New South Wales

Special Commission of Inquiry into Healthcare Funding

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SUBMISSION TO SPECIAL COMMISSION OF INQUIRY INTO HEALTHCARE FUNDING

Maari Ma Health Aboriginal Corporation is an Aboriginal community controlled regional health service based in Broken Hill providing quality primary health care services and community programs to Aboriginal people in Broken Hill and the communities of Wilcannia, Menindee, Ivanhoe and Balranald. Our constitutional footprint covers the almost 200,000 sq.kms from the Queensland border to the Victorian border, and from the South Australian border eastwards as far as Ivanhoe. Maari Ma was established in 1995 as an outcome of the ATSIC-era Murdi Paaki Regional Council, the peak Aboriginal governance group of western and far west NSW, and retains close linkages with its successor, the Murdi Paaki Regional Assembly. We have an annual budget of $20million and employ more than 100 people, ⅔ of whom are Aboriginal making Maari Ma the largest employer of Aboriginal people in the far west.

Remote NSW's health profile is the worst in the state and presents unique health service delivery challenges. There is an urgent need for organisational change that ensures a greater focus on Remote NSW and promotes new ways of working in primary health care in the region.

We have defined Remote NSW as incorporating the Far West and North West regions of the state. For Aboriginal people the same area is known as the Murdi Paaki region and we will use this terminology in our submission.

This area covers over one-third of the landmass of NSW. But with under 50,000 people it has less than 1% of the NSW population. The Australian Bureau of Statistics has classified most of the area as Remote or Very Remote (the exception being the Broken Hill LGA and part of the Wentworth LGA). Around 15% of the area's population is Aboriginal, compared with about 3% in the State. This predominance is even more obvious in many of the LGAs, for example Brewarrina (61%), Central Darling (40%), Bourke (32%), Walgett (30%) and Coonamble (26%).

Living in remote areas is itself an independent health risk factor due to multiple factors including geographic isolation, cultural diversity, socioeconomic inequality, health inequality, resource inequity, and a full range of climatic conditions. However, because Aboriginal people make up a substantial proportion of Remote NSW, the overall poorer health status is more likely due to be a reflection of Aboriginal health issues and their social determinants.

Over the last 30 years, the administration of health services in remote/far west NSW has undergone serial changes approx. every 5-10 years:
Prior to 1995 – Orana District, managed out of Dubbo
1995 Far West Area Health Service, managed out of Broken Hill
2005 Greater Western Area Health Service, managed out of Dubbo
2011 Far West Local Health District (FWLHD), managed out of Broken Hill.

Each iteration had its strengths – knowledge and understanding of the unique challenges of service delivery in rural and remote NSW, management close to where the services are delivered - but each one has ongoing weaknesses which have never been, and cannot be, easy over ridden or ignored – that is, too small a population for safety and quality purposes.

History shows that the 'innovation' so often touted as being necessary to address the special needs of special populations is possible – it just takes guts and cooperation. Far west NSW has seen a number of successfully implemented 'innovations' in health service delivery:

1) From 1995 to 2012, a unique agreement existed between Maari Ma Health Aboriginal Corporation and Far West Area Health Service and then Greater Western Area Health Service whereby the mainstream health provider contracted Maari Ma to manage the mainstream services in the far west outside of Broken Hill (Tibooburra, Wilcannia, Menindee, Ivanhoe, Wentworth, Dareton and Balranald) on their behalf as a means of improving the delivery of health services to Aboriginal people.
2) In the 1990s, the Commonwealth ran Coordinated Care Trails (CCT) across Australia. Wilcannia was a CCT site which saw all available MBS and PBS funds cashed out on the basis of population and funds pooled for the benefit of the community with services purchased that were not otherwise available.
3) In the Commonwealth's transition over time from Divisions of General Practice to Medicare Locals to Primary Health Networks (PHN), the call for organisations to bid to become a PHN was successfully answered in the western and far west NSW by a consortium between existing practitioners with experience supporting general practice and Aboriginal community controlled organisations (Maari Ma and a consortium of separate ACCHOs called Bila Muuji) which had Aboriginal health front and centre for needs assessments and commissioning services in western NSW. Western Health Alliance Limited is the entity which won the Western NSW PHN contract and proceeded to implement a number of firsts for PHNs across Australia: an Aboriginal Health Council (alongside the standard Consumer Council and Clinical Council) and an Integrated Team Care contract, again awarded to an Aboriginal consortium, which chose a brokerage model designed by and for Aboriginal people on the basis of the failure of the previous ITC contract to provide sufficient services.
4) In the early days of FWAHS a formal partnership with Western Sydney Area Health Service/Westmead Hospital was established whereby specialist medical staff from Westmead (a general surgeon and anaesthetist) relocated to Broken Hill for one year to support the surgical and critical care roles of BHBH.

The Murdi Paaki region, or Remote NSW, remains a problem yet to be solved by service providers such as NSW Health.

Back in 2010, during the planning stage for the new LHDs, Maari Ma wrote to the then Minister for Health and flagged exactly these issues: the small population in remote NSW and the high proportion of Aboriginal people, eventually proposing:

> *"While we note the proposed Far West LHN includes the 'hospitals' in Tibooburra, Wilcannia, Menindee and Ivanhoe, these are in fact all primary health care facilities with an after hours accident and emergency capacity, with backup from the Royal Flying Doctor Service (based in Broken Hill) through aero-evacuations and medical consultations by telephone. Wilcannia also has 8 residential aged care beds, but no acute beds. As such we would seek to meet with you urgently to propose an alteration to the announced Far West LHN:*
> - *Broken Hill Base Hospital to immediately become part of a South Australian-based LHN. This would be entirely sensible and has been mooted and discussed several times over recent years, given Broken Hill's natural flows into South Australia's, and specifically Adelaide's tertiary facilities.*
> - *The management of the facilities in Tibooburra, Wilcannia, Menindee, and Ivanhoe remain under the management of Maari Ma. None of these facilities has acute beds and all*

have been successfully managed by Maari Ma on behalf of Far West, and subsequently, Greater Western Area Health Service for almost 15 years."

Our thinking on this has evolved somewhat and we would now propose that

- Broken Hill Base Hospital could reasonably be managed by one of the large Sydney-based LHDs with sufficient capacity to rotate the necessary expertise through to Broken Hill without metropolitan-based doctors having to permanently uproot; and
- The remote health services to be managed by Maari Ma or RFDS (or both, for example, RFDS managing acute GP services and Maari Ma managing community health/chronic disease GP services).

The focus on care in far west NSW needs to be primary health care: keeping people well and improving the management of chronic conditions. This has been the mantra for more than 30 years (not just in the far west but within NSW Health) where we know that more spent on preventative/primary health care reaps savings to the secondary and tertiary care sectors. We also know that the entire cost of the FWLHD would almost equal the admin budget of a large Sydney LHD. There would have to be significant cost benefits in adding Broken Hill Base Hospital into the hospital portfolio of Sydney LHD or similar.

Do we have any examples of why the system of LHDs, and FWLHD in particular, is currently a bit broken? We do.

The NSW Ministry of Health has an Environmental Health Branch with expertise in a range of issues including lead in the environment and its impact on human health, in particular children. FWLHD, back in 2011 was deemed to be too small to have its own Public Health Unit (PHU), responsible for managing public health issues such as lead from the environment impacting. So FWLHD and Western NSW LHD share a PHU, which is based in Dubbo with a few staff in Broken Hill.

Broken Hill is the largest lead-silver-zinc mine in Australia and has produced more wealth for this nation than any other mining operation. Broken Hill's children have elevated blood lead levels, with Aboriginal children in particular, more affected than the rest of the child population, largely due to the poor quality of available housing.

Has the PHU meaningfully shown itself to be able to manage or lead the child blood lead issue in Broken Hill? It has not. This public health issues is currently being managed by the State's environmental watchdog, the NSW EPA.

Similarly during the COVID outbreak in western NSW, due to the lack of existing NSW Health public health infrastructure to manage the outbreak, the LHD's PHU was reliant on the public health expertise within Maari Ma and the Broken Hill University Department of Rural Health. While the PHU in Dubbo had the official responsibility, they did not have the time or wherewithal to manage the Far West's outbreak, in addition to the outbreaks in Orana and Central West.

Another example? Sure.

Public health dental services have for more than a decade been a collaborative 'contract' between the FWLHD and its predecessors providing the bulk of the funding, the RFDS providing the dentists, and Maari Ma providing some token funding via our seat at the table advocating for Aboriginal people in Broken Hill and the small communities. However, due to mismanagement and small town politics, this successful arrangement broken down in September 2022 leaving NO dental services for

the communities of Wilcannia, Menindee, Ivanhoe and Tibooburra for more than 12 months. And the FWLHD's eventual solution was a new contract that ignored Maari Ma's previous role and proposed to halve the services to Broken Hill's Aboriginal population: lets hear it for building trust through partnerships (NSW Aboriginal Health Plan Strategic Direction #1), ensuring integrated planning and service delivery (Strategic Direction #3) and providing culturally safe work environments and health services (Strategic Direction #4) not to mention the Plan's underlying principles of

- The valuable and unique role of ACCHSs,
- The participation of Aboriginal people at all levels of health service delivery and management, and
- Partnership with Aboriginal communities through ACCHSs [and the AH&MRC].

Reiterating advice provided to the relatively recent (2022) Parliamentary Inquiry in to Rural and Regional Health:

Failing General Practice

(Why mention general practice in a NSW Health Inquiry? Because primary health care is important to keep the pressure off our tertiary services.)

General practice in small towns in the Murdi Paaki Region has now reached a critical point. Western NSW PHN projections show that 41 towns, and approximately a quarter of the population in that PHN region, are at risk of having no general practitioner in their communities over the next 10 years unless remedial action is taken now.

The recruitment and retention of GPs has become increasingly difficult due to a convergence of individual, workplace and health system factors. Also, the recruitment of GP Registrars has become increasingly hard for many of the same reasons.

As a consequence, general practice has become increasingly reliant on locums and incurs substantial costs in their employment, reducing funds available for other key practice developments (e.g. improved systems and staff to support chronic disease prevention and management).

This high turnover of GPs is also having a negative impact on the continuity of primary care, especially for patients with chronic and complex conditions. This is particularly an issue in remote health care where there are increasingly fragmented services and without a regular GP, who has a good knowledge of both the patient's medical issues and the referral pathways available, many patients experience undue difficulties in accessing services. Poor continuity of care also particularly affects Aboriginal patients, many of whom are anxious in unfamiliar clinical situations and with unfamiliar practitioners, who respond best to trusted longer term relationships. As a service we constantly worry about the undoubted missed diagnoses and opportunities for preventive care which are occurring because services are forced to rely on staff who can only offer short term placements.

The region's practices have had to rely on overseas trained doctors, and less on locally trained doctors. Many of the overseas trained doctors require substantial support to adjust to new cultural contexts and often stay only until they meet registration requirements. However, even overseas trained doctor opportunities have dried up due to the pandemic restricting travel.

For private practices that rely on patient billing income to remain viable, the scale of the population served; its socio-economic profile; the absence of mixed billing and the proclivity of episodic care-related rebates has meant that there is insufficient revenue to adequately support the practices. Furthermore, the need for private general practice to remain financially viable in a tight fiscal environment has at times resulted in overly competitive behaviours towards local ACCHOs in order to achieve market power.

While the ACCHO sector has grown in its capacity and capability to deliver general practice services it is also constantly challenged by the poor supply of general practitioners and GP Registrars.

While the Rural Generalist model has emerged as a means for hospitals to provide secondary and primary medical care, there are recognised limitations in its capacity to provide comprehensive primary health care, as well as limited opportunities for these models to complement and support existing private general practice (e.g. difficulties for private practice to meet Rural Generalist salary, competition for GP training places, less opportunities for private GPs to gain VMO rights to hospitals).

Need for meaningful ACCHO engagement and leadership

Notwithstanding the rhetoric of partnership which has been at the forefront of Government-initiated discourse since the first ACCHO was established in the Murdi Paaki Region in Wilcannia in 1974, true partnership has rarely been a reality. The power imbalance has existed for a variety of reasons. These include mistrust arising from the legacy of Australia's colonial history; a failure to appreciate the time and effort needed to build trusting relationships within Aboriginal communities and organisations; the difficulties of sharing power in a western-dominated health care system; inherited paternalism; institutional racism; and a lack of resourcing to realistically support the partnership process.

Aboriginal health institutions are amongst the most stable and consistent providers of primary care in remote NSW however this clinical and cultural knowledge and authority is not reciprocated in authentic partnership, investment nor advocacy from LHD or PHNs.

Given, a growing Aboriginal population in the region with continuing health disadvantage, a declining non-Aboriginal population, and market failures in both the public and private health systems in the Murdi Paaki Region, the ACCHO sector needs to be engaged and supported to take a greater role in the planning, design and delivery of the region's health services to ensure their sustainability, accessibility and quality, because the ACCHO sector is the future. A remote health strategy must recognise the clinical and cultural leadership of ACCHOs to secure health improvement.

To achieve this there needs to be major reform in the way that 'business' is conducted in the Murdi Paaki Region. It is time to move away from a fragmented regional governance system; duplicative and siloed service development and coordination efforts; and old, failed models for engagement between Aboriginal people and governments. These approaches have no part to play in place-based governance and leadership in the Murdi Paaki Region.

Many of the factors described above have prevented the mainstream primary care services from leveraging existing ACCHO capacity and capability to co-design and jointly deliver culturally safe and accessible services for people living in the Murdi Paaki Region. The current systems for state based

and primary health care are not capable of recognising or responding effectively to the needs of individual Aboriginal communities in the Murdi Paaki Region.

To address this challenge, we need to stop, pause and rethink. A fresh new service delivery approach is needed.

The ACCHO's unique comprehensive Primary Health Care model of care, and the more recent Commonwealth Government's Health Care Homes program, has the potential to address the failing primary care landscape in the Murdi Paaki Region. However, ACCHO leadership and push will be required on a regional level to achieve the necessary integrated system-wide general practice and primary health care reforms. To rely on the mainstream, in particular the WNSW Primary Health Network, for such innovation and drive at this stage would be a mistake. There is an obvious need for greater investment into primary care organisations that have cultural authority, industrial agility, live and work in communities and are regionally governed.

Attracting and recruiting skilled staff

The challenges of maintaining a robust workforce in rural and remote health services are widely recognised. The provision of quality primary care services requires the availability of skilled doctors, nurses, Aboriginal health practitioners, allied health professionals and ancillary staff. The Murdi Paaki Region, like many other rural and remote settings, has experienced increasing difficulties in recruiting and retaining an appropriate number and mix of skilled health professionals. These challenges have been exacerbated by drought, a shifting regional demography and changing expectations of the primary care workforce.

These recruitment and retention challenges have caused a substantial and adverse impact on the provision of primary care services in the Murdi Paaki Region. It has led to disruption in services and in some cases, service closures, failing continuity of care, weakened business and clinical systems and worsening health outcomes. Lack of partnerships with the Aboriginal health organisations and no meaningful commitment to Aboriginal workforce development are compounding this chronic deficit.

As an example, hospital medical officer needs should not be mutually exclusive of general practice needs within communities, including ACCHOs. Models need to be developed collaboratively to harness structural synergies, enhance coordination and sustainability and maximise cultural safety and population level outcome measures. Of equal importance is the development of an Aboriginal health workforce development strategy: this should be developed in accord with the UN Declaration on Rights of Indigenous People and in collaboration with ACCHOs. This would be a meaningful and substantial building block in demonstrating government bona fides and partnership goals.

Declining Broken Hill Base Hospital services

Sadly, Broken Hill Base Hospital's regional hospital capacity has slowly declined over the last two decades due to many cross-cutting challenges including a shrinking catchment population, increasing operating costs, significant budgetary constraints, older and sicker patients who can no-longer be locally managed, decreasing local hospital medical services capability, increasing reliance on locums and agency staff impacting on the continuity of care and quality of the local hospital referral process, and geographic isolation in terms of being part of a wider hospital network and partnering with a large urban tertiary hospital.

As a result, more and more patients are being referred to Adelaide hospitals and medical specialty services for assessment and ongoing treatment. This in turn is highlighting the importance of the need for increased clinical collaboration in the delivery of services across the state border.

Regular complaints from our front-line GPs include poorly integrated care, poor communication from specialist providers, reluctance to hand-back care, poor pre-referral guidance in terms of work-up, unnecessary travel requirements, ongoing patient travel and accommodation barriers, and so on.

In addition, the hospital's workforce challenges impact on its capacity to develop a culturally responsive workforce which is well educated in trauma informed care. This is no better highlighted than in the hospital's maternity service.

The LHD behaves as a 'closed system' that is vertically integrated and has a clinical superiority complex. Living in remote areas necessitates out of area referral with necessary care coordination and often navigation of complex care systems. The lack of investment in GP and ACCHO lead primary care partnerships and models of shared care result in delayed treatments, poor engagement, and patient participation, and often discharge against medical advice.

NSW Health has provided no leadership to support the codesign and development of consistent, culturally safe care pathways across primary, hospital and social care domains and this is contributing to poor experience of care by vulnerable patients, increased morbidity, persistent potentially preventable hospitalisations (PPH) and mortality.

Access to transport is one of the single largest barriers to timely and appropriate care. Remoteness means travel, travel means cost to the patient and their carer. The current transport assistance program is grossly inadequate, underutilized by Aboriginal people, poorly administered, and culturally unsafe.

Conclusion:

There needs to be a clear and urgent commitment to the National Cultural Respect Framework (supposedly endorsed by all States and Territories).

There needs to be greater accountability for health equity for Aboriginal people living in remote areas and LHDs need to achieve outcome improvement at a population level – not hospital activity statistics. This Commission should review the success of the FWLHD over the last 10+ years given its small population base from the perspective of self-sufficiency, sustainably, cost-effectiveness, recruitment and retention of specialist administration and clinical workforce and then consider the suggestions made early in this submission regarding putting Broken Hill Base Hospital under the administration of a Sydney-based LHD and leave primary health care and small facility management to Maari Ma and the RFDS.

All forms of institutional racism need to stop and should be subject to independent assessment to ensure this critical barrier to healthcare is removed.

There is a critical need for immediate improvements in relationships, power sharing and transparency.

There is a need for a NSW remote health strategy, including consideration of how well current State and Commonwealth health boundaries have proven to drive health improvement and sustainability of provider networks. LHDs can't choose to 'play' in the primary care space without being accountable for population level outcomes including child and maternal health development needs, health screening and prevention, and optimising management of chronic conditions. Remote NSW, the Murdi Paaki region, requires its own specific strategy to ensure the decline in services witnessed over the last two decades is reversed and the residents of this region have access to the requisite sustainable primary health care services that will ensure their ongoing health.

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