NATIONAL RURAL HEALTH ALLIANCE INC.

COUNCILFEST

COMMUNIQUÉ

30 September 2014

Annual face-to-face meeting of the National Rural Health Alliance 2014

All-Party support for rural and remote health?

CouncilFest, the annual face-to-face meeting of the National Rural Health Alliance, enabled delegates from its 37 member bodies to agree on five priorities to take to parliamentarians in delegations on Monday 22 September.

That was the day on which there was a lockdown in Parliament House due to a security alert. After a photo-shoot with all members of Council in their #loverural t-shirts, access to the public area of the House was made difficult by the lockdown.

It takes more than a security alert to stop the Alliance and its supporters from working to improve the health and wellbeing of people in rural and remote areas. A number of parliamentarians with a particular interest in improving rural and remote health, led by Assistant Minister Fiona Nash, came to our aid and the fortress was breached (without any security provisions having been overlooked). A media release resulted.

Internal movement of the Alliance's delegations was restricted and our special thanks are due to all of those we visited, and some we didn't, who helped us by accompanying our groups from one office to another.

The Alliance's purpose in Parliament House was to ensure that the voice of the people of rural and remote Australia is heard on contemporary policy issues affecting their wellbeing. A secondary purpose was to inform those who were not already aware of it that the Alliance is a capable, respected and inclusive voice for the interests of country people. The Alliance is always available to provide information and briefings on rural and remote issues to relevant organisations and people.

The five priorities

In the House the Alliance discussed with parliamentarians many of the issues currently affecting the health of people and communities in rural and remote areas. The five priorities given particular consideration related to rural and remote aspects of:

- the transition from Medicare Locals to Primary Health Networks;
- a 'last mile' program to enhance access to broadband and telephony (fixed and mobile);
- the deregulation of university fees;
- the operational plan to be the basis of action within the agreed National Aboriginal and Torres Strait Islander Health Strategy; and
- governmental commitments to additional resources for public dental health services.

Access to health care can be improved through successful transition to locally-controlled Primary Health Networks (PHNs) and by improved internet access in rural and remote areas. The rural and remote health workforce is likely to be jeopardised by increased university fees. The Alliance seeks governmental commitments to practical proposals for improving health outcomes for Aboriginal and Torres Strait Islander people, and for those in rural and remote areas needing oral health care.

Each of these five will be briefly discussed below.

1. Primary Health Networks (PHNs) that serve rural and remote areas must be locally managed, and should plan and deliver services where there is unmet need but should not compete with established services.

The NRHA speaks for a wide range of rural and remote stakeholders and is keen to be involved with the transition from Medicare Locals to PHNs.

It remains concerned about the ability of large PHNs to deliver on key principles for their success. To be effective, PHNs must be closely connected with local patients and clinicians, managed locally, and have close collaborative relationships with their Local Health/Hospital Networks. LHNs will also need to work effectively with their local Clinical Training Network or Rural Clinical School.

The tender process for PHNs should ensure that these principles will apply in the PHNs' decision-making, governance structures, management and operation. To be sure these principles do apply locally, consideration should be given to the exclusion of large commercial entities and State and Territory Governments from the PHN tender process.

The Government must provide certainty of funding and contracts beyond the end of this current financial year to ensure that rural and remote communities have continuity of care and are protected against the loss of existing health professionals and services during the transition to PHNs. Rural health service capacity is fragile and, once lost, difficult to be rebuild because of the challenge of recruiting staff.

Given the high levels of unmet need for health care in rural and remote areas, PHNs in those areas should be involved in direct service delivery, and their work will be done best if they are accountable locally. This will include direct delivery of mental health and other services programs, which must be sufficiently flexible to meet local need, such as those that arise following adverse weather events.

The ongoing delivery of services through rural PHNs will be one means of making up for the $2.1 billion annual primary care deficit currently experienced by people in rural and remote areas.

2. The NRHA would like to see internet connectivity in rural and remote areas improved through a 'last mile' program

The NRHA has consistently advocated for the provision of high speed broadband, by whatever technical means are best, to communities, health services, businesses and households in more remote areas at the same price that people in major cities have to pay.

The NRHA supports the proposal included in the Broadband for the Bush Alliance's communiqué that many of the more challenging places could be provided broadband through a program focused on 'Last mile solutions'. The program would give priority to connection for premises or communities close to

fibre; and to connections to a community node for individual premises in communities where there is fibre to that node.

The focus should be on getting digital infrastructure right – both through the rational use of existing infrastructure and expanding infrastructure. The expansion of mobile phone coverage as a means of providing internet connection as well as voice connections should also be included, although it does not yet provide sufficient bandwidth for all purposes.

The health sector needs connectivity for continuing professional development, online education, mentoring, clinical decision and other support for the current and next generation of health professionals to go bush – as well as for health service delivery and management.

3. The NRHA opposes the plan before the Senate to deregulate university fees and make changes to university funding in 2016.

Deregulation is likely to increase the cost to students of University education. It is already the case that, despite their lower incomes on average, rural families have to pay some $25,000 a year extra for a child to attend university or TAFE education that is only available in the major cities. These additional costs, including HECS fees, may not be repayable within a lifetime.

Such barriers to higher education may exacerbate disadvantages already faced by people from rural and remote areas in terms of access to tertiary education.

Regional universities may be adversely affected by deregulation of fees and other funding cuts through competition with metropolitan universities (especially Group of 8 universities) for both funding and student places. These regional universities play a critical role in providing a pipeline for students from rural areas to go through all stages of education and training across a range of professions until they end up practising back in rural areas.

Higher enrolments in university health professional courses due to deregulation and competition for student numbers could adversely affect the quality and number of courses on offer and the quality of rural clinical placements.

Whatever arrangements are agreed for student fees, the provisions currently in place establishing quota systems for rural students and support for Aboriginal and Torres Strait Islander health students must be preserved.

A submission from the Alliance to the Senate Inquiry into the Higher Education and Research Reform Amendment Bill 2014 can be seen here.

4. The NRHA confirms its support for the development of a strong and coherent implementation plan for enacting the National Aboriginal and Torres Strait Islander Health Plan

The development of the implementation plan should be done in partnership with Aboriginal and Torres Strait Islander people, including through the National Health Leadership Forum, and focus on activities that will support progress toward achieving the agreed Closing the Gap targets and improving health outcomes of Aboriginal and Torres Strait Islander people.

NRHA supports long term commitment to programs that have the broad support of the Aboriginal and Torres Strait Islander community to improve health outcomes for Indigenous Australians. We note that many community programs and positions are vulnerable in rural and remote areas during the transition from Medicare Locals to Primary Health Networks. Funding certainty in this environment is critical, particularly for programs that have long lead times (such as smoking cessation programs).

The implementation plan may also provide an opportunity for additional development of the Aboriginal and Torres Strait Islander health workforce.

5. The NRHA supports increased Commonwealth investment in State and Territory public dental services

The NRHA seeks assurance from the Abbott Government that the additional Commonwealth investment in State and Territory public dental health services, postponed due to the 2014 Budget crisis, will be delivered in the 2015-16 budget. This additional public sector funding would be able to be deployed in the private sector where public dentistry is unable to meet demand.

Longer term priority issues

Social determinants of health. The NRHA supports the position of the Social Determinants of Health Alliance that, given support for it by both the Coalition and Labor Parties, the Senate report written in response to the WHO document should be adopted in Australia and steps begun to act on its proposals.

MyHealth record. The NRHA welcomes the ongoing government support for the MyHealth record and favours the opt-out model.

Co-payments

The Alliance is opposed to any additional barriers between needy patients and primary care. People in more remote areas who have little or no access to a doctor at all may find the debate somewhat hypothetical. There may be nothing wrong with the general principle of people who can afford to pay being asked to do so for essential services like primary care and medications. However this current proposal will have the greatest impact on those who are most vulnerable and who already have poorest access to care.

Telehealth

Telehealth should be seen as an adjunct to local services, not an adequate or sensible replacement for them. Telehealth cannot get a snake out of your washing machine's water intake! Telehealth item numbers should be extended to include rural clinician to rural clinician contact; and for audiology.

NRHA's Executive

A new Board was elected at the 23nd AGM on 23 September. Chairperson is Tim Kelly, a GP from South Australia.

For further information and a link to the Alliance's Fact Sheets, go to www.ruralhealth.org.au or contact nrha@ruralhealth.org.au