National Rural Health Alliance

The equitable, healthy and sustainable access for rural, regional and remote communities across Australia

13th March 2025

Dr Joe McGirr MP
Member of the NSW Legislative Assembly
Member for Wagga Wagga
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Dear Dr McGirr,

I wish to thank you for the tremendous work undertaken to deliver the New South Wales (NSW) Legislative Assembly Select Committee (the 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* (the Inquiry).

The Select Committee's detailed examination of health outcomes and access issues in rural, regional and remote NSW and comprehensive recommendations to address the challenges are commendable and show leadership to other Australian jurisdictions.

As you are aware, the vision of the National Rural Health Alliance (the Alliance) is for equitable, healthy and sustainable access for rural, regional and remote (hereafter rural) communities across Australia. This vision drives us to advocate for better health outcomes including improving healthcare access and equity of funding for rural communities.

Indeed, as you will be aware, the Alliance was privileged to provide input into the Inquiry, with several submissions, questions on notice and appearances since the inception of the Inquiry. We were pleased to have been able to give a national perspective on the healthcare challenges faced by rural residents as part of your Inquiry.

As an example of a viable model for addressing service gaps across the health system, the Alliance has consistently proposed our place-based Primary care Rural Integrated Multidisciplinary Health Services (PRIM-HS) model as one that could be adopted in rural NSW communities to sustain primary healthcare services in the community. PRIM-HS was previously referred to as Rural Area Community Controlled Health Organisations (RACCHOs).

This model is inclusive in its approach to developing place-based solutions by including stakeholders that are a part of the community: local government, local health districts, local tourism and business organisations, private and public health stakeholders, university and training programs, PHN and the local workforce agency amongst some of these. It is important, as they see the needs and the opportunities and add to the economic and social fabric of a community. Without this collaboration, health services are likely to continue providing the same services as the previous year with the same or similar funding, lacking the genuine cooperation needed to address problems effectively. The initiative is chaired by an independent chair to prevent conflicts of interest or bias toward specific priorities. It is fundamentally focused on population health needs while fostering collaboration.

It has been the Alliance's understanding that under Recommendation 10, the NSW Government supported the Inquiry's recommendation to establish a RACCHO test site which would be evaluated and refined for rollout in all areas of NSW where existing rural health services do not meet community needs, as indicated in the NSW Government Response to the Inquiry.

However, I note from the status of Recommendation 10 in NSW Health's *Progress Report, Parliamentary Inquiry into Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote New South Wales, as at 30 June 2024* (the Progress Report) that the NSW Government has stated in its outline of progress on this recommendation, that the recommendation is being progressed via the Collaborative Care Program and Urgent Care Services following the Bilateral Regional Health Forum in December 2022 and October 2023.

I understand the Collaborative Care approach is a place-based planning approach to help develop a site-specific model of care, which appears to have some synergies with the Alliance's PRIM-HS mode. However, they are not the same, and we believe there is merit in NSW funding test sites for PRIM-HS as a way of comparing different models and determining how investment in primary health care can lead to improved health outcomes for rural communities and reduce State expenditure through the more expensive hospital and acute sector.

The PRIM-HS model is an evidence-based solution that is intended to build the rural primary healthcare workforce and improve access to affordable, high-quality, culturally safe care when and where it is needed. It is a way to improve healthcare literacy and foster collaboration to better address community needs. Of note is that the PRIM-HS model includes a planning component that involves bringing together all rural stakeholders (which I outlined earlier) to facilitate discussion, planning and collaboration. This on-the-ground collaboration makes the model truly community-led, facilitating a grassroots approach to meeting primary care needs in rural populations through secure, ongoing employment of the workforce.

A key component of the PRIM-HS model is that in addition to attracting normal fee-for-service rates, it should be supported by block funding (as often the market is thin, or has failed) to enable the service to employ a multidisciplinary workforce that meets the particular health needs of a community by supporting employment of a range of primary healthcare professionals, including GPs, nurses and midwives, dentists, allied health professionals (such as physiotherapists, podiatrists, psychologists, paramedics and pharmacists). This approach is particularly important because Medicare bulk billing and similar initiatives often fall short or are not implemented in a way that meets the community's service requirements.

It also enables the employment of a practice manager and other administrative staff, supported by integrated information technology systems, to ensure a high standard of support that allows clinical staff to focus on clinical practice. Rural generalists are also supported by the model to provide opportunities that deliver comprehensive continuity of care for rural communities according to need and local circumstances. Indeed, the model provides opportunities for additional training and placement for students and clinical work rotations.

There are many benefits to the PRIM-HS model and its rollout would see the NSW Government leading the way in implementing an innovative model of care. The outcomes of the evaluation to assess the impact of the model on hospital admissions in NSW could then be shared.

As noted in our recent submission to your Inquiry, the Alliance is seeking funding to establish a Rural Health Innovation and Evidence Hub which we consider is necessary so that rural communities with similar challenges in other jurisdictions could learn from and adapt the findings to their local area. The PRIM-HS model is now being trialed at a site in Mareeba North Queensland through the support of an Australian Department of Health and Aged Care Innovative Models of Care (IMOC) grant which will provide another testing site for other jurisdictions to work with and share learnings.

The Alliance commends the NSW Government for renewing its focus on rural health and taking action on the Inquiry's many recommendations. However, in the case of Recommendation 10, it would be a missed opportunity for the NSW Government if it has indeed abandoned the PRIM-HS model, as it has the potential to improve access to primary healthcare and reduce avoidable hospitalisations for rural NSW residents.

I urge you, as the Chair of this Inquiry, to pursue the matter with the relevant officials overseeing the recommendations to seek their reconsideration of the implementation of the PRIM-HS model in NSW.

We know from more than 30 years of work with rural communities that tweaking will no longer work. We have to be bold to try new ways of supporting our rural communities, as their shorter life expectancy and higher rate of illness are issues that we can no longer watch to decline further.

I would be pleased to discuss this matter further.

Yours sincerely,

[redacted]

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