Submission No 256

INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NEW SOUTH WALES

Organisation: Marathon Health Ltd

Date Received: 11 December 2020

11 December 2020

The Hon Greg Donnelly MLC
Chair - Portfolio Committee No 2 – Health
Legislative Council
Parliament of NSW
SYDNEY NSW 2000
Portfoliocommittee2@parliament.nsw.gov.au

Dear Mr Donnelly

Re: Inquiry into health outcomes and access to health and hospital services in rural, regional and remote NSW

Thank you for the opportunity to respond to the inquiry into health outcomes and access to health and hospital services in rural, regional and remote NSW. Marathon Health was established in 2015 as a not-for-profit, registered charity, with a vision of enabling communities to thrive through improved health and wellbeing. We are the largest non-profit allied health workforce in regional NSW, contributing more than $17 million in wages into regional Australia in 2019-20.

We are passionate advocates for equal access to quality health services for people, wherever they choose to live and take pride in the fact that our workforce works and lives in regional Australia. In the past five years, we have grown from 60 to nearly 300 employees and we work across more than 80 rural, regional and remote NSW communities. We have more than 120 clinicians from a range of disciplines, including psychologists, social workers, occupational therapists, speech pathologists, dietitians and credentialed diabetes educators. Approximately two-thirds of our work is in the mental health space, including the operation of six NSW-based headspace centres, and we have a strong focus on delivering primary health supports that complement NSW Government services.

We are also a proud NDIS provider, with a focus on outreaching services to isolated and vulnerable people. Our multi-disciplinary allied health and support coordination team provides person-centred supports to enable NDIS participants to achieve the best outcomes from their NDIS plans. In 2019-20 we supported 992 NDIS clients across 52 communities in Western NSW and the Murrumbidgee. We delivered 1,917 services and our support coordinators helped activate 470 NDIS plans to ensure people had the services they needed.

The challenges

Allied health services can help people stay fit and well, be more mobile and stay out of hospital. It can also support people with disability to improve their function and quality of life and build their independent living skills. Services can support better patient flow through the health system, improve quality of life, and prevent readmission and reliance on the health care system. Yet, access to allied health services is not universally accessible or affordable for people living in rural, regional and remote NSW.

Since the introduction of the NDIS, the availability of Medicare-billed allied health services has practically disappeared from the market. There is now only limited access to community allied health for children, and limited opportunity to gain funding for supports for early intervention or preventative health. We see a complete cohort of children who do not have an NDIS plan missing out on early intervention that will

support their smooth transition into school, help achieve their optimal learning outcomes and live long healthy lives.

In our experience, there are not enough allied health clinicians to address the current health challenges experienced by the population in these areas. Statistics show that for all registered professions, the number of employed full-time equivalent clinicians decreases with remoteness - a trend seen each year since 2013[i]. For Australians living in regional and remote NSW, difficulties in availability are common and are only compounded by the fact that clinicians do not usually work in areas close to them.

One of our biggest challenges is recruitment and retention of our allied health workforce. In some instances, there is a total gap in service with no locally based service provider available. This often results in patients traveling longer distances to get assistance. This is one of the reasons for longer waiting times of up to six and 12 months for patients outside major centres. Service demand simply exceeds the capacity of the existing workforce.

Building rural workforce capacity

In addition to the widely-accepted and researched barriers to student placement experiences of: financial disincentives; travel; personal and social issues; and barriers imposed by learning institutions, a 2017 Melbourne University study[ii] found that nursing and allied health students also felt under-prepared for being exposed to, or participating in, work activities in rural locations.

We have committed significant resources to the student pathway over the past three years to help boost the workforce in our footprint. We partnered with universities across NSW, the ACT and Victoria to deliver student placements across a range of disciplines, including at our headspace centres. The program continues to grow, with 41 students undertaking placements with us in 2019-20 in speech pathology, occupational therapy, social work and psychology. This year our clinicians also supervised students on a virtual placement trial that took them into the remote communities of Brewarrina and Lightning Ridge, including one student from Melbourne who delivered telehealth to rural NSW clients.

This program is an asset to country communities, promoting exposure of rural and remote allied health opportunities. Of the eight new graduates we employed in 2019-20, half had completed a placement with us. We are committed to growing the workforce for the benefit of our communities and the allied health industry – particularly to support people with disability. We are also supporting staff on the job to meet the emerging needs of remote communities. We supported all but one of our diabetes educators to achieve their credentialled status on the job. We are currently training two Aboriginal Health Workers and we are supporting allied health students to gain paid experience by recruiting them as allied health assistants in their final years of study and leading up to graduation.

We want to ensure that quality services continue to be delivered to remote communities, which are often subject to poor clinical expertise and subsequent reduced health outcomes. But this commitment has not been publicly funded and comes at a cost to us in terms of student supervision and coordination that cuts into NDIS billable time – a cost that local providers like us are bearing to grow a sustainable allied health workforce for the benefit of the wider rural NSW community.

Growing chronic disease burden

In rural, regional and remote NSW, there is an increasing burden of chronic disease, particularly in Aboriginal communities, which experience higher rates of illness, hospitalisation and death[iii]. Our weekly Indigenous Chronic Disease program in Bathurst supports more than 250 Aboriginal people, to manage their health and wellbeing. The program provides integrated, specialist support services that include

diabetes education, dietetics, endocrinology, exercise physiology, podiatry, psychology, pharmacy, respiratory and optometry. In 2019-20, our multi-disciplinary team delivered 2,643 occasions of service to 257 clients from this clinic - achieving a range of outcomes from keeping people well and out of hospital to improving their capacity to self-manage their health and wellbeing. Regrettably, with a focus on those who already have diagnosed chronic conditions, we continue to see the incidence of chronic disease growing in Aboriginal families, with our clinic now seeing multi-generations of families, including a 10-year-old boy with Type 2 diabetes.

This reflects a trend in our community, with Indigenous adolescents with Type 2 diabetes currently over 10 times more likely to be hospitalised than non-Indigenous adolescents.[iv] To address this issue, we have been funded for an innovative research program at Wellington that we designed to deliver to Aboriginal families with Type 2 diabetes. The program aims to address the lack of access to services for people at significantly high risk of developing diabetes, based on their social determinants and family history. It will work across generations to build health literacy, knowledge and self-management skills in a bid to break Wellington's intergenerational cycle of disease and help develop an evidence base for the whole-of-family approach to diabetes management and prevention.

Instances of diabetes are growing in our region. Across Australia, someone is diagnosed with diabetes every five minutes, which adds up to almost 300 people every day and a $16 billion cost to the Australian economy every year.[v] Our team of diabetes educators and dietitians supported 2,156 people living in 24 rural communities in Western NSW during 2019-20. Of these, 30% identified as Aboriginal or Torres Strait Islander. In a display of the kind of difference a person-centred, goal-oriented and coordinated approach can make, of the 529 diabetes clients who had their BMI measured and monitored last year, 65% saw a reduction in their BMI over the 12 months.

It is our view that more needs to be done to overcome the rise in diabetes in rural and remote communities so that we can focus on other chronic health complications and reduce the number of avoidable hospital admissions. However, programs like our Indigenous Chronic Disease clinic and outreach clinics are only available to people with two or more chronic conditions. We need pathways for people showing early signs of chronic disease and to reduce inter-generational transmission of risk, particularly at a time when we are seeing rising levels of childhood obesity.

NDIS waiting lists

In rural and remote NSW, waiting times for NDIS support services are currently up to a year. This is in stark contrast to a NSW study[vi] that found carers of people with disability in rural Australia exhibited strongest preferences for:

- short waiting times (0–3 months)
- no out-of-pocket cost
- travelling up to four hours to receive a therapy session.

As at the end of November this year, we had 197 NDIS clients on our waiting list across Western NSW, in an area stretching from Bathurst to Lightning Ridge and Brewarrina. A further 138 NDIS clients are waiting for support in the Murrumbidgee region. Nearly 200 of these people have received no NDIS supports at all to date. Their needs are mainly for occupational therapy (55% in Western and 42% and the Murrumbidgee) and speech pathology (32% in Western and 28% and the Murrumbidgee), while there is also demand for psychology, behaviour support, dietetics, counselling, social work and psychology. This constant level of demand is driving our push to recruit and retain clinicians to support the health needs of rural and remote NSW communities.

Telehealth

Put simply, telehealth support for rural and remote communities makes better healthcare more affordable, accessible and equitable. And, post-pandemic, it is likely to become part of what communities expect, with reduced travel times and associated costs for both clients and clinicians in rural areas one of the key benefits.

We have a robust telehealth infrastructure to deliver allied health services across our footprint, both one-on-one and as a group. We offer telehealth from all of our Marathon Health offices and have 83 telehealth sites spread across 41 towns, with 50% of those sites being in GP practices and multi-purpose centres, while the others are based at schools and pre-schools.

However, we value face-to-face supports and envisage a blended model that allows our staff to be introduced to the community, to establish a trusted, therapeutic relationship and then continue their time via telehealth. In fact, during the pandemic, our data shows that existing clients were keen to pursue their treatment plans via telehealth, whereas new clients were reluctant.

We agree with SARRAH position paper that telehealth provides a viable means of accessing allied health services not otherwise available to health consumers in rural and remote areas of Australia, but that it should not be used as a substitute for the provision of face-to-face health care.[vii] Our diabetes education and dietetics clinics are delivered in a 1:2 model of one face-to-face session to two telehealth sessions, allowing the clients to develop a relationship with the clinician in person from the outset.

Our experience suggests that clinicians also need to have a strong appreciation of the cultural and community constraints around health care in rural and remote Aboriginal communities. We deliver cultural awareness training to help both our clinicians and students develop culturally-safe and appropriate treatment plans.

Advocating for an integrated team approach

We welcome the NSW Government Planned Care for Better Health program that was released in September this year and recognises the important role of care coordination and health coaching. Our focus is on collaborative primary care health models, with the GP at the centre of a client's care team and wellness journey. In Australia, allied health represents 25 per cent of the health care workforce. But we continue to find that the three key health care components (medicine, nursing and allied health) are not designed – or funded - to work as an integrated multi-discipline team, especially out of the hospital setting. To achieve a blended funding model, we need health care professions to work more closely together, in a patient-centred model, so that we can reduce the economic burden on the health care system and reduce the out-of-pocket expenses that are proving a significant obstacle for people accessing the therapies they need for long-term recovery, or quality of life.

We support the wrap-around health model and have found success in delivering care coordination across a number of programs for vulnerable and disadvantaged clients, particularly those with chronic disease. Integrated Care Coordination is a service is for people with complex health needs and chronic disease concerns living in the Murrumbidgee region. Our care coordinators supported more than 300 clients last year - coordinating and supporting access to the health services they needed to stay well and out of hospital. This is a program delivered in partnership with the GP and embedded in local communities as the key to the person-centred care model. It addressed the common problem where someone's health journey to end abruptly because they don't know where to start. The Integrated Team Care program addresses this by supporting Aboriginal people with chronic disease in the Murrumbidgee

region. Our team of care coordinators works with the client's GP to support access to the right health services and to cover any related costs.

Summary

In our experience, the contribution of allied health clinicians, including psychologists, social workers, occupational therapists, speech pathologists, dietitians, diabetes educators, allied health assistants and Aboriginal health workers is not widely understood, despite significant research demonstrating how various allied health interventions result in measurable health outcomes, including early intervention pathways and person-centred and goal-oriented pathways to health and wellbeing and prevention of chronic disease.

Inquiries into the aged care and disability sectors have thrown the spotlight on the needs of the elderly and disabled and the pandemic has highlighted the social and economic impact of mental ill health adding further strain on an already under-funded allied health sector. These areas of health and wellbeing need more – consistent – funding and to be simplified to meet the needs and capacity of both the client and clinician.

Programs that can only be delivered for 12 months do not allow us time to build a relationship with our clients and to gain their trust so that we can work with them to achieve real, long-lasting change. We also face recruitment and training challenges with short-term programs and sometimes find that we set up a program in a vulnerable or remote community and then have to abandon it if ongoing funding does not eventuate. Rural and remote communities have experienced this funding barrier too often. They have had their hopes dashed before and many are now hesitant to welcome new services to their area, in fear that they will be unable to deliver lasting outcomes. Funding uncertainty also poses a reputational risk for us, at a time when we are striving to deliver consistent, quality services to communities where we embed our staff so that we can develop real relationships and partnerships.

Recommendations

Addressing allied health workforce shortages would make a significant difference to health outcomes if addressed alongside other rural health priorities. Some of the changes we believe could improve health outcomes and increase the life expectancy of people living in rural, regional and remote NSW include:

1. Sustainable, long-term investment in community-based services that keep people well, avoid the rising increase in chronic disease and focus on intervention when risk factors are identified (rather than waiting until a person has two or more chronic conditions so that they are eligible for support).
2. Support for developing the allied health workforce to ensure people in rural, regional and remote NSW have access to the allied health they need to keep them well and out of hospital
3. A review of allied health services available to people in rural, regional and remote NSW whose conditions are not classified as acute and who do not meet the NDIS threshold.
4. The exploration of not-for-profit and public health partnerships to deliver cost-effective allied health services to take the strain off the hospital system.

Thank you for the opportunity to make a submission to the inquiry into health outcomes and access to health and hospital services in rural, regional and remote NSW. Our vision is to enable communities to thrive through improved health and wellbeing. We feel that highlighting the opportunities to improve people's quality of life and reduce the burden on the healthcare system can only benefit some of the

most disadvantaged members of those communities we work in and allow us to break down the barriers that are causing inequity based on postcode. We look forward to the opportunity to participate in public hearings next year.

Yours sincerely

Megan Callinan
CEO

cc: Mr Dugald Saunders, Member for Dubbo
Mr Mark Coulton, Minister for Regional Health, Regional Communications and Local Government and Member for Parkes

---

[i] Health Workforce snapshot, Australian Institute of Health & Welfare, published 23 July 2020, cited 30 November 2020, https://www.aihw.gov.au/reports/australias-health/health-workforce
[ii] Experiences of nursing and allied health students undertaking a rural placement – A study of barriers and enablers, Bradley, Bourke and Cosgrave, 2017
[iii] Australia's health 2020: in brief, Australian Institute of Health & Welfare, published 23 July 2020, cited 1 December 2020, https://www.aihw.gov.au/reports/australias-health/australias-health-2020-in-brief/contents/summary
[iv] Emerging diabetes and metabolic conditions among Aboriginal and Torres Strait Islander young people, Angela Titmuss, et al, Medical Journal of Australia, Published online: 18 February 2019
[v] Diabetes facts and figures, Diabetes NSW & ACT, downloaded 1 December 2020, https://diabetesnsw.com.au/about-diabetes/what-is-diabetes/facts-and-figures/
[vi] Carers' preferences for the delivery of therapy services for people with disability in rural Australia: evidence from a discrete choice experiment, G. Gallego, et al, Journal of Intellectual Disability Research, May 2018
[vii] Telehealth and allied health, Services for Australian Rural and Remote Allied Health (SARRAH), July 2012