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EDITORIAL

AJRH National Rural Health Alliance WILEY

A rural health governance model that is fit for purpose—It's not them and us: It's 'we'

Things have never been better for rural health in Australia. Our rural health infrastructure and capacity are world leading.

1 | DO WE HAVE THE BEST RURAL HEALTH INFRASTRUCTURE IN THE WORLD?

At a recent Australian Journal of Rural Health (AJRH) International Advisory Board meeting, one of our overseas participants noted that Australian rural health is the envy of the world. This caused me to reflect on the state of rural health in our nation. We have a Rural Health Minister, a Rural Health Commission, the National Rural Health Alliance and a score of rural health professional and rural health representative organisations. Rural health is prominent in strategy and planning documents. We have had the Healthy Horizons[1] rural health plan, National Strategic Framework for Rural and Remote Health[2] and our Stronger Rural Health Strategy,[3] and rural health is prominent in most state and national health plans and workforce strategies.

Health services are primarily governed locally. While the Rudd 'funded nationally, run locally' health policy directions never fully fledged, we now have local health districts/networks/services and Primary Health Networks, which, despite their challenges, are essentially, place-based. In addition, we have a widely dispersed rural health workforce in pharmacy, allied health and general practitioner small businesses supported by the Medical Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme (PBS) and Medicare funding.

The last 25 years have also seen remarkable growth in rural health research and training capability. Australia's $197m per annum[4] rural health training and research program has 16 University Departments of Rural Health and 19 Rural Clinical Schools staffed by over 1300 clinical academics.[5] We also have new initiatives proceeding such as rural medical schools,[6] rural health research insititute[7] and significant targeted funding to develop rural research capacity.[8] In addition, we have 11 rurally based universities conducting research and delivering degree programs in allied health, nursing, public health and community development. Although there are no published data available, this would entail many more than 1000 full-time academics contributing to rural health. (A recent audit across 6 of these universities revealed 240 academic staff in the area of mental health alone.)

Our understanding of rural Australia is enhanced by the authoritative work of the Australian Bureau of Statistics (ABS) and Australian Institute of Health and Welfare, which routinely produce reports on rural Australia and examine rurality factors in most of their general analyses and reports. These national data provide important evidence to inform rural health advocacy, policy and planning.

The AJRH, now coming into its 30th year, is one of the most respected rural health journals in the world. Supported by the editorial team and 100s of reviewers, who all contribute their time and expertise pro bono, the journal plays the important role in curating and disseminating the scholarship emanating from our rural health sector. Over 10 000 institutions can access its content, with an average of 850 research articles downloaded every day, or put another way, an article download every 1 minute and 40 seconds. The recent Council of Australian University Librarians open access agreements,[9] will result in a significant increase in AJRH downloads.

We should ponder on the previous paragraphs for a moment. That is a substantial capability! No wonder our international rural health colleagues hold Australia in such high esteem. These advancements did not just happen. They result from decades of persistent, thoughtful advocacy[10] from the likes of Gordon Gregory, Lesley Barclay, John Humphreys, David Lyle and countless others. It was under the leadership of Gordon Gregory that the AJRH became the research journal of the National Rural Health Alliance in 1996.

Australia has superb foundations to develop the best and most comprehensive rural health services in the world. We have the policy, organisational, research and training foundations in place, but these are only the foundations. As I have argued in previous editorials, there is still much work to do to better integrate,[11,12] coordinate[13]

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and focus[14] these elements. The next key step is to embed effective governance mechanisms and processes to enable all these elements to come together to best support local communities. Recent unanticipated transformations in rural health have suddenly made this an achievable goal.

2 | COVID-19 AND ZOOM HAVE BEEN THE CATALYSTS FOR A REVOLUTION IN WORK AND RURAL HEALTH CARE

The storm that disrupts, sometimes clears a path

COVID-19 has stress tested our health systems,[15,16] workers[17] and leaders.[18] In the process, some profound transformations have transpired. Tele-health and remote consultations suddenly became MBS billable in private health services and routine in public health services. Health providers invented creative ways to provide care to all, including hard-to-reach and vulnerable populations. Clinicians met virtually for case consultations, clinical supervision and clinical advice. Each of these initiatives has profound implications for rural health.

Online meetings are now an everyday occurrence. Meeting participants no longer need to travel vast distances for meeting attendance. Video conference apps have proliferated. Some health service planning, management and support staff no longer travel at all because working from home is an option. Rural advocates champion equality and equity. During the height of COVID-19 lockdowns, a profound and new equality in meetings arose. All were equally at home. Rural participants were no longer travelling to meetings in capital cities. Better yet, they were no longer on the end of a teleconference phone line, where they could not hear much of the discussion, and the chair often completely forgot that rural participants were dialled-in at all. (RIP the phone teleconference!) Previously, rural participants had difficulty hearing and having their voices heard via the teleconference pods. Now, thanks to video-link meetings, rural attendees, for the first time in history, all have equal right to hear: 'you are on mute.' Puzzlingly, Canberra-based participants also now seem to lose connection due to poor bandwidth. Equality!

I remember in October 2019 needing to apply for a 'special' university zoom account that allowed international participants to access an online Equally Well[19] meeting. Two years later, remote health consultations are commonplace and rural participants routinely meet with associates from across Australia and the world via video link. Rural researchers can seamlessly connect with experts in the field, across the road, across borders and seas to bring international expertise to local projects. What a profound transformation!

3 | THE ACCELERATING VITALISATION OF RURAL AND REGIONAL COMMUNITIES

COVID-19 forced many people to work from home. As a result, many organisations have realised that staff don't *have* to be physically together in a central office, but can effectively and productively work from home.[20] Consequently, more Australians are choosing to live and work in rural and regional communities.

COVID-19, zoom and soaring capital city real estate prices all factor in the net migration from the cities to the regions.[21] In the last 12 months of reported data, the ABS reported that 44 673 people migrated from the city to live in rural and regional areas.[22] Internal migration from the city to the country has been a consistent trend since before 2011, but the rate has doubled over the last 12 months[22] reflecting the increase in people working from home.[20] This surge probably includes the migration of a professional middle class into rural communities, with all its flow-on impacts. Currently, each day 122 people from our cities migrate to live in rural communities, and with many of these from the middle class, the expectations and demands on rural health services are increasing. This underscores the need to ensure effective local health service governance.

4 | LET A HUNDRED FLOWERS BLOSSOM (AND 50 DIE?): POTENTIAL PROBLEMS WITH PLACE-BASED, CO-DESIGN

This revolution in work practice coincides with the rise of the 'place-based' and 'co-design' imperatives. Ironically, this can augur an exclusionary tone of 'you just give us the money and we will decide what to do with it.' This approach risks the development of programs that are not based on need, with no research evidence, out of step with best-practice and not aligned with national and international policy imperatives. This method of 'let a hundred flowers blossom and a hundred schools of thought contend...' could also lead to a disconnected hotch-potch of approaches that are impossible to coordinate, evaluate and learn from. In addition, it risks extensive unnecessary planning and transaction costs, duplicating work that has already been done elsewhere. As such, this is an overreaction to past examples of the central bureaucracy's

unilateral declaration 'this is the program: you have to implement it in your community.'

Working in partnership with the 'technocracy'—central planning, administration and policy expertise—is important to ensure place-based expertise is combined and aligned with the evidence and policy base. Placed-based expertise is vital, but co-design must be with *all* those who can make a valuable contribution.

5 | RURAL VS CITY: THE 'THEM AND US' MEME IS TOXIC

To make the progress needed over the last 30 years, the data demonstrating inequity of health service provision and outcomes for rural Australians have been highlighted. This approach is necessary but risks the development of a 'them and us' mindset. This is unhelpful for many reasons. It can reinforce the same mindset in centrally based administrators. It therefore risks making rural the 'other' in the mind of centrally based policymakers, service providers and clinicians. Rural should be an integral part of *'the'* thing they focus on, not be an 'other' thing to focus on. For instance, when a major specialist service in a major metropolitan teaching hospital gets funding to run a statewide service, they should not plan the new service or program and then think 'now what about rural?'. Instead, the mindset should be, how do we incorporate the core rural aspect into our basic service provision model? The 'them and us' approach creates a tendency to assign rural to an afterthought. This rarely ends well.

Exclusion based on place of residence, social status, gender or population group is not helpful. An inclusive service philosophy should not only include 'hard-to-reach' and marginalised groups, and it should also include city-based experts who can make a valuable contribution to rural health. Exclusion in all forms is bad for health. We must provide the narrative that places rural as a core element of everyone's agenda.

6 | OPERATIONALISING THE 'WE'

In leadership, the key question is, how do we convert aspiration to action? In this case, how to convert the 'we' aspiration to concrete actions and processes. If COVID-19 infections and zoom meetings have taught us anything it is, we are all interconnected and interdependent in more ways than we can imagine. This applies to all groups, those of different races, social status, gender, sexual orientations, lifestyles and places of residence. Creating inclusive health services at all levels of governance and service provision is the foundation stone for better health for all of us.[23]

So how should we operationalise inclusion in ways that work for rural communities? We already have the organisational infrastructure via our local health districts/services/networks and Primary Health Networks. Firstly, we should ensure our governance models include experts by experience and place-based experts, as they should also include policy and planning experts. The research evidence should be also be included in a way that is accessible and applicable. Processes should facilitate mutual respect and appreciation of others' expertise and perspectives and the value this brings to legitimate governance.

7 | WHAT ARE THE ESSENTIAL ELEMENTS OF RURAL HEALTH SERVICE GOVERNANCE?

My colleagues and I have outlined our views on the essential elements of good health service governance previously,[24,25] but they bear repeating here.

Effective, legitimate rural health service planning and delivery:

- *respects the (equal) rights of rural Australians to quality health care*
- *incorporates the knowledge and skills of rural experts*
- *integrates principles of citizen participation and community development*
- *combines national and international technical expertise with local, place-based knowledge and expertise*
- *appreciates that power and control are key to rural health, and that the exercise of power is manifest through funding, planning, and decision-making*
- *values the perspectives of rural communities in evaluating health services and programs in rural areas*
- *understands that critical mass requires effective articulation of available city-based and rural-based service capacity*
- *makes provision for sufficient time and effort for ongoing communication, collaboration and partnership building work*[25(p.20)]

Money is power, and it is important for funding to be controlled locally.[24] There are numerous proof-of-concept examples of how this has worked well. One of these was a federally funded, locally managed and externally evaluated integrated care trial.[26] Another was a state-wide program to enhance older persons' services.[27] The common key features of these programs were as follows: locally controlled funding, central-agency engagement, mutual accountability and rigorous

evaluation. Other shared characteristics of these programs were as follows: the inclusion of place-based experts, lived-experience experts, local leaders, clinicians and researchers working respectfully together to guide, monitor and manage the program.

In Australia, the time is right for a new inclusive model of health governance, where place-based, research, central-policy, administrative and lived-experience expertise all have a voice, and indeed, a powerful hand in rural health service planning, provision and evaluation.

'We' are all better together.

STATEMENT OF INTEREST

Prof Roberts is a Chief Investigator on a grant awarded by the Regional Research Collaboration Program.

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