Submission No 56

THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO THE DELIVERY OF SPECIFIC HEALTH SERVICES AND SPECIALIST CARE IN REMOTE, RURAL AND REGIONAL NSW

Organisation: National Rural Health Alliance

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National Rural Health Alliance

Submission 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 the delivery of specific health services and specialist care in remote, rural and regional NSW

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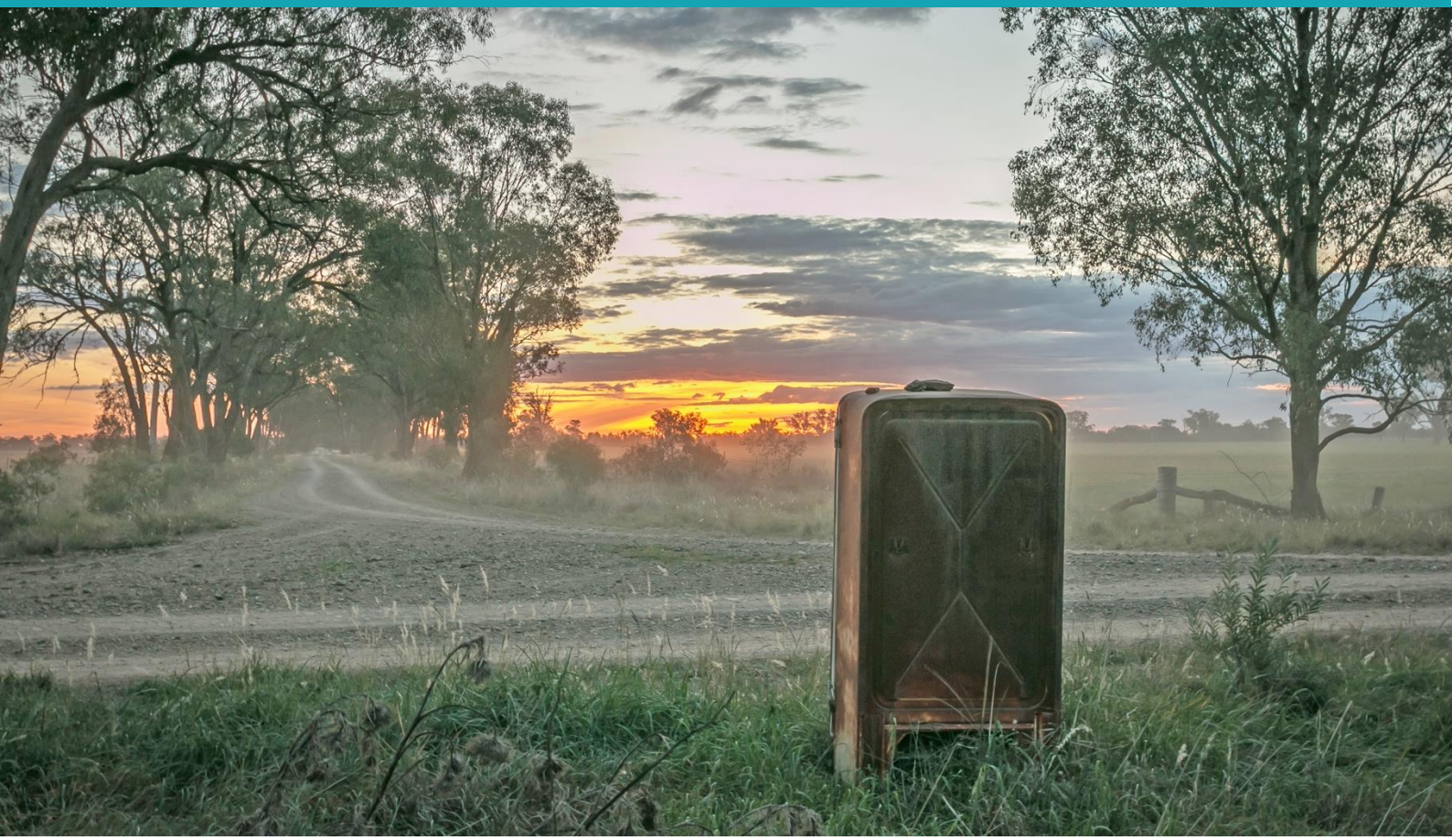

Healthy and sustainable rural, regional and remote communities across Australia.

National Rural Health Alliance

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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) Legislative Assembly Select Committee on Remote, Rural and Regional Health Inquiry into the Implementation of Portfolio Committee No 2 recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional health.

In January 2021, the Alliance made a comprehensive submission to the NSW Legislative Council Portfolio Committee No 2 Inquiry into Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote NSW (the NSW Inquiry). The Alliance was pleased to see a comprehensive set of recommendations coming out of this Inquiry and the outline of progress that has been made in NSW to work towards better access to health care for NSW rural residents.

The Alliance also made a submission 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. Some of the commentary provided in that submission remains relevant here and we will make reference to it where appropriate.

About the Alliance

The Alliance is Australia's peak body for rural, regional and remote health (herein rural). The Alliance comprises 52 national organisations[a] 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, over 7 million people (approximately 30 per cent) of Australia's population residing outside our major cities. Our Members include healthcare and medical professionals, health service and support providers, health and medical educators and students, rural researchers and consumers, and the Aboriginal and Torres Strait Islander health sector.

Terms of Reference

That the Select Committee on Remote, Rural and Regional Health inquire into and report on the progress of and issues relating to the implementation of Portfolio Committee No. 2 recommendations relating to health outcomes and access to health and hospital services,

including:

1) The delivery of specific health services and specialist care in remote, rural and regional New South Wales, including:

a) Maternity services, obstetrics and paediatrics (including Recommendations 19, 20, 26 and 27)

b) Patient transport and paramedicine (including Recommendations 3, 28 and 29)

c) Indigenous health services (including Recommendations 23, 31, 32, 33, 34, 35 and 43)

d) Mental health services, and drug and alcohol services (including Recommendation 11)

e) Aged care and palliative care (including Recommendations 18, 23 and 24)

f) Cancer care and oncology (including Recommendation 21 and 30)

g) Other specialist care and allied health services, as they pertain to the Portfolio

[a] Please see www.ruralhealth.org.au/about/memberbodies for details.

Committee No. 2 recommendations (including Recommendations 5, 10, 30, 42, 43, 44).

2) Any updates or further observations relating to the progress of implementing Portfolio Committee No. 2 recommendations relating to workforce issues, workplace culture and funding issues, as per the Select Committee on Remote, Rural and Regional Health's previous inquiry.

We will respond to the terms of reference listed in bold above.

1) The delivery of specific health services and specialist care in remote, rural and regional New South Wales, including:

a) Maternity services, obstetrics and paediatrics (including Recommendations 19, 20, 26 and 27)

Recommendation 19 of the NSW Inquiry is:

That the rural and regional Local Health Districts:

• formalise and remunerate on call arrangements for nurses and midwives across all public health facilities in accordance with industrial awards

• engage with the emergency departments in their area to develop agreed plans to address security issues with timeframes and regular progress reporting

• increase and formalise professional development opportunities for nurses and midwives, ensuring that rostering accounts for this.

Recommendation 20 of the NSW Inquiry is:

That NSW Health, as part of its review of the nursing and midwifery workforce:

• develop stronger partnerships with the university sector to more proactively engage local people and support them through rurally and regionally based education, training and professional development to become qualified nurses and midwives

• develop partnerships between rural, regional and metropolitan Local Health Districts to devise programs for nurses and midwives who are either early career, specialised or are experienced to practice in rural and remote locations

• implement professional, financial and career enhancement incentives for nurses and midwives who work in rural and remote locations.

Recommendation 26 of the NSW Inquiry is:

> That the NSW Government implement the midwifery continuity of care model throughout rural, regional and remote New South Wales.

Recommendation 27 of the NSW Inquiry is:

> That the rural and regional Local Health Districts, and those metropolitan Local Health Districts that take in regional areas of the state, review their maternity services in order to develop plans for midwifery, GP Obstetrics, specialist Obstetrics and newborn services.

The NSW Government response was that recommendation 19, 20 and 26 were supported in principle, and recommendation 27 was supported. The government stated:

NSW Health supports improved access to maternity care options for all women in NSW.

Many local health districts have already undertaken a review of their maternity services and are currently creating action plans and implementing recommendations to support resilient, safe and sustainable maternity services.[1]

We refer the Committee to the following excerpt from our Submission 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.

Yet, the recently released NSW Health maternity services policy, *Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW*, for which an expert advisory group is about to be established[2], has a limited focus on the needs of rural women in NSW or prioritising their access to the proposed care. But around the country, the state of maternity care outside of metropolitan areas is dire and a significant commitment and body of work are needed to ensure that the key issues are addressed.

The National Rural Maternity Services Forum (the Forum), held in Canberra in August 2023, highlighted the need for the federal, state and territory governments to work collaboratively to improve access to high-quality maternity services, close to home, for rural women around the country. The forum recommended that:

- work be done to update a nationally agreed implementation plan to improve rural maternity care
- a set of minimum service standards be developed
- a national workforce plan be developed and funded
- Birthing on Country models of care be implemented for Aboriginal and Torres Strait Islander women
- the RISE Framework be considered as a tool for planning locally appropriate services throughout rural Australia more broadly.

It was also considered imperative that the issue be placed firmly on the political agenda – both nationally and for the states and territories. Funding mechanisms were frequently mentioned as an important barrier to providing best-practice care.

This issue has persisted over many years with minimal improvement. There were 255 rural maternity units closed around the country between 1992 and 2011 and closures have continued since then.[3] Research shows that existing units are not distributed according to population needs.[4] When women don't have access to birthing services close to home, they experience poorer health outcomes and higher rates of intervention[5], along with increased rates of giving birth before arrival at a health facility.[6] 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.[7] The lack of antenatal and postnatal care close to home has the potential to reduce the comprehensive nature of care, and the lack of local maternity services also has broader negative repercussions for rural communities.

Alliance recommendations:

- That the NSW Government ensures rural NSW is represented on the new maternity services policy expert advisory group.

- That the NSW Government strengthens its focus on access to maternity services in rural NSW, by committing resources to enable the development of locally co-designed services that are of high quality, culturally safe, sustainable and meet the needs and expectations of local communities, including the development of Birthing on Country models of care for Aboriginal and Torres Strait Islander women. This involves consideration of models of care, workforce needs and funding models and requires collaboration with the Australian Government.

Since the above submission was written, the Alliance has continued to work towards improved access to maternity care for rural, remote and regional women, babies and families. We have been working with a multi-stakeholder group led by the National Rural Health Commissioner, to update the 2008 National Consensus Framework for Rural Maternity Services, as prioritised in the August 2023 Forum. This document will provide sound contemporary strategic guidance via principles and strategies for implementation, to improve the likelihood that rural, regional and remote women and babies in NSW (and around the country) will be able to receive high quality, culturally safe maternity care close to home now and into the future. We encourage the committee to seek out this document, which we hope will be released for consultation in mid 2024.

We would also like to bring to the Committee's attention a recent publication by Roe, Allen and Haora et al. which utilised participatory action research methods to investigate the barriers and enablers to implementation of Birthing on County services by Aboriginal and Torres Strait Islander community-controlled health services.[8] This article focusses on the Queensland and New South Wales context and is therefore of specific relevance. It provides actionable recommendations to enable scale-up of these services, noting that establishment to date has been slow, despite the considerable research evidence to support their benefits for First Nations women and babies.

The Alliance also highlights the work being done by researchers at the Molly Wardaguga Research Centre at Charles Darwin University, specifically as part of their Medical Research Futures Fund, RISE Safely research project, to implement Birthing on Country models in rural, remote and very remote parts of Australia.[9] This includes the Alukura Birthing Service in Alice Springs.[10] This research will provide insights and learnings to facilitate the scale-up of similar services and is likely to be relevant to rural NSW.

Paediatric Care in Rural New South Wales

The Alliance has serious concerns about an issue that could have potentially dire consequences for paediatric care for children living in rural NSW. The Royal Australasian College of Physicians (RACP) is reviewing the training requirements for paediatric trainees, and it is understood that the College is giving consideration to removing the requirement to undertake six months training in a rural location. This is a major concern for the Alliance and our constituents as it will clearly lead to detrimental outcomes for rural communities. Such a change would exacerbate the existing maldistribution of the medical workforce in Australia and set back policy changes that have been in place to support rural placements, not only encouraging doctors to consider studying, training and practicing in rural Australia, but understanding the issues faced by rural patients and their carers.

We know that not only do rural training placements offer exposure to doctors considering rural placements for their future career, they also provide a wider diversity of experience in terms of their clinical practice. While it is hoped that a rural training placement may open up the possibility of doctors considering a longer-term practice in rural Australia, we also know that metropolitan based doctors who have had experience rurally in their training are better equipped to understand the needs of rural patients and their families when they are required to come to the city for treatment and care.

Conversely, we know that doctors who have had no exposure to rural practice in their training can lack understanding, empathy and critical awareness of clinical factors that need to be considered in treatment and care options for patients and their families coming from - and returning to – rural locations. We also know that having compulsory rural placements in paediatrics and other disciplines is essential to rural hospitals being able to maintain their services in those disciplines. Registrars and junior doctors can be the lifeblood of rural hospitals enabling more senior doctors to devote time to supervision and training and ensure that services can be offered around the clock with safe working hours for all physicians and clinical staff.

Should the proposed RACP change go ahead, in the short term this will result in rural hospitals having extreme difficulty recruiting registrars. In the longer term this will result in a significantly smaller pool of potential candidates who will consider a career working as a Paediatric Consultant Specialist in a rural area. Feedback to the Alliance has been emphatic - that if these rural placements are not compulsory, paediatric departments will close and patients will suffer. Certainly, the remaining rural physicians and clinical staff will be left to pick up the pieces, leading to unsafe working hours and further clinical overload.

This issue should be a major concern for the NSW Government. It will lead to a significant increase in financial costs to regional health services which will become reliant on locum registrars and consultants. Reliance on locum staffing will soon lead to a loss of RACP accreditation, removing the capacity to train registrars who choose to a rural placement (unaccredited units are predominantly staffed by locums). This increasingly leads to the situation where it is only city based tertiary hospitals that will attract pediatric trainees leaving the rural children and their families with depleted options for care leading to increasing burdens of illness and social challenges.

Feedback from pediatricians to the Alliance has noted that:

> *The initial changes will include a loss of remote outreach clinics, quickly followed by a significant reduction in outpatient clinics and inpatient services. It is expected several inpatient Paediatrics units will eventually close as a direct result of this policy change. Rotating locum staffing is well known to provide less health care, at a lower quality, at a significantly higher cost to the health service…. Almost all inpatient care for neonates and children in regional units is provided by General Paediatricians, the largest paediatric division of the RACP. There is no ready alternative to rural Paediatricians, these roles cannot be filled by Emergency Physicians or General Practitioners. When staffing falls, there is a direct and proportional reduction in health care delivery.* [b]

The NSW government needs to take further action to support rural based paediatric trainee placements. The following provides a snapshot of some of the existing issues relating to access to paediatric care (without any further disadvantaging changes being enacted by RACP training requirements). The following insights were collated by *Royal Far West* – a charity with a team of almost 150 paediatric clinicians supporting country kids with speech and language delays, behavioural and learning difficulties and mental illness through three service areas: Child & Family, School & Early Years and Community Recovery. *Royal Far West* is a member of the National Rural Health Alliance and a valued service provider in NSW. These insights were collected by *Royal Far West* from conversations with rural paediatricians and General Practitioners:

- **Dubbo** and **Orange** have closed books for developmental or behavioural referrals
- **Coffs Harbour** – 24 month wait to see paediatrician
- **Bega** – 18-24 month wait to see paediatrician

[b] Correspondence sent to the National Rural Health Alliance by a concerned alliance of rural paediatricians, April 2024.

- There is no public paediatric care in the Eurobodalla LGA, families need to travel to Bega or Wollongong where there are extensive waitlists. Bega is about a 2 hour drive from Batemans Bay
- **Tamworth** have long wait times – local families have been told they will be waiting "up to six years" for an appointment and to try elsewhere
- Clients have noted that they try to access other regions, but they won't take clients from out of area so have no where to go.
    - Client lives in Bowraville and tried getting into a Paediatrician in Armidale, Port Macquarie and Gold Coast however wouldn't take client as they are out of area. "Where am I supposed to go?"
    - Client lives in Walgett and can't get into a Paediatrician. The closest is Dubbo and they aren't taking behavioural referrals
    - Mudgee client said "Our doctor, speech therapist and occupational therapist have said their child needs to see a paediatrician, but we can't get into anyone. My sister lives in Sydney so have asked around but they have all said they aren't taking on any new patients outside of Sydney.
    - "I have tried Orange, Bathurst, Cowra and Wagga for an ADHD assessment for my son with no luck"

Another option is to access private paediatricians and there are a number who run outreach clinics are travel across the state, so are not permanently based in the regions.

- There is one private paediatrician across the region based in Nowra, he too has a long waitlist.
- Families were previously going to Canberra to access a private paediatrician but as of end of last year all their books are closed unless it is a medical referral.
- Clinicians have been providing details of private paediatricians in Sydney as an option for families. Anecdotally, a few families chose to travel to Sydney and pay for a private paediatrician as the wait time for Bega public paediatrician was too long. This comes as a huge cost to families who don't necessarily have extensive disposable income.

  A private paediatrician in Armidale has just announced his retirement with no identified replacement.

The Alliance urges the Committee and the NSW government to take immediate action to advocate to the RACP that the six-month rural paediatrician training placement is maintained and to invest in existing rural paediatric units in rural and regional hospitals. The NSW Government has a major role to play in resourcing paediatric units and supporting registrar placements including increasing the provision of benefits and supports to these registrars. This extends to relocation costs; providing administrative support to trainees and their families to assist with relocation and offering assistance in the form of support for spouses and children to access appropriate childcare and schooling options for the duration of placements.

d) Mental health services, and drug and alcohol services (including Recommendation 11)

Recommendation 11 of the NSW Inquiry is:

> That NSW Health work with the Australian Government collaboratively to immediately invest in the development and implementation of a 10-Year Rural and Remote Medical and Health Workforce Recruitment and Retention Strategy. This should be done in consultation with rural, regional and remote local government, schools, community services, human services, unions, professional organisations, general practice, pharmacists and community organisations. It should set out a clear strategy for how NSW Health will work to strengthen and fund the sustainability and growth of rural, regional and remote health services in each town including quantifiable targets for tangible improvement in community-level health outcomes, medical and health workforce growth, community satisfaction, and provider coordination and sustainability. It must also address hospital and general practice workforce shortages, including General Practitioner, nurses and midwives, nurse practitioners, mental health nurses, psychologists, psychiatrists, counsellors, social workers, paramedics, allied health practitioners and Rural Generalists.

We refer the Committee to the following excerpt from our Submission 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.

> The NSW Government response to this recommendation states that NSW Health will work with the Commonwealth if they are committed to investing in a 10-Year Rural and Remote Medical and Health Workforce Recruitment and Retention Strategy.
>
> The Alliance believes the NSW Government, and indeed all jurisdictions, together with the Australian Government should be committing to a National Rural Health Strategy. The Alliance considers that obligations to rural people would be better met if Australia had a National Rural Health Strategy.
>
> The Alliance has advocated for an integrated National Rural Health Strategy and Implementation Plan to address enduring healthcare workforce, access and affordability issues and to include the rural health sector in responding to climate change, local disaster planning and emergency management.
>
> The federal and state governments have an obligation to work together and support the full spectrum of healthcare services throughout rural Australia. The emergence of significant new health challenges in recent years gives added impetus for a new and current National Rural Health Strategy.
>
> The health effects of climate change should be incorporated into this strategy, recognising the increased frequency and intensity of bushfires, droughts and floods and, more importantly, that rural communities experience these challenges above the existing triple disadvantage and are impacted significantly more than urban populations.
>
> Further, since the development of previous strategies and frameworks, the impact of the COVID-19 pandemic has exposed the vulnerability of rural Australians due to the lack of capacity in the rural health system. Workforce shortages, the lack of appropriate facilities, and a higher proportion of older and vulnerable people all contribute to this risk. A comprehensive and integrated National Rural Health Strategy and Implementation Plan is the best way forward to drive the necessary policy change and reform.
>
> A commitment from all levels of government to support a National Rural Health Strategy will be critical to its success and capacity to drive reform and structural change, as well as to ensure its development and implementation shares the objectives of the National Health Reform Agreement Addendum.

Since the above submission was written, the Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025: Final Report was published in late October 2023: https://www.health.gov.au/sites/default/files/2023-12/nhra-mid-term-review-final-report-october-2023.pdf. The report correctly outlines:

There is a need for the NHRA [National Health Reform Agreement] to adopt a coordinated national approach to address the health disparities in rural and remote communities, recognising the significant differences in health outcomes between rural and remote communities and metropolitan areas. The Mid-Term review report is clear in its recommendation which the National Rural Health Alliance fully supports for implementation:

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 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 weightings to ensure rural and remote hospitals are funded fairly.
e) Ensuring an accountable and equitable distribution of the TTR [Teaching, Training and Research] funding pool to regional and rural hospitals to underpin sustainable health workforce training.

Alliance recommendation:

- That the NSW Government takes immediate steps to advocate for a National Rural Health Strategy underpinned by a compact between Australian and state/territory governments which can be enacted in the Implementation Schedule of the next National Health Reform Agreement.
- That the NSW Government supports the development of a definition of the minimum standard of health care that all Australians no matter where they live, should enjoy, factoring in:
    - Demographic and socioeconomic profile;
    - Population health status; and
    - Distance from nearest tertiary hospital.

f) Cancer care and oncology (including Recommendation 21 and 30).

Recommendation 30 of the NSW Inquiry is:

That NSW Health:

- commit to providing continuity of quality care with the aim of a regular on-site doctor in rural, regional and remote communities
- commit to a model of care under which virtual care technology is used to supplement, rather than replace, face-to-face services
- where virtual models of medical care are operating, roster additional suitably trained nursing staff to assist in the provision of the physical care usually attended to by the medical officer
- provide staff members with training on how to effectively use telehealth and other virtual models of care
- create a public information campaign specifically targeted to rural, regional and remote communities in order to assist patients to effectively engage with virtual care, including factsheets and checklists to set expectations and support positive interactions
- ensure that the use of virtual care, if required, is undertaken in consultation with community members, health providers and local governments in rural, regional and remote areas
- investigate telehealth cancer care models to improve access to cancer treatment and care including the Australasian Tele-trial model to boost clinical trial participation in regional areas.

The NSW government supported this recommendation in principle and, with reference to the final dot point, highlighted the work of the Cancer Institute of NSW on integrating cancer services with statewide virtual care initiatives.

We refer the Committee to this excerpt from our Submission to the Australian Cancer Plan Consultation.

> Digital health care: improving access to specialised cancer care services in rural Australia
>
> Advances in technology have been transforming the way health care is delivered for many years, with the use of digital modalities exploding as a result of the COVID-19 pandemic. A body of evidence has been building over the past decade to support the use of telehealth broadly and in the context of cancer care in rural areas. Recent Australian research supports the use of telehealth models of care in rural areas across the spectrum of cancer care, from diagnostic radiology to chemotherapy, radiation oncology and to increase access to clinical trials.
>
> Chemotherapy
>
> A collaboration in north Queensland has developed a model to enhance access to high-quality, safe chemotherapy services outside of large rural centres – the Queensland Remote Chemotherapy Supervision (QReCS) model.[11] In this model, rural generalist nurses administer chemotherapy under the supervision of chemotherapy-proficient nurses from larger primary centres via videoconference. The model also utilises telehealth to enable medical oncologists and oncology pharmacists from larger primary centres to provide guidance to local rural generalist doctors and pharmacists. A retrospective study of the implementation of the QReCS model was undertaken to assess its feasibility for scaling up safely.

- The researchers reported that the model was implemented at six sites between 2014 and 2016, enabling treatment of 62 patients (including 12.9 per cent who were Indigenous).
- Treatment delays, adverse events and hospital admissions occurred at similar rates to those receiving standard care (and there were no differences between Indigenous and non-Indigenous patients).
- Implementation was enabled by good leadership, support for the model by health service executives, funding from government (including for shared medical records and telehealth infrastructure), Australian Government incentives for doctors to participate in telehealth, and utilisation of a government-endorsed guide to the model.
- Barriers included the turnover of management and clinical staff and interruption to internet connectivity.
- Many hospitals and health services in Queensland are now providing chemotherapy services utilising this model and there is scope for it to be implemented more broadly, taking the learnings from this study into account.

Radiation oncology

As was discussed in our answer to the previous question, access to radiation oncology services for rural people is often limited to regional centres, requiring significant travel and with the potential to impact treatment decisions.

Hamilton, Van Veldhuizen and Brown et al. reported on the use of telehealth in radiation oncology in north Queensland.[12] While patients were still required to travel to a Regional Cancer Centre (RCC) for radiation therapy treatment, 'initial' and 'review' medical consultations were available via telehealth. While uptake of this model was low, those who participated were satisfied with the care provided and travel savings were rated as the top advantage by patients. The model was deemed applicable to Aboriginal and Torres Strait Islander peoples who comprised 7.1 per cent of the cohort. While this descriptive study did not assess the impact of teleradiology consultations on patient outcomes, the results are promising and encourage further development in this area.

Diagnostic radiology

Telehealth is also being used to facilitate access to diagnostic radiology services in rural areas.

A study from 2020 reported on the implementation of a remote radiology assessment model at four BreastScreen services across three Australian states or territories, three of which were outside of major cities.[13] In this model, teleradiology was used for diagnostic assessment of mammograms by a radiologist at a remote site and could also incorporate asynchronous or synchronous telesonography. Communication between the various health professionals and the client at the local site and remote site was enabled via telehealth. Service providers from implementation sites were interviewed and while the study did not report on patient outcomes, service providers were satisfied with the remote radiology assessment model and felt it provided improved access to high-quality assessment services.

Key components of safe implementation included: strong support for clinical governance with the flexibility to adapt to the local context, the ability to adapt the model over time, well-functioning teams, and appropriate equipment and adequate technological support. This model, while narrow in its scope, has the potential to improve the timeliness of diagnosis of cancer for rural people. Assessment of its use in the diagnosis of other forms of cancer and in a broader array of settings is warranted.

Clinical trials

Support for clinical trials in regional centres and rural areas has the potential to increase access to novel treatments for rural people, with flow-on effects for outcomes.

The Clinical Oncological Society has been instrumental in the development of the Australasian Teletrial Model to increase access to cancer clinical trials in rural populations, in collaboration with industry, government and research bodies. The teletrial model aims to decentralise clinical trial processes via the use of telehealth to connect primary and satellite trial sites. Satellite sites include smaller regional or rural sites who would otherwise not have the capability to provide clinical trial access to patients.

A lack of access to clinical trials close to home is a barrier to participation for rural people. Sabesan, Brown and Poxton et al. reported on the implementation of a teletrial in north Queensland across four sites from 2017 in a case study, focusing on enablers and challenges.[14] This is a promising development for rural people worthy of support in the Plan.

These examples illustrate the potential for telehealth to enhance access to specialist cancer care services in rural Australia, in a way that is safe and effective, and acceptable to patients and clinicians. The Plan should focus on enabling expansion of these models so their benefits can be realised by a broader section of the rural Australian population. Further funding for health systems and policy research is required to evaluate the success of measures aimed at reducing the city– country divide in cancer outcomes.[15] Ongoing research in this area and evaluation of programs that are implemented will ensure continuous quality improvement and development of the body of knowledge about how we can better serve rural Australians who experience cancer.

Additionally, the Alliance encourages the Committee to follow the implementation by Cancer Australia of the Australian Comprehensive Cancer Network, which is focused on addressing disparities in cancer outcomes for different populations, including rural people and First Nations peoples.

g) Other specialist care and allied health services, as they pertain to the Portfolio

Committee No. 2 recommendations (including Recommendations 5, 10, 30, 42, 43, 44).

Recommendation 10 of the NSW Inquiry is:

> That the NSW Government work with the Australian government to establish a Rural Area Community Controlled Health Organisation pilot, with a view to evaluating and refining it for rollout in all areas of New South Wales where existing rural health services do not meet community needs.

We refer the Committee to the following excerpt from our Submission 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.

The Alliance developed a model which was previously called Rural Area Community Controlled Health Organisations. The model's name has changed in the past year to avoid confusion with Aboriginal Community Controlled Health Organisations (ACCHOs). The model, which we have now termed Primary care Rural Integrated Multidisciplinary Health Services (PRIM-HS), 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.

There has been considerable interest in this model from across the health sector, specifically from several primary healthcare practices that would like to see the model funded and implemented. The Alliance has identified several NSW providers that are shovel-ready to implement a PRIM-HS model in their location.

The Alliance has previously provided information to the Committee about the PRIM-HS model and how it could be supported by the NSW government for immediate implementation.

Since the above submission was written, the Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025: Final Report was published in late October 2023: https://www.health.gov.au/sites/default/files/2023-12/nhra-mid-term-review-final-report-october-2023.pdf. The report (page 104) includes the PRIM-HS model as a Case Study:

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.

There is now further evidence that governments should be investing in and supporting rural communities through resourcing community organisations to provide primary healthcare. While the Mid-term Review of the National Health Reform Agreement report suggests that this could be undertaken within the next National Health Reform Agreement, there is no reason for state governments to delay in funding these models to make a tangible difference to the health outcomes of rural residents.

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.

Conclusion

The Alliance is pleased to see the attention being given to ensuring that the findings and recommendations of the Inquiry into Health outcomes and access to health and hospital services in rural, regional and remote NSW are addressed. We support the work being undertaken by the NSW Legislative Assembly Select Committee on Remote, Rural and Regional Health to inquire into and report on the progress of and issues relating to the implementation of Portfolio Committee No 2 recommendations specifically relating to the delivery of specific health services and specialist care in remote, rural and regional NSW.

As the Alliance noted in our submission to your Inquiry in October 2023, in 2023 the Alliance released a report – *Evidence base for additional investment in rural health in Australia*[16] – which 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 to approximately $850 less expenditure annually per rural person for accessing health care, when compared to their urban counterparts. This inequity has since been reinforced by the Royal Flying Doctor Service (RFDS) in their recently released Best for the Bush Report .

In this submission, the Alliance has welcomed the opportunity to provide evidence for how governments including the NSW government could work towards addressing this health expenditure inequity through measures to support maternity, paediatric care, cancer care and primary care. We call for a National Rural Health Strategy which involves a compact between the Australian government and State and Territory governments and which could be enacted through full implementation of the recommendations made in the mid-term review of the National Health Reform Agreement report. In particular, the Alliance supports the Mid-Term Report recommendation for a dedicated Schedule for rural and remote health care services as part of the next National Health Reform Agreement. The Alliance also calls for the development of a definition of the minimum standard of health care which should be available to all Australians regardless of where they live.

The Alliance would be pleased to elaborate on any of the issues covered in this submission.

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