National
Rural Health
Alliance

# 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 – SUPPLEMENTARY QUESTION RESPONSE

20 December 2023

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

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## About the Alliance

The National Rural Health Alliance (the Alliance) is Australia's peak body for rural, regional and remote health (herein rural). The Alliance comprises 50 national organisations[1] and our vision is for healthy and sustainable rural communities across Australia. The Alliance is focused on advancing reform to achieve equitable health outcomes for rural communities, that is the 7 million people (30 per cent) of Australia's population residing outside our major cities. Our Members include healthcare and medical professionals, health services and support providers, health and medical educators and students, rural researchers and consumers, and the Aboriginal and Torres Strait Islander health sector. This group of entities are working towards equitable policy, funding and access to services, and a redistribution of the $6.55 billion dollar per annum health underspend (or $848 per person) in rural Australia.

In context, rural people bring in two thirds of Australia's export income, 50% of tourism income and place 90% of Australia's food on our tables.

## 1. Your submission promotes the Primary Care Rural Integrated Multidisciplinary Health Services (PRIM-HS) as a place-based model for rural health care (pp.7-8).

### a) What role could this model play in developing and strengthening the regional health workforce?

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 category.

*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 PRIM-HS model does not purport to solve rural health workforce challenges on its own. It is a key policy measure designed to sit alongside other critical, effective policies and programs such as the

recruitment of rural students to rural health and medical degrees; the provision of high-quality, positive, longitudinal experience in rural areas during these health and medical degrees, if not end-to-end rural training; and access to rural pre-vocational and vocational training positions. The various levers of the Federal Government, including those that will be examined as part of the Working Better for Medicare Review (sections 19AA and 19AB of the Health Insurance Act 1973; the Distribution Priority Area (DPA), District of Workforce Shortage (DWS) and the Monash Modified Model (MMM) classifications) will also need to be improved to be fit for purpose.

Rural communities should not receive less well-trained doctors and health staff and these professionals need to be provided with supportive supervision. The same, if not more, comprehensive medical and health care needs to be provided to rural communities, as their health outcomes and access to other services are worse than those of their urban counterparts. Internationally trained doctors and health professionals are helpful to rural areas, but they are not the solution. Further, they must be trained to the same standard as locally trained health professionals.

## b) Has there any progress been made in trialing or implementing this model?

The PRIM-HS model of care has been developed with Alliance Members, as well as rural primary care organisations and individuals who work on the ground in rural communities. These communities are desperate for healthcare solutions and have worked with the Alliance to develop a model that will work for them.

PRIM-HS has been developed using an evidence-informed methodology, incorporating the learnings from recent experience and evaluation of community-led and innovative models of care.

The PRIM-HS model is based on a sound body of research evidence and practical experience from the Aboriginal Community Controlled Health Organisation (ACCHO) sector, suggesting that community designed and governed organisations providing comprehensive primary healthcare in alignment with local population health needs, with a component of block funding and the ability to employ staff in a flexible manner to meet these needs, have a positive impact on experiences and health outcomes for Aboriginal and Torres Strait Islander people.[2,3,4]

The PRIM-HS model also draws on the principles of the Community Health Program[5], ongoing in a way that is true to its original intent only in Victoria. In this model, not-for-profit organisations or health and hospital services in Victoria can apply for funding under the Community Health Program, to provide comprehensive primary healthcare services guided by a social model of health. This model acknowledges the social, environmental and economic factors that affect health, in addition to the biological and medical, and enables the provision of holistic care and wrap-around services by multidisciplinary teams, with a focus on vulnerable populations. Program funding enables delivery of nursing, allied health and counselling services. Independent community health services utilise multiple funding streams, as appropriate and available, to deliver services in accordance with community needs.

PRIM-HS documentation includes a program logic and detailed principles and operating practices. These have already been developed by the Alliance (drafted in conjunction with primary care communities in rural Australia) and are available to Governments to commence shovel-ready PRIM-HS now.

The Alliance has been working with communities nationwide over the last few years, as it has iteratively developed the model. In 2023, the Alliance applied for funding via the Australian government's Innovative Models of Care grant program to progress the development of PRIM-HS-aligned models already in existence in rural communities, and we hope to be successful in the upcoming round. Exemplars of PRIM-HS principles and shovel-ready organisations that would benefit from funding to fully implement the PRIM-HS model, exist in multiple jurisdictions, including New South Wales.

PRIM-HS was recently included as a case study in the Final Report of the Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025. Much of the Alliance's work has been referenced and highlighted in its recommendations, which will feed into the next round of Commonwealth and state/territory hospital and health funding agreements, commencing in 2025. The review refers to PRIM-HS an example of 'an evidence-based model of care that could be supported and enabled by the future National Health Reform Agreement.' Further, it recommends a dedicated Rural and Remote Schedule in a future Agreement between the Australian government and states/territories, to ensure equitable access to healthcare services.

Following are three case studies of our own that illustrate the organisational implementation of the PRIM-HS principles in practice, each in different contexts.

Bogan Shire Medicare Centre, NSW see Appendix A

Robinvale District Medical Centre, Vic see Appendix B

Alpine Health, Vic see Appendix C.

## 2. Where should investment be targeted to improve early intervention and preventative care?

In our submission to your Inquiry, the Alliance outlined several key issues regarding access to primary healthcare and preventive health services in rural Australia. We demonstrated that a lack of access to these services leads to a demonstrable rise in presentations for hospital stays and emergency department visits. This is the basis for the Alliance advocating for the Australian government and state and territory governments to work together to fund primary healthcare where markets are thin or failed and rural people are missing out on essential care and paying the price with higher disease burden and reduced life expectancy. The evidence for these assertions was provided in the following report, produced by Nous, for the Alliance: *Evidence base for additional investment in rural health in Australia*.

In response to this question on notice, we draw your attention to another key finding of the Nous report about broader preventive health solutions:

> Funding and policy to address inequality in rural Australia requires an integrated view of the interlocking systems and services. The implications of poorer health in rural settings cannot be considered in abstraction from the broader social context in Australia.

Taking the example of paediatric and developmental health, outcomes are affected by the absence of early childhood education facilities. The 2022 Deserts and Oases report presents compelling evidence of disproportionate childcare deserts in non-urban areas, contextualised in the role that early learning has in brain development before primary schooling starts at the age of five. Critically, this benefit is known to be greatest for children from financially disadvantaged backgrounds. Provision of childcare also provides opportunity for detection of developmental delay and detection of family units that may require external support.[6]

We would also like to draw your attention to the importance of maternity services and reiterate the key issues outlined in our submission relating to maternity. Our submission included details of the research that shows when women don't have access to birthing services close to home, they experience poorer health outcomes and higher rates of intervention, along with increased rates of giving birth before arrival at a health facility. Having to relocate or travel away from work and family to give birth increases stress and psychological distress and generates added financial costs for women. The lack of antenatal and postnatal care close to home has the potential to reduce the comprehensive nature of care. The importance of maternity care and the first 2000 days of life (which includes birthing), is well documented and is recognised by NSW Health.[7] Substantial investment in all aspects of maternity care in rural locations, together with investment to support the first 2000 days of life, will go some way to addressing determinants of health and lead to better health outcomes.

## 3. Your submission notes the importance of a national rural health strategy (p.10).

### a) Does the National Medical Workforce Strategy 2021-2031 appropriately address rural needs?

The *National Medical Workforce Strategy 2021–2031* outlines several initiatives and strategies to support the national medical workforce generally, with specific references to the needs of the medical workforce in rural areas. Dr Jenny May, representing the National Rural Health Alliance, was one of the lead authors of this Strategy, and it reflects a deep understanding of the issues affecting rural and remote health. In this respect, it is an excellent document to set the direction for future policy responses in health. Some of the relevant references in this Strategy include:

Specialties that can operate to their full scope of practice outside metropolitan centres will be expected to provide training in rural areas. Accreditation and supervision standards will be adjusted to recognize excellence in rural training and to facilitate longer and more placements in rural areas. This may also occur through innovative supervision approaches, networked models, and relationships with tertiary hospitals in cities (page 3).

Funding models need to better remunerate practitioners in rural and remote areas and better promote generalist medical careers. (page 18)

There needs to be better clinical support for practitioners in rural and remote areas, including in relation to after-hours and 'on-call' arrangements. (page 18)

Specialist training reform is required to better meet the needs of rural and remote Australia, particularly in relation to selection and accreditation processes. (page 18)

The training model needs to be 'flipped' to focus on delivering training in rural and remote areas, with rotations into metropolitan centres where necessary. (page 18)

> There is a stigma about medical practice in rural and remote Australia. This includes perceptions that working outside metropolitan areas is a form of exile or substandard practice. There are clearly challenges to some rural practice, such as limited resources and potential isolation, however this is not uniform and rural practice provides benefits including clinical variety, greater levels of autonomy and a sense of being part of a community. Medical leaders need to promote and support rural practice if the health needs of all Australians are to be adequately served. (page 20)
>
> Infrastructure limitations – some areas, particularly rural and remote areas, do not have the infrastructure to support the delivery of medical training and some clinical services. (page 34) … [for] general practitioners, communities should be able to access services within their region. The current concentration of specialists in metropolitan areas has developed over time rather than by design, and requires assessment. Consideration needs to be given to how services are funded so practitioners can provide and maintain sustainable services. The Strategy will build on current trials of innovative funding models for primary care that seek to provide more localised solutions developed in consultations with community and local service providers. (page 40)
>
> Recruiting more rural origin students into medicine, rural scholarships and positive learning experiences in regional medical schools and rural clinical schools has increased students' interest in working in rural areas. Longer placements in rural areas have more impact. The challenge is how to manage location after medical school. The majority of interns and prevocational and vocational training positions are in public hospitals in metropolitan areas, which means that rural interest and connections are frequently lost. Changes are needed to enable students who have an interest in rural practice to have a positive rural experience in PGY1 and PGY2, and then continue most of their vocational training in rural areas (page 48)
>
> Achieving more widespread distribution of trainees in regional, rural and remote areas to better reflect local capabilities, needs and systems will result in safer and more sustainable rural clinical services. (p54)

It is important to note, however, that the National Medical Workforce Strategy 2021 –2031 was written for the medical practitioner (doctor) workforce. High-quality healthcare in rural areas relies on the contribution of the multidisciplinary health workforce, including nursing and midwifery, pharmacy, paramedicine, dentistry, allied health professionals and Aboriginal health workers and practitioners. There are also workforce shortages in aged care and disability in rural areas – not just health.

Therefore, the National Medical Workforce Strategy 2021-2031 will not be enough, on its own, to address all rural health needs. Consideration needs to be given to the various strategies required to produce an equitably distributed health workforce in rural locations across all health professions.

## b) What different responsibilities and roles do the NSW and federal governments need to fulfill in order to address worker shortages

Since the Alliance appeared at the hearing of your Committee, the *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025 Final Report* has been published. It makes a recommendation (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 regionality 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.

The Alliance supports the recommendation for a rural and remote schedule. It considers the parameters of a dedicated schedule will outline measures agreed between the Australian government and each state/territory government to address issues contributing to worker shortages.

In addition to the current roles split between the Australian government and the state and territory governments, the following also needs to be considered:

- Both levels of government should consider financial incentives and support for qualified health professionals to work in rural and remote Australia. Examples include relocation allowances, HECS debt relief, housing subsidies, childcare subsidies and financial support to maintain or attain further qualifications. As noted in the report commissioned by the Alliance (and undertaken by Nous) titled *Evidence Base for Additional Investment in Rural Health in Australia:*

  > *Another missing piece is lifestyle support for practitioners with families. Access to affordable and quality childcare, housing, schools for children, work for partners as well as flexible work arrangements, can all be challenging in non-urban areas. Providing support for these needs can help practitioners to balance their work and family commitments and improve their ability to remain in rural areas.*[8]

- State governments must be cognisant of pay inequity between the state-operated hospital system and the primary healthcare system. As much as possible, employment conditions and pay rates should be equitable across the health and system and either avoid competition between parts of the system, and or be willing to cross subsidise practitioners in the private systems where market is thin or access to health practitioners is low e.g. MMM5 areas. Offering ongoing stable, transferrable employment, pay, job security, conditions and incentives to work in rural communities will help healthcare organisations attract and retain health professional staff.

- State-run hospitals in rural locations must be resourced to provide appropriate supervision, infrastructure, training facilities and resources for health professionals and health students to attract people to rural locations to undertake their student placements and work rotations. This increases the chances they will choose to stay or move rurally in the longer term. Rural communities must not be seen as a “dumping ground” for medical and health clinicians who do not have the equivalent skills, experience and training to the Australian trained doctors and health practitioners. We do not expect the same from urban communities.

- Legislative and regulatory barriers across all fields of health professional practice that restrict work to full scope of practice. Ensuring health and medical professionals can work to their full breadth and depth of scope is essential in rural locations where the workforce is limited, and practitioners needs to have a wide range of generalist skills to meet population health needs.

## 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.

<u>Other important links:</u>

- 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.

<u>Funding</u>

- 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.

## Appendix B

# Robinvale District Medical Centre, Victoria – Case Study

| PRIM-HS Principles: | |
|---|---|
| × | Local governance |
| ✓ | Local co-design (to some degree) |
| ✓ | Multi-disciplinary care (working towards) |
| ✓ | Component of block funding |
| ✓ | Flexible employment models (working towards) |

**Descriptor**
Market failure in primary healthcare – general practice purchase by not-for-profit organisation with philanthropic funding has enabled ongoing operation of the service and its expansion.

**Demographics**[9]

- Official population 2,441 in 2021 according to the Census. Local government research puts the population at closer to 7,500.
- **9.6 per cent** of the population identify as **Aboriginal and/or Torres Strait islander** (higher than state and national average).
- Higher than Australian average proportion of the population between 25–44-year-old.
- **Multicultural community**, with higher than Australian average proportion of the population born overseas – Malaysian, Tongan, Vietnamese, Cambodian communities.
- **Low educational attainment**.
- High proportion of the community work in **labouring jobs – agriculture** is the main industry for employment.
- Much **lower** than Australian average **income** (median weekly income $1334/family/week).
- Average levels of multi-morbidity.

Robinvale is in **Modified Monash Model (MMM) category 5** – a small rural town. It is a border community on the Murray River, adjacent New South Wales. Robinvale is just over 60 minutes' drive time (89km) from Mildura, an MMM3 or large rural town. There are limited public transport options available.

**The Problem (as at the beginning of 2023)**
Local general practitioner was close to burnout and seeking assistance to run her small practice – it would otherwise have been at risk of closure, significantly reducing access to general practice medical and nursing services in the community. The clinic is **not currently financially sustainable** and requires supplementation with donor funds for business-as-usual at present. Investment was required to remediate cyber risks and bring in additional staff to reduce the risk of burnout. Notably, a considerable number of non-Medicare eligible residents in the area need access to primary healthcare to reduce potentially preventable hospitalisations. There are **gaps in service provision** in the local community, particularly for **alcohol and drug, mental health, and allied health services**, with travel to Mildura required to access care.

**The Solution**

RFDS Victoria purchased and took over operational management of the Robinvale District Medical Centre in May, 2023, at the request of the local general practitioner, to support better work/life balance for local primary healthcare clinicians and protect the future of the clinic for the community. Donor funds supplement the functions of the practice. As RFDS Victoria has a longstanding relationship with the Robinvale community due to service provision over a number of years, they have good relationships with many stakeholders. They have commenced working with stakeholders and community members on coordination and expansion of the services offered locally within the medical centre, in accordance with local population needs and existing service gaps.

**Current Model of Care, Services and Staffing**

RFDS manages clinic operations utilising their well-functioning systems and expertise, with economies of scale. Robinvale District Health Service provides rooms as in-kind support, hence the clinic is co-located with the multipurpose service.

Staffing

- GPs (one local working part-time, others remote via telehealth with a visiting presence).
- The nurse practitioner is on site 1-2 days/week.
- Primary healthcare nurse.

Changes to date

- Employment of a local practice manager.
- Stable rotation of 5 GPs in place.
- Implementation of regular telehealth clinics.
- GPs have admitting rights to multipurpose service.
- Support for residents in aged care.
- Improved clinic cyber security.
- Practice undergoing re-accreditation under RFDS ownership.
- Skills of all current GPs mapped and plan to expand services offered based on this skills matrix. This will aid financial sustainability.
- Have collaborated with stakeholders on shared training positions, both nursing and medical.

Plan

- Work towards improving financial sustainability of the organisation with reduced reliance on donor funds.
- Work with the MPS to further assess service gaps – likely alcohol and drug and mental health services and step down care for clients leaving hospital in Mildura.
- Look at provision of allied services in Robinvale and building delegated models of care for allied health assistants – very difficult to fund and recruit/retain workforce. Looking at collaboration with Sunraysia Community Health Services (Mildura) regarding outreach in Robinvale.
- Set up local steering group early in 2024.

Other Local Services

RFDS has had long history of engagement within the Robinvale community, providing various services over a period of years including:

- Flying Doctor Telehealth (consultant medical specialist services)
- Rural Women's GP service
- Flying Doctor Speech Therapy (Robinvale District Health Service)
- Community transport.

Integration of these services into the GP clinic has commenced, largely supported work between GP and Community Transport staff provide care within the community and bring them to that care.

Funding

- The practice will return to mixed billing in 2024.
- Streams: Medicare (Australian government), individual contributions and RFDS Victoria philanthropic funding.

**Consumer, Community and Stakeholder Engagement**

- Community members were involved in local community sessions regarding the RFDS Victoria 10 year strategic plan, along with survey and focus groups.
- They will have the opportunity to participate in the steering group.
- Key stakeholders:
    - Robinvale and District Health Service
    - Murray Valley Aboriginal Cooperative
    - Swan Hill Rural City Council
    - Sunraysia Community Health Service
    - University of Sydney
    - Rural Workforce Agency Victoria
    - Murray Primary Health Network
    - Other local health services
    - Industry.

## Appendix C

# Alpine Health, Victoria – Case Study

PRIM-HS Principles:

- ✓ Local governance
- ✓ Local co-design
- ✓ Multi-disciplinary care
- ✓ Component of block funding
- ✓ Flexible employment models

**Descriptor**

Multipurpose service with three sites providing variety of services to the local community across the health and social care sector and traversing levels of care.

**Demographics**[10]

- Local government area population 13,235 in 2021.
- Towns of Bright, Dinner Plain, Mount Beauty and Myrtleford are within LGA – services in Bright, Mount Beauty and Myrtleford. Home based community services provided throughout additional local government areas.
- Lower than Australian average proportion of the population identify as Aboriginal and/or Torres Strait islander (lower than state and national average).
- **Older age distribution** compared with Australian average.
- Higher than Australian average proportion of the population has both parents born in Australia and speak English at home.
- **Lower** than national average **high-school completion** and university level **educational attainment**.
- **Tourism**, especially accommodation provision, contributes to employment.
- **Lower** than Australian average **income** (median weekly income $1769/family/week).
- Slightly **higher** than national average levels of **long-term health conditions**.

Bright, Mount Beauty and Myrtleford are all in **Modified Monash Model (MMM) category 5** – small rural towns.

- Bright is just over 60 minutes' drive from an MM2 regional centre or MM3 large rural town (Wodonga 94km and Wangaratta 80km)
- Myrtleford is between 30 and 50 minutes' drive of the same (Wodonga 65km and Wangaratta 50km)
- Mount Beauty is between 60 minutes and 1.5 hours of the same (Wodonga 86km and Wangaratta 116km).

**The Problem**

Series of small rural communities in need of a variety of services, across the spectrum of care, provided close-to-home. Needs relate to residents and visitors to the region. There is no growth funding coming into the rural health system, there are inherent policy settings that perpetuate inequity, and the service confronts a redefined health landscape through both State and Commonwealth reform.

**The Solution**

Alpine Health is a Multi-purpose Service, receiving flexible, block funding under the MPS Program from the Australian government. MPS services also receive health services funding from state governments. They access additional funding streams as appropriate and where available.

Alpine Health is **locally governed** via a board of directors and executive team. They partner with consumers via their Community and Health Advisory Groups (CHAG's) and undergo a rigorous process of service planning, looking at population needs, service gaps and aligning this with government policy directions.

They aim to provide integrated, sustainable local health services to improve the overall health and wellbeing of local communities. Assessment of local population health needs and service gaps means that they do not currently provide general practice medical services or services under the Victorian Community Health Program but have seen growth in demand for home-based services and a need for all services to integrate across the sector.

They are able to employ staff but flexibility is limited by industrial agreements that are not fit-for-purpose in rural areas.

Note: there are other MPS in Victoria who provide different services in alignment with their population health needs, including general practice and allied health services.

**Current Model of Care**

- Acute services (urgent care and hospital) are nurse-led with medical support from local general practitioners as required.
- Residential aged care services.
- Community services, including community nursing and home support services, maternal and newborn care, breast care nursing and health promotion.
- Education and training services to provide local training opportunities and grow the local workforce.

**Key Stakeholders**

- Health services in larger rural and regional towns: Albury-Wodonga Health, Northeast Health Wangaratta
- Gateway Health – community health
- Albury Wodonga Aboriginal Health Service
- Mungabareena Aboriginal Corporation
- Private general practice
- Private allied health
- Rural Workforce Agency Victoria
- Murray Primary Health Network
- Other local health services.

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