Submission
No 39

THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO WORKFORCE ISSUES, WORKPLACE CULTURE AND FUNDING CONSIDERATIONS FOR REMOTE, RURAL AND REGIONAL HEALTH

Organisation: Maari Ma Health Aboriginal Corporation

Date Received: 10 October 2023

Submission to 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.

Maari Ma Health Aboriginal Corporation is an Aboriginal community controlled regional health service based in Broken Hill implementing sector-leading strategies to improve health across the age spectrum and improving child development and wellbeing in far-west NSW. Maari Ma is 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 120 people, ⅔ of whom are Aboriginal making Maari Ma the largest employer of Aboriginal people in the far west.

We provided a submission to the Portfolio Committee No. 2 back in 2021 and were invited to appear via link before the Committee. Maari Ma's written submission focussed on:

- The poor health profile in remote NSW
- Impact of dismantling of State-funded community health and community mental health services
- Failing general practice
- Need for meaningful ACCHO engagement and leadership
- Attracting and recruiting skilled staff
- Declining Broken Hill Base Hospital services, and
- Poor public dental services.

We have been contacted to review and respond to the Committee's recommendations (in Report 57, May 2022) relating to workforce issues, workplace culture and funding considerations for remote, rural and regional health and comment on their implementation. As such, we will confine our comments to only some of the Report 57's recommendations.

Recommendation 2: IPTAAS

As a regional Aboriginal health service with patients in Broken Hill, Wilcannia, Menindee, Ivanhoe and Balranald, Maari Ma is very aware of the barrier that distance is to access the care required to maintain or manage health, in particular, chronic disease. We are unaware of any changes to IPTAAS following the Committee's report. The most recent changes to IPTAAS were a few years agoand had limited impact of our clients due to travel distance already being in excess of 100kms for all of our communities.

However the financial impact on people in far west NSW accessing the services they need is significant. Since 2014, Maari Ma has been managing our own in-house IPTAAS program for a number of years, supporting clients who require our help to access IPTAAS with Maari Ma paying the upfront costs and the gaps not paid by IPTAAS and recouping what we can from the State-based IPTAAS. We started with an initial self-funded budget of $20,000 and now have a self-funded budget of $120,000 (despite tightening our criteria for clients eligible for our assistance). This year, that budget was over-run by $145,000. In-house analysis of this blowout indicates that while we have been better at getting our clients to attend appointments in other cities (most often, Adelaide) reimbursement from the NSW IPTAAS scheme has not been possible in 43% of cases because Part C was not returned, costing us $103,000. Returning Part C (the section of the IPTAAS form filled in by the consulting specialist) successfully to Maari Ma so we can claim the funding has been a consistent problem for our clients. A system that negates this paper-based requirement, or one that ACCHOs can use on behalf of their clients, is required. Alternately, fully funding ACCHOs the cost of supporting their clients to access the health services they need – that is, the IPTAAS funding gap – is required.

Recommendation 3: Health-related transport

Public transport options in far west NSW are few and far between. Certainly for Maari Ma's communities these options are very sparse, sometimes costly and irregular. The Government is to be applauded, however, in making the Broken Hill to Mildura and Broken Hill to Adelaide bus services permanent. This provides a much more affordable option to flying for people seeking health and other services in these larger cities. The current missing transport links for our clients is Balranald to Swan Hill and Balranald to Mildura.

At this stage, we are unaware of any changes to the transport network as a result of the Committee's recommendation.

Recommendation 3: Air transport

Sadly regional airlines appear to be more diminished since the pandemic and have not returned to pre-pandemic schedules or fares. In 22/23, Maari Ma's in-house IPTAAS program saw a 115% increase in flights. With 1 week notice of a specialist appointment, the return flights is $545 on Rex (the only option between Broken Hill and Adelaide); with 2 weeks notice, its $512; with 3 weeks notice, it's $508; with 4 weeks notice, it's $488. So marginal savings by delaying health services to 'more affordable' flights.

The benefit of air travel is that flights are 6 days/week. The alternative is a much cheaper but longer (6 hrs vs 1 hr) bus trip but which may require multiple nights accommodation on top. Swings and roundabouts.

At this stage, we are unaware of any changes to funding for air transport as a result of the Committee's recommendation.

Recommendation 8: Supporting growth of the primary health sector to reduce avoidable hospitalisations

Maari Ma would certainly support any efforts by the NSW Government to support and improve primary health care in the most remote parts of NSW. Maari Ma has been doggedly implementing a whole-of-life course approach to chronic disease since 2005. Our strategy was positively evaluated in 2016 however since the pandemic, we have lost ground in some of the basic indicators of successful

chronic disease management. Despite this, we know that what we do and how its done makes a difference. We are not alone: the Australian Institute of Health and Welfare (AIHW) publishes data reported by all of the ACCHOs across Australia and routinely finds results relating to access, immunisation and chronic disease management better than in mainstream services. And we know that ACCHOs make a difference and provide the joined up care Aboriginal people need to stay well and avoid hospitalisations. The key to avoiding hospitalisations in the Murdi Paaki region of far west and north west NSW (the most remote parts of NSW) is supporting ACCHOs to provide care required by their communities.

At this stage, we are unaware of any steps to support the growth of primary health care in remote NSW as a result of the Committee's recommendation.

In NSW Health's response to a number of the Committee's Recommendations (EY report: Independent Review, Rural Health Inquiry, NSW Ministry of Health, June 2023) (for example **Recommendations 14, 15 and 20**), reference is made to the NSW Government's commitment of $883 million to be spent over the next 4 years to attract and retain staff in rural and remote NSW. Maari Ma has made sure that we offer pay and conditions that are as good as, if not better than, similar staff working for the FWLHD. As is being seen across Australia, attracting and retaining staff in non-metropolitan areas is particularly difficult. Maari Ma has certainly been paying a premium for locum GPs and nurses to fill vacancies while we recruit. We are also in the process of updating pour enterprise agreement and need to take on board recent pay increases being promised to groups such as nurses and midwives.

NSW Health's $10,000 incentive to attract staff to remote locations is now also being paid as a one-off payment to existing staff in remote locations and is also being offered to existing staff as an increase in hourly pay. This is having an immediate and detrimental impact to our staff, particularly those working within LHD facilities alongside LHD staff who are now being paid more per hour for the same work. NSW Health grand gesture will now have a flow on effect to every other service provider in the region: ourselves and other AMSs, aged care facilities, home care supports.

Greater thought should have gone into whether or not some more generalised supports could be offered: housing support, travel/transport, other non-directly monetised incentives.

Recommendation 34: Formalise partnerships with ACCHOs

Maari Ma experience of this recommendation is particularly poor. Maari Ma's history of positive working relationships with the mainstream health provider goes back to Maari Ma's roots when we were established in 1995 with the Far West Area Health Service (FWAHS, as it was at the time) acting to provide Maari Ma's bureau services – payroll, HR, fleet, procurement, etc and in return, Maari Ma managed the FWAHS facilities outside of Broken Hill: Tibooburra, Wilcannia, Menindee, Ivanhoe, Wentworth, Dareton and Balranald. That bold and visionary partnership between mainstream health and Aboriginal health, called the Lower Western Sector Agreement, was renewed many times and remained in place until 2013, 17 years after it started.

The Lower Western Sector Agreement was replaced with contracts between the LHD and Maari Ma for delivery of services. Not a partnership: a commercial arrangement.

We signed a partnership agreement with the LHD in 2018 which frankly wasn't worth the paper it was written on and has not been replaced. There is currently no formal 'partnership' between Maari Ma and FWLHD. We continue to have a contractual arrangement between ourselves, FWLHD and MoH for provision of services.

Another example of a working partnership which no longer exists is the Tri-partite dental agreement which was in place between FWLHD, RFDS and Maari Ma for more than a decade. FWLHD and Maari Ma contributed financially towards adult public health dental services which were delivered by the RFDS in Broken Hill (at the LHD's community health centre and at Maari Ma's Primary Health Care Service, PHCS) and in the small communities outside Broken Hill. The agreement was due to be renewed in July 2022 but because of tension between key players within the LHD and RFDS, a 3 month extension of the existing agreement was implemented, and at the end of that period, the agreement lapsed. There have been virtually no adult public health dental services in the region since – 12 months! – other than those Maari Ma has funded for ourselves or those provided gratis by the RFDS for a short period at our PHCS because they were locked out of the LHD's facilities!

Nine months of negotiating between the LHD and RFDS – without Maari Ma at the table, despite being a partner to the Tri-partite agreement for more than a decade! – has ended with Maari Ma being offered half the clinic numbers we used to get under the previous agreement.

Has the FWLHD sought to enter into a new partnership agreement with Maari Ma? No

How would we respond if we were approached? On the basis of the above experience, probably not enthusiastically.

Recommendation 38: Development of the next Rural Health Plan

First and foremost it is important to recognise that not only are 'rural and remote health systems fundamentally different to urban and regional health systems' but rural health systems are different from remote health systems. While NSW Health is obviously choosing to lump the less than 1.5% of NSW's population that lives in remote NSW (less than 120,000 people) with the 13% (1,040,000 people depending on definitions) that reside in rural NSW, the two regions are very different. As a starting point, remote NSW has about 23% Aboriginal population: when you are looking at provision of health services that has to be the most important consideration given the physical and mental health impacts colonisation has had on Aboriginal people.

Maari Ma notes that the new Rural Health Plan came out in February 2023. We met briefly with the Director (now Deputy Secretary) for Rural Health in November 2022 on matters other than our input to the new Rural Health Plan.

It should be noted that of the 38 instances of the word 'remote' in the NSW Regional Health Strategic Plan 2022 – 2032, 34 of those are in the phrase 'regional, rural and remote' indicating the depth of thinking being afforded remote communities.

(The other instances: 1) 'develop long term funding models… to address solutions for remote hospitals'; 2) 'address privacy and security concerns for individuals particularly in small and remote communities'; 3) improve virtual care/access to remote monitoring devices, and better IT support to enable remote monitoring in the home (which assumes adequate mobile phone/internet access which is not necessarily a given); 4) mobile clinics to remote communities.

Recommendation 39: NSW Health and LHDs to upgrade their collaborative work with PHNs

Sadly, there is no evidence of either positive or negative collaborations between the FWLHD and Western NSW PHN.

Recommendation 43: Place-based health needs assessments

The Committee would do well to point the LHDs, Regional NSW and anyone else interested in place-based needs assessments, in the direction of the exemplary work which has been done by Murdi Paaki Services, the operational arm of the peak Aboriginal governance group in western NSW, the Murdi Paki Regional Assembly. Each of the 16 communities in the Murdi Paaki region has a detailed Housing and Environmental Health Plan done in 2022 (which follows on from an audit of housing in the 16 communities done in 2017) and an overarching regional plan.

Maari Ma would be pleased to think that our original submission and this subsequent feedback will prove useful to the Committee. We remain to be convinced.