New South Wales

Special Commission of Inquiry into Healthcare Funding

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Dear Mr Beasley QC

Submission to the Special Commission of Inquiry into Healthcare Funding

Background

Three of the authors come from the Australian Centre for Health Law Research (ACHLR). ACHLR is a specialist research Centre within the Queensland University of Technology's Faculty of Law. ACHLR undertakes empirical, theoretical, and doctrinal research into complex problems and emerging challenges in the field of health law, ethics, technology, governance and public policy. ACHLR has research strengths in the governance and regulation of health care and a commitment to pursue transdisciplinary research into real world problems. The fourth author is a rural sociologist who is a member of QUT's Centre for Justice: a think tank for social justice that aims to empower and enable citizens, consumers, and communities through solutions-oriented research.

Introduction

Several important contextual issues underpin the examination of the *effective* and *equitable* funding of health care services in New South Wales (NSW), noting the aim of supporting 'the safe delivery of high quality, timely, equitable and accessible patient-centred care and health services.' First, is the relevance of a human rights-based framework utilising development, implementation and monitoring to effect authentic improvement, especially given the existence of the right to the highest attainable standard of health in international instruments ('the right to health').[1] Second, the importance of justice and equity when considering resource allocation decisions. This submission particularly focuses on regional, rural, and remote New South Wales, as areas where the recent Legislative Council report has demonstrated that residents of regional, rural, and remote places in New South Wales have both poorer health outcomes and "inferior access to health and hospital services" compared to their metropolitan counterparts (Legislative Council 2022, ix). The significant challenges facing the provision of health care services in regional, rural and remote areas (exacerbated by current funding and workforce

[1] See, for example: Art. 25 UDHR; Art. 12 ICESCR; Art. 5(e)(iv) CERD; Art. 11 (1) (f), 12 and 14 (2) (b) CEDAW; Art. 24 CRC; Art 28, 43(e) and 45(c) CPRM; Art 25 CRPD. Acknowledging that not all Australian States and Territories, including New South Wales, have a right to health in their domestic legislation.

models) is not unknown, including a shortage of health and allied health practitioners and the need to travel long distances (noting additional issues of public transport availability in rural and remote areas) to access health care services (Legislative Council, 2022; Nous Group, 2023).[2] However, real change to improve service delivery is not occurring and until it does the aim of delivering high quality, timely, equitable and accessible patient-centred care and health services will fail, particularly for people located outside metropolitan and inner regional areas. In this context, we also highlight the impact on older people who live in regional, rural, and remote areas and who are particularly disadvantaged by current models.

Given this, the following **submissions** emerge from the below discussion:

1. The need to adopt a human rights-based model to the provision (including funding) of health care services promoting a person-centric distinct from economically based paradigm.

2. The need to fund evidence-based research into the (lack of) accessibility and affordability of health care services for people in rural and remote locations, including the lived experiences of people and family/friends/carers, to engage in the development of real systemic change for the betterment of health care service delivery and outcomes in these areas.

3. The need to change governance models to enable participatory democracy, especially in the context of the provision of services in regional, rural and remote areas of New South Wales.

Human Rights-Based Framework

The use of human rights-based dialogue in health care settings is increasing. In addition to the right to health, non-discrimination (including ageism) and equality (Baer et al., 2016), other relevant rights include, for example, the right to freedom from torture, violence and abuse (*ICCPR* articles 7 and 9); dignity and privacy (*ICCPR* article 17); life (*ICCPR* Article 6); freedom of movement (that is, restraint) (*ICCPR* article 12); autonomy, legal capacity, and access to justice, including to redress (*ICCPR* article 26); and participation (UN General Assembly, 1991; Kornfled-Matte, 2017). This helps focus attention on people who may not be, or are at risk of not being, able to access affordable quality health care (Baer et al, 2016), giving rise to issues of the *cost* of care but also its *accessibility* and *quality* in a person-centric approach. Ageing 'well' throughout the life course is predicated upon ready access to quality 'health' and the interrelated issue of financial security (Staudinger et al, 2016). It is also connected to environmental, familial, and social influences (Beard, Officer & Cassels, 2016; European Network of National Human Rights Institutions, 2017). As people age there will therefore be an increasing need for accessible and affordable public, as well as private, systems of health care, including a larger and better educated and trained workforce. The right to health supports this (Baer et al., 2016).[3]

[2] See, for example, a recent report by commissioned by the National Rural Health Alliance undertaken by Nous Group consultancy (2023) noted that there is a significant disparity between those situated in metropolitan and rural areas with rural residents experiencing a poorer health status including in terms of funding, access and outcomes (<https://www.ruralhealth.org.au/document/evidence-base-additional-investment-rural-health-australia>).

[3] See also, for example: Art. 25 UDHR; Art. 12 ICESCR; Art. 5(e)(iv) CERD; Art. 11 (1) (f), 12 and 14 (2) (b) CEDAW; Art. 24 CRC; Art 28, 43(e) and 45(c) CPRM; Art 25 CRPD.

Integral to the practical implementation of the right to health are the workforce and available facilities, which should incorporate human rights-based, ethical principles that are culturally appropriate and gender-responsive, noting that older women in particular face barriers to accessing affordable and quality health care (Baer et al., 2016). The progressive realisation principle is also relevant (WHO, 2015; Baer et al. 2016). That is, States should devote their maximum available resources to aim to meet the right to health. A fundamental design element is facilitating the participation of end users in systemic design, development, implementation, assessment and accountability, and improvement (Simpson & McDonald 2017; McDonald & Malatzky, 2023; WHO, 2015). Participation also being reflective of a human rights-based and person-centric approach to health care distinct from an economically driven one (noting that a human rights-based model incorporates recognition of relevant legal and equitable obligations and available remedial relief) (European Network of National Human Rights Institutions, 2017, 15-6). Any future systemic or policy response should also recognise (including through appropriate funding) that health care systems are currently focused on acute health conditions rather than chronic conditions. This is particularly of concern for the rights of older people or persons with a lower-socioeconomic background who are required to leave their homes, often travelling significant distances, to receive treatment because of a lack of workforce and/or facilities available locally (Simpson & McDonald, 2017).

As McDonald & Malatzky (2023) have noted that values and assumptions underlie public policy and require assessment (Sharpe 2004). From a sociological perspective, public policies are products of social institutions that must be perceived as acceptable and fair to be considered legitimate (Johnson, Dowd, and Ridgeway 2006; Woo, Ramesh, and Howlett 2017). Gilson (2003) argues that health systems - and, by extension, decisions about health funding - contribute to the (re)production of wider societal values, norms, and established social orders. An inquiry into Canada's health system noted a comment by a person who participated in community consultation, Jose Amaujaq Kusugak, stated:

> I believe that … the success of our Health Care System as a whole will be judged not by the quality or service available in the best of urban facilities, but by the quality of service Canada can provide to its remote and northern communities (*Romanow 2002,* 165).

This comment has equal application to NSW.

Regional, Rural and Remote Considerations

There is a shortage of skilled health and allied health professionals in regional but especially rural and remote areas that must be addressed, including through the provision of adequate funding. There are also limited services, the combination of which can negatively impact the provision of timely, quality health care services (Legislative Council, 2022; Nous Consulting). Treatment can consequently require coordination across not only health and allied health care professionals and settings but also geographical locations (especially where treatment requires relocation to another, larger treatment centre resulting in travel and accommodation costs not well understood in metropolitan areas) (WHO, 2015; Simpson & McDonald 2017). The Hunter New England Local Health District, for example, covers a region of 131,785km² which is bigger than England (at approx. 130,000km²). If a person needs emergency care in, for example, Glen Innes in Northern NSW, they are triaged at the local hospital (where there is no doctor on staff) and then relocated to wherever a bed is available in the Local Health District given their care needs, for example Armidale (approximately a 1 hour drive away), Tamworth (approximately a 2½ hour drive away) or Newcastle (approximately a 5½ hour drive away).

The coordination, and consequently quality of treatment, can therefore weaken with the patient (and/or their family) forced to carry the burden of understanding, effectively communicating and actioning treatment plans and associated information, often in stressful or emergency situations (WHO, 2015; Legislative Council 2022). There is also generally no notification to the next of kin if a person is being transferred or where to, noting this can be anywhere in the Local Health District subject to bed availability. Systemic and communication breakdowns can unintentionally result in people experiencing complications in treatment programs that can affect their ability to access affordable quality health care in a timely manner (WHO, 2015). The existence of discipline silos and lack of effective communication, especially where people are required to seek emergency treatment in a larger hospital away from their general practitioner (if they can access one given the difficulties with attracting general practitioners to rural and remote areas), also needs to be addressed noting that this can result in unnecessary and invasive interventions and polypharmacy, misdiagnosis or the need for treatment being missed altogether (Legislative Council, 2022; Nous Group 2023; WHO, 2015).

This is an especially pertinent point in the context of older people who may experience limited mobility, problems that can be exacerbated by the limited transportation infrastructure that can exist in regional, rural and remote areas of NSW, noting that frequently significant distances have to be covered by patients and or family members/friends in order to access health care and support their loved one, let alone *quality* health care (Legislative Council, 2022; Simpson & McDonald, 2017). When a person is forced to leave their place of residence, their home, they are leaving a familiar environment that is conducive to positive health outcomes, at least arguably more so than being removed to an unfamiliar and potentially intimidating environment in which to seek health care (in addition to the stress caused by the medical condition itself) (Simpson & McDonald, 2017). Removing a person from their familiar surroundings, frequently without their support people and systems (when, for example, an emergency occurs and the ill person is taken to another hospital in a larger centre but the family will not be made aware of the patient's location), can cause anxiety and stress, negatively impacting the person's health (Lewis, Purser & Mackie, 2020; WHO, 2015). There are also practical implications of this for people from rural and remote centres in particular, for example, who does the person's washing if family members cannot travel to visit the person in need of care in hospital? Who buys additional food if they are hungry? Who sits by their side to spend time with them given they are unwell and away from their familiar environment and support networks? All practical outcomes of the need to travel to access health care services felt by rural and remote Australians that can have a negative impact on the person's dignity and health outcomes.

When considering the best allocation of funding to support high quality and timely patient-centred care, the use of assistive technologies is an important and nuanced consideration, but also one automatically touted as a solution to the geographical challenges presented by the size of NSW. While benefits undoubtedly exist, it is also necessary to be cognisant that an inappropriate reliance on such technologies could instead result in unintentional harm, for example, through isolating people or adopting patronising or demeaning practices (related to age, rurality etc). The issue with accessibility, especially in rural and remote areas, is also important in the context of not only availability and affordability of appropriate devices but also the internet. It is therefore suggested that more evidence-based data critically examining how technologies can be utilised effectively is needed.

Health workforce

Health services cannot be delivered without appropriately qualified and trained personnel. Ensuring the supply and continuity of health providers is a critical consideration in relation to how health service provision is funded in NSW (McDonald & Malatzky, 2023). This is particularly the case for rural NSW where ongoing issues of maldistribution and poor retention are disproportionately affecting rural residents, and contributing to health disadvantage based on place location (Malatzky & Couch, 2023).

The maldistribution of the health workforce remains a serious issue for the health and wellbeing of those living outside of metropolitan centres. More needs to be done across the pipeline to change the distribution pattern so more health professionals, including allied health practitioners, are located outside of metropolitan centres. Much attention has been given to the attraction of staff at the supply end - getting people into health professions, and providing some rural training pathways, and much of the conversation is dominated by the issue of student placements. While these are important dimensions of attraction to consider, greater attention needs to be given to training a broader range of health professionals for rural practice and importantly, to how governments can support rural communities and health organisations to attract health professionals who are a good fit for their communities (Attract Connect Stay Project Team, 2023); that is, a focus throughout the pipeline. This is more than just ensuring a greater number of students from rural communities enter health professions, it is also about how we train health professionals in mainstream contexts, and the strategies we employ to retain health professionals in rural places. Again, there has been a narrow focus here. Financial incentives do not necessarily lead health professionals to stay rural in the medium to long term. There is a need to focus on issues such as career advancement, the organisation of rural health services, and how communities can be actively involved in the attraction and retention of health professionals who are a good fit for their towns (Cosgrave et al., 2019). A key area of wastage are costs associated with high staff turnover, which emphasises the need to invest in strategies that engage with the latest research on rural health workforce retention.

Current funding arrangements do not adequately consider important differences between place context and how rurality adversely affects access to care for those in NSW. Equality, that is applying ‘the same’ across the board, does not equal equity (Berman & Paradies, 2010) – where everyone has access to the resources needed for good health. Given the ageing population concentrated in rural areas, coupled with higher rates of chronic disease, disability and injury, demand is often high in rural communities, but workforce shortages mean that much of this demand – people’s health care needs - goes unmet (Australian Institute of Health and Welfare, 2021a, 2021b, 2022; Dintino et al., 2019). It is important for resources to be allocated in ways that enable rural health care needs to be addressed, and this may look different to the status quo, designed in and by those in metropolitan settings. For example, promising innovations for improving health outcomes include the nurse-led ‘Teen Clinic’ model of integrated primary care, which has improved young people's access to care in rural NSW communities (Dalton et al., 2023), and the development of what are being termed post-professional roles in allied health which again have been found to be an effective, value for money solution to providing client-centred care to those with complex health and social care needs and avoiding hospital admissions (Moran et al., 2019). These examples illustrate an important shift in focus to what skills and capacities are needed to meet health and social care need, rather than which particular professional group should offer it.

Governance

As McDonald and Malatzky (2023) have noted, local health districts in New South Wales are notionally designed to enable the needs of residents to be assessed by local districts. However,

the operations and priorities of these districts remain implicitly regulated by the State and Federal governments through contracts, policy, and other directives. These levels of governance undermine and inhibit the development of truly local governance and reinforce what Pesut, Bottorff, and Robinson (2011, 6) describe as a perception of "decision-making by strangers, at a distance." To remedy this divide, the Legislative Council report (2022) recommends 'genuine consultation' and an acceptance that metropolitan areas are 'fundamentally different' from rural places (s. 7.56). The NSW government accepts this recommendation (NSW Government Response – Inquiry into health outcomes and access to health and hospital services in rural, regional, and remote New South Wales – Health 2022) (NSW Response). This recommendation for consultation is now included in priority 4.2 of the NSW Regional Health Strategic Plan 2022-2032 by including local communities in the 'design of services and sustainable local health service development'. The NSW Regional Health Strategic Plan 2022-2032 also incorporates the specific challenges of rural places with a priority strategy – this appears to support an acceptance that metropolitan centre health systems have different issues from the rural health system.

The literature on health system reform discusses the benefits and deficits of centralised versus decentralised models of health system governance (Sreeramareddy and Sathyanarayana 2019). However, in countries like Australia, this is usually at the level of central versus regional. In the main, more devolved mechanisms for health system governance at the local level are ignored (Simpson and McDonald, 2017). When these are discussed, for example, with respect to Indigenous managed health services (metro or non-metro), ongoing practices of colonialisation often silence or undermine comprehensive accounts centring on Indigenous perspectives—on what local governance can and should look like. This has implications, noted in part in the NSW Report (Legislative Council, 2022), for the provision of culturally (un)safe care and (dis)empowerment of local decision-makers. The NSW Report (Legislative Council, 2022) highlighted the impact of the hub and spoke model on regional, rural, and remote services. It was found that hubs (usually a regional centre) can be far removed from the concerns of people in smaller rural and remote places (those living nearer to the spokes) in their districts (s7.4), which enables the broader system and policymakers to effectively ignore these concerns. However, if NSW accepts recommendation 44 of the NSW report (2022, 7.71) to follow South Australia's Health in All Policies approach - that the 'health of people in New South Wales is central to government decision making' including rural communities - then hopefully, there will be less ability to ignore the concerns of rural areas.

The NSW Report (2022) discusses governance in terms of consultation with local communities and expresses uncertainty about whether this is done well (s. 7.4). However, in its broadest sense, justice includes participatory democracy, the belief that citizens and communities should be given opportunities to participate, more broadly than through consultation, in the governance of systems and structures that are important to them (Simpson and McDonald 2017). Although NSW has agreed with recommendation 42 and 43 of the NSW Report in the NSW Regional Health Strategic Plan 2022-2032 to improve community consultation and has stated in Strategic Priority 4.2 an aim to co-design health services - it is nevertheless difficult to ascertain the level of participatory democracy that will eventuate from such community involvement.

In the health context, the enterprise of a universal public health system builds on the value of solidarity. Citizens within a nation–state pool and re-distribute taxpayer funds to support each other to access the resources needed for health, including access to health services, and achieve broadly congruent health outcomes (Prainsack and Buyx 2015). This sense of solidarity and

trust in the system can be undermined if a segment of the population does not benefit in an equitable way compared to others (Simpson and McDonald 2017). According to Tenbensel and Silwal (2023; also see, Wu, Howlett and Ramesh 2015), for a 'network governance' health system to optimally function, there needs to be 'operational capacity' through effective 'management of collaborative processes' at the meso level (organisational level) (Tenbensel and Silwal 2023, 50, 51, 53). Once a strong 'operational capacity' is established, this creates a 'positive feedback loop' with 'political capacity' and 'analytical capacity' and ultimately further strengthens 'operational capacity' (Tenbensel and Silwal 2023, 53, 54, 56). That is, collaborative community engagement ('operational capacity') 'based on trust' with rural Local Health Districts (LHDs) and their community is the precursor to strong 'political capacity' which in turn will strengthen the 'pooling of information and analytical expertise' ('analytical capacity') and this will further support meaningful rural involvement ('operational capacity') – this should result in optimal 'policy capacity' for the rural health system (Tenbensel and Silwal 2023, 49, 51, 53, 54). Based on this reasoning, rural participatory democracy rather than mere rural consultation, is critical to the success of the rural health system.

One remedy is citizen engagement, in both metro and non-metro contexts. However, this may be even more relevant in regional, rural, and remote contexts where health services may be seen, by some, as central to the continuance and maintenance of their community (Simpson and McDonald 2017; Barnett and Barnett 2003). Also, citizen engagement may serve a functional end: to challenge metrocentric norms in health service design and delivery and develop systems that are more adaptive to local conditions and better meet local needs. However, community committee participants should be sufficiently informed to engage in meaningful discussions to effect change. A complaint in NSW, noted in the Strengthening of Local Health Committees in Regional NSW Report (2023, 7), is that, in addition to insufficient funding, community committees unable to comprehend the 'workings of the health system has been a difficulty'. Although the Strengthening of Local Health Committees in Regional NSW Report (2023, 8) provides an extensive list of factors that will make committees 'flourish', committee members need to understand the health system or be supported in understanding the health system. The Strengthening of Local Health Committees in Regional NSW Report (2023) states that, in addition to:

> those who bring a consumer perspective to local health committees, there is a significant proportion of members who have professional experience in the health system. Members who possess a combination of health system knowledge and community identify help to build the capabilities of local health committees (2023,5).

Supported community engagement comprising of a mix of health workforce participants and local committee participants should be a key to meaningful collaboration and ultimately, rural health progress.

It also serves a democratic end - to maximise citizen engagement in governance, which also supports the enactment of values such as solidarity and furthers human rights. Further, citizen engagement addresses the aspect of realizing justice that relates to accountability. The capacity for both prospective and retrospective accountability is enhanced by broadening the role of public participation in local health service governance (Sharpe 2004). As Sharpe (2004, 14) notes, "prospective responsibility is oriented to the deliberative and practical processes involved in setting and meeting goals." The NSW Report (Legislative Council, 2022) recommendation 38 considers 'realistic, measurable and quantifiable goals in terms of tangible

health outcomes' are required for rural health. These goals are included in the NSW Regional Health Strategic Plan 2022-2032. However, the extent that goals will stem from communities themselves is yet unknown. Thus, rural residents and communities need access to their own data to scrutinize the operations of local health services and discuss and contest the values underpinning service design as well as the pragmatics of opportunities/constraints in-place. In accordance with this view, the NSW Report (Legislative Council 2022) recommendation 42, considers communities require further data published including 'minimum service standards' for their health district. The NSW Response (2022) '[s]upported' this recommendation. This is also reflected in the NSW Regional Health Strategic Plan 2022-2032 – Strategic Priority 4.5.

Some mechanisms to increase citizen engagement suggested in the NSW Report (2022) include greater use of local engagement committees (Recommendation 42), and place-based needs assessments undertaken with input from communities (Recommendation 43). The NSW Response (2022) has '[s]upported' recommendation 42 and '[s]upported in principle' recommendation 43 in the NSW Report (Legislative Council, 2022) – to address community involvement with Local Health Advisory Committees and Consumer, Community Consultation and to develop 'Place-Based Health Needs Assessments and Local Health Plans' to 'ascertain local community needs and variations'. The NSW Regional Health Strategic Plan 2022-2032 – Strategic Priority 4.2 and Strategic Priority 5.4 reflects the NSW's Response (2022) to recommendations 42 and 43 of the NSW Report (2022). Other possibilities could include greater devolution of responsibilities to communities, but only when those communities are willing and have the capacity to undertake this responsibility (Barnett and Barnett 2003).

As noted by Simpson and McDonald (2017), 'not all rural communities are the same' – there are variations in the level of community engagement across rural health districts. A recent study in New Zealand has highlighted variations in rural areas (see Tenbensel and Silwal 2023). In New Zealand, to 'facilitate health system improvement at the local system level', in 2016 the New Zealand Ministry for Health established The Systems Level Measures Framework (SLMF) (Tenbensel and Silwal 2023, 50). Tenbensel and Silwal (2023) studied 'three divergent local cases of implementation of the SLMF' (Tenbensel and Silwal 2023, 49). In order 'for a network governance to take off', Tenbensel and Silwal (2023) found that:

> [s]pecific initiatives planted to foster network governance (e.g., mandated networks) usually fail to thrive where local histories and institutional practices are not supportive (2023, 60).

Tenbensel and Silwal (2003) note that:

> the key challenge, for both research and practice, is understanding what is necessary at the local level to stimulate the policy capacity necessary for network governance where it is relatively absent (2023, 60).

As noted earlier, Tenbensel and Silwal (2003, 51), highlighted the importance of 'collaborative processes' as a key factor to the success of a network governance structure. Accordingly, in rural areas where there is weak community engagement, arguably greater support and duration of time will need to be given in such rural health areas before meaningful collaboration may be attained (also see, Johnston et al, 2021).

Several obstacles are associated with realizing such a vision and are evident in the NSW Report (Legislative Council, 2022). One is the tension between the potential for local health systems governance and the purported need to ensure the maintenance of quality standards across the system (urban and regional/rural/remote) as a whole. Inherently, however, standards are imbued with societal norms, often urban-centric, which stifle place-conscious innovation (Simpson and McDonald, 2017). The privileging of metrocentric knowledge and viewpoints within health systems and policy means that innovations driven from rural places, by rural knowledge and experiences, for rural places are difficult to progress and realize (Roberts and Green 2013). Given the recruitment and retention issues discussed extensively in the NSW Report (Legislative Council, 2022) and the literature more generally (Cosgrave, 2020; World Health Organization, 2021), such innovations are critical to improving access to rural health services and the health outcomes of people living outside of metropolitan places.

A qualitative study by Johnston et al (2021, 1,6) in rural British Columbia, supports that successful rural health systems need autonomy – decisions that 'did not require the blessing of a hierarchical, top-down system'. Insufficient autonomy impedes rural health innovation. Additionally, Johnston et al (2021, 6) also found that 'good relationships between providers, health authority administration, external specialist services and community members' were important for sustainable rural health. And lastly, for successful rural health systems, there needs to be a willingness to respond and 'adapt' to changes in rural areas to 'continue to deliver effective health services' (Johnston et al, 2021, 7). In view of these study findings, a placed-based focus for rural health fostering autonomy, a collaborative culture and an understanding of the rural health district is likely to yield a more successful system of rural health than a metrocentric approach. These findings are similar to the findings of Tenbensel and Silwal (2003).

To support local rural health involvement, government transparency and accountability, there are multiple bodies to consult with/report to/oversee the progression of the rural health system (see generally, NSW Report (Legislative Council, 2022) and the NSW Regional Health Strategic Plan 2022-2032). In addition to the Minister for Rural Health, rural and remote LHDs and LHDs Advisory Committees, there is also a Regional Health Advisory Panel; a Regional Health Division; a Regional Health Committee; and a Regional Health Plan Steering Committee (see generally, NSW Report (Legislative Council, 2022) and the NSW Regional Health Strategic Plan 2022-2032). While the NSW Report (Legislative Council, 2022, s7.52) recommends greater transparency and accountability within the rural health system, it is difficult to yet ascertain the extent that this governance structure with numerous bodies will support rural place innovation that stems from the rural place itself. Concurrently, the true devolution of local governance in a neoliberal state is restricted by the choices of governments to under-resource local levels with the expectation that individuals and communities will fill the gaps left by state and federal government disengagement (Simpson and McDonald 2017). For example, the NSW Report (2022) raises concerns about the reliance on charity and community organisations to provide support and services (2.77). In the rural context, this sense that the community will be willing and able to fill the gaps may draw strength from the common stereotyping of the "rural idyll" and the construction of rural communities as self-reliant, self-sufficient, stoic, and resourceful (Malatzky and Bourke 2016; Simpson and McDonald 2017). This stereotype both shapes and justifies some of the assumptions underlying governance decisions affecting regional, rural, and remote health service design and delivery.

State resistance to local governance of health services by regional, rural, and remote communities may also stem from—and be justified by—stereotypes, common in highly

urbanized Australia, that rural residents are inferior to those in metropolitan areas (Malatzky and Bourke 2016; Malatzky and Bourke 2018; Simpson and McDonald 2017). Here, urbanised spaces are constructed as "… progressive, where things happen and where diversity, excitement and innovation operate" (Malatzky and Bourke 2016, 161). Rural places, on the other hand, are often characterized as static or backwards looking. Further, rural health practice is popularly constructed as where health professionals who fail at urban practice go (Malatzky and Bourke 2016; Simpson and McDonald 2017). These dominant negative discourses centred on rurality and rural health support work are used to justify the metrocentric assumption that there is a lack of capacity for good governance within rural communities. This is despite examples of flourishing rural health (Barnett and Barnett 2003) and social enterprises and businesses in some, but not all rural places, indicating motivation and capacity. Simpson and McDonald (2017) argue this stereotyping has substantial implications for justice and, as such, there is a moral imperative to deconstruct its impact on the practices of health system governance. Any such stereotyping also has the potential to undermine human rights and threaten the legitimacy of the system.

Thank you for the opportunity to contribute to this Project. We would be pleased to assist the Commission further if additional information is required.

Yours sincerely

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