challenges of delivering primary health care in those settings.

What are PRIM-HS?

PRIM-HS will be community-based organisations that offer a comprehensive and affordable range of primary healthcare services. They should be not-for-profit organisations funded by government, designed and established by local communities to meet their primary healthcare needs in flexible and responsive ways.

PRIM-HS will employ a range of primary healthcare providers including rural generalists, nurses and midwives, dentists and allied health professionals. The mix of practitioners employed will depend on the needs and circumstances of individual communities, with consideration of existing healthcare providers. Health practitioners will be supported by administrative staff (including practice managers), to ensure that clinical staff can focus on clinical practice. The PRIM-HS paradigm supports medical and allied health rural generalist models and pathways, including opportunities for structured supervision and support.

PRIM-HS overcome the barriers to attracting and retaining a rural health workforce outlined above. They provide secure, ongoing employment with a single or primary employer, attractive conditions including leave provisions (holiday, personal, parental and long service leave) and certainty of employment and income.

Most importantly, PRIM-HS are not an urban-based corporate entity, 'cherry picking' the profit out of rural communities. The Alliance believes that Australia has a social and economic contract to build regions, not just to take the best from them. This requires support to determine need and investment at the grassroots, in local people, local services and regions.

PRIM-HS do not rely on health practitioners committing to establish their own practice, with the attendant responsibilities of operating a financially viable, standalone business (managing staff, administration and compliance), in what are generally thin markets. This employment model makes it easier for health practitioners to take up a rural position, knowing they can focus on their professional

practice without the stress of establishing, purchasing or running a practice in a thin or failed market. They can also easily change their minds if their circumstances change.

PRIM-HS support work–life balance, minimising social and professional isolation through peer support from a multidisciplinary team and overcoming related negative perceptions of rural practice. Employment conditions recognise and support continuous professional development and specific accreditation requirements and can provide the opportunity for training and research collaborations. PRIM-HS provide ready connection to the local community, with support and advice available regarding accommodation, employment opportunities for partners, education options for children, and social and recreational activities.

The health workforce shortage in rural Australia often means that older people or people with disabilities cannot access the support and interventions they need and are eligible for, including medical, nursing, allied health, dental and pharmacy, across a range of settings: residential aged care facilities (RACF); National Disability Insurance Scheme (NDIS) benefits; and support through the Department of Veteran's Affairs (DVA). PRIM-HS has the potential to provide in-reach services for RACF, NDIS and DVA recipients, as well as for rural people with chronic disease, including those with chronic disease management or other similar care plans.

PRIM-HS are not intended to compete with ACCHOs. Where appropriate, PRIM-HS will work collaboratively to ensure that all primary healthcare services, serving the full spectrum of community members, can thrive. PRIM-HS acknowledge the holistic, comprehensive and culturally appropriate health services provided by these distinct organisations.

PRIM-HS are also not intended to compete with existing health professionals in a community or threaten the viability of existing services. PRIM-HS are aimed at supporting communities where there is a lack of primary health care and would be implemented to ensure existing services are enhanced. Hence, PRIM-HS will be co-designed with local health consumers, providers and organisations to address local needs, offering a range of services that are better integrated across all sectors.

The Alliance has been working with various stakeholders that have driven this proposal. This has included specifically working with primary care organisations (PHNs, local government, RFDS, private practice, community organisations) to develop the model. These organisations have been based in New South Wales, Queensland, South Australia and Tasmania where the market has already or just about failed. The Alliance proposes that the model is relevant for primary care organisations based in MM3–7 locations.

How does the PRIM-HS model meet the Government's other policy priorities?

The Alliance has developed the model for PRIM-HS in recognition that the Government has made commitments to develop new models of care for rural Australia. But, to date, the implementation of these commitments has been trial or pilot based and has not been fully realised.

The implementation of PRIM-HS will support the Government in meeting the obligations and policy priorities already committed to:

1. Commitments made under the *Addendum to the National Health Reform Agreement 2020–2025.*
2. National Rural Health Commissioner's Model for Rural and Remote Multidisciplinary Health Teams.
3. Innovative Models of Care Program, 2022–2023 Federal Budget.
4. Strengthening Medicare Taskforce Directions.
5. *Australia's Primary Health Care 10 Year Plan 2022–2032.*
6. *National Medical Workforce Strategy 2021–2031.*

Further details about these commitments and policy priorities, and how PRIM-HS can support them, are outlined below.

1. Commitments made under the Addendum to the National Health Reform Agreement 2020–2025

PRIM-HS comprehensively address the ambitions outlined in the *Addendum to the National Health Reform Agreement 2020–2025*, including joint planning and funding, identifying rural and remote areas where there is limited access to health care, reorienting health systems around individuals and communities and addressing workforce issues.

This Addendum states that the Commonwealth and the States will be jointly responsible for:

> 9. h. identifying rural and remote areas where there is limited access to health and related services with a view to developing new models of care to address equity of access and improve outcomes[3]

2. National Rural Health Commissioner's Model for Rural and Remote Multidisciplinary Health Teams

The National Rural Health Commissioner has been developing a Consensus Statement (known as the Ngayubah Gadan Consensus Statement, meaning 'coming together' in the Yidinji language) following the Ngayubah Gadan Summit held in Cairns, Queensland, in June 2022. This statement details a model of care that the National Rural Health Commissioner has termed Rural and Remote Multidisciplinary Health Teams.

The Alliance's PRIM-HS model would provide the structure and framework to support the work the National Rural Health Commissioner is leading, which clearly has support from a broad spectrum of rural and remote organisations across Australia. The groundswell of support for the work being led by the National Rural Health Commissioner demonstrates the critical need for broader multidisciplinary health care in rural Australia.

3. Innovative Models of Care Program, 2022-2023 Federal Budget

In the most recent Federal Budget, the Government announced $24.7 million over four years, from 2022–23, to fund an additional three rounds of the Innovative Models of Care Program to trial new primary care models. The commitment by the Government to support innovative models of care is welcomed and the Alliance calls for additional funding for organisations ready to start implementing (not just trialling) PRIM-HS. This will add further support to the work that the Government is committed to in delivering innovation for primary care in rural Australia.

4. Strengthening Medicare Taskforce Directions

The Alliance commends the Government on its priority to examine Medicare and to support the work of the Strengthening Medicare Taskforce to develop strategic solutions for primary care in the future. Clearly the direction that the Strengthening Medicare Taskforce is taking demonstrates the willingness of the Government to consider and invest in innovative models for delivering primary care. The most recent Communique of the Strengthening Medicare Taskforce specifically notes:

> 1. Increasing access to equitable and affordable primary care
>
> Members agreed that person centred care must underpin a transition of Australia's world class universal primary healthcare system to more blended systems and funding over time, to better address increasingly complex and chronic patient needs and inequities in access and individual outcomes. Funding needs to recognise and support models of care that are responsive to local needs in outer metropolitan, rural and remote areas, and to enable multidisciplinary care including nurse-led, allied health and other primary care models. Members supported an increased focus on wrap-around care for those who need it and the importance of continuity of care.

2. Encouraging multidisciplinary care

Members supported greater use of multidisciplinary team-based care models in primary care. This will require all governments to work together to enable legislative and regulatory barriers to practitioners working to their full scope of practice to be reviewed and addressed, and to improve system integration and workforce planning at local and regional levels. Cultural change will enable healthcare professionals to work together across their full scope of practice, including through changes in education and training to ensure workers have the skills required to support an integrated, person-centred system.[4]

5. Australia's Primary Health Care 10 Year Plan 2022–2032

The Alliance's PRIM-HS model also supports the objectives and emphasis in *Australia's Primary Health Care 10 Year Plan 2022–2032*. The 10 Year Plan correctly acknowledges the challenges for rural and remote Australians and the workforce that cares for them. The Plan states (Stream 2):

> Rural health will also be a major focus, with systematic scaling up of innovative approaches to supporting general practice and comprehensive primary care teams in areas of market failure. This will include the development of local community-developed and supported models to provide improved primary health care for rural and remote communities.[5]

Further, a specific short-term action within the 10 Year Plan (which could therefore be implemented as soon as possible) is:

> Trial the establishment of rural area community-developed innovative models of care in MMM4-7 regions to support comprehensive primary health care teams in areas of market failure.[5]

Funding PRIM-HS will help fulfil the Government's commitments under *Australia's Primary Health Care 10 Year Plan*.

6. National Medical Workforce Strategy 2021–2031

The *National Medical Workforce Strategy 2021–2031* outlines several initiatives and strategies to support the national medical workforce generally, with specific references to the needs of the medical workforce in rural areas. The Strategy notes:

> Financial viability and sustainability of clinical practice is important to encouraging rural practice. … [for] general practitioners, communities should be able to access services within their region. The current concentration of specialists in metropolitan areas has developed over time, rather than by design, and requires assessment. Consideration needs to be given to how services are funded so that practitioners can provide and maintain sustainable services. The Strategy will build on current trials of innovative funding models for primary care that seek to provide more localised solutions, developed in consultations with community and local service providers.[6]

A specific priority and action item is to reduce barriers and improve incentives for doctors to work and train in rural and remote communities with the details stating:

> 7.2 Build innovative funding and incentive models for GPs in rural and remote areas in collaboration with regional networks and the National Rural Health Commissioner and the Primary Health Care 10 Year Plan.[6]

Clearly the Government's strategies are outlining the need for innovative models of care for rural Australia. The Alliance is pleased that our PRIM-HS model can be implemented to address these priorities and strategies of the government.

Role of the National Rural Health Alliance in implementing PRIM-HS

The Alliance is well placed to assist the Government to work with these communities at the grassroots in the roll out of PRIM-HS. The Alliance can act as a facilitator and coordinator of the program to achieve the following aims:

- Ensure consistency across sites to enable the development of best practice that aligns with the core principles of the model.
- Enable information sharing across sites regarding learnings, processes and resource development.
- Ensure consistent evaluation of the program.
- Identify duplication to maximise efficiency, particularly in relation to business and finance, human resource management processes, education and training (including accreditation requirements).
- Work with the Alliance Members and other organisations to ensure their input and involvement in the whole-of-person patient journey through the health system, and whole-of-health medical clinician journey from school, education, training and work to retirement.
- Engage with key stakeholders such as local government, state or territory local health services, Rural Workforce Agencies (RWAs), PHNs, ACCHOs and other organisations, and connect them where appropriate, especially during the development phase.
- Work with the Australian Government as a link organisation for the roll out of the program.
- Advocate to the Australian Government, jurisdictional governments and other key stakeholders in order to progress the PRIM-HS model of care.

What makes PRIM-HS the solution for primary care in rural Australia?

- PRIM-HS have been developed with the Alliance Members, as well as rural primary care organisations and individuals who work on the ground in seven different communities. Rural communities are desperate for healthcare solutions and have worked with the Alliance to develop a model that will work for them.
- PRIM-HS were developed with the RFDS, private general practice, PHNs, not-for-profit primary care organisations, university-led primary care organisations and local government. The Alliance has extensive buy-in for this model as it can be developed to be fit for purpose in each community.
- PRIM-HS have been developed using an evidence-based methodology, together with incorporating the learnings from recent experience and evaluation of community-led and innovative models of care.
- PRIM-HS work in thin markets and where markets have failed.
- PRIM-HS include a program logic and detailed principles and operating practices. These have already been developed by the Alliance (drafted in conjunction with primary care communities in rural Australia) and are available to the Government to commence shovel-ready PRIM-HS now.
- PRIM-HS fit perfectly to support existing Australian Government priorities and ambitions for primary care reform in Australia. There is also an opportunity to support NDIS and aged care access in thin markets.
- PRIM-HS rectify the healthcare underspend in rural areas and address savings to the health system that can be made through preventing avoidable hospitalisations.
- PRIM-HS support general practice and a fully integrated multidisciplinary team approach to providing care.

- PRIM-HS acknowledge that one size does not fit all. They can be tailored to fit the health needs of specific communities and utilise and augment the services and infrastructure already in existence.
- PRIM-HS will improve the rural health and medical training and workforce pipeline by offering a secure employment model (single employer) and support funding where market fails.
- PRIM-HS position the Alliance to work with the Government to help roll out the program. We can make linkages, identify efficiencies and economies of scale, and support program evaluation.

Funding and budget

The PRIM-HS model requires government funding from dedicated, additional and ongoing mechanisms to ensure their sustainability in thin and failing rural markets that serve, on average, older, sicker and more disadvantaged communities, and those which have often not received the access they require.

Rural hospitals and ACCHOs receive block funding in acknowledgement that activity-based funding is not sufficient to support sustainable services in rural areas. The funding of primary health care should be no different. The issues with lack of sustainability in primary care are the same as in secondary and tertiary care.

The current funding streams for rural practice are fragmented, complex and narrowly focused, and act as a disincentive to rural practice and the establishment of multidisciplinary teams. These teams should include an appropriate mix of medical, nursing and midwifery, allied and other health practitioners.

Dedicated, ongoing PRIM-HS funding will recognise the increased costs of delivering health services in rural areas, the lack of economies of scale inherent in thin markets and, on average, the older and lower socioeconomic status and poorer health of rural communities.

A single PRIM-HS (using a population of 3,000 as an example, noting that the population will vary) is estimated to cost, starting in the first year, $3,361,600 ($2,361,600 taking into account Medicare billing income of $1 million). Given the significant unmet need in primary health care in rural areas, the Alliance believes that the Government should commit to the roll out of a significant number of PRIM-HS in order to make a real impact on the lives and wellbeing of rural Australians. The Alliance has up to seven potential sites that are shovel-ready for PRIM-HS and there are other organisations that would also be ready to commence. There will be further sites that will be ready for implementation over the next few years of the forward estimates.

Each PRIM-HS will be different, with a different population and have a different budget. The Alliance has used the figures provided by several primary health organisations that are servicing regions of 3,000 plus population, to estimate the budget required for a ‘mean’ or ‘average’ size PRIM-HS.

The Alliance considers that submitting an estimated cost for a set number of PRIM-HS, using this average costing figure, will ensure that a range of services can be funded, noting that they will be of different sizes and have differing staffing requirements. Using our modelling as a pro forma, communities would present to Government their individual budgets related to the needs of their specific community, including how the PRIM-HS will work with existing services such as RWAs, PHNs, local health services and other clinical services.

PRIM-HS budget

	1 PRIM–HS				
PRIM-HS salaries and on costs	**2023–24**	**2024–25**	**2025–26**	**2026–27**	**2027–28**
Item	**Amount ($)**				
GPs x 2 FTE (aim for 3.7 FTE) long-term contract plus allowance for leave	1,000,000	1,030,000	1,060,900	1,092,727	1,125,509
Practice nurse x 1.5 FTE	180,000	185,400	190,962	196,691	202,592
Allied health practitioner x 2 FTE	200,000	206,000	212,180	218,545	225,102
Allied health assistant x 1 FTE	66,950	68,959	71,027	73,158	75,353
Community health worker x 1 FTE	72,100	74,263	76,491	78,786	81,149
Receptionist x 1 FTE	60,000	61,800	63,654	65,564	67,531
Practice manager x 1 FTE	150,000	154,500	159,135	163,909	168,826
Clinical manager – safety and quality assurance 0.5 FTE	70,000	72,100	74,263	76,491	78,786
Board secretariat officer	24,720	25,462	26,225	27,012	27,823
Superannuation 12% – GP, long term contract	120,000	123,600	127,308	131,127	135,061
Superannuation 12% – other employees	116,661	120,161	123,766	127,479	131,303
On costs 25% – paid leave, Workcover, onboarding, professional development	275,062	283,314	291,813	300,568	309,585
GP – locum travel accommodation and meals	82,400	84,872	87,418	90,041	92,742
Locum cover	200,000	206,000	212,180	218,545	225,102
Administration					
Insurance – contents, building, public liability	5,150	5,305	5,464	5,628	5,796
Insurance – professional indemnity GP long-term contract	12,500	12,875	13,261	13,659	14,069
Insurance – professional indemnity all other employees	10,712	11,033	11,364	11,705	12,056
Recruitment fees	45,000	47,000	50,000	52,000	52,001
Accounting, bookkeeping and audit expenses	19,000	19,570	20,157	20,762	21,385
Cleaning and maintenance (post pandemic)	20,000	20,600	21,218	21,855	22,510
Security (CCTV, contractors)	40,000	41,200	42,436	43,709	45,020
Board expenses (travel, accommodation, governance expenses, eg memberships)	51,500	53,045	54,636	56,275	57,964
Legal costs – employment, lease, practice	15,000	15,450	15,914	16,391	16,883
Accreditation costs	11,000	–	–	–	12,000
Research on local needs	25,000	5,000	5,000	5,000	5,000
Ongoing consultation and co-design costs with local communities	20,000	5,000	5,000	5,000	5,000
Infrastructure and facilities					
Rates	1,545	1,591	1,639	1,688	1,739
Rent	45,000	46,350	47,741	49,173	50,648
Telephone and internet	15,000	15,450	15,914	16,391	16,883
Utilities (electricity, water, gas)	10,300	10,609	10,927	11,255	11,593
Fit out, paint, etc	250,000	25,000	–	–	–
Furniture and electricals (including seating, kitchen goods, etc)	10,000	5,000	2,500	1,250	625
IT operational costs/software	41,200	42,436	43,709	45,020	46,371
Medical and professional equipment/clinical supplies	30,900	31,827	32,782	33,765	34,778
Postage, printing, stationary	8,150	8,395	8,646	8,906	9,173
Consumables	3,090	3,183	3,278	3,377	3,478
Vehicles					
2 vehicle leasing, repairs and maintenance	35,000	36,050	37,132	38,245	39,393
Registration and insurance	6,000	6,180	6,365	6,556	6,753
Fuel	12,360	12,731	13,113	13,506	13,911
Total for single PRIM-HS (prior to Medicare income)	**3,361,300**	**3,177,309**	**3,245,518**	**3,341,759**	**3,451,490**
Offset from MBS (approximate) *(could be more based on 2 GPs, will be different if start up or restart failed service)*	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000
Total per annum Government block funding required	**2,361,300**	**2,177,309**	**2,245,518**	**2,341,759**	**2,451,490**

Proposal 2 – Inter-site governance support, process and outcome evaluation of PRIM-HS sites

The Alliance is seeking the funding of a national integrated support mechanism to offer governance support across the PRIM-HS sites. The funding of this support underpins the process and outcome evaluation that will allow for the following to occur across sites:

- pre-PRIM-HS set up and grassroots collaboration support, to connect with all stakeholders in the region, to effectively utilise existing services
- clinical and corporate governance standards, learning and sharing to support learnings, implementation, reducing isolation and preventing wastage
- across-site accreditation for the teaching of rural and remote medical and allied students and medical, allied and nursing training and learning
- administrative staff connection and learning
- movability of staff and clinicians across various sites.

Evaluation of the community-led PRIM-HS approach will include the interaction with local community, stakeholders and patients; the impact on patient outcomes; and the extent to which attracting and retaining the health workforce has been achieved. The evaluation will consider access to primary care and affordability issues for the communities implementing the model. The evaluation process can also demonstrate where the model has helped communities in responding to climate change and in local disaster planning and emergency management.

Federal Budget	2023–24	2024–25	2025–26	2026–27
Item	**Amount ($)**			
Development of PRIM-HS sites and development of stakeholder interaction				
Department of Health and Aged Care staff involvement	*150,000*	*150,000*	*150,000*	*150,000*
Coordination/administration by the Alliance	400,000	400,000	400,000	400,000
Round 1 consultation (nine regional sites) – including travel, accommodation, facilitator, venue, catering	500,000			
45 Alliance Members in-kind feedback and consultation	—	—	—	—
Round 2 consultation (nine regional sites) – including travel, accommodation, facilitator, venue, catering		500,000		
University and training provider consultation	10,000	10,000	10,000	10,000
45 Alliance Members in-kind feedback and consultation	—	—	—	—
Scientific symposiums, conference presentations of PRIM-HS progress evaluation		15,000		15,000
Evaluation and process evaluation (commence methodology, university consultation, selection of consultant)	30,000	150,000	50,000	70,000
Total	1,090,000	1,225,000	610,000	640,000
Grand total: $3,565,000 ***(of which Department of Health and Aged Care staff costings are $600,000)***				

Proposal 3 – National Rural Health Strategy and Implementation Plan

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

The Government has an obligation to support the full spectrum of primary healthcare services throughout the country. The emergence of significant new health challenges in recent years gives added impetus for a new and current National Rural Health Strategy.

The health effects of climate change should be incorporated, recognising the increased frequency and intensity of bushfires, droughts and floods. This is particularly relevant for rural communities, which are disproportionately affected by these extreme weather events.

The Alliance notes that the Australian Government has committed $3.4 million in its 2022–23 Federal Budget to fund Australia's first National Health and Climate Strategy and a National Health Sustainability and Climate Unit, to better prepare the health system for the challenges of climate change. This is welcomed by the Alliance but does not meet the existing and ongoing health needs of rural Australia, beyond the one-off disasters that come on top of an already taxed system.

Further, since the development of previous strategies and frameworks, the impact of the COVID-19 pandemic has exposed the vulnerability of rural Australians due to the lack of capacity in the rural health system. It has also emphasised the social contract that 70 per cent of the population and the Government must make with rural Australians. Workforce shortages, the lack of appropriate facilities, and a higher proportion of older and vulnerable people, all contribute to this risk. The way forward is a comprehensive and integrated National Rural Health Strategy and Implementation Plan to drive necessary policy change and reform.

A commitment from all levels of government to support a National Rural Health Strategy will be critical to its success and capacity to drive reform and structural change. Support for the objectives of the Strategy, as well as collaboration and action across governments, will be key drivers required to achieve the aims of improved accessibility, equity and rural health outcomes. In particular, a commitment is required from governments to additional funding to support rural access to the full spectrum of health professionals, including medical, nursing, allied health, dental, paramedicine and pharmacy.

It will be important that there is close engagement with the National Rural Health Commissioner, the Aboriginal and Torres Strait Islander health sector, rural health stakeholder and peak bodies, health practitioners and professional bodies, educators, funders, researchers and consumers.

The outcomes of the Stronger Rural Health Strategy Evaluation, which is currently being conducted by the Department of Health and Aged Care, will also provide critical input to the development of a new and fully comprehensive National Rural Health Strategy.

Development of a National Rural Health Strategy and Implementation Plan

The Alliance estimates that the cost of development of the Strategy and Implementation Plan would be $3,200,00, of which $1.3 million would be Departmental staff costs as detailed in the following cost breakdown.

Federal Budget	2023–24	2024–25	2025–26	2026–27
Item	**Amount ($)**			
Development of Strategy and Implementation Plan				
Department of Health and Aged Care staff involvement	*450,000*	*450,000*	*250,000*	*150,000*
Coordination/administration by the Alliance	140,000	140,000	140,000	140,000
Round 1 consultation (nine regional sites) – including travel, accommodation, facilitator, venue, catering	500,000			
45 Alliance Members in-kind feedback and consultation	—	—	—	—
Round 2 consultation (nine regional sites) – including travel, accommodation, facilitator, venue, catering		500,000		
University consultation	15,000	15,000		
45 Alliance Members in-kind feedback and consultation	—	—	—	—
Launch event and promotion		90,000		
Evaluation and process evaluation (commence methodology, university consultation, selection of consultant)	30,000	70,000	50,000	70,000
Total	1,135,000	1,265,000	440,000	360,000
Grand total: $3,200,000 ***(of which Department of Health and Aged Care staff costings are $1,300,000)***				

Policy background

The first *National Rural Health Strategy* was released in 1994. There have been various updates and revisions of the document 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 30 per cent of the population that comprises rural Australia does not have a current rural health strategy and this requires a consultative process that includes significant input from the Alliance and other rural health stakeholders.

While the Framework can still be accessed through the Department of Health and Aged Care website, it is not being utilised as a strategic driver of health policy. No reporting has been undertaken against the goals of the original strategy nor has there been an evaluation of the effectiveness of the Framework in addressing its goals. 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.

Thus, 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, however there is a pressing need to invest in and support nursing, allied health and other non-medical health professions.

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

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 those living in rural Australia. It should consider the barriers and incentives for attracting and retaining a rural health workforce, how to incentivise and provide greater investment in preventive health as well as acute care, and how to fund and administer models of care that are flexible and responsive to local needs. It will also address the need to mitigate the impacts of climate change and disasters in respect to health access and outcomes for people in rural areas.

Considering they represent 30 per cent of the population, there is an urgent need for a health strategy for the seven million people living in rural Australia.

We welcome the opportunity to work with the Australian Government and Ministers for Health and Rural Health, as well state and territory governments and, importantly, local communities that have market failure. The Strategy is current and fit for purpose as a foundation to be built upon.

Proposal 4 – Data on rural health

Data is a useful tool in policy and program development and associated advocacy efforts. While there are a multitude of rich data sources of relevance to health and social care, their use requires skill in sourcing the data, interpreting and analysing it, then translating the key findings into accessible messages. At the Alliance we endeavor to understand the data sources available and bring them together so that the key findings can be readily utilised by clinicians, health service managers, health planners and policymakers from within and outside our membership, for the benefit of the health and wellbeing of rural Australians.

The Alliance has been able to foster good working relationships with many operational areas of the Australian Institute of Health and Welfare (AIHW). They are very amenable to feedback about the most helpful ways to present data related to the health of rural Australians and we will continue to work with them to maximise the utility of the data they hold, analyse and publish. However, some important data gaps remain. We are most concerned about the lack of routine reporting on health expenditure by geographical classification, as this is an important tool in understanding how the health system is working for rural people.

To support improved data analysis and reporting on holistic measures of health expenditure (that incorporate as much of the expenditure in the system as is possible), we request that the AIHW be funded to perform this work as part of their broader work on health expenditure, potentially as part of their *Disease Expenditure* reporting.

We also request that routine reporting performed for the Department of Health and Aged Care – across the spectrum of measures related to health outcomes, health services and health workforce – includes analysis by geographical classification, both at the national level and smaller local area level. The improved synthesis, analysis and publication of data related to the primary healthcare system, including data collected by PHNs and by the Department of Health and Aged Care itself, would add considerable value to the sector and enable the development of a more detailed and accurate understanding of various health and social care measures.

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