Aboriginal and Torres Strait Islander people should be aware that this document may contain images, voices and names of deceased persons.

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

SUBMISSION

Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

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

Wiradjuri

Ngiyani Yindyamali Aboriginal Mayiny Murrubandhda Mayinny galangga NSW Ngangaagi

English

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

[1] This submission is dedicated to the many rural and remote residents who die prematurely every year in NSW as a result of health inequality and lack of access to health care services and to the General Practitioners, Nurses, Health and Social Workers who live and work in these communities and work tirelessly to ensure rural and remote people get a fair go.

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

Submission to the Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

TERMS OF REFERENCE

1. That Portfolio Committee No. 2 - Health inquire into and report on health outcomes and access to health and hospital services in rural, regional and remote NSW, and in particular:

(a) health outcomes for people living in rural, regional and remote NSW;

(b) a comparison of outcomes for patients living in rural, regional and remote NSW compared to other local health districts across metropolitan NSW;

(c) access to health and hospital services in rural, regional and remote NSW including service availability, barriers to access and quality of services;

(d) patient experience, wait-times and quality of care in rural, regional and remote NSW and how it compares to metropolitan NSW;

(e) an analysis of the planning systems and projections that are used by NSW Health in determining the provision of health services that are to be made available to meet the needs of residents living in rural, regional and remote NSW;

(f) an analysis of the capital and recurrent health expenditure in rural, regional and remote NSW in comparison to population growth and relative to metropolitan NSW;

(g) an examination of the staffing challenges and allocations that exist in rural, regional and remote NSW hospitals and the current strategies and initiatives that NSW Health is undertaking to address them;

(h) the current and future provision of ambulance services in rural, regional and remote NSW;

(i) the access and availability of oncology treatment in rural, regional and remote NSW;

(j) the access and availability of palliative care and palliative care services in rural, regional and remote NSW;

(k) an examination of the impact of health and hospital services in rural, regional and remote NSW on indigenous and culturally and linguistically diverse (CALD) communities; and

(l) any other related matters.

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Recommendation 3
1. The NSW Government develop, in consultation with local communities, a *Rural and remote health service framework* comparable to the one in Queensland that defines the functions of each type of facility and the services that rural and remote residents can expect to receive in each town.
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VMO Budgets should be allocated to Hospitals and tied to the provision of VMO services in that location.

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Annual budgets and monthly expenditures are published for each hospital to increase accountability to the community.

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1. A state-wide system of Visiting Medical Officer rights should be established to reduce the uncertainty of current processes.
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The NSW Government fund rural and regional senior GPs to provide supervised practice and training for doctors who want to work in rural and remote general practice as GP/VMOs.

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The NSW Government adopts a policy that it will not compete in the provision of health services in rural and remote towns that can be delivered locally by general practice.

Recommendation 13

To give effect to the Statement by the Minister for Health that Telehealth will not be used to replace local rural GP/VMOs the NSW Government adopt a policy that:

1. A decision to reduce or vary the fees payable under an existing VMO contract, or in the negotiation of a new VMO contract, must be supported by a written analysis that demonstrates that any variation of fees will not result in any reduction of Primary Health Care and hospital services to the relevant rural and remote town and must not be undertaken for a purpose which includes the introduction of Telehealth to replace or reduce the number of hours of on-site GP/VMO services below 24 hours, 7 days a week.
2. The Service Agreements between the Minister and Local Health Districts are updated to include an obligation that Local Health District must ensures the delivery of 24/7 on-site GP/VMO services to rural and remote communities at all times.
3. Local Health Districts are provided with funding to fulfil these obligations.

Recommendation 14

The NSW Government undertakes to remove unnecessary red-tape around rural and remote funding and to introduce minimum term contracts of 3 years for contracted services.

Recommendation 15

The NSW Government:

1. Expand the NSW Human Services Framework to become a whole-of-government framework that incorporates NSW Health specific obligations and accountabilities to drive a state-wide focus on human and health outcomes.
2. Incorporate into future NSW Health Plans quantifiable outcome measures for rural and remote health that align to the Framework.
3. Establish a trial of social prescribing in collaboration with rural and remote General Practice to evaluate its impact on the delivery of health and social services, supporting the sustainability of rural general practice.

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NSW Government adopt a Place-Based Planning Approach led by local communities to addressing the health and human services needs of local communities.

INTRODUCTION

Thank you to the Committee for the opportunity to provide a submission to the Inquiry into health and hospital care in rural and remote NSW communities. For reasons that will be obvious, our submission will focus primarily on health access and outcomes for the most vulnerable and disadvantaged people in NSW rural and remote communities.

Rural and Remote Medical Services Ltd (RARMS) was established in 2001 as a Charity by a group of dedicated rural General Practitioners (GP's) working with local communities to address the ongoing shortage of rural doctors that was contributing to high rates of chronic disease and early mortality.

Today, RARMS delivers high quality health, medical and social services in 10 communities, serving the needs of more than 22,000 people across NSW. We are not only their health provider but fulfil an important role in advocating for their needs.

We are contracted to various Local Health Districts in NSW to deliver Visiting Medical Officer (VMO) services to rural and remote communities both on-site and through our Telehealth service.

Our rural and remote GP Telehealth service provides access to care for a catchment of more than a quarter of a million rural people across NSW, supporting rural and remote doctors to achieve a good work/life balance while improving access to care for rural and remote communities through effective integration of local GP and health services and new technology.

When we talked to members of our communities about what they wanted us to tell the Inquiry they asked us to talk about solutions. They told us that they were scared of losing access to local hospital services and GPs if things keep going on as they are. They are terrified of ending up with a Telehealth doctor when there is an emergency and one of their kids or their Mum needs a local doctor to help. They are tired of going to the local hospital to find that hours of operation or the types of services they can access has been changed without prior notice; making them feel as though they don't matter. They are disappointed by the number of medical trainees who are sent to their towns who say they want to work in rural and remote practice, but rarely stay.

Our communities told us that they wanted to be involved in decision-making about future changes to health care in their towns rather than reading about it in the newspaper after the decision has already been made. They told us they want a chance to explain their experiences directly to the Committee, because they feel too often "rural health experts" in our urban and regional cities, and the health industry, get a larger voice in the discussion of their needs than the people who are affected by decisions on the ground.

Our dedicated doctors and health staff told us they fear for the future because of decisions being made in Macquarie Street or Canberra about their communities without an understanding of the flow-on impacts to the wider health system, their patients, jobs and communities.

It was media attention from the *Sydney Morning He*rald, *60 Minutes* and *the ABC* about alleged failures in our rural and remote health system that resulted in this Inquiry, not the needless loss of 174 rural and remote lives each month in NSW. The latter is well documented, but rarely stirs systemic action.

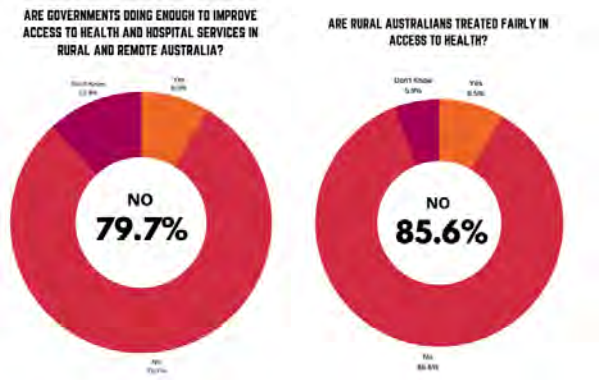
The lived reality for rural and remote people is that the systemic problems of our rural and remote health system rarely attract attention. Our communities feel that their needs are only attended to when there is a crisis – be it floods, drought, unfairness or death – and that this results in a patchwork response rather than the systemic reform that is needed.

We want to make clear upfront that the situation in rural and remote NSW is not the fault of rural doctors, nurses or communities. There will be times when mistakes are made, sometimes with devastating impacts, and we have systems that are well-designed to address these – whether this occurs in Caringbah or Cobar. It is the job of Hospital Clinical Governance Committee and the Coroners Courts to inquire into hospital errors and understand how to mitigate, amend and improve them for future practice.

The larger challenge for this Inquiry is to recognise that the challenges of rural and remote health are systemic, and it is only through system change that we can hope to affect a solution. Our hope is this Inquiry might leave a legacy that ensures no other rural or remote family will be compelled to endure the loss of kin due to the systemic inequality that is built into our system of rural and remote health care.

Australia has catalogued in numerous inquiries, reports and research articles the problems and challenges of rural health services delivery and the adverse impact this has on health outcomes in rural and remote communities. Billions have been spent to identify and implement solutions. Millions of person-hours have been expended discussing, reviewing and evaluating initiatives. There is no want for dedicated and committed people working on rural and remote health who are trying to find solutions. But the simple fact is that the gaps in health outcomes between metropolitan and rural and remote residents of NSW remain, and access to local health services continues to decline.

Our communities and patients tell us they are tired of being told about the huge amounts of money being spent on rural and remote health, as though this is an answer, when they can see with their own eyes the loss of on-the-ground services and the growing gaps between the cities and the bush. If you ask residents of rural and remote communities whether the government is closing the gap, the resounding response is “No”.



SOURCE: Rural and Remote Communities Health Care Survey 2020 at https://www.ruralandremotehealth.org.au/publications

This begs the question: Why?

The constant refrain that “rural and remote health is complex” and “doctor shortages are a result of fewer medical graduates wanting to work in rural and remote communities” reinforce the idea

that the challenges of rural and remote health are unresolvable and, the best outcome is the status quo.

I grew up in Western Sydney, not Western NSW. When I grew up my backyard looked out onto paddocks and market gardens. Where we lived was characterised as a wasteland in much the same way as Western NSW is represented today in metropolitan culture.

When I moved to Orange in 2003, it was considered by some in the cities as the last outpost of humanity before the vast nothingness of the western plains. We had a run-down hospital, a small government department and an ageing Grace Brothers, a remnant of the once great Dalton Stores, that was holding on for dear life.

Today, Western Sydney is the economic powerhouse of the State and Orange is a rapidly growing population hub with a major referral hospital, university medical and dental school, global businesses and a thriving cultural scene.

As the former CEO of a regional economic research institute, I do not contend that the models of transformation of Western Sydney and Central Western NSW can be applied to far Western NSW. The context is different.

But in order to bring about systemic solutions, we need to change the way we talk about and understand rural and remote communities. We need to put aside the deficit discourse that pervades our policy outlook in the cities, as we did in Western Sydney and Orange, and talk with rural and remote people about their strengths and how we can leverage these to build solutions.

In setting policies, many people in rural and remote NSW believe our governments prefer to listen to metropolitan-based “rural” experts about our “problems” rather than talk to rural and remote people about their solutions. It appears to many people across rural and remote NSW that, as more and more money pours into metropolitan organisations to solve “our problems”, more and more services are withdrawn from their communities.

We have official consultative committees and forums that rural and remote people can express their views, but too often rural and remote people say they don’t feel they can exercise real influence on health policy, planning and funding decisions.

At the very least, they do not feel our health system understands the importance of access to integrated health and hospital services in rural and remote areas and, are too willing to entertain a reduction in services that would never be contemplated in the cities.

What we see every day are elderly residents who are afraid of what will happen to them if a local GP isn’t available when they need it. Further, young parents who tell us they are thinking about leaving town because they cannot risk bringing up their children in a town where there are no local hospital services.

The “Experts” often say to rural and remote people, their communities are simply too unattractive to sustain permanent doctors like they once did. Even senior rural health leaders say rural and remote health is a “market failure” as though health is a “market” and economics is the only benchmark against which the community is permitted to judge access to health care.

But this is not the complete experience of rural and remote people.

In rural and remote NSW, RARMS has been providing on-site/face to face Primary Health Care, acute hospital services and workforce solutions for 20 years, to the most difficult to recruit towns in the State. This is expensive, but it works when the right resources are allocated.

The Aboriginal Community Controlled Health Organisations sector across Australia have been recruiting a medical and health workforce, to deliver health and medical services in rural and remote communities even longer. Expensive – Yes. Works – on the whole, yes.

In Queensland the rate ratio of GPs per 100,000 rural and remote people compared to Major Cities is 0.83, and in South Australia it is 0.80 times compared to 0.71 times in NSW. This suggests that other States, which have generally much larger rural and remote territories, are able to recruit GPs into rural and remote Primary Health Care more effectively. Expensive – Yes. Worth it – absolutely.

The fact is the problem is less about the attractiveness of our rural and remote towns than attractiveness of working in the NSW health system in rural and remote areas.

RARMS has spent 20 years engaging doctors to work in rural and remote NSW within their Primary Health Care and local hospital sectors; we have been delivering face to face quality care that has resulted in a reduction in potential preventable hospitalisations across our locations of 65 percent in the last 5 years; and, our communities are accessing health services at a higher rate than other towns without GPs because we have a model that has been shown to be among the most stable and sustainable of rural and remote health care models in Australia.

In rural and remote communities, we see the local Rotary raising hundreds of thousands of dollars for the Royal Flying Doctor Service in Lightning Ridge, the community in Collarenebri donating a house as a site for a new medical centre in town and Wee Waa raising funds to build accommodation for doctors to live in. Rural and remote people have built on their strengths and achieved significant outcomes which too often go unrecognised.

In our experience working in rural and remote NSW for 20 years governments don't talk to rural and remote people enough in formulating rural and remote health policies and solutions. This is driven by a fear that this will expose government to demands that it cannot meet.

But rural and remote people don't expect a Royal Prince Alfred Hospital in every town or a linear accelerator every 30 minutes. They expect however, if they are having a heart attack, a serious farming accident, have internal bleeding or have gone into premature labour that there is going to be a 'flesh and blood' doctor in town who can provide hands-on, face to face care. They expect to have access to a regular GP in town who knows them, can provide continuity of care and can holistically manage their health to reduce their likelihood of developing a lifelong chronic condition..

These are not unreasonable expectations in a country that has committed to the principle that 'All Australians have access to appropriate health care, regardless of where in the country they live'.

Despite our ambitions, we have struggled for decades to get the policies right to achieve this. This is because, in our view, we too often ask "what is wrong with rural and remote communities" placing responsibilities for the "problems" at the feet of these communities.

But why should rural and remote communities bear the blame for a failure of policies and programs that have largely been designed in our cities. This is not to suggest we haven't made important progress, but we have not closed the gap in access to health and hospital care in rural and remote areas. The right question is ""what is wrong with our policies and approach?".

The Committee will be provided with data about how the ratio between Major Cities and Remote areas in the proportion of FTE GPs per 100,000 population in NSW has improved over the last 20 years due to sustained government effort. This is true.

But, the important question has never been whether rural and remote communities have more doctors, but whether the proportion of FTE GPs living and working in rural and remote areas reflects the geographic and population health needs of rural and remote people.

Having one more doctor in a town that needs 4 more doctors will not reduce GP burn out or ensure that GPs can provide their patients with the time required to deliver quality health care. We will never get to the right solution if we do not measure the right things and have the policies in place to achieve them.

As the Chief Executive Officer of the charity RARMS I know everyone engaged at the frontline of rural and remote health are doing their best in a system that sometimes feels stacked against them.

Our Local Health Districts staff work tirelessly to address the inequalities that beset our communities. But at the end of the day, they are required to administer a rural health system within a policy framework set far from the experiences of our communities and which, by and large, is simply not appropriate.

We cannot go on as we have for the last two decades. We need a fresh approach. We need a need new blanket, not another patch to cover up the gaps.

For the last 20 years or so I worked with a group of dedicated people at Charles Sturt University, and other regional universities to advance an evidence-based case that training more rural and remote kids in rural areas to become doctors and health professionals was a proven solution to our workforce challenges.

This case was opposed by silence or active opposition by almost every professional association and "rural" professional advocacy organisation in the country (invariably located in our cities) despite the overwhelming evidence of its effectiveness.

Why? Because rural and remote health sits within a much larger system that has different goals and priorities to ensuring access to on-site health and medical care in Collarenebri, Walgett, Gilgandra or Lightning Ridge.

We argue that the challenge of our rural and remote health system is not access to doctors *per se*. Poor access is a symptom of a fragmented and hospital-centric system of care designed to meet the needs of major cities, not the needs of rural and remote communities.

We will elaborate on this and other points in our submission.

The NSW Government has historically played a critical role in supporting the sustainability of rural and remote health and hospital services through its funding of rural GPs as Visiting Medical Officers (VMOs). In the future there are significant opportunities to advance the health and well-being of rural and remote communities through improved coordination of care services around social determinants at a local level.

This Inquiry, like all before, will be added to a decades-old catalogue of research and policy that will influence the future direction of rural and remote health. For the members of the Committee this is an opportunity to reframe the question from “what is wrong with rural and remote health” to “how can we build on the strengths of rural and remote communities to better meet their needs”.

We would appreciate the opportunity to address the Inquiry directly at hearing. We also suggest hearings be held in a number of rural and remote centres so that the Committee members have the opportunity to hear directly from these communities.

Rural and Remote Medical Services Ltd

ABOUT RURAL AND REMOTE MEDICAL SERVICES

RARMS is a charity that was formed in 2001 through a collaboration between the Walgett Community Health Forum, NSW Rural Doctors Network, Aboriginal Medical Service, Far Western Area Health Service and rural doctors to address the lack of access to primary healthcare services in disadvantaged rural and remote communities.

The people involved in the formation and development of RARMS did not start from a belief that there was no way to improve rural and remote health. This positivity remains central to the ethos of RARMS today.

We don't exist to make money, but rather to make a difference.

The 'Easy Entry, Gracious Exit' model is simple: recognising that Medicare is insufficient to meet the cost of running a rural or remote GP practice, the Local Health District "cashed-in" Visiting Medical Officer (VMO) contracts and provided this to RARMS to support recruitment of both a GP and VMO to rural and remote towns that struggled to attract and retain doctors. RARMS is able to attract doctors by offering a complete package that covers Primary Health Care and hospital services and enables us to negotiate on behalf of doctors with the hospital system. If a permanent rural doctor requires leave, or decides to relocate, we use our retained funds to backfill the position with a roster of regular rural locums until a new permanent GP/VMO can be secured. Retained funds also enable us to deliver health promotion, technology, training, management, clinical governance and organisational support to ensure practices are efficient and effective and communities have access to a broad health service capacity.

In many ways, the RARMS model is a modernised version of the rural and remote health ecosystem where the local GP ran the hospital through a Primary Health Care lens rather than the hospital running the GP through an acute care lens.

Where it differs from the past is that an experienced third-party charity with a board of professionals governs service delivery and clinical quality working with local communities. This has enabled us to deliver sustainable services across multiple communities while also ensuring we are matching our services to local needs through the engagement of our local doctors and staff with the community.

We coordinate doctors, specialists, nurses and allied health professionals to deliver a mix of Primary Health Care and hospital care.

It's a simple but highly effective model - if we generate excess funds we use them to subsidise services in towns which could not sustain viable general practice services. This allows us to manage funds for the sole benefit of the health of our communities and not to deliver profits to shareholders or to achieve some policy goal that is important to the cities but not our communities.

The 'Easy Entry Gracious Exit' implemented by RARMS was created as a product of innovative thinking about the challenge of recruiting and retaining medical workforce to keep general

practice and hospital services going in rural and remote communities. As described in a report on the model funded by the Commonwealth:[1]

> "The Easy Entry, Gracious Exit approach to recruiting GPs began as a crisis response to chronic doctor shortage and high doctor turnover in North West NSW, rather than as a researched and planned "sustainable model" exercise. However, it has evolved into a model that, with some variation across the four towns involved, is delivering a vastly improved supply of doctors and medical services …
>
> The Easy Entry, Gracious Exit model differs from previous recruitment models, in that it involves a third-party provider. Ideally a local community entity provides the infrastructure necessary for continuity of the practice. **Previous models have concentrated on the continuity of the doctor, rather than the continuity of the practice or practice management structure".**

As noted in the Report on Rural and Remote Medical Services: [2]

> "Experience has shown that this model, or variations of it, has been very successful in expanding and improving the stability of the general practice workforce ...

It has been independently reviewed by academic researchers and health care organisations and found to be one of the most successful and sustainable models of rural and remote health care provision. The Australian Medical Association has adopted a formal policy statement on the model.[3]

A recent review by Wharton Strategy Consulting for the Northern Territory Primary Health Network (2017) observed that the 'Easy Entry Gracious Exit' model:

> **… represent[s] the most sustainable typology of rural and remote models.** These exist in settings where population and economies of scale support the model in the absence of many unique barriers faced by rural and remote communities …

Wakerman *et al* noted that: "Easy Entry, Gracious Exit GP models overcame the barrier of significant practice infrastructure investment in country towns by GPs through the purchase and maintenance of these by a local council or university".[4]

Continuity of Practice

The importance of the shift to "continuity of practice" and our ability to deliver a sustainable and consistent service over 20 years cannot be underestimated. The loss of a rural or remote GP practice results in the loss of practice infrastructure and equipment, clinical records, skilled staff and a deep corporate knowledge of the needs and circumstances of local communities. Even if a private GP wanted to establish a practice in the town, the cost of entry would be prohibitive without an established practice meaning towns that lose their local GP practice typically struggle to re-establish health and medical services in the future without significant upfront subsidies.

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1 https://www.nswrdn.com.au/client_images/246595.pdf
2 https://www.nswrdn.com.au/client_images/246595.pdf
33 https://ama.com.au/position-statement/easy-entry-gracious-exit-model-provision-medical-services-small-rural-and-remote
4 Wakerman, J and Humphries J (2011) Sustainable Primary Health Care services in rural and remote areas: innovation and evidence, Aust J Rural Health 2011 Jun;19(3):118-24 doi: 10.1111/j.1440-1584.2010.01180.x.

The rural GP is also typically the local Visiting Medical Officer. The loss of a general practice medical centre therefore has implications for the sustainability of on-site 24/7 hospital services in rural and remote towns and the cost of hospital services delivery for the State.

The focus on "continuity of practitioner" also ignores the wide range of other key contributors in the care relationship that exist within rural and remote practice. The receptionist, nurse, pharmacist, Allied Health Practitioner and social worker all have local knowledge, experience and relationships that make them as much a part of the continuum of care as the GP. Historically we have entwined "continuity of care" to "continuity of practitioner" in a way that sets up rural and remote health for failure. RARMS broke this mould and showed "continuity of care" can be achieved by investing in the sustainability of a practice team.

In this way, when a doctor leaves town, RARMS simply recruits a locum from its roster of experienced rural and remote GPs to fill the gap where possible ensuring practice services continuing uninterrupted until a new permanent GP can be recruited. This avoided the disruption of doctors without experience in our communities coming to work in the hospital every week, or none at all, and provides our patients with the confidence that the same nurse, receptionist and Allied Health team will always be there, and their health records are maintained.

This system works if there is cooperation between the NSW government and Primary Health Care on a town-by-town basis to ensure the resources are available to fund a mix of permanent GP/VMOs and regular locums to service the Primary Health Care and hospital service needs of a community.

Designing a Telehealth service

In designing our rural and remote Telehealth service we have applied the same philosophy. We actively avoided the "any GP" approach because it undermines health outcomes by fragmenting continuity of care and risks competing with local on-site rural GPs forcing them out of rural and remote communities.

We designed our Telehealth model to be able to adapt and support different regions and contexts. Our rural and remote Telehealth services are location specific. Our doctors are either from the region or have experience working in the regions ensuring they can connect with patients and provide informed care. We coordinate closely with existing local GPs, pharmacies and, allied health and aged care to augment and support existing capacity to ensure continuity of care in rural and remote areas, rather than competing with local rural doctors or replacing them with Telehealth making their small businesses unviable.

This requires more detailed consideration of what is already available and planning to configure services to slot into the gaps, rather than a 'one size fits all' solution. It is more expensive than just setting up a call centre and hiring doctors from Australia and overseas to staff a roster. But we need to give weight to all aspects of our commitment to the people of NSW - the delivery of the "right care in the right place" not just the "right time". We must ensure that we do not lose sight of those aspects of good quality continuity of care that deliver the right health outcomes.

What we have learned over decades is "access" to care, whether in rural or metropolitan communities, means more than being able to see any doctor. Being able to see a doctor who you don't trust, and in whom you do not have confidence, is not access at all. As noted by Humphries and Russell: "the concept of access [includes] availability, geography, affordability,

accommodation, timeliness, acceptability and awareness".[5] Continuity of care with a regular treating practice is what the evidence tells us is the key to health improvement.[6]

Telehealth is a critical tool that is central to innovation in health care in rural and remote communities and Rural and Remote Medical Services is one of its most ardent proponents, but it cannot stop internal bleeding and is limited in capacity to affect genuine improvement across all the domains of access.

It cannot give insight into locational factors that influence behaviour and inform treatments and community-led activities to improve health outcomes and reduce avoidable hospitalisations.

It does not work if you do not have broadband or have unreliable reception, or when the connection is lost during a fire, cyclone, flood, electrical storm, a denial of service cyber-attack, maintenance or upgrades to infrastructure or when some bloke accidentally runs a backhoe through the fibre cable.

We still need doctors on the ground who live in the community and provide a consistent interface for patients to local services and a connection to referral services in our urban and regional cities. Telehealth should be used to support this capacity, but it cannot be a replace local GPs without further risking lives in our communities.

Primary Health Care is about addressing the causes of poor health built on a trusting relationship with patients and deep knowledge of the drivers of health within a local community. Knowing your patients, how they live, the challenges of a town and the factors that influence the health of individuals and families is critical to the design and delivery of the right care in the right place at the right time.

We understand and accept that Telehealth is well suited to hospital environments because it replicates a hospital model of care which is built around episodic presentations and connecting an acute patient with relevant clinical expertise. That is why we have implemented Telehealth consultations for our patients with specialists delivered at our community medical centres.

But when you attend a GP to talk about fertility issues and the alternatives, you need someone who you can trust and who you know will give you advice attuned to your needs. If you are feeling stressed at work and life is too hard, you often need someone you trust to talk with about the future. Trusting therapeutic relationships are central to effective health care.

Telehealth is a brilliant tool to augment many aspects of Primary Health Care delivery, but it is not a solution to all health needs. It must be attuned to the context in which it is being delivered or it will exacerbate poor health outcomes in our communities.

For 20 years RARMS has been providing sustainable and stable access to health and medical services to some of NSW's and Australia's most socioeconomically disadvantaged communities. While other services have been progressively withdrawn from these communities, we have expanded on-site health care to include Allied Health, dentistry, pathology and specialist consultations in collaboration with other NGOs.

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[5] DJ Russel, JS Humphries et al (2013) "Helping policy-makers address rural health access problems" 21:2 Australian Journal of Rural Health
[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4979920/

ABOUT OUR SUBMISSION

In this submission we draw a distinction between “rural and remote” NSW (comprised of those part of the State that are classified under the ASGC Remoteness Areas as Outer Regional, Remote and Very Remote) and urban and regional cities (classified as Major Cities and Inner Regional).

It is often convenient for government to group Inner Regional, Outer Regional, Remote and Very Remote areas of the State under the general banner of “rural” for administrative purposes. The NSW “Rural Health Plan – Towards 2021” assumes this approach.

We would argue however that this is one of the reasons why policies and programs to address health inequality in “rural NSW” struggle to improve health access and outcomes in these communities. Put simply, a town like Orange has nothing in common with a town like Walgett or Collarenebri. Grouping these communities under a single strategic umbrella is inappropriate.

Health services in Orange are constructed around a large referral hospital system with numerous specialists and a thriving market of competing general practices and allied health services. A hospital-centric model of care is both viable and appropriate in these dense communities, compared to more thinly populated rural and remote areas.

This document relies on data produced by the Public Health Information Development Unit (PDIHU). The PHIDU was established in 1999 with funding from the Commonwealth Government to provide public access to independent data on a broad range of health and other determinants across the lifespan allowing fair comparisons of performance to be made across jurisdictions and regions.

Located at Torrens University Australia since November 2015, the PDIHU produces standardised data drawn from various national and State datasets to enable the community and policy makers to compare the performance of different jurisdictions and geographies to allow:

1. monitoring of inequality in health and wellbeing, and
2. supporting opportunities to improve population health outcomes.

Throughout the submission we use comparisons between Major Cities and Remote areas of NSW as the small population size in Very Remote NSW can result in variability in trend data which may give an erroneous view of the overall state and trajectory of rural and remote health.

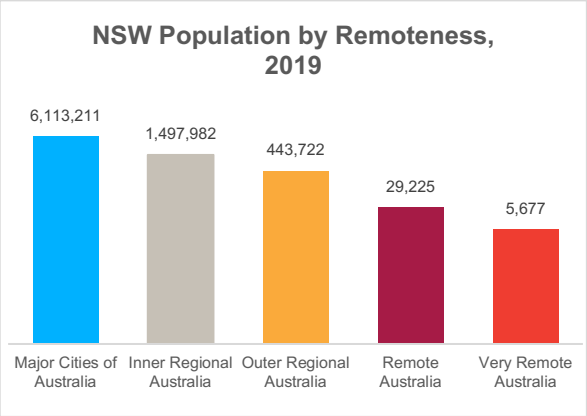
We would appreciate the opportunity to address the Inquiry directly at hearing.

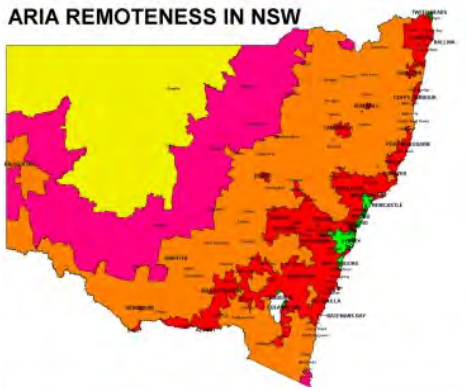
RESPONSE TO TERMS OF REFERENCE

SYSTEMS, STRATEGY AND QUALITY

(a) health outcomes for people living in rural, regional and remote NSW;
(b) a comparison of outcomes for patients living in rural, regional and remote NSW compared to other local health districts across metropolitan NSW;
(d) patient experience, wait-times and quality of care in rural, regional and remote NSW and how it compares to metropolitan NSW.
(e) an analysis of the planning systems and projections that are used by NSW Health in determining the provision of health services that are to be made available to meet the needs of residents living in rural, regional and remote NSW.

Introduction
2 million people live in Inner Regional, Outer Regional, Remote and Very Remote NSW comprising 24.4 percent of the NSW population. Almost ½ million people live in Outer Regional – Very Remote areas comprising 5.9 percent of the NSW population.



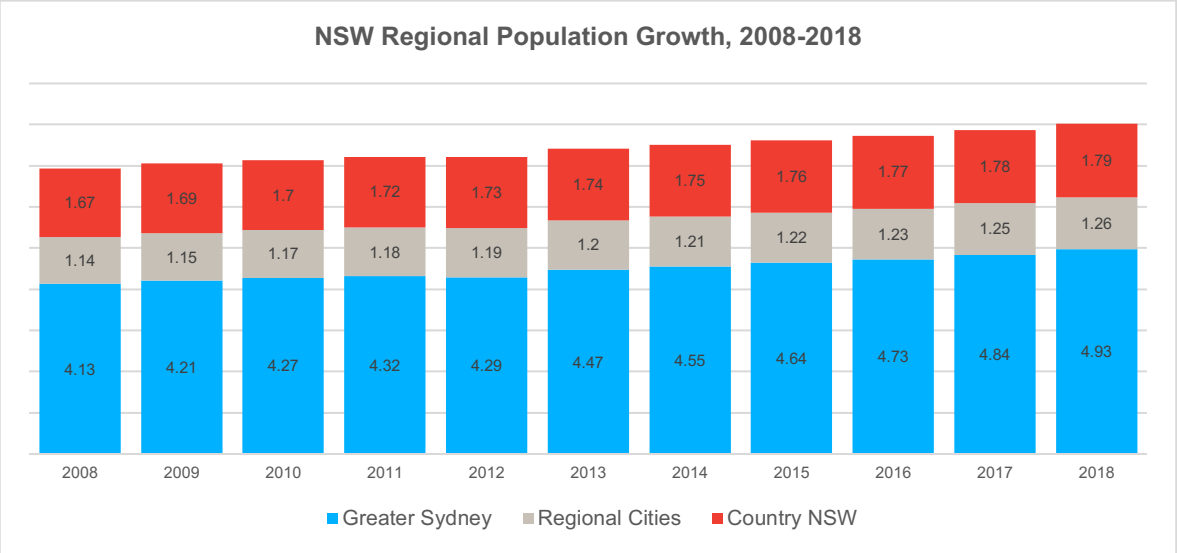


Source: Australian Bureau of Statistics, 3218.0 Regional Population Growth, Australia and NSW Department of Family and Community Services, Aboriginal Housing Office

Rural and regional NSW plays a critical role in the NSW economy delivering export wealth (food, fibre, energy, construction materials, manufacturing inputs, tourism, education, R&D) and as an economic anchor which takes on critical importance during periods of global economic instability in the services industries.

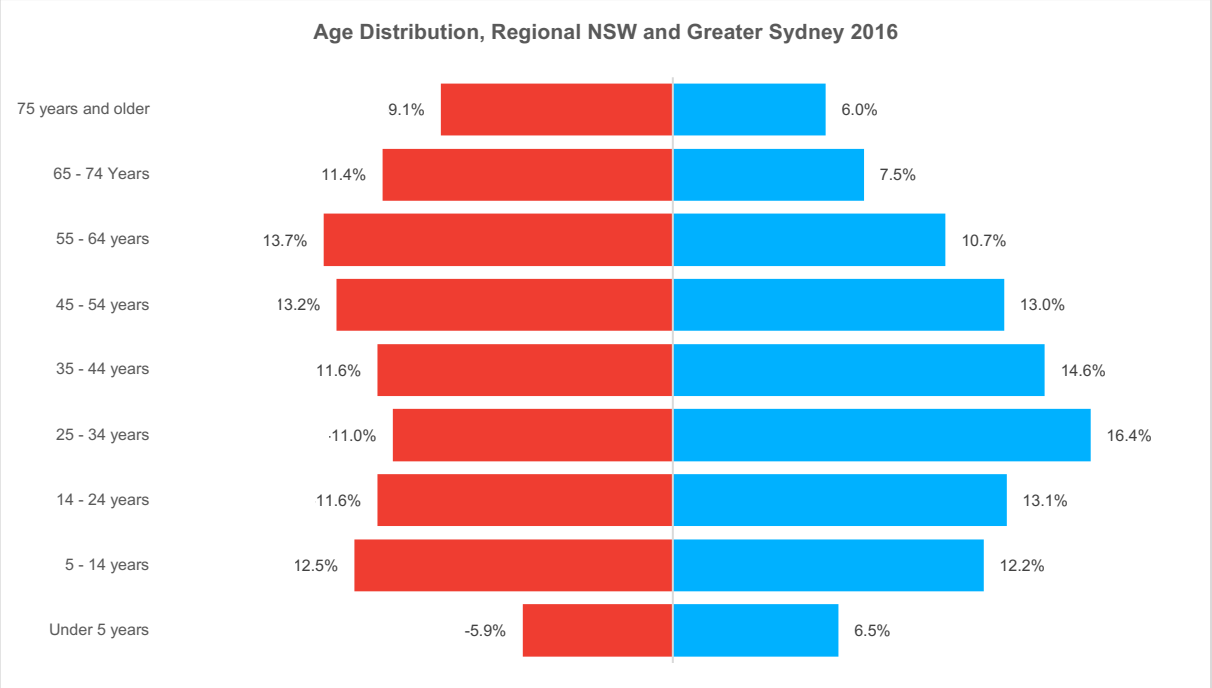
While there are no clear estimates, production and trade in rural commodities and services create significant employment in major cities through associated economic activity (commodity traders, ports, shipping, finance, legal, manufacturing, public sector, trade, construction, retail, health etc). According to 2019 SGS Economics research the Gross Regional Product of NSW's regions was $152.97 billion.

Despite popular misconceptions, the population of country NSW is growing.

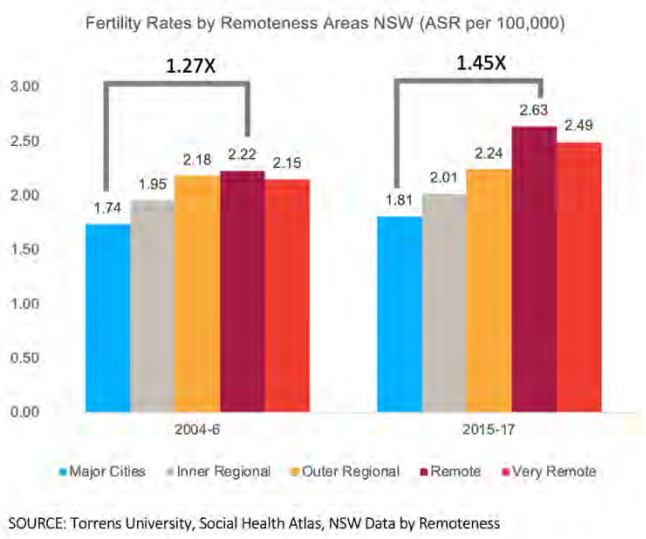


SOURCE: NSW Parliamentary Research Office (2020) Regional NSW: A demographic and economic snapshot at https://www.parliament.nsw.gov.au/researchpapers/Documents/Regional%20NSW%20Snapshot.pdf

The population is also ageing with a higher proportion of residents aged 55 years and over compared to Major Cities. This is expected to result in a significant increase in demand for Primary Health Care and hospital services in rural and remote NSW.



At the same time, fertility rates in rural and remote communities are higher than those in major cities and the rate per 100,000 people is increasing compared to major cities. This is expected to increased demand for pre-natal, neo-natal and post-natal services, and child and family health.



SOURCE: Torrens University, Social Health Atlas, NSW Data by Remoteness

The growth in demand for hospital services in rural and remote communities has been recognised in the NSW State Infrastructure Plan. It estimated an increase of between 22-41 percent in demand for rural and remote sub-acute care (care for people who are not severely ill but need support to manage their health conditions) in Western NSW, Murrumbidgee and Hunter New England, while demand for acute hospital care will increase by only 5-16 percent.[7] Tthe bulk of this demand is expected to be in regional cities but a proportion reflects the growing burden of chronic disease in rural and remote parts of these regions, resulting from a lack of access to on-site health care services in these communities.

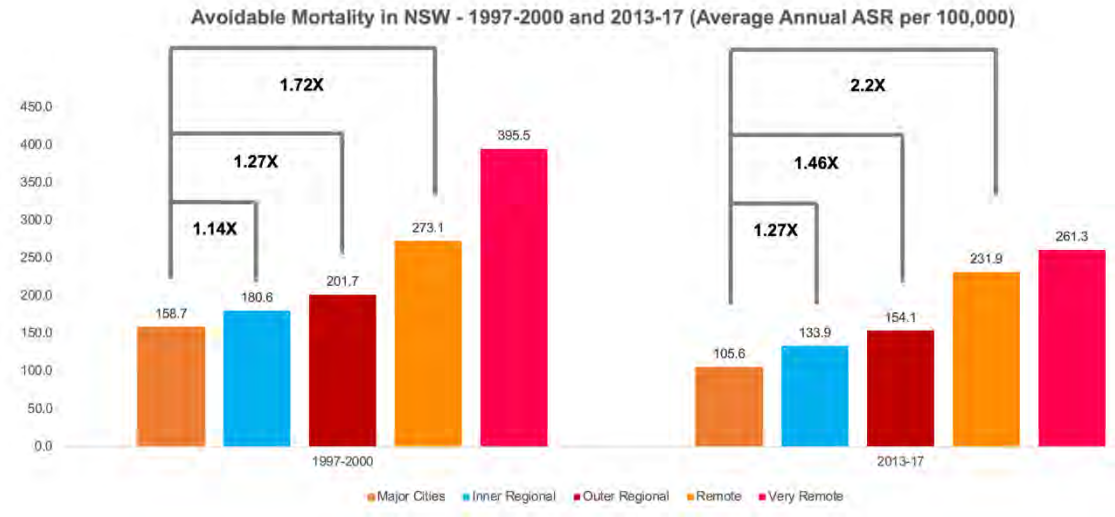
Regional Action Plan Area	Average Available Beds*	Bed Occupancy Rate	Forecast Increase in Demand, Acute Care	Forecast Increase in Demand, Sub-Acute Care	Major Works
Hunter New England	3.2	75%	13%	41%	Tamworth Redevelopment and Stage 3
					Maitland/ New Hunter
					Morisset/ Kestral
					Armidale Redevelopment
Illawarra	1	97%	24%	67%	Bega Hospital
Southern	0.5	75%	24%	67%	Goulburn Base Redevelopment
Mid North Coast	0.7	95%	13%	183%	Kempsey Redevelopment
					Port Macquarie Base Hospital
Northern Rivers	0.8	95%	13%	42%	Lismore Base Hospital Stage 3
					New Northern Rivers Hospital
Western	1.5	74%	5%	41%	Parkes, Forbes Hospitals
					Dubbo Hospital
					Gulgong MPS
Murrumbidgee	1.3	70%	16%	22%	Lockhart MPS
					Wagga Wagga Stage 3
Far West	0.2	66%	No increase	No increase	

Sources: NSW Health; PwC.
*Beds per 1000 head of population.

[7] http://www.infrastructure.nsw.gov.au/sis-2018

Rural and Remote Health Outcomes

Based on the PHIDU data of performance by State and remoteness areas, the rate of potentially avoidable deaths in NSW declined between 1997-2000 and 2013-17 across all remoteness areas in NSW. However, the gap in the rate of potentially avoidable deaths increased between Major Cities and all other remoteness areas (1.72 to 2.20 times the Major City rate in Remote areas and 1.27 to 1.46 times the Major City rate in Outer Regional areas) over the same period.



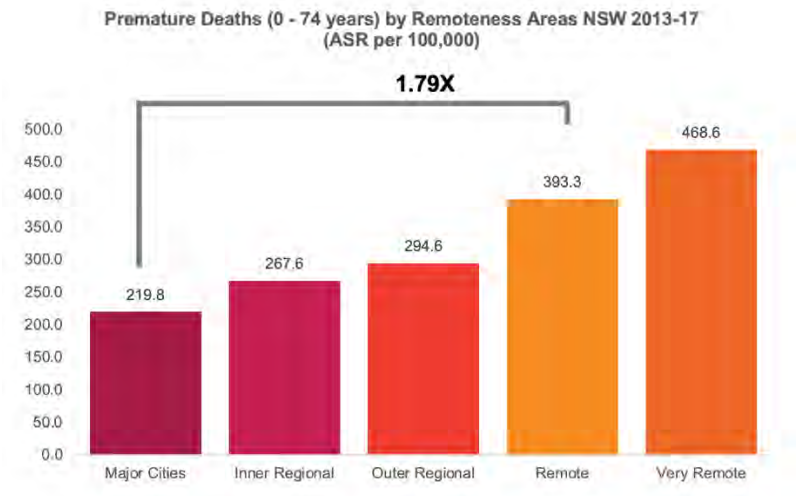
SOURCE: Torrens University, Social Health Atlas, Data by Remoteness

When avoidable deaths by cause are considered, the data shows an increase in the rate ratio between remote NSW and Major Cities across all categories except breast cancer and colorectal cancer. With respect to these two causes of mortality, rates of avoidable death were likely impacted by targeted Community and Primary Health Care breast and bowel screening preventative health initiatives suggesting changes in health services delivery by NSW hospital services were not fundamental to changes in overall rates of avoidable mortality.

Remoteness Area NSW - 0 to 74 years - Average annual ASR per 100,000 (Rate Ratio Remote NSW/Major Cities)	**1997-2000**	**2013-2017**	**Variance**
Deaths from cancer	1.27	1.33	^
Deaths from colorectal cancer	1.28	1.08	v
Deaths from lung cancer	1.59	1.77	^
Deaths from breast cancer (females)	1.13	1.03	v
Deaths from diabetes	2.26	2.59	^
Deaths from circulatory system diseases	1.69	2.22	^
Deaths from ischaemic heart disease	1.58	2.45	^

Remoteness Area NSW - 0 to 74 years - Average annual ASR per 100,000 (Rate Ratio Remote NSW/Major Cities)	1997-2000	2013-2017	Variance
Deaths from cerebrovascular diseases	0.96	1.55	^
Deaths from respiratory system diseases	2.21	2.38	^
Deaths from chronic obstructive pulmonary disease	2.58	3.05	^
Deaths from external causes	2.26	2.95	^
Deaths from road traffic injuries	2.86	5.40	^
Deaths from suicide and self-inflicted injuries	1.91	1.92	~

Similarly, the gap in the rate of premature deaths between Remote NSW and Major Cities increased from 1.61 times in 1997-2000 to 1.79 times in 2013-14.



SOURCE: Torrens University, Social Health Atlas, Data by Remoteness

While overall health outcomes are improving in terms of preventable and avoidable mortality, the gap between Major Cities and rural and remote NSW is increasing over time.

This suggests that the NSW Rural Health Plan – Towards 2021, the aim of which was to “make sure people in rural areas can access the right care, in the right place, at the right time” has not been as effective as rural and remote people had hoped in achieving sustained improvements in health access and closing the gap in health outcomes with Major Cities.

Where there have been improvements in outcomes, including breast cancer and colorectal (bowel) cancer, this appears to be largely driven by investments in preventative screening programs.

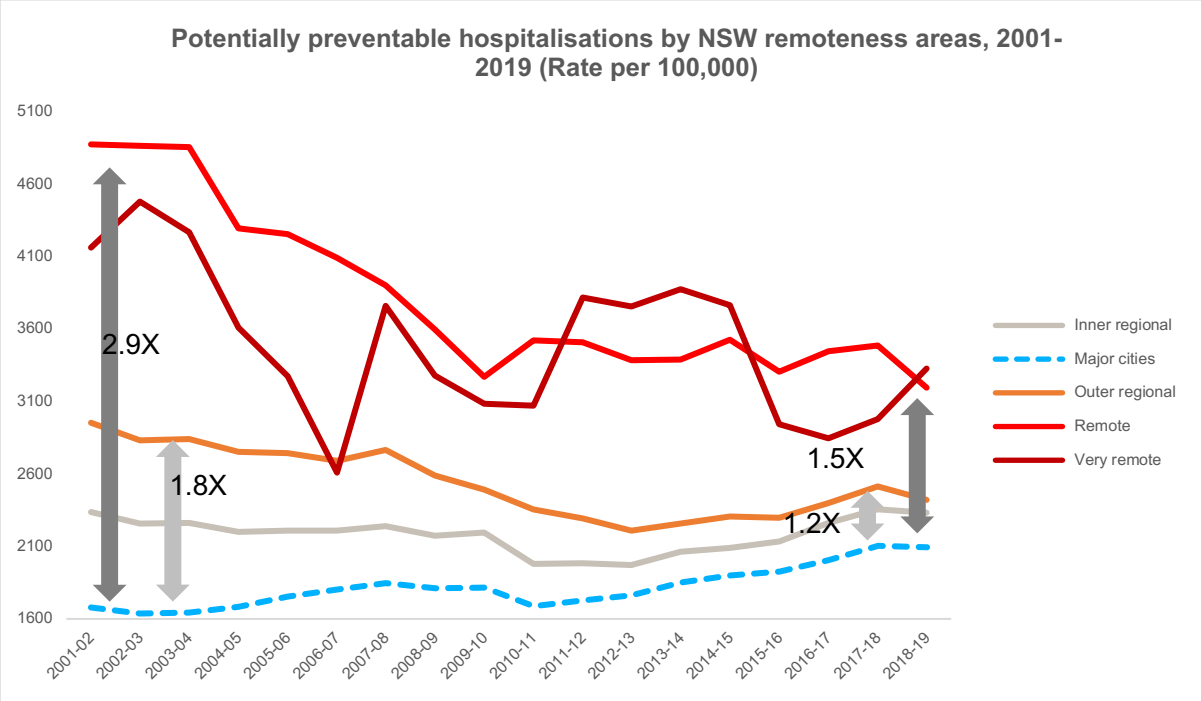
Quality of Rural and Remote Health Care

In 2019-20, 83.2 percent of Australians visited a general practitioner (GPs) and 15.4 percent of attended a GP for urgent medical care or to seek treatment after-hours. By comparison, 6.7 percent of Australians visited a hospital emergency department for a potentially avoidable general practitioner type condition.

Of this 14.4 percent, 47 percent[8] were potentially avoidable GP-type presentations (PAGPP). That is, the NSW Government funded services (cost) for patients that could have been generating revenue for the State economy through Medicare in General Practice or Allied Health. PAGPPs are defined as presentations to public hospital emergency departments where the patient is allocated a Triage category of 4 (Semi-urgent) or 5 (Non-urgent) – that is, ED patients that could have been treated by a local GP.[9]

In summary, hospital EDs managed 6.77 percent of all GP-type Primary Health Care consultations in Australia, while community-based General Practitioners managed 83.2 percent of all primary care consultations.

General practice is widely regarded as the most cost-effective and safest form of care. Potentially preventable hospitalisations (PPH) are a recognised proxy measure of Primary Health Care effectiveness. PPH are specific hospital admissions that potentially could have been prevented by timely and adequate access to health care in the community.[10]



In NSW, rates of PPH have declined in Outer Regional, Remote and Very Remote locations. More importantly, the gap in rates of PPH between Major Cities and Remote areas has declined

8 https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care
9 https://meteor.aihw.gov.au/content/index.phtml/itemId/598744
10 Australian Institute of Health and Welfare, Disparities in potentially preventable hospitalisations across Australia: Exploring the data at https://www.aihw.gov.au/reports/primary-health-care/disparities-in-potentially-preventable-hospitalisations-exploring-the-data/contents/introduction

from 2.9 times to 1.8 times between 2001 and 2018, while the gap between Major Cities and Outer Regional areas has declined from 1.8 times to 1.2 times over the same period.

Between the same years, the rate of PPH in Major Cities increased from 1678.8 per 100,000 population while the PPH rate in Remote communities declined from 4075,2 to 3195.2 per 100,000 population.

The key constraint on quality and health outcomes is the lack of funding and structures to support strong and sustainable rural and remote health care systems in these communities. While communities with access to General Practice services typically have a local VMO on-call, there is a growing number of communities forced to rely on Telehealth or which have limited services available locally.

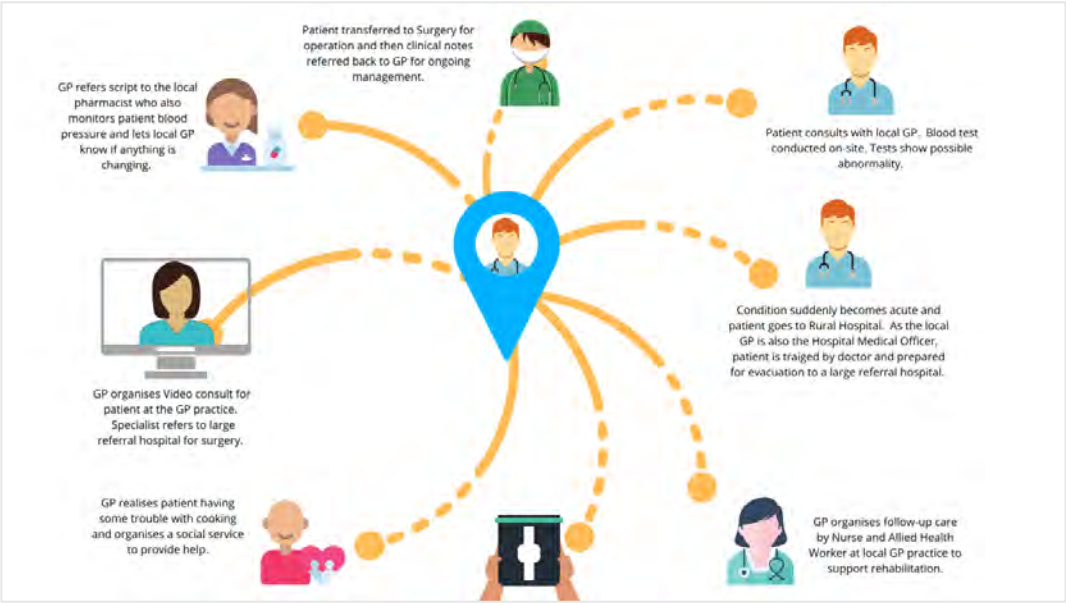
RECOMMENDATIONS

Rural and Remote Health Plan

Rural and remote communities share no similarities with inner regional and metropolitan cities in terms of the availability of health infrastructure, workforce or models of care. Indeed, rural and remote towns rarely share common characteristics with other rural and remote towns.

Urban and regional metropolitan health care have been designed around a dense market of primary, secondary, hospital and social services providers located in close proximity to users who typically self-navigate between competing options.

Rural and remote health systems are characterised by thin markets with multiple parties working together to coordinate available resources across Primary Health Care, Specialist Services, Hospital Services and Human Services.



As a result, rural and remote General Practice tends to play a more active role in helping users to navigate health and human services compared to urban and regional cities.

The differences in the way in which health systems operate in urban and regional cities, and in rural and remote communities, are poorly articulated in NSW health planning and policy. Rural and remote towns each have different circumstances, challenges, resources and decision-making processes. Aggregation of rural and remote health at a strategic level with inner regional health is inappropriate and has contributed to a misalignment between what the health system delivers in rural and remote communities and what these communities need. Understanding and articulating the differences between rural and remote health, and urban and regional city health, is a first and critical step to defining the challenge we are seeking to address.

Recommendation
The NSW Government acknowledges that urban and regional city health systems are fundamentally different to rural and remote health systems, and develops plans, policies and programs that specifically target the needs of these communities.

Outcome Based Targets
To address the health needs of rural and regional communities, the NSW Government approved the *Rural Health Plan – Towards 2021* as a supplement to the NSW State Health Plan. While the document identifies the importance of community engagement, integrated primary health and hospital care and the application of new technologies, it is principally designed to set the direction of hospital services in regional NSW and does not contain any specific actions or measures to address improvements to health outcomes in rural and remote communities.

It is not clear how people living in rural and remote communities were consulted on the development of the Plan and whether it addressed their priorities.

Objectives in the Plan commit the NSW Government to “strengthen” and “improve” various aspects of health services delivery. While this conveys a sense of progress, it lacks the specificity required to measure whether particular activities are contributing to health outcomes.

The ongoing gaps in health outcomes between residents of rural and remote communities, and urban and regional cities, however, suggests our institutional focus needs to change.

Specific and measurable targets, such as reducing child mortality, are difficult to achieve. But if we do not specify this as a commitment there is nothing to drive performance, direct resources to right programs or hold providers accountable for outcomes.

The lack of a clear definition of 'what success looks like', the absence of specific targets for rural and remote health access and outcomes, and the lack of measurable performance indicators limits the capacity of the NSW Rural Health Plan to drive the broader health system reform to bridge the gap in health access and outcomes and makes it difficult for health services (hospitals, GPs, NGOs) to collaborate towards common goals.

Recommendation
The NSW Government develop realistic, measurable and quantifiable goals that the community understands and can support (e.g., child mortality will be reduced to the national average; 10 percent reduction in obesity) and provides the funding and support required to deliver against those goals.

Open Data Access
Rural and remote people have told us they cannot easily obtain access information and data about health services and outcomes in their communities.

Granular data at a town level is not available on the Internet, and where resources are available, they are often presented in formats that are complex for general community users to interpret or use to inform local planning.

The My Hospitals web site developed by the Commonwealth Government contains a wide range of information on the performance of hospitals, however, this does not align with what rural and remote communities want to know.

What rural and remote communities want to know is things like:

- What are the minimum service standards for my local hospital (e.g,. opening hours, access to emergency care) and was this achieved?
- How much money was budgeted for on-site VMO services, what services were contracted, was this money spent and were those services delivered?
- How many people in my town require dialysis compared to other towns, and do we have the same access to dialysis as other towns based on population need?
- How many residents in my town died by Triage Category compared to other towns?
- How many people in my town died prematurely and how many died from preventable causes?

Lack of access to relevant data in user-friendly formats reduces the capacity of communities to engage in planning for a healthy future.

RARMS was asked in 2019 to help the small community of Goodooga to get access to data on the health profile of the town because they were unable to get this information. The aim was to

help the community to understand what types of health services they need and what they could do as a community to address some of the underlying reasons for poor health.

RARMS undertook an internal data project to pull together all the data it could find online to paint a picture for the community of the drivers of community health in order to help the community set its priorities. This involved reviewing and interpreting publicly available data sources from across multiple locations. The second stage of the initiative, to develop a Place-Based Health Plan, which has been delayed due to COVID, however will recommence with the community in 2021.

A similar issue arose in a rural NSW community that requested our help to secure another doctor for their town. Following discussion, it was agreed that it would be useful to first understand the health profile of the town before deciding what types of health services were required. It was hypothesised that perhaps a Diabetes Educator or a Mental Health Worker working in collaboration with the existing doctor, or funding for a nicotine replacement program, could achieve a better outcome if we had a better understanding of what was driving poor health in the community.

This led RARMS to develop the Cooee Initiative with Seer Data Analytics to develop local community health portals in collaboration with community organisations.[11] The aim of this project, funded internally, is to give the community access to baseline and actionable data via a user friendly local portal that incorporates local social determinants (employment, income, etc), health behaviours (smoking, drinking, drugs, diet) and health outcomes (mortality, diabetes, cardiovascular disease). The tool will be used to support communities to collaboratively understand and prioritise community actions to improve health and access to services, allowing the community to see the impact on health behaviours and outcomes.

The My Budget portal produced by NSW Treasury could be a model for improving health information flow and increase accountability to local communities. It is a simple, clear and informative web site that enables people to find information quickly. The Budget site has three data categories (Mapping the Budget, Where the Money Goes, Where the Money Comes from) which transmit information quickly and clearly.

A similar community health portal for every town may provide each community with data on the Social Determinants of Health, Behaviours Affecting Health, Community Health Outcomes.

Recommendation
The NSW Government funds the development of Place-Based Health Profiles that are accessible online to local communities to improve health literacy and understanding, help communities engage in planning for their future health needs and be used to inform health strategies and plans for local communities.

What are we actually measuring – waiting times and other things
Wait times, like readmissions and avoidable hospitalisations, are indicators used by the health system to measure its performance.

In relation to wait times, different anticipated times are allocated based on a Triage Category related to the urgency of the provision of medical care.

[11] https://www.ruralandremotehealth.org.au/post/the-cooee-initiative

The efficacy of this data and its accuracy is not clear.

For example, according to data published on My Hospitals in Trundle 96 percent of patients[12] who presented to Trundle MPS in an Emergency (T2) received medical care within the target timeframe, yet according to HealthShare there are no resident GPs in Trundle.[13] However only 45 percent of patients who presented to Molong Hospital in an Emergency (T2) [14] received medical care within the target timeframe yet a search on HealthShare found that Molong has 4 resident GPs.[15]

It is not clear whether waiting times include access to Telehealth doctors in some towns, while in others it refers to the time taken to access an on-call doctor.

Waiting times are one example of how we use process measures, rather than community health outcome measures, that are designed to drive health system efficiency and performance. But for a patient with suspected internal bleeding, waiting 15 minutes for a local rural doctor to arrive after attending a dying patient at the local nursing home may be clinically safer than having immediate access to a virtual doctor located in Sydney. While a virtual doctor may be better able to meet the waiting time target, this does not mean that the patient will have a better health outcome.

There is also a lack of clarity whether waiting times are a measure of the performance of doctors or the performance of the health system. In rural and remote communities, the hospital ordinarily funds the doctor to be 'on-call'. If the GP/VMO is attending a critical patient elsewhere when the emergency arrives, this can delay attendance at the Hospital. The question is: has the doctor failed to meet waiting time performance requirements or has the system failed to ensure adequate capacity to deal with multiple emergency presentations?

Waiting times remain one measure of performance, however, more granularity may be required to ensure a fair comparison of performance in rural and remote communities particularly as new technologies are integrated into medical care.

If Telehealth attendance is counted in waiting times data it could create an artificial perception that virtual doctors are performing better than on-site doctors, without providing insight into whether patients are getting the right care.

As we expand the use of Telehealth in Australia's rural and remote hospitals, data definitions should be reviewed to ensure that it is clear what we are measuring and that it is consistent with standards of clinical safety and quality.

In relation to the classification of patients by Triage Category, a stronger focus is needed to ensure we have independent systems to guarantee that the assignment by hospitals of patients is accurate in all cases. If the local hospital assigns a triage category incorrectly, this could result in the patient not getting care in a timely manner or result in medical resources being wasted to attend to a patient at the hospital rather than a higher need patient in a residential aged care facility. There is also a risk that incorrect triage classification could be used to unfairly reflect on the performance of a doctor or service.

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12 https://www.aihw.gov.au/reports-data/myhospitals/hospital/h0217
13 https://www.healthshare.com.au/directory/doctors-gp-in-trundle-2875-nsw/
14 https://www.aihw.gov.au/reports-data/myhospitals/hospital/h0212
15 https://www.healthshare.com.au/directory/doctors-gp-in-molong-2866-nsw/

One method to determine if triage categories are being assigned appropriately is to publish real-time data to the community on health performance, based on measures the community value, such as premature deaths and avoidable hospitalisations by triage category for each hospital.

For example, if a Hospital has a high proportion of Triage Category 3 (Urgent) deaths or hospitalisations compared to similar hospitals, this may suggest that the process of assigning categories needs to be reviewed. A more rigorous system of independent evaluation of data would build confidence among prospective rural and remote doctors that they will be evaluated fairly and consistently and for communities that the hospital system is delivering a quality service.

Recommendation
The NSW Government review data definitions to separate service provision on-site and by Telehealth and establish independent mechanisms to monitor data collection and collation to ensure data integrity.

Define the Role of Primary Health Care in the NSW Health System
There is an urgent need for the NSW Government to make a strategic commitment to a central role for Primary Health Care in rural and remote communities. While the Rural Health Plan acknowledges the importance of "integration" of primary and hospital care, there is a lack of consistency in the approach across NSW to supporting the sustainability of Primary Health Care and general practice.

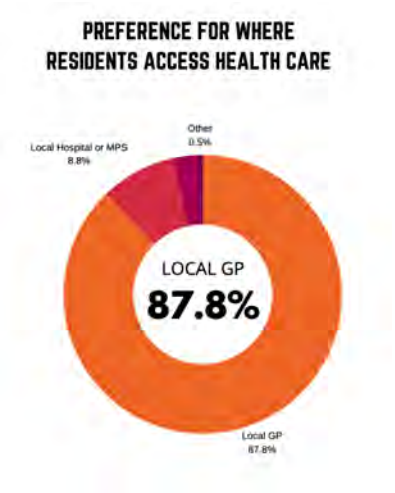
Research consistently shows that strengthening Primary Health Care will deliver reduced costs, improved health outcomes and lower rates of mortality.

Primary Health Care providers like RARMS, which is located in rural and remote communities, has also demonstrated a capacity to recruit doctors to live and work in rural and remote practice because of their local understanding. Doctors who enter this field of speciality do so because they want to work with communities to improve health for which they are trained. General Practice is designed to support this distinctive approach to health promotion and prevention relative to the acute disease-focussed model of hospital care.

This is part of the reason why many doctors prefer for RARMS to negotiate on their behalf arrangements for VMO rights with Local Health Districts.

General Practice is responsible for more than 80 percent of the health care needs of rural and remote communities and has been shown to be one of the most cost-effective forms of health service provision in Australia. Without General Practice supporting a permanent GP workforce in rural and remote towns, as shown by the establishment of RARMS, the cost of retaining Locums to deliver VMO services will become prohibitive.

Rural and remote people also prefer to access health care through a local GP. In the 2020 Rural and Remote Communities Healthcare Survey. 87.8 percent preferred to access healthcare through a local general practice. Only 8.8 percent of rural and remote residents preferred to access healthcare through a local hospital.



Expanding the number of general practices like RARMS in disadvantaged towns is not only a health priority, but an economic opportunity. Primary Health Care in rural and remote communities is delivered by a broad range of small-medium NSW businesses including general practice, allied health, dentists and social support providers that have a high degree of mutual reliance.

The health and social assistance sector is generally the 2nd or 3rd largest employer in rural and remote communities. RARMS alone is estimated to generate 16 full-time equivalent jobs and $1.1 million in direct economic activity in communities in which it operates (Attachment B).

Without a GP, the local community Pharmacy has no-one to issue prescriptions for medications, similarly without the community Pharmacy, local GPs lack the support of professionals able to deliver point of care testing (e.g., blood pressure checks), conduct medication compliance reviews or administer seasonal vaccinations.

Supporting small-medium businesses contributes to the sustainability of rural and remote towns more generally and reduces other costs to government that arise from the decline in employment and economic dislocation. Many farmers would not have survived the drought or bushfires without access to reliable off-farm income that is generated by employment in the health and social assistance sector. Continuity of General Practice is central to resilience in rural and remote communities.

The World Health Organisation has argued health care funding of Primary Health Care is not a cost, but an investment when all the downstream impacts are taken into account. [16]

The policy case for a shift to a Primary Health Care led health system is well-established in Australia and around the world. The stronger reliance on Primary Health Care in rural and remote towns makes it a perfect test bed to trial how the NSW health system could be evolved to reduce the growing cost of hospitalisation, increase support for rural and remote businesses, reduce government costs and increase economic capacity and resilience in small towns.

The success of organisations like RARMS provides a strong foundation for building a new model of care that is more suitable for rural and remote communities, and which has the capacity to provide a test bed for future development of health services in the State. It has been proven to be a successful model when properly supported.

[16] Economic and Social Impacts and Benefits of Health Systems (World Health Organization, 2019)

In our view, the role of rural and remote health care in sustaining local employment and economic activity, particularly during drought and other natural disasters, should also form part of the NSW Government's economic development strategy for rural and remote communities.

A strategy to grow small-medium Primary Health Care businesses in rural and remote NSW would support NSW to increase revenue flows from the Commonwealth to the NSW economy through Medicare services and PBS scripts, increase local employment, grow rural and remote economies and reduce the range of social and economic supports that are required as a result of the loss of economic capacity in these towns. More effective Primary Health Care is shown to reduce chronic disease, avoidable hospitalisations and lost productivity.

Recommendation

1. The NSW Government fund the expansion of Rural and Remote Medical Services practices to an additional 15 disadvantaged towns over the next 3 years to expand Primary Health Care and hospital services delivery in rural and remote towns.
2. The NSW Government prepare an Economic Plan for Growing Rural and Remote Health and Social Care.

ACCESS AND WORKFORCE

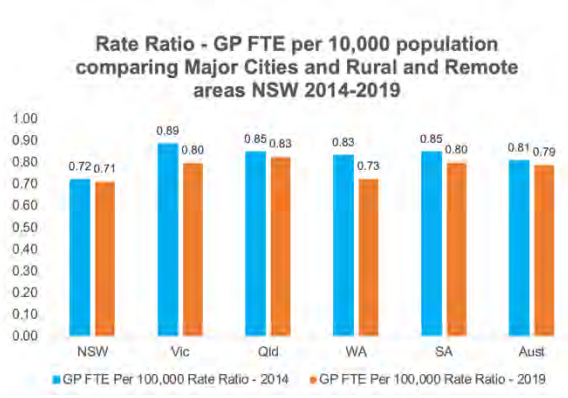
(c) access to health and hospital services in rural, regional and remote NSW including service availability, barriers to access and quality of services.

(g) an examination of the staffing challenges and allocations that exist in rural, regional and remote NSW hospitals and the current strategies and initiatives that NSW Health is undertaking to address them.

An important contributor to poor health outcomes is lack of access to Primary Health Care and hospital services in rural and remote NSW. There is not a "doctor shortage" in NSW or Australia, at least not to the extent that this is the principal cause of lack of access in rural and remote communities. Rather, Commonwealth and State policies and programs have failed to deliver an appropriate local medical and health workforce to rural and remote NSW.

This is not to suggest there are not complexities around the issue of health and medical workforce distribution. But in terms of addressing the geographic maldistribution governments have spent millions on medical education and training, rural exposure, bonded medical places, incentive schemes and myriad other initiatives that have not delivered the needed change that rural and remote communities require today.

Rural and remote residents of NSW are less likely to have access to General Practitioners (GPs), and therefore VMOs, compared to people who live in urban and regional cities with the availability of GPs in NSW declining with increasing remoteness.



SOURCE: Source: Department of Health - General Practice Primary Care Statistics (calendar year): 2014 to 2019

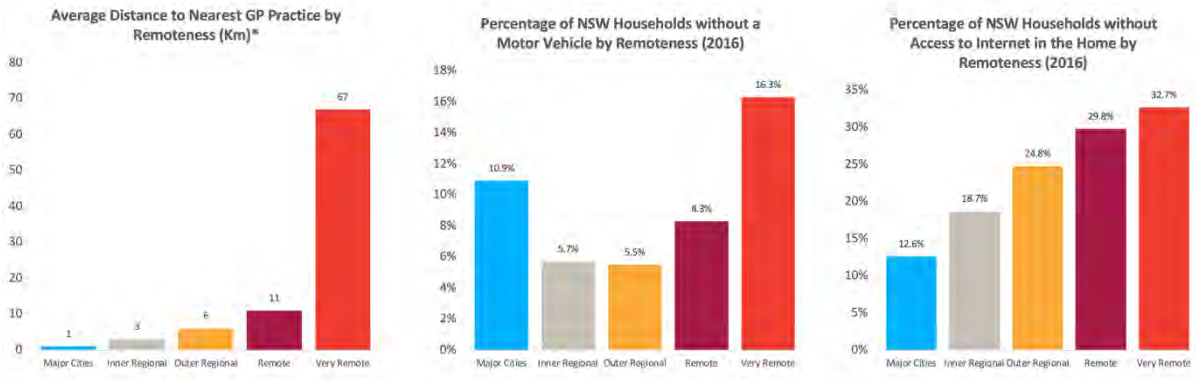
While the number of Full Time Equivalent (FTE) GPs has increased in all remoteness areas over the last 5 years, the gap in access between the city and the bush has not improved. Rural medical workforce initiatives over the last 20 years designed to increase the proportion of doctors choosing to work as GPs in rural and remote practice in NSW have not bridged the gap.

The GP Full-Time Equivalent (GP FTE) measure is a method of estimating the workload of GPs providing Primary Health Care services in Australia. The method calculates a GP's workload based on the Medicare Benefit Schedule (MBS) services claimed as well as patient and doctor factors that affect the duration of a consultation. One GP FTE represents a 40-hour week for 46 weeks of the year.

Using this measure, the data shows that while the GP FTE in rural and remote communities has improved over the last 5 years, the rate ratio of GP FTE per 100,000 population has not changed between Major Cities and rural and remote communities over the same period. Major Cities have access to 1.4 times the GP FTE per 100,000 compared to rural and remote areas despite higher levels of chronic disease and mortality in rural and remote communities.

The failure to deliver an appropriate local workforce is contributing to an increasing trend of part-time emergency departments, loss of local Primary Health Care in rural and remote towns and the growing use of Telehealth as a replacement for rural GPs. For rural and remote doctors, the increasing demands of a patient cohort typified by high relative rates of chronic disease stretches capacity and increases the long-term risk to the quality of patient care. While Primary Health Care should be helping people to reduce illness, rural GPs are instead focused on trying to manage chronic disease and the consequences of poor health.

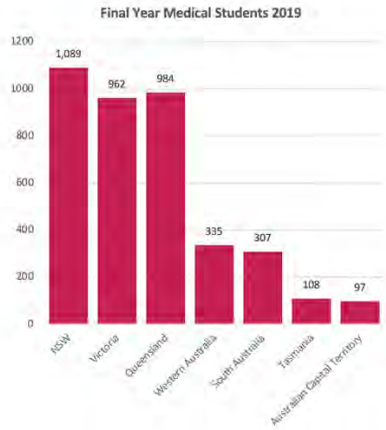
Poor access to health and hospital services has a more significant impact on rural and remote NSW communities because of the larger distances between residents and health services. The further away you live from a Major City, the longer the distance to see a local GP. At the same time rural and remote residents of NSW are less likely to have a motor vehicle to drive to their local GP or hospital or Internet access in the home to access Telehealth services.



Note: * distance calculated as weighted average of direct lines to Census mesh block centroids, actual drive times will be longer.

Source: Australian Bureau of Statistics, 2016 Census of Housing and Population, NSW By Remoteness

While NSW is amongst the poorest performers of any State in terms of access to GP and VMOs in rural and remote areas, it graduates more medical students by headcount compared to other States.



SOURCE: Deans of Australian and New Zealand Medical Schools, National Data Report 2020 at https://medicaldeans.org.au/md/2020/08/2020-MSOD-National-Data-Report_2015-2019-Full-report.pdf

The workforce failure in NSW is not related to supply of medical graduates, or the characteristics of rural and remote towns, but rather the performance of strategies and programs to increase the number of graduates choosing general practice as a specialty and the number working as rural GP/VMO compared to other States and Territories.

A wide range of rationales will be presented to the Committee for this failure from constitutional limitations on civil conscription of doctors, the work/life pressures of general practice making other forms of specialism more attractive, the failure of bonding and the hidden curriculum that devalues rural general practice. These are all true, but they are context and not the cause.

We have known about these issues for more than 20 years and we have failed to effectively address them.

There is ample evidence for example to show training rural and remote students in rural areas to become doctors is highly effective in growing the rural medical workforce, but this has not been our approach for 20 years. Instead, we enrolled largely regional city kids and educated them in metropolitan areas using a curriculum designed to produce specialists for major city hospitals. The result was fewer medical graduates wanting to become GPs and even fewer wanting to work in rural and remote practice.

There are rural medical schools that understood the importance of genuine rurality, like James Cook University, and they are unsurprisingly producing doctors for rural practice in Queensland.

However, a 2015 study showed students admitted to JCU medical school from rural and remote areas were more likely to “a lower tertiary entrance score ($p<0.001$), a lower interview score in the medical school selection process ($p<0.001$), … taking longer to complete the 6-year course ($p=0.009$) and having a lower academic achievement across years 1 to 3 ($p=0.002$, $p=0.005$ and $p=0.025$, respectively)”.[17]

The critical finding however wasdespite initial challenges rural and remote-origin students “do just as well in the exams in the clinical years (years 4-6) and are much more likely to practise in rural and remote areas”.

In short, to get the right students into the study of medicine for rural and remote practice means metropolitan universities have to lower the entry bar significantly and provide substantially more support and resources to help these students achieve in the early years of medical education to address poorer educational opportunities in their high school years. This requires a fundamental change in the way our universities recruit and educate students.

A new regional medical school has now been approved at Charles Sturt University in Orange. At the sod turning in 2019 the Deputy Prime Minister, The Hon Michael McCormack, said: "There were those in the medical profession who were naysayers, there were those in the political cycle who were naysayers”.[18] Indeed, almost every industry body that terms itself “rural” opposed the creation of a rural medical school in NSW despite wide and strong support within rural and

[17] https://www.researchgate.net/publication/298712748_James_Cook_University%27s_rurally_orientated_medical_school_selection_process_Quality_graduates_and_positive_workforce_outcomes

[18] https://www.centralwesterndaily.com.au/story/6539838/ground-broken-on-22-million-school-of-rural-medicine-at-csu/

remote communities and the evidence that this approach works. Reforming rural and remote health care requires an acknowledgment of the barriers created by the broader health system.

The new school in Orange has publicly guaranteed that 80 percent of its students will be from rural and regional backgrounds with a strong preference for students from rural and remote areas. If this new rural medical school remains true to its foundation purpose, vigorously pursues policies that guarantee rural and remote entry, and ensure students are exposed to a curriculum and program that strengthens their commitment to rural and remote practice, NSW will have a pipeline of rural graduates in 10 years.

This make it imperative that NSW has a clear plan for Rural and Remote Health to ensure that rural and remote health care is sustained while this pipeline of new graduates develops.

In short, NSW needs a well-funded 10-year plan and targeted investment program to build and sustain a rural and remote Primary Health Care and hospital system to ensure that there are sustainable practices available for this new cohort of graduates and that rural and remote residents continue to receive high quality care while the program is developed.

The comparative data on the performance of different States in access to GPs in rural and remote areas contests the idea that the “unattractiveness” of rural and remote towns is the main reason for the challenges in NSW. The data shows that other States and Territories have higher ratios of GPs to population working in rural and remote practice. This suggests incentives and supports to work in rural and remote NSW are not as attractive as other States and Territories or that working conditions in NSW are not as good.

Based on the 20-year experience successfully recruiting GP/VMOs to rural and remote practice, RARMS has identified the following factors as the most relevant in attracting GP/VMO to work in rural and remote practice:

1. A ‘walk-in, walk-out’ model reduces the feeling of being bonded and unable to leave when it is time.
2. An attractive remuneration package that includes block funding to act as the Visiting Medical Officer.
3. A supportive workplace environment and conditions.
4. A third-party practice provider to deal with the local Hospital administration on the doctor’s behalf.
5. A social justice model built around patient-centred care and continuity, rather than profit.
6. A career pathway for doctors and staff.

GPs that work in rural and remote NSW are inadequately compensated for the cost of delivering quality care in an isolated environment. This is a product of inadequate Medicare and VMO funding for rural and remote practice.

There is little recognition of the broader community service role played by rural and remote GPs in coordinating across a wide range of social services, attending residential aged care facilities and engaging in community activities and forums.

A strategy to address this deficit in our workforce approach, and to improve the sustainability of Primary Health Care in rural and remote towns, is for rural and remote GP practices to be funded for the broader role they play in community service coordination and provision.

A Community Service Obligation payment could be comprised of funding currently allocated to VMO contracts, community health and other grants that are made available to rural doctors through other sources. Combined, this funding would shift resources from administration of 'rural workforce programs' and into rural health delivery improving the remuneration available for GPs and attract more doctors into rural practice.

Significant amounts of money are allocated annually to rural and remote health to address the gap in outcomes, but a substantial proportion is defrayed in the overheads of administering bodies. Getting more of this money into the actual delivery of health services and attracting rural doctors would be a significant step forward in ensuring rural health is properly funded and can attract doctors and nurses to live and work in these communities.

Recommendation

1. The NSW Government approve a 10-year Investment Plan for Rural and Remote Health to sustain rural and remote Primary Health Care and Hospital Systems and ensure the retention of health system capacity to support new rural doctors graduating in NSW over the next decade.
2. The NSW Government establish a Community Service Obligation payment to recognise and define the role of General Practice in the delivery of local health access and outcomes.

Minimum Service Standards for Rural and Remote Health

Our communities inform us it is difficult to find information on exactly what health services their local hospital should be delivering, or which it is funded to deliver. Estimated hospital budgets are published in some cases, but the local community has trouble finding out what was actually spent.

The *Queensland rural and remote health service framework* [19] classifies rural and remote health facilities and describes the services each of these health facilities provide.

The framework aims to:

- "provide a consistent approach to the classification of and terminology for public rural and remote facilities in Queensland
- describe characteristics that should be considered to support sustainable and safe levels of service provision in rural and remote communities
- provide a general overview of the service mix, service capability and workforce profile for each classification of rural and remote health facility
- promote health service networks that have:
  - formal links between rural and remote health services
  - higher level services provided from regional and specialist services".

The framework guides the provision and planning of sustainable health services to evolve over time and to provide continuing improvements in quality that meet the needs of rural and remote communities.[20]

[19] https:// www.publications.qld.gov.au/dataset/rural-and-remote-health-service-planning/resource/F0d627e3a-1a38-443a-80e5-6b60fd837b8f&usg=AOvVaw0MYKNmAQVygYJKCJNGPX_b
[20] https://www.health.qld.gov.au/__data/assets/pdf_file/0027/436815/better-health-bush.pdf

The development of a user-friendly and easy to access classification and standard for health services in different towns developed through engagement with local communities would enable communities to understand their entitlements and plan services more effectively by providing clarity around the health care models of care and health services NSW will support for each town.

This information could be made available through a Community Hospital Portal including real time information on What We Plan to Spend, What We Have Spent, Health Outcomes Achieved from Our Spending (possibly using the NSW Treasury My Budget model).

Recommendation

3. The NSW Government develop, in consultation with local communities, a *Rural and remote health service framework* comparable to the one in Queensland that defines the functions of each type of facility and the services that rural and remote residents can expect to receive in each town.
4. The NSW Government establish a community hospital portal that provides real time information on hospital performance.

State-wide VMO rights

A key challenge for general practice in attracting GPs to work in rural and remote areas is the uncertainty surrounding the process of obtaining rights for GPs to work as Visiting Medical Officers (VMO) in each Local Health District.

As a result, GP practices like RARMS are required to make offers to GPs on the assumption they will be granted VMO rights which may not be forthcoming. This impacts on the capacity to recruit GPs to rural and remote practice.

RARMS has had a situation where a highly qualified doctor with years of experience in emergency medicine in Sydney hospitals, and without any concerns or complaints lodged with the Australian Health Practitioners Registration Agency, was recruited to a small rural town and subsequently refused VMO rights on the ground that his metropolitan experience was not translatable to a small rural hospital. This forced the closure of our medical services in this town.

While it is critical to ensure that all GPs granted VMO rights are capable of exercising their responsibilities, the flow-on impact of refusal can result in the loss of both hospital and Primary Health Care services in rural and remote towns. A more rigorous and independent system is required at a state-wide level.

A state-wide system of VMO approvals would enable common standards to be established for working in rural and remote hospitals, increase transparency and reduce the impact of local factors in decision-making.

In parallel with the development of standards, funding should be provided by the NSW Government to enable doctors wanting to work rurally to undertake extra training, or for the provision of clinical supervision, to address any areas that could assist their performance and enable doctors to work independently as a VMO in rural and remote towns.

Recommendation

4. A state-wide system of Visiting Medical Officer rights should be established to reduce the uncertainty of current processes.
5. Funding should be made available to support doctors to obtain VMO rights under a state-wide system for rural and remote services.
6. Decisions of the state-wide decision maker should be appealable to the Civil and Administrative Tribunal to ensure transparency and accountability of decision-making.

Clinical Supervision Support Funding

As more rural doctors approach retirement age, the cohort of doctors able to provide supervision for incoming rural and remote GP/VMOs is contracting. It is often the case that new doctors entering rural and remote practice require a period of 3-12 months of supervision from a senior rural doctor before they can operate as independent practitioners.

RARMS has historically sustained a flow of new permanent doctors into rural and remote practice by using our existing Fellowed doctors in our practice network as required by the relevant registering authority. This cohort is thinning as the population of rural doctors is ageing.

Recommendation

The NSW Government fund rural and regional senior GPs to provide supervised practice and training for doctors who want to work in rural and remote general practice as GP/VMOs.

Protect local GPs from competition with government services

Services such as Telehealth, influenza and childhood vaccinations (under the National Immunisation Program) are a critical source of revenue for rural and remote general practices and are increasingly required to subsidise the costs of delivering on-site health and medical services as traditional sources of funding decline.

The delivery of rural and remote GP Telehealth services, and delivery of other Primary Health Care services such as immunisations, by government health services risk the viability of on-site general practice and medical care in these communities. The NSW Government should establish a policy that government health services should not deliver GP Telehealth services or vaccinations programs in competition with small general practice businesses in rural and remote towns. Where required, these services should be tendered to rural and remote practices to support their sustainability.

Recommendation

NSW Government adopts a policy that it will not compete in the provision of health services in rural and remote towns that can be delivered locally by general practice.

Telehealth not to replace rural GPs

There is a growing view in rural and remote communities that Telehealth is being used to replace full-time VMO services in rural and remote communities. The NSW Health Minister has publicly committed that Telehealth will not be used to replace local GP/VMOs. The Minister is reported as saying "*Telehealth is a 21st century backup when doctors aren't available but the first step should always be to try and get doctors to work in regional hospitals"*.

Telehealth is a critical part of the future way in which health care will be delivered in NSW. RARMS has deployed it extensively to enable patients in isolated communities to get an appointment with their doctor for routine matters and to check up on the progress of chronic disease patients.

The use of Telehealth to increase access to specialist appointments through our partnerships with specialist services has significantly increased our ability to deliver the right care at the right time and has been widely embraced in rural and remote towns.

However, there is deep concern in rural and remote communities about the appropriateness of a remote virtual doctor replacing local VMOs in an emergency.

A growing concern that has been expressed in rural and remote towns is that existing rural GP/VMOs are being replaced because Telehealth is cheaper.

The *Mudgee Guardian* reported in 2020 that Coolah GP Dr Abbas Haghshenas left practice in this town after five years after a new contract offered less pay. He was quoted as saying: "It was disrespectful I thought, after five years and training two more doctors. I didn't expect a pay rise but not pay cut either". [21]

The decision was more distressing for members of the local community because Dr Abbas was highly regarded, and the community had just secured a second doctor for Coolah after considerable funds were expended on recruitment who initially needed supervision by Dr Abbas in order to work independently. The decision of the Local Health District to reduce the Contract payment to Dr Abbas resulted in the loss of two doctors, the closure of the Coolah Valley Medical Centre, a reduction in on-site VMO services, and increased use of Telehealth. The remaining Coolah GP has now announced that she would be leaving Coolah in 2021 leaving Coolah without any local doctors.

This illustrates the problem when we rely on “continuity of practitioner” rather than “continuity of practice”. RARMS operated a medical centre in Coolah for years without a permanent doctor while trying to recruit a permanent doctor. The practice operated at a considerable annual loss, but as a Charity this was what we were established to do. However, this became unsustainable as COVID impacted on our medical workforce capacity. When Dr Abbas left Coolah, we also lost the capacity to supervise the new permanent GP recruited to live and work in Coolah. As a result, the town lost a medical centre and staff lost their jobs. Only months later, the other GP in town decided to leave.

A holistic focus on sustaining the health system in this town through “continuity of practice” would have avoided all these devastating consequences for this community.

In Gulgong it was alleged in the *Sydney Morning Herald* the local doctor, Dr Nebras Yahya, left the town after “negotiations broke down because the health district wanted to reduce his pay and support more patients with telehealth”.[22] Gulgong resident, Dawn Trivett, subsequently died in the local health care facility without a local doctor present to attend to her needs in an emergency. Dr Yahya was subsequently re-appointed.

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[21] https://www.mudgeeguardian.com.au/story/6965204/mum-was-only-66-hayley-olivares-whose-mother-died-at-a-doctorless-gulgong-hospital-says-something-needs-to-change/
[22] https://www.smh.com.au/national/nsw/health-minister-demands-action-over-shocking-death-in-hospital-20201012-p564be.html

In 2020, the Western Local Health District announced a tender which included the option to replace 24/7 VMO services across six remote towns serviced by RARMS with a blended model of Telehealth and part-time emergency care using a hub and spoke model. Following opposition from RARMS and the public, this proposal was reversed. RARMS was subsequently unsuccessful in the tender.

The approach in Western NSW has left many people in rural and remote communities confused. While both the State and Commonwealth government promote the fact that they are spending hundreds of millions of dollars to get more doctors into rural and remote practice, in some areas existing rural doctors are being let go over minor pay issues. This strongly suggests that recurrent funding is insufficient for rurally based Local Health Districts and should be increased.

Other health areas, like the Murrumbidgee Local Health District, has taken a different approach by collaborating with organisations like RARMS to deliver a GP-led Telehealth service that augments local rural GP capacity, linking with existing health and medical resources on the ground where available. This approach ensures that the Local Health District does not compete with small business in the provision of general practice services and provides needed funds to support the sustainability of on-site general practice in rural and remote towns.

Recommendation
To give effect to the Statement by the Minister for Health the NSW Government adopt a policy that:

1. A decision to reduce or vary the fees payable under an existing VMO contract, or in the negotiation of a new VMO contract, must be supported by a written analysis that demonstrates that any variation of fees will not result in any reduction of Primary Health Care and hospital services to the relevant rural and remote town and must not be undertaken for a purpose which includes the introduction of Telehealth to replace or reduce the number of hours of on-site GP/VMO services below 24 hours, 7 days a week.
2. The Service Agreements between the Minister and Local Health Districts are updated to include an obligation that Local Health District must ensures the delivery of 24/7 on-site GP/VMO services to rural and remote communities at all times.
3. Local Health Districts are provided with funding to fulfil these obligations.

HEALTH FINANCES

(f) an analysis of the capital and recurrent health expenditure in rural, regional and remote NSW in comparison to population growth and relative to metropolitan NSW.

The data shows that NSW health system has not been competitive in offering packages that encourage more doctors to work in rural and remote practice. While Queensland has 108.2 FTE GP per 100,000 people in outer regional, remote and very remote areas, South Australia 98.4 and Victoria 94.1, NSW had 88.3 FTE GPs per 100,000 population.

We are often too quick to claim “workforce shortages” as the main reason for the low proportion of GPs in rural and remote NSW but workforce availability is a product of more than just supply.

When a GP evaluates the options for working in a rural or remote community in NSW, or an offer from a Queensland town, they are looking at the amenity, community, school, employment, access to transport and social factors. They are also looking at whether the local General Practice in town is supportive of their doctors and if they can build a good relationship with the community pharmacy. They want to know whether the hospital is supportive of rural and remote General Practice and VMOs, the quality and experience of the health and administrative staff in the local hospitals and whether they are going to be called out at 3 am in the morning for minor things that are within the scope of practice of the nurse, the remuneration offered, the fairness of performance evaluation systems and the working conditions.

The attractiveness of the remuneration however is a major consideration as it is for most people looking for a job. The package is comprised of both the remuneration and conditions. For example, GP/VMOs generate income from General Practice and VMO contracts. If the Hospital staff are not experienced, or the administration is poor, a GP may be called to the Hospital unnecessarily which means they cannot see patients in their practice and will lose money. If the working conditions in the Hospital are poor this can impact on the perception of the overall package conditions.

Doctors aren’t looking solely at the hospital, they are looking at the overall health system in a town, in making decision to locate to rural and remote practice. The funding and quality of the support provided by Local Health Districts to the whole health system is important. LHDs have a substantial influence on which towns can attract VMOs and therefore have access to hospital services.

At Rural and Remote Medical Service we routinely survey the satisfaction of our doctors and regular Locums with our practice management to identify issues that may impact on their performance or willingness to remain in rural and remote areas. Clinical engagement is recognised as being central to both performance and morale in the health system.

On this point, the NSW Auditor General’s report on Local Health District Governance found: “Clinician engagement is, at best, variable across the health system. We found that the deep and broad engagement anticipated by the Garling Inquiry, by government policy and reform on devolution, by model by-laws for LHDs, and by NSW Health Governance Standards, has not

been achieved with any consistency".[23] An independent survey conducted by the Department of rural and remote doctors would assist in determining the perceptions of doctors in rural and remote areas and identifying the barriers to working in rural and remote hospital system in NSW.

In the meantime, we are of the view that the NSW Government should allocate a tied on-site VMO budget to each community that reflects actual market rates to each rural and remote hospital/MPS etc matched to community needs and ensures that this money can only be spent on VMOs in that location only. As suggested above, linking these funds to a collaborative state-wide approach to rural and remote GP/VMO recruitment would in our view improve the performance of the health system in recruiting medical workforce.

Recommendation
VMO Budgets should be allocated to Hospitals and tied to the provision of VMO services in that location.

Holistic Funding for Rural and Remote Health System
Unlike major cities, the attractiveness of working in a rural or remote town relies on the overall attractiveness of the system. A GP/VMO will work predominantly in general practice, so having a brand new hospital and a poor quality general practice, will detract from the capacity of a town to recruit workforce.

Future capital and recurrent investments should be targeted to build an attractive rural and remote health system, rather than investing only in hospitals. This should incorporate the whole health system including pharmacies, allied health and social services.

In saying this, the 'health campus or precinct' approach in which services are co-located is not appropriate for rural and remote towns. The GP Super Clinic program is a good example of how building central health infrastructure in rural and remote towns is problematic.

As shown during the recent COVID outbreak, many people do not want to go to a hospital due to its association with disease, and for others cultural factors that make hospitals undesirable. Further, co-location risks clustering services in a way that brings people together and increases transmission risks. In a post-COVID world, maintaining the distribution of health functions within a town represents the safest pathway.

Rural and remote hospitals are also typically located on the periphery of towns, while general practice, community pharmacy, optometry etc are typically located in non-medical settings amongst local shops and cafes.

The capacity to attract doctors and health staff is based on the attractiveness of the rural and remote health system, not the local hospital alone, which requires investment across locations that professionals work. This could be achieved for example by decentralising functions, such as community health services, to local general practice.

[23] https://www.audit.nsw.gov.au/our-work/reports/governance-of-local-health-districts

Recommendation
Funding for rural and remote health should be based around the health system rather than hospitals incorporating all stakeholders in the health ecosystem to build the attractiveness of the town to future doctors.

Transparency of Budgets
Residents of rural and remote communities have advised that gaining access to hospital budgets and expenditure is very difficult. Rural and remote residents have expressed uncertainty about whether funds allocated to rural and remote hospitals are being fully acquitted against the budget.

To build confidence and accountability, detailed budgets should continue to be published for each hospital annually and be accessible from the web page of each hospital. In addition, monthly reports should also be published online of expenditure against budget to enable communities to review progress in achieving funded goals.

This would assist in building confidence in rural and remote communities that money dedicated to their health services is being spent to improve local health outcomes.

Recommendation
Annual budgets and monthly expenditures are published for each hospital to increase accountability to the community.

Consistency of funding and reduced bureaucracy
A significant issue for rural and remote communities is short-term funding of health services contracts. Contracts to deliver health services of 3 or 6 months are not uncommon which makes it difficult for contractors to recruit qualified staff and give certainty around employment and provide patients with certainty that a service offered will continue to be available for the duration of their needs.

This is a sectoral problem across all rural and remote health funding bodies as more and more layers of bureaucracy have been added at both a State and Commonwealth level to the rural and remote health system over the last decade.

It creates an impression in rural and remote communities that funding is used to create jobs in our urban and regional cities, rather than ensuring the most efficient system for delivering funding to rural and remote health services providers and communities.

Recommendation
The NSW Government undertakes to remove unnecessary red-tape around rural and remote funding and to minimum term contracts of 3 years for contracted services.

ABORIGINAL HEALTH

(k) an examination of the impact of health and hospital services in rural, regional and remote NSW on indigenous and culturally and linguistically diverse (CALD) communities.

More than 26 percent of RARMS patients are Aboriginal and Torres Strait Islander peoples. In many of our towns, we service 100 percent or more of the local Aboriginal population (which includes people from outside our towns).

We aim to work collaboratively with local Aboriginal Medical Services by complementing their service offerings and providing choices for Aboriginal and Torres Strait Islanders when they need it. We work closely with Coonamble Aboriginal Medical Services in delivery of VMO services in Coonamble, and with Dubbo Aboriginal Medical Service in the delivery of Health Assessments in a variety of locations.

We are of the view that the Aboriginal Medical Services are best placed to provide insight into Aboriginal and Torres Strait Islander health in rural and remote communities and defer to our colleagues on this question.

OTHER MATTERS

(l) Any other matters

A Whole-of-Government Approach to the Social Determinants of Health
According to the World Health Organisation:

> "The social determinants of health (SDH) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.
>
> The Social Determinants of Health have an important influence on health inequities - the unfair and avoidable differences in health status seen within and between countries. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health …
>
> Research shows that the social determinants can be more important than health care or lifestyle choices in influencing health. For example, numerous studies suggest that Social Determinants of Health account for between 30-55% of health outcomes. In addition, estimates show that the contribution of sectors outside health to population health outcomes exceeds the contribution from the health sector".[24]

The Australian Institute of Health and Welfare (AIHW) states[25]:

> "Our health is influenced by the choices that we make—whether we smoke, drink alcohol, are immunised, have a healthy diet or undertake regular physical activity. Health prevention and promotion, and timely and effective treatment and care, are also important contributors to good health. Less well recognised is the influence of broader social factors on health".

ADAPTED FROM: Dahlgren & Whitehead, 1991

[24] https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1
[25] https://www.aihw.gov.au/getmedia/11ada76c-0572-4d01-93f4-d96ac6008a95/ah16-4-1-social-determinants-health.pdf.aspx

Social determinants contribute to a broad range of social and economic outcomes including rates of incarceration, homelessness and domestic violence. It is estimated that 20 percent of patients consult their GP for what are primarily social problems.[26]

The economic benefits of addressing the social determinants of health were evaluated by the National Centre for Social and Economic Modelling. The evaluation found that closing the health gap between the most and least disadvantaged groups in Australia would result in:

- 500,000 Australians avoiding a chronic illness;
- 170,000 extra Australians entering the workforce, generating $8 billion in extra earnings;
- Annual savings of $4 billion in welfare support payments;
- 60,000 fewer people admitted to State hospitals annually, resulting in savings of $2.3 billion in hospital expenditure;
- 5.5 million fewer Medicare services each year, resulting in annual savings of $273 million;
- 5.3 million fewer Pharmaceutical Benefit Scheme scripts each year, resulting in annual savings of $184.5 million each year".[27]

There is a growing recognition that reducing inequality in health outcomes between rural and remote populations, and urban and regional metropolitan populations, requires a whole-of-Government approach engaged with local communities to address social determinants. As noted by the World Health Organisation:

> "Health policy generally, and health equity in particular, to a large extent depend on decisions made in sectors other than health and are fundamentally linked to several interrelated issues such as governance, environment, education, employment, social security, food, housing, water, transport and energy. **It means that health outcomes cannot be achieved by taking action in the health sector alone, and that actions in other sectors are critical**."[28]

This has led to the development of various initiatives to better coordinate health and human services policies and activities.

These exist on a continuum from loose to tight coordination.

A common feature of the main approaches is a recognition that each part of the system has a unique role to play. Hospitals are experts in acute and emergency care; general practice are the

[26] Torjesen I. Social prescribing could help alleviate pressure on GPs. BMJ 2016;352:i1436.
[27] https://www.cha.org.au/images/CHA-NATSEM%20Cost%20of%20Inaction.pdf
[28] *Joint statement of the UN Platform on Social Determinants of Health (2015)* "Health in the post-2015 development agenda: need for a social determinants of health approach" at https://www.who.int/docs/default-source/documents/social-determinants-of-health/un-platform-final.pdf?sfvrsn=d4adf14_1&download=true.

experts in coordination of holistic patient centred Primary Health Care; and human services are the experts in social support.

The goal of the majority of these models is not to centralise the provision of services under a single body, but rather to improve the coordination of service delivery among contributors within the system allowing each to play to their strengths.

South Australian Health In All Policies
The South Australian government has adopted a Health in All Policies (HiAP) approach. The HiAP approach aims to systematically account for the health implications of all public policy decisions and promote horizontal collaboration across multiple policy domains to reduce harmful health impacts in order to improve population health and health equity.

The web site of the program states:

> Health in All Policies is about promoting healthy public policy, based on the understanding that health is not merely the product of health care activities, but is influenced by a wide range of social, economic, political, cultural and environmental determinants of health. Actions to address complex, multi-faceted 'wicked problems' such as preventable chronic disease and health care expenditure require joined-up policy responses.
>
> The South Australian Health in All Policies initiative is an approach to working across government to better achieve public policy outcomes and deliver co-benefits for agencies involved including to improve population health and wellbeing.
>
> Established in 2007, the successful implementation of Health in All Policies in South Australia has been supported by a high-level mandate from central government, an overarching framework which is supportive of a diverse program of work, a commitment to work collaboratively and in partnership across agencies, and a strong evaluation process.[29]

While the Health in All Policies approach is in its infancy, a whole-of-government plan to address health and inequalities is consistent with the evidence on the social determinants of health. The model promotes a joined-up approach within government to addressing the social determinants of health, crime, educational disadvantage etc is self-evident.

NSW Human Services Outcomes Framework
The NSW Human Services Outcomes Framework was developed in recognition of the need for government, NGOs and other social services to have a common strategic framework to enable them to work more collaboratively to achieve improvements in early intervention to reduce the escalation of issues that impact on human development.

[29] https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/about+sa+health/health+in+all+policies/south+australias+hiap+approach

The then Department of Families and Community Services stated: “Early intervention is a critical activity across many NSW Government agencies. Each year the Department of Family and Community Services (FACS) invests over $134m in Targeted Earlier Intervention (TEI) programs and services, which aim to intervene early and prevent problems from escalating among vulnerable children and their families … Government’s response [are often] not evidence-based and are not tailored to meet the multiple and diverse needs of clients”.

The framework specifies seven wellbeing outcomes for the NSW population: Safety, Home, Economic, Health, Education and Skills, Social and Community, and Empowerment.

The now, Department of Communities and Justice has developed a set of 37 core client outcomes that have been identified as crucial to ensuring children, young people, families and other community members are safe and can thrive.

The essential element of this program is that providers remain independent of each other, however, they have access to a common framework and outcome indicators that support decision making regarding the services that government funds and the outcomes expected.

Victorian Government Primary Care Coordination Program
The Victorian Government has developed the Primary Care Coordination Program. Under this program providers remain independent of each other, while cooperating to give consumers a seamless and integrated services. Primary Care Coordination is funded by the Victorian government to promote improved cooperation and information sharing. The web site describes the function of the program:

> There are many different types of services available across Victoria's health and human services system. No common system automatically links services to allow people with multiple needs to access coordinated care.
>
> The service coordination framework was developed as part of the Primary Care Partnership Strategy. It helps health service providers to work together to align practices, processes and systems so:
> - people access the health services they need, no matter what service they go to first
> - providers exchange the right information, so consumers receive good care from the right providers at the right time
> - people have their health and social needs identified early, preventing deterioration in health.

- Service coordination places consumers at the centre of service delivery. The idea is to maximise consumers' likelihood of accessing the services that they need.[30]

The benefit of this approach is that government directly funds organisations to coordinate health and social services in a location.

UK Social Prescribing
The Consumer Health Forum of Australia described social prescribing as:

> the practice where health professionals, including GPs, have the resources and infrastructure to link patients with social services – or even social groups – in a bid to address the social determinants contributing to poor health and stave off the epidemic of loneliness and social isolation. A GP may, for example, suggest a patient join a local running group to enjoy the benefits of exercise and interaction.[31]

The UK National Health Service summarise the social prescribing model as follows:

> Social prescribing is a way for local agencies to refer people to a link worker. Link workers give people time, focusing on 'what matters to me' and taking a holistic approach to people's health and wellbeing. They connect people to community groups and statutory services for practical and emotional support.
>
> Link workers also support existing community groups to be accessible and sustainable, and help people to start new groups, working collaboratively with all local partners.
>
> Social prescribing works for a wide range of people, including people:
>
> - with one or more long-term conditions
> - who need support with their mental health
> - who are lonely or isolated
> - who have complex social needs which affect their wellbeing.
>
> When social prescribing works well, people can be easily referred to link workers from a wide range of local agencies, including general practice, pharmacies, multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations and voluntary, community and social enterprise (VCSE) organisations. Self-referral is also encouraged.

An evaluation of a social prescribing program undertaken by the National Health Service found "a clear overall trend that points to reductions in patients' use of hospital resources after they had been referred to Social Prescribing:

- Inpatient admissions reduced by as much as 21 per cent
- Accident and Emergency attendances reduced by as much as 20 per cent
- Outpatient appointments reduced by as much as 21 per cent

[30] https://www2.health.vic.gov.au/primary-and-community-health/integrated-care/service-coordination
[31] https://chf.org.au/social-prescribing

- Greater reductions in inpatient admissions and Accident and Emergency attendances were identified for patients who were referred on to funded VCS services". [32]

A social prescribing trial is being undertaken by the North Western Melbourne Primary Health Network through a Community Health Collaboration involving a local GP practice, local council, university and PHN.[33] The PHN is providing $125,000 in funding to create a network between the GP practice and community services providers to improve coordination and better address client needs.

The social prescribing model moves beyond coordination and funds specific roles, Link Workers, to work within local communities to join-up services and case manage users through the care system. The NHS projects that there will be 1,000 social prescribing link workers in place by 2020/21 servicing a cohort of 900,000 people.

Aboriginal Controlled Community Health Organisations

Aboriginal Community Controlled Health Organisations (ACCHO) are the oldest and most successful model of integrated and coordinated primary health and social support in Australia. The model has been well-researched and shown to be effective in addressing many of the flaws of our current arrangements in Australia by bringing health and social services under a single organisational umbrella that is directly controlled by local communities.

ACCHOs are "a Primary Health Care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community who controls it, through a locally elected Board of Management".[34]

The ACCHOs are a tightly integrated and coordinated form of Primary Health Care that has developed a uniquely integrated socio-medical model. ACCHOs support their clients to address social factors such as employment, housing, income, intergenerational disadvantage, and health behaviours at both an individual and community level.

The ACCHOs have transcended "a specialised medical clinic and function as community spaces through which Indigenous people attempt to deal with their immediate health needs and the underlying structural causes that produce very poor health outcomes".[35]

As the name indicated, ACCHOs are community-controlled giving local communities a direct say over the strategic direction, priorities and approaches to health and well-being. They are well-resourced by government on a population basis, rather than an activity basis, providing the ACCHOs with a degree of flexibility in prioritisation and the most effective ways in which the needs of the community can be addressed taking into account the dynamics of the locale in which they work.

Conclusions

Social determinants are key factors in the levels of poor health, preventable conditions and avoidable hospitalisations in NSW rural and remote communities. It is estimated that between 30 – 55 percent of poor health outcomes are a result of social determinants, and 20 percent of people consult their local GP about problems that are social in nature. Addressing the causes of

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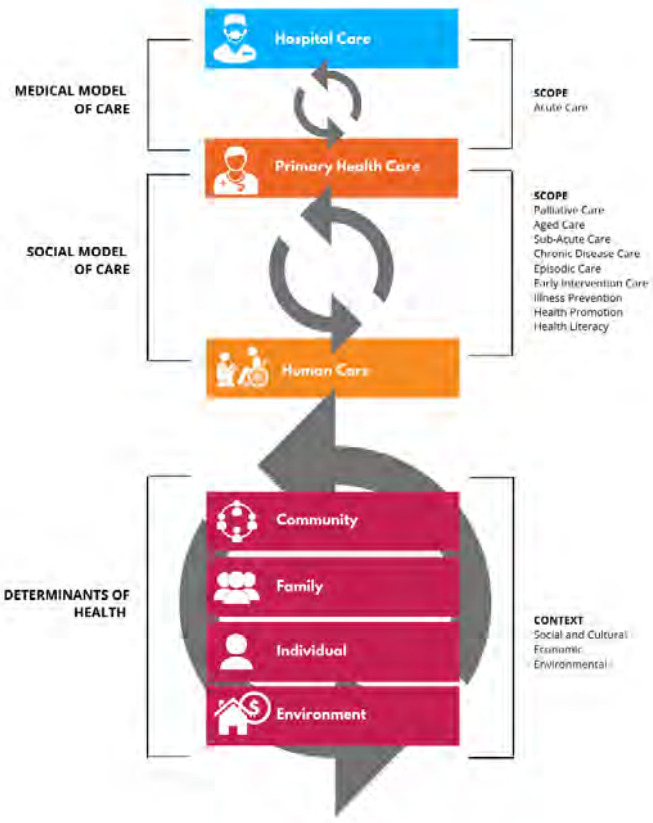
32 https://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/social-economic-impact-rotherham.pdf
33 https://nwmphn.org.au/commisioned-activity/social-prescribing/
34 http://www.naccho.org.au/about.
35 Khoury P. Beyond the biomedical paradigm: the formation and development of indigenous community-controlled health organizations in Australia. Int J Health Serv. 2015;45(3):471–94.

poor health is a cost effective and successful strategy to reducing the burgeoning cost of hospital care in Australia.

Better integration and coordination of health and social services in rural and remote communities aligns with research on the importance of addressing both the cause and consequences of poor health holistically.

While the ACCHO model has proven to be highly successful in promoting improved coordination of services, it has been uniquely designed to redress historic disadvantage of Aboriginal and Torres Strait Islander communities.

The social prescribing model has the potential to transform the way in which health and social services are delivered in rural and remote NSW and the capacity to address both the cause and consequence of poor health. This model could also address the sustainability of rural and remote health and hospital services and improve the capacity to attract more doctors to rural and remote General Practice.



Recommendation

1. Expand the NSW Human Services Framework to become a whole-of-government framework that incorporates NSW Health specific obligations and accountabilities to drive a state-wide focus on human and health outcomes.
2. Incorporate into future NSW Health Plans quantifiable outcome measures for rural and remote health that align to the Framework.

3. Establish a trial of social prescribing in collaboration with rural and remote General Practice to evaluate its impact on the delivery of health and social services, supporting the sustainability of rural general practice.

Place-Based and Community-Led Approaches

Rural and remote health is incorporated within a broader regionalised decision-making framework that has contributed to a reduction in the perception that local communities have a voice in health policy and planning. While formal community consultation structures are in place across all Local Health Districts, NSW lacks any clear goals for community engagement or a definition of what constitutes effective community engagement despite this being a core obligation of the Local Health Districts under the *Health Services Act.*

A 2019 Review of the Governance of Local Health Districts by the NSW Auditor General[36] observed that being "responsive to local needs, and engaging with local patients, carers and communities, are important requirements of LHDs".

Yet the Review went on to note:

> On 1 July 2011, legislation to establish 15 LHDs and their boards came into force, supported by governance arrangements to devolve responsibility and accountability within the health care system and improve the capacity of health services to respond to the needs of the communities they serve.
>
> The reforms were underpinned by a desire to make public health services more responsive to local needs, including through engagement with the local community, a greater decision-making role for local clinicians, and local boards that had visibility and local knowledge to provide strategic direction. Local health service provision is guided by system-wide strategy, policy, and oversight.
>
> Despite the importance of community and consumer engagement, it remains underdeveloped in existing governance arrangements, including the accountability mechanisms. It is difficult for boards or the Ministry to know with confidence that community and consumer engagement is being done effectively. If devolution was intended to bring the management of health services closer to local communities, then there is little way to know whether this is being achieved.
>
> However, there are examples of better practice.
>
> For example, the South Eastern Sydney LHD's Mental Health First Aid Youth Program was developed as a result of that district's inter-sectorial Board of Community Partnerships Committee (BCPC). Regular monitoring and evaluation of the quality and efficacy of the program partnership was essential to support the Implementation Group to action an effective youth mental health program. The evaluation tool was the Victorian Health Partnerships Analysis Tool, a resource designed for organisations working in partnerships to assess, monitor and maximise its ongoing effectiveness.

[36] https://www.audit.nsw.gov.au/our-work/reports/governance-of-local-health-districts

> Similarly, at Hunter New England LHD, the effectiveness of all 46 local community partnerships are evaluated annually and reported to the board's community partnerships committee".

An ongoing issue identified in rural and remote communities is that engagement often involves the community being told of decisions that had already been made without opportunity to influence or change the decision making to reflect local needs.

As noted in the Review, some Local Health Districts undertake this responsibility well such as the Hunter New England model but the lack of consistent standards and requirements for engagement across the State means that in many cases community views are not consistently taken into account in the development of health services plans that have significant implications for the future of a community.

Another example of positive community engagement arose from RARMS engagement in a joint project with the Murrumbidgee Local Health District to develop a rural and remote workforce support and community access Telehealth service to fill gaps in access to Primary Health Care in small communities. This involved an extensive engagement with local rural GPs, emergency medical clinicians, nurses, local pharmacies and community members to discuss how such a service could augment existing capacity and provide better quality care. The model was co-designed in collaboration with community, clinicians and small-medium businesses leading to a very high rate of stakeholder satisfaction. What this example demonstrates is ways to redesign services in collaboration with communities and local businesses that does not lead to the loss of on-site services in local communities.

Problems with community engagement exist within the broader context of the centralisation of services in regional cities.

This has contributed to a decline in the focus on unique locational factors that are integral to understanding health needs and designing programs to address them.

Wakerman and Humphries *et al* developed a "conceptual framework of rural and remote health comprising six key concepts: (i) geographic isolation, (ii) the rural locale, (iii) health responses in rural locales, (iv) broader health systems, (v) broader social structures, and (vi) power relations at all levels".

The framework identifies the critical importance of local factors in each town in understanding how to enact change to improve health outcomes. The authors identify geographic isolation as a starting point.

They note that "a cardiac arrest on a dirt road 1200 km from a city and 200km from a town with a small hospital accentuates the geographical dimension of rural health. Distance from larger centres alter access to health care for local consumers, the type of practice provided by local professionals (for example, generalist care, high levels of autonomy, overlapping relationships), the lack of appeal for 'going rural' among health professionals, and so forth".

They note that "being the same distance from a metropolitan centre does not assume locations are similar" and that "rural health is more than the practice of health in another location". This is a key reason why RARMS is committed to maintaining practices in rural and remote towns.

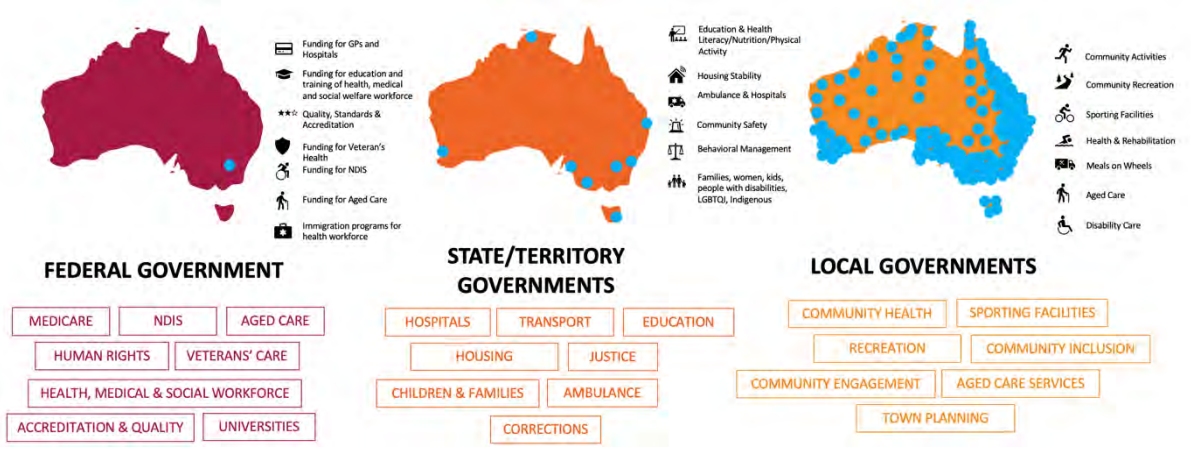
The authors also note the importance of rural locale which broadly describes how different communities act, interact and react based on the different personalities, capabilities and resources available to the specific community. In short, two rural communities may have identical health profiles (e.g. levels of diabetes or physical activity) but that does not mean that the same policies will be equally successful in each community.

Place-based planning is an approach that takes into account locational factors in determining priorities, actions and plans to address rural health improvement and access to services. In thin markets different configurations of services necessarily arise based on local assets that are already in place and areas of gaps that need to be addressed.

A more localised approach to planning and service delivery has practical and fiscal implications. For example, a meals on wheels service run by the local council may send a volunteer to visit a resident who is immobile. This can create an opportunity for a community 'check up' on the resident's health and reporting back to the local GP. In another town this might be the local Rotary or an NDIS provider. The local pharmacy may offer blood pressure or oxygen testing to reduce the strain on the local GP, with any substantial changes reported back. Within rural and remote communities, there are significant opportunities for improved coordination, adaptation and innovation to maximise the utilisation of the different resources available in each town.

However, this requires a commitment to improved coordination at a local level of services within rural and remote communities and a distinct approach to the delivery of health and human care.

Place based planning is beyond the scope of our existing health system which is organised around acute care and regions rather than people and places. Needs Assessments often lack the granularity to identify how specific circumstances of particular communities' impact on health profile or outcomes. To achieve planning that reflects the needs of each community requires engagement with that community in understanding needs, understanding the factors that may be contributing to health outcomes and engaging influencers and contributors in the town to motive change. Put simply, this cannot be done at a distance.



A place-based model is also more reflective of the way health and human services are delivered in NSW. Local government, local schools, local Police, local Pharmacist, local PCYC, local Aboriginal Land Council, local GPs, local Rotary and Lions etc have a unique position within communities to help identify priorities, and design and deliver services that reflect local community needs. Rural and remote communities have an enormous knowledge and skill base

and infrastructure on the ground, but we do not plan consistently across government at a local level.

The COVID-19 pandemic has focussed attention on the importance of place based and community engaged approaches. In Victoria, community organisations were identified as an essential resource not only because of their established presence in local communities which enabled them to mobilise intra-locale resources more effectively but provided government with intelligence to inform transmission reduction strategies in a way that reflected how different communities operate.

Evidence from past epidemics has shown the importance of local engagement capacity to "reach marginalised populations and to support equity-informed responses". This has led researchers to argue that governments need to "assess existing community engagement structures and use community engagement approaches to support contextually specific, acceptable and appropriate COVID-19 prevention and control measures".[37]

In place-based planning the local community, NGOs, industry and all levels of government work closely together to improve community wellbeing through a shared strategy and via place-based initiatives that respond to the specific circumstances of individual communities.

The framework recognises the importance of community and industry readiness and values the active participation and responses of all stakeholders in any place-based approach.

The Queensland Government has developed a model for Place-Based Planning which recognises the valuable and important role of local contributors (community, government, NGO, industry) in coordinating actions and joining up efforts to improve the social, economic and physical wellbeing of a defined geographical location. The Queensland Government notes that "these approaches are highly collaborative, take time and are ideally characterised by partnering and shared design, shared stewardship, and shared accountability for outcomes and impacts. Place-based approaches are often used to respond to complex, interrelated or challenging issues such as social and economic disadvantage, natural disasters or environmental problems".[38]

The development of a Place-Based approach to social and health planning links to the proposal for a trial of social prescribing in rural and remote NSW.

Recommendation
NSW Government adopt a Place-Based Planning Approach led by local communities to addressing the health and human services needs of local community.

[37] https://gh.bmj.com/content/5/10/e003188
[38] https://www.communities.qld.gov.au/resources/dcdss/community/place-based-approaches/ministers-framework-pba.pdf

ATTACHMENTS

1. Rural and Remote Medical Services Strategy 2021-22
2. Rural and Remote Communities Healthcare Survey 2020 No. 1 (COVID)
3. Rural and Remote Communities Healthcare Survey 2020 No. 2 (GENERAL)
4. Rowdan (2020) Economic and Social Impact of Community Rural Healthcare

167,374

Number of primary care consultations with rural, remote and Indigenous patients in 2019/20.

21,003

Number of hospital ED services provided by RARMS Doctors in 2018/19.

7.4

The average number of Medicare services received by RARMS rural and remote patients.

-65.0%

Reduction in the number of low acuity presentations to local EDs resulting from increased access to primary care.

DONATE

$2.85M

Charitable reserves for investment in continuity of medical workforce in rural and remote communities.