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

RARMS HEALTH

HEALTHY RURAL & REMOTE COMMUNITIES REPORT

ANNUAL REPORT TO OUR COMMUNITIES & SUPPORTERS

2020

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.

ABOUT RARMS

Rural and Remote Medical Services Ltd was established as a not-for-profit charity in 2001 by the NSW Rural Doctors Network (RDN).

RARMS works in some the most socio-economically disadvantaged communities in Australia, and around 27 percent of our patients are from Indigenous backgrounds.

RARMS was established in response to the dual problem of rural GP shortages and the growing cost incurred by the NSW Government in recruiting Locums to staff rural and remote hospitals. The lack of access to regular primary care in our communities contributed to escalating rates of chronic disease and avoidable hospitalisation increasing demand and the cost of hospital services.

RARMS was established by rural doctors who were convinced that it is possible to attract GPs to live and work in rural or remote Australia by properly supporting them and recognising their dedication to the health of local people.

The rural doctors that helped form RARMS were proven right. For 20 years, RARMS has ensured that more than 22,000 rural, remote and Indigenous Australians have had local access to both primary care and on-site emergency department services delivered by doctors, nurses and health staff who live and work in rural and remote towns.

This is not only important to the health of our communities, but also to reduce the economic burden of rapidly growing hospital costs. Between 2014/15 and 2018/19 the total number of low acuity presentations to Hospital Emergency Departments in RARMS locations declined by 65.5 percent due in part to improved access to primary care saving the NSW Government millions of dollars in hospital costs. The cost of transporting patients to larger centres has fallen dramatically and hospitalisations for preventable conditions have fallen by more than 10 percent in 5 years.

RARMS' role is to help communities to develop their skills and capabilities to understand their own health needs, develop programs to address the social determinants of health, build and operate their own sustainable local health services, recruit permanent GPs, nurses and health staff to their town and advocate to government for investment in cost-reducing rural health.

We are thankful for the support of our patients, communities, donors and supporters to ensuring health equality for rural, remote and Indigenous Australians.

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INTRODUCTION

Rural and Remote Medical Services Ltd (RARMS) is dedicated to providing high-quality, accessible, integrated, patient-centred, culturally-responsive and inclusive health and medical services to disadvantaged rural, remote and Indigenous communities.

Every day, our staff deal with some of the most consequential health and social issues facing rural, remote and Indigenous communities that have long-term impacts on the lives of rural, remote and Indigenous people and the future of whole communities.

More than any other thing our health status is determined by the places we are born, grow, live, work and age. That is why we are committed to a holistic and place-based approach to community health and well-being.

Our doctors and health staff live and work in rural and remote communities building knowledge of the local context and the relationships with local residents that are essential for good primary care and better health outcomes.

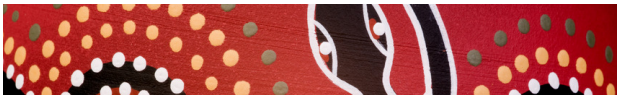
This proven approach to delivering on-site primary and hospital care in rural and remote communities is under threat. There is a growing belief that safe and quality health care can be provided in rural and remote towns using Telehealth delivered from major cities. This is wrong.

Telehealth may be a cheap short-term option but it is not appropriate for dealing with an emergency that can occur at any time of the day or night, such as a heart attack or premature labour.

Telehealth risks stripping out millions of dollars of income that health and social assistance services bring into rural and remote communities leading to even greater costs to government in providing welfare and social support to rural and remote communities.

More importantly, Telehealth lacks a proven model of care as a complete system of healthcare in rural and remote communities, risking lives of the most vulnerable people in Australia.

RARMS fundamentally believes that the only way to improve health outcomes in our communities, and reduce the growing cost of preventable illness and avoidable hospital admissions, is through the provision of on-the-ground continuity of care that only rural GPs can provide.



As this report shows, this is not just what RARMS believes but what it delivers. Our communities have seen:

- a 65 percent drop in avoidable low acuity hospital presentations at hospital emergency departments over the last 5 years;
- an increase in the rates of Medicare services per capita in RARMS's rural and remote communities;
- a 25 percent drop in hospital admissions in RARMS towns (compared to a national increase of 14 percent); and
- an 10 percent drop in preventable illness hospitalisations in RARMS western NSW LGAs (compared to a national increase of 16 percent).

Strong and sustainable primary care on-the-ground in rural and remote communities works not only to improve health access and outcomes, but also reduce the cost of increasing rates of preventable illness and avoidable hospitalisations.

Over 20 years, our staff have developed a deep knowledge and insight into the challenges of rural, remote and Indigenous Australians, and direct experience of what works and what doesn't on a place-by-place basis.

Our work improving health access and outcomes for our communities requires substantial resources. On behalf of the staff and the Board, we are grateful to everyone who has provided financial and in-kind support over the last year.

As we look to the challenges that we will be called on to address in the coming year we will continue to do all that we can to preserve the trust that our communities and supporters have placed in us.

In this report you will find highlights of our achievements over the past year. We are thankful for the support of our Board, and our staff, as we begin a new and exciting era for RARMS and our communities.

RARMS delivers impact because we do not see rural health as a problem, but a challenge to be solved.

We remain committed to continuing to deliver practical, effective, community-led and proven solutions that improve the health and well-being of rural, remote and Indigenous communities.

Mark Burdack
Chief Executive Officer

Richard Anicich AM
Chair, Board of Directors

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OUR PATIENTS

Rural and remote communities are characterised by high rates of chronic disease, earlier age of death and poorer access to on-site GPs who live and work in the community. RARMS was established to address the inequity that results from poor access to primary and hospital care in vulnerable rural, remote and Indigenous communities. The following information provides a high level overview of RARMS communities.

PATIENTS < 6 YEARS OF AGE

9.3%
(at Jan 2020)

PATIENTS > 75 YEARS OF AGE

18.2%
(at Jan 2020)

ABORIGINAL & TORRES STRAIT ISLANDER PATIENTS

26.3%
(at Jan 2020)

PATIENTS WITH CARDIOVASCULAR DISEASE

30.6%
(at Jan 2020)

PATIENTS WITH MENTAL HEALTH CONDITIONS

14.5%
(at Jan 2020)

PATIENTS WITH DIABETES

9.8%
(at Jan 2020)

PATIENTS WHO SAW A GP MORE THAN 5 TIMES

54.3%
(at Jan 2020)

DELIVERING WHAT RURAL COMMUNITIES WANT

87.3%
rural, remote and indigenous patients prefer a GP rather than a hospital for healthcare.
(Rural and Remote Healthcare Survey 2020)

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CONTINUITY OF PRACTICE FRAMWORK

WALK-IN, WALK OUT

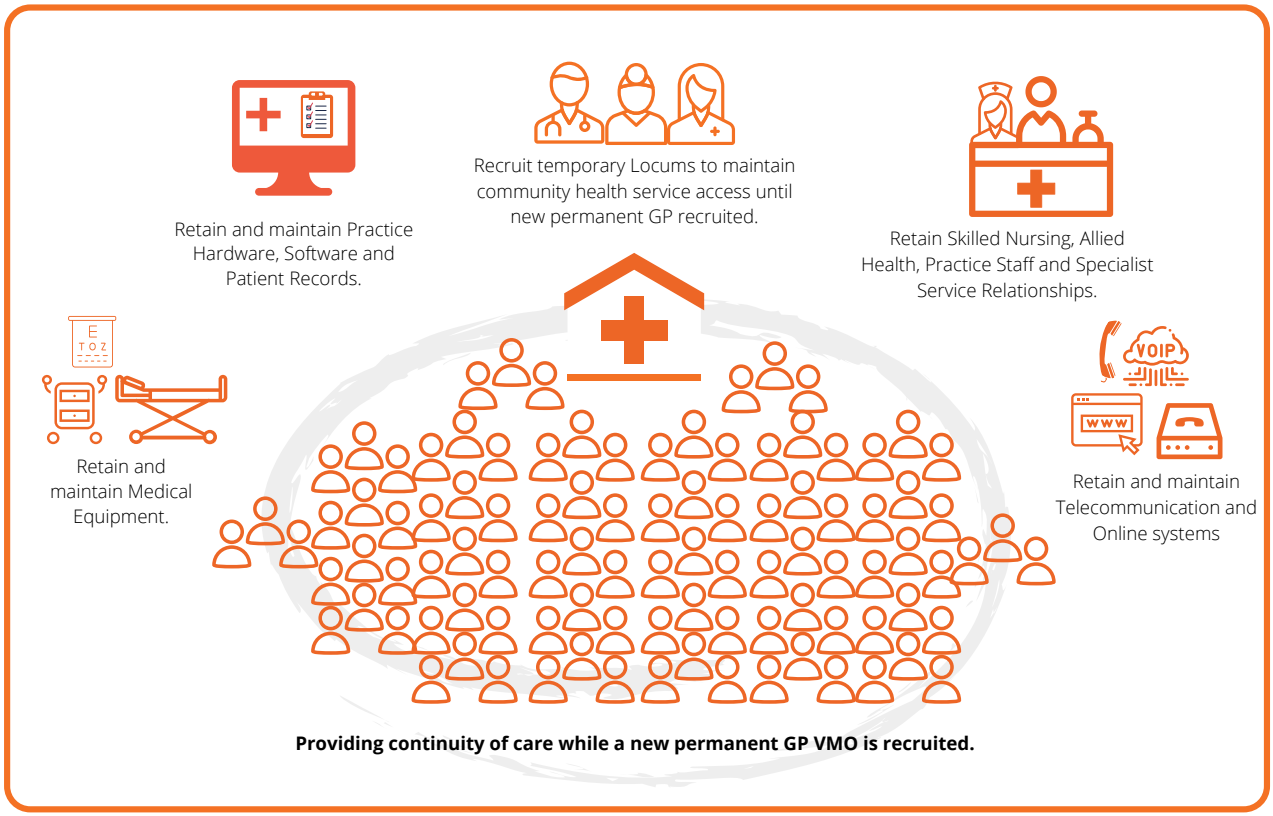

Dr Patrick Giltrap, Gilgandra

The 'Walk-In, Walk-Out' model pioneered by RARMS aims to make general practice in 'difficult to service' rural and remote areas more attractive. The approach enables GPs to work as clinicians without the cost and risk of having to buy or establish their own medical practice in a rural and remote town or become a small business owner. Domestic and surgery accommodation, experienced nurses and practice staff, a full practice infrastructure and equipment, patient records and community networks are all maintained by RARMS - even when there is no permanent GP in town and no revenue from medical care.

RARMS was established to ensure rural and remote communities have access to ongoing health and medical care even when a permanent doctor leaves by focussing on the key gap in Australia's rural health policy - "continuity of practice". By ensuring practices continue to deliver services, and support medical training, even when permanent doctors move on RARMS has ensured the continuation of rural health and medical care, as well as hospital and aged care services, in rural and remote communities for 20 years.

RARMS keeps rural general practices and hospitals open for business until a new permanent GP can be found. This model is marginally more expensive than other approaches, but has the advantage of removing many of the previous barriers to sustainable rural practice and has ensured that more than 22,000 rural and remote residents in RARMS towns having access to health and medical services 24/7 for the last 20 years at a fraction of the cost of other rural and remote health programs.

The success of the model relies on RARMS retaining funds in good years to enable it to fund Locums, nurses and other activities beneficial to our communities during periods of workforce shortage while we recruit and train new permanent GP VMOs for rural and remote practice.



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RURAL HEALTH EQUITY FRAMEWORK

Rural and remote communities require different health service approaches compared to major cities and regional centres. Residents in major cities and regional centres typically have access to a wide variety of health and hospital services, and specialist care, in close proximity to where they live and are generally well-supported to navigate their service needs. Rural and remote communities however rely solely on general practice, which also services the medical needs of the local hospital, as a central point for coordination of care across health and human services. The RARMS Health Equity Framework maps how RARMS general practice leverages its place within the community to strengthen community health literacy, plan for community needs and improve the health care experience and outcomes for rural, remote and Indigenous people.

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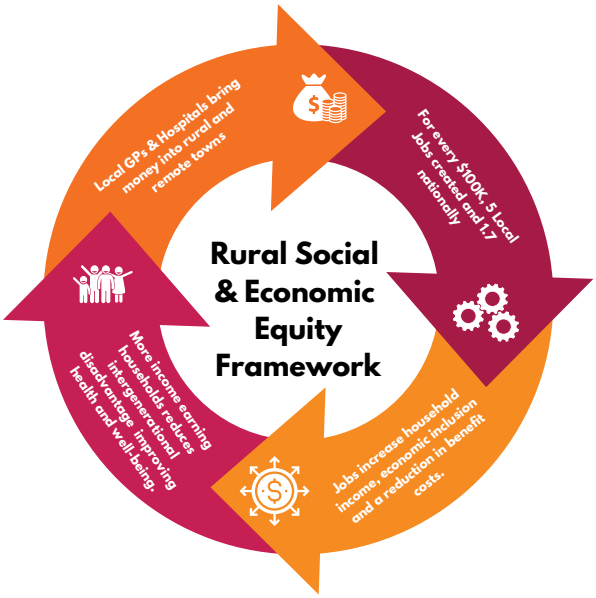
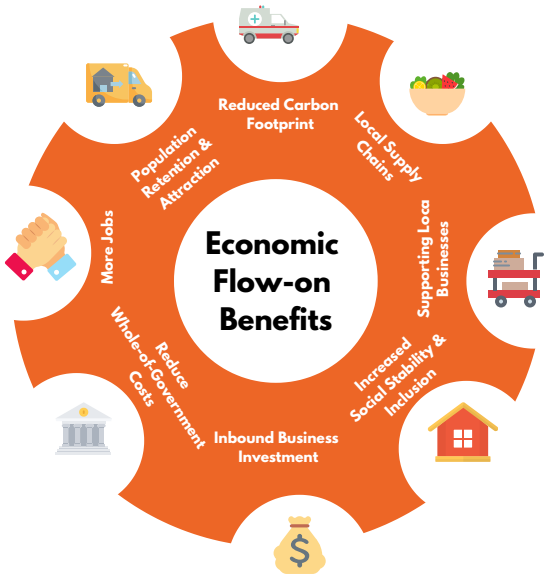
RURAL SOCIAL & ECONOMIC EQUITY FRAMEWORK

Health systems play a central role in the sustainability and growth of rural and remote jobs and economies. According to the World Health Organisation, the provision of health services has a significant multiplier effect including: sustaining other small health (e.g. local pharmacy) and retail businesses (e.g. supermarket) generating jobs in other sectors; increasing population and tourism attraction; providing an essential foundation for economic investment attraction; reducing carbon emissions by providing services locally; increasing social inclusion through employment and economic empowerment; reducing intergenerational disadvantage by increasing adult employment and providing positive role models for children; and, population stability through increased economic activity. When the flow-on and induced effects of investment in rural health are taken into account the World Health Organisation found that local health systems are major contributors to addressing the social determinants of health, and reducing whole-of-government costs.

The RARMS Social and Economic Equity Framework informs the way in which RARMS works with our communities to maximise flow-on employment outcomes for local people, support growth in economic activity and ultimately help address the socioeconomic determinants of health. This ranges from RARMS Policy on Local Procurement to RARMS involvement in providing clinical training in rural and remote practice to medical and health students, bring income, jobs and opportunities to our communities.





RARMS is Australia's first GEOGRAPHIC OPPORTUNITY BUSINESS. RARMS developed the logo for organisations and businesses that want to demonstrate their support for rural and remote social and economic development through local employment, procurement and service delivery. The framework will be further developed in 2020/21. At RARMS all positions are available to work in any location in rural and regional Australia. RARMS prioritises local procurement wherever possible. RARMS engages more than 145 staff and doctors in rural and remote NSW, delivering jobs, economic activity and contributing to address both the social determinants of health and the needs of the community.

GEOGRAPHIC OPPORTUNITY BUSINESS

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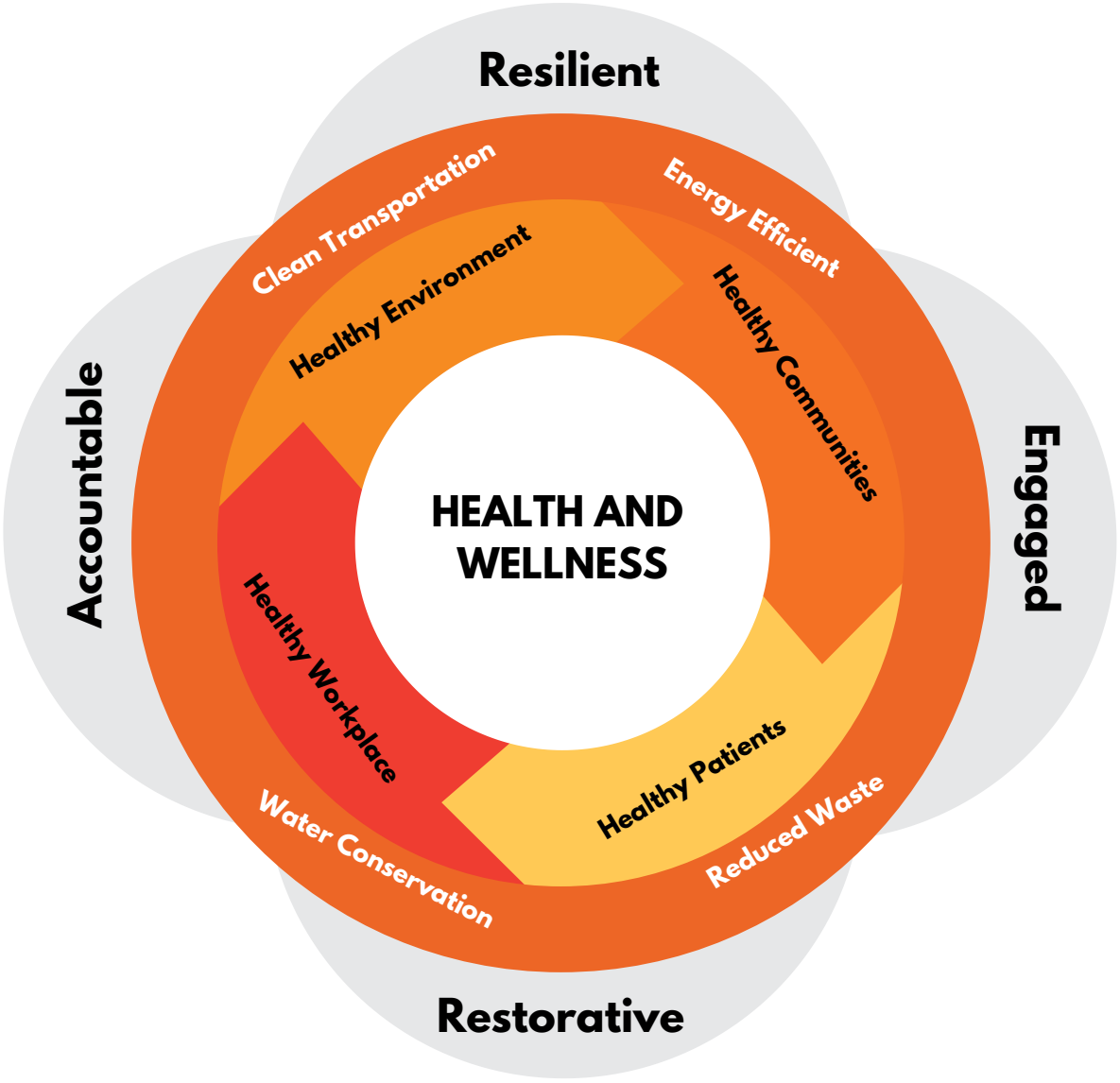
RARMS SUSTAINABILITY FRAMEWORK

The Mission of the RARMS is to improve the health and wellbeing of people in rural, remote and Indigenous communities. Improving resource efficiency and addressing the causes of climate change helps to reduce some of the contributors to poor health and well-being in our communities.

RARMS' Sustainability Framework enables RARMS to ensure our operations are environmentally sustainable balancing the needs of the natural environment and our rural and remote communities. RARMS' Green Plan requires a combination of behavioural change, which is often low or no cost, and targeted investment in facilities and enabling infrastructure. The Plan covers the period 2020 to 2025 and will be reviewed annually. It outlines how RARMS uses its resources in three key areas – energy, water and waste, and commits to taking specific actions in each of these areas.



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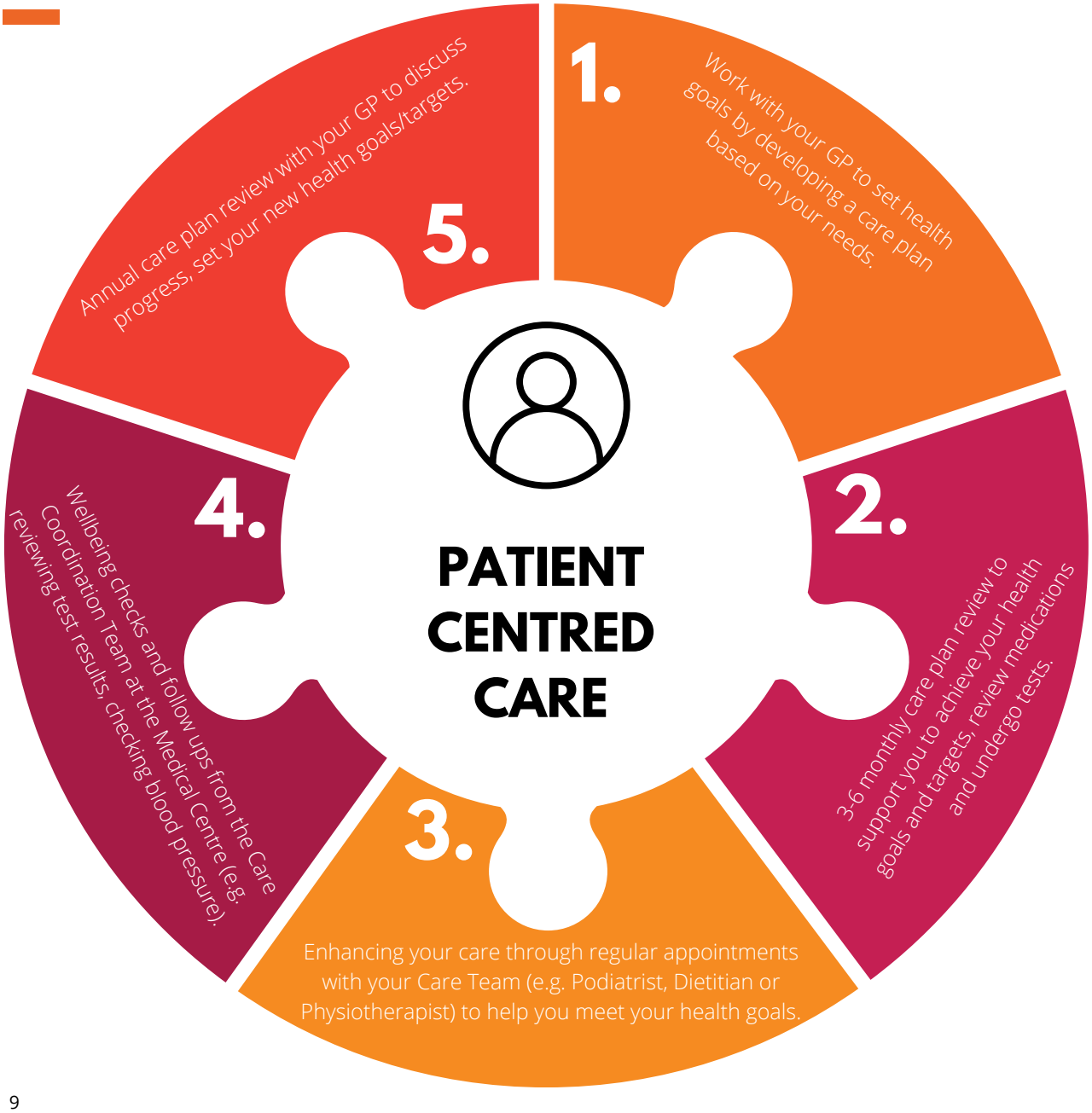
RARMS CHRONIC DISEASE CYCLE OF CARE

Rural and remote communities have higher rates of chronic disease, avoidable hospitalisation and preventable mortality compared to major cities and regional centres. The role of GPs is to improve community health outcomes and wellness, and intervene early to reduce the number of people in the community that develop chronic conditions requiring hospital admission and which impact quality of life. The RARMS Chronic Disease Cycle of Care provides a broad framework through which RARMS works with our patients to provide a multidisciplinary team based approach to improving health and managing chronic diseases to reduce unnecessary hospitalisations.



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RARMS HEALTH

2019/20 OUTCOMES

2005
GP of the Year
(Dr Patrick Giltrap)
Royal Australian College of General Practice

2009
Practice of the Year
(Walgett Medical Centre)
Royal Australian College of General Practice

2018-2020
AGPAL Quality Accreditation
Royal Australian College of General Practice

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IMPACT

22,091
CATCHMENT POPULATION
CENSUS 2016

22,685
RARMS ACTIVE PATIENTS
JAN 2020

5,011
INDIGENOUS CATCHMENT POPULATION
CENSUS 2016

5,971
RARMS INDIGENOUS ACTIVE PATIENTS
JAN 2020

145
RARMS STAFF
2019/20

99
PERMANENT & ROSTERED RURAL GPs
2019/20

RARMS' total and ATSI population catchment is calculated using Census 2016 LGA Data (Bourke, Brewarrina, Gilgandra and Warren) and State Suburb (SSC) data for small rural towns that are located in larger LGAs. GP Practices typically service a local population catchment bounded by suburbs. RARMS Medical Centres also service surrounding towns that do not have access to a local GP or hospital. The data shows the extent to which communities rely on RARMS Medical Centres beyond the immediate catchment suburb in which we operate.

102.7%

OF TOTAL POPULATION ARE RARMS ACTIVE PATIENTS

119.2%

OF TOTAL INDIGENOUS POPULATION ARE RARMS ACTIVE PATIENTS

$2.58M

RARMS INVESTMENT FUND

2019/20

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HEALTH PERFORMANCE SUMMARY


Anne-Marie Andersen, Practice Manager, Bingara

RARMS Health Performance Indicators are a set of measures we use to assess our progress in meeting local health outcomes. RARMS continued to improve access to GP primary care in our communities throughout 2019/20.

RARMS met all its indicators in 2019/20 except for its target for ATSI Health Plans. As many of RARMS towns have a local Aboriginal Medical Service performance against this target varies based on the level of activity of AMS practices in the community.

In 2020/21, RARMS established the "Improving Aboriginal Health - A Study of the Impact of Incentives and Other Strategies on ATSI Health Plan Compliance and Outcomes". The project is a response to concerns about non-compliance and a lack of detailed monitoring to determine the impact of Plans on community health. The project will look at ways to increase the number of ATSI Patients obtaining Plans, and complying with agreed measures, and monitor and report health outcomes annually.

Community Health Performance Indicator	Target	2019/20 Outcome	Status
Maximise the number of residents of RARMS towns that have access to high quality primary care in their communities	80%	102.7%	✓
Maximise the number of ATSI residents of RARMS towns that have access to high quality primary care in their communities	33%	119.2%	✓
Increase Medicare per capita occasions of service to a level equal to, or greater than, Outer Regional Areas	>6.0	7.4	✓
Ensure patients are satisfied with the care provided by RARMS	>=90%	94.9%	✓
Improve ATSI health outcomes through completion of ATSI Health Assessments	>=33%	31.9%	✗
Reduce the average number of low acuity (T5) presentations to Hospital Emergency Departments by expanding access to local primary care in RARMS communities	>=5%	13.5% 5 Year Average	✓
Reduce the average number of Potential Preventable Hospitalisations by expanding access to quality primary care in RARMS communities	>=3%	6.7% 5 Year Average	✓
Increase access to 'care in place' and reduce avoidable patient transfers by increasing access to local Telehealth support in rural and remote areas without GPs	>=25%	43.4%	✓
Increase access to Telehealth to support the rural and remote GP workforce and improve access to 'care in place'	No Target	3,084 Patients	✓

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RURAL & REMOTE PRIMARY CARE

Gilgandra Medical Centre Staff and Community

Rural and Remote Medical Services Ltd was established as a charity in 2001. In 2019/20 we delivered 167,374 occasions of service from 12 Rural and Remote Medical Centres to 22,685 active patients, 26.3 percent of whom are Aboriginal and Torres Strait Islanders.

The Australian Institute of Health and Welfare reports that in 2017/18 residents of remote communities received an average of 4.9 Medicare services per person, and outer regional (rural) receive an average of 6.0 services. This is due to the shortage of doctors and nurses in rural and remote communities. By comparison, residents of major cities receive an average of 6.3 occasions of service under Medicare per annum.

In communities where RARMS works, patients received an average of 7.37 Medicare GP, Nurse and Aboriginal Health Worker services per person which better reflects the level of chronic disease in these communities, ensuring health equity for rural, remote and Indigenous residents.

INCREASING RURAL ACCESS

167,374

Primary care occasions of service
(2019/20)

ENSURING RURAL EQUITY

7.4

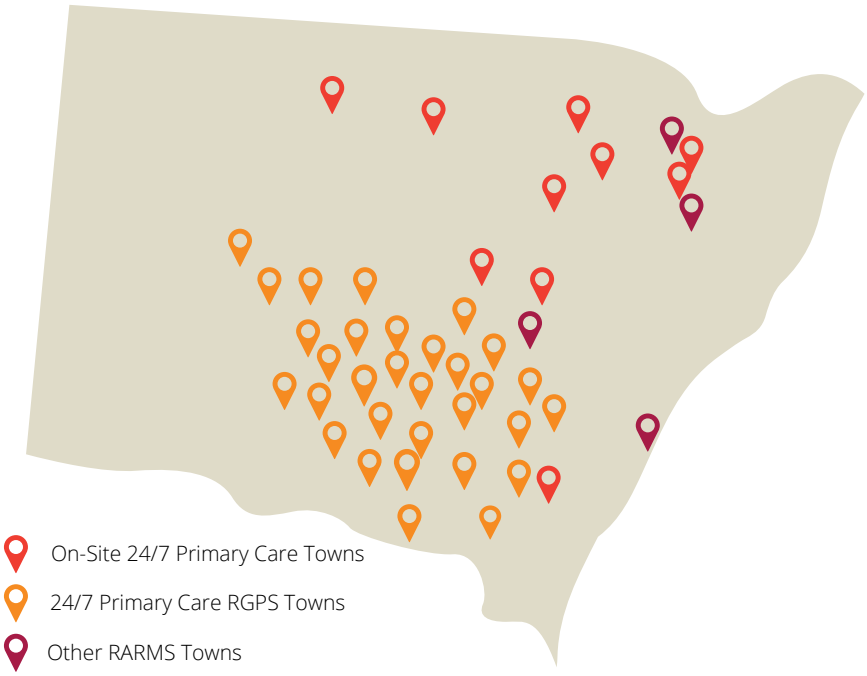
Occasions of Service per person in RARMS remote towns
(RARMS GP/AHW/Nurse Occasions of Care) compared to 6.0 and 4.9 per person nationally for rural and remote residents respectively in 2017/18)

MEETING RURAL NEEDS

94.9%

Rural, remote and Indigenous patients satisfaction with their RARMS GP service experience
(RARMS Patient Satisfaction Survey 2019/20)

EXPANDING RURAL REACH



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ABORIGINAL & TORRES STRAIT ISLANDER CARE

Aboriginal and Torres Strait Islander people comprise up to 60-70 percent of some RARMS communities. Aboriginal and Torres Strait Islanders suffer from significantly poorer health outcomes compared to non-Indigenous Australians due to historic disadvantage, the ongoing trauma of dispossession and poor access to culturally appropriate health and medical services in rural and remote communities.

For example, there remains a 15 year gap in the median age of Aboriginal and Torres Strait Islander people compared to non-Indigenous people; one in three Aboriginal and Torres Strait Islander youth experience high levels of psychological distress compared to non-Indigenous people; and, 64 percent of the burden of disease amongst Aboriginal and Torres Strait Islander people stems from chronic diseases.

One of RARMS's key priorities is to work collaboratively with Aboriginal and Torres Strait Islander communities and organisations to improve health access and outcomes for residents.

Location	Active ATSI Patients	ATSI Population	Proportion of ATSI Population that are RARMS Patients	Completed ATSI Health Assessments 2019/20
Bingara	122	76	**160.5%**	**36.9%**
Braidwood	28	36	**77.8%**	**3.6%**
Bourke*	999	829	**120.5%**	**34.8%**
Brewarrina*	803	1,011	**79.4%**	**41.2%**
Collarenebri	313	276	**113.4%**	**22.7%**
Gilgandra*	471	597	**78.9%**	**16.1%**
Lightning Ridge	787	517	**152.2%**	**39.9%**
Walgett	762	935	**81.5%**	**32.8%**
Warialda	166	114	**145.6%**	**42.2%**
Warren*	464	396	**117.2%**	**13.1%**
TOTAL	**4,915**	**4,787**	**102.7%**	**31.9%**

The proportion of Active Aboriginal and Torres Strait Islander patients reflects the fact that RARMS Medical Centres are sometimes the only health and medical service that is accessible to Aboriginal and Torres Strait Islander people in a region and therefore the data includes patients that attend our practices from outside our practice towns. The ATSI population data is based on 2016 Census Data for each LGA (marked with an asterix) and State Suburb for small towns within a larger LGA.

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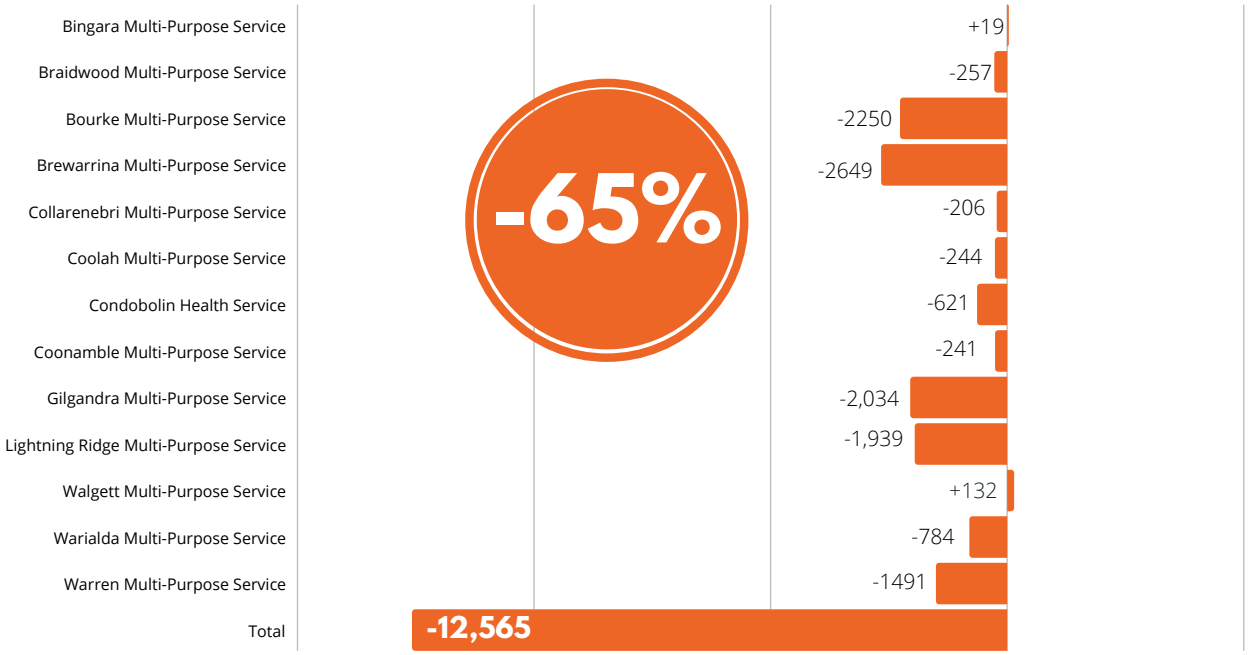
RURAL & REMOTE HOSPITAL CARE

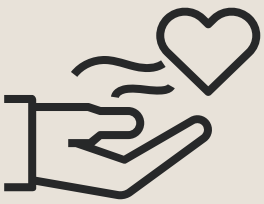

Dr Di Coote and Dr Clem Gordon, Warialda

The cost of Australia's health care system is increasing due in part to the over-use of hospitals for conditions that can be treated by a local GP. An important role played by RARMS in rural and remote communities is to expand access to primary care to reduce the avoidable use of high-cost hospital Emergency Departments for matters that can be addressed in a community context.

Between 2014/15 to 2018/19 the number of low acuity (Triage Category 5 - Non Urgent) patients presenting to the local ED in RARMS GP VMO towns declined from 19,362 to 6,761 (65 percent). According to the National Hospital Cost Data Collection the average cost per non-admitted ED presentation in Australia in 2017/18 was $561 compared to a Medicare Schedule Fee received by a GP of $38.75 in 2020. Increasing primary care access in rural and remote communities frees up high-cost hospital resources for acute and emergency care, while improving community access to primary health care and improving patient health outcomes.

Reduction in Low Acuity ED Presentations in RARMS Towns 2014/15 and 2018/19





+94.5%

RARMS supplies VMO only services to one hospital in rural and remote NSW, but does not deliver GP primary care services. That town experienced a 94.5% increase in low acuity presentations to the local hospital between 2014/15 and 2018/19 compared to a 65.5% decline across towns in which RARMS delivers primary care and hospital services in parallel. The integrated delivery of primary and hospital care has been proven to be the most cost-effective and patient-centred approach to the delivery of health services in rural and remote communities.

CASE STUDIES

COVID-19 RESPONSE


Vivian Slack-Smith, Practice Manager, Brewarrina

The critical importance of on-the-ground charities like RARMS was again shown during the COVID-19 pandemic. As our health system geared up to respond to an anticipated increase in acute care needs in our major cities, charities like RARMS filled the gaps in rural and remote communities by providing information to local people, delivering primary care and testing services, printing information posters and signage about COVID-19, advising the government on key issues and ensuring our communities remained safe. An overview of the RARMS response is provided below.

4,153 hrs

Nursing Hours Provided During COVID-19
To 31 July 220

8,764 hrs

GP Hours Provided During COVID-19
To 31 July 220

7,114

COVID-19 Telehealth Consultations
To 31 July 220

10

Rural and remote Flu Vaccination Clinics providing access for 22,000 patients
To 31 July 220

2,000 L

Hand sanitiser made available for free to health and medical services, schools and emergency services in our communities in partnership with Manildra.

274 people

provided with access to an online service to get essential food and household supplies to reduce the risk of infection.

100's

Local councils provided with free online access to the RARMS *Guide for Rural and Remote Local Councils to Covid.*

Surveys

RARMS established and conducted the *Rural and Remote Community Healthcare Survey - Attitudes During COVID* to hear from rural and remote people and advise government on priorities.

CASE STUDIES

RURAL & REMOTE TELEHEALTH

IN THE MURRUMBIDGEE

NSW GOVERNMENT Health
Murrumbidgee Local Health District

Rural & Remote Medical Services Ltd.
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Dr Ken Mackey AM, RARMS Director

Rural and Remote Medical Services Ltd is the largest charitable provider of rural-specific, GP-led telehealth workforce support services in NSW. The Remote GP Service (RGPS) is unique because it is staffed by GPs who work in rural and remote communities, or who have direct experience working in the regions we cover. This not only increases our contribution to employment and economic activity in our local rural and remote communities, but ensures that patients can talk to doctors who understand their local circumstances.

In 2019/20 RARMS partnered with the Murrumbidgee Local Health District to trial a new model of telehealth workforce support and patient access across 33 hospitals.

The aim of the trial was to determine if Telehealth could be deployed to treat low acuity matters as an integrated support service in rural communities that are experiencing a temporary GP vacancy, improve rural GP work/life balance by reducing unnecessary call-outs during unsociable hours and at night and reduce unnecessary patient transfers to referral hospitals for conditions that could be managed locally allowing patients to be treated safely in their home town near family and friends.

3,084
Rural, remote & Indigenous patients seen via Telehealth
(Dec 2019 - July 2020)

33
Rural & Remote Emergency Departments

93.1%
Hospital and clinical staff satisfaction
(Survey of Clinicians, Nurses and Staff of Murrumbiudgee Local Health District who participated in RGPS Service Dec 19 to Jul 20)

94.5%
Patients comfortable to see GP via Telehealth
Rural and Remote Healthcare Survey 2020 (Proportion of patients that have used Telehealth who responded as Neutral - Very Positive)

43.4%
Avoided transfers to Referral Hospital
(Based on the number of patients that would have been transferred (1,339) divided by the number of patients during the period Dec-Jul 2020 (3,084) when this RGPS services was commenced.

$4.08M
Estimated gross annual transfer and admission savings
(based on an average estimated cost of $1,000 for patient transfers to a Referral Hospital and $1,030 average cost for admitted ED presentations, Annualised)

Feedback

FROM PATIENT: The telehealth services facilitated in Hillston (which I believe were being tested for implementation over the last few months) have been absolutely fantastic and the staff in Hillston are feeling much more supported through this initiative.
ABOUT RARMS: A diverse and inclusive organisation. Open to different ideas of how to work. Doctors keen to have a go.
ABOUT RGPS GPs: Excellent communication and clinical skills.
ABOUT MLHD: Love having a dedicated service to provide medical support to sites without an on-call GP.

CASE STUDIES

SOCIAL DETERMINANTS OF HEALTH

THE COOEE INITIATIVE
RURAL & REMOTE COMMUNITY-LED HEALTHY FUTURES INITIATIVE

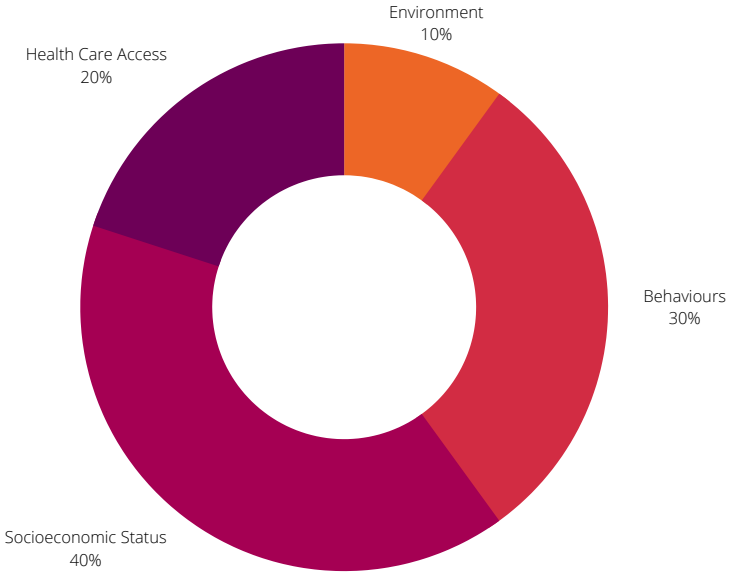
The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of resources between communities. The social determinants of health are the main cause of health inequality in Australia - the unfair and avoidable differences in health status in rural and remote communities.

The Robert Wood Johnson Foundation estimates that only 20 percent of health outcomes can be attributed to access to health and medical care. Upstream social determinants of health account for the other 80 percent, including socioeconomic factors (40 percent), environmental (10 percent), and behaviours (30 percent).

Research has shown that targeted interventions to address social determinants at a local level can significantly improve health outcomes in rural and remote communities, reduce preventable illness and reduce the economic burden of increasing hospital and aged care costs resulting from higher levels of chronic disease.

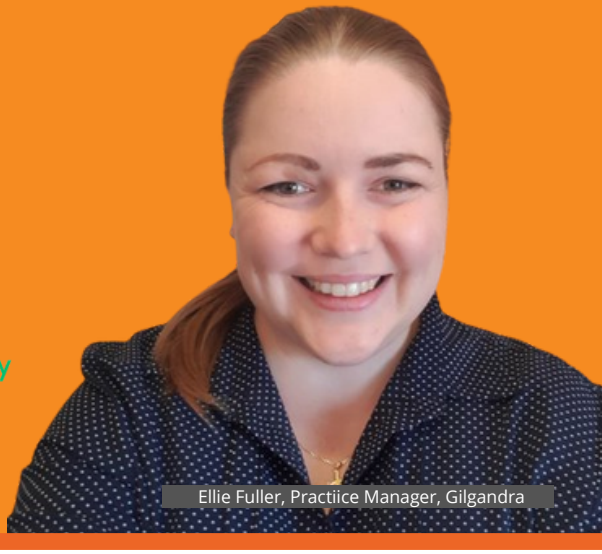
For example, people with poor health literacy are between 1.5 and 3 times more likely to experience an adverse health outcome; walking 30 minutes a day reduces the burden of disease by 26 percent according to the Australian Institute of Health and Welfare; quitting smoking before 40 years of age will reduce the risk of dying of a smoking related illness by 90 percent after 10 years.

Improving health and well-being requires engagement by the health and human services system at a community and individual level. Successful programs engage local communities in planning for their own health futures encouraging improved health literacy, greater community awareness of the causes of poor health and better coordination of existing resources and services. Community Health Partnerships bring together the community with local health and human service providers to improve the targeting of issues, jointly improve access to services and provide continuity of care for people in their community.



A key barrier to effective community and individual engagement is the lack access to clear and easy to understand information and data to define local problems and opportunities. Communities also need help to develop place-based solutions and grow local health leadership capacity.

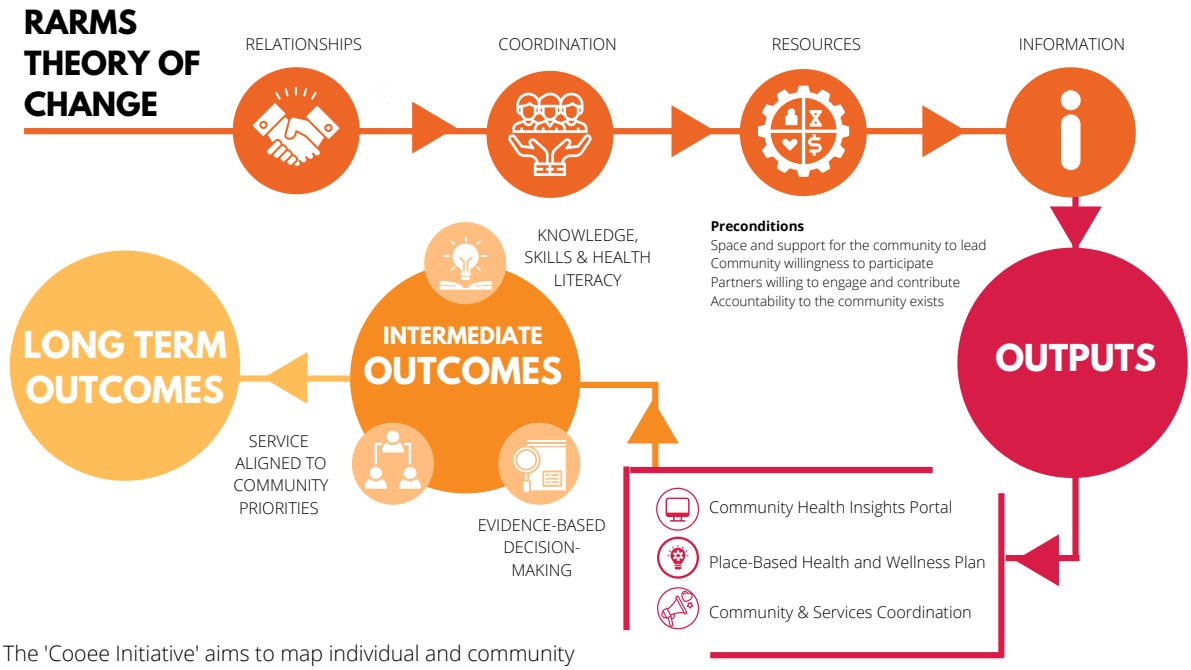
In 2019/20 RARMS funded the Cooee Initiative to trial a model to support community-led place-based health planning in three vulnerable rural and remote communities in NSW.



Theories of change describe how interventions can bring about long-term improvements in community and individual health through a logical sequence of intermediate outcomes. They are used to design and measure the impact of public health programs through monitoring and evaluation.

Underpinning RARMS Theory of Change is a number of assumptions:

- While rural and remote communities share common health characteristics, each community is unique in terms of its voice, culture, history, experiences and decision making processes
- All communities are equal and their unique voices deserve to be heard
- Individuals can change with the right information, skills and support
- Systems and institutions can become more responsive to communities by developing a common language and shared aims.



The 'Cooee Initiative' aims to map individual and community health through a stepped process:

1. Develop and implement a new approach to patient history taking to capture baseline information on social determinants and to track changes over time resulting from interventions.
2. Use de-identified data to populate a public insight portal that will provide the community with insight into their shared challenges and opportunities.
3. Engage community, government, NGOs and community organisations to develop a Place-Based Health Plan in response to insights.
4. Measure the impact of interventions in a way that demonstrate value.

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HEALTHCARE PARTNERSHIPS


Dr Joe McGirr, Member for Wagga Wagga and Mark Burdack, CEO of RARMS

Keeping Rural and Remote Hospitals Open

RARMS partners with the Western NSW Local Health District and Hunter New England Local Health District to supply GP VMO services into rural and remote hospitals to keep local hospitals and emergency departments open and accessible to local communities.

Improving the Management of Chronic Disease in Rural and Remote Towns

RARMS delivers the Chronic Disease Management Prevention Program (CDMPP) which funds nursing support in rural and remote communities to improve the management of chronic disease patients.

Expanding Rural & Remote Allied Health Services

RARMS has partnered with PhyzX 2U and the University of Sydney to deliver an integrated GP/Allied Health mobile service model engaging final year students from the University of Sydney in providing supervised services to RARMS chronic disease patients under a GP care plan arrangement.

Enabling Rural & Remote Clinical & Medical Training

RARMS is working with a number of University partners to expand clinical training opportunities for medical, nursing and allied health students in rural and remote practices to grow the next generation of rural health professionals.

Delivering Rural & Remote Specialist Access

RARMS partners with Access Telehealth to provide improved access to Medical Specialist services for our rural, remote and Indigenous patients and Nursing Home residents from within their own local community.

Expanding Rural and Remote Participation in Clinical Trials

RARMS has partnered with Monash University, The Menzies Institute for Medical Research at the University of Tasmania, the University of Newcastle and Curtin University of Technology in the *Statins in Reducing Events in the Elderly (Staree)* placebo controlled clinical trial. The trial will enable rural, remote and Indigenous patients to contribute to our understanding of whether statin therapy should be taken routinely by healthy rural, remote and Indigenous people aged over 70 years.

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EVIDENCE-LED INNOVATION


Bourke Medical Centre

Rural and Remote Medical Services Ltd has built a wealth of knowledge about how to deliver sustainable, cost-effective and quality healthcare to rural, remote and Indigenous communities over 20 years and attract rural GPs, nurses and health workers to the bush. RARMS staff work and live in rural and remote communities giving them a deep understanding of what works, what doesn't and why in rural health and workforce policy.

In 2019/20 RARMS has continued to work to share our knowledge and expertise by collaborating with our communities, research institutes, universities and government departments. This supports RARMS aim to improve our professional practice and aims to assist researchers and policy makers to deliver workable solutions for better rural and remote health care.

HIGHLIGHTS

menzies school of health research

RARMS is working with the Menzies Schoiol of Rural Health on a project titled "Improving access to primary health care and reducing hospitalisations by optimising Telehealth for remote and rural Australians." There is limited research on the impact of Telehealth on the quality and safety of care in rural and remote communities, or rural health ecosystems. The project will systematically examine factors relating to the appropriate use of Telehealth in remote and rural areas from both consumer and provider perspectives, and account for systemic issues such as models of care.

THE UNIVERSITY OF SYDNEY

RARMS has partnered with the University of Sydney and PhzX2U to develop and evaluate a new model of integrated GP and allied health care in rural and remote communities. The model will bring together the expertise of RARMS and PhyzX in improving access to health services using an integrated direct and telehealth model of care.

ANU
THE AUSTRALIAN NATIONAL UNIVERSITY

RARMS has partnered with the Rural Clinical School at The Australian National University to undertake a study into the "role of GP VMOs in patient safety, satisfaction and quality outcomes for patients who are treated by their preferred GP in a hospital or emergency setting". This project aims to expand our understanding of the impact of on-site VMOs in rural and remote communities on health care improvements.

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ANNUAL RURAL & REMOTE HEALTHCARE SURVEY


Christine Letton, Practice Nurse, Warren

One of RARMS founding principles is that communities have within themselves the knowledge, commitment and capacity to address their own health and wellbeing challenges and opportunities. Part of our role is to help give a voice to rural, remote and Indigenous communities and support them to understand the issues, develop their own plans and advocate for their rights. The Annual Rural and Remote Community Healthcare Survey 2020 is designed to hear directly from rural, remote and Indigenous people and patients about their health needs and preferences. A summary of the first 2020 Survey results is set out below.

87.3%
Patients prefer to receive healthcare from a GP

54.7%
Positive or Very Positive about Use of Telehealth

8.8%
Prefer to receive healthcare in a hospital

Western NSW

29.0%
Aboriginal and Torres Strait Islander Respondents

40.5%
Assessed health as poor or average.

88.4%
Prefer to receive healthcare from a GP

8.7%
Prefer to receive healthcare from a Hospital

33.3%
Downloaded COVID-19 App

43.5%
Receive health information through TV

Hunter New England NSW

14.0%
Aboriginal and Torres Strait Islander Respondents

27.2%
Assessed health as poor or average.

87.1%
Prefer to receive healthcare from a GP

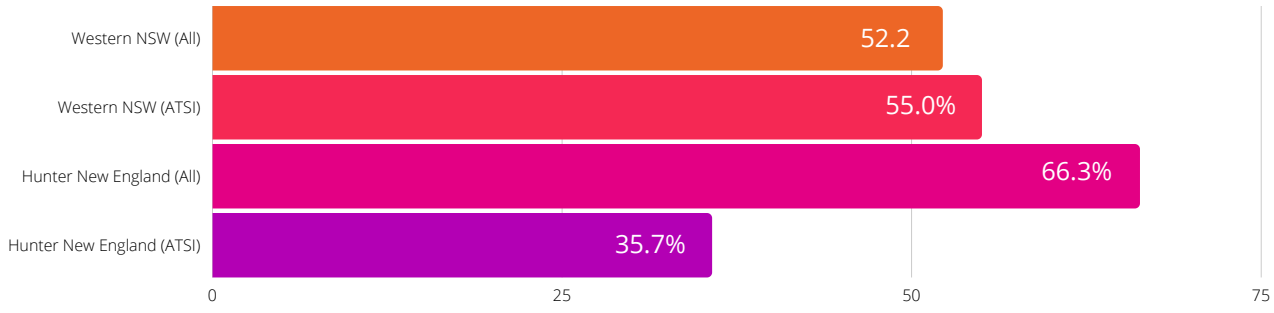
8.9%
Prefer to receive healthcare from a Hospital

37.6%
Downloaded COVID-19 App

59.4%
Receive health information through TV

Views about Government COVID Response by Region

While rural and remote people were marginally more positive than not about the Government's COVID Response, positive views lagged behind the national average in all regions except the Hunter New England.



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FINANCIAL PERFORMANCE


Marg Thompson, Practice Nurse, Bourke

RARMS has delivered rural and remote health and medical care on-site in rural, remote and Indigenous communities for 20 years. This has been achieved through careful management of its retained funds.

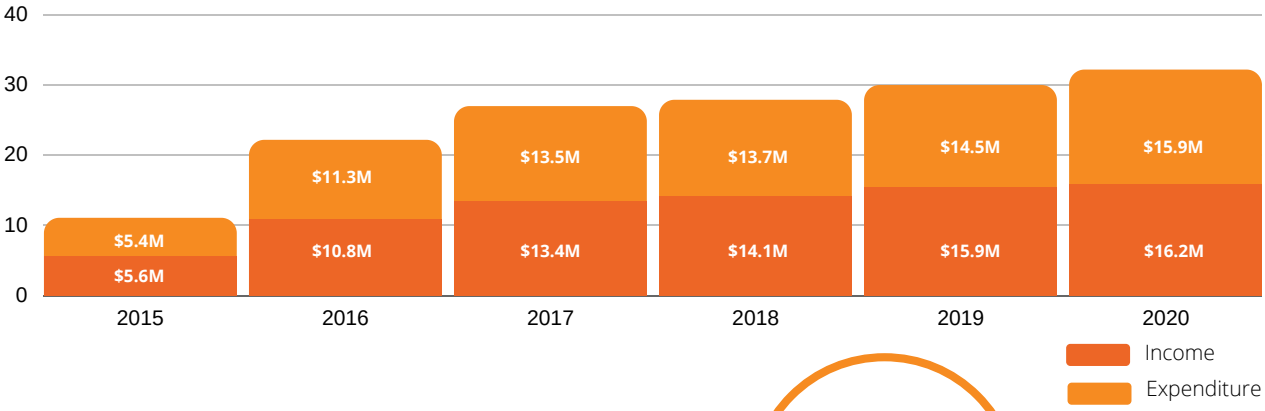
When RARMS has access to permanent medical workforce we retain any surplus we make in order to sustain health and medical services in rural and remote communities in periods of workforce shortage. This model has saved the Commonwealth and State governments millions of dollars over the last 20 years while ensuring primary care is accessible and hospitals remain open 24/7, 365 days a year.

RARMS uses the fund to ensure continuity of care during short-term vacancies in our permanent medical workforce, offer enhanced benefits to recruit and retain rural GPs (such as extended annual and study leave), support community health initiatives to improve health outcomes and to advocate for the health interests of our communities. This is why RARMS has an unmatched level of success in recruiting and retaining rural GPs compared to other providers.

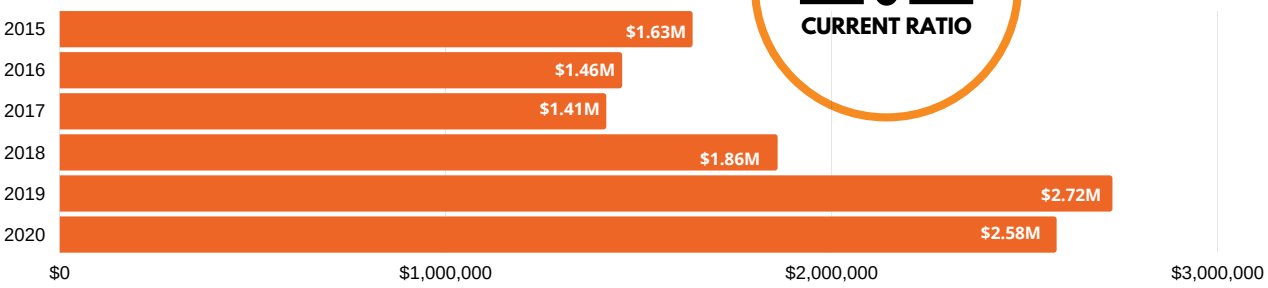
Over the last 5 years the Board of RARMS has implemented a strategy to grow its retained funds reflecting sharp increases in rural GP shortages due to the failure of policies to deliver an increase in rural medical workforce supply and the resultant increase in Locum and recruitment costs. This strategy has unfortunately been shown to be prudent as Locum costs have doubled in some cases over the last 24 months requiring RARMS to rely further on its retained funds to maintain health and medical care and keep our hospitals open.

While the 2019/20 result is lower than 2018/19, it was nonetheless a pleasing result taking into account the significant disruption and expense caused by COVID-19. The results were impacted by a significant increase in costs for Personal Protective Equipment (PPE) supplies for our staff and patients, an expansion of support for vulnerable patients who were self-isolating so that they could maintain access to regular care, adding a 1800 number to reduce cost barriers to accessing health services and online bookings for patients on prepaid mobiles. The Federal Government's JobKeeper initiative and incentives program during COVID-19 were an important support during this period.

Income & Expenditure



Retained Funds



2.2
CURRENT RATIO

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RARMS HEALTH

STORIES OF US

Goodooga residents

KEEPING OUR COMMUNITIES WELL

Self-isolation has played a critical role in keeping Indigenous Elders and remote communities safe during the COVID-19 pandemic.

But self-isolation has flow-on consequences - how to ensure people continue to have access to essential supplies like food, medicines and toilet paper.

This was the challenge confronting the small Indigenous community of Goodooga located around 20km from the Queensland border in outback NSW.

Three-quarters of the residents of Goodooga are Indigenous. If COVID-19 spread into this community it would have a serious impact on a town that experiences very high rates of chronic disease.

Reducing unnecessary travel to larger centres was a key strategy to minimise the risk of transmitting the infection into the community. But this meant reducing travel to the nearest large centre of Lightning Ridge for shopping.

While organising shopping is not a typical role for a local GP practice in the cities, in this case an apple a day was needed to keep COVID away.

The Manager of the RARMS practice in Lightning Ridge, Helen Evans, and her staff called on the local community for help.

RARMS talked to Khan's Supa IGA, the local supermarket operator, which agreed to set up a special ordering system for Goodooga residents to shop online.

But not everyone in Goodooga had access to a computer or device to access online ordering so we worked with Roslyn Forrester from the Goodooga Primary School to organise access for locals to put in orders.

Now the only issue was getting the orders to Goodooga, a two hour round trip through northern NSW's desert landscape. The Lightning Ridge Bowls Club immediately volunteered to drive the shopping to Goodooga, with pick ups organised 15 mins apart to maintain social distancing.

Rural general practice plays a critical, but often overlooked, role in rural and remote communities. RARMS doctors and staff are members of their local community, and they know that good health care is not just about treating an illness, but working with the community to support wellness.

Bingara Junior Netball Club

ADDRESSING THE SOCIAL DETERMINANTS

Primary care is about supporting our communities to stay well, not just caring for them when they are sick.

Research shows that people with a low level of health literacy, for example, are between 1.5 and 3 times more likely to have an adverse health outcome [1].

We know from research that an increased level of physical activity is strongly linked to a decrease in lifelong burden of disease.

According to the Australian Institute of Health and Welfare, taking a brisk walk for just 15 minutes for 5 days a week reduces the lifetime burden of disease by 14 percent, while a 30 minute brisk walk will decrease the lifetime risk by 26 percent [2].

RARMS is committed to engaging our communities in health and wellness programs such as community sporting and movement activities.

Because our GPs and staff live in rural and remote communities, RARMS is better able to identify key initiatives that will have a sustained impact on rural and remote wellness.

Some of the examples of our work in 2019/20 include:

- We launched a new video targeted to our communities on the Social Determinants of Health to improve community understanding about how individual behaviours can significantly influence the burden of disease, and some actions communities and individuals can take to address this;
- Supported a range of sporting and physical activity initiatives, including the Bingara Junior Netball Club.
- Supported the Lightning Ridge Breakfast Program recognising the importance of good nutrition in the First 2000 Days of Life to long term health outcomes.

Good health is not just about access to health care or individual behaviour. Communities play a key role in creating an environment that promotes better health literacy and improved health outcomes. RARMS is proud to provide economic and in-kind support to help our communities stay well.

[1] Joanne Protheroe *et al* "Health literacy: a necessity for increasing participation in health care" *British Journal of General Practice* 2009 Oct 1; 59(567): 721–723.
[2] AIHW, *Australia's Health 2018* at https://www.aihw.gov.au/reports/australias-health/australias-health-2018/contents/burden-of-disease-scenario-modelling/insufficient-physical-activity.
[3] Medicare, *ZTZhe Cost of Physical Inactivity (2008) at $13.8 billion.*

Councillor Tiffany Galvin from Gwydir Shire Council at the Bingara Medical Centre

PARTNERING WITH COMMUNITIES

RARMS was formed through a partnership between rural GPs and local governments that were struggling to attract and retain local doctors.

This partnership is the backbone of RARMS's success over 20 years in delivering GP and Hospital care in rural and remote communities 24 hours a day, 7 days a week and 365 days a year.

As a charity, RARMS relies on the support of local government in particular to provide access to low-cost local community medical facilities.

During 2019/20 RARMS received generous support from the following local councils:

- Bourke Shire Council
- Brewarrina Shire Council
- Gwydir Shire Council
- Gilgandra Shire Council
- Warren Shire Council

Being a member of our local communities is the key point of differentiation between RARMS and other health services. Our staff live and work in our communities, giving them a strong interest in making sure that our communities have the best health services they can deliver.

For example, during the COVID-19 pandemic RARMS asked our local communities for help to install Protection Screens at Community Medical Centres to increase protection for our staff and patients. Gwydir Shire Council stepped up immediately to fund the installation of screens in Bingara.

The Gwydir Shire Council also allocated $230,000 to fund renovations to expand the Community Medical Centre in Warialda.

A community advocacy campaign saw the installation of automatic doors in Bingara to make it easier for frail and disabled patients to access our practice.

These are some of the many examples of how working with our local communities delivers better health services and outcomes.


William Beech Resident

DELIVERING CARE WHERE IT IS NEEDED

Older Australians are among our most vulnerable people, and they deserve the best care possible. The Productivity Commission has found that a majority of older Australians prefer to 'age in place' in their own homes, and supporting them to do so requires a greater provision of flexible models of rural and remote GP services

A survey on Aged Care Services undertaken by the AMA however found that rural GPs were typically not paid for many of the services they provide including locating patients, filling in scripts and paperwork, talking to relatives, renewing scripts over the phone, and phone calls to staff while back in their surgery.

The underfunding of aged care support has contributed to a shortages of rural GPs able to treat residents in aged care homes and at-home.

To address this crisis, RARMS developed the Virtual Aged Care Service.

in Condobolin when a GP shortage left residents unable to see GPs face-to-face.

The Virtual Aged Care Services was deployed to support 23 residential aged care residents.

A telehealth supported model of care maintained essential access to face-to-face GP services, avoiding the need to send elderly residents to the local emergency department (reducing hospital and transport costs).

Dr Freddy Chafota is the Clinical Lead for the Virtual Aged Care Service. He said: "It was a very fulfilling experience for me as a clinician. With the help of the local nursing staff, I was able to review the residents via video, provide the medical management required, update the clinical notes in an electronic health record and provide an encounter summary back to the resident's usual GP."

According to Sam Georgy, Service Director, Video Call, Healthdirect Australia: "This primary healthcare-led collaborative solution can be applied in many different healthcare settings to support communities with limited access to face-to-face services".

GROWING THE RURAL HEALTH WORKFORCE

Australia has a chronic geographic maldistribution of doctors.

Remote communities have access to 83 GP Full-Time Equivalent (FTE) Doctors per 100,000 people, compared to 121 per 100,000 in major cities. Rural communities have just 101 GP FTE per 100,000.

This is despite the fact that rural and remote people have substantially higher rates of chronic disease and avoidable hospitalisation, and higher needs for access to local GP care.

RARMS engages some of Australia's most dedicated and expert rural and remote GPs as members of our Clinical Team to address the inequitable distribution of workforce across Australia.

Dr Patrick Giltrap at the Gilgandra Medical Centre is fast approaching his 40th year of providing primary care to communities across rural and remote NSW. Dr Dianne Coote and Dr Clem Gordon at the Warialda Medical Centre celebrated 30 years of service in 2019/20.

As senior Fellowed clinicians these doctors not only deliver life-saving care to their communities, but also play a key role in growing the next generation of rural general practitioners and health professionals by supervising Registrars and supporting Interns and students to gain clinical experience in a supportive rural and remote practice environment.

During 2019/20 RARMS signed an Agreement with the Australian National University's Rural Clinical School to collaborate in research, education and training.

This complements agreements with Monash University, University of Newcastle and the University of Sydney for placement of nursing and allied health students.

RARMS is working with the new Charles Sturt University Medical School to provide longitudinal training placement for their new medical students in our practices in rural and remote communities.

This is an important step in providing more rural health and medical students with a positive experience of rural and remote practice, and to create a lifelong learning pathway for graduates to a producitive and successful rural career.

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THANK-YOU

Since its founding in 2001, Rural and Remote Medical Services Ltd has relied on its supporters to help us deliver high-quality, GP-led, independent health and medical services to rural, remote and Indigenous communities. These individuals, corporations, foundations, governments and other organisations share our belief in the power of better health to change lives and communities. Individual contributions of unrestricted gifts, no matter how small, and in-kind contributions strengthen and sustain RARMS and have immense collective impact in helping us to advance our work. Funding flexibility allows RARMS to be proactive in the face of a changing health and policy landscape, enabling us to respond quickly to community needs while also pursuing our longer-term goals that are not completely funded by other income.

Memberships

Organisation

Staff

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GOVERNANCE

The Board of Rural & Remote Medical Services is committed to strong, ethical and effective governance to ensure the long-term sustainability of on-the-ground health and medical services for rural, remote and Indigenous communities.

The Board is comprised of directors selected on the basis of their skills, qualifications and experience, and their commitment to advancing the improvement of primary and hospital health services for the benefit of disadvantaged rural, remote and Indigenous communities.

Key Outcome Areas

1. New strategic planning framework approved and implemented.
2. New 2020-21 Strategy approved and implemented.
3. New Governance Charter approved.
4. Board committees reformed to align with new Charter and Strategy to ensure appropriate focus on oversight of core governance responsibilities.
5. New Delegations and Authorisations Policy approved, and new delegations schedules, to ensure staff were empowered to manage the business in alignment with the Strategy with clear accountabilities back to the Board.
6. New Financial Reporting systems implemented incorporating a financial forecasting capability and enhanced financial oversight of key initiatives.
7. New Budget approved reflecting long-term outlook for health workforce and increasing patient needs.
8. Skills Matrix updated and new Directors, Dr Ian Opperman and Dr Kim Webber, appointed to bring strategy, digital health and data skills to support RARMS focus on community-led, place based planning and technology supported service delivery.
9. Clinical Governance Committee reviewed and expanded membership including additional nursing and medical experience to the oversight of clinical performance and enhance clinical learning.

We support THE ULURU STATEMENT

In June 2020 the Board of Rural & Remote Medical Services Ltd was proud to join with our management to endorse the Uluru Statement from the Heart.

The delivery of improved health outcomes in Indigenous communities relies on trust between patients and practitioner, patients and practice.

RARMS recognises that there remains a deep wound flowing from the dispossession of the sovereign rights of Indigenous Australians to their lands, water and country.

The Board and management of RARMS are committed to contributing to the best of our ability to address this historic wrong and create a new platform of trust that is essential to our work and the future health of our communities.

OUR BOARD

RICHARD ANICICH AM BCom LLB FAICD
Chair, Board
Chair, Executive Committee
Conjoint Professor, School of Law, University of Newcastle
Consultant Sparke Helmore Lawyers
Chair, Committee for the Hunter
Chair, Hunter Primary Care

PROFESSOR AMANDA BARNARD BMed (Hons) FRACGP
Deputy Chair, Board
Deputy Chair, Executive Committee
Deputy Chair, Clinical Governance Committee
Dean, Rural Clinical School, Australian National University

DR IAN OPPERMANN MBA(Lon) PhD (Syd) FIEEE FIEAust FTSE FACS GAICD
Chair, Audit and Risk Committee
NSW Chief Data Scientist, NSW Customer Service
Chief Executive Officer, NSW Data Analytics Centre
Former Director, Digital Productivity and Services Flagship, CSIRO

DR KIM WEBBER PhD (Medicine) (Monash)
Member, Audit & Risk Committee
Executive Lead, Strategy, Co-Health
Senior Fellow (Hon), University of Melbourne
Former Special Advisor, Commonwealth Department of Health
Foirmer GM, Strategy, Australian Digital Health Agency
Former, CEO Rural Health Workforce Agency
Former CEO, National Rural Health Alliance
Director, Health Equity Research and Development Unit

DR KEN MACKEY AM MBBS (UNSW) Dip Obst (RCOG) FACRRM FAICD
Chair, Clinical Governance Committee
Rural General Practitioner
Former President, Rural Doctors Association of Australia

TIM HORAN Dip App Policing Dip OHS Adv Dip Bus
Member, Nominations & Governance Committee
Director, Bila Muuji
Wellington Aboriginal Health Service
Former CEO, Coonamble Aboriginal Medical Service

RETIRED

JAN NEWLAND M.Clin Epi. BA. GAICD
Former Chair, Audit and Risk Committee
Former CEO, GP NSW
Former Chair Advisory Committee, Centre for Primary Health and Equity
Former Member, Practice Committee, Cancer Institute NSW

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STRATEGIC LEADERSHIP


Temeka, Receptionist, Bourke

SHANE HATTON
CHIEF EXECUTIVE OFFICER
(to September 2019)

MARK BURDACK
BA BLegS (Hon) (Macq) FGIA GAICD
CHIEF EXECUTIVE OFFICER
Adjunct Senior Lecturer, La Trobe University School of Rural Health
(from September 2019)

MELANIE FREEMAN
BFinAdmin (UNE)
GROUP MANAGER, ORGANISATIONAL PERFORMANCE & SUSTAINABILITY

BIANCA WILSON
BNursing (Newcastle) RN
GROUP MANAGER, RARMS HEALTH

CROYDON DOWLEY
BFinAdmin (UNE) CA
GROUP MANAGER, FINANCIAL STRATEGY & SUSTAINABILITY

TRACY HAIG DHRM
DBus DMM
GROUP MANAGER, MEDICAL WORKFORCE & TELEHEALTH SOLUTIONS

TEGAN CATTLE
BBus (HRM)
GROUP MANAGER, PEOPLE & CULTURE


Lightning Ridge Medical Centre

Australian General Practice Practice Accreditation Limited (AGPAL) is the premier general practice accreditation agency. AGPAL undertakes assessments to ensure general practices operate in accordance with the requirements of governing industry standards set by the Royal Australian College of General Practitioners (RACGP). All of RARMS' general practices are accredited by AGPAL as meeting the high standards of quality required of medical and health services in Australia.

DONATE

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 remote patients (compared to a national average of 4.9)

-65.0%

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

244

Number of doctors, nurses and staff engaged with RARMS.

$2.85M

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