Submission No 716

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

Organisation: Maari Ma Health Aboriginal Corporation

Date Received: 23 November 2021

SUBMISSION TO INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NSW

Maari Ma Health Aboriginal Corporation is an Aboriginal community controlled regional health service based in Broken Hill providing quality primary health care services and community programs to Aboriginal people in Broken Hill and the communities of Wilcannia, Menindee, Ivanhoe and Balranald. Our constitutional footprint covers the almost 200,000 sq.kms from the Queensland border to the Victorian border, and from the South Australian border eastwards as far as Ivanhoe. Maari Ma was established in 1995 as an outcome of the ATSIC-era Murdi Paaki Regional Council, the peak Aboriginal governance group of western and far west NSW, and retains close linkages with its successor, the Murdi Paaki Regional Assembly. We have an annual budget of $20million and employ more than 140 people, ⅔ of whom are Aboriginal making Maari Ma the largest employer of Aboriginal people in the far west.

Remote NSW's health profile is the worst in the state and presents unique health service delivery challenges. There is an urgent need for organisational change that ensures a greater focus on Remote NSW and promotes new ways of working in primary health care in the region.

We have defined Remote NSW as incorporating the Far West and North West regions of the state. For Aboriginal people the same area is known as the Murdi Paaki region and we will use this terminology for the rest of our submission.

This area covers over one-third of the landmass of NSW. But with under 50,000 people it has less than 1% of the NSW population. The Australian Bureau of Statistics has classified most of the area as Remote or Very Remote (the exception being the Broken Hill LGA and part of the Wentworth LGA). Around 15% of the area's population is Aboriginal, compared with about 3% in the State. This predominance is even more obvious in many of the LGAs, for example Brewarrina (61%), Central Darling (40%), Bourke (32%), Walgett (30%) and Coonamble (26%).

Living in remote areas is itself an independent health risk factor due to multiple factors including geographic isolation, cultural diversity, socioeconomic inequality, health inequality, resource inequity, and a full range of climatic conditions. However, because Aboriginal people make up a substantial proportion of Remote NSW, the overall poorer health status is more likely due to be a reflection of Aboriginal health issues and their determinants.

Over the last 10-15 years, governments and their departments have slowly fragmented (e.g. NSW Health's responsibility for Remote NSW is split between two Local Health Districts (LHDs)) and transferred responsibility for the executive management of service planning, design and decision making for the Murdi Paaki region to centres outside the region (e.g. Western NSW Primary Health Network's (WNSWPHN) headquarters is ostensibly in Orange). This consolidation to Canberra, Sydney and the Central West has only increased the distance and gaps in understanding of local needs, autonomy and solutions and is unsatisfactory on many levels. The one size fits all approaches, coupled with complex and competitive tendering and grant arrangements, do not provide the flexibility to respond to the unique geographical and cultural challenges of the region and lead to fragmented, duplicative and siloed services that are not suitable or sustainable for providers or communities.

Since the establishment of the Primary Health Networks (PHNs), remote communities and the regionally based primary health care organisations in NSW have experienced disinvestment on a scale never seen previously. Without a joint remote primary health care strategy (including mental health) there is ambiguity of responsibility, a preference to force a fragile market to deliver options, and poor population health intelligence and planning. Commissioning practices are poorly prepared, rarely include joint investment, and place little confidence in local provider networks.

The much vaunted 'collaborative commissioning' is another example where new programs are introduced without appropriate collaboration, led by the likes of NSW Health, NSW Rural Doctors Network and the WNSWPHN, and directly contribute to significant decommissioning and disinvestment of local and regional primary health care providers and organisations including Aboriginal community controlled health organisations (ACCHOs).

Whether intended or unintended, commissioning in remote areas must be undertaken with and through local organisations with greater emphasis on leveraging from established services close to communities. Competitive tendering rather than well supported transformational engagement and strengths-based approaches is undermining the sustainability of regional service providers in remote areas and stifling innovation and cultural safety.

Centralisation of bureaucracy is also mirrored by the devolution of grants and program contracts to major NGOs with governance and senior management functions based in metropolitan and regional areas, which have increasingly resulted in services being delivered from outside of the Murdi Paaki region on a FIFO basis and/or via telehealth.

In contrast, strengthening regional organisational autonomy and capability will help to draw together and enhance local, state and Commonwealth government investment in health services in the Murdi Paaki Region; bring accountability, decision-making, funding and service delivery closer to the regional level thereby facilitating strategically targeted solutions tailored to community needs; drive collaboration to integrate service delivery in pursuit of improved patient access and care outcomes; and build the community capacity and social infrastructure necessary to address the social determinants of health.

Stop dismantling State Government funded community health services, including community mental health services

In the following discussion, 'health' includes both physical health and mental health: sadly, mental health is often an after-thought but it is actually one of the greatest areas of under-servicing in Remote NSW, particularly for Aboriginal people, children and adolescents, and anyone in a community of less than 20,000 people (in other words, all of them!). Hospital-centred services continue to dominate health care service provision in Australia despite numerous significant reports over decades pointing to the need for adequate investment in primary health care and prevention of illness balanced by appropriate (versus runaway) investment in services that cater to the already sick (the classic allegory: a fence at the top of the cliff or an ambulance at the bottom). In the last decade, the two LHDs in western NSW have presided over the gradual erosion of community-centred health services in parts of the Murdi Paaki region. Community health budgets have become easy prey for cash-strapped LHD administrations which have had to balance their budgets, but been unable to control their bigger hospital(s) causing budgetary blow-outs. Today, the future of State Government operated community health services in the Murdi Paaki region is under serious threat.

These local community-centred health services are not only an important part of the provision of regional health services. They also contribute to the social capital of the towns. Their disbandment not only means a loss of local services but a possible downgrading of the social and economic infrastructure in the towns. Unfortunately, there has been a trend over recent years to replace on-the-ground service providers with fly-in, fly-out or telehealth options.

Instead of dismantling community-centred health services, the State Government should be reconceptualising and resourcing them as the centre of gravity of local, effective and affordable primary health care services for the region. Community-centred health services should be placed in the centre of their communities, closely organised, commissioned and co-located with other primary health care services (e.g. private general practice and ACCHOs), and functionally integrated with their respective hospital-based services.

Failing General Practice

General practice in small towns in the Murdi Paaki Region has now reached a critical point. Western NSW PHN projections show that 41 towns, and approximately a quarter of the population in that PHN region, are at risk of having no general practitioner in their communities over the next 10 years unless remedial action is taken now.

The recruitment and retention of GPs has become increasingly difficult due to a convergence of individual, workplace and health system factors. Also, the recruitment of GP Registrars has become increasingly hard for many of the same reasons.

As a consequence, general practice has become increasingly reliant on locums and incurs substantial costs in their employment, reducing funds available for other key practice developments (e.g. improved systems and staff to support chronic disease prevention and management).

This high turnover of GPs is also having a negative impact on the continuity of primary care, especially for patients with chronic and complex conditions. This is particularly an issue in remote health care where there are increasingly fragmented services and without a regular GP, who has a good knowledge of both the patient's medical issues and the referral pathways available, many patients experience undue difficulties in accessing services. Poor continuity of care also particularly affects Aboriginal patients, many of whom are anxious in unfamiliar clinical situations and with unfamiliar practitioners, who respond best to trusted longer term relationships. As a service we constantly worry about the undoubted missed diagnoses and opportunities for preventive care which are occurring because services are forced to rely on staff who can only offer short term placements.

The region’s practices have had to rely on overseas trained doctors, and less on locally trained doctors. Many of the overseas trained doctors require substantial support to adjust to new cultural contexts and often stay only until they meet registration requirements. However, even overseas trained doctor opportunities have dried up due to the pandemic restricting travel.

For private practices that rely on patient billing income to remain viable, the scale of the population served; its socio-economic profile; the absence of mixed billing and the proclivity of episodic care-related rebates has meant that there is insufficient revenue to adequately support the practices.

Furthermore, the need for private general practice to remain financially viable in a tight fiscal environment has at times resulted in overly competitive behaviours towards local ACCHOs in order to achieve market power.

While the ACCHO sector has grown in its capacity and capability to deliver general practice services it is also constantly challenged by the poor supply of general practitioners and GP Registrars.

While the Rural Generalist model has emerged as a means for hospitals to provide secondary and primary medical care, there are recognised limitations in its capacity to provide comprehensive primary health care, as well as limited opportunities for these models to complement and support existing private general practice (e.g. difficulties for private practice to meet Rural Generalist salary, competition for GP training places, less opportunities for private GPs to gain VMO rights to hospitals).

Need for meaningful ACCHO engagement and leadership

Notwithstanding the rhetoric of partnership which has been at the forefront of Government-initiated discourse since the first ACCHO was established in the Murdi Paaki Region in Wilcannia in 1974, true partnership has rarely been a reality. The power imbalance has existed for a variety of reasons. These include mistrust arising from the legacy of Australia's colonial history; a failure to appreciate the time and effort needed to build trusting relationships within Aboriginal communities and organisations; the difficulties of sharing power in a western-dominated health care system; inherited paternalism; institutional racism; and a lack of resourcing to realistically support the partnership process.

Aboriginal health institutions are amongst the most stable and consistent providers of primary care in remote NSW however this clinical and cultural knowledge and authority is not reciprocated in authentic partnership, investment nor advocacy from LHD or PHNs.

Given, a growing Aboriginal population in the region with continuing health disadvantage, a declining non-Aboriginal population, and market failures in both the public and private health systems in the Murdi Paaki Region, the ACCHO sector needs to be engaged and supported to take a greater role in the planning, design and delivery of the region's health services to ensure their sustainability, accessibility and quality, because the ACCHO sector is the future. A remote health strategy must recognise the clinical and cultural leadership of ACCHOs to secure health improvement.

To achieve this there needs to be major reform in the way that 'business' is conducted in the Murdi Paaki Region. It is time to move away from a fragmented regional governance system; duplicative and siloed service development and coordination efforts; and old, failed models for engagement between Aboriginal people and governments. These approaches have no part to play in place-based governance and leadership in the Murdi Paaki Region.

Many of the factors described above have prevented the mainstream primary care services from leveraging existing ACCHO capacity and capability to co-design and jointly deliver culturally safe and accessible services for people living in the Murdi Paaki Region. The current systems for state based and primary health care are not capable of recognising or responding effectively to the needs of individual Aboriginal communities in the Murdi Paaki Region.

To address this challenge, we need to stop, pause and rethink. A fresh new service delivery approach is needed.

The ACCHO's unique comprehensive Primary Health Care model of care, and the more recent Commonwealth Government's Health Care Homes program, has the potential to address the failing primary care landscape in the Murdi Paaki Region. However, ACCHO leadership and push will be required on a regional level to achieve the necessary integrated system-wide general practice and primary health care reforms. To rely on the mainstream, in particular the WNSW Primary Health Network, for such innovation and drive at this stage would be a mistake. There is an obvious need for greater investment into primary care organisations that have cultural authority, industrial agility, live and work in communities and are regionally governed.

Attracting and recruiting skilled staff

The challenges of maintaining a robust workforce in rural and remote health services are widely recognised. The provision of quality primary care services requires the availability of skilled doctors, nurses, Aboriginal health practitioners, allied health professionals and ancillary staff. The Murdi Paaki Region, like many other rural and remote settings, has experienced increasing difficulties in recruiting and retaining an appropriate number and mix of skilled health professionals. These challenges have been exacerbated by drought, a shifting regional demography and changing expectations of the primary care workforce.

These recruitment and retention challenges have caused a substantial and adverse impact on the provision of primary care services in the Murdi Paaki Region. It has led to disruption in services and in some cases, service closures, failing continuity of care, weakened business and clinical systems and worsening health outcomes. Lack of partnerships with the Aboriginal health organisations and no meaningful commitment to Aboriginal workforce development are compounding this chronic deficit.

As an example, hospital medical officer needs should not be mutually exclusive of general practice needs within communities, including ACCHOs. Models need to be developed collaboratively to harness structural synergies, enhance coordination and sustainability and maximise cultural safety and population level outcome measures. Of equal importance is the development of an Aboriginal health workforce development strategy: this should be developed in accord with the UN Declaration on Rights of Indigenous People and in collaboration with ACCHOs. This would be a meaningful and substantial building block in demonstrating government bona fides and partnership goals.

Declining Broken Hill Base Hospital services

Sadly, Broken Hill Base Hospital's regional hospital capacity has slowly declined over the last two decades due to many cross-cutting challenges including a shrinking catchment population, increasing operating costs, significant budgetary constraints, older and sicker patients who can no-longer be locally managed, decreasing local hospital medical services capability, increasing reliance on locums and agency staff impacting on the continuity of care and quality of the local hospital referral process, and geographic isolation in terms of being part of a wider hospital network and partnering with a large urban tertiary hospital.

As a result, more and more patients are being referred to Adelaide hospitals and medical specialty services for assessment and ongoing treatment. This in turn is highlighting the importance of the need for increased clinical collaboration in the delivery of services across the state border.

Regular complaints from our front-line GPs include poorly integrated care, poor communication from specialist providers, reluctance to hand-back care, poor pre-referral guidance in terms of work-up, unnecessary travel requirements, ongoing patient travel and accommodation barriers, and so on.

In addition, the hospital's workforce challenges impact on its capacity to develop a culturally responsive workforce which is well educated in trauma informed care. This is no better highlighted than in the hospital's maternity service.

The LHD behaves as a 'closed system' that is vertically integrated and has a clinical superiority complex. Living in remote areas necessitates out of area referral with necessary care coordination and often navigation of complex care systems. The lack of investment in GP and ACCHO lead primary care partnerships and models of shared care result in delayed treatments, poor engagement, and patient participation, and often discharge against medical advice.

NSW Health has provided no leadership to support the codesign and development of consistent, culturally safe care pathways across primary, hospital and social care domains and this is contributing to poor experience of care by vulnerable patients, increased morbidity, persistent potentially preventable hospitalisations (PPH) and mortality.

Access to transport is one of the single largest barriers to timely and appropriate care. Remoteness means travel, travel means cost to the patient and their carer. The current transport assistance program is grossly inadequate, underutilized by Aboriginal people, poorly administered, and culturally unsafe.

Poor dental services

Often the unseen/unheard/least squeaky part of the rural/remote health wheel is that of dental services. The private dental market is tiny and precarious and exists in only the largest of communities in the Murdi Paaki region. Virtually every resident of Remote NSW is reliant on the visiting service supplied by the RFDS. This service is augmented again in some communities by dental students. The supply of new dentists in the bush is as dire as it is for new doctors: existing private dentists are ageing and new dentists don't seem to want to leave the city. The ability of the RFDS to recruit dentists is also waning: the RFDS 'brand' does not seem to have the same recruitment pulling power it once did, leaving remote communities with a pain management service only rather than the preventative and restoration service that is a necessary part of health maintenance and primary health care.

The Commonwealth's funding of public health dentistry to the State, and the State's funding to LHDs based on dental activity or occasions of service (measured in Dental Weighted Activity Units or DWUAs) has meant the LHDs are putting substantial pressure on the dental providers to achieve daily/weekly/monthly DWAU targets that do not seem to take into account the service delivery landscape, its acuity or the clientele. This has dental providers pressured to remain in the larger centres with higher throughput at the expense of the smaller communities: yet another blow to the health of residents of Remote NSW who will be, on weight of numbers, Aboriginal.

Conclusion:

There needs to be a clear and urgent commitment to the National Cultural Respect Framework (supposedly endorsed by all States and Territories).

There needs to be greater accountability for health equity for Aboriginal people living in remote areas and LHDs need to achieve outcome improvement at a population level – not hospital activity statistics.

All forms of institutional racism need to stop and should be subject to independent assessment to ensure this critical barrier to healthcare is removed.

There is a critical need for immediate improvements in relationships, power sharing and transparency.

There is a need for a NSW remote health strategy, including consideration of how well current State and Commonwealth health boundaries have proven to drive health improvement and sustainability of provider networks. LHDs can't choose to 'play' in the primary care space without being accountable for population level outcomes including child and maternal health development needs, health screening and prevention, and optimising management of chronic conditions. Remote NSW, the Murdi Paaki region, requires its own specific strategy to ensure the decline in services witnessed over the last two decades is reversed and the residents of this region have access to the requisite sustainable primary health care services that will ensure their ongoing health.