SOCIAL DISRUPTERS: CONSTRUCTING A NEW WAY TO DELIVER PRIMARY HEALTH SERVICES IN A RURAL SETTING

Lisa A. Caffery*
School of Business and Law, Central Queensland University, Emerald, Qld, 4720, Australia. Email: lisa.caffery@cqumail.com

Olav T. Muurlink
School of Business and Law, Central Queensland University, Brisbane, Qld, 4000, Australia. Email: o.muurlink@cqu.edu.au

Andrew W. Taylor-Robinson
School of Health, Medical & Applied Sciences, Central Queensland University, Brisbane, Qld, 4000, Australia; College of Health and Human Sciences, Charles Darwin University, Casuarina, NT, 0810; College of Health Sciences, Vin University, Hanoi, Vietnam. Email: a.taylor-robinson@cqu.edu.au

*Corresponding author

ABSTRACT: In this paper, we investigate the role of social enterprise in bridging a gap in health provision that is experienced commonly in rural Australia. Drawing on an exploratory case study conducted in the small town of Emerald in Central Queensland, we use primary interview data to understand better how one, wholly community-owned, not-for-profit, social enterprise has moved beyond the traditional primary health care model and constructed a new way to deliver services in a rural setting. This case study provides an example of a community-driven response that endeavors to transform health service challenges into opportunities. This research identifies key strategies, strengths and business factors that have contributed to a locally responsive health service. We also focus on the business model and examine how innovation has shaped the operation. Key findings are presented as ten critical actions that helped the business establish itself as a thriving social enterprise in rural Australia.

KEYWORDS: Social enterprise, rural health, primary health care, social innovation, general practice.

ACKNOWLEDGEMENTS: The authors would like to acknowledge the assistance provided by Central Highlands Healthcare Ltd.

1. INTRODUCTION

Regional population centres continue to shrink relative to urban concentrations, with smaller population unable to sustain basic services, such as general medical practices, the focus of this current study. Despite narratives around globalisation and the increasing use of technology to bridge rural-urban healthcare divides, a health divide persists in regional Australia, one which has deep roots in both location and policy. More than a million rural and regional Australians have distinctly lower levels of access to basic medical care than those living in metropolitan Australia (Duckett and Breadon, 2013). That equity differential translates to significantly compromised health outcomes, which may be predicted by distance from capital cities (Australian Institute of Health and Welfare (AIHW), 2020). People living in medically under-served areas tend to live shorter lives, experience greater incidences of disease and endure poorer access to health services compared to people who live in urban areas (Wakerman *et al.,* 2008). For example, people who live in rural and remote areas experience higher death rates (1.3 times) than people living in major cities (AIHW, 2017).

Although regional Australia is positioned as a 'minority' relative to the nation, it contributes disproportionately to the country's national economy, with 67% of exports (in terms of value) coming from regional, rural and remote areas (National Rural Health Alliance Australia, 2021). Despite this strategic importance, the population retained in rural Australia is forced increasingly to commute to receive primary health care (Mitton *et al.,* 2011). More serious medical cases require individuals and their carers or family members to 'migrate' to receive specialist medical treatment at the closest city.

This case study examines a unique success story from the 2010 Australian government's $355.2 million funding announcement for building and upgrading GP super clinic facilities. This was the only community-led social enterprise response to emerge. Like many rural centres, the regional hub of Emerald in Central Queensland (population 13,500) faced the consequences related to the speed of access to care: availability of general practitioners (GPs) for initial primary care advice and access to specialist services without needing to visit larger regional centres. The Emerald response was initiated by a group of veteran local GPs who were nearing retirement and had no viable business succession plan for their Emerald practices. What follows is an example of social disrupters challenging the status quo and constructing a new way to deliver primary health services in a rural setting. Social enterprise in health care

provision has attracted significant attention at least at an applied level, but very sparse literature assessing how social enterprise works as an alternative delivery mechanism (Roy *et al.,* 2014).

Roy's proposed model shows the value of harnessing and linking community and individual resources. Using third sector providers to address gaps—or even mainstream healthcare provision—has a substantial history, particularly in the UK where in the 1970s and 1980s, there was an effort to reduce the strain on nationalised health resources (Millar, 2012). This trend is relatively less present in Australia. Typically, primary health care in rural Australia, in particular, is delivered by hundreds of privately owned and operated small businesses (Swerissen *et al.,* 2018). However, there has been a clear upward trend of the 'corporatisation' of general practice across the country since the late 1990s with the three largest corporate chains employing 15 per cent of GPs (Erny-Albrecht and Bywood, 2016). Public health or 'single issue' campaigns have been more likely to be the target of social enterprise efforts in Australia and internationally—there is no shortage of examples of state-sponsored healthcare resources being paired with or funding community-based efforts working to address smoking, alcohol, and exercise outcomes for example, but these efforts tend to be charity rather than sustainable social enterprise in character. Whereas funding for public health measures, such as the Australian campaign to address the risk of skin cancer (Montague *et al.,* 2001) form the minority of health budgets, primary and secondary healthcare continues to dominate total health spend in Australia, which continues to rise albeit gently (Callander *et al.,* 2019).

Broadly speaking, social innovation is constituted as "social experiences aiming at finding new solutions to unsolved problems" (Drewe *et al.,* 2008, p. 22). However, innovating in a complex system like the health care sector is not a straightforward process. Other industries, such as mobile technology, have evolved rapidly by focussing on customer's inherent needs and developing a solution that meets these needs (Roberts *et al.,* 2016). Disruptive innovating and new technology often results in greater affordability and convenience to the consumer (Hwang and Christensen, 2008). This study examines an otherwise 'conventional' health clinic that has significant potential to sustainably disrupt the delivery of healthcare services in rural and remote regions by harnessing a social enterprise model. In addition, the case study examines other aspects of the model that contribute to its sustainability.

2. BACKGROUND

In May 2010, the Australian Government led by Prime Minister Kevin Rudd announced $355.2 million in funding to build and upgrade GP Super Clinic facilities across Australia (Australian Government Department of Health, 2010), the aim of which was to inspire local communities to become involved in designing their own health care solutions. Three local Emerald General Practitioners (GPs) and several community leaders formed a working group to envisage a new way of delivering front-line health services in their rural town. They partnered with the Central Queensland Division of General Practice (now CQ Rural Health) to apply successfully for federal government funding that enabled the creation of a new 'one-stop-shop' for primary health care in Emerald. CQ Rural Health was chosen because it was viewed as independent but still locally invested in the community. What was unique about this approach was that *no single GP would benefit personally from the funding*. In addition, the business structure and model had evolved in response to local needs and was designed to leave a lasting legacy for the entire community. Once CQ Rural Health had executed the AUS 5 million grant and the construction of the new facility was complete, ownership of the medical clinic was transferred to a newly formed social enterprise. In October 2015, Central Highlands Healthcare Ltd (CHH) took ownership of the newly built GP Super Clinic and commenced trading shortly thereafter under the business name of the Emerald Medical Clinic (see Table 1 for key characteristics of the clinic). The determined focus of this social enterprise was to provide coordinated quality local health care to the Central Highlands community and improve local health outcomes.

Table 1. Case Study Snapshot – Central Highlands Healthcare Ltd. Source: the Authors.

Town, Region	**Emerald, Central Queensland**
Country	Australia
Addressed Themes	Primary Healthcare
Development Stage	Scaled
Founding Year	2012
First Trading Year	2015
Organisation Structure	Private Limited Company with Charity Status
Organisation Type	Social Enterprise
Organisation Size	Small Enterprise (< 50 employees)
Annual Income	AUD 4 million
Total Equity	AUD 5 million

3. METHODS

Case study analysis allows an examination of outliers, particularly important in studies of innovation, where the novel is by definition uncommon, and thus difficult to examine use quantitative means. We examine how a small group of determined community leaders formed a social enterprise to address health options and explore spillover effects on the local economy. The single case of CHH was selected because it is unique and allows the analysis of an isolated phenomenon (Mills *et al.,* 2010). The scope of the study was bounded to the one organisation (CHH) that was located in Emerald, in Central Queensland, Australia. The CHH business is a novel example of a rural social enterprise operating in the Australian primary healthcare sector. The combination of uncommon attributes and the uniqueness of the case warranted unitary exploration of the topic (Crowe *et al.,* 2011; Liamputtong, 2013; Silverman, 2017). This exploratory case study is based on documentary analysis, including the analysis of minutes of meetings, publicly available annual reports, and community and media comments on the development. In addition, in-depth, semi-structured interviews were conducted with ten key stakeholders, who either volunteered (in a permanent or part-time capacity) or worked for remuneration in the social enterprise. An informal conversational style of interviewing was particularly well-suited to the rural social enterprise setting (Yeo *et al.,* 2013). Interviews with stakeholders were transcribed and anonymised, and in the following analysis care has been taken to de-identify stakeholders in order to preserve confidentiality. This study was conducted following formal review by the Human Research Ethics Committee of Central Queensland University, with approval number 21472.

4. RESULTS AND DISCUSSION

The Social Enterprise Business Model

For the purposes of this case study research, a social enterprise is defined broadly as a business that trades to further social (rather than *purely* business) goals (Steiner and Teasdale, 2017). CHH is both a social enterprise and a limited public company with a social purpose. The mix of 'enterprise' with 'social purpose' ensures that the structures and inherent sustainability built into a conventional business are attached to a desired social outcome. In this regard, the goal of CHH is to achieve meaningful

and sustainable improvements in access to local health care services. The limited company organisational structure offers limited liability protection to its members, while a local, volunteer, skills-based board oversees the company's governance, a structure that has acted as a framework for innovation within the organisation. A full-time chief executive officer (CEO) oversees the day-to-day management of the business, and the medical staff are led by a globally renowned principal GP. The senior management team is comprised of the CEO, sentinel GP (senior GP), practice manager, training and education manager, nurse manager and senior receptionist. The company is an entirely community-owned asset, for which all retained earnings are reinvested in the CHH operation. Moreover, the board members are not compensated for their time, nor are dividends paid to members. That is, unlike most GP clinics in Australia, CHH seeks to maximise social returns rather than to distribute profits to shareholders or owners. CHH is registered with the Australian Tax Office as a Deductible Gift Recipient (DGR) and all donations over AUS$2 are tax deductable. CHH trades as the Emerald Medical Clinic and, as previously mentioned, the construction of the building in which the clinic is housed was fully funded by the Australian Federal Government's *GP Super Clinics Infrastructure Program.* An overview of the CHH social enterprise model is provided in Table 2.

> ***We needed a company structure that was big enough and bold enough to continue to invest in itself and grow as a business — CHH Board Member***

With a focus on the future, the CHH Board of Directors has taken a modular approach to its business in both design and operation. At the centre of the organisation is the Emerald Medical Clinic and this acts as the main hub. As the business grows, it was the Board's explicit plan to establish or 'bolt on' new facilities and services around the GP clinic. This has begun to happen. In its third year of operation, CHH funded the construction of a chemist building adjoining the GP clinic. This second module also made available additional clinical space for visiting specialist services and a coffee kiosk. The extra commercial space also contributes a source of secondary revenue for the social enterprise through rent received from lease agreements. A diagnostic ultrasound unit was also added to the complex in the 2019-2020 financial year. As the business matures there are further plans to add more modules, such as a day surgery wing, an education and training wing, a palliative and aged-care unit and x-ray and radiology unit. The realisation of each of these expansion plans is dependent on several critical factors, including community need, business

sustainability and funding sources, but the clinic is more able to access funding due to its non-profit foundations.

Table 2. Overview of the CHH Social Enterprise. Source: the Authors.

Enterprise Orientation	• **Directly involved in providing health services** • **Viable trading organisation generat**ing **revenue and profit** • **In operation since December 2015**
Attributes	• Explicit social aim to challenge health care delivery model • Autonomous organisation with governance structures based on community ownership • Seeks to make an impact and to alleviate a social challenge • Profits reinvested in the business or used for the benefit of the community • Business delivery model unique to rural health sector • Local leadership and collaborations with public and private institutions
Scalability	• Innovative business model has potential to be applied to other geographical areas or population groups • Financial, organisational and market aspects of the business are sustainable
Competitive Advantages	• Adopts a mission that sustains social value • Agility in aligning with mission • Ability to leverage non-profit status • Maximises limited resources • Skills-based volunteer board

Another strategic aspect of this 'hub and spoke' operating model is the strategic partnering agreements with other medical service providers to achieve diversification of health care provision. Rather than try to attract and retain medical workers or to compete with high-demand health service providers (which may have had some unintended negative consequences) the Board of Directors has chosen to co-locate these businesses within the Emerald Medical Village precinct. QML Pathology collection service was the first business to trial this model by establishing a collection laboratory in the same building as the GP clinic. Since this successful pilot, other services have followed and co-located within the precinct. The overarching

strategic goal is to provide multiple medical services, previously not available in the town, on one site (a one-stop shop). The outcome has been a consumer-driven model of care offering a comprehensive range of health services.

Evidence from the CHH case study reveals four key characteristics of the model that appear to be linked to its success: (a) a grassroots response to local health needs, (b) a focus on community, (c) critical partnerships with statutory authorities; and (d) governance.

(a) Grassroots Response

Different regions have distinct characteristics—treating 'regional and remote' communities in a generic manner clearly has weaknesses, and this project was clearly founded on principles of human-centred design. Community engagement and consultation have been a critical component in the establishment and ongoing operation of the business.

> ***The business model didn't just happen. It was a lot of blood, sweat and tears and many sleepless nights for a lot of people — CHH Board Member.***

For instance, the original idea for the social enterprise was borne out of a town hall public meeting to discuss the threat of closure of local maternity services. More recent community consultation activities have centred on young people's mental health and responding rapidly to an increase in youth suicide rates across the Central Highlands region. CHH led a youth-focused movement called #BigRural in response to regional mental health and wellbeing issues. The primary aim of this initiative is to bring together a range of agencies and support workers to provide outreach youth health services to where they are frequently needed. Most often, this is in geographically dispersed and isolated rural communities that do not have easy access to a dedicated health service. This outward-facing and community-centred approach is changing radically how primary health care is delivered in rural locations. Another example of meeting the needs of a specific population is Indigenous Health. Of the population of Emerald 3.24 per cent identify as Aboriginal and Torres Strait Islander (Central Highlands Regional Council, 2016), while 6.5 per cent of patients registered on the CHH database identify as First Nation people. This two-fold increase in indigenous access indicates that the clinic is engaging successfully with a wide range of Aboriginal and Torres Strait Islander clients not only living in Emerald but from across the region. These discussions lead to the emergence of the CHH.

(b) Rural Orientation

Health solutions that may work in the city cannot be transplanted readily into a rural setting. One board member commented: "You can't just pick up a run-of-the-mill GP Clinic from the city and plonk it in a country town and expect it to thrive or even survive". The CHH board recognised quickly the need for a bespoke primary health care model that involves real consultation with local communities. The flexibility to tweak the model and to take into account unique characteristics of the region (rather than 'rural Queensland' in general) was crucial. The model harnesses the power of place and values the people who call the Central Highlands home.

> ***The community must feel like they own this place — CHH board member.***

CHH has successfully established itself as a business that collaborates and gives back to the rural health professionals it employs and the local community it serves. For instance, it often holds public health information sessions that are open to the whole community and sets up a free health check stand at local events like the annual Emerald Show. Another example of meeting the specific needs of a rural client base was the establishment of a Q-Fever vaccination clinic. Q-Fever is a bacterial infection that can cause a severe influenza-like illness. The bacteria are contracted from animals, mainly cattle, sheep and goats, so it is predominantly a disease common among people living with domesticated animals and working in the livestock industry (SA Health, 2019). The clinic formed an alliance with a local 'Beef Expo' so that rural workers could be screened for Q-Fever while in town attending the industry event. Around 100 people attended the first screening clinic, which involved dermatology and haematology tests. A follow-up visit was organised to check the results and clients were administered a vaccination if required. Without this targeted pop-up clinic, many rural residents would not have access to Q-Fever testing and vaccination.

(c) Creative Partnerships

The CHH case study is an example of a cross-sector partnership to address a social need. The three main societal pillars – business, government and civil society – together are applied to a social issue. Local government has played an instrumental role in the establishment and ongoing success of CHH. Traditionally, health services provision in Australia is viewed as a state government function with funding support from the Australian government. It is not usually a space for local

government involvement. However, the Central Highlands Regional Council (CHRC) and its supporting not-for-profit entity, the Central Highlands Development Corporation (CHDC), have adopted an atypical mind set and resolved to take a very different approach. They came to view health not just as a service but as an economic driver for their community. The Council's contribution to the project development process was principally in-kind but nevertheless significant. The Council's financial support in making land available of the clinic site (see next section) was pivotal in supporting the viability of the project – without this help the project would never have got off the ground.

> ***Without the local government partnership and advocacy this primary health care model would never have emerged — CHH Board Member***

CHRC utilised town planning strategies and resources to identify vacant council-owned land that was suitable to be leased to the social enterprise to develop. The two-hectare greenfield site was chosen as the preferred location not only because it met CHH's needs but it aligned closely with the Council's Economic Master Plan (KPMG, 2017) and vision for a sustainable health care sector in the region. Although considered 'on the edge of town', the site selection was advantageous in being located opposite the airport, thus facilitating easy access for medical evacuations, was in a flood-free zone and, most importantly, established the only medical facility on the eastern side of the Nogoa River. One Board member said this was especially important to Emerald because now there is joint access to medical facilities and an airport during those times of isolation due to flooding and other natural disasters. The area was also identified as having future development potential for residential retirement housing and aged-care facilities. CHRC designed an innovative, long-term, lease-to-buy land purchase agreement that allowed the not-for-profit entity to secure the plot and then pay it off in manageable instalments. Council's involvement strengthened the viability of the project during the early stages, and also strengthened the appeal of the project for further funding from federal and state funding bodies.

> ***Local government have a mandated role of supporting the provision of health services in order to keep their community strong— CHH board member***

CHRC also completed the necessary planning approvals, head works and roadworks, so the greenfield site was accessible and ready for development. The Council and CHDC each provided a high-level representative to sit on the CHH Board of Directors and CHDC provided secretariat support during the start-up phase in order to ensure good

governance. Local government also played a pivotal advocacy role to secure federal funding for the infrastructure build as well as providing leadership for the project within the community.

(d) Transformative Governance

The governance structure of a business acts as the framework for organisational innovation (García *et al.,* 2009), but beyond having 'some' governance, lies the importance of having 'good' governance. A range of studies is beginning to confirm that public funding of social enterprises—such as in this case—are particularly effective in terms of job creation if the entrepreneurs are experienced managers/leaders (Rey-Marti *et al.,* 2016). The clinic project attracted an experienced group of entrepreneurs and managers–including an accountant, a property valuer, a real estate developer, two local Councillors, a GP practice manager and an economic development specialist.

The group maintained a focus on the core business: delivering local health services. Due to the company structure, the board had the flexibility to make minor changes, sometimes in response to understanding the specific challenges of the rural location. Clinical governance is also an important feature of the CHH organisational structure. The highly regulatory nature of contemporary GP clinics demands well-developed and integrated systems and procedures that understand how health services are different to (say) engineering services. CHH places a strong emphasis on a systematic approach both to health and safety and to quality of service but equally views patient experiences as a key measure of quality care. So the leaders of the project drew on patient feedback and using data translation at the practical level both help to improve service delivery, as an integral component of CHH's clinical governance framework.

Beyond direct health provision benefits, the key secondary benefits to Emerald and the surrounding community produced by CHH's innovative business approach include the creation of local skilled employment opportunities; strengthening local procurement and supply chain; enhanced training opportunities for the health workforce. Out of what was a 'purely' health provision 'target', there emerged secondary economic benefits in businesses built around health. New activities such as health education and aged-care developments are boosting the region's economy and adding value to the local health system. Table 3 provides a summary of the differences between CCH and traditional rural GP clinics in Australia.

Table 3. Comparison of Primary Health Care Models. Source: the Authors.

	CHH Social Enterprise	**Traditional Rural GP Clinic**
Ownership	Community-owned – Limited Company	Privately-owned – Proprietary Limited Company
Governance	Discrete, independent Board of Directors controlled by the community	Self-governed with limited or no third-party or independent oversight
Management	Stand-alone and clearly defined management structure with CEO and executive leadership team accountable to the governing body	Owner/operator model – business oversight by medical practitioners, often a married couple or a professional partnership. No accountability to an external governing body
Strategy Development	Board of Directors has strategic oversight which is separate to management implementation	No separation of duties – owners develop and implement business strategy
Profit Distribution	Not-for-profit – surplus funds are reinvested in the business and community	For profit – surplus funds are distributed directly to the business owners
Infrastructure Ownership	Community-owned	Privately-owned
Workforce Supply	Development of a large pool of GPs (15+) through targeted retention strategies and education programs	Difficulty recruiting and/or retaining a private GP
Funding	Sustainable business model. Access to external government grants	Private funds
Partnerships	Extensive inter-sectoral partnerships with private enterprise, government and non-government organisations	Limited linkages with other local GPs (seen as competitors) or agencies
Training	Profits reinvested in workforce training and professional development. Significant participation in the rural generalist training program	Training often only available after hours or when GP role can be backfilled with locums
Scope of Services	Wide range of on-site care facilities; specialist, medical, pharmacy, pathology, ultrasounds, x-rays and allied health services in one location with clear clinical pathways	Limited on-site services (GP only) – all referrals off-site

Unique Business Factors

The CHH case study is an example of how non-government organisations engaging in partnerships with government can play a unique role in strengthening the health systems by absorbing the risk that is intrinsic to the experimentation required to discover innovative service delivery models. CHH is agile in nature and complemented by its ability to build relational capital and achieve operational sustainability. Most social enterprises are small-scale and often fragile. CHH is a significant business (within a rural context) that has grown exponentially and in turn extended the portfolio of local health services. There are three broad factors underlying the success, which may not be easy to replicate in other contexts:

(a) Leadership

Board members were experienced business leaders, at a 'give back to the community' stage of their careers, individuals who explicitly understood the local context and were highly motivated to undertake new initiatives and to foster growth.

> ***Local government is the closest level of government to the people and need to provide strong leadership regarding local health issues in order to cement the sustainability of rural and regional communities — CHH board member***

The group also coalesced around a single 'marquee' stakeholder, the sentinel GP, Dr Ewan McPhee, who is recognised globally for his level of skill and knowledge in Rural and Remote General Practice Medicine. This is a characteristic of CHH that cannot easily be replicated in other contexts, however.

Retaining a high calibre sentinel doctor attracts other high calibre medical staff to the clinic. Dr McPhee is also at the forefront of training medical graduates and junior doctors in rural medical practice. Leveraging Dr McPhee's status, CHH has been able to establish itself as a rural medical training practice and is an active participant in the rural training pathway continuum for medical education and training in Australia. A recent industry survey suggests that 70 per cent of GPs work in practices employing fewer than 10 GPs (BEACH, 2017). However, the CHH business model seeks competitive advantage and enhanced employee attractiveness through scale and thus aims to recruit a larger cohort of GPs. Although Australia has an oversupply of medically qualified practitioners, there is a general reluctance to leave the major metropolitan areas in search

of work in rural and remote regions. The CHH model is breaking down this geographical barrier and giving city-trained doctors a supportive environment in which to live, work and play.

(b) Social Capital

> ***There was community consensus to do something completely different and create a model to address unmet health service demand but not at the expense of other existing GP practices in town — CHH board member***

CHH is an example in which local community leaders found local solutions to issues that ' big government' may fail to resolve. The level and characteristics of social capital present in the Emerald community may not be present in other superficially 'similar' rural communities. There remains a high level of societal consensus and social capital in the organisation, as evidenced by the substantial amount of time donated by volunteer board members to support the organisational mission. Another social capital initiative is the CHH Community Palliative Care Volunteer Program that provides in-home visits and support to local community members and their families living with a life-limiting illness. Developed in response to identified community needs the program trains volunteers to provide friendship and practical help to make it easier for a person to receive palliative care in their rural community and, should they wish, to die at home. The support that CHH has may be dependent on a particular mix of social characteristics in the community, that cannot be revealed by a single case study.

(c) Technology

Traditional narratives (and indeed in some cases, evidence) (Wiseman *et al.,* 2019) that suggest that rural communities are not willing or able to embrace modern technology were not a factor here. Information technology is a key feature of the CHH business, enhancing its ability to communicate with patients, manage health records, collect business data, source medical diagnostic results and even conduct virtual telehealth consultations online. Ensuring that a rural GP practice is equipped with the tools required to provide comprehensive care is no easy feat. The start-up phase of the CHH enterprise involved creative collaboration to access high speed internet as Australia's National Broadband Network was not available in the region at the time. Initially, a microwave antenna was installed on top of the GP clinic roof that had a direct line of sight to the

Queensland Rail tower. This microwave link then accessed a direct fibre connection to Brisbane, the state capital, which has provided a stable and steady supply of data to the business. Interestingly, this had wider economic implications for the community: the CHH's technology solution attracted a new internet service provider to Emerald offering faster, cheaper and more reliable internet to rural customers using the existing state-owned fibre optic network – again, an unintended (positive) consequence. Access to technological advances coupled with business model innovation continues to deliver more affordable and convenient health care services to CHH patients.

Challenges

Rural health is characterised by many complex challenges that are not encountered in an urban context. Within the primary health care setting, rural GP practices often face low profitability, withdrawal of physical public health services seen as economically unviable, as well as issues relating to workforce recruitment and retention. Interview data from this exploratory study identified three critical challenges for the CHH business – red tape, funding model viability and staff renumeration.

(a) Bureaucracy

GPs are the cornerstone of primary care. There are about 25,000 registered GPs working in Australia (Medical Board of Australia, 2017). Although there is a national oversupply of doctors, access to a general practice varies depending on location (Swerissen *et al.,* 2018). The medical workforce is not evenly disbursed – there are many more GPs located in major cities than there are in rural or remote areas. There is an ongoing challenge to redistribute the medical workforce to better meet geographical needs. Yet, the bureaucratic processes behind the recruitment of GPs by rural practices can also stifle productivity. For example, CHH has experienced delays of up to six months for newly-hired GPs to receive their Medicare provider number and prescriber number from the Australian Government.

(b) Funding Model Sustainability

> ***Gone are the days where GPs are going to get rich by owning and operating their own small rural clinic. It is no longer an attractive proposition to many GPs — CHH employee***

The Grattan Institute reported that primary care is the most accessed component of the health system and accounts for a quarter of all health expenditure (excluding pharmacy) (Swerissen *et al.,* 2018). GPs are compensated on a fee-for-service basis and patients receive a rebate through the Commonwealth Medicare Benefits Schedule (MBS). A complaint common to general practice in Australia is that the MBS has failed to keep pace with the increasing expense of medical services provision and that out-of-pocket costs to consumers have risen due to successive Medicare indexation freeze policies (Australian Medical Association, 2018). Interview data in this case study concurred with the widely held view that the MBS had not evolved to match the complexity or cost of providing high-quality medical services in a rural setting. A prevailing opinion among the CHH Board of Directors was that it is very difficult to make money in general practice. Profit margins are slender. In general terms, large private hospitals work on a three per cent profit margin. CHH by comparison has done well, achieving a 4% margin (Central Highlands Healthcare, 2018), but such slim profit margins mean that achieving scale becomes essential in the sector. This explains the recent trend to corporatise general practice clinics and thereby to achieve greater economies of scale.

CHH, as a social enterprise has been advocating for a system-wide funding reform to raise quality standards, secure future sustainability of the health system and to deliver better outcomes to patients. CHH has publicly advocated for the introduction of the type of capitalisation-based funding model that is currently used in New Zealand, whereby the amount of government funding equates directly with the number of patients enrolled at a primary health organisation. This means that general practices are paid up-front according to the size of the patient register, not retrospectively based on the total number of GP consultations and other clinic activities in a given year.

(c) Staff Renumeration

Rural general practices compete with the public hospital system to recruit and retain staff. Attractive salary packages and employment conditions for rurally located doctors in the public system are enticing GPs away from jobs in general practices. Many rural GP clinics thus lose key staff to the public health system. CHH has endeavoured to at least partially offset this wage disparity by leveraging its charitable status and obtaining a tax advantage for their staff who are eligible to salary sacrifice a portion of their income. These compensatory steps make their salary package more

competitive with those offered by the local public hospital for comparable roles.

In commercial terms, another issue for any GP clinic in Australia is that the remuneration ratio for doctors is significantly higher than it is for most other professions. There is an expectation among junior doctors that they should earn up to 70 per cent of medical fees collected, a figure that far exceeds the remuneration expectations of other professions—for example, property valuers working in the rural sector may expect 40-50 per cent of fees for every billable hour. The high fee payment ratio in general practice results in only 30 per cent of revenue being available to cover all other operational expenses, such as insurance, electricity, rates, accreditation, administration, IT, equipment upgrades and other overheads. Given that the lion's share of the practice income is allocated to salary expenses, budget oversight and control are critical to the ongoing sustainability of the CHH business model. This remains a pinch point that requires constant and scrutiny.

5. SYNTHESIS AND CONCLUSION

The Emerald Medical Clinic is the only not-for-profit, community-owned clinic funded through $355.2 million federal Australian plan to build and upgrade GP Super Clinic facilities across Australia. Remarkably, it is one of the few medical practices in Australia to succeed—and continuing to succeed—under this funding package. That is, it is one of the few GP Super Clinics still operating under the original contract terms. Many of the other clinics that received funding were privately-owned businesses which have subsequently financially failed and closed (Australian Medical Association, 2014). It is therefore valuable to analyse how the Emerald Medical Clinic defied this national trend.

This exploratory case study of the CHH social enterprise model suggests its success is strongly linked to its social enterprise approach. By harnessing community skills, its emergence from community (rather than commercial) needs, its ability to forge public-private partnerships, and its leveraging of non-profit status to facilitate access to government funding, have proven important to its sustainability. Rural health providers globally struggle with maintaining the human and other resources in the community, at the point of need. CHH, remarkably, has not just partially overcome this challenge, but has proven itself to be, to date, sustainable and financially resilient, while promoting community cohesion and adding value to the local economy through employment, training and education.

This outcome demonstrates the value of community engagement, inclusiveness and adopting a multi-stakeholder approach to enhance rural health care delivery. Innovative interventions and programs are reaching vulnerable populations in historically under-serviced rural and remote areas of Central Queensland. Findings from this study suggest that social enterprise in the primary health care space has the potential to address rural health issues at a local level, and to deliver additional positive benefits in terms of economic sustainability. The clinic proved to be a seed for local health-related enterprise, gaining economies of scale in quite a small community, and even helped drive enterprise beyond the health sector (for example, leading to improvements in IT infrastructure in the community). Thus, CHH offers an integrated service that, emerging from community needs rather than imposed by state or federal government thinking, is almost custom designed, or at least responsive, to geographical context. Productive collaboration and trust-based relations with key stakeholders such as regional government have mobilised the local community to help itself to transform challenges into opportunities.

With health budgets still focused on a conventional medical model of addressing 'problems' as they arise, rather than prevention, for social enterprises focusing on primary care, such as the case examined here, there is an opportunity to not just draw seed capital into a social enterprise project, but to link their sustainability with the continuing need to provide primary health care in the regions. While social health programs focused on preventative health approaches may offer good value for money in rural communities (Harvey, 2001) building primary healthcare centres around high volume/high demand primary can address preventative and primary health care in the same footprint. The current case shows how high volume primary health care can act as an 'engine' for other forms of health services. To illustrate, after just three years of operation, CHH had 27,000 registered patients—from a population of 30,000. Few social enterprises other than a health-related enterprise could draw these numbers, but these numbers also illustrate the enterprise's success in meeting local needs.

CHH thus offers one possible model for rural health care provision. The host region may not be typical of 'all' rural Australian towns, with its blend of mining and agriculture, but it does illustrate the potential of grassroots-initiated change—what is termed in the language of social innovation, a design-thinking or human centred design approach (Van der Bijl-Brouwer and Dorst, 2017). Social enterprise may thus also have a role to play in addressing social isolation and disconnection in the community (Kelly *et al.,* 2019).

This case study suggests that social enterprises not only have a role to play in 'solving' or responding to rural health challenges, but in doing so also more broadly contribute to rural development—having unintended positive consequences for whole communities, rather than purely a single sector.

REFERENCES

Australian Government Department of Health (2010). More GP Super Clinics and Extra GP Infrastructure [Press release]. Online version accessed April 2019, https://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2010-hmedia04.htm.

Australian Institute of Health and Welfare (2020). Australia's Health 2020 in Brief. Online version accessed May 2021, https://www.aihw.gov.au/getmedia/2aa9f51b-dbd6-4d56-8dd4-06a10ba7cae8/aihw-aus-232.pdf.aspx?inline=true.

Australian Medical Association (2014). GP Super Clinics 'not so super'. Online version accessed May 2021, https://ama.com.au/media/gp-super-clinics-not-so-super-ama.

Australian Medical Association (2018). New Figures Show Impact of Years of Medicare Freeze. Online version accessed May 2021, https://ama.com.au/gp-network-news/new-figures-show-impact-years-medicare-freeze.

Ball, S. J. and Olmedo, A. (2011). Global social capitalism: Using enterprise to solve the problems of the world. *Citizenshop, Social Economics Education*, 10(2-3), pp. 83-90. doi:http://dx.doi.org/10.2304/csee.2011.10.2.83

BEACH (2017). Bettering the evaluation and care of health. Retrieved from http://sydney.edu.au/medicine/fmrc/beach/.

Callander, E. J., Fox, H., and Lindsay, D. (2019). Out-of-pocket healthcare expenditure in Australia: trends, inequalities and the impact on household living standards in a high-income country with a universal health care system. *Health Economics Review*, 9(1), pp. 1-8.

Central Highlands Healthcare (2018). Annual Report 2017-2018. Online version accessed March 2021, https://www.acnc.gov.au/charity/4dd3b88ab4a4a5e93b79ea13e46eb03e#financials-documents.

Central Highlands Regional Council (2016). Population - Indigenous Status. Online version accessed

April 2019, https://www.communityprofile.com.au/centralhighlands/population/indigenous-status#!bar-chart;i=12.

Crowe, S., Cresswell, K., Robertson, A., Huby, G., Avery, A. and Sheikh, A. (2011). The case study approach. *BMC Medical Research Methodology*, 11(1), pp. 100.

Drewe, P., Klein, J.-L. and Hulsbergen, E. (2008). *The Challenge of social innovation in urban revitalization* (Vol. 6). Techne Press.

Erny-Albrecht, K. and Bywood, P. (2016) *Corporatisation of General Practice - Impact and Implications. PHCRIS Policy Issue Review*. Primary Health Care Research and Information Service, Adelaide.

García, M., Eizaguirre, S. andPradel, M. (2015). Social innovation and creativity in cities: A socially inclusive governance approach in two peripheral spaces of Barcelona. *City, Culture and Society, 6*(4), pp. 93-100.

Harvey, P. (2001). Preventive social health programs: Are they Australia's answer to rising health care costs in rural communities? *Australian Journal of Rural Health*, 9(6), pp. 293-296.

Hwang, J. and Christensen, C. M. (2008). Disruptive innovation in health care delivery: a framework for business-model innovation. *Health Affairs*, 27(5), pp. 1329-1335.

KPMG (2017). Central Highlands Economic Master Plan 2017-2022. Central Highlands Development Corporation, Emerald.

Liamputtong, P. (2013). *Qualitative Research Methods, 4th Edition*, Oxford University Press, Melbourne.

Medical Board of Australia (2017). Registrant data: 1 October 2017 to 31 December 2017. Online version accessed April 2020, https://www.medicalboard.gov.au/.

Millar, R. (2012). Social enterprise in health organisation and management: hybridity or homogeneity? *Journal of Health Organization and Management*, 26(2), pp. 143-148.

Mills, A., Durepos, G. and Wiebe, E. (2010) *Encyclopedia of Case Study Research*, Sage, London.

Mitton, C., Dionne, F., Masucci, L., Wong, S. and Law, S. (2011). Innovations in health service organization and delivery in northern rural and remote regions: a review of the literature. *International Journal of Circumpolar Health*, 70(5), pp. 460-472.

Montague, M., Borland, R. and Sinclair, C. (2001). Slip! Slop! Slap! and SunSmart, 1980-2000: Skin cancer control and 20 years of

population-based campaigning. *Health Education & Behavior*, 28(3), pp. 290-305.

National Rural Health Alliance Australia (2021). Economic contribution of regional, rural and remote Australia. Online version accessed May 2021, https://www.ruralhealth.org.au/book/economic-contribution-regional-rural-and-remote-australia.

Roberts, J. P., Fisher, T. R., Trowbridge, M. J. and Bent, C. (2016). A design thinking framework for healthcare management and innovation. *Healthcare*, 4(1), pp. 11-14.

Rey-Martí, A., Ribeiro-Soriano, D., & Sánchez-García, J. L. (2016). Giving back to society: Job creation through social entrepreneurship. *Journal of Business Research*, 69(6), pp. 2067-2072.

Roy, M. J., Donaldson, C., Baker, R. and Kerr, S. (2014). The potential of social enterprise to enhance health and well-being: A model and systematic review. *Social Science & Medicine*, 123, pp. 182-193.

SA Health (2019). Q fever - including symptoms, treatment and prevention. Online version accessed May 2021, https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/conditions/infectious+diseases/q+fever/q+fever+including+symptoms+treatment+and+prevention.

Silverman, D. (2017). *Doing Qualitative Research: A Practical Handbook, 5th Edition*, Sage, London.

Steiner, A. and Teasdale, S. (2017). Unlocking the potential of rural social enterprise. *Journal of Rural Studies*, 70, pp. 144-154.

Swerissen, H., Duckett, S. and Moran, G. (2018). *Mapping Primary Care in Australia*. Grattan Institute, Australia.

Wiseman, L., Sanderson, J., Zhang, A. and Jakku, E. (2019). Farmers and their data: An examination of farmers' reluctance to share their data through the lens of the laws impacting smart farming. *NJAS-Wageningen Journal of Life Sciences*, 90, pp. 100301.

Van der Bijl-Brouwer, M. and Dorst, K. (2017). Advancing the strategic impact of human-centred design. *Design Studies*, 53, 1-23.

Yeo, A., Legard, R., Keegan, J., Ward, K., McNaughton, C. and Lewis, J. (2013). In depth interviews. In McNaughton, C (Ed) *Qualitiative Research Practice, 2nd Edition*, Sage, London.