New South Wales

Special Commission of Inquiry into Healthcare Funding

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Murrumbidgee Local Health District submission to the NSW Special Commission of Inquiry into healthcare funding

The Murrumbidgee Local Health District (MLHD) welcomes the opportunity to provide a submission to the Special Commission of Inquiry into Healthcare Funding in New South Wales. The District's contribution aims to assist the Commissioner in the inquiry in relation to Section A, Section B, and Section F of the Special Commission Letters Patent.

This submission should be read in conjunction with the Murrumbidgee Local Health District Board Submission.

INTRODUCTION

The impetus for this submission is to highlight the evolving nature of healthcare, the changing demands of the health workforce and the changes to society which are leading to a new era of rural healthcare. Future healthcare models and services can be aligned to address the health needs of the community, strengthen the rural health workforce, and utilise the considerable health resources in a more sustainable way.

Previous generations of rural people relied on the accessibility of local family general practitioners (GPs) and local hospitals to provide all encompassing health care, from birth to death. There was an understanding that good services were those that were provided locally. From the 1970s, accessibility has changed drastically with medical specialisation and defined evidenced-based clinical pathways. Until the recent introduction of rural generalism, rural medicine has not been well defined as a distinct field and as a result, the number of rural GPs has rapidly declined.

The 47 facilities, including 33 hospitals operated by the MLHD, are historically arranged in a 1950-60s medical model, and the advancing health delivery paradigm has created gaps, with few new models of care emerging that fulfil expectations. The District provides services to rural, regional and remote communities who often rely on outreach services from larger centres, district hospitals and multi-purpose services.

The MLHD covers 125,243 square kilometres in southern NSW and services a population of almost 250,000. 9% of the population live in areas of high socioeconomic disadvantage and many of our communities experience lower levels of education, health literacy and household income. In comparison to state averages, MLHD has a significantly higher rate of hospitalisation for all causes and potentially preventable causes. Our communities have increased incidence of chronic illness, lower rates of private health coverage, and subsequently, a higher demand on the public health system.

The MLHD has a relatively high proportion of Aboriginal and Torres Strait Islander residents compared to NSW. Aboriginal people make up 5.9% of the MLHD population compared to 3.4% of NSW. 9% of the Aboriginal population are aged 65+ years, compared to 23% non-Aboriginal population.

With 38.3% of New South Wales population living in regional areas, the distribution of healthcare funding must also consider the statistically poorer health outcomes, the vast distances required to travel, the increased complexity of models of care and the larger population of Aboriginal and Torres Strait Islander people in these communities (Australian Bureau Statistics, 2023).

Section A. *The funding of health services provided in NSW and how the funding can most effectively support the safe delivery of high quality, timely, equitable and accessible patient-centred care and health services to the people of NSW, now and into the future.*

There are two important influences on health service needs: population, and age demographics. Population is about quantum of health services; age demographics is about type of health services. In regional areas external shocks, such as bushfires, droughts, and floods are an additional factor impacting community resilience and health needs.

As of June 2022, the MLHD had a usual resident population of 249,164; 19.2% of the population is aged under 15 years and 21.5% is aged 65 years or older. The MLHD population has increased by more than 1,000 people aged 65 years and older each year since the 2016 Census.

Key Fact: There is a projected increase of 8,000 people aged 75+ years from 2021 to 2031.

The population projection to 2041, shows increases in the cities of Wagga Wagga and Griffith, their satellite towns, and in the border communities. In the remaining local government areas, there is limited population growth or decline .

Ageing populations influence the health system in multiple ways. These include increased use of health services and hospitals by older age groups, whose health service requirements are more complex due to high levels of multi-morbidity. Disability is also an important issue related to ageing which requires health system resources, in combination with other social support measures.

The configuration of healthcare services within MLHD could be realigned from historical geographic locations to a population health needs model. The data shows that a high proportion of our region's healthcare needs are primary care based. With 16.6% of adults are diagnosed with diabetes, 36% with high cholesterol, 31% with high blood pressure and 24% of children are assessed as developmentally vulnerable in one or more domains in their first year of school; these incidences indicate that the key health requirement in our communities is primary care. In addition, the Murrumbidgee population has a higher prevalence of many lifestyle-associated risk factors than NSW (NSW Health, 2023).

The current hospital-centred models of care are disease-focussed and do not provide access to early intervention or preventative strategies. To address the healthcare disparities and to provide healthcare matched to health needs, it is imperative that healthcare shifts towards an integrated approach that combines hospital care with primary and secondary health services (Clarke et al., 2017).

Moving to integrated service models, creates a comprehensive healthcare system and a continuum of care, allowing for better management of chronic conditions, implementation of preventive measures, and early intervention.

By placing greater emphasis on multi-disciplinary integrated healthcare models, as opposed to fragmented episodic in-hospital care, communities can access essential services closer to home. This

model also reduces the demand on larger hospitals, offers a more effective use of health resources and delivers a more holistic, patient-centred approach to healthcare. This transition enhances healthcare quality and boosts the overall health and well-being of regional populations, bridging the historic inequalities in healthcare access and addressing specific needs more effectively (Starfield, Shi & Macinko, 2005).

While it is not feasible for rural towns to provide highly specialised services, partnerships and well-established clinical pathways and the use of virtual care between larger, tertiary facilities and specialised services can create an effective and sustainable healthcare ecosystem. (Australian Commission on Safety and Quality in Healthcare, 2018). With the use of linked clinical networks, rural communities can have increased access to specialised expertise and diagnostics. Such partnerships also facilitate ongoing knowledge exchange, training opportunities and the development of standardised protocols which enable continuous improvement and shared expertise (Australian Government, Department of Health, 2021). These collaborative efforts not only enhance patient care but also create a cohesive healthcare system that is better equipped to address the diverse and evolving healthcare needs of a population spread across both metropolitan and regional areas.

Multi-disciplinary integrated community centres could be established with a diversion of current resources. They would include collaborative multi-disciplinary teams, including doctors, nurses, social workers, and allied health professionals, creating a rural-specific discipline of healthcare using a holistic approach to patient care. This would not only improve health outcomes but will enhance patient satisfaction and overall well-being (Taberna et al., 2020).

Strategy 1: *By shifting the emphasis from reactive hospital-based care to proactive, community-based care, multi-disciplinary community health services are instrumental in improving healthcare accessibility, reducing pressure on the hospital system... and is responsive to the evolving needs of the population.*

Section B: *The existing governance and accountability structure of NSW Health, including:*

ii. the engagement and involvement of local communities in health service development and delivery;

In regional areas, community engagement plays an important role in strengthening relationships with local health services, improving health literacy among the community and building community resilience.

The MLHD Community Engagement Strategy priorities the engagement and involvement of local communities in health service development and delivery.

Communities are not just recipients of healthcare but are also invaluable stakeholders who possess a unique understanding of the specific health needs and the socio-cultural dynamics within their community. Our governance arrangements empower true community engagement; the MLHD's 33 Local Health Advisory Committees (LHACs) are paramount in configuring local services that align with health needs of the local community.

The MLHD draws information from the community through the LHACs who work together with their local hospital and/or health service sites. Each Committee comprises up to seven community representatives (inclusive of a staff representative) who discuss local issues, provide feedback on District-wide service planning and relay information to and from the wider community on health service activities. The LHACs, along with facility managers, are invited to participate twice yearly in a Community Forum. Concerns and comments from their communities have a transparent escalation pathway from the local LHAC to the MLHD Chief Executive and Board every month.

LHACs' primary function is to provide a vital and ongoing mechanism for community engagement in local health service planning, priority setting and the evaluation of strategic and service planning processes. Additionally, LHACs play a vital role in health promotion and ensuring communities are aware of health services available to them.

For example, in response to a concerning spike in youth suicide, an LHAC designed and developed a silicon wrist band which has a QR Code, allowing the user to visit associated mental health help and wellbeing websites. The LHAC worked with local High Schools and the local media to distribute these wrist bands to local school children in Years 7 and Year 8.

This collaborative relationships with communities results in innovative solutions, improved accessibility and creative problem-solving, leading to more cost-effective healthcare delivery. By actively involving community residents in the decision-making process, health services can be tailored to address the most pressing concerns and priorities, fostering a sense of trust and collaboration with our communities.

Strategy 2: *Health District governance arrangements should commit LHDs to actively involve communities in ongoing engagement, priority-setting and in the governance of their own local health services.*

Section F: *The current capacity and capability of the NSW Health workforce to meet the current needs of patients and staff, and its sustainability to meet future demands and deliver efficient, equitable and effective health services, including:*

i. the distribution of health workers in NSW;

iii. evaluating financial and non-financial factors impacting on the retention and attraction of staff;

Health-related workforce shortages are nationally apparent; and can be due to the demand on the healthcare system from an ageing population, an increase in chronic disease burden, challenging work environments and fatigue and burnout (Bahlman-van Ooijen et al., 2022). The workforce shortage in rural areas is compounded by a maldistribution of experienced healthcare workers, particularly nurses, medical and allied health professionals. This imbalance not only hinders access to healthcare services, but also places undue pressure on the existing healthcare workforce.

Resolving this maldistribution and meeting the demand for healthcare workers in regionals areas will not be solved by increasing the supply of healthcare workers. It requires the implementation of new training pathways and workforce pipelines that equip health workers with the required skills and knowledge for working in regional areas and the recognition of the associated costs of premium labour.

60% of MLHD's current nursing and midwifery workforce vacancies exist in small rural and remote regions. Sites and services are heavily reliant on premium labour to maintain service continuity; significantly increasing the operational costs associated with delivering health services and increasing competition amongst employers throughout the state. The recent implementation of financial incentives above the current award entitlements, under NSW Health's Rural Health Workforce Incentive Scheme, aims to stabilise the supply of health workers in rural areas while acknowledging the challenges of attracting and retaining a skilled workforce.

Financial incentives are only part of the solution to address workforce shortages in rural areas. While financial incentives may attract healthcare professionals to rural settings in the short term, they often fail to provide a sustainable, long-term solution. Other strategies must address the challenges of rural practice, such as professional isolation, distance from family, limited development opportunities and workloads.

Addressing this problem comprehensively, requires a holistic approach that not only includes financial incentives but also focuses on developing team-based multi-disciplinary models of care, providing career opportunities that allow health professionals to utilise their full scope of practice and creating a supportive and educational environment for healthcare workers to thrive.

Establishing robust workforce pipelines for rural health workers is imperative to addressing the longstanding healthcare disparities faced by rural communities. These pipelines must be designed to identify, train, and retain healthcare professionals specifically for rural settings (Murray & Craig, 2023). Investments in health workforce development must be aligned with identified gaps in service delivery and skill shortages.

The MLHD has had limited success with targeted recruitment strategies aimed at attracting people from cities or other states and countries. Our true success has been in our 'grow our own' strategies, collaborating with educational institutions to identify prospective healthcare students from rural backgrounds, and offering scholarships or incentives to encourage them to pursue careers in healthcare.

This longer-term strategy needs to be accelerated and scaled to deliver results. Our education and training programs are tailored to the unique challenges and needs of rural healthcare, including exposure to rural practice settings through clinical rotations. They promote rural generalism medicine for nursing and allied health professionals as well as doctors delivering primary and hospital care in rural settings.

An example of a successful MLHD strategy is the Murrumbidgee Single Employer Model, aimed to attract, train, retain, and support rural generalist doctors who work in the local health district.

The District has been successful in attracting early career nurses to the region. Traditionally, new graduate nurses are not placed in small rural hospitals, where there may be limited support after hours. To overcome this, MLHD has implemented Virtual Nurse Assist (VNA) to deliver high - quality care to patients or residents by harnessing virtual care technology to assist frontline nursing staff to build their confidence and capability. This model provides 24-hour clinical advice, support and education to the frontline nurse and is unique as it is a 'nurse to nurse' support framework.

By nurturing and supporting individuals throughout their educational and professional journeys, workforce pipelines can help ensure a consistent and dedicated supply of healthcare professionals committed to delivering quality care in rural areas, ultimately improving health outcomes for the population they serve (Russel et al., 2021).

Strategy 3: *Strengthen the rural health workforce by aligning training and education with projected health needs and through end-to-end training pathways delivered in rural LHDs by rural education providers, for the rural workforce.*

Murrumbidgee Single Employer Model

The Murrumbidgee Single Employer Model has been developed to attract, train, retain, and support rural generalist doctors who work in the local health district.

This four-year pilot project with the Australian Government began in 2021. This pathway, developed in collaboration with the UNSW Regional Training Hub, provides a rural workforce model where GP trainees receive support and certainty during their training. Trainees know where they'll work, how much they'll earn, and their working conditions.

The pathway, now expanded to 80 places across NSW, focuses on supporting GP trainees to develop the advanced rural generalist skills needed to support our rural hospitals.

The Murrumbidgee Model not only sets a new direction for our state, but for the entire country. We have transformed the Rural Generalist Training Pathway in our nation.

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Acknowledging our Aboriginal communities

MLHD acknowledges the Traditional Custodians of the lands across our footprint, traditional lands of the Wiradjuri, Wamba Wamba / Wemba Wemba, Perrepa Perrepa, Yorta Yorta, Nari Nari and Muthi Muthi nations. We recognise their continuing connection to lands, waters and communities. We pay respect to Elders past, present and emerging.

References:

Australian Bureau Statistics. (2023). *Regional Population Growth, Australia.* https://www.abs.gov.au/statistics/people/population/regional-population/latest- release#new-south-wales

Australian Commission on Safety and Quality in Healthcare. (2018). *Review of key attributes of high-performing person-centred healthcare organisations.* Australian Commission on Safety and Quality in Healthcare: Sydney.

Australian Government Department of Health. (2021). *National medical workforce strategy: investing in our medical workforce to meet Australia's health needs.* Australian Government: Canberra.

Calder, R., Dunkin, R., ROCHFORD, c. & Nichols, T. (2019). *Australian Health Services: too complex to navigate A review of the national reviews of Australia's health service arrangements*. The Australian Health Policy Collaboration, Victoria University./sites/default/files/australian-health-services-too-complex-to-navigate.pdf

Clarke. J., Bourn. S., Skouufalos, A., Beck. E. & Castillo, D. (2017). An Innovative Approach to Health Care Delivery for Patients with Chronic Conditions. *Population Health Management, 20*(1). doi: 10.1089/pop.2016.0076

Cosgrave, C., Malatzky, C., & Gillespie, J. (2019). Social Determinants of Rural Health Workforce Retention: A Scoping Review. International Journal of Environmental Research and Public Health, 16(3). doi: 10.3390/ijerph16030314. PMID: 30678350; PMCID: PMC6388117.

Holman, H. (2020). The relation of chronic disease epidemic to the health care crisis. *American College of Rheumatology, 2*(3). doi: 10.1002/acr2.11114

Murray, R. & Craig, H. (2023). A sufficient pipeline of doctors for rural communities is vital for Australia's overall medical workforce. *Medical Journal of Australia, 219*(3). doi: 10.5694/mja2.52022

New South Wales Health. (2023). *MLHD at a glance: population health indicator data 2023.* Murrumbidgee Local Health District: Wagga Wagga. http://www.mlhd.health.nsw.gov.au/about-us/population-data-and-health-statistics

Russell, D., Mathew, S., Fitts, M., Liddle, Z., Murakami-Gold, L., Campbell, N., Ramjan, M., Zhao, Y., Hines, S., Humphreys, J. & Wakerman, J. (2021). Interventions for health workforce retention in rural and remote areas: a systematic review. Human Resources for Health 19(103). 103 (2021). doi: https://doi.org/10.1186/s12960-021-00643-7

Starfield, B., Shi, L. & Macinko, J. (2005). Contribution of primary care to health systems and health. *Milbank Quarterly, 83*(3). doi: 10.1111/j.1468-0009.2005.00409.x

Swami M. & Scott A. (2021). Impact of rural workforce incentives on access to GP services in underserved areas: Evidence from a natural experiment. National Library of Medicine, 281. doi: 10.1016/j.socscimed.2021.114045.

Taberna, M., Moncayo, F., Jane-Salas, E., Antonio, M., Arribas, L., Vilajosana, E., Torres, E. & Mesia, R. (2020). The Multidisciplinary team approach and quality of care. *Frontiers in oncology, 10*(85). doi: 10.3389/fonc.2020.00085

Wilson, N., Cooper, I., Vries, E., Reid, S., Fish, T. & Marais, B. (2009). A critical review ofinterventions to redress the inequitable distribution of healthcare professionals to rural and remote areas. *Rural and Remote Health, 9*(1060).

World Health Organisation. (2010). *Increasing Access to Health Workers in Remote and Rural Areas Through Improved Retention: Global Policy Recommendations*. National Library of Medicine. https://www.ncbi.nlm.nih.gov/books/NBK138626/