Central Queensland Rural Division of General Practice Trading As

Rural Health Management Services Pty Ltd

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27th January 2022

Minister for Housing and Assistant Treasurer
Hon MICHAEL SUKKAR
Pre-Budget Submissions
prebudgetsubs@treasury.gov.au

Dear Hon Michael Sukkar,

Re: 2022-23 Pre-Budget Submission to the Australian Government - Rural General Practice – Locals Leading Local Health Care

I write today on behalf of *Rural Health Management Services* (RHMS) in response to your call on the 6 December 2021 for Submissions regarding priorities for the 2022-2023 Budget. We invite you to consider our submission that will support our ongoing commitment and focus on the provision of primary care services and community led health planning in rural and regional Queensland.

I was afforded the opportunity to meet with your colleague the Minister Dr David Gilliespie MP with our local federal Member Mt Ken O'Dowd MP in Emerald on Wednesday 19th January and address the historic commitment our Organization has made to the delivery of primary health services and the growth in our "footprint" which has been a direct result of the demise in GP services and the decline in service delivery to these regional and remote areas.

Rural Health Management Services is a profit for purpose charity providing sustainable healthcare practice management solutions for rural communities. Our vision is 'Sustainable Rural Healthcare'.

Our organization which originated from the former Central Queensland Division of General Practice is active now not only in the Central Queensland region but in the provision of services in other rural and remote areas, for example areas of North Queensland and the Burnett area as well as indigenous communities such as Hopevale and Badu Island. Our organization has recently taken over the administration of the Hughenden Medical Centre at the Request of the NW HHS and has played an active role in establishing Community Control Health service delivery in the Hopevale Community with the benefits to that community clearly ascertainable in the increase in preventative services and management of health outcomes.

Our organization has an ongoing relationship and assists the relevant PHN in the delivery of services such as Mental Health and Suicide prevention and provides consultancy in Health Planning for several HHS in central and Norther Queensland.

The services that our organisation offers and has experience in providing, assist GP's to continue to staff practices with experienced staff. However, once a practice is established at the request of the GP or the HHS we transition out of those areas where the practice is capable of operating without our involvement or if required with reduced involvement. Thus, once profitable and sustainable the practices are delivered to the local GP to ensure the continuation of health care for that local community.

As an organization Rural Health Management Services is well placed to assist with the establishment and delivery of Rural area Community Controlled Health Organizations as recommended by the National Rural Health Alliance. We support this model of Health Service delivery and can actively assist in facilitating such programs.

To ensure our ongoing strategic growth and to implement the technology and infrastructure needed for the ongoing service delivery, in the face of increased costs for staffing and escalated risk management costs as experienced at all

levels of Health Service delivery, the assistance of the Federal Government is sought as set out in the attached submission.

Rural Health Management Services is seeking, in the attached submission, the allocation of grant funding of $1,050,000 (GST Exclusive) payable over the next three years by payment of $350,000 / annum. The purpose of the application for un-tithed funding is to ensure that our organization is able to continue to deliver the services that we have established and to actively assist in arresting the demise in GP services and the decline in allied health service delivery to these regional and remote areas.

In summary and as set out in the attached submission Rural Health Management Services is well-experienced in

- Managing rural and remote General Practice
- Providing project management for infrastructure development
- Planning locally integrated Primary Health Care services
- Recruiting Medical, Nursing, Allied Health and support staff for Primary Care
- Developing local training programs and professional development pathways
- Ensuring systems and standards are developed to maintain quality primary health care services
- Developing locally integrated services to ensure the services are locally accessible, multi-disciplinary and sustainable.
- Establishing private and public partnerships at the local level.

The attached submission is requesting budget funding to allow Rural Health Management Services to;

- Continue, where needed to take up and maintain access to services (General Practice and Allied Health services)
- Support the development of improved access to local services through the development of local health plans and community led rural and remote primary care services
- By direct involvement to assist in establishing Rural area Community Controlled Health Organizations
- Advocate for change in partnership with local leaders, all levels of government and health service providers.

Thank-you for your consideration of our proposal. Please do not hesitate to contact me should you require clarification or elaboration with respect to any aspect of this submission.

Warm regards,

Ms Margo Purcell
Director
Rural Health Management Services Pty Ltd

Rural Health
MANAGEMENT SERVICES

Sustainable Rural Healthcare

2022-23 Pre-Budget Submission to the Australian Government

Rural General Practice

Locals Leading Local Health Care

Contact
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Rural General Practice – Locals Leading Local Health Care

1 INTRODUCTION

Primary care has long been recognised as the cornerstone of health service delivery. General Practice remains the *'home of healthcare'* and links the patients to all health services and provides many of these services within the General Practice. This is a different role to an urban GP or an Emergency Department. The rural and remote GP has a specialist role in supporting all aspects of healthcare within that community and often at all hours.

The provision of a general practitioner (GP) and related primary health services to rural, and regional Australians, is in crisis. The Australian Federal government acknowledged the failings and on 4 August 2021, the Senate referred an inquiry into the provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians to the Senate Community Affairs References Committee for inquiry and report by the last sitting day in March 2022.

Rural communities are well positioned to locally manage their health service planning. However, communities need initial support to guide the health service planning process to optimise outcomes which result in the delivery of accredited and sustainable health services.

2 THE HEALTH OF RURAL AUSTRALIA

The challenges of geographic spread, low population density, limited infrastructure, and the higher costs of delivering rural and remote health care can affect access to health care.

Around 7 million people—about 28% of the Australian population—live in rural and remote areas, which encompass many diverse locations and communities (ABS 2019d).

Data show that people living in rural and remote areas have higher rates of hospitalisations, deaths, injury and also have poorer access to, and use of, primary health care services, than people living in Major cities. (Australian Institute of Health and Welfare, 2021)

Australians living in remote areas are admitted to hospital at 1.3 times the rate of their urban and regional peers. For Australians living in very remote areas the rate is nearly double the urban rate. Potentially preventable hospitalisations also increase steeply with remoteness. The difference is most marked for acute conditions where remote rates are almost 2.5 times that of urban areas. The median age at death in major cities in Australia is 82 years, in outer regional, remote and very remote areas it is 3, 9 and 18 years younger and the statistics are much worse for First Nations Australians. (Australian Institute of Health and Welfare, 2021)

3 BACKGROUND

Rural Health Management Services was formed in 2010 by the Central Queensland Rural Division of General Practice in order support rural general practices. The organisation is now operating

throughout rural and remote Queensland supporting individual services, organisations and State and Commonwealth services to increase access to and quality of primary health care services.

3.1 ABOUT US

Name	Rural Health Management Services Pty Ltd (RHMS)
ACN	141 687 774
Vision	Sustainable Rural Healthcare.
Mission	We are a profit for purpose charity providing sustainable healthcare practice management solutions for rural communities
Corporate Form	We are a wholly owned subsidiary of Central Queensland Rural Division of General Practice. The corporate entity is a proprietary limited company with Deductible Gift Recipient approval and Charity status.
Our Board	• Margo Purcell MELG - Chair • Dr Richard Tan – MBBS (Q) DRANZCOG FACRRM • Ms Jess Burrey – BPharm • Mr Zak Nicol - BHealthSc (Physiotherapy) • Dr Ewen McPhee – FACRRM, MBBS, FRACGP • Ms Rose Plater – BHealthSc (Health Management) BBus (Accountancy) CPA • Mr Andrew Hayward – MBA (Business Administration and Management)
Our Objects	Objects of Company 1.3 The objects for which the Company is established is the advancement of health and attainment of the highest standard of health care for the people in rural and remote Queensland who have a need for health and associated services by reason of geographical isolation, social or economic circumstances or sickness through the following: 1.3.1 supporting the provision of high quality and accessible health care by providing and advocating for flexible, multidisciplinary patient-centred care in the rural and remote regions through: a) integration of local programmes and initiatives; b) encouraging and facilitating integration across primary health care organisations, tertiary health care and the community; c) creating pathways between existing and future public and private sector health – related services; d) creating an environment for the efficient and effective use of information technology to facilitate better health outcomes; 1.3.2 supporting the current and future primary care workforce to provide health care to aid in the prevention and control of disease which encompasses, amongst other things: a) the encouragement of students and health practitioners to acquire the skills and experience necessary for health practice; b) the provision of professional development to health professionals where appropriate; c) the fostering of professional networks and support for health practitioners; d) enabling and supporting research into improving the health of communities;

	e) supporting an integrated environment which will attract and retain a strong workforce of health practitioners to increase the amenity of rural and remote Queensland; f) providing opportunities to increase the number of health practitioners within rural and remote Queensland, 1.3.3 being responsive to local community needs and priorities, including the needs of Aboriginal and Torres Strait Islanders and other cultural and linguistically diverse people; 1.3.4 providing support for preventative care and control of disease which encompasses: (a) diagnoses and treatment; (b) integrating programs and initiatives for the benefit of the community; (c) providing a multidisciplinary and community approach; (d) providing access to health practitioners, including, but not limited to: (i) mental health nurses, (ii) General Practitioners, (e) Providing support services that reduce chronic disease in rural populations; and 1.3.5 if endorsed as a Deductible Gift Recipient, seek donations and funding from the public and all levels of government to fund the activities of the Association; 1.3.6 advance health by undertaking any of the following activities: a. establishing and operating public medical centres for the diagnosis, treatment and management of illnesses and diseases; b. providing community health services focused on the needs of the community, such as mobile screening for diseases and symptoms of diseases; c. providing patient transport services to and from public medical centres where necessary to enable patients to access healthcare; d. undertaking research into the causes, diagnosis, treatment and/or management of illnesses and publishing the results of that research; and e. providing training for medical professionals regarding the most recent developments in best practice for diagnosing, treating and/or managing illness; f. donating/distributing any funds to another charitable organisation with charitable purpose(s) similar to, or inclusive of this clause 1.3, 1.3.7 undertaking any activity ancillary to, or which supports the above objects, including (without limitation) to use its assets for remuneration purposes, acquiring, disposing of, or leasing any building, or any asset and the making of investments for the purposes of (or in connection with), carrying out the above objects;

	1.4 The Company may do all things that help it to achieve these objects, in accordance with this Constitution. 1.5 The Company and its directors may only do things and use the income and assets of the association (including those held on trust for the association or its purposes) for its objects. 1.6 The Company must operate consistently with legal requirements for registered charities.
Our Capability	The organisation is responsive to the need to support Rural and Remote Primary Care and provides a service to allow access quality primary health care services by; • Managing rural and remote General Practice • Providing project management for infrastructure development • Planning locally integrated Primary Health Care services • Recruiting Medical, Nursing, Allied Health and support staff for Primary Care • Developing local training programs and professional development pathways • Ensuring systems and standards are developed to maintain quality primary health care services • Developing locally integrated services to ensure the services are locally accessible, multi-disciplinary and sustainable. • Establishing private and public partnerships at the local level.
Accreditation	• ISO 9001 Accredited – Quality Management System • 100% of managed practices are accredited to RACGP 5th Standards.

3.1.1 Our Achievements

First as a Division of General Practice and later as an independent organization we have actively worked to maintain, rebuild and primary health care service services in rural and remote communities.

3.1.2 General Practices

These General Practices have been managed and developed with the intent to build sustainable local services over time. Many are no longer managed and some of them have been managed several times.

General Practice	Years of RHMS Management	Transition
Moura Dawson Medical	2013-2015 2021 - Current	GP managed until October 2021 – RHMS operated business
Springsure Medical	Current	Checkup funded GP Clinics provided by Rolleston Clinic
Clermont Surgery	February 2014 – July 2021	Closed Practice in 2021. Dr Sarah McLay manages a GP led clinic in the community.
Monto Medical Centre	February 2011 – October 2013 April 2014 – February 2019	Transitioned to GP management in 2019

Rolleston Health Centre	Built the clinic and commenced management in 2010.	Continue to Manage in partnership with Rolleston Health Group
Baralaba Private Practice	December 2015 – Current	RHMS operated business
Wowan Outreach Clinics	Current	Checkup funded GP clinics provided by Baralaba GP's.
Eidsvold Family Practice	February 2012 – February 2019	Transitioned to GP Management in 2019
Mt Morgan Medical	January 2015 – July 2018 May 2019 – October 2021	Transitioned to GP Management in 2018 & 2021
Gayndah Medical	January 2014 – March 2016	Transitioned to GP in 2016
Biggenden Medical	May 2015 – September 2018	Transitioned to GP Management 2018
Mundubberra Medical	March 2014 – February 2015	Transitioned to GP in 2015
Flinders Medical Centre (Cloncurry)	October 2017 – July 2020	Transitioned to GP Management in 2020.
Kingaroy Medical Centre	June 2019 - Current	RHMS owned practice.
Julia Creek Medical Centre	September 2018 – July 2021	Returned to HHS primary health care centre on request of NWHHS.
ACE Medical Centre	November 2018 - current	Practice management – GP owned practice
Ravenshoe Medical Centre	October 2020- current	RHMS owned practice
Herberton Medical Centre	October 2020 - current	RHMS owned practice
Mt Garnett Clinic	October 2020 - current	RHMS owned practice
Hughenden Doctors Surgery	2022 - current	RHMS operated business

3.1.3 Allied Health Services

Allied Health services were originally developed as part of the *Integrated Allied Health in Rural Communities* for rural communities and since have been self funded or funded through the Primary Health Networks. Some services are now being developed in conjunction with managed General Practices. The following disciplines have been developed as funded and fee for service in many of the communities.

- Psychologist
- Mental Health Nurse
- Mental Health Social Worker
- Midwife
- Dietician
- Occupational Therapist
- Diabetic Educator,
- Speech Pathologist
- Generalist Social Worker
- Community Nurse

- Clinical Psychologist
- Physiotherapist
- Community Social Worker

3.1.4 Health Planning

In recent years Rural Health Management Services has been involved in working with Communities, State and Federal Organisations to facilitate local solutions.

- Integrated Allied Health Services Central Queensland
- CQ Suicide Prevention Plan
- Julia Creek Integrated Service Model (not implemented by NWHHS)
- North West Corridor Plan
- Accreditation Plan Hope Vale Primary Health Centre
- General Practitioner services in Aged Care Rockhampton
- Integrated Medical Services Palm Island Primary Health Care
- Magnetic Island Health Plan
- Accreditation, Business Plans and Health Plans Inner West Cluster Torres Strait
- Gladstone Health Plan

3.1.5 Infrastructure

When the Commonwealth grants were available for development of local health infrastructure, Rural Health Management Services provided project management and governance for the following infrastructure projects

- Rolleston Health Centre
- Monto Medical Centre
- Theodore Medical Centre
- Dysart Medical Centre
- Gayndah Medical Centre
- Extension of the Moranbah Medical Centre
- Emerald GP Superclinic
- Ace Medical Centre

3.1.6 Locations

Click on the link to view our geogaphical footprint.

Rural Health Management Services - Google My Maps

3.1.7 Rural Health Management Services Examples of Impact

The following are some examples of work to support the sustainability of GP and Primary Health Care services in local communities.

Case Study One – Moura Medical - A Community in Crisis

Moura is a well-established town situated in the Central QLD region of Banana Shire. Moura hospital supports two doctors and services the town and surrounding communities, which has a population of around 3500. An estimated 1500 fly-in-fly-out workers also rely on the hospital. The medical superintendent position includes the right to private practice at the GP clinic, Moura Dawson Medical Centre. In 2013, the community were at risk of losing their GP Services.

Rural Health Management Services were instrumental in brokering negotiations between the CQHHS and Moura Health Action Group. RHMS commenced management of the practice in 2013 and transitioned the practice to GP led management in 2015. After 6 years of GP management, RHMS took on management of the Moura Dawson Medical Centre in 2021 allowing the existing GP to transition out of the community. RHMS will maintain the local GP services and support the recruitment of permanent GPs (Currently a husband-and-wife team are looking to fill the vacant positions).

Case Study Two – Kingaroy – Gracious Exit

Kingaroy is a small community with 5 General Practices all with closed books and high proportion of GP patients presenting at Kingaroy Emergency Department. RHMS stepped in to manage a local practice which was closing in 2019 and has sustained the business with the intent to grow from a single GP Practice to a four GP clinic with co-located Allied Health Services. Kingaroy Medical remains the only practice continuing to take on new patients and has commenced a local Dietitian service.

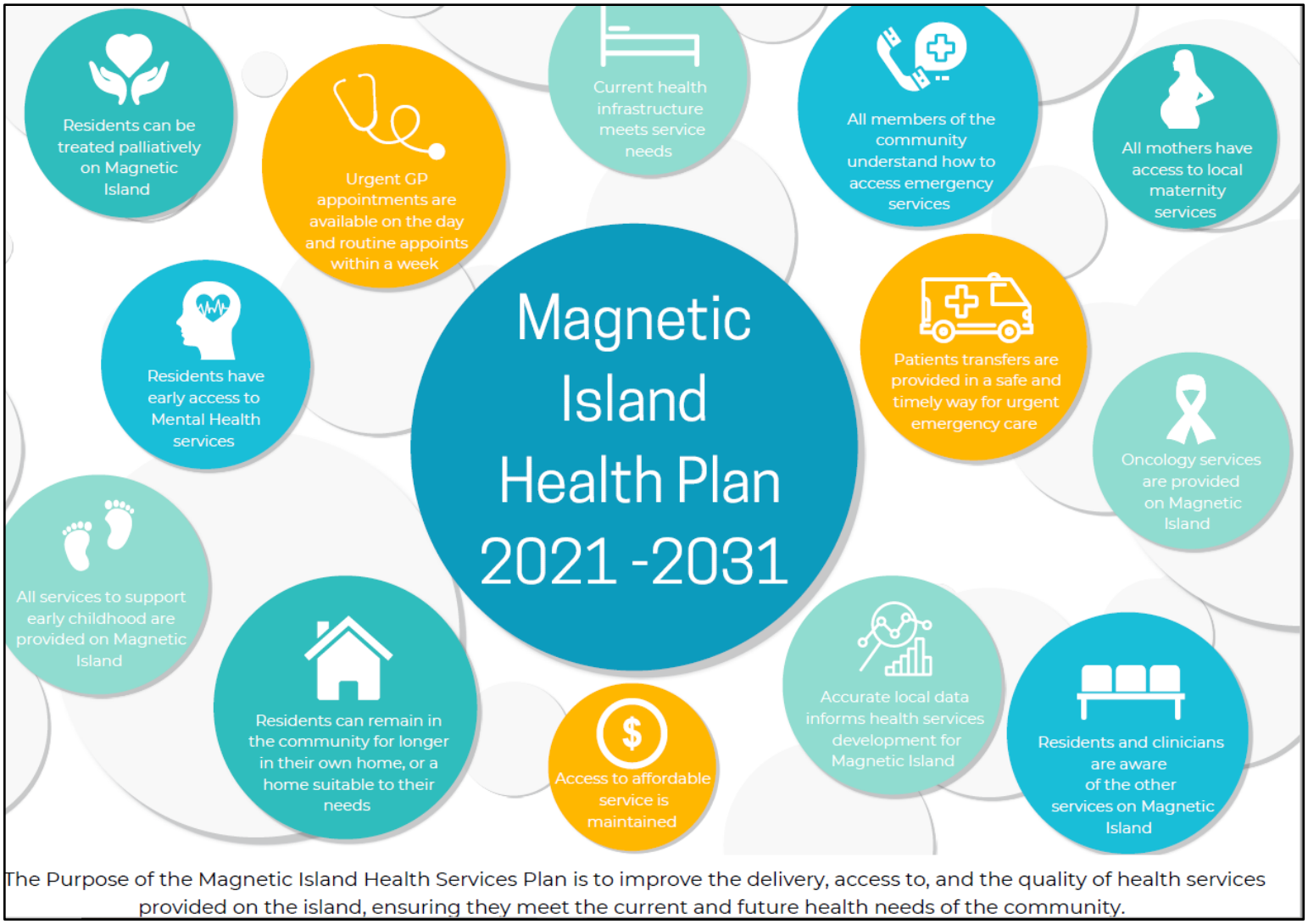
Case Study Three –Emerald Superclinic/Central Highlands Healthcare – Healthcare Infrastructure for the Future

In 2014, Central Qld Rural Health collaborated with the Central Highlands Community to successfully access $5million via the GP Super Clinics Program. This project included the planning and development of the infrastructure as well as the establishment of a not-for-profit social enterprise, Central Highlands Healthcare that continues to own and manage the General Practice.

Case Study Four – Magnetic Island Health Plan – Community Led Health Service Planning

In July 2020 GP services collapsed on Magnetic Island with the exit of the last practicing GP. RHMS worked with local, State and Federal Services to re-establish a 4 GP practice and Medical Services for the local Primary Health Centre. RHMS was then contracted by the local HHS and PHN to work with all providers to develop a 10 year health plan for the community with shared roles for all health providers

3.1.8 Example of Local Led Health Plans



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4 GOALS

This proposal is underpinned by the goals set under the 2020–25 National Health Reform Agreement (NHRA).

Signed by all Australian governments, the 2020–25 Addendum to National Health Reform Agreement (NHRA) aims to improve health outcomes for all Australians and ensure our health system is sustainable.

The goals of the NHRA are to:

- deliver safe, high-quality care in the right place at the right time
- prioritise prevention, and help people manage their health across their lifetime
- drive best-practice and performance using data and research
- improve efficiency and ensure financial sustainability.

Goal	**How does this proposal achieve this principle?**
Deliver safe, high-quality care in the right place at the right time	• Keeping the doors of General Practice open close to home • Building the skills, knowledge and infrastructure for local General Practices • Support General Practice to achieve accreditation • Develop sustainable business models for community based General Practice in Rural and Remote • Establishing sustainable Allied Health services • Supporting training positions for rural health clinicians of all disciplines
Prioritise prevention, and help people manage their health across their lifetime	• Develop population based services through General Practice • Support the development of childhood screening and health assessments through General Practice • Support the development of health education programs supporting self management. • Support access to allied health services to support implementation of chronic disease plans and preventative health.
Drive best-practice and performance using data and research	• General practices that are accredited • Early adopters of nationally recognised Best Practice guidelines • Financial benchmarks that ensure sustainability • Participation in Primary Health Care research • Sharing of health outcomes data
Improve efficiency and ensure financial sustainability.	• Develop local health plans to ensure all services are accessible locally or via outreach services • Develop integrated health services that recognise and access all funding options for health services • Ensure strong multi-disciplinary models of health care are in place • Develop strong business plans • Ensure there are local training and career pathways for all clinicians and support staff.

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The 6 reforms outlined in Schedule C of the NHRA are:

- empowering people through health literacy – person-centred health information and support will empower people to manage their own health well and engage effectively with health services
- prevention and wellbeing – to reduce the burden of long-term chronic conditions and improve people's quality of life
- paying for value and outcomes – enabling new and flexible ways for governments to pay for health services
- joint planning and funding at a local level – improving the way health services are planned and delivered at the local level
- enhanced health data – integrating data to support better health outcomes and save lives
- nationally cohesive health technology assessment – improving health technology decisions will deliver safe, effective and affordable care.

This proposal supports the reform number four;

- joint planning and funding at a local level – improving the way health services are planned and delivered at the local level.

Rural Health Management Services has been working to this goal for many years and is in a unique position to support communities, government, and health care providers to plan and deliver locally owned health care services.

5 INVESTMENT AND OUTCOMES

Communities and health service providers need to access all available funding sources to address local healthcare needs in a more targeted way, including;

- programs administered or commissioned by Primary Health Networks (PHNs),
- Rural Workforce Agencies (RWAs),
- the National Disability Insurance Scheme (NDIS),
- aged care funding, and
- locally based services delivered by local providers such as local government and local health networks (LHNs). (Healthcare Management , 2021).

Rural Health Management Services is uniquely placed to develop health plans which reflect the local health service needs and ensure there is equity of health investment from all sources of health funding including some fee for service and private health insurance funding. The health plans for each community should drive investment in health services and determine the health status of the community to effectively target and measure specific health outcomes for each community.

Rural Health Management Services request an investment of $350,000 per annum for three years. It is vital to the sustainability of the organisation to access backbone funding to support the continuation of services that it has provided over the last 30 years. The Commonwealth has changed the way Primary Health Care is supported over this time but the need for RHMS's experience in the planning and delivery of rural and remote Primary Care remains paramount.

It is essential organisations like RHMS are funded and continue to work to restore sustainability to rural general practices and support health services models to develop locally led health service plans

that continue to care for rural people. Rural Health Management Services role in delivering rural General Practice services through a model of 'Rescue, Rebuild and Release' has already ensured that 20 communities have maintained access to their primary care service in times of crisis. Our unique model supports the 'Easy Entry, Gracious Exit' model of primary healthcare in the bush. We support General Practitioners to enter into the management of GP practices in communities that welcome a local Doctor to service their health care needs.

Rescue	RHMS has worked with local councils, Health and Hospital Service and private GP practices to step in and take on the management of rural and remote General Practices to maintain access to services locally. RHMS has also started new practices and re-opened clinics that have been closed for a number of years in order to establish local GP services.
Rebuild	In all cases when we are asked to work with the General Practice there are opportunities to further develop services. This can be through implementing local systems, staff development, infrastructure, recruitment, business planning or health planning. This process takes investment and time to complete. In most cases this can be funded through receipts over time or grant funding. The set-up process and operations of the organisation during this time are not funded. To continue to maintain the organisation back bone funding is needed.
Release	The capacity to release General Practices and Allied Health Services to the operation of the local clinicians has aided the attraction and retention of clinicians locally. As the GP works in the practice and observes the functioning of the business, they take on more of a leadership role and on many occasions then strive to also take on the ownership and management of the business. This changes a two-year term to a five-year term or in many cases longer. The same applies to Allied Health as they see themselves as a respected part of the team and strive to manage their own workload and income.
Retain (if required)	RHMS have retained two General Practices where at this time there is no clear direction to release. This strategic investment has been considerable, and we are only in the rescue/rebuild phase. There will always be some situations where an ongoing managed business is preferred.

We are able to provide this service through cost sharing across our managed practices. Our focus is on systems and processes that support sustainability for the practice and community. However, we incur considerable expense as we 'rebuild' the practice by investing in recruitment, equipment, staff development and training, planning and accreditation. Often, we transition the practice back to GP led management once the profitability is stabilised.

The federal government contribution will allow us to continue this investment throughout the re-build phase without jeopardising the overall viability of the company. The investment will also ensure the organisation is able to mentor GPs and communities as they work towards sustainable services. The backbone funding will ensure templates and resources are developed and available across communities, skills are shared and successes promoted locally, within Qld and across the Australia.

5.1 HOW ARE WE ACHIEVING THIS?

There are a number of key principles that ensure the actions to support the redevelopment of rural and remote General Practice and other Primary Health Care services which are successful and sustainable. It is through developing the skills to work across and with different organisations at the local level that the services have developed and thrived in the local settings. All of these principles need to be addressed in each community. RHMS has developed the skills, knowledge and resources to ensure each of these areas are addressed in each community over time.

5.1.1 Community Led solutions

Engagement with community leaders is key to long term success. There must be a genuine commitment to supporting access to health services locally. Community leaders can facilitate the success of primary care services through demonstrated support of the local providers, support for infrastructure development, advocacy for new or extended services and leadership in the local health planning process. In many cases local leaders can direct the development of health services to meet the needs of their communities. Local leadership also means local solutions and facilitates integrated service models, service funding from multiple sources and local solutions to gaps in infrastructure, equipment and other resources.

5.1.2 Private General Practice / Private Allied Health

There must be a commitment to establishing some access to private services based on fee for service or where income is derived from productivity. There is at times, a reluctance for clinicians to enter this type of service, where there is a high upfront cost (financial and time investment). The initial investment in developing small business models is often prohibitive, especially if there is not a long-term commitment to the location. However, the advantage of a fee for service model or payments to clinicians based on income generated is the delivery of sustainable and higher quality health services for local communities.

Where there is some relationship between payments made and services provided there is increased efficiency for general timed consultations, a focus on providing procedural services if appropriate and a commitment to Chronic Disease planning and regular health assessments for eligible patients. There is also a recognition that the relationship with the patient is a long-term relationship and there needs to be a planned approach to addressing all the health care needs of the patient and not just the presenting problem of the day.

The improved outcomes from a productivity-based service model are the same for General Practice and Allied Health services. Patients' health outcomes will improve as there is a greater level of commitment to continuity of care and treatment of all aspects of the patient's health within a private practice model.

5.1.3 Private / State Partnerships

There are some aspects of patient care which are difficult to provide in a private practice model. When there is a genuine commitment to full partnership the services are provided by the right organization to meet all the patient's healthcare needs.

Partnerships depend on strong / respectful relationships which are best developed locally. RHMS has been able to facilitate these relationships and support planning for local services. Policy at the State and Federal level to support local planning and partnership can support these partnerships. RHMS is very supportive of the proposed model for community-controlled health services for rural and remote communities. This model provides real potential to facilitate local partnerships between private practice, State, Federal and Local government, business and non-government organisations.

RHMS has worked to develop locally integrated service models for primary care for rural communities where the support has been funded through local Health and Hospital services or local government.

5.1.4 Local Health Plans

Many services in rural and remote communities have been established and led by local clinicians or identified in response to a critical need. These plans and services are effective for as long as the leader remains to drive the integrated local services. There is a desperate need for services to be planned locally to respond to the specific needs of the community and maximise the local resources available. Integrated health service plans need to be underpinned by locally shared vision and goals with clear actions. Additionally, a strong governance framework must underpin that plan which will ensure its sustainability beyond individuals and organisations.

The planning process needs to be collaboratively led by both State and Federal policy makers and supported by all organisations funded for the provision of health services in a community, including non-government organisations and private providers. There are many available resources to support an effective planning process but very few organisations or individuals with experience in leading this process with local communities. RHMS has this capacity and a proven track record and could support other organisations and individuals to develop capacity in local health planning.

Health plans should be led by community leaders and endorsed by local organisations who remain committed to implementing and reviewing the local health plans. It is important as part of the planning process to ensure there is a policy commitment to the planning process and a long-term process to develop, implement, review and continually measure outcomes included in the local plan. RHMS has been able to work establish this process in some communities where there is the strategic leadership locally to plan for locally improved access to health services and health outcomes for the community.

5.1.5 Commonwealth / State Partnerships

Historically and unfortunately health funding is siloed, with the resulting in competition to access health funding. RHMS has worked locally to bring together local and regional Commonwealth and State services to ensure there is collaborative planning. This happens to a limited extent at the regional level but unfortunately does not often lead to local collaboration, co-funded positions, joint commissioning or measuring and planning health services specifically for each community as normal practice.

If health services are planned locally to ensure the desired health outcomes are achieved for the community, and results are measured, there will be more efficient use of all available health funding. Joint planning will ensure services are developed to address actual local needs and the joint

health expenditure delivers the results for the community. Local partnerships and service planning will ensure the highest level of access to services for each community from all available health funding. Rather than each agency capping available funding which results in decreased access to services and duplication in services.

5.1.6 Business and Strategic Planning

RHMS has extensive experience in developing strategic and business plans for Primary Care services, both allied health and general practice services. These skills have been provided to support development of local services developing strong strategic and business plans for rural and remote General practice and Allied health services and supporting the rescue and rebuilding of local services.

As local health plans are developed, each organization will then need to develop local strategic and business plans to support meeting the local goals and health outcomes established for the community. These plans will then assist in setting priorities for regional, state and federal health planning and funding.

6 EXPECTED BENEFITS

The crisis in rural and remote primary health care makes the timing right to move to rebuild those services and enable policy and organisations that facilitate improved access to services. Supporting organisations like Rural Health Management Services will ensure there is capacity to achieve these goals. There is a clear need for organisations who are able to fill the gaps in services as needed and work with rural and remote communities to plan for and lead the development of health services in their community. Backbone funding will enable these services to be provided but will also ensure there is a capability to work with local communities to provide skills, resources and mentorship for the initial development phase until services are developed, viable and independently managed.

Core funding to Rural Health Management Services will ensure three key outcomes.

6.1.1 Increased Access to Services –
RHMS is able to work with communities, local, state and federal governments to rescue, rebuild and release at risk health services. It is essential that the services provided remain available across rural and remote Queensland for the next 3 years to ensure existing services are protected and new services can be developed. As part of increasing access to services RHMS will be available to collaborate with communities to develop health plans for their community. RHMS also has the skills and resources to support the communities to develop community-controlled health services to meet local health plans.

6.1.2 Improved quality of patient care.
There is clear evidence that accessible primary health care reduces the impact of disease for individuals and reduces presentations to emergency departments and the need for hospital-based services. There has been a progressive decrease in access to primary health care for many communities with State services becoming the default provider. RHMS is in a unique position, with the capability of working with State and Commonwealth health services to rebuild Commonwealth funded and productivity based models for the delivery of local primary health care services (GP and Allied Health).

6.1.3 Advocacy for Rural and Remote communities
RHMS staff have experience in working across sectors. Ensuring communities, PHN's, Workforce Units, HHS's and other local organisations have access to an organisation to

support local change. RHMS provides this role to many organisations now but is not funded to continue to be available for this role. It is essential for the development of local responses that RHMS continue this role. Many rural residents, clinicians and health leaders have limited experience in working across services or planning collaborative local responses. RHMS is able to support organisations and individuals to develop this capacity providing mentorship, resources and education.

6.2 KEY DELIVERABLES

Key Deliverables	Baseline	Yr1	Yr2	Yr3
Access to Services				
Emergency management response	0	+ 1	+ 2	+ 2
Transition in practices	7	+ 2	+ 2	+ 3
Transition out practices		+ 1	+ 2	+ 2
Community Planning	2	+ 2	+ 2	+ 2
Establishment of community-controlled health services	1	+ 1	+ 1	+ 2
Improved quality patient care				
Increase in number of patients accessing care through RHMS supported services	10,000	+ 5%	+ 7%	+ 10%
Decrease in patients accessing Emergency department services for GP Care where RHMS are supporting primary care services	TBC	- 5%	- 7%	- 10%
Number of accredited primary health care services supported by RHMS	7	+ 2	+ 2	+ 2
Number of allied health services providing private, and Medicare funded consultations supported by RHMS	5	+ 2	+ 2	+ 2
Advocacy for rural and remote communities				
Regions benefitting from RHMS Support	8	+ 2	+ 2	+ 2
Community consultation meetings held		6	6	6
HHS meetings to support Primary Care		6	6	6
Increased collaboration plans developed		2	2	2
Partnership agreements signed		2	2	2
Workforce plans developed		2	2	2

It is also important to expect and measure effective change in how Rural and Remote health services are planned and provided. It is anticipated that each year RHMS would report on changes supported in each region. This report would include detailed information on;

- Types of service changes
- Changes to the local planning process in each community
- Impacts of change in services in each community
- Other broader community or regional benefits
- Population likely to be impacted by changes
- Services gaps identified and future service needs to be addressed

7 FINANCIAL MODELLING

This submission seeks to secure backbone funding as part of the Commonwealth budget for 22/33. To maximise the benefit the funding should be recurrent for at least 3 years. Longer term, developing similar funded roles for non-government organisations in each State will support the redevelopment of rural and remote Primary Health Care. Business capacity funding will ensure RHMS services are available to support local communities, primary health care and government organisations when required. RHMS will then have capacity to provide services working in partnership with each community and Commonwealth, State and Local Government, local PHNs / HWAs if appropriate.

Rural Health Management Services Pre-Budget Submission FY 2023				
Rural General Practice – Leading Local Health Care				
Redevelopment of Primary Health Care Services in Rural and Remote Queensland				
	FY23	FY24	FY25	Total 3 year funding
	$	$	$	$
INCOME				
Proposed Triennial funding	350,000	350,000	350,000	1,050,000
TOTAL FUNDING	350,000	350,000	350,000	1,050,000
SERVICE DELIVERY EXPENDITURE				
Audit Fees	5,000	5,000	5,000	15,000
Community consultation	25,000	20,000	17,500	62,500
Finance and administration	80,000	85,000	90,000	255,000
Governance costs	35,000	35,000	35,000	105,000
Information technology support and development	73,000	63,500	55,500	192,000
Insurance	9,000	9,000	9,000	27,000
Legal services	5,000	5,000	5,000	15,000
Marketing, promotion, and web-based services	5,000	5,000	5,000	15,000
Practice development and modelling	80,000	85,000	90,000	255,000
Quality assurance and accreditation	9,000	9,000	9,000	27,000
Training and development	5,000	6,000	5,000	16,000
Travel and accommodation	15,000	18,000	20,000	53,000
Utilities, telecommunications, and office supplies	4,000	4,500	4,000	12,500
TOTAL SERVICE DELIVERY EXPENDITURE	350,000	350,000	350,000	1,050,000
SURPLUS / (DEFICIT)	-	-	-	-

7.1 ASSUMPTIONS / NOTES

Rural Health Management Services has developed a proposed budget for expenditure. Funds will be used to support organizational costs that are currently difficult to cover and support existing services that are not able to be internally, or grant funded.

This proposal allows triennial funding is fixed at $350,000 per year. The backbone funding will support fixed costs;

- 50% of fixed cost of audit fee for three years.
- Finance and administration cost associated with the initial phases of 'rescuing' general practices and facilitating local led health plans
- Investment in the IT upgrades to ensure reliable access to connectivity to improve outcomes for clinicians and patients.

Additionally, the funding will support the local led health planning that will underpin health service delivery in rural areas and ensure the services remain sustainable. The investment in community health planning will be utilized to achieve the following;

- Travel to communities
- Community Led forums
- Researching population Health data to identify barriers and support proposed solutions
- Engaging consultants as required to support community led health planning
- Developing strong local governance underpinned by systems and processes.

RHMS have historically either internally funded or sought partner (where possible) to support the development of locally developed health plans. This investment will ensure at risk communities are empowered to develop solutions that are unique to their community.

8 GOVERNANCE FRAMEWORK

Backbone funding for organisations like RHMS should be a Commonwealth responsibility. Organisations that provide similar roles are then able to support local change processes, support development of local health plans, develop or deliver primary health services and provide mentorship, skills and resources to community leaders need to remain viable and available in each State. The organisations should be Commonwealth funded through Dept of Health and managed in conjunction with PHN and Health Workforce Agency programs in each State.

9 FUTURE SUSTAINABILITY

Established viable local models of care, infrastructure, integrated services, documented solutions, established local planning processes and shared governance at local level support sustainability. To establish sustainable services, communities and local providers need access to expertise and support. Backbone funding to RHMS will ensure this support is available in Rural and Remote Queensland.

As RHMS works with each community, unique solutions are developed, and the set of templates and resources expanded to include responses to new issues and innovative solutions are developed. Capacity for other organisations to follow templates created and resources for service development and planning at the local level will support the long-term sustainability and capacity to plan and deliver services locally.

10 SUMMARY

Funding Rural Health Management services for three years ($350,000 per year) will ensure there is an organisation in place to;

- Continue, where needed to take up and maintain access to services (General Practice and Allied Health services)
- Support the development of improved access to local services through the development of local health plans and community led rural and remote primary care services
- Directly assist in establishing Rural area Community Controlled Health Organisations
- Advocate for change in partnership with local leaders, all levels of government and health service providers.