Submission No 677

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

Organisation: Royal Flying Doctor Service of Australia (South Eastern Section)

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Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

Submission from

Royal Flying Doctor Service of Australia (South Eastern Section)

Contents

Introduction

The Royal Flying Doctor Service of Australia South Eastern Section (RFDSSE) welcomes the opportunity to provide the response into the Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales.

Our response is comprised of three components;

1. The context and perspective for RFDSSE's responses;
2. A general outline of both issues and improvements to improve services access and health and wellbeing outcomes; and
3. Specific summary response to each criterion contained in the Committee's Terms of Reference.

RFDSSE presents this submission and information using the history of 90 years of direct experience working in emergency retrieval and primary health in rural and remote areas in the Far West and the West of NSW. We have an intimate knowledge of the challenges faced by the many and varied communities and plan our services to support these communities.

The growth of the service in Primary Health in recent years has expanded the connection and engagement with remote communities where RFDSSE is the provider of Healthcare, and in turn the knowledge and understanding of these services. This is backed by working in partnership with other providers and targeted research specifically looking at rural and remote health and communities.

RFDSSE is well placed to provide a comprehensive health service to many of the most disadvantaged and remote communities in North West, Western and Far Western NSW**.**

Recommendations

	Terms of Reference	**Recommendation**
1(a)	*health outcomes for people living in rural, regional and remote NSW;*	The health service model for each community must be responsive to the variations in determinants, lifestyle and disease burden for each community and its population. The most appropriate service to be engaged. Rural communities require a relationship with a reliable, sustainable health services. The decline in available General Practice and in community acute care service has contributed significantly to poorer health outcomes in remote and rural populations. RFDSSE is well placed to provide comprehensive services from birth to death to rural and remote communities where access is deemed as a significant barrier to service provision.
1(b)	*a comparison of outcomes for patients living in rural, regional and remote NSW compared to other local health districts across metropolitan NSW;*	
1(c)	*access to health and hospital services in rural, regional and remote NSW including service availability, barriers to access and quality of services;*	The health service comprises a comprehensive service with a team of specialists who visit the communities face to face. It is patient centred and engaged. RFDSSE deliver comprehensive services to selected rural and remote communities.

1(d)	*patient experience, wait-times and quality of care in rural, regional and remote NSW and how it compares to metropolitan NSW;*	RFDSSE funding be enhanced to deliver additional comprehensive clinic services into remote communities and fly around specialist clinics in the West, North West and Far West of NSW via a 10-year funding cycle to allow foradequate planning, particularly workforce planning. NSW Government adequately fund remote specialistservices taking into account remoteness, and not purely population based. A Care Coordinator/Navigator position should be funded and included as an integral member of every healthcare team.
1(e)	*an analysis of the planning systems and projections that are used by NSW Health in determining the provision of health services that are to be made available to meet the needs of residents living in rural, regional and remote NSW;*	Community and consumer engagement to be integralto collective and integrated planning, with a lead agency and support agencies responsible for each community. Collaborative/integrated planning occurs first, and funding is allocated against the plan.
1(f)	*an analysis of the capital and recurrent health expenditure in rural, regional and remote NSW in comparison to population growth andrelative to metropolitan NSW.*	Funding for rural and remote health services be aligned with distance to/from access health services It is vital that transport costs are included as part of the healthcare funding for rural and remote services Timeframes for service planning and funding is extended to a 5-10-year timeframe.
1(g)	*an examination of the staffing challenges and allocations that exist in rural, regional and remote NSW hospitals and the current strategies and initiatives that NSW Health is undertaking to address them;*	Workforce planning is prioritised and funded with a focus on rural and remote qualifications and pathways and attractive working and living environments. Funding be provided to have a model whereby specialist or Rural Generalist training can be undertaken primarily in a more remote regional centre with some established rotations to bigger centres to ensure adequate clinical exposure and training.
1(h)	*the current and future provision of ambulance services in rural, regional and remote NSW;*	Road and air Ambulance services in Broken Hill be enhanced; and RFDSSE road retrieval vehicles (current and future) are integrated into the emergency plans for NSW Ambulance around the Dubbo and Broken Hill region.
1(i)	*the access and availability of oncology treatment in rural, regional and remote NSW;*	Support for Cancer patients is provided in a patient centred and consumer and community engagement approach and tailored to each individual patient and their family. The ‘Care Navigator’ model drives this approach and is included as part of the health service team for each community.
1(j)	*the access and availability of palliative care and palliative care services in rural, regional and remote NSW;*	Palliative care staff are funded to visit each community with the team – ensuring care plans are managed for each individual person and their family.

1(k)	*an examination of the impact of health and hospital services in rural, regional and remote NSW on indigenous and culturally and linguistically diverse (CALD) communities; and*	Aboriginal Health staff are employed and engaged to work in every health service that supports remote communities as part of the Health Service team, and services are provided within 1hour travel time for all communities. Care Coordinators/Navigators and Aboriginal Health staff are included as part of the team.

About the RFDSSE

RFDSSE is part of the largest and most comprehensive aeromedical organisation in the world providing 24-hour emergency and pre-hospital services as well as extensive primary health services in communities and locations that have little or no health service access.

Whilst historically, RFDSSE was primarily a remote emergency and retrieval service in areas of health service market failure (beyond normal medical infrastructure), through the last decade, it has significantly developed and grown as a provider of general and specialist primary care services. The focus is on provision of/facilitation of comprehensive healthcare to rural and remote areas with a focus on excellence and a mandate supported by communities and driven by community and consumer engagement and involvement. In addition to this RFDSSE is committed to providing access to these services in parts of the country where reach and provision of a range of services is limited. **The unique proposition supports access to comprehensive Healthcare for rural and remote people and communities.**

The principles of access according to the RFDS publication, '*Equitable Patient Access to Primary Healthcare in Australia*'[1] is deemed to include physical accessibility to readily available services, financial affordability and acceptability described as a patient's willingness to accept and seek services.

To illustrate this, our current reach and scale of activities is outlined in our most recent Year in Review and Financial Report at Appendix 1 and 2. In summary in 2019/20 RFDSSE provided;

- 53,000 occasions of care;
- 4,200 clinic and health services;
- 2 new health clinics opened in Tilpa and Louth;
- commenced both Primary Health and Mental Health services in the North West of the state in communities north of Bourke and Lightning Ridge such as Grawin and Angledool;
- Our Dental Van and staff provide care (757 clinics and 5,012 dental patient visits) in the most remote places in the state where they are the sole provider; and
- Our Primary Health teams commenced services by road in support of comprehensive health assessments and chronic disease management, an area that has been sadly neglected in many communities. This is in addition to fly in clinics provided under the commonwealth service plan.

We are a community governed organisation whose service funding is shared between NSW Government, Commonwealth Government and community/donor funding. The service has an 85-year relationship with Western NSW communities as their 'mantle of safety'. It is these long-standing relationships that provide RFDSSE with an insight into the challenges, concerns, resilience and above all the health status and progression of the people within their service area. We work to provide the finest care to the furthest corner and our Mission is to provide improved access supporting better health outcomes to remote, rural and regional communities.

[1] Gardiner, F. W., Bishop, L., de Graaf, B., Campbell, J. A., Gale, L., Quinlan, F. (2020) Equitable patient access to primary healthcare in Australia. Canberra, The Royal Flying Doctor Service of Australia. [Online at: https://www.flyingdoctor.org.au/news/equitable-health-access-all-australians/] (accessed 6/1/2021)

General Outline

The association between poorer health outcomes and access to quality primary, secondary and tertiary health services and supporting social determinants of health is also well evidenced[2]. The vast majority of care provided by available and accessible services in Western NSW is of appropriate quality and of a standard expected in any part of the broader state-wide and national health system.

Disparity in health and wellness status in rural and remote communities is more often associated with gaps and vacancies in access to services as opposed to service quality. Addressing issues of access to services and understanding the current health systems limitations in appropriately filling these service gaps, should be the principle recommendation arising from this Inquiry. In addition, the recommendations must look beyond a singular model (Dr or hospital) to include all aspects of health and healthcare managed in a comprehensive model across the lifespan. In the recent RFDS report titled '*Equitable patient access to primary healthcare in Australia* [3], it is noted that rural and remote populations have both poorer levels of health outcomes and lower levels of access to healthcare. Equitable access strives for equal quality in healthcare, and this report states that there are 42 805 Australians with no access to any primary healthcare within a 60-minute drive time. This report goes on the define '*Primary Healthcare'* to include *'Nursing, General Practice, Dental, Mental health and Aboriginal Health services'.*

Existing secondary health systems, typically regional or remote services provided by a range of different organisations, are increasingly required to supplement a declining rural and remote primary health system. With respect to both these dimensions, the declining core primary health rural and remote system has seen closure or downgrading of health facilities and corresponding services, leading to less staff, agency/locum staff, shorter operating hours, and services that are only open 'at times'. All of this leads to a breakdown in comprehensive care and engagement between health services and communities.

RFDSSE now offers Healthcare across the following. This is, at times in partnership with other organisations.

- Emergency and retrieval
- Primary Care
    - Broken Hill GP (General Practitioner) services
    - Remote clinic/community services
    - GP services to LHD (Local Health District) locations
    - Telehealth
- General Practice including registrar positions and rural generalists
- A range of mental health and alcohol and other drugs services and clinicians including
    - Peer support
    - Counselling
    - Group therapy and individual care
    - Child Play therapy
- Chronic disease management
- Maternal and Child health
- Womens health
- Aboriginal Health
- Dental services

[2] Australian Institute of Health and Welfare 2020. Rural & Remote Health Status And Outcomes – Australian Institute of Health and Welfare [online at: https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health/contents/health-status-and-outcomes]

[3] Gardiner, F. W., Bishop, L., de Graaf, B., Campbell, J. A., Gale, L., Quinlan, F. (2020) Equitable patient access to primary healthcare in Australia. Canberra, The Royal Flying Doctor Service of Australia. [Online at: https://www.flyingdoctor.org.au/news/equitable-health-access-all-australians/] (accessed 6/1/2021)

- Training and development – emergency services and primary care
- Rural and remote Area Nursing services

Response to Terms of Reference

1(a) health outcomes for people living in rural, regional and remote NSW; and 1 (b) a comparison of outcomes for patients living in rural, regional and remote NSW compared to other local health districts across metropolitan NSW;

The following is a snapshot evidenced from the Western NSW Primary Health Network[4] and RFDSSE's own experience of the issues that contribute to the picture of health and communities in rural and remote NSW. It provides a strong argument for a response that addresses the range of primary health care challenges and outcomes specifically in Western and Far Western NSW.

The population of Western and Far Western NSW is just over 309 000 (4% of total NSW population) and covers over half of the land area of NSW. The population has a higher proportion of Aboriginal people than the rest of the state, being 11% of the total population of this part of the state, compared to 2.9% nationally. At the 2016 census, there were 31 455 Aboriginal people, with percentages as high as 61% in Brewarrina and 40% in central Darling.

The region's population is slightly older than the NSW average, with the average age being 40 years compared to 32 years in the whole of NSW. The majority of the population in the west and far west is in the 0-15- or 50-69-year age brackets. Residents also have lower life expectancy than the rest of the state with Aboriginal people having a lower life expectancy than non-Aboriginal people[5].

There are high levels of socio-economic disadvantage in the area and residents have poorer health outcomes than the rest of NSW. They have higher rates of preventable hospitalisation and a high level of chronic disease risk factors, something the RFDSSE is seeing firsthand. The health behaviours that influence these statistics include greater than the average smoking rates, obesity, and alcohol consumption. Potentially avoidable deaths are significantly higher than NSW averages.

More than one third of the regions LGA's are classified as remote or very remote under the Modified Monash Model, with RFDSSE's Primary Health team servicing many of the very remote sites in North West and Far West NSW. The area includes the cities of Orange, Bathurst, Dubbo and Broken Hill. While these cities continue to experience growth, many of the remote and very remote populations are static or declining.

Hospitalisation, complications and death are significantly higher (as much as 40-50%) in the remote areas of the North West and Far West for diabetes, respiratory disease, cardiovascular disease, and cancer. Suicide rates and intentional self-harm are higher in this part of the state, and anxiety and depression are up to 80% higher. The mortality rates attributed to alcohol and other drugs are the highest in the state and estimated to be 41% higher than the remainder of NSW. Domestic violence rates are recorded in most of these areas as the highest in the state.

In summary Primary Health outcomes are poor, death and disease outcomes are worse than other parts of NSW, and more people are hospitalised, deteriorate and die from chronic disease. Mortality rates for cancer, diabetes, respiratory disease, and cardiovascular disease are alarmingly worse than state averages.

Mental Health and Alcohol and other Drugs echo the same patterns, with hospitalisations, emergency presentations, and suicide rates all being the highest in the state, with severity increasing with remoteness.

[4] Western NSW Primary Health Network – Health Profile 2019 [Online at: https://www.wnswphn.org.au/about-us/our-region]
[5] Western NSW Primary Health Network – Aboriginal Health Profile 2019 [Online at: https://www.wnswphn.org.au/about-us/our-region]

RFDSSE works to bridge the inequities in health outcomes in rural, regional and remote NSW with funding through the Commonwealth and State governments, however this funding is often for short defined periods and this makes long term planning and continuity of care difficult to maintain. RFDSSE maintains reasonable continuity of services through supplementing with donor funding or RFDSSE enhancement funding.

RFDSSE is best placed to provide comprehensive services from birth to death to rural and remote communities where access is deemed as a significant barrier to service provision.

Recommendation:

The health service model for each community must be responsive to the variations in determinants, lifestyle and disease burden for each community andits population. The most appropriate service to be engaged.
Rural communities require a relationship with a reliable, sustainable health services. The decline in available General Practice and in community acute care service has contributed significantly to poorer health outcomes in remote and rural populations.
RFDSSE is well placed to provide comprehensive services from birth to death to rural and remote communities where access is deemed as a significant barrier to service provision.

1(c) access to health and hospital services in rural, regional and remote NSW including service availability, barriers to access and quality of services;

Access to Health services across rural and remote areas is variable. Services should be aligned with the community and population needs and current health priorities. They should address the volume of work required and focus on management and disease control/prevention and harm minimisation. Access is about how difficult/easy it is to find appropriate health care and how long one must wait to access that service.

The RFDS study[6] found Nationally 42,000 people did not have access to Primary Healthcare Services within 60 minutes of their home and noted there is no Nationally recognised definition of what constitutes reasonable access to Healthcare nor a prescribed maximum distance. The table below highlights the NSW population that has no access to Healthcare (non-RFDSSE and RFDSSE) within 60mins drive of their home. The Bourke-Cobar-Coonamble Region (n=2,230; 5.2%) was one the highest population of people without access to Primary Healthcare within a 60-minute drive.

Table 1 Rural and remote regions with lowest levels of access to primary healthcare (RFDS and non-RFDS) within a 60-minute drive

States and territories	Permanent population 2016 (%)	Population without any primary healthcare coverage within 60 minutes' drive† (%)	Population without GP coverage within 60 minutes' drive† (%)	Population without nursing clinic coverage within 60 minutes' drive† (%)	Population without dental services coverage within 60 minutes' drive† (%)	Population without mental health coverage within 60 minutes' drive† (%)	Aboriginal population without Aboriginal health coverage within 60 minutes' drive† (%)
Western Australia (WA)	2,555,978 (10.6)	16,301 (38.1)	27,043 (41.6)	81,069 (18.4)	52,522 (36.9)	48,397 (45.3)	9,428 (22.6)
Queensland (Qld)	4,845,152 (20.0)	10,882 (25.4)	11,590 (17.8)	59,092 (13.4)	19,814 (13.9)	17,110 (16.0)	7,468 (17.9)
Northern Territory (NT)	245,678 (1.0)	6,053 (14.1)	13,662 (21.0)	40,927 (9.3)	25,302 (17.8)	19,030 (17.8)	6,579 (15.8)
New South Wales (NSW)	7,732,858 (32.0)	4,365 (10.2)	5,428 (8.3)	8,439 (1.9)	15,761 (11.1)	10,452 (9.8)	1,378 (3.3)
South Australia (SA)	1,712,843 (7.1)	1,940 (4.5)	3,743 (5.8)	39,175 (8.9)	5,809 (4.1)	6,432 (6.0)	1,100 (2.6)
Tasmania (Tas)	522,414 (2.2)	1,210 (2.8)	1,342 (2.1)	124,012 (28.2)	7,711 (5.4)	2,779 (2.6)	13,439 (32.2)
Victoria (Vic)	6,173,172 (25.5)	2,054 (4.8)	2,242 (3.4)	87,673 (19.9)	15,350 (10.8)	2,648 (2.5)	2,366 (5.7)
Australian Capital Territory (ACT)	403,104 (1.7)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Australia	**24,191,199 (100.0)**	**42,805 (0.2)**	**65,050 (0.3)**	**440,387 (1.8)**	**142,269 (0.6)**	**106,848 (0.4)**	**41,758 (0.2)**

[6] Gardiner, F. W., Bishop, L., de Graaf, B., Campbell, J. A., Gale, L., Quinlan, F. (2020) Equitable patient access to primary healthcare in Australia. Canberra, The Royal Flying Doctor Service of Australia. [Online at: https://www.flyingdoctor.org.au/news/equitable-health-access-all-australians/] (accessed 6/1/2021)

The SPOT (Service Planning and Operational Tool)[7] is an Australian first. It is an RFDS custom made software tool developed to assist the RFDS in planning where services should be located, relative to need. This is done by mapping existing services (both RFDS and other services) and overlaying these with population data. It clearly indicates where services are lacking and where additional services should be placed. The extracts provided at Appendix 4 demonstrate the current service locations for General Practice, Mental Health & Alcohol and other Drugs, Dental services and Nursing Services across Western and Far Western NSW. The distance used for service planning is 60 minutes by car.

Transport is an integral component of healthcare and is vital to the delivery of patient centred care. The focus of LHD's is often on reducing transport costs to the detriment of the patient journey. Transport costs should be considered as an extension of healthcare and not as a separate cost.

In addition to distance/ proximity to services barriers to access include issues such as availability to specialist services, relationships and trust with service providers, costs, attitudes, and beliefs of the service providers and consumers, and general awareness and understanding of the lifestyle and management impacts. It is commonly accepted that the workforce in largely made up of locums and FIFO workers who do not live-in community and pass-through communities providing care for a short time only. This means that knowledge of communities and patients is limited, compromising the continuity of care that is so necessary in this environment. In rural and remote areas, the number of General Practitioners practicing is below the state averages. This means that people accessing or requiring services often revert to the emergency services of local hospitals, telehealth or the RFDSSE. As recently as 7 January 2021 communities continue to see the loss of GP services, with the Coolah community, north-east of Dubbo, now without a GP after the sole doctor announced the permanent closure of her clinic[8].

For many communities, the Multi-Purpose Services (MPS) provides a majority of aged care beds, with other patients being transferred to regional or city hospitals. Of particular note is the 0-18 age group which cannot be accommodated overnight in many MPS's and are instead, assessed and then moved on to a regional hospital with extended care facilities.

RFDSSE provides a quality service to many rural and remote communities especially in the Far West of NSW. Where we are supported to provide these services, they are quality services, focussed on continuity of care throughout life, and in line with the health status of rural and remote people, are structured around chronic disease management, wellness and person-centred care. RFDSSE has developed a model of care that is aimed to overcome the gaps found in general health services; a Primary Care model, where comprehensive health assessments are followed up with Care Plans, General Practice, Allied Health and a Retrieval Service. This is demonstrated whereby in 2020 RFDSSE commenced providing Primary Health services into the North West of NSW following requests from communities and extensive community consultation. Communities were concerned with the lack of continuity, lack of General Practice and Primary Health support, and a huge need for mental health and drought support. RFDSSE has been providing mobile dental services to the region for a number of years and recognising along with the communities the gaps in services, has introduced Primary Care services to North West NSW.

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[7] Gardiner, F. W., Gale, L., Ransom, A., Laverty, M. (2018). Looking Ahead: Responding to the health needs of country Australia ns in 2028/ the centenary year of the RFDS. Canberra, Australia, The Royal Flying Doctor Service [Online at: https://www.flyingdoctor.org.au/what-we-do/research/] (accessed 7/01/2021

[8] Source 9 News Central West [Online at: https://aus01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.facebook.com%2F9NewsCentralWest%2Fvideos%2Fcoolah-clinic-closed%2F388962348870845%2F&data=04%7C01%7CMaria.Cade%40rfdsse.org.au%7Cbfe01e33fc4d4ac34ddb08d8b356834c%7C3014a8895c7c45bea4b41bed227a160b%7C0%7C0%7C637456531444409788%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C2000&sdata=VG%2FHzjYvHfxJ8H8IAn3fzB8yiBjUnEb8B3a5JpqPXLQ%3D&reserved=0 (Accessed 8/01/2021)

RFDSSE is well respected by remote communities who refer to the RFDS as '*our health service'.* The unique proposition and strength of RFDSSE in Primary Health is our service plan, aimed at prevention, care and management throughout life, and includes: General Practice, Primary and Remote Area Nursing, Mental Health, Alcohol and Other Drugs, Dental Services and Aboriginal Health services delivered into communities, and throughout life, by aircraft and road vehicles under a community and consumer engagement framework.

Recommendation:
The health service comprises a comprehensive service with a team of specialists who visit the communities face to face. It is patient centred and engaged.
RFDSSE deliver comprehensive services to selected rural and remote communities.

1(d) patient experience, wait-times and quality of care in rural, regional and remote NSW and how it compares to metropolitan NSW;

Wait times and quality of care in Western and Far Western communities is variable, and dependent on a range of services, some that are uncoordinated and intermittent. This leads to care that is erratic and spasmodic, and ultimately leads to, uncontrolled disease/care, increased hospitalisation, poor outcomes, and higher mortality rates. For example, there can be long waiting times for endoscopies in Broken Hill Base Hospital. This is a relatively simple and common procedure in metropolitan and many regional centres. The NSW state government should fund the provision of specialist services in remote areas such as Broken Hill.

RFDSSE is funded to provide annual service plans that includes specific numbers of clinics to specific communities in Far Western NSW through Government. These clinics are weekly (or more often), monthly or quarterly, and are supported by Telehealth and 24-hour Retrieval Services. In 2020 RFDSSE conducted 6,925 Telehealth consults plus 51 where clinics had been cancelled due to weather etc. There are a number of these communities that would benefit from additional clinics, and RFDSSE has the capacity to provide similar services to areas in the West and North West of the state. These communities lack specialist care and patients generally need to travel many hours to major centres to access specialist services. RFDSSE provides a number of specialist clinics where a team of specialists visits several locations during a week and are transported from place to place by aircraft. These 'fly around' specialist clinics/services are in high demand and are a potential model for consideration in support of improved health outcomes for rural and remote people and communities.

The disparity in the patient journey between a capital city and a very remote town is demonstrated in the RFDS example at Appendix 3.

The model of care should support Health providers to allocate resources to care co-ordination as an integral member of all teams. Care Coordinators/Navigators support people through their journey; following and interpreting their Care Plan and navigating the system. This includes appointment and treatment in their community and when they must travel away from their homes for medical treatment. Care Coordinators/Navigators are a key position in ensuring comprehensive care and navigating the system.

Community and consumer engagement are integral to ensuring the services are targeted and appropriate for each community. Collectively the health organisations work on the concept of integrated care models and agree on targets and outcomes for care.

Recommendation:
RFDSSE funding be enhanced to deliver additional comprehensive clinic services into remote communities and fly around specialist clinics in the West, North West and Far West of NSW via a 10-year funding cycle to allow for adequate planning,particularly workforce planning. NSW Government adequately fund remote specialist services taking into account remoteness, and not purely population based.
A Care Coordinator/Navigator position should be funded and included as an integral member of every healthcare team.

1(e) an analysis of the planning systems and projections that are used by NSW Health in determining the provision of health services that are to be made available to meet the needs of residents living in rural, regional and remote NSW;

There are many organisations working in healthcare in Western and Far Western NSW. Each organisation plans their service in line with their organisational strategy and funding. NSW Health research, data and notes should be widely available to all interested parties and used collaboratively in planning processes. There have been many attempts to integrate notes, and provide shared access, however there is still no ideal solution.

A whole of region plan could potentially include all parties planning together and including individual strengths. Funding could then be allocated to organisations against the plan, rather than the other way around. Plan first, with the patient and community at the centre, and then fund services to address needs.

Recommendation:
Community and consumer engagement to be integral to collective and integrated planning, with a lead agency and support agencies responsible for each community. Collaborative/integrated planning occurs first, and funding is allocated against the plan.

1(f) an analysis of the capital and recurrent health expenditure in rural, regional and remote NSW in comparison to population growth and relative to metropolitan NSW;

Providing services to rural and remote areas creates increased costs for both the health services and the consumers and communities due to distances travelled, lack of infrastructure, and dispersed local and specialist services.

RFDSSE notes the following points for consideration:

- Funding is generally short term which presents recruitment challenges, and a lack of continuity of care as service planning and recruitment is only a year at a time.
- Activity based funding does not take into consideration distances and environmental factors i.e. drought, flood etc.
- Funding shortages mean that capital works (health services) have required RFDSSE donor funds to purchase assets. (E.g. Tilpa and Louth Clinic facilities, motor vehicles for Primary Health and Mental Health)
- RFDSSE has a collaborative and strategic agenda (including a centre of excellence) for rural and remote education programs to train/support staff. This will require funding.
- RFDSSE regularly supports program funding (provided by government) with enhancement funds as program funding only covers some costs.
- Transport costs for delivery of services to rural and remote area is significantly more that in regional and metropolitan centres. This includes both services delivered into communities and patients who travel out of community for health services, investigations, and treatment. These costs should be factored into funding for health services in rural and remote areas, so people who live and work in these areas are not disadvantaged. We note that access involves both availability to services, and financial impact of accessing services. Travel is a major cost for health service delivery and for individuals.

Recommendation:
Funding for rural and remote health services be aligned with distance to/from access health services
It is vital that transport costs are included as part of the healthcare funding for rural and remote services.
Timeframes for service planning and funding is extended to a 5–10-year timeframe.

1(g) an examination of the staffing challenges and allocations that exist in rural, regional and remote NSW hospitals and the current strategies and initiatives that NSW Health is undertaking to address them;

Traditional models of health service delivery and staffing have involved General Practice and Visiting Medical Officer models. These models have become increasingly difficult to support due to staff shortages and challenges of living in remote areas, combined with declining populations, poor health outcomes, and conditions that limit the ability to make positions economically viable. Once Primary Care is compromised, the health sector is shaped by acute presentations and immediate responses.

The sector in general has seen the growth in the use of locum workforces, and telehealth as an option to replace face to face care. RFDSSE uses Telehealth as an addition to (rather than a replacement for) face to face services and strives to build a workforce of engaged and permanent staff across the health service. In addition, RFDSSE service model is to transport a Primary health team to each of the communities and provide a full and comprehensive health service.

The RFDS report[9] to the Commonwealth noted "*...existing policies have included offering primary healthcare infrastructure grants, increasing generalist training in rural and remote areas, increasing skilled immigration, and encouraging provider substitution. There have been some problems with these policy interventions, such as an over-reliance on overseas-trained clinicians, time delays, a lack of national coordination, and a lack of a focus on retention of the rural and remote workforce.*

Future policies, aimed at improving retention of health workers in rural and remote Australia, should consider supporting: interventions that employ/admit students from rural and remote backgrounds; the establishment of rural and remotely located medical schools with a focus on training rural students; clear career educational progression; enhanced scope of practice; and improving living conditions for the rural and remote workforce."

RFDSSE workforce planning involves training and training pathways for rural and remote health workers. The strategic collaboration aims to support a centre of excellence, building a workforce of the future that includes pathways, training and many levels of qualification in support of rural and remote health workers.

The aim of the Health Service is to support and maintain wellness, in a patient centred model of care. This model involves strong engagement with people and communities, and a workforce that is engaged with rural and remote people and the services they work with. Health providers aim to develop a workforce that is appropriately qualified and experienced, and will be supported with development opportunities, attractive working and living environments, and a career pathway in line with their aspirations. Workforce development requires a strong focus on both present and future needs.

Recommendation:
Workforce planning is prioritised and funded with a focus on rural and remote qualifications and pathways and attractive working and living environments. Funding be provided to have a model whereby specialist or Rural Generalist training can be undertaken primarily in a more remote regional centre with some established rotations to bigger centres to ensure adequate clinical exposure and training.

[9] Gardiner, F. W., Bishop, L., de Graaf, B., Campbell, J. A., Gale, L., Quinlan, F. (2020) Equitable patient access to primary healthcare in Australia. Canberra, The Royal Flying Doctor Service of Australia. [Online at: https://www.flyingdoctor.org.au/news/equitable-health-access-all-australians/] (accessed 6/1/2021) p25

1(h) the current and future provision of ambulance services in rural, regional and remote NSW;

RFDSSE provides air ambulance services to regional, rural and remote communities through our Primary Evacuation, Inter-Hospital Transfer and Non-Emergency Patient Transport Services. RFDSSE has identified that at times, road services can provide a faster response, ensuring that clinical care is available on site, or the patient is transported to an appropriate facility in shorter timeframes. Road vehicles also help to minimise the holding time for patients between departure and/or arrival between RFDSSE aircraft and Broken Hill Base Hospital.

RFDSSE has recently added a road vehicle (ambulance fitout) to the Dubbo fleet and will shortly add a road vehicle to the Broken Hill Base to support timely patient transport and care. Resourcing of ambulances (and staffing) is sometimes challenged in Far West NSW, particularly from Broken Hill. This occurs because of the far west location and intermittent requirements for ambulance and medical transport requirements. This is evidenced when there are delays in urgent patient transfers for patients between Broken Hill Base Hospital and Broken Hill Airport. RFDSSE is regularly required to fly to Menindee to retrieve patients back to Broken Hill, when road transport would take less time. Menindee is approximately one hour's drive from Broken Hill. In most other parts of NSW these transfers would be performed by road ambulance. If a road ambulance is not available, these transfers are performed by air.

RFDSSE has self-funded a road retrieval vehicle for Dubbo. This unique service means that a medical officer can be tasked with the road vehicle. These vehicles should be available and tasked by NSW Ambulance as part of an accelerated or specific response when there is a major or appropriate incident close to Dubbo or Broken Hill. They could be tasked as part of the NSW Ambulance fleet.

Recommendation:
Road Ambulance services in Broken Hill be enhanced; and RFDSSE road retrieval vehicles (current and future) are integrated into the emergency plans for NSW Ambulance around the Dubbo and Broken Hill region.

1(i) the access and availability of oncology treatment in rural, regional and remote NSW;

Cancer is the second leading cause of death in western NSW and both the incidence and mortality rates are higher than NSW as a whole[10].

Oncology services are specialised and located in regional centres. For complex tests and treatment many people are required to attend a major regional centre or a capital city. Access (or lack of access) to services within a realistic distance of the persons home, means that choices can be limited, and people will elect surgery over more conservative treatment. At times due to the lack of services and the financial impact, people will decline lifesaving treatment. It is unrealistic to expect oncology services to be in some of the remote locations, however the health services can provide support and financial assistance to enable people to travel for treatment. Health Services must engage with rural and remote cancer patients to provide support that is appropriate and tailored to each person's individual needs.

Recommendation:
Support for Cancer patients is provided in a patient centred and consumer and community engagement approach and tailored to each individual patient and their family. The 'Care Navigator' model drives this approach and is included as part of the health service team for each community.

[10] Cancer Statistics NSW – Cancer Institute of NSW [Online at: https://www.cancer.nsw.gov.au/research-and-data/cancer-data-and-statistics/cancer-statistics-nsw#//analysis/incidence/] (accessed 5/1/2021)

1(j) the access and availability of palliative care and palliative care services in rural, regional and remote NSW;

In remote parts of NSW, Palliative Care NSW lists only Walgett and Broken Hill as having Palliative Care services[11]. Despite this lack of service, the mortality and disease rates for rural and remote areas are higher than other parts of NSW, indicating the need for appropriate services in community. It is desirable for these services to be working as part of the health 'team'.

Recommendation:
Palliative care staff are funded to visit each community with the team – ensuring care plans are managed for each individual person and their family.

1(k) an examination of the impact of health and hospital services in rural, regional and remote NSW on indigenous and culturally and linguistically diverse (CALD) communities; and

Indigenous Australians account for between 11.3 and 31.4% (nationally) of people without access to primary health care services[12] as outlined in the RFDS research publication: Equitable Patient Access to Primary Healthcare in Australia. The percentages of Aboriginal Australians living in rural and regional areas is far greater than metropolitan centres. The disease burden is significantly greater than non-Aboriginal Australians whether they live in cities or in very remote locations. We understand that having access to Aboriginal health services and Aboriginal Health workers/practitioners which are known to provide appropriate Healthcare improves health outcomes.

In line with the overall population of rural and remote areas, the numbers of Culturally and Linguistically Diverse people is less across rural and remote areas, than in metropolitans and regional centres. There are, however, particular locations where CALD populations are centred e.g. Lightning Ridge. Services need to be adapted in these areas to build engagement with a range of people and CALD communities. Interpreter services must be readily available, and staff must be aware of how to access them. Care Navigators, where included as part of a multidisciplinary team can be included to assist in CALD communities.

Research from the Australian Institute of Health and Welfare has shown that accessibility remains one of the most significant barriers to provision of appropriate healthcare. The 60-minute travel time by motor vehicle that is seen as a barrier to access in rural and remote areas is consistent with the research that found that *20% of rural indigenous patients travel more than 30 minutes to seek Aboriginal Health Services but only 8% would travel longer than 60 minutes.*[13]

Recommendation:
Aboriginal Health staff are employed and engaged to work in every health service that supports remote communities as part of the Health Service team, and services are provided within 1hour travel time for all communities.
Care Coordinators/Navigators and Aboriginal Health staff are included as part of the team.

[11] Palliative Care Services Directory – Palliative Care NSW [Online at: https://palliativecarensw.org.au/new/get-equipped/services-directory/] (accessed 5/2/2021)
[12] Gardiner, F. W., Bishop, L., de Graaf, B., Campbell, J. A., Gale, L., Quinlan, F. (2020) Equitable patient access to primary healthcare in Australia. Canberra, The Royal Flying Doctor Service of Australia. [Online at: https://www.flyingdoctor.org.au/news/equitable-health-access-all-australians/] p10
[13] Gardiner, F. W., Bishop, L., de Graaf, B., Campbell, J. A., Gale, L., Quinlan, F. (2020) Equitable patient access to primary healthcare in Australia. Canberra, The Royal Flying Doctor Service of Australia. [Online at: https://www.flyingdoctor.org.au/news/equitable-health-access-all-australians/] p.13

Appendix 1: RFDSSE 2019/20 Year In Review

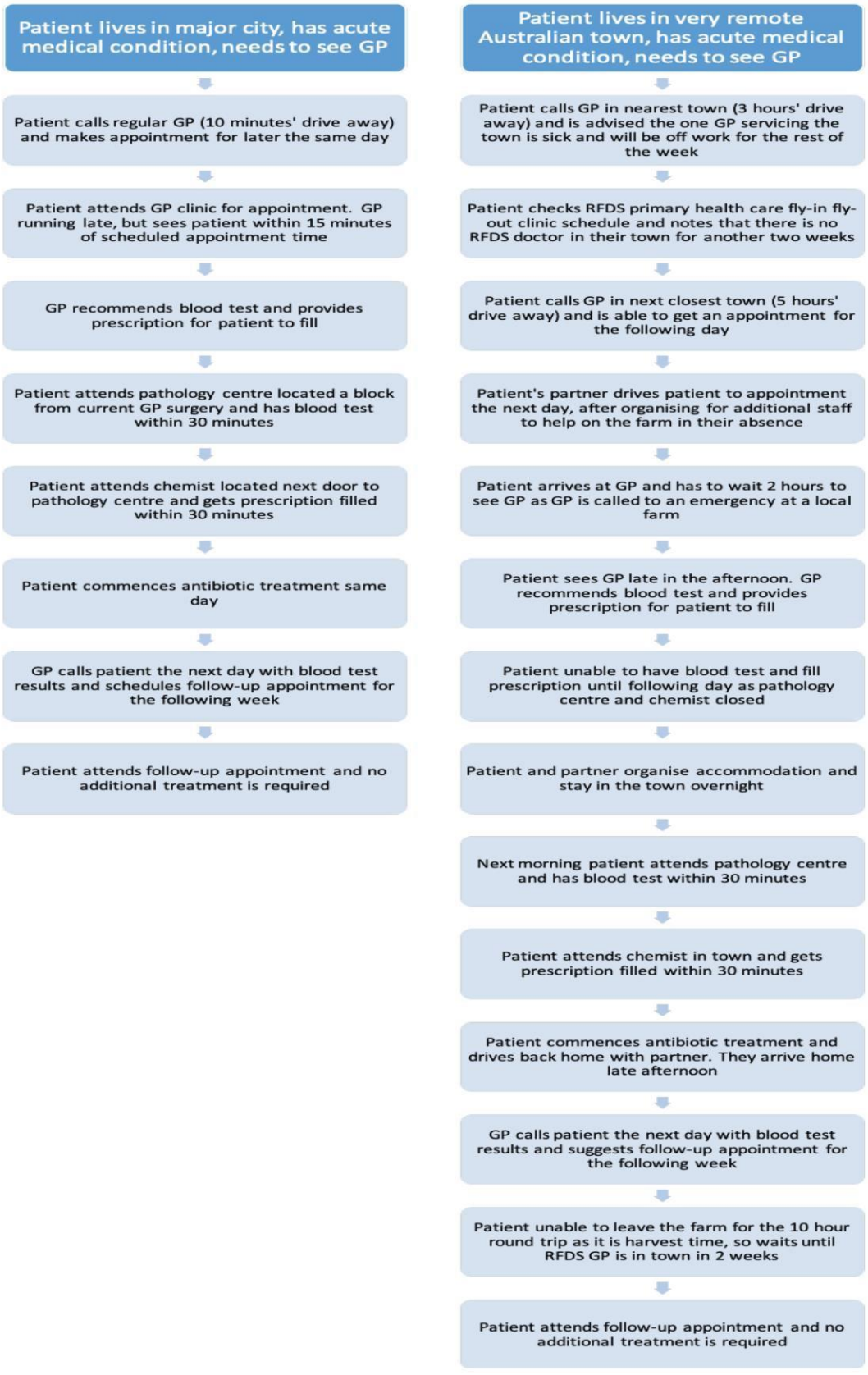
Separate attachment.

Appendix 2: RFDSSE 2019/20 Financial Report

Separate attachment.

Appendix 3: Patient Journey Comparison

Comparison between a major city and a very remote patient journey



Appendix 4: RFDS Service Planning and Operational Tool

The RFDSSE use the RFDS Service Planning and Operational Tool (SPOT) is designed for exploring healthcare coverage in rural and remote Australia. It was developed by Operational Research in Health (ORH) in 2018 for use by the RFDS.

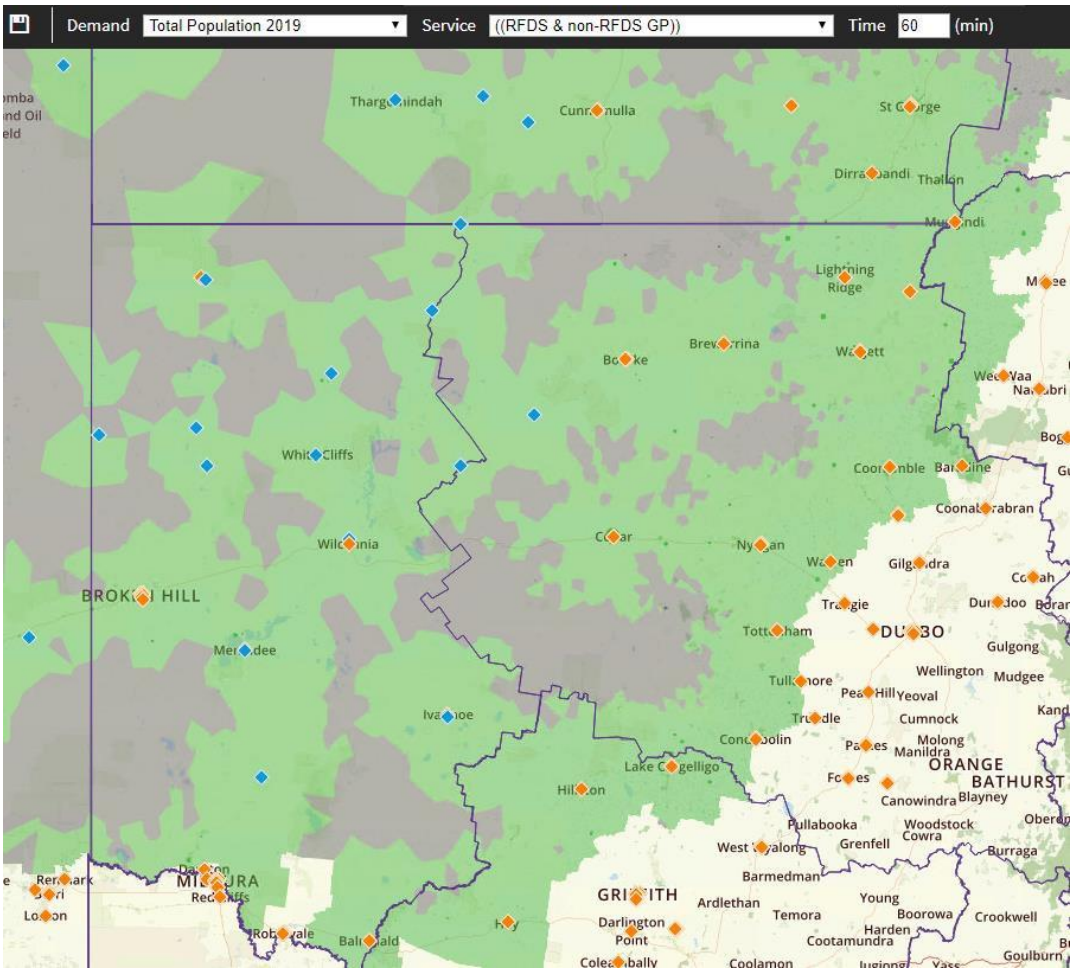
SPOT works from a geographical distribution of 'demand' and a set of healthcare facilities that provide cover for a range of services. SPOT calculates the proportion of demand covered by those facilities within a user-specified drive time. The tool is used to assess the current coverage provided for different services provided by the RFDS. It is used to identify 'gaps' in healthcare coverage for different demand/service pairings and can suggest the best new service locations for improving coverage.

Click here for more information on SPOT.

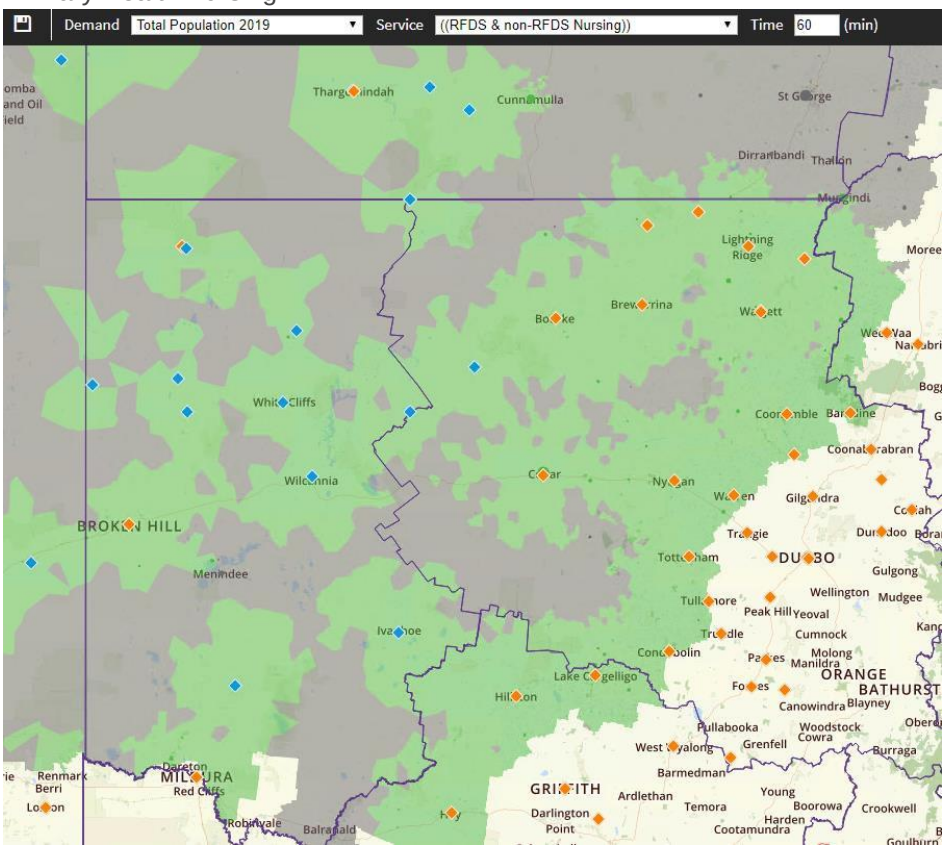
The below graphs provide a snapshot of gaps across Western, North West and Far Western NSW. With gaps in these Regions for General Practice, Primary Health Nursing, Dental, and Mental Health (and Alcohol and Other Drugs).

Blue is RFDSSE service and orange is for other publicly available services.

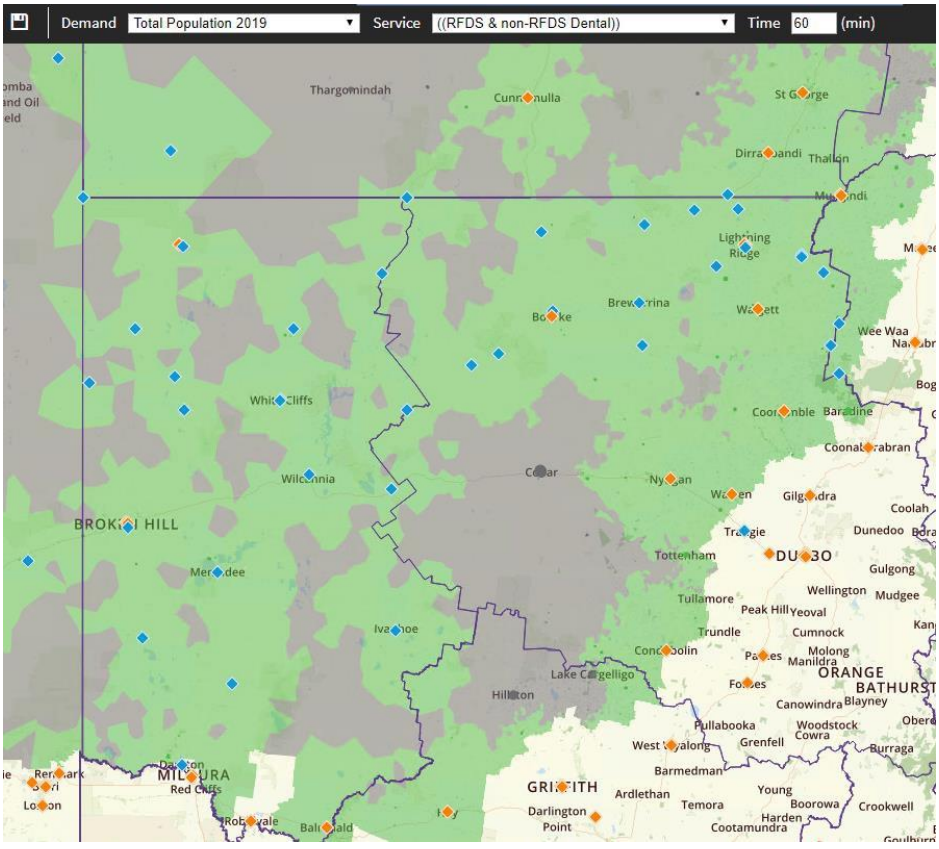
General Practice



Primary Health Nursing



Dental



Mental Health