FACT SHEET

RURAL COMMUNITY HUBS PROPOSAL

Rural and remote communities are different to cities. In cities, residents have the option of going to one of twenty local GPs, ten local pharmacies, four local physios, two Centrelink offices and four community service centres all in proximity to their homes. In rural and remote towns, the small population size means that these services must be delivered in more joined-up and integrated ways. That is why applying metropolitan models of care has always failed rural and remote people.

THE PROBLEM

People living in rural and remote Australia have poorer access to health and social services in their local community than other Australians.

This means that people living in rural and remote towns have a higher incidence of poor health and negative life outcomes.

A new model of rural and remote community service delivery is needed to systemically address these poorer outcomes. This means moving away from short term programs and trials which are contributing to increasing fragmentation of services and which have failed to deliver systemic improvement for rural and remote people.

HOW WOULD COMMUNITY HUBS WORK?

Community hubs would be a one-stop-shop, like Service NSW centres, for access to primary health (that are delivered by local businesses and charities in NSW), social support and community development services. Importantly, they would be located in rural and remote towns to ensure that services reflect the priorities and needs of the local community. Services would be delivered by a contracted NGO on behalf of the community to provide the workforce and service flexibility to align programs to community needs.

The first principle of the Community Hubs is that health is everyone's business in rural and remote towns from the local convenience store to the school, pub, local council, police station and Aboriginal land council.

A Community Hub would initially be a State government funded centre (reflecting the fact that 90 percent of the services would fall into the responsibility of the State (e.g. GP and primary health care, as well as government services such as housing, domestic violence support, child services and so forth). Over time, the Commonwealth government could be encouraged to integrate funding from its social and health service programs such as job networks, aged care and disability care. Funding agreements would be similar to the Aboriginal Community Controlled Health Organisation (ACCHO) funding model) that is community-governed and led.

Each Hub would have a community board comprised of community members, key stakeholders (education, police, hospital, community services, jobs network, enterprise centres, regional development, local government, business) and independent experts. It would work with the community to develop and deliver a comprehensive 10 year Community Plan that reflects the issues and priorities of the community.

Services that already exist in towns, such as schools or business enterprise centres, would continue to operate as per usual but their priorities and plans would be collaboratively determined through engagement with the community through the Hub.

While these Plans would have common government-determined goals (e.g. improve educational attendance, improve health outcomes, reduce youth incarceration), the model would allow communities to identify how this would be achieved in their town.

It would be a" one-size-fits-all" model that embeds a "one-size-doesn't-fit-all" mentality.

Block funding would go straight to Community Hubs for health and social care, and regional development, eliminating the waste of rural health and social services funding in administrative fees as it travels from one agency to another. This alone would return millions of dollars in funding to rural and remote health and care.

Data would inform and drive all decisions to achieve positive progress.

Each Hub would have the capacity to configure its business model and staffing to reflect the local availability of skills and the priorities identified within a community.

For example, a Hub may have a 0.6 Women's Health Nurse who could be appointed to a conjoint 0.4 Domestic Violence Officer role.The capacity to mix and match resources based on what is available locally would overcome the challenge experienced by individual agencies of supporting lone and fractional officers in far away places. Jobs would return to the bush, addressing one of the key social determinants of health – economic exclusion.

In some smaller towns, Hubs may only require 2 days a week of on-site medical services.Instead of the Hub closing for 3 days, it would continue to function 5 days a week because of its broader role. That would allow nurses and other professionals to continue to be available across the week to maintain high quality health care delivery even when doctors are not physically in the office.

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Instead of multiple agencies running multiple programs in isolation, the Hubs would have a single community approved plan that would guide and direct all services towards common community-approved goals and government-determined State and national priorities.

A team-based service model would enable the free flow of information between professionals, with appropriate confidentiality and privacy rules in place, enabling staff to work together to align services based on community and individual needs. A single care record would enable the Hub to identify factors beyond the biomedical that may be impacting upon individual or community health.

As a locally based service, Hubs could undertake health promotion and prevention in a way that reflected the local community. No more posters designed in Melbourne, and 'workshop facilitators' flow in for a half day from Brisbane touching the sides of an issue, but never really embedding change.

Local people would design local programs that target the issues that are a priority for their community. Community Hubs would design and deliver programs that embed positive community-wide cultural change that its essential for programs to deliver lasting impacts.

Departments would have direct access to on-the-ground intelligence from rural and remote people to inform strategies and share information about programs that work, while communities would have access to highly coordinated, integrated and responsive services through which the needs of people could be case managed holistically.

A critical function of these Hubs would be local development. A core driver of poor health is lack of jobs which contributes to low educational aspiration, poor educational attainment, unemployment and poverty.If we are to address the social determinants of wellbeing, we need to tackle economic exclusion head on.

The Hubs, as employment nodes, would make an important contribution to employment generation in their own right as both employment and training centres. However, their role should extend to working with local businesses and others to identify strategies that would contribute to meaningful and locally-informed economic development and employment creation.

Rather than having 10 organisations delivering fragmented services from afar, we would have one community-governed and led organisation delivering integrated services in town.

The Community Hubs model assumes that the problem communities are trying to address is how to sustainably and systemically improve community health and well-being.This change in starting-point frees communities to think more deeply about the type of workforce they actually need.

For example, a town with a high diabetes risk may find that it is best served by recruiting a Diabetes Educator to support individuals and develop a targeted community-led health campaign around nutrition and exercise. Closely located Community Hubs could work together to share resources while retaining local direction and control over how this function fits into the delivery of the Community Plan.

Another town with high student absenteeism may choose to work with the local school to invest in a youth counsellor to case manage engagement with young people around education, contributing to increased health literacy.

Some of the capabilities required will already exist in rural and remote towns (schools, police, paramedics, NGOs), while others would need to be funded. Regardless, the Community Plan would become the driver of a multidisciplinary and multi-jurisdictional approach, and would identify the long term funding needed to achieve transformative change at the root cause level.

The benefits of Community Hubs include:

- bring an end the cost-shifting debate that has resulted in the loss of services in rural and remote communities and poorer outcomes.
- genuine community engagement in the co-design of programs and services, generating greater buy-in and ownership over goals and outcomes.
- better coordination and alignment of services to the unique needs and priorities of individual communities reducing fragmentation and waste.
- team-based and multidisciplinary care tackling the causes of poor health before they become acute, rather than waiting to deal with the consequence of illness.
- shared accountability for outcomes between government and the community
- greater flexibility in configuring a staffing profile that reflects the availability of skills in the local market and community needs.
- align rural and remote services to evidence-base about preventing the onset of disease and reducing avoidable hospitalisation.
- improved physical and mental health outcomes for the communities involved.
- less stress for rural and remote staff.
- improved access to health and social services.
- improve sustainability of primary health care and social services in rural and remote towns by aggregating services and funding, addressing higher backend costs of services delivery.
- more local jobs contributing to improvements in educational participation and attainment, reductions in poverty and improvements in health.

There are myriad NGOs working in rural and remote communities that are already performing some, or all, of these functions. These local community organisations know their towns and the issues affecting their people. It is time to give back power and responsibility for health and social care to local communities so that our communities can once again have control of their own futures.

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FOR MORE INFORMATION

To discuss your community needs, email or call us.

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