Submission
No 82

# THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO CROSS-JURISDICTIONAL HEALTH REFORM AND GOVERNMENT CONSULTATION WITH REMOTE, RURAL AND REGIONAL COMMUNITIES

**Organisation:** National Rural Health Alliance

**Date Received:** 8 November 2024

National
Rural Health
Alliance

# The Select Committee on Remote, Rural and Regional Health: Inquiry into the Implementation of Portfolio Committee No 2 Recommendations Relating to Cross-Jurisdictional Health Reform and Government Consultation with Remote, Rural and Regional Communities in NSW

8 November 2024

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

| | |
|---|---|
| Postal address: | PO Box 280 Deakin West ACT 2600 |
| Address: | 10 Campion St Deakin ACT 2600 |
| Phone: | 02 6285 4660 |
| Email: | nrha@ruralhealth.org.au |

# The Select Committee on Remote, Rural and Regional Health: Inquiry into the Implementation of Portfolio Committee No 2 Recommendations Relating to Cross-Jurisdictional Health Reform and Government Consultation with Remote, Rural and Regional Communities in NSW

## Response by the National Rural Health Alliance

The National Rural Health Alliance (the Alliance) welcomes this opportunity to provide input to the Select Committee's Inquiry into the implementation of key health recommendations affecting remote, rural and regional NSW communities. The Alliance comprises 52 national organisations committed to improving the health and wellbeing of the over 7 million people[1] in regional, rural and remote (hereafter rural) Australia. Our diverse membership includes representation from health professional organisations, health service providers, health educators, students and the Aboriginal and Torres Strait Islander health sector.

The Alliance provides a united voice for people and health professionals living and working in rural communities and advocates for sustainable and affordable health services. Our most important role, underpinned by our broad representative base, is listening to the people of rural Australia and facilitating their views and ideas to government.

## Rural Australia

Over 7 million Australians – approximately 30 per cent of the population - live outside the major cities. They contribute significantly to Australia's social and economic landscape:

- Over 90 per cent of the food and beverages consumed by Australians are grown or made in rural Australia.[2]
- Approximately two thirds of Australia's export earnings come from regional industries such as agriculture, minerals, tourism, retail, services and manufacturing.[3-6]
- Australia exported $80.4 billion in agriculture, fisheries and forestry (AFF) products in the 2022–23 financial year – a record high.[4]
- Mining contributed a record $466bn in export revenue for Australia in the 2022–23 financial year.[5]
- Tourism, worth $63.0 billion to the Australian economy in 2022-23[7] with 40 to 50 per cent of tourism dollars spent in rural destinations.[8]
- Regional Australia is essential to the renewable energy transformation, with continuing investments in large-scale renewable generation projects, and record investments in storage in 2023.[9]
- The importance of rural life is embedded in Australia's national story, however contested it might be.[10]
- Approximately 60 per cent of Australia's First Nations people – representing the world's longest continuous living culture of over 50,000 years – live outside the major cities.[11]

## Health outcomes for rural Australians

Rural Australians experience significantly worse health outcomes than their urban counterparts, a disparity that conflicts with international human rights commitments to the highest attainable standard of health[12] and is a poor reflection on a western country.

According to the Australian Institute of Health and Welfare[13]:

- the burden of disease from chronic diseases including coronary heart disease, type 2 diabetes, chronic kidney disease, lung conditions is higher for rural Australians, and increases with remoteness
- rural Australians have higher rates of arthritis and chronic obstructive pulmonary disorder (COPD – lung disease) than people in the major cities[14]
- rural Australians have higher incidence of many cancers and lower 5-year survival rates from cancer than people in the cities
- rural Australians are more likely to engage in behaviours that put their health at risk, such as smoking and consuming alcohol at levels that put them at increased risk of alcohol-related diseases or injuries, compared with people living in the major cities[15]
- mental health outcomes are worse for rural Australians. People outside the major cities have higher rates of mental and behavioural conditions and a higher burden of disease from suicide and self-inflicted injuries
- women living outside major cities are 1.5 times as likely to have experienced partner violence than women living in major cities.

This higher burden of disease and higher risk factors contribute to lower life expectancy for rural Australians:

- Men in outer regional areas have a life expectancy 3 years lower, in remote areas 7 years lower, and in very remote areas 13 years than their city counterparts
- women in outer regional areas have a life expectancy 2 years lower, in remote areas 6 years lower, and in very remote areas 16 years lower than their city counterparts.[13]

**Health care access for rural Australians**

Rural Australians face significant barriers in accessing healthcare services, particularly primary health care. According to the AIHW[13]:

- Medicare claims data from 2022–23 show that the number of non-hospital non-referred attendances per person, such as general practitioner (GP) visits, were lowest in remote and very remote communities.
- People outside the cities are less likely to visit the dentist. According to the National Study of Adult Oral Health 2017-18[16], the proportion of people aged 15 years and over who saw a dentist in the last 12 months was 52 per cent compared to 59 per cent in capital cities.
- The rate of potentially preventable hospitalisations (conditions that could have been avoided through effective access to primary care) is higher for rural Australians, increasing with remoteness. People living outside major cities also have lower usage of chronic disease management services.
- In 2021–22, people living in very remote areas were hospitalised at almost twice the rate as people living in major cities, and people in remote areas at 1.3 times the rate. This can be an indicator of poorer access to primary health care services.

- People in major cities have higher rates of rehabilitation care hospitalisations compared with rural Australians.

With primary care services in rural communities being limited and often underfunded, patients frequently wait weeks for appointments, delay or go without. Urgent care needs are met at the hospital which might have workforce shortages. For patients who do not have a usual general practice, the hospital may also meet routine care needs, or people defer or go without care.

This occurs when all the evidence points to the need for a greater investment in primary care as essential for quality health care and to reduce hospitals admissions and lengths of stay. The Mid-term review of the National Health Reform Agreement correctly notes that:

> At its simplest, care delivered outside an acute setting that can reduce the likelihood of an acute presentation or mitigate its complexity is likely to be a more efficient way of allocating funding and improve patient outcomes. This is particularly the case in an environment of an ageing population and a rise in chronic and complex conditions.[17]

**National Rural Health Expenditure Shortfall**

The Alliance has previously advised the Committee about the rural health expenditure deficit in Australia. Nous Group undertook independent analysis of key health expenditure in Australia evaluating both publicly available and privately sourced data sets, including the Australian Institute of Health and Welfare (AIHW), Australian Bureau of Statistics (ABS), National Disability Insurance Scheme (NDIS), Medicare benefits scheme (MBS), pharmaceutical benefits scheme (PBS) and census data, working to align them to demonstrate the component parts of the rural health spend. Nous Group found that there was an annual gap in health expenditure on rural Australians of $6.55 billion, or $848.02 per person, compared to health care spending on people in the cities.[18]

This gap is a measure of the significant shortfall in access for rural Australians to health care services, which results in poorer health outcomes. It represents a major inequity in Australia's health care system and a denial of the rights of rural Australians to the highest attainable state of health.

This $6.55 billion annual inequity needs cuts across Australian government and state/territory health expenditure. While the figures are not available to be broken down by jurisdiction, NSW and all state/territory governments are accountable to ensuring that the health spend per person in their jurisdiction should be equitable across metropolitan and rural.

With this figure at top of mind, the Alliance welcomes the emphasis that this Committee has placed over a significant period of time to investigate the access issues to healthcare in remote, regional and rural NSW and to investigate the progress that has been made in the Implementation of Portfolio Committee No 2 Recommendations Relating to Cross-Jurisdictional Health Reform and Government Consultation with Remote, Rural and Regional Communities in NSW.

## Terms of reference for this Inquiry

1. Cross-jurisdictional cooperation between the New South Wales and Australian governments, in particular:
    a. Long- term strategic planning to improve health services and health outcomes in remote, rural and regional areas, including in relation to primary health (including recommendations 1, 7, 8 and 11)
2. Collaboration between NSW Health and Australian government bodies on particular health initiatives, services or training programs (including recommendations 9, 10, 14, 21, 22 and 39)
3. NSW Government consultation with health stakeholders and communities in remote, rural and regional New South Wales, in particular:
    a. Improving communication between communities and health services (including Recommendations 5, 42) and
    b. Developing place-based health plans (including Recommendation 43)
4. NSW Government action to prioritise the health of regional communities in government decision making (including Recommendations 36, 37 and 44).
5. Any updates or final observations relating to the progress of implementing any Portfolio Committee No. 2 recommendations that the Select Committee has considered in its previous inquiries.

## Addressing specific Terms of Reference

1. Cross-jurisdictional cooperation between the New South Wales and Australian governments, in particular:
    a) Long-term strategic planning to improve health services and health outcomes in remote, rural and regional areas, including in relation to primary health (including recommendations 1, 7, 8 and 11)

While jurisdictions have committed to improving the interface between primary and acute care services under the National Health Reform Agreement, funding silos persist hindering strategic planning to build better services for people living in rural communities. The National Health Reform Agreement Addendum (2020-25) mentions 'rural' 10 times, mainly in relation to block funding for small rural hospitals and to support the COAG S19(2) arrangements. It includes two reform-oriented commitments in relation to rural in the Agreement, on which there has been limited delivery:

> **Para 9.h** that the Commonwealth and the States and Territories are jointly responsible for "identifying rural and remote areas where there is limited access to health and related services with a view to developing new models of care to address equity of access and improve outcomes"
>
> **Para F16.d** that the Parties will "work towards sustainability and improved coordination of health, primary health, aged care and disability services particularly in regional, rural and remote communities".

The review of the Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025[15] highlights:

- people in rural and remote communities continue to experience poorer health outcomes
- the need for a coordinated national approach is needed addressing health disparities that encompass models of care able to function where workforce and infrastructure is limited, with health providers operating at a full scope of practice and greater integration across sectors to get the most from available resources
- a shared plan of action focused on equity of access in rural and remote areas should form a Schedule of a new [National Health Reform] Agreement with priority actions and milestones, national datasets and minimum access standards, appropriate regionality weightings in funding formulae and equitable distribution of Teaching, Training and Research funds.

The Alliance supports these findings and calls for the recommended Schedule to the next National Health Reform Agreement to sit under a National Rural Health Strategy. Current approaches are not delivering coordinated or sustained solutions, and a clear, coordinated and funded plan is needed to ensure the inequity between rural and urban Australia is addressed and benchmarked.

## The Need for a National Rural Health Strategy

All Australians, regardless of where they live, have a human right to the highest attainable state of health. This cannot be delivered without better access to health care services, including primary health care services. Commonwealth Governments over the last decades have made attempts to improve access to health care for rural Australians.

- Aboriginal Medical Services began to be funded by the Whitlam Government in 1972 through a grants program which has evolved and grown over the decades into the Indigenous Australians Health Program (IAHP), which now supports Aboriginal Community Controlled Health Services across the country, including many in rural and remote areas.
- Medicare, in various iterations, as Australia's universal health care insurance scheme, has since 1973 subsidised patients for out of hospital health services, at lower or no cost.
- In 2006-07, the then Council of Australian Governments (COAG) agreed the COAG Section 19(2) Exemptions Initiative – Improving Access to Primary Care in Rural and Remote Areas. This allows the MBS to be claimed for primary care services delivered by rural hospitals but has very limited effectiveness in improving access to primary care.
- In 2009 the federal and state governments worked together with the NRHA and other rural stakeholders to develop the National Strategic Framework for Rural and Remote Health which promotes a national approach to policy, planning, design and delivery of health services in rural and remote communities. This was agreed in 2011 by the then COAG Standing Committee on Health, though with no tied funding or timeline for implementation. It has now lapsed.
- Since 2010, the Workforce Incentive Program (and predecessor payments) and rural loadings on Practice Incentive Payments have provided additional funding for general practice in rural areas.
- Many other workforce programs – including scholarships, bonded placements and rural medical schools – have over time operated to try to encourage more health professionals to work in rural areas.

- In 2018-19, the Commonwealth Minister for Health announced the Stronger Rural Health Strategy, which was a Commonwealth strategy not agreed with the States and Territories and focused on workforce measures, including the Murray-Darling Medical Schools network and the National Rural Generalist Pathway. The Office of the National Rural Health Commissioner was established at this time.
- In 2020-21, the first Innovative Models of Care (IMOC) trials commenced, to trial new multidisciplinary primary care models designed to reduce chronic workforce shortages and improve patient access in a range of locations (including remote towns). There have now been five founds of funding, with small scale trials being run by 20 organisations.
- Over the same time frame, Single Employer Model trials for GP registrars in regional, rural and remote trial site locations have been expanded, to make it easier for rural GP registrars to accrue and access employment entitlements. These have been generally well received but remain trials, with their long-term future and scale unresolved.
- On 1 January 2022, rural bulk billing incentives under the MBS were increased to 160-190% of the metropolitan rate, increasing the incentive for rural GPs to bulk bill children and concession card holders. The current Government's tripling of the bulk billing incentive in November 2023 has further increased the benefit for rural patients, helping to maintain bulk billing rates, particularly in rural areas.

The AIHW data revels poorer health outcomes and limited access for rural Australians[13], alongside an annual $6.55 billion shortfall in expenditure[18]. Collectively, these efforts have yet to achieve equitable health service access or improve health outcome equity for rural Australians.

The Commonwealth's rural health measures have mostly lacked coordination with States and Territories. A recent example - this Committee's Inquiry into "Health outcomes and access to health and hospital services in rural, regional and remote New South Wales" found in 2022 that "the Commonwealth/State divide in terms of the provision of health funding has led to both duplication and gaps in service delivery".[19]

Clearly, the impetus, and we would argue, the obligation is there for NSW and other jurisdictions to work with the Australian government to commit to supporting the recommendations of the Mid-Term Review, including the call for a Schedule to the next National Health Reform Agreement which could be the funding mechanism to underpin the broader policy directions outlined in a much needed National Rural Health Strategy.

**What the National Rural Health Strategy should cover**

The Alliance would like to see broad consultation with rural communities, consumers and peak bodies, First Nations groups, health professionals, practices and health services (including Local Hospital Networks, Primary Health Networks, Rural Workforce Agencies) and local Government, in developing the Strategy.

At a minimum, and in alignment with the findings of the Mid-Term Review of the National Health Reform Agreement, a National Rural Health Strategy should include:

- Funded priorities for action with timelines and milestones attached to ensure viable health services are developed and maintained.

- Definition of a minimum reasonable level of access to care for rural Australians, starting with primary health care. This should:
    - Cover the full range of parameters of access including availability, affordability, appropriateness, approachability and acceptability.
    - Balance the advantages of virtual care and telehealth in improving access with the continuing need for health professionals on the ground to provide quality face to face care.
    - Be measurable with available data to support accountability.

- Coordinated actions to maintain and grow the rural health workforce, incorporating findings and recommendations from the Scope of Practice Review and numerous related inquiries, reviews and evaluations.
- Coordinated actions to support First Nations health, consistent with the National Agreement on Closing the Gap and the National Aboriginal and Torres Strait Islander Health Plan 2021-2031.
- Coordinated delivery of mental health services as part of and alongside hospital and primary and community health care services.
- Coordinated and equitably funded arrangements for patient transport and accommodation where required.
- Appropriate regionality weightings in funding formulae and equitable distribution of Teaching, Training and Research funds, as proposed in the Mid-Term Review report.
- Actions to address the health and wellbeing impacts of climate change and the contribution of the health system to climate change, consistent with the National Health and Climate Strategy
- Commitments to health research in rural communities, with a fair share of research funding going to rural researchers, including and benefiting rural communities directly.

**Recommendation:**
**That the NSW Government commit to working with the Australian government to develop a National Rural Health Strategy with Implementation Plan and the inclusion of a Rural and Remote Schedule to the next National Health Reform Agreement (2025-2030)**

**Supports for the Rural Health Workforce**
Recommendation 11 [abbreviated] of the Portfolio Committee No 2 Report recommended that NSW Health work with the Australian government collaboratively to immediately invest in the implementation of a 10-Year Rural and Remote Medical and Health Workforce Recruitment and Retention Strategy. The Alliance agrees about the importance of such a recommendation but notes that ideally this would form part of a larger National Rural Health Strategy. Further, work to support a Rural and Remote Medical Health Workforce Recruitment and Retention Strategy would sit with the work undertaken to implement the National Medical Workforce Strategy 2021 to 2031, the current development of a National Nursing Workforce Strategy and the early work underway to develop a National Allied Health Workforce Strategy.

Feeback to the Alliance from rural health professionals highlights several key factors affecting recruitment and retention in rural health. Certainly recruitment and retention incentives, relocation support and professional development opportunities are fundamental. The Alliance also consistently

hears about a shortage of accommodation options for rural health professionals, and students across various health professions and those on training rotations as part of specialist and advance qualification attainment. It is no longer enough to invest in health facilities alone. Rural locations need further investment in housing infrastructure so that it is realistic for health professionals and students to consider placements and work opportunities in rural locations. The Alliance notes the recent NSW investment to commit an additional $200.1 million to increase key health worker accommodation across rural and regional areas of the state as part of the 2024-25 NSW Budget.

According to announcement, the funding is intended to support the recruitment and retention of over 500 health workers and their families in regional NSW by providing a range of new worker accommodation and it will secure approximately 120 dwellings which may include the building of new accommodation, refurbishment of existing living quarters, and possible purchase of suitable properties such as motels.[20]

More investment to augment this announcement will be needed over the coming years to build the required infrastructure and capacity to support rural communities to attract and retain a workforce. Such investment brings wider economic benefits to these communities through the construction and fit out of premises supporting local trade and retail businesses.

Another important issue is access to quality childcare for rural health professionals. Simply put, for many health professionals, a lack of access to suitable and quality childcare options can be the reason for making a decision to move – or not – to a rural location.

In this respect, the Alliance would like to acknowledge NSW's commitment to the Welcome Experience Program. As a free service supporting essential workers (and their families) who are considering applying for or have accepted a job in regional NSW, Local Connectors help an essential worker with the practicalities of finding housing, choosing childcare, exploring job opportunities for partners and introducing the family within the broader community. The Alliance has heard support for this program from a range of NSW stakeholders and health professionals.[21]

**Recommendation:**
**That the NSW Government commit to further funding to increase housing infrastructure, child care and concierge services for rural communities to support healthcare (and other essential) workers.**

## Teaching, Training, Research (TTR) funding to rural hospitals

Another key area for supporting the rural health workforce is to ensure that those health professionals who are interested in teaching, research and supervision are given the opportunities to undertake this work in rural health facilities, particularly in rural hospitals and further, that they receive appropriate compensation for this work. The Mid-Term Review of the National Health Reform Agreement made the point very strongly that state-government funding for rural hospitals needs to improve. The Alliance recommends that the NSW Government note the finding in the Mid-Term Review that:

> The block funding model for small rural hospitals does not include teaching and training funding, which is currently only available for tertiary and larger regional hospitals. This model does not acknowledge the important role that small rural hospitals play in providing

teaching and training for various healthcare professions, including medical students and registrars, especially in the field of Rural Generalist medicine and other medical specialties. In rural hospitals where teaching occurs, there are additional challenges related to GP Visiting Medical Officer (GP VMO) arrangements. For instance, in New South Wales and Victoria, where hospital inpatient services are contracted to GP VMOs, the current system pays one fee for services when a registrar is on-call. Under these arrangements, there is no compensation provided for supervisors providing training or assistance to the on-call registrar. This reduces the incentive to maximise teaching opportunities and may discourage supervisors from providing help when needed.[17]

Further, the reports states:

> To enhance teaching opportunities and create a supportive environment in rural hospitals, supervision of registrars should have a separate budget allocation, distinct from fee-for-service arrangements. Investing in supervision has a substantial positive impact on retaining these doctors in rural and remote areas beyond their training period.[17]

**Recommendation:**
**That the NSW Government follow the direction of the mid-term review of the current National Health Reform Agreement and increase funding for teaching, training and research (TTR) and clinical supervision for health professionals in rural hospitals.**

## Term of Reference 2

2. Collaboration between NSW Health and Australian government bodies on particular health initiatives, services or training programs (including recommendations 9, 10, 14, 21, 22 and 39).

Recommendation 10 relates specifically to the model of primary care recommended by the Alliance:

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

The RACCHO model was developed by the Alliance and is now referred to as Primary care Rural Integrated Multidisciplinary Health Services (PRIM-HS). 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. The Alliance believes that the NSW Government has not responded adequately to this recommendation and should commit to identifying sites where the PRIM-HS model could be implemented. The Alliance would like to draw the Committee's attention to a PRIM-HS trial currently in place in Mareeba North Queensland. The Alliance has partnered with a social enterprise in Mareeba - Mareeba and Communities Family Healthcare (MCFHC) organisation through a successful Australian Government Innovative Models of Care (IMOC) grant to trial PRIM-HS. Here is a short description of the trial as outlined on the Australian Government Department of Health and Aged Care website.

**Innovative Models of Care (IMOC) Program – Primary Care Rural Integrated Multidisciplinary Health Service (PRIM – HS) Mareeba Community Primary Care Trial**

Mareeba and Communities Family Healthcare will deliver the Primary Care Rural Integrated Multidisciplinary Health Service (PRIM – HS) Mareeba Community Primary Care Trial: testing flexible employment models including a single or primary employer model.

**Round 5: Mareeba and Communities Family Healthcare** Mareeba Community Primary Care Trial
**Location:** Mareeba QLD
**Funding:** $1.6 million over 4 years from 2024

The activity will trial the National Rural Health Alliance (NRHA)'s Primary care Rural Integrated Multidisciplinary Health Service (PRIM-HS) model. Mareeba and Communities Family Healthcare (MCFHC) has worked with the National Rural Health Alliance (NRHA) on the development of this model.

This PRIM-HS model overcomes many of the barriers to attracting and retaining a rural health workforce by bringing all rural stakeholders including local government, community, health service clinicians, hospital and health services and industry together. Together stakeholders will discuss, plan and work to provide the services needed by a local community.

This is done by providing a community grass roots approach to secure, ongoing employment. The grant will support the co-design, development and testing of flexible employment models. These models recognise the complex relationship between people, place and health and the role communities play to identify needs and come up with solutions which are fit for purpose. The identified priority workforce for the Mareeba community includes psychology/mental health, general practitioner, social services, and other allied professions.

The PRIM-HS model recognises the importance of community-led, population health need and fit for purpose priority setting and prioritises developing models of health care that meet these needs. MCFHC will recruit a team to manage the project. The grant will also support travel costs, consultation, training, health system literacy, and community engagement activities. This will allow testing of flexible employment models that were explored through planning workshops. Through training and sharing of what is learnt, employment conditions and the working across of several sites, positions can be tailored to the population, clinician and local services, to sustainably recruit and retain health professionals.

Integration will increase understanding of how employment conditions and community can increase attractiveness of roles across the Mareeba community and surrounding areas.
Project stages:

- Project management: through the entire project phase, reporting framework, evaluation plan to align with IMOC objectives, regular progress meetings.
- Project establishment: appoint project team to finalise implementation approach to match completed co-design. Launch the trial, including evaluation.

- Flexible employment models: develop and test flexible employment models involving multiple organisations and document suitable employment conditions.
- Innovation in multidisciplinary care; setting the ground for the development of health services, offered in line with community needs and health care gaps
- Financial sustainability: review health service funding options and increase awareness and expertise in accessing funding.

MCFHC and NRHA will collaborate to develop an evaluation plan at the beginning of the trial. Evaluation will be ongoing. The approach will consider adaptability in rural settings and be based on the action research model. This will reflect on actions taken and assess effectiveness against the project outcomes outlined below.

Expected outcomes and benefits:

- A sustainable model of a grass roots led multidisciplinary primary health care for the Mareeba community, including high-risk groups.
- Improved primary health care through population based, patient-centred and coordinated care.
- Improved health outcomes through culturally safe, quality care for people with acute/chronic conditions and a focus on health promotion/preventive health checks.
- A sustainable, skilled and appreciated health workforce supported to deliver high-quality care.
- Health care and health system literacy in community, through inclusion in planning and sharing of process

Services start date is 1 June 2024.[22]

With this trial underway in QLD, it would be an ideal time to have NSW sites trialling the model to enable exchange of information and evaluation methodologies and to provide evidence for the value of the model across different jurisdictions and community profile.

**Recommendation:**
**That the NSW Government 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.**

## Term of Reference 3

3. NSW Government consultation with health stakeholders and communities in remote, rural and regional New South Wales, in particular:
   c) Improving communication between communities and health services (including Recommendations 5, 42) and
   d) Developing place-based health plans (including Recommendation 43)

This term of reference correctly identifies the importance of sharing information, research and learnings across rural health services. The Alliance would like to take this opportunity to share with the NSW Government the Alliance's call for a Rural Health Innovation and Evidence Hub.  The

Alliance is seeking funding for this Hub from the Australian government and would also welcome commitment from the NSW Government to endorsing the need for this shared resource across all Australian jurisdictions. Some more background about the need for a Rural Health Innovation and Evidence Hub is outlined below.

**Proposal for a Rural Health Innovation and Evidence Hub**

Across Australia, there is renewed enthusiasm for community-led health approaches that define and establish the necessary health services in rural areas. Many rural communities are collaborating, or aiming to collaborate, with other communities to develop grassroots driven solutions, supported by Government. However, lessons from Government grants, pilots, innovative models of care and rural research are not readily shared to enable their adaptation to meet community needs . Additional, there is currently no national 'smart' hub to facilitate real-time information sharing and exchange, which could help address the challenges faced by rural communities.

The Hub would bring together rural health clinicians, researchers and communities to enable sharing of what works well in rural community settings, and lessons learned from Government grants, pilots, innovative models of care and other rural research that can be adapted to address community need. More than just a knowledge hub that supports information sharing and exchange, the Hub would provide a foundation for evidence-based policy and practice by systematically synthesising, reviewing and translating resources and research, and disseminating this information so it can be adapted to address rural health needs.

To ensure the health system learns from innovation in rural communities, the Alliance is seeking Government commitment to fund a Rural Health Innovation and Evidence Hub, hosted by the Alliance that operates as a community of practice to:

- Support independent evaluation and consolidate and share the learnings from the Innovative Models of Care trials, the Single Employer Model and other rural health care innovations.
- Support implementation of the community primary health care services established by the proposed National Rural Health Fund through monitoring, evaluation and learning approaches.
- Build on existing mechanisms - the Australian Journal of Rural Health, the annual National Rural Health Conference and the Rural and Remote Health Scientific Symposium – to help the health system and rural communities learn through regional workshops and information sharing on a centralised learning and innovation hub.
- Ensure rural research is translated and communicated widely to inform broader rural health policy and practice.
- Remain independent and objective and not aligned to any one university or research body
- Work across the Australian government together with State and Territory governments to share learnings across jurisdictions.

**Recommendation:**

**That the NSW Government express its commitment for the National Rural Health Alliance to be funded to establish and administer a Rural Health Innovation and Evidence Hub to share and translate findings from rural health research and implementation of health models across the country.**

## Term of Reference 4 and 5

Our key points have already been covered in addressing Terms of Reference 1 to 3.

## Conclusion

The Alliance respectfully urges the NSW Government to recognise the urgent need for a unified, equitable approach to rural health reform. By adopting the recommendations for a National Rural Health Strategy, supporting rural workforce initiatives, expanding TTR funding, piloting PRIM-HS, and endorsing a Rural Health Innovation and Evidence Hub, NSW can lead efforts toward sustainable health improvements in rural communities.

Thank you for considering our feedback. We are available to provide further information or clarification as needed.

## References


[1] Australian Bureau of Statistics. Regional population. 2022-23 financial year. Data downloads: Population estimates by LGA, Significant Urban Area, Remoteness Area and electoral division, 2001 to 2023. Table 3. 30 June 2023 [cited 30 October 2024]. Available from: https://www.abs.gov.au/statistics/people/population/regional-population/latest-release

[2] Australian Government Department of Agriculture, Fisheries and Forestry. Food [webpage]. 2023 Mar 30 [cited 2024 Oct 30]. Available from: https://www.agriculture.gov.au/agriculture-land/farm-food-drought/food

[3] Reserve Bank of Australia. Composition of the Australian Economy Snapshot [Internet]. Reserve Bank of Australia. 2024. Available from: https://www.rba.gov.au/snapshots/economy-composition-snapshot/

[4] Australian Government Department of Agriculture, Fisheries and Forestry. Snapshot of Australian Agriculture 2024. Australian Bureau of Agriculture and Resources Economics and Sciences. [Internet] March 2024 [cited 30 October 2024]. Available from: https://daff.ent.sirsidynix.net.au/client/en_AU/search/asset/1035603/0

[5] Australian Government Department of Industry, Sciences and Resources. Resources and Energy Quarterly. Office of the Chief Economist [Internet]. September 2024 [cited 30 October 2024]. Available from: https://www.industry.gov.au/sites/default/files/2024-09/resource_and_energy_quarterly_september_2024.pdf

[6] Australian Regional Tourism Ltd. About ART [webpage]. 2024 [cited 30 October 2024]. Available from: https://regionaltourism.com.au/about-art/#whogov

[7] Australian Bureau of Statistics. Australian National Accounts: Tourism Satellite Account. [Internet] 6 December 2023 [cited 31 October 2024]. Available from: https://www.abs.gov.au/statistics/economy/national-accounts/australian-national-accounts-tourism-satellite-account/latest-release

[8] Australian Government Department of Infrastructure, Transport, Regional Development, Communications and the Arts. State of Australia's Regions 2024. [Internet] February 2024 [cited 31 October 2024]. Available from: https://www.infrastructure.gov.au/sites/default/files/documents/state-of-australias-regions-2024.pdf

[9] Clean Energy Council. Renewable Projects Quarterly Report (Q1 2024). [Internet] 7 June 2024 [cited 31 October 2024]. Available from: https://cleanenergycouncil.org.au/news-resources/renewable-projects-quarterly-report-q1-2024

[10] Watson D. The Bush: Travels in the Heart of Australia. Penguin Group Australia; 2014.

[11] Australian Institute of Health and Welfare. Profile of First Nations people. 2 July 2024 [cite 31 October 2024]. Available from: https://www.aihw.gov.au/reports/australias-welfare/profile-of-indigenous-australians?embed=true

[12] United Nations Human Rights Office of the High Commissioner. International Covenant on Economic, Social and Cultural Rights [Internet]. 16 December 1966 [cited 31 October 2024].

Available from: https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights

[13] Australian Institute of Health and Welfare. Rural and remote health [Internet]. 2024 [cited 30 October 2024]. Available from: https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health

[14] Australian Institute of Health and Welfare. Australian Burden of Disease Study 2018: Interactive data on disease burden. 24 November 2021 [cited 30 October 2024]. Available from: https://www.aihw.gov.au/reports/burden-of-disease/abds-2018-interactive-data-disease-burden/contents/remoteness-areas

[15] Australian Institute of Health and Welfare. Use of alcohol and other drugs in Major cities, regional areas, and remote areas [Internet]. Canberra: Australian Institute of Health and Welfare, 2024 [cited 2024 Oct 30].

[16] Chrisopoulos S, Luzzi L & Ellershaw A 2019. Dental Care. P97-124. In: ARCPOH. Australia's Oral Health: National Study of Adult Oral Health 2017–18. Adelaide: The University of Adelaide, South Australia.

[17] Huxtable R, Psm A. Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025 Final Report. [Internet]. 2023. Available from: https://www.health.gov.au/sites/default/files/2023-12/nhra-mid-term-review-final-report-october-2023.pdf

[18] Nous Group. Evidence base for additional investment in rural health in Australia. National Rural Health Alliance. [Internet]. 2023 June 2023 [cited 30 Oct 2024]. Available from: https://www.ruralhealth.org.au/sites/default/files/publications/evidence-base-additional-investment-rural-health-australia-june-2023.pdf

[19] Parliament NSW Legislative Council. Health outcomes and access to health and hospital services in rural, regional and remote New South Wales. Portfolio Committee No. 2 – Health. Report 57. May 2022 [cited 31 October 2024]. Available from: https://www.parliament.nsw.gov.au/lcdocs/inquiries/2615/Report%20no%2057%20-%20PC%202%20-%20Health%20outcomes%20and%20access%20to%20services.pdf

[20] NSW Government. Media release: $200.1 million boost to rural health worker accommodation. [Internet] 17 June 2024. [cited 31 October 2024]. Available from: https://www.nsw.gov.au/media-releases/2001-million-boost-to-rural-health-worker-accommodation

[21] NSW Government. The Welcome Experience: Helping essential workers relocate, settle in and become one of the locals. [cited 31 October 2024]. Available from: https://www.nsw.gov.au/regional-nsw/makethemove/welcome-experience

[22] Department of Health and Aged Care. Innovative Models of Care (IMOC) Program – Primary Care Rural Integrated Multidisciplinary health Service (PRIM-HS) Mareeba Community Primary Care Trial. [Internet] 2024 [cited 31 October 2024]. Available from: https://www.health.gov.au/sites/default/files/2024-07/innovative-models-of-care-imoc-program-primary-care-rural-integrated-multidisciplinary-health-service-mareeba-community-primary-care-trial.pdf