Rural & Remote Medical Services Ltd.
An Australian Medical Charity Since 2001

RARMS HEALTH

HEALTHY WEE WAA

COMMUNITY HEALTH ACTION PLAN

We live and work on the lands of the First Australians. We pay our respects to Elders past, present and emerging.

GAMILARAAY

Dhayn ngiyani winangaylanha NSWga ganunga-waanda yanaylanha, dhaymaarr ganugu-waanda nhama ngarrangarranmaldanhi

ENGLISH

We respect Aboriginal peoples as the First Peoples and custodians of NSW.

Rural & Remote
Medical Services Ltd.
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MISSION

Help rural, remote and Indigenous communities to maintain and sustain local, high-quality, accessible, integrated, patient-centred, culturally-responsive and inclusive health & medical services.

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WHAT IS RARMS?

Rural and Remote Medical Services Ltd (known as RARMS) was established as a not-for-profit charity in 2001 by a group of passionate rural GPs and the NSW Rural Doctors Network NSW (RDN).

RARMS was established in response to the decline or general practices and hospital services.

The lack of access to primary health care in our communities contributed to escalating rates of chronic disease, preventable illness and mortality up to 11 years earlier than people who live in metropolitan areas.

All the research shows that a strong and sustainable primary care system was the key to improving rural community health. While hospitals play an important role in managing health in an emergency, or for acute conditions, the key to preventing illness, reducing hospitalisation and increasing years of life was GP-led primary care.

The doctors involved in the creation of RARMS knew that it was possible to attract GPs to live and work in rural or remote Australia. However, this required cooperation and the pooling of funding across all tiers of government, and with other sectors such as education, social services and housing to build an integrated rural system.

In short, the population of rural and remote towns is too small to financially sustain a primary care service on Medicare rebates alone.

By combining funding from the local, State and Federal governments, rural communities were able to recruit GPs who could run the local hospital and coordinate health and human services.

But this required a focus on sustaining primary care services. Dependency on a local GP meant that when the doctor left the services would often decline. Focussing on continuity of services, RARMS was able to successfully sustain rural and remote primary and secondary care until a new doctor was recruited.

This is what makes the RARMS model successful. For 20 years, RARMS has ensured that 25,000 rural, remote and Indigenous Australians have local access to appropriate and affordable health and medical care delivered by doctors, nurses and health staff who live and work in their towns.

Within 2 years of working to establish its first remote practices in Walgett and Lightning Ridge, RARMS tripled the number of local permanent GPs, increased the number of patient services by 69% and dramatically reduced hospital presentations by 80% by improving community health access.

RARMS' role is to help communities to develop their skills and capabilities to understand their own health needs, develop programs to address the social determinants of health, build and operate their own sustainable local health services and help to recruit permanent GPs, nurses and health staff to their town.

BASICS

2,080

POPULATION (2016)

16.8%

INDIGENOUS (2016)

RATIO OF FSE GP TO PATIENTS (NARRABRI)

1:1677

COMPARED TO 1:1000 IN AUSTRALIA

NO. OF GPS PER 1,000 PATIENTS (WEE WAA)

0.48

0.71: 1,000 (AUSTRALIAN GP:1,000 PATIENT RATIO)

EMERGENCIES IN WEE WAA

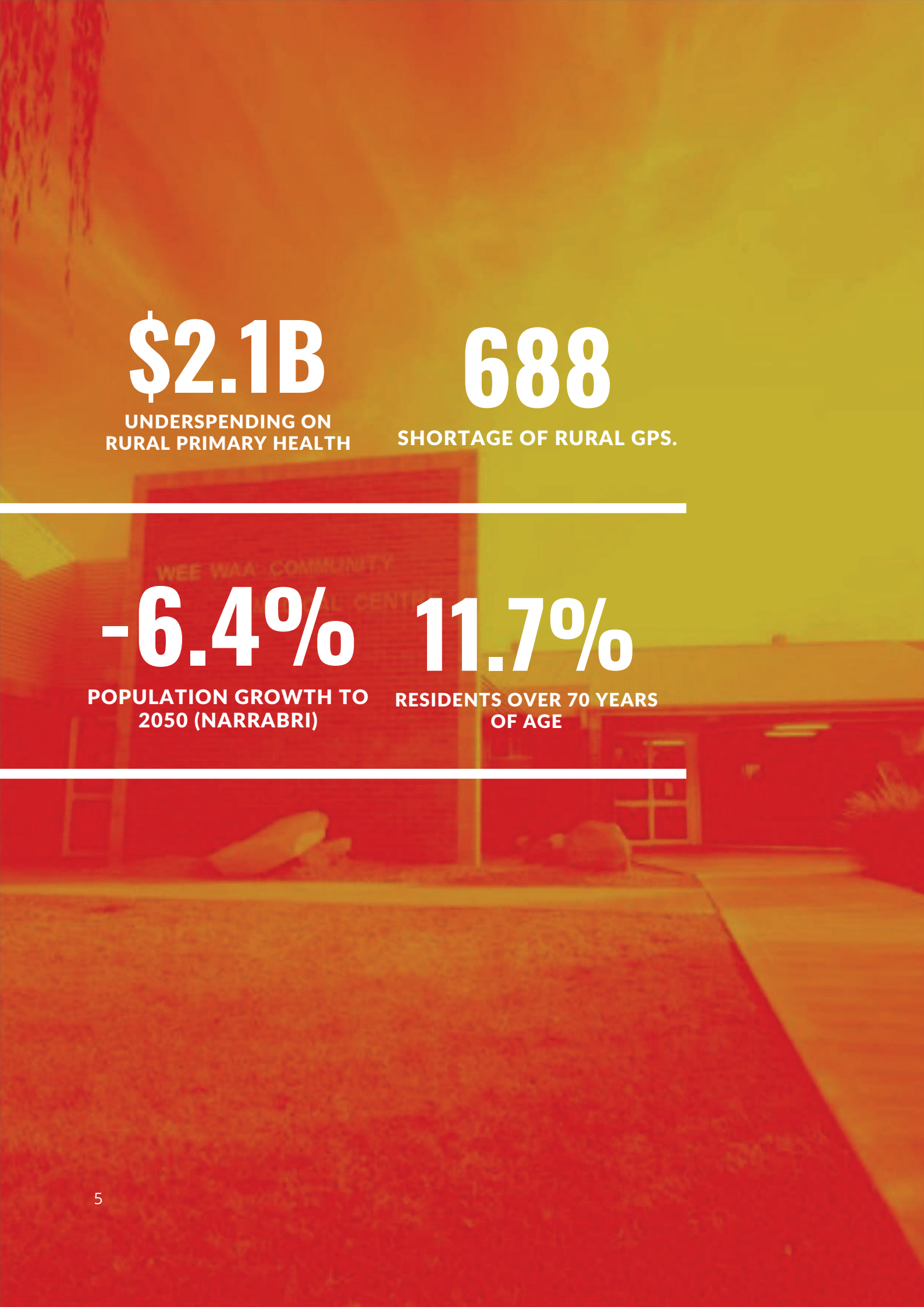
597

NUMBER OF EMERGENCY PATIENTS AT WEE WAA HOSPITAL (2018)

OCCUPATIONS (WEE WAA)

10%

HEALTH IS THE 3RD LARGEST OCCUPATION IN WEE WAA AFTER AGRICULTURE AND RETAIL



$2.1B

UNDERSPENDING ON RURAL PRIMARY HEALTH

688

SHORTAGE OF RURAL GPS.

-6.4%

POPULATION GROWTH TO 2050 (NARRABRI)

11.7%

RESIDENTS OVER 70 YEARS OF AGE

RETHINKING RURAL HEALTH

To ask the right question is already half the solution to a problem.
Carl Jung

- If everyone was healthy, and we had a shortage of doctors, would we care?
- ***The*** problem of rural health is not a shortage of doctors, but poor community health outcomes.
- Too often we focus on workforce shortages because it is seen as easier (and cheaper) than actually improving rural community health.
- Rural towns get caught in an unending cycle of gaining a doctor, losing a doctor, and gaining a doctor again.
- Does this lead to improved community health outcomes? Maybe.
- The question to ask is: Has focussing on rural doctor shortages for the last 20 years actually improved rural community health and access to services?
- Governments spend millions on rural health, but very little changes:
    - "We have spent more than a billion dollars on rural medical education programs over the last 20 years" - OK, but the number of medical graduates who want to become GPs has actually declined from 40% to 15% so we have actually made the problem worse.
    - "We have increased the number of rural doctor training positions" - sure, but we can't even fill existing rural training places so how does adding more help.
    - "We have funded new primary health service agencies" - great, but our hospitals have become first aid centres that cannot deal with anything serious.
    - "Rural people can now access hospital services using telehealth." Thats fine, but what if there is car accident and four people require immediate care?
- So what have we actually achieved by focussing on rural medical workforce?
- Rural people still have higher rates of preventable illness, avoidable hospitalisation, poorer access to primary care and die earlier compared to cities.
- Rural and remote communities need to redefine the problem we are trying to address.
- If the outcome is that we need a doctor, then getting any doctor solves the problem - but we know that getting a new GP only solves part of the problem.
- If the outcome we want is improved community health, then the solutions that our communities need become more comprehensive.
- For example, if we want a sustainable reduction in diabetes and related illnesses then rural communities need a sustainable primary care system that can work with the community over the long term to address the causes of poor health.
- The answer might be two or three GPs, a specialist, a mobile clinic to service small surrounding towns, new school education programs to promote healthy eating, a diabetes nurse educator, a staffed dialysis unit at the hospital and a community education program.
- Communities need to define the problem, set out the outcomes they want to achieve and then define the services and programs that must be funded to support this outcome.
- This way the community is setting out what is required of the health system, rather than the health system defining what the community is allowed to have.

RARMS PROCESS

Step 1

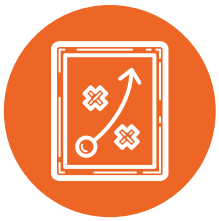
Establish Wee Waa Community Health Forum with representatives of Local Health District, Health Providers (pharmacy, dentist, optometrist, AMS etc), schools, human services (e.g. FACS, NDIA), aged care, community organisations (Rotary, CWA) to agree to develop a comprehensive shared plan.

Collate data to define the health problems.

Develop a Place Based Health Plan that sets outcomes and the health and social service mix required to address them.

Secure buy-in from stakeholders and commitments to fund their parts of the solution.

Step 2



Medical Workforce

Develop Business Plan to support operation of an integrated primary and secondary health service.

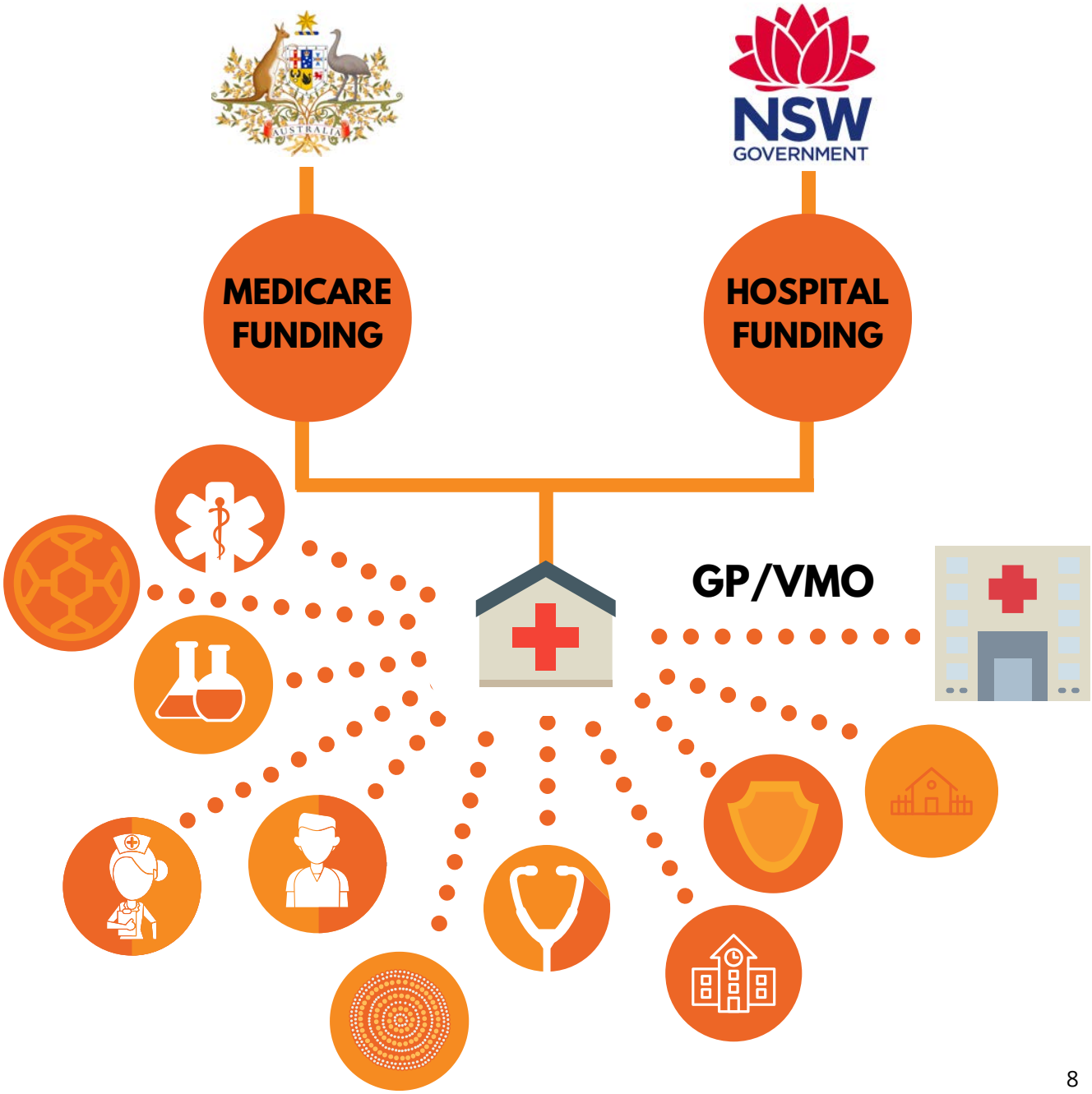
Step 3

Health Outcomes

Establish integrated primary and secondary care service.

INTEGRATED RURAL HEALTH CARE SYSTEM

Successful rural and remote health systems are designed as "integrated health systems" where the local GP coordinates primary and secondary (hospital) care. Research shows this is the most effective model for ensuring the sustainability of health and hospital services in rural and remote communities and improving community health. This is because of small population of rural towns means that Medicare rebates are insufficient to make rural general practice financially viable. To ensure rural practice is attractive to GPs they have historically been appointed to the position of Visiting Medical Officer (VMO) at the hospital, allowing health and hospital funding to be pooled, and making rural practice viable for GP VMOs.



UNDERSTANDING THE PROBLEM AND BUILDING A PLAN

Communities, local government and social enterprises need good data to help make decisions about where to invest time and resources, and to evaluate the impact of what they are doing. It is also essential if communities want to ask government for funding in a highly competitive environment. RARMS has partnered with two of Australia's leading data analytics organisations to help our communities to argue their case for support for better health services, and prove the impact of community initiatives on health outcomes.

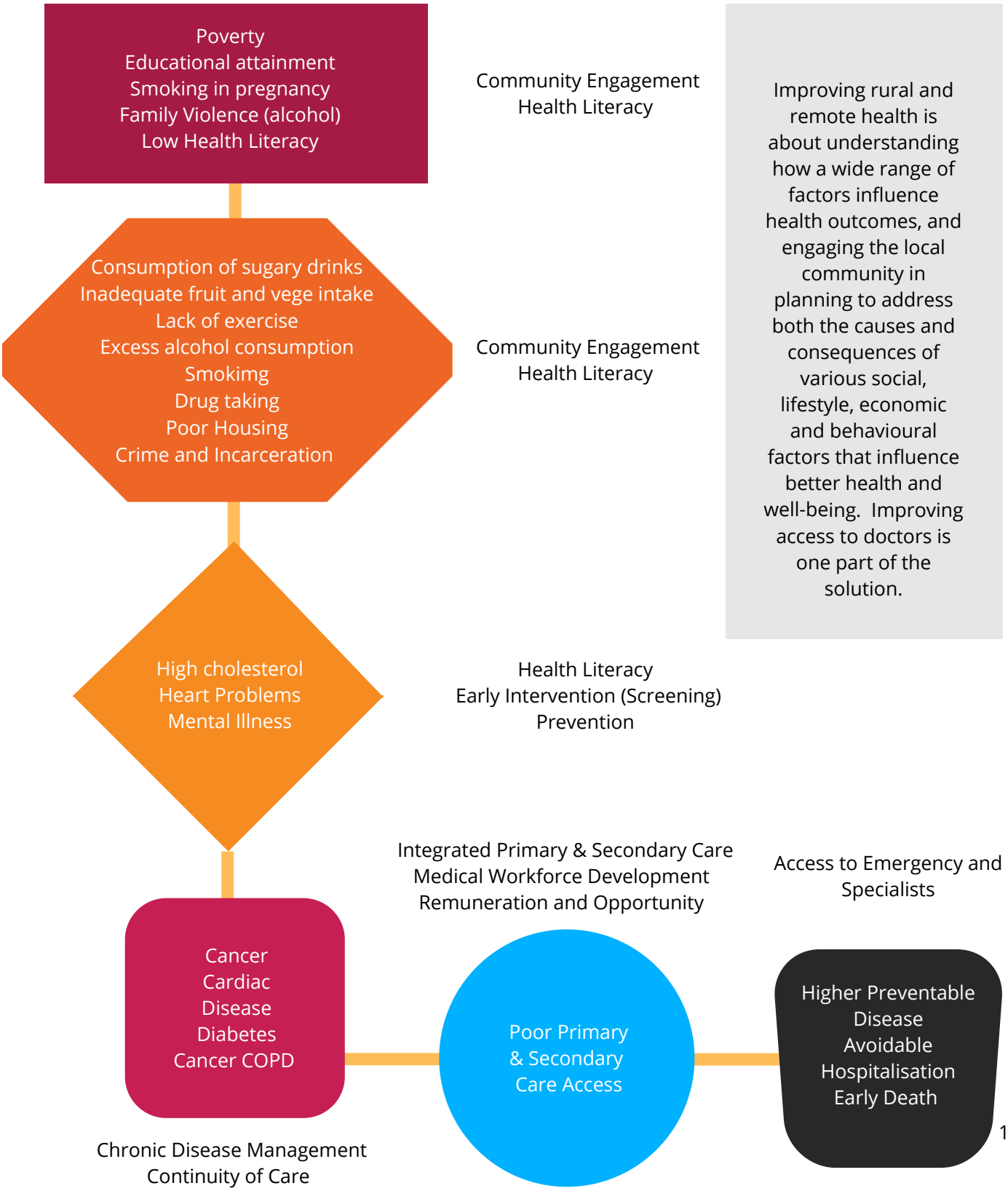
Seer Data & Analytics

Seer works with Federal, State and Local Government, and the NGO sector, to improve community access to, and understanding of, data. Seer supports the development of community led insight portals that are open to the community and help to define problems and solutions based on the specific needs of a place.

AUSTRALIAN SOCIALVALUE BANK

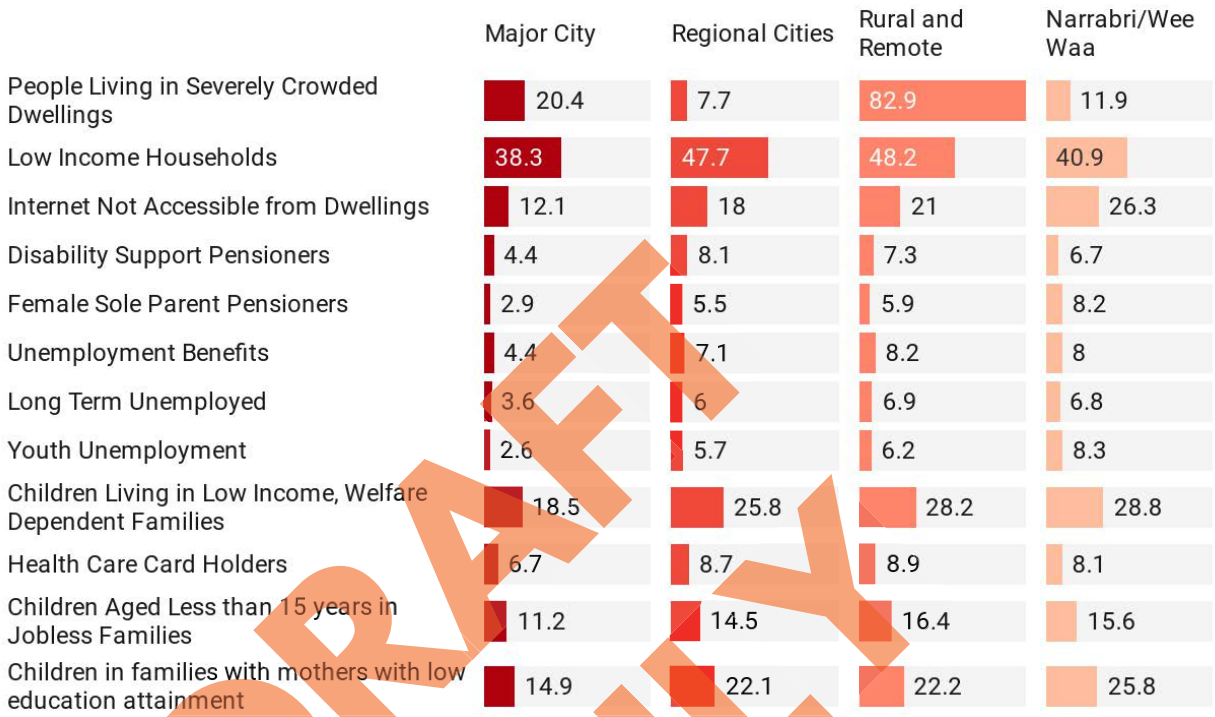
The Australian Social Value Bank is used by RARMS to measure the social impact of various programs and activities in a way that no other impact tool currently can. The ASVB is the largest bank of methodologically consistent and robust social values ever produced in Australia; putting a well researched economic value on the improvement in wellbeing of Australians.These social values, together with the online Value Calculator, allows RARMS to translate the net benefit of social impact in dollars, using Cost Benefit Analysis and prove to government the value of investing in communities.

THE DETERMINANTS OF HEALTH

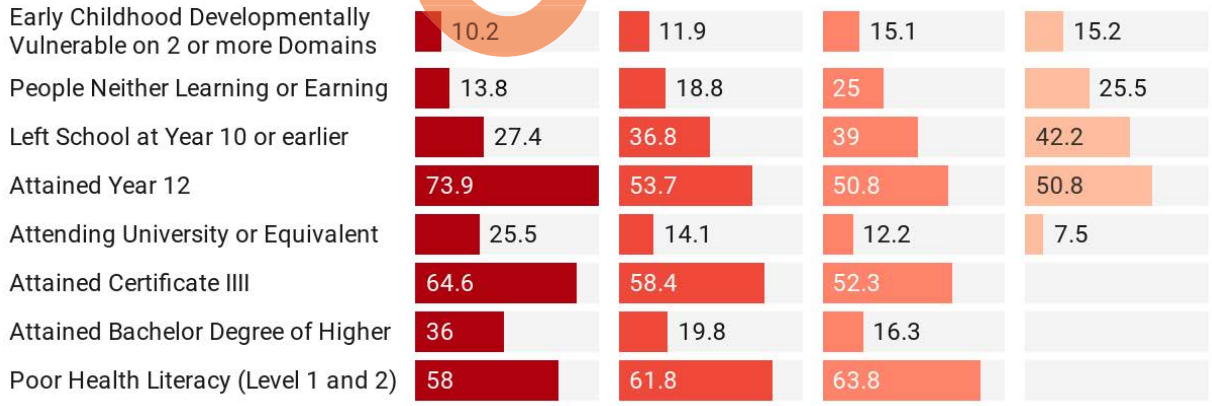


Improving rural and remote health is about understanding how a wide range of factors influence health outcomes, and engaging the local community in planning to address both the causes and consequences of various social, lifestyle, economic and behavioural factors that influence better health and well-being. Improving access to doctors is one part of the solution.

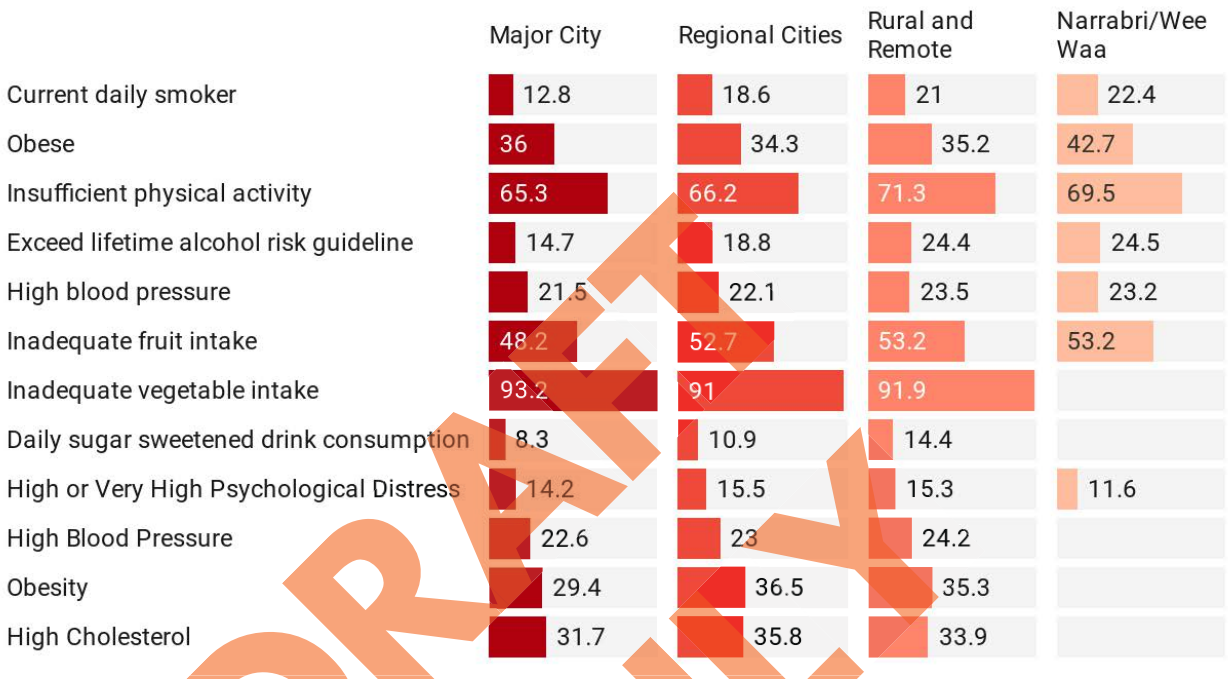
Economic Determinants



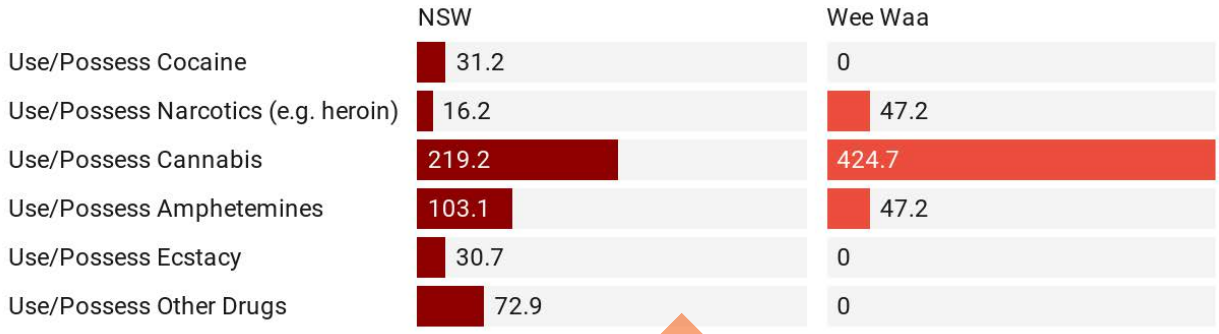
Educational Determinants

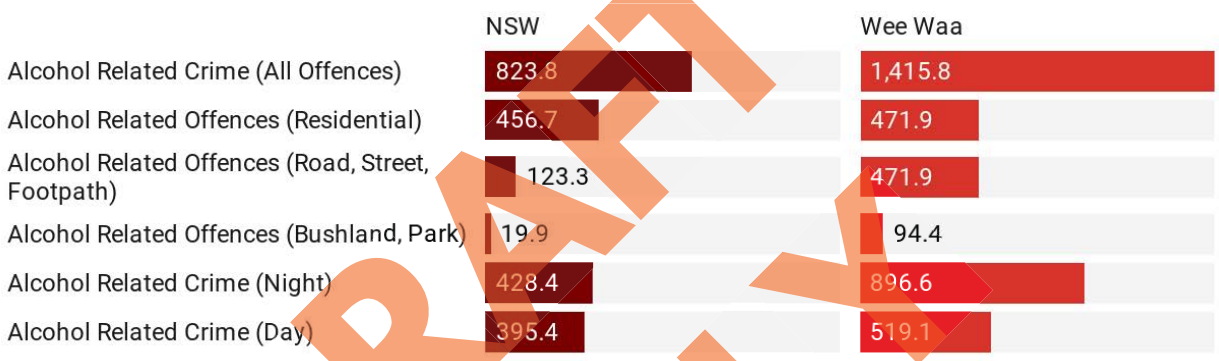


Behavioural Determinants



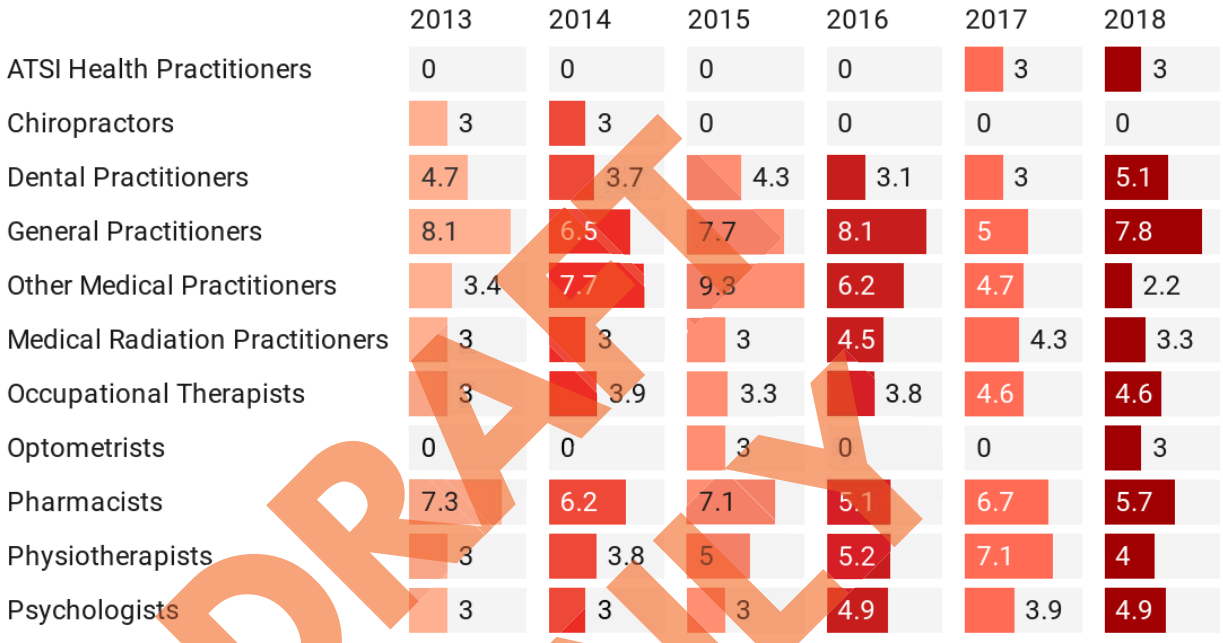
Social Determinants

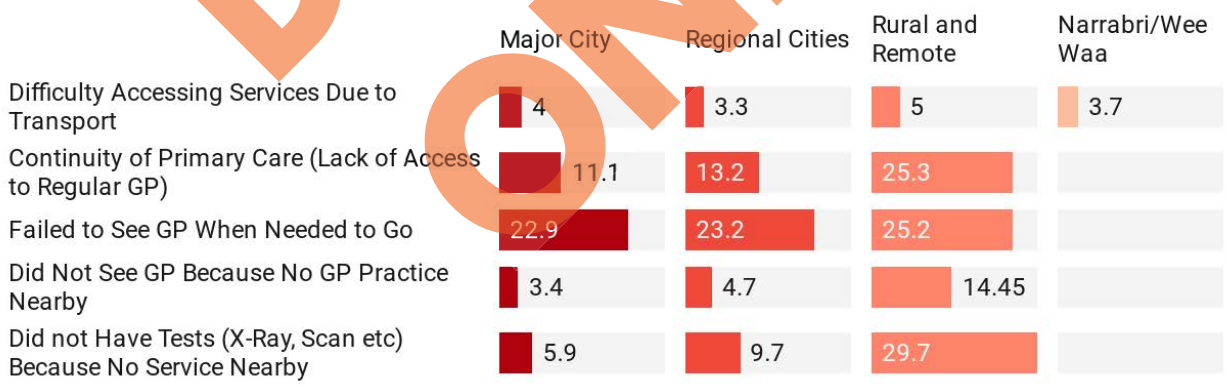




Health Access Determinants

Health and Medical Practitioners - Narrabri LGA (Full Time Equivalent Clinical)





DETERMINANTS OF HEALTH

Matrix

	Economic	Educational	Social	Behavioural	Access	Health Outcomes
CAUSE	Youth Unemployment	Low Year 12 compeltion rates	Domestic Violence	Excess Alcohol Consumption	District of Medical Workforce Shortage	Diabetes
	Long Term Unemployment	Low Further Education Participation	Alcohol Related Crime (Community)	Smoking	Lack of Access to Regular GP (Continuity of Care)	Respiratory Disease
			Cannabis Use	Inadequate intake of Fruit and Vege	Did not See GP When Needed to	Cardiac Disease
				Lack of Exercise	Did not Get Diagnostic Tests When Needed to	Cancer
				Excess Consumption of Sugary Drinks		
CONSEQUENCE	Low Income Households	Poor Health Literacy	Intergenerational Disadvantage	High Cholesterol	Lack of Prevention	Preventable Illness
				Obesity	Lack of Early Intervention	Avoidable Hospitalisation
				High Blood Pressure		Early Death
POSSIBLE SOLUTIONS	*Year 12 Retention Strategies*	*Community Health Forum to engage residents*	*Community Policing*	*Alcohol Free Zones*	*Health Service Mix*	*Increased focus on early intervention and chronic disease management*
	Attract Country University Centre	*Council sponsored health weeks*	*Anti-Domestic Violence Campaigns*	*Community Education*		
	Focus on Growth Industries in Personal Services (Aged Care, Health, NDIS)		*Diversion Programs*			
	Focus on Location Independent Services Sector (ICT, Finance etc)					

THANK-YOU

Since its founding in 2001, RARMS has relied on its supporters to help us deliver high-quality, GP-led, independent primary health care to rural, remote and Indigenous communities. These individuals, corporations, foundations, governments and other organisations share our belief in the power of better health to change lives and communities.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SYDNEY


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NSW Rural
Doctors
Network


MANILDRA GROUP
100% AUSTRALIAN OWNED


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SOCIALPILOT


ANU
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SUPA IGA
KHAN'S


Angel
Flight


COUNTRY WOMEN'S ASSOCIATION
N.S.W.


THREE RIVERS UDRH


NSW
GOVERNMENT
Health
Hunter New England
Local Health District


Australian Government


RSL
LifeCare

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TEGAN CATTLE
GROUP MANAGER, PEOPLE & CULTURE

WHEN "I" IS REPLACED WITH "WE" EVEN ILLNESS BECOMES WELLNESS.

Malcolm Little