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National
Rural Health
Alliance

Submission to the NSW Special Commission of Inquiry into Healthcare Funding

20 December 2023

Healthy and
sustainable rural,
regional and remote
communities
across Australia.

National
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Introduction

The National Rural Health Alliance (the Alliance) welcomes the opportunity to make a submission to the New South Wales (NSW) Special Commission of Inquiry into Healthcare Funding. The following references the material which we spoke about at our hearing with you on 6 December 2023. In doing so, we also make note that the Alliance made reference to a number of these issues in our submission, verbal evidence and subsequent questions on notice to the (NSW) Legislative Assembly Select Committee on Remote, Rural and Regional Health Inquiry into the Implementation of Portfolio Committee No 2 recommendations relating to workforce issues, workplace culture and funding considerations for remote, rural and regional health. Many of the issues raised for the NSW Parliamentary Inquiry also relate to your Special Commission of Inquiry on Healthcare Funding.

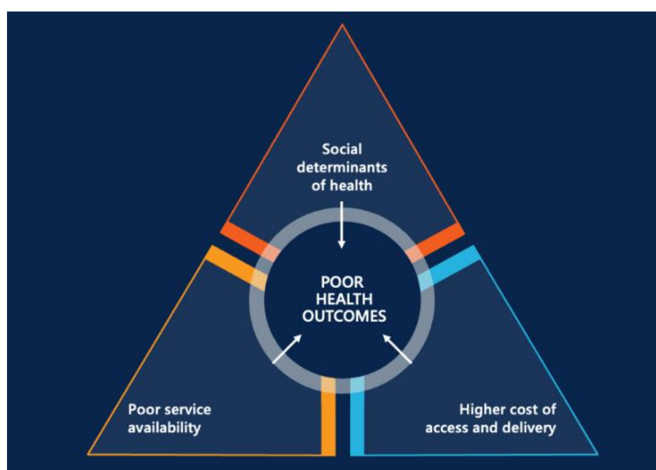
Further, since the time of our meeting with you, the Final Report of the Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025[1] has been released and it has made a number of relevant findings and recommendations of relevance to your Inquiry.

The gaps in rural health – key findings

A 2023 report released by the Alliance – *Evidence base for additional investment in rural health in Australia*[2] – provides data on the annual health spending deficit in rural Australia compared to metropolitan Australia. It demonstrates that rural Australia has a health access spending deficit of $6.55 billion annually, equating on average to $848.02 less expenditure annually per rural person for accessing health care, when compared to their urban counterparts. The report looks at the overall Australian picture; unfortunately, data analysis constraints mean that the information cannot be provided at a state and territory level.

The report was commissioned by the Alliance and undertaken independently by Nous Group. The Nous report identified a triple disadvantage for rural Australians: negative social determinants of health, poor service availability, and higher cost of access and delivery have resulted in poor health outcomes. This does not include the additional stresses of fires, floods, droughts and other disasters that negatively impact rural communities.

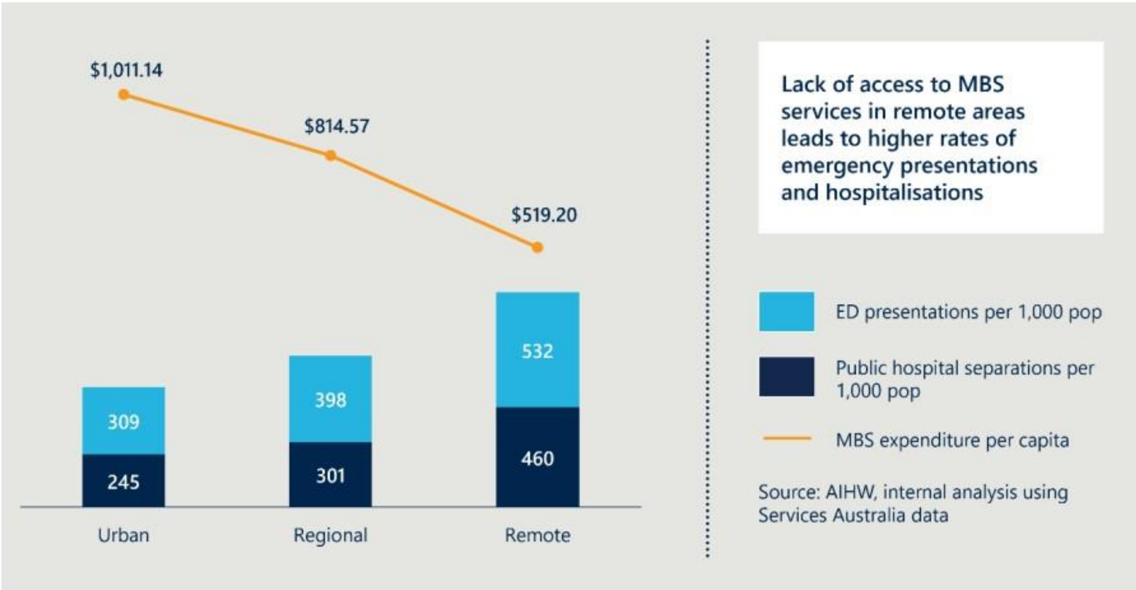
The triple disadvantage to rural health outcomes



Source: Nous Group. *Evidence base for additional investment in rural health in Australia*, p29. Available from: www.ruralhealth.org.au/content/nous-report-evidence-base-additional-investment-rural-health-australia

The Nous report identifies that, in the Australian healthcare system, general practitioners (GPs) are commonly the referral pathway for service access and funding. Low GP access results in flow-on impacts to accessing allied health and medical sub-specialty services. It is recognised that, where primary care access is low, patients access emergency departments at higher rates. GP consults drop as areas become more remote, with increased emergency department attendance. The Nous report identifies that with a drop in Medicare Benefits Schedule (MBS) expenditure – a proxy for services like general practice – the rate of emergency department presentations rises.

The following diagram from the Nous report demonstrates the impact of a lack of access to primary health care on the use of public hospitals and emergency departments.



Source: Nous Group. *Evidence base for additional investment in rural health in Australia*, p25. Available from: www.ruralhealth.org.au/content/nous-report-evidence-base-additional-investment-rural-health-australia

The prevalence of health professionals on a per capita basis (including most allied health practitioners, dentists, pharmacists, GPs and non-GP medical specialists) is reduced in rural areas.[3,4] As a result, Australians living in rural areas have, on average, shorter lives, higher levels of disease and injury, and poorer access to and use of health services, compared with people living in metropolitan areas.[5] Data also shows that people living in rural areas have higher rates of hospitalisation, mortality and injury, but poorer access to and use of primary healthcare services, compared with those living in metropolitan areas.[5]

Inadequate supply and uneven distribution of the allied health workforce greatly impede rural communities' access to essential allied health services, particularly in remote areas. This impact is most pronounced for residents of towns with populations of 15,000 or less. The smaller population size across rural Australian areas makes it impractical and unsustainable to establish permanent teams of specialised providers capable of delivering the required allied health services.[6] Despite the pressing demand for healthcare services in these areas, attracting and retaining healthcare professionals remains difficult. The workforce pipeline suggests this pattern will not soon change. Surveys of final-year medical students consistently demonstrate a strong preference to work in capital cities, with 2021 data showing graduates' intention to work as follows:

Capital city	Major urban centre	Regional city/ large town	Smaller town	Small community
61.1%	19.5%	13.3%	4.2%	1.9%

Source: Nous Group. *Evidence base for additional investment in rural health in Australia*, p26. Available from: www.ruralhealth.org.au/content/nous-report-evidence-base-additional-investment-rural-health-australia

The Alliance aims to ensure that rural health services receive equitable funding and access to essential services. The Alliance supports innovation and long-term reform and clearly there is scope for much more of this, particularly as it relates to primary health care in rural Australia, including NSW. The Alliance believes that a concerted effort is needed to drive reform and improve governance and funding arrangements to enable place-based planning that reflects demographic and geographic need. Equitable funding is required to do this. It is the view of the Alliance that urban-based models have failed to deliver equitable care in rural Australia.

A major external factor influencing the demand for hospital care is the ability to access primary health care. This adversely impacts people living in rural Australia. In the year 2021–22, the prevalence of GPs providing primary care was lowest in the most rural and remote parts of the country, reducing from 125 per 100,000 population in metropolitan areas, to 84.9 in small rural towns, 75.0 in remote areas and 66.8 in very remote areas.[7] As previously mentioned, the prevalence of other health professionals working in primary care is also reduced in rural areas.

People living in remote and very remote areas also have lower uptake rates of preventive services like cancer-screening programs, including bowel, breast and cervical cancer screening.[8]

Access to high-quality, affordable primary healthcare services prevents avoidable hospital admissions and reduces hospital stays. Primary health care is in dire straits in many rural locations – and indeed has failed much of the population – where communities are receiving little or no access to care due to a shortage of doctors, nurses and other health professionals, inequity of funding, inadequacy of funding mechanisms and a lack of support. It is important to note that the preventive aspects of primary health care, regarding use of the acute health system, require not only access to traditional primary care, but also multidisciplinary care provided by a variety of health professionals, especially in the context of rising rates of chronic disease.

In addition to general hospital admission, it is known that where primary healthcare access is low, patients access emergency departments at higher rates.[9] Further work is needed to improve health literacy, health promotion, rates of various health and behavioural risk factors, and social and emotional wellbeing in rural communities, along with addressing inequities in the socioeconomic determinants of health. Preventing illness will always take pressure off more expensive clinical interventions.

For rural communities, the *Strengthening Medicare Taskforce Report* offers a solution:

> Rural and remote communities need rural and remote solutions. A variety of options are needed to improve access to affordable health care tailored to the needs and drawing on the strengths of local communities and to support sustainable primary care solutions in rural and remote communities now and into the future. Rural and remote communities should have the flexibility to design and fund solutions that better reflect the reality of what's needed and can be sustainably delivered. This can only be achieved through consumer and community engagement, collaboration, and co-decision making at the local level. With support from all levels of government, introducing more blended funding models alongside fee-for-service will support primary care sustainability and foster innovative models of primary care in rural and remote communities.[10]

The Alliance believes that place-based models based on local population health needs and community stakeholder engagement need to be supported with equitable funding, appropriate

funding mechanisms and innovative mechanisms for the engagement of workforce and delivery of services. Rural health care at the community level must be viewed from a whole-of-system perspective, given the limited resources available. The federal and state governments must work together at the local level, rather than being hamstrung by funding and governance mechanisms that do not allow for place-based planning and delivery to occur.

This requires a much greater emphasis on, and requirement for, joint or multidisciplinary planning, development and implementation of health services between primary health networks (PHNs) and local health networks (LHNs), together with enhanced grassroots community engagement in influencing what services are needed and where health resources must be focused.

At our meeting with you, we discussed a model of rural primary health care developed by the Alliance now known as **Primary care Rural Integrated Multidisciplinary Health Services (PRIM-HS**). This model is specifically designed in conjunction with a local community (consumers, local government, local area health service, clinicians) to address the challenges of delivering primary health care in those settings, in accordance with local population health needs and services currently available locally.

A description of Primary care Rural Integrated Multidisciplinary Health Services

At its core, the PRIM-HS model has been developed as a health workforce intervention. It aims to address the three categories of barriers to regional, rural and remote health workforce recruitment and retention, as we see them – professional, financial and social. The environment and population have changed significantly over the last 30 years, but policy, strategy and funding have not. Indeed, it does not reflect what works in rural communities and has resulted in underservicing and lack of access for a population needed for Australia's economic well-being.

• **Professional barriers** – professional isolation and lack of peer support; limited access to supervision and mentoring; reduced prospects for diverse experiences and career progression; limited networking opportunities and access to professional development; and work-life balance issues

• **Financial barriers** – difficulties sustaining the financial viability of small health businesses, the requirement of on-call to work across multiple settings to meet community needs and generate adequate income, administrative burden due to multiple sources of funding and business acumen requirements. There has also been an expectation of the Government and community to bulk bill when Medicare payments were never developed to cover the total cost of service.

• **Social barriers** – social isolation due to movement away from family and friend support networks, perceived cultural and recreational limitations, concerns about employment opportunities for partners, access to childcare and high-quality education for children, and concerns about access to housing.

Following is a discussion of how the PRIM-HS model addresses each of the above three barriers.

Professional

- The PRIM-HS model overcomes the perception that rural practice means professional isolation and a lack of peer support through the key principle of a multi-disciplinary team.
- Supporting a multi-disciplinary team also aims to manage organisational workload by ensuring all health practitioners can work to their full scope of practice, with the appropriate health professional providing care, to maximise the efficiency and quality of care and enhance workforce satisfaction.
- The model aims to enable practitioners to provide holistic care that is integrated, coordinated and continuous, leading to better patient outcomes and increasing job satisfaction for practitioners.

- The model relies on stakeholders (aged care, state health jurisdictions, PHN, Workforce agencies, the disability sector, medical and health. clinic, local government and sometimes Indigenous health service) with an independent community leader as Chair to ensure equity in voice.
- PRIM-HS ensures a critical mass of health practitioners to support sustainable on-call and after-hours demands and cover for leave without reliance on costly locum practitioners.
- Provides a hub for professional development to support interprofessional understanding and facilitate work to the full scope of practice.
- It provides a base for visiting consultant medical specialists and other visiting health professionals and a location for supported patient-end services for telehealth. This further develops the team atmosphere and opportunities for collaboration, learning and breadth of experience.
- Provides in-reach services for residential aged care facilities (RACF), support for recipients of the National Disability Insurance Scheme (NDIS), My Aged Care and Department of Veterans Affairs healthcare recipients, again adding breath and diversity to professional roles.
- Supports student placements across the spectrum of health professionals, along with medical vocational trainees. This helps to build the next generation of the workforce, while providing opportunities for diverse work experiences including teaching, supervision, and mentoring.
- Association of PRIM-HS organisations with University Departments of Rural Health, Rural Clinical Schools, Rural Training Hubs, and medical specialist colleges is important to the teaching, supervision and mentoring of students and vocational trainees, but also provides opportunities for academic appointments, which broaden the appeal of rural health roles.
- Ensures practices can meet accreditation requirements, which are necessary to enable medical, nursing, and allied health training placements. This is critical for 'grow your own' and 'rural pipeline' workforce development strategies.

Financial

- PRIM-HS is a structure based on secure, ongoing employment with a single or primary employer, possibly a hybrid model of income, providing certainty of income and conditions.
- It is a flexible employment model, adaptable to professional and community needs, which works with existing services (hospital, multi-purpose service (MPS), general practitioner (GP) or other health professional practices), with scope for conjoint appointment.
- Employment arrangements should be flexible to provide scope for services to be delivered in the PRIM-HS, via out-reach services, in local hospitals and MPSs and RACFs, where appropriate.
- These organisations would have the capacity to employ staff on a contractual basis where appropriate, offering long-term contracts to maximise the attractiveness of positions.
- Remuneration should be sufficient to attract and retain high quality staff, acknowledging the additional professional, financial, social, and personal costs of rural location and re-location and the comparative salaries of those working in local health services.
- Employment conditions should recognise and support continuous professional development, supervision or mentoring and specific professional accreditation requirements.
- They do not rely on practitioners establishing their own practices, with the problems attendant with operating a financially viable, stand-alone business - including managing staff, administration, and compliance.

- PRIM-HS should include a business manager and other administrative staff to ensure administrative, compliance and reporting requirements are met to a high standard and to allow clinical staff to focus on service delivery.
- Removes the need for health practitioners, particularly early career professionals, to have the skills to establish and operate a financially viable rural practice - a significant disincentive for working rurally.
- Moves away from current fragmented and variable funding streams, to minimise the complexity of income streams, facilitating sound financial planning, maximising financial viability, and reducing administrative burden.
- Streamline financial and administrative accountability to reduce the burden of reporting and accountability requirements with a focus on outcomes and transparency.
- Acknowledge that additional funding is necessary to ensure that PRIM-HSs are financially viable and can provide a comprehensive range of services in thin markets.
- Deliver funding which recognises the increased costs of delivering health services in rural areas.
- Provide funding certainty and consistent income streams covering salaries, overheads and infrastructure which is critical for the ongoing viability of Primary care Rural Integrated Multidisciplinary Health Services (PRIM-HS).
- Requires innovative and flexible approaches to funding including pooled funding from range of governments and sources.

Social

- Given the close links between a PRIM-HS and the local community, it is expected that health practitioners will have opportunities to connect with and get to know key stakeholders and community members, helping them to become embedded in the community and form an attachment to the place.
- PRIM-HS are encouraged to deliver services for local health practitioners that are appropriate for context to aid their transition into the local community, ensuring they can access appropriate housing and childcare, understand educational options, and assist partners with their employment and career development needs.
- These services would also help to connect newcomers with social and recreational activities that meet their needs.
- The link with medical, nursing and allied health training (if supported) will ensure rural students will have the opportunity to access rural training and stay rural.

The Final Report of the Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025 which has been released since our hearing with you refers to the Primary care Rural Integrated Multidisciplinary Health Service (PRIM-HS) model as a case study of an example of an evidence-based model of care that could be supported and enabled by the future National Health Reform Agreement. The following is an excerpt from the Report at page 104:

Case study: Primary care Rural Integrated Multidisciplinary Health Services (PRIM-HS)

PRIM-HS is a model of care and funding for providing primary healthcare in rural areas. PRIM-HS involves non-profit, community-based organisations offering a wide range of affordable primary healthcare services to meet the primary health care needs of local communities in flexible and responsive ways.

PRIM-HS has the following unique features that make it a viable and scalable solution for primary health care in rural Australia:

- Employs various primary healthcare providers, including RGs, nurses, nurse practitioners, midwives, dentists and allied health professionals, depending on each community's specific needs and where appropriate working collaboratively with ACCHOs.
- Addresses the challenges of attracting and retaining rural healthcare workers by offering stable employment, attractive conditions, and job security. It does not rely on health practitioners committing to establish their own practice in what are generally thin markets.
- Supports work–life balance through peer support from a multidisciplinary team, overcoming negative perceptions of rural practice, continuous professional development and specific accreditation requirements and ready connection to the local community.
- Potential to provide in-reach services across care settings for RACF, NDIS and DVA recipients, as well as for rural people with chronic disease (management).

The PRIM-HS is an example of an evidence-based model of care that could be supported and enabled by the future NHRA. It was co-developed with Rural Health Alliance members, as well as rural primary care organisations and individuals who work on the ground in rural communities. Critically, it can be tailored to fit the specific health needs of rural and remote communities, using and augmenting the services and infrastructure already in existence.

At our hearing, you asked for examples of the PRIM-HS model and we referred to the model of primary health care provided by Bogan Shire Council as example of an entity that has used a similar model out of necessity while at the same time, doing this at a loss or opportunity cost to their other Council services. A case study about the Bogan Medical Centre is at Attachment A.

Alliance recommendation:

- That the NSW Government could immediately fund many NSW primary health sites using the PRIM-HS funding and program model. This would provide an evidence base for evaluating a model that has the potential to improve access to primary health care and, as a result, reduce avoidable hospitalisations for rural NSW residents.

Block Funding for public hospitals

Block funding is not keeping pace with the true cost of delivering healthcare services – such as how inflation and rising costs of living affect rural hospitals, including higher fuel and energy costs, food, materials and consumables. Locum doctors are increasingly needed and their costs have increased dramatically. Our Members have noted that a locum used to cost in the low $2,000s per day only a couple of years ago. This cost is now easily $3,000+ per day, plus on-costs. The Alliance believes that the current system does not support those people we have on the ground working in rural hospitals, who are committed to staying in the location.

Rural hospitals are also significantly impacted by the increasing rates of natural disasters, through climate change or otherwise. Drought, floods and fires increase pressures on rural communities and impact health substantially and this flows through to hospitals. One-off drought, fire, flood and emergency funding does very little for recovery and ongoing block funding is critical to ensure the necessary infrastructure is in place on an ongoing basis so that the structures are in place when disasters strike.

Medical and other health professional students and those in early stages of their careers need to be supported to do long-term placements in rural hospitals. This benefits the students and early career professionals themselves and is more likely to lead to them staying and working in rural locations over the longer term. Block funding plays a role here, but current funding is not adequate to support the necessary teaching, research and supervision required to design and deliver quality teaching and learning experiences. High-quality supervision, research and teaching in rural hospitals is integral to the delivery of positive experiences for rural students, but it must be resourced or it won't happen.

Further, block funding has not kept pace with the changes that have occurred with nurse-to-patient ratios in acute settings, together with increased compliance and accreditation costs for health services and in the case of some services (such as the Multi-Purpose Services – MPS program), aged care accreditation and compliance costs.

The Final Report of the Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025 recognised these same factors and it was noted:

> *Block funding does not adequately fund regional and rural hospitals for the higher costs of health delivery.*
>
> - *Rural hospitals face higher costs in delivering their services for a multitude of reasons, such as greater incidence of natural disasters, fewer doctors, and the impact of distance. In addition [Teaching, Training and Research] TTR funding is perceived as largely consumed by large tertiary/quaternary services with a lack of rural and regional recognition.*[1]

Final Report of the Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025 recommendations

Finally, I would like to draw your attention to Recommendations 35 and 36 of this Report. No doubt you are fully across the recommendations made in this Report given its relevance to NSW in the future. The Alliance sees merit in State Governments supporting and advocating strongly to ensure that the rural and remote recommendations, particularly 35 and 36 are implemented in their entirety. They are:

35. The [National Health Reform Agreement] NHRA should set out the **roles and responsibilities in the governance of rural and remote health care provision** and include provisions that:
    a) Outline the **Commonwealth's stewardship role** in ensuring the accessibility and sustainability of primary, aged and disability care in thin rural and remote markets.
    b) Establish **clear accountability and escalation** mechanisms to address the market failures in rural and remote primary, aged and disability care.
    c) Establish governance and pathways to support the development of **flexible models** to improve access to primary, aged care and disability care in rural and remote areas.

36. The importance of improving equitable access to health care services in **rural and remote areas should be reflected in a new and dedicated Schedule in a future Agreement**, with priority actions and milestones incorporated. The Schedule should include:
    a) Establishing **consistent national datasets and minimum standards of access** to primary, disability, aged and hospital services to ensure maintenance of services across rural and remote areas.
    b) Implementing **models of care** within the infrastructure and workforce limitations in rural and remote areas.
    c) Developing a **sustainable health workforce** in rural and remote areas.

d) Reviewing **regional weighting** to ensure rural and remote hospitals are funded fairly.

e) Ensuring an **accountable and equitable distribution of the TTR funding pool** to regional and rural hospitals to underpin sustainable health workforce training.

Appendix A

Bogan Shire Medical Centre NSW – Case Study

PRIM-HS Principles:

- ✓ Local governance (via democratically elected Councillors)
- ✓ Local co-design (to some degree)
- ✓ Multi-disciplinary care
- ✓ Component of block funding (subsidised by Shire Council)
- ✓ Flexible employment models (working towards including working with the WNSW LHD on their Single Employer Model)

Descriptor

In 2017 Bogan Shire Council took on the responsibility of establishing and operating the Bogan Shire Medical Centre to be the only primary healthcare provider in the LGA using Council funds to operate the practice.

Demographics

- Population – Shire has approximately 3220 with approx. 2,500 in Nyngan.
- **17.8 per cent** of the population identify as **Aboriginal and/or Torres Strait islander** (higher than state and national average). There is no local Aboriginal Community Controlled Health Organisation.
- **Employment –** Mining 13%; Farming 7%.
- **Unemployment –** 3.2 per cent (NSW average 4.9 per cent)
- Much **lower** than Australian average **income** (median weekly income $1,444 week).
- 11.2 per cent living in economic disadvantage.

Nyngan, is located in the Centre of NSW within the Bogan Shire LGA and is a MMM6 location. It is 700 km west of Sydney with the closest regional centre 165 km away in Dubbo.

The Problem (2015-2017)

The establishment of the Bogan Shire Medical Council was prompted by the retirement of two long-term GPs leading up to 2017. PHN data at the time indicated poorer health presenting as premature mortality, and higher than general rates of hospital admissions. Many residents were travelling to Dubbo (165 km away) to see a GP.

The Solution

Recognising that market failure would soon result in there being no GP/primary healthcare services in Nyngan, Bogan Shire Council purchased a block of land in Nyngan's main street for a new Medical Centre in 2015. A quality accredited practice for the Bogan Shire community was established around a purpose built, modern facility that opened its doors in 2017. The Council opted to administer and operate the Bogan Shire Medical Centre as an integral part of its business because of the benefits of having the Practice 100% community-owned and consequently accountable to the community. The practice, with over 3,600 active patients has grown over the last six years, with two building extensions to accommodate a range of services.

Current Model of Care, Services and Staffing

The Bogan Shire Medical Centre is administered and operated by the Bogan Shire Council. The Council administration incorporates all aspects of financial management and information technology which are carried out by the relevant staff under the management of the Director Finance and Corporate Services. The relevant staff carries out all human resources management functions under the management of the Director People and Community Services. The following health staff are employed under various employment arrangements:

- 1. Term Contracts
  - General Practitioners
  - Aboriginal Health Practitioner
  - Diabetes Educator
- 2. Local Government Award
  - Registered and Enrolled Nurses
  - Sonographer
  - Practice Manager
  - Support staff
- 3. Service Agreements (room rental, administrative support)
  - Physiotherapist
  - Podiatrist
  - Pathology
- 4. Placements
  - Medical Students
  - Registrars

Locums are required to fill gaps.

Other important links:

- Telehealth services are used to supplement services, including access to specialists (e.g. psychiatrists).
- The GPs refer to specialists and visiting allied health providers and work closely with the local pharmacy to deliver medications and medication reviews.
- The practice works closely with the local Multipurpose Health Services (MPS – Hospital) to manage patient care between both services when required.
- The Nyngan Residential Aged Care Facility accommodates 36 residents, all of whom are patients at the Bogan Shire Medical Centre.
- The Centre uses My Health Record and patients can access wearables and remote health monitoring.

Funding

- The Bogan Shire Medical Centre is a bulk-billed practice with gap fees payable for certain sonography and other allied health services.
- Streams: Medicare (Australian government), rate payer contributions.
- The Council has a shortfall of between $600,000 to $900,000 per year, which is subsidised by rate payers Council funds. This needs to be more equitable as Local Councils serving in urban communities to not have to carry this financial burden.
- The amount of this shortfall will not be significantly reduced with the recent increase in the MBS bulk billing incentives which will see an estimated increase in billings of $120,000.

- The high losses faced by the Council are mainly attributable to the cost of employing GPs. The cost of securing 2FTE GPs is over $1.2 Million, including travel and accommodation, whilst Medicare billings are projected to be around $700,000.
- The increasing cost of providing GP services due to market forces since the practice opened will, in the long run, erode Council's accumulated funds and limit the amount of discretionary spending available to fund other essential Council services. This is further exacerbated by increasing costs to the Council as a result of natural disasters, including drought and floods.

Consumer, Community and Stakeholder Engagement
NSW Local Government has established a mechanism for engaging local residents and businesses through the Integrated Planning and Reporting process to ensure that their input is considered and planned for.

This model cannot be sustained, nor should a community have to raise funds nor pay again for a service they have paid for through Medicare levy, taxes and rates, indeed through working in the industries that support the Australian economy.

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