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Rural Health Systems Change

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Much effort has been expended in recent years attempting to reform the Australian health system in order to deliver more efficient and effective systems of care for an ageing and increasingly chronically ill population. Rural health care systems in particular have been a focus of reform programs, and new initiatives such as University Departments of Rural Health, Regional Health Service structures and Commonwealth primary care initiatives have been designed to improve service provision and health status for rural people. However, with these attempts to reform the way rural communities understand and manage their health care, surprisingly little has changed in the day-to-day business of health care in rural and regional areas. Paradoxically, while rural communities have moved to embrace new farming technologies and environmental perspectives along with modern land management practices, revegetation and sustainable production systems, the same enthusiasm for change does not appear to have been kindled in relation to health system reforms. Rural communities, in terms of health care, are still using the equivalent of outmoded farming practices and other environmentally and economically unsustainable approaches to managing their affairs. Why might this be and what can be done to improve the current state of health reform in our rural and regional areas? The paper explores systems change in relation to health reform in rural communities and highlights several strategies for bringing about a functional synthesis of research and health service practice to create a more effective health care system in rural South Australia.

Key words: *Rural Health System Reform; Change; Sustainability; Efficiency; Integration; Collaboration*

The extent of the health crisis in rural Australia is well documented, indicating that rural people suffer a greater burden of disease, and that their health status is more likely to be affected adversely by a wide range of risk factors, than is the health status of their metropolitan counterparts (Harvey 2003b, 2004; Smith 2004; Wilkinson & Blue 2002). The paper focuses on some of the more recent attempts to deal with emerging health care problems, such as increased rates of chronic disease, rising service provision costs, and recruitment and retention of health professionals. An overview of possible reasons for the failure of change initiatives in rural health systems (Harvey, 1996, 2000, 2002) is offered with a description of key phenomena surrounding the business of rural health care.

Recent Change Initiatives

In response to health systems stresses in recent years, rural communities across Australia have been the recipients of significant funding to support a range of new primary health care initiatives. Much of this funding, additional to normal recurrent budgets in the health system, has been allocated to facilitate change and development through demonstration and research projects across South Australia in both mainstream and indigenous health systems:

Considerable effort and money has been invested in rural and remote health in Australia since it emerged as an identifiable field of activity some fifteen years ago. There has been significant investment in a rural general practice strategy; in rural and remote academic infrastructure through the University Departments of Rural Health and Rural Clinical Schools; some additional funding for regional and Aboriginal health services and financial support for advocacy groups and rural professional associations. Have there been good returns for those investments? What has been achieved? What are the continuing challenges? (National Rural Health Alliance 2004).

Further, programs such as those outlined below have been developed to enhance rural health care systems:

- Council of Australian Governments (COAG) coordinated care trials

- More Allied Health Services (MAHS)

- Enhanced Primary Care (EPC) funding for GPs and allied health services

- Commonwealth Regional Health Service initiatives (CRHS)

- Quality Use of Medicines (QUM)

- Community packages for aged care services

- Indigenous Chronic Disease Self-Management pilot program (CDSM)

- Chronic Disease Self-Management (CDSM) programs - Sharing Health Care SA

- Chronic Disease Self-Management (CDSM) programs in indigenous communities.

In addition to the initiatives and resources listed above, funding has also been provided by the Commonwealth to establish the combined University Departments of Rural Health (UDRH) across Australia. This new funding has led to substantial developments in chronic illness management in particular, but in spite of the considerable injection of resources in support of the change and development process in rural health systems, major impediments to change still exist.

The following phenomenological analysis of the change process in rural health attempts to outline some of the key factors involved in leading and managing the emerging rural health environment and offers some suggestions for improving collaboration and cooperation within and between the various components of the system that may contribute to the process of sustaining improved health outcomes for rural people.

The Culture of Rural Health Units

Rural health units form a unique culture, and have achieved an importance and status comparable with that of the local churches, schools, or the police service in small rural communities. They are often holders of major recurrent budgets and are frequently, like schools and other formal institutions, among the largest employing bodies in the community. Because of this, and the importance and status of health professionals in rural communities, health units exercise power in the local culture.

Those who work within these structures are frequently the most qualified and influential professionals in the community. They often sit on other boards of management and on community management structures because of their level of education and expertise in management, finance, and health. The hospital and health units portray an image of dependability, strength, purpose and formality.

Leadership in rural health

Many rural health unit leaders have spent a lifetime in the health system, usually working their way through the various levels of the service and grafting on, in the process,

a certain attitude to management in the health care arena. This 'attitude' might be characterised in terms of a leadership style that focuses predominantly on the management of resources rather than on the management of human capital and other related resources. It is difficult for rural health system leaders, having been nurtured in a certain school of thought, to confront these constraints and to work outside of this way of thinking.

The Service Funding Dilemma

Private providers (general practitioners [GPs] and other practitioners) are paid a 'fee for service', so there are incentives in the system for providers to provide services without necessarily focusing on health outcomes to be achieved through service provision. One solution to this dilemma might be to change the way providers are remunerated for the work they do. An example could be to fund GPs, for instance, to do more preventive, early intervention, and patient management work to keep people out of hospital, and to reduce their reliance on medical and pharmaceutical interventions. The idea of providing linked funding for specific health related outcomes underpins the Commonwealth government's Enhanced Primary Care (EPC) program (Commonwealth Department of Health and Ageing 2002a, 2002b, 2002c; Commonwealth Department of Health and Family Services 1998), which is inexorably moving health service provision in Australia towards the application of structured protocols for the management of health care services for patients with chronic conditions such as diabetes and arthritis, as is the case now in other developed countries (Alessandrini et al. 2001; Dally et al. 2002; Light 1999; Zuckerman et al. 2002).

In the United States and other developed countries, those who manage health systems, health insurance schemes, and other funding bodies providing health services are recognising a new imperative to manage this major social resource in a more effective and efficient manner in order to improve the return on these resources for the individual and the community generally (Robinson 2004). No longer can health care remain as an uncapped commodity in modern societies. It is far too valuable a resource to allow major inefficiencies to inflate the cost of providing comprehensive health care services. As Bodenheimer et al. (2002, p. 2470) argue in relation to new trends in patient self-management, for example, there is no longer a question about whether we manage things differently, but how we manage to do that.

Hospitals in particular are funded through the 'casemix' formula for admissions in various illness categories. If hospital managers initiate processes in the community to prevent or mitigate admissions and clinical costs, they might lose funding and ultimately find themselves unable to fund even basic clinical care. An example of this is the reducing capacity of small rural hospitals to maintain clinical services like obstetrics and the need for the State to keep many small hospitals open at great cost to operate virtually as aged care and long-stay facilities because other medical work can no longer be carried out in these facilities. Many small rural hospitals are expensive monuments to earlier days when they were staffed to carry out major medical procedures and when the focus of health care was predominantly acute services. Today the focus of health care is changing to preventive, earlier intervention programs, and for reasons of safety and the fear of litigation, the range of acute services provided in rural hospitals is reducing.

There appears, constantly, to be insufficient funds allocated through central authorities for health units to deliver what they need to deliver. New developments around the implementation of the Generational Health Review (GHR) in South Australia, for example (South Australian Department of Human Services 2003), and the advent of 'Population Based

Funding' may lead to more extensive change. However, even the advent of new population funding models based on aggregated population need and adjusted for disadvantage and remoteness will carry the rider that rural communities will need to realise efficiencies in the management of their health services. Sustainability, as is now being realised in the wider rural context, is also an imperative in the management of rural health services.

As local communities begin controlling their own population-based funding they will need to make their own changes to meet funding allocations whereas today they enjoy relative insulation from this harsh economic reality and look to outside agencies such as state and federal governments for direction and support. Population funding might not only give rural communities funding freedom and flexibility at the local level, but also it could provide the responsibility that goes with this freedom (Harvey 2005). Communities themselves, not unknown public servants, will then be responsible for their future business management decisions. While a positive outcome in terms of ownership and self-determination, this development would also bring new difficulties (Harvey 2001, 2003a).

Service duplication and competing interests

Historically, numerous funding mechanisms for health service resources have emerged. Hospital and allied health services are funded directly by state government while the Commonwealth government funds private service provision through the Medical Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS). In addition, the Commonwealth also funds a range of new initiatives such as Divisions of General Practice to support GPs, research and development activities, the relatively new Commonwealth Regional Health Services, and Aboriginal Health Services. Many of these systems overlap resulting in competing activities and service duplication. At best these elements can be coordinated by local groups, but at worst they run unchecked. Divisions of General Practice, for example, have from time to time become de facto service providers, being funded to introduce mental health services, more allied health services (MAHS) and the EPC program. The Divisions of General Practice were originally established as a professional resource for GPs, not as service providers.

Currently the new care planning and Enhanced Primary Care (EPC) initiatives from the Commonwealth, while offering increased resources for communities which can organise well enough to tap them, also present the possibility that privately run primary care teams could emerge to duplicate, compete with, and ultimately perhaps replace struggling, state-based allied health services. This might be part of the declared Commonwealth intention to 'take a greater interest in the direct funding of health services in the states' (The Australian Federal Health Minister, Mr Tony Abbott, speaking at a luncheon forum in Whyalla, South Australia, 16 June 2004).

People who work in rural health units, from managers, to clinicians and maintenance workers either come from or tend to become attached to small communities and many are not able easily to move place of employment. Hence, there is limited opportunity to bring in external staff, as existing permanent employees remain as stable members of the community. The task of revitalising, refreshing and re-training long-term locally based staff, therefore, becomes crucial for rural health units.

Rural communities still need to address, as do all communities, the necessity for lifelong learning and re-skilling. There is no 'qualification for the whole of life' now and although living in rural communities carries its disadvantages (Anderson & Thomson 2002; Simmons & Hsu-Hage 2002; Wakerman & Lenthal 2002), rural people will need to come to grips with the

challenge to up-skill, re-train and re-think about the way they live and work. There is a price to be paid for living in rural communities and social justice frameworks and principles of fair play might not protect rural people in the future to the extent that they might expect or hope (Lockie 2000; Smith 2004)

In addition, the problem of attracting to and retaining new professionals in remote regions is still possibly one of the most difficult challenges facing rural communities. This is exacerbated now that individuals are making decisions about where and how they work based on a new range of personal priorities; priorities that do not always rank income as the most important criterion when selecting where to work (Florida 2003).

Fear of the unknown can be a pronounced problem in rural health systems, as is the belief that external people and ideas should not disproportionately inform local practice. There is a perception among rural people that external agencies and individuals do not live in or understand rural communities and that they should not presume to tell rural people how to arrange their business. Rural communities are fiercely independent and they resent the intrusion into their culture of ideas originating from what they might perceive to be a city culture. This is epitomised in the notion that families may need to live for generations in a rural community before they are classed as 'locals'. Smith reminds us of this phenomenon when she writes:

> There is often distrust and suspicion of newcomers, who can be defined as those who have not been born in the town, or do not have their family name on a plot at the cemetery (Smith 2004).

Being independent, rural people do not necessarily embrace the notion of teamwork and collaboration, and might be reluctant to share information about how they do or have done things. There might also be a belief among health service managers that research and subsequent policy proposals might not contribute much of real value to health service management:

> As Donald Horne has noted in The Lucky Country *there is an impatient optimism in the Australian temperament which makes for an intolerance of carefully thought out proposals* (Conway 1985, p. 36).

This idea has translated into a kind of 'muddling through' in rural Australia specifically where practical measures are valued above intellectual approaches to problem solving or systems change.

The Way Forward: Rotation Programs for Health Service Leaders

There are initiatives, such as newly established University Departments of Rural Health (UDRH), that have the potential to make contributions to regional health service development if potential differences between managers of health services and academics are overcome. Health units might ignore the potential for university departments to become effective business partners, and universities need to be able to convince managers of rural health units of their value in training and research to the health system. For a synthesis between these two groups to be realised, a way forward needs to be found.

One way forward might be for the newly established academic and training frameworks to create opportunities for leaders of the two worlds to rotate their roles and experiences and in the process to learn from each other. UDRH structures have been established in the bush because practitioners have been unable to gain access to ongoing professional development and because it has been, and is becoming, more difficult to attract new health professionals to work in the rural sector.

Mentoring

A GP mentoring program developed in one UDRH has resulted in GPs partnering with researchers to develop research, writing, and grant application skills. Each leader in a

health unit would benefit by being matched to a researcher or educator in the university sector. This would not only support ongoing study and professional development, but also provide a mentoring relationship that would serve to inform both through the process of regular interaction, discussion, problem solving, and publishing.

Coordination and funds pooling

As discussed above, the competing interests in the public service provision arena can lead to duplication and inefficiency. It makes sense for small health services to pool their resources and to deal directly with the Commonwealth in setting budgets and planning priorities at the local level. This is potentially the case with the new commonwealth Regional Health Service and Multi-purpose Services (MPS) arrangements in some areas. At the very least, such a direct fund pooling approach would see rural communities funded more equitably on the basis of need and the cost of service provision rather than, as is the case currently, on the basis of fees paid for services provided. This is inequitable as there are insufficient rural providers to provide all the services communities require. Some rural communities therefore lose revenue as in the case of GP service provision where GPs simply cannot see enough patients, on a fee for service arrangement, to ensure service parity between rural and metropolitan patients who have similar health service needs.

The potential to pool health related resources, avoid cost shifting and service duplication and fund populations on the basis of need is a much more equitable way to approach rural funding, provided, of course, that communities have the financial and managerial expertise to run such a system properly. The main risks in such a process are that the pooling coefficients used to calculate funding allocations might not be adequate in cash-out arrangements and that considerable testing of the model would be required to finetune it. As discovered during the recent Council of Australian

Governments (COAG) Coordinated Care Trials (Battersby et al. 2005; Centre for Health Care Evaluation (CHCE) 2000; Commonwealth of Australia 1999, 2001; Harvey 2000), this would be expensive, as would the provision and maintenance of the necessary information technology (IT) systems to monitor and report on utilisation costs and resultant health outcomes for individuals and populations. Another important factor to consider would be the ability of organisations to manage for capital development and facility renewal over time. Currently, the cost of maintaining infrastructure is managed at a state level and is often politically driven.

These potential problems notwithstanding, locally managed fund-pooling is a promising option, however, and could be seriously explored by leaders of smaller rural communities as a way of ensuring the provision of more services in a more efficient manner. This would avoid the pitfalls of the current three and four tiered funding devolution model, in which considerable resources are consumed in the process of distributing and managing these resources.

Communication

In addition to a mentoring program for all senior health service staff, the universities in rural areas could invest in the services of a facilitator for communication between the various agencies and bodies for which the university sector may be of benefit in one way or another. This is not simply a matter of having people coordinating and promoting activities across the country, of publicising conferences and workshops, but of being involved with health unit managers in their work to understand what they need in order for them to do their job more systematically. The burgeoning UDRH sector could then be in a better position to mesh its activities with those of the health services in rural communities and, in the process, bring the functions of both organisations closer together. Such a communication strategy would provide a

connection between the two worlds, enabling a dialogue between them out of which could grow mutual respect, beneficial relationships, research work, teaching and learning; a genuinely collaborative relationship that would build the capacity and skills of both sectors of the health system.

Conclusion

Is it time to move beyond tentative primary health care programs such as chronic illness management and other short-term initiatives and into rural health system reform? For example, it has now been shown that there is much to be gained, both for patients and for the system, from new initiatives such as improved coordination of primary care services and initiatives such as self-management programs for patients with chronic conditions (Bodenheimer et al. 2002; Fries & McShane 1998; Lorig et al., 1999; Lorig et al. 2001; PricewaterhouseCoopers 2005; Strong et al. 2005). Better management leads to improved patient health outcomes and can reduce demand for unplanned hospital and emergency services. Many admissions to rural hospitals requiring expensive services, in terms of infrastructure and staffing, could be either prevented, or, if not prevented outright, patients could be managed more effectively in the community as part of a wider primary health care program. These efficiencies, if achieved, might underpin the long-term survival of rural health services as they become more and more financially independent and sustainable into the future.

In addition, the development of a more productive intellectual culture in rural health services, through collaboration and sharing between key agencies, as well as leading the wider community towards lifelong learning and development, might ensure that rural cultures adjust favourably over time to the changing health care system. The survival of the rural health care culture, like the survival of the rural primary production systems, is linked to people in both realms doing business differently, perhaps even less traditionally than has been the case historically. Modern farmers cultivate less so as to use less fuel and conserve and nurture the soil out of which their livelihood grows (Diamond 2005). Such strategies are equally applicable to the way rural communities might approach the task of building and sustaining their health care industries.

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