Submission
No 452

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

Organisation: NSW Rural Primary Health Networks (PHNs)

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Inquiry into Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote NSW

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1. INTRODUCTION

Primary Health Networks (PHNs) were established by the Federal Government in 2015 to improve health outcomes across urban, rural and regional and remote Australia, through the commissioning of primary care health services, by increasing the capability and capacity of primary care and by providing an interface between primary care and the hospital sector. The following NSW PHNs, which encompass rural, regional and remote areas, have joined together to present a submission to the NSW Legislative Council *Inquiry into Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote NSW*:

- Hunter New England and Central Coast PHN
- Murrumbidgee PHN
- North Coast PHN
- South Eastern NSW PHN
- Western NSW PHN.

A key focus for our PHNs is to increase access to healthcare across a range of demographics; including older people, Aboriginal and Torres Strait Islander peoples, other culturally and linguistically diverse (CALD) communities, people with mental health issues, and people in rural, regional and remote communities - in particular those affected by drought, flood and the Black Summer bushfires. The effects of the coronavirus pandemic on physical and mental health, and the delay to routine healthcare have been more recently overlaid onto our existing challenges.

Along with many other developed nations, Australia is on an evolving path of healthcare reform, moving away from the siloed, episodic and fragmented healthcare delivery model to one where healthcare is person-centred, decisions about planning and spending are made collaboratively between stakeholders at the local level, there is integration between the different services and sectors, and the resulting system becomes more sustainable and cost-effective. In our submission, we propose that any examination of the health system (such as the hospital sector), must also include a consideration of the primary care, community and mental health systems; and that all components of the health system must now be considered as inextricably interlinked. A failure in one component will have dramatic follow-on effects in the other sectors of the health system.

Health workforce supply and sustainability is the biggest challenge we face regarding improving the health of our communities.

In rural, regional and remote areas, partnerships across the various stakeholders in the healthcare sector and with other sectors are needed to address the unique, local needs of these communities, including the economic, social and environmental determinants of health. Our Aboriginal and Torres Strait Islander communities have unique health, cultural and social care needs that can only be addressed by all of the health and social care sectors working together. Digital health and telehealth services are essential to improving services and access to specialists for rural areas.

We urge the NSW Government to accelerate progress towards overcoming barriers to person-centred integrated healthcare by working with the Federal Government and PHNs to fast-track and implement new workforce models, and continue to support joint activities that enhance integration and coordination of local services, both within the health sector and with other sectors such as aged care, community care and social services. Improving these areas will ensure better access to appropriate person-centred services, improved cost-efficiency, and will help address healthcare disparities in our society.

Our submission below focuses on four key inquiry Terms of Reference that we feel are of the most importance in addressing these challenges and improving the health of rural, regional and remote communities.

TOR 1A. Health outcomes for people living in rural , regional and remote NSW.

2. HEALTH OUTCOMES AND CHARACTERISTICS OF RESIDENTS IN RURAL AREAS

Australians living in rural areas have worse health outcomes compared to those in metropolitan areas. Generally, mortality and illness levels increase with distance from major cities. People in rural areas have shorter life expectancy, higher incidences of injury and chronic disease, and higher levels of disadvantage and risky behaviours such as tobacco smoking and alcohol issues.[1] There are widely differing health needs in rural communities which must overcome the challenges posed by wider geographic spread, low population density, higher rates of injuries and chronic diseases, higher rates of people in older age groups, as well as limited infrastructure and the significantly higher costs of healthcare delivery. On the other hand, people in rural areas also report a high rate of community cohesiveness and community engagement, which has proven essential to building community resilience after natural disasters such as drought and bushfire.[2]

The following population groups are of particular focus in our submission:

- People with chronic conditions and multi-morbidities. Older people have a higher incidence of chronic conditions and multi-morbidities. The proportion of people aged 65 and older is highest in inner regional, outer regional and remote areas of NSW (over 19%) compared to the major cities (14%).[4]
- People with mental health issues (including those at risk of suicide). According to national surveys, the rates of mental illnesses are similar across metropolitan and non-metropolitan areas, with a spike in inner regional areas, however access to treatment varies.[1]
- Aboriginal peoples, who have worse physical and mental health outcomes compared to the non-Aboriginal community. According to figures from the last census (2016), one in three Indigenous Australians live in NSW.[3] Although in NSW the majority of Aboriginal people live in metropolitan areas, Aboriginal people represent a higher proportion of the population of outer regional and remote areas. For example, the proportion of the population who identify as Aboriginal is approximately 11% in Western NSW and Far West NSW. This increases to 40% of people identifying as Aboriginal in very remote areas of NSW. [4]

In this submission, the generic term ‘rural’ will be used to denote all areas outside of Australia’s major cities (urban areas); unless otherwise specified.[5]

[1] Australian Institute of Health and Welfare (2019). *Rural & Remote Health. Cat. no. PHE 255*. Canberra: AIHW. https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health

[2] Gibbs L et al. (2016). *Beyond Bushfires: Community Resilience and Recovery Final Report 2010-2016*. Victoria: University of Melbourne.

[3] AIHW, (2020). Aboriginal and Torres Strait Islander Health Performance Framework 2020. Canberra: Australian Government. https://www.indigenoushpf.gov.au/getattachment/744a8cf6-8eb3-4bb3-8d12-474a65bc1aa6/attachment.aspx

[4] Bureau of Health Information (2016). *The Insights Series: Healthcare in Rural, Regional and Remote NSW*. Sydney: NSW Government. www.bhi.nsw.gov.au/BHI_reports/Insights_Series/healthcare_in_rural,_regional_and_remote_nsw

[5] Most data sources used in this submission have utilised the Australian Bureau of Statistics classification of remoteness: major cities, inner regional, outer regional, remote and very remote areas.

TOR 1C. Access to health and hospital services in rural, regional and remote NSW including service availability, barriers to access and quality of services.

3. ACCESS TO PRIMARY CARE IN RURAL AREAS

Primary care is the foundation of healthcare in the community. Primary care is the entry level to the health system and includes a broad range of activities and services that are delivered outside the hospital setting - from health promotion and prevention, to treatment and management of acute and chronic conditions. The major primary care services are general practice, allied health, pharmacy, primary care nursing, some community mental health services, and maternal and child health services. Strong primary care is central to an efficient, equitable and effective health system.

Australia has good-quality primary care by international standards, however people in rural areas find it hard to access general practitioners, pharmacists and other healthcare services, which can lead to poorer outcomes for the individual as well as the economy. The availability of the primary care workforce to non-metropolitan areas is a key issue for any government that intends on improving rural health.

3.1. Access to GP services

General practitioners (GPs) play a key role in the health system in rural, regional and remote areas: including early detection of conditions, health promotion, ongoing management of chronic disease and facilitating access to appropriate specialist services. GPs are an important first point of contact for people to manage both their physical and their mental health. In rural areas, GPs often have to work at an enhanced scope of practice and provide the type of care that would normally be referred to a specialist in metropolitan areas. They often also play a role in the local hospitals as Visiting Medical Officers.

Under the Australian healthcare model, general practices are privately-owned businesses. A small number of practices are still owned and run by solo practitioners, but many general practices operate as partnerships or groups of associates. One survey suggested about 70 % of GPs work in practices of fewer than 10 GPs.[6]

Australia has a high rate of general practitioners per capita, and the number appears to be increasing. However, the distribution is unequal, with the majority concentrated in major cities and inner regional areas.[6,7] Our networks have reported to us that some rural areas are suffering from a severe shortage in the primary care workforce. This is in the face of increasing need for medical services due to underlying disadvantages as well as increasing chronic disease and morbidity due to our ageing population. Deloitte have forecasted that both urban and rural areas will become progressively undersupplied by the medical workforce over the ten years to 2030.[8] In western and far western NSW alone, there are 41 small towns at risk of having no GP workforce in ten years.[9]

The AIHW has reported that the FTE of GPs per capita in rural areas is not currently able to be accurately determined, as doctors work longer hours and cover a wider geographical distance, and may also provide care in the acute settings (GPs may be appointed as Visiting Medical Officers of the local hospital), which complicates the FTE figures.[7] However, we do know that people in major cities **received over 42% more Medicare-billed GP services per head of population** (6.4 MBS services per

[6] Swerissen, H, Duckett, S and Moran, G. (2018). Mapping Primary Care in Australia. Melbourne: Grattan Institute. https://grattan.edu.au/report/mapping-primary-care-in-australia/

[7] Australian Institute of Health and Welfare (2019). Rural & Remote Health. Cat. no. PHE 255. Canberra: AIHW. https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health

[8] Deloitte Access Economics General Practitioner Workforce Report (2019). www2.deloitte.com/au/en/pages/economics/articles/general-practitioner-workforce-report-2019.html

[9] Information provided by Western NSW PHN.

capita) than those living in outer regional and remote areas of NSW in 2014-2015 (4.5 MBS services per capita), see figure below.[10]

Due to the lack of supply of GPs and other primary care services, rural communities are heavily reliant on outreach and locum services from metropolitan centres, and also on overseas-trained doctors (OTDs). Relying on locums and a transient workforce cannot assure continuity of care and may lead to worse health outcomes for rural residents. OTDs are over-represented among rural GPs, probably as a result of Australian government policy requirements that dictate where they can work. OTDs comprise 22% of GPs in metropolitan and regional centres. However, OTDs comprise 27% and 29% of other medical specialists in metropolitan and large regional centres respectively, and 38% of specialists in smaller regional centres of less than 50,000 population.[11]

In 2018, the Federal Government launched its Stronger Rural Health Strategy which has an objective of building a sustainable, high quality health workforce that is distributed across the country according to community need, particularly in rural and remote communities. The use of OTDs is an essential component of the strategy. Although the use of OTDs has been a life-saver for rural communities, it is disguising the underlying issues regarding the attractiveness of rural areas as a viable workplace.

3.2. Increased emergency department (ED) utilisation in rural areas

The lack of access to primary care has serious flow-on effects for our health system and economy. For example, people in outer regional and remote areas tend to use hospital emergency departments as a source of primary care to a greater extent than people in cities. According to the Australian Bureau of Statistics,[12] people living in outer regional, remote or very remote areas were more likely to report visiting an emergency department (ED) because a GP was not available when required than those living in major cities (29.5% of ED attendances were due to GP unavailability vs 17.8% of ED attendances in major cities).[13]

In NSW, residents in outer regional and remote areas of NSW were most likely to visit an ED, and 27% visited an ED at least once during the year 2014–15. People in Northern NSW were almost twice as likely to visit an ED as those living in Northern Sydney (24% vs 14%, see figure below).[14]

People living in rural areas are also more likely to be admitted to hospital for conditions that could have potentially been prevented through access to primary care services (potentially preventable hospitalisations, PPH). PPH rates are frequently shown to increase with increasing remoteness and socioeconomic disadvantage, and both factors disproportionately affect Indigenous Australians.[15]

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[10] Bureau of Health Information (2016). *The Insights Series: Healthcare in Rural, Regional and Remote NSW*. Sydney: NSW Government. www.bhi.nsw.gov.au/BHI_reports/Insights_Series/healthcare_in_rural,_regional_and_remote_nsw

[11] Summarised in: O'Sullivan B, Russell DJ, McGrail MR. et al. (2019). Reviewing reliance on overseas-trained doctors in rural Australia and planning for self-sufficiency: applying 10 years' MABEL evidence. Hum Resour Health **17**: 8.

[12] Australian Bureau of Statistics (2019). *Patient Experiences in Australia: Summary of Findings*. Canberra: ABS. www.abs.gov.au/statistics/health/health-services/patient-experiences-australia-summary-findings/latest-release

[13] The scope for Multipurpose Household Survey included households residing in urban, rural, remote and very remote parts of Australia, but did not include the residents of the Indigenous Community Strata.

[14] Bureau of Health Information (2016). *The Insights Series: Healthcare in Rural, Regional and Remote NSW*. Sydney: NSW Government. www.bhi.nsw.gov.au/BHI_reports/Insights_Series/healthcare_in_rural,_regional_and_remote_nsw

[15] ACSQHC (Australian Commission on Safety and Quality in Health Care) & AIHW (Australian Institute of Health and Welfare) (2017). The Second Australian Atlas of Healthcare Variation. Sydney: ACSQHC. Duckett S & Griffiths K (2016). Perils of Place: identifying hotspots of health inequalities. Melbourne: Grattan Institute. Falster M & Jorm L (2017). A guide to the potentially preventable hospitalisations indicator in Australia. Centre for Big Data Research in Health, University of NSW, in consultation with the ACSQHC and the AIHW. Sydney: ACSQHC.

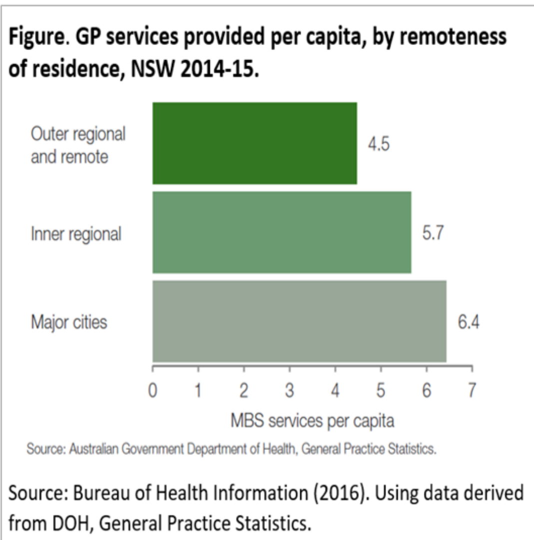

Figure. GP services provided per capita, by remoteness of residence, NSW 2014-15.

Source: Bureau of Health Information (2016). Using data derived from DOH, General Practice Statistics.

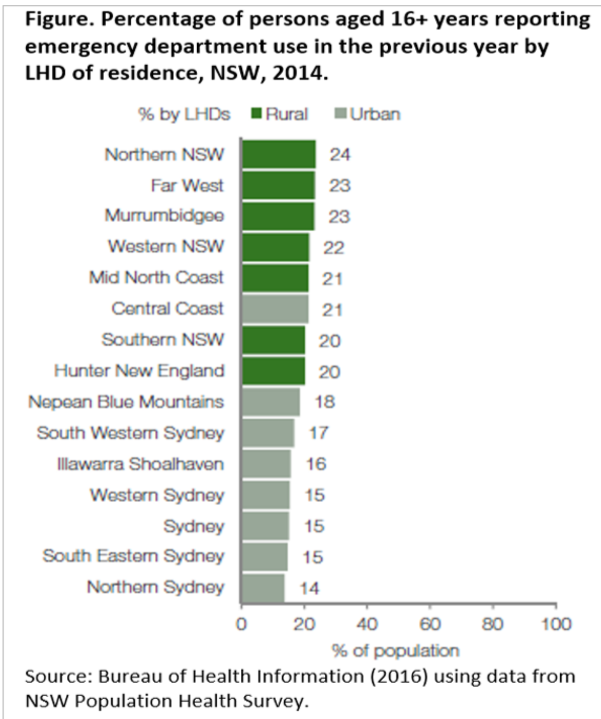

Figure. Percentage of persons aged 16+ years reporting emergency department use in the previous year by LHD of residence, NSW, 2014.

Source: Bureau of Health Information (2016) using data from NSW Population Health Survey.

3.3. Rural GP financial viability

Since the 1990s, federal governments have provided financial incentives for GPs to relocate to or remain in rural areas of Australia. The incentives have included one-off payments, training grants, components of the Practice Incentive Payments (administered by PHNs), bulk billing incentives, as well as the General Practice Rural Incentives Program (known as the Workforce Incentive Program (WIP) from January 2020).

Although not much evidence is available, one study found that the previous General Practice Rural Incentives Program funding had only a minimal effect on increasing the supply of GPs to rural areas, and then only on newly-trained GPs.[16]

General practices in small towns of less than 5,000 people are financially 'fragile' and urgent action is required to address the ongoing loss of GP workforce. The issues in recruiting GPs to rural locations are multifactorial. Firstly, there are concerns about the financial sustainability of practices in some small towns and other locations, due to low volume of services and not being able to take advantage of economies of scale. Recently the drought, bushfires and the pandemic have also led to local economic issues that have a flow-on effect on GPs.

There are also issues faced by GPs in rural areas such as a lack of work-life balance, finding employment for their spouse or partner, or ensuring adequate education opportunities for their children as well as generally lower returns from housing investment. The way GPs were deployed as a resource during natural disasters was very *ad hoc* across Australia and has been raised as an issue at the various government inquiries into the Black Summer bushfires (see Emergency Response section below).

3.4. Rural primary care training programs

The Federal Government also announced funding from 2019-20 to develop a National Rural Generalist Pathway – a training program to produce more rural generalist doctors, with core emergency skills, and including training in procedural disciplines like obstetrics, anaesthetics and surgery, as well as

[16] Yong J, Scott A, et al. (2018) Do rural incentives payments affect entries and exits of general practitioners? Social Science & Medicine, Volume 214: 197-205.

non-procedural disciplines such as mental health and palliative care; all of which are desperately needed in rural areas. This may also assist with the process of recognising "rural generalist" medicine as a specialist field, which could eventually attract a higher level of MBS funding. The Medical Board of Australia is apparently considering a proposal to confer national recognition of the distinct work and skill set of rural generalists as a category of general practice.[17]

The NSW Rural Medical Generalist Training Program has largely drawn on the highly successful Rural Generalist model that was established in Queensland in 2005 to stabilise emergency and procedural services in smaller hospitals/towns in rural and remote Queensland.

However, we recommend that NSW Health implements critical elements of the Qld model including:

- Quarantined and adequate number of internships in rural and regional hospitals to enable medical graduates to transition to a rural training pathway at the completion of their university training (rather than an initial internship in a metropolitan location where there is the risk of leakage from the rural pathway).
- Adequate resourcing of program staff and medical mentors to provide vocational guidance and support trainees to plan and execute their training pathway.
- A regionally focused workforce and training plan that ensures that rural generalist trainees are pursuing advanced skills training in a discipline that is required in preferred or identified location (i.e. training in a skill with a known job destination).
- Industrial recognition of the rural generalist qualification – in Qld this is equivalent to Staff Specialist.

Although NSW maintains the VMO model for GPs providing procedural services to rural hospitals under the NSW RDA settlement package, there is no financial recognition/ differentiation of the Advanced Skills Training in mental health, paediatric and palliative care – all of which are priorities in rural areas where access to psychiatrists, paediatricians and palliative care specialists is very limited. Therefore, NSW Health should develop a mechanism to remunerate GPs/Rural Generalists with Advanced Skills Training in mental health, paediatrics and palliative care as the key providers of specialised care in rural and remote communities and must maintain the procedural services in rural hospitals.

The role of **nurse practitioners** as independent healthcare providers is being assessed by the Federal Government. Currently nurse practitioners do not have access to independent MBS billing; they can only access items via their employing GP. Other countries (the Netherlands, UK, Sweden etc) have allowed nurse practitioners to have an independent role in prescribing.[18] Although this issue is contentious in Australia, in some rural areas there may be no other option than to allow greater independence of nurse practitioners. There is an opportunity for NSW to liaise with the Federal Government to support the enhanced role of nurse practitioners, which could substantially improve access to primary care in rural areas.

There are many opportunities for NSW Health to continue to partner and pool funding to support innovative schemes that attract primary care clinicians to the regions, and support the primary care system as a whole to reduce the burden on GPs. One particular strategy to assist in overcoming the shortage of the primary care workforce in regional and remote areas is to upskill multidisciplinary clinicians in rural areas across NSW (see case studies below).

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[17] Australian College of Remote and Rural Medicine (2019). Media release: Recognising Rural Generalist Medicine as a specialist field. www.acrrm.org.au/about-us/news-events/media-releases/2019/12/19/recognising-rural-generalist-medicine-as-a-specialist-field

[18] Maier, CB. (2019) Nurse prescribing of medicines in 13 European countries. Human Resources for Health **17**, 95.

However, the results of the above initiatives including additional trained GPs are not expected to materialise for many years. The supply of GPs in rural areas, as well as nurses and allied health practitioners, is complex and requires significant resources and funding. Therefore, NSW Health needs to continue to support and bolster these effective and innovative training and upskilling programs that s empower the primary care workforce to be more confident in their abilities to serve the community.

CASE STUDY: St Vincent's Hospital Psychogeriatric SOS service
St Vincent's Hospital has designed a clinician to clinician e-health solution that provides multidisciplinary psychogeriatric expertise to clinicians in rural and remote areas of NSW based on an integrated, multidisciplinary, team management model of psychogeriatric care currently used in St Vincent's Hospital Psychogeriatric Mental Health and Dementia Service. The **Psychogeriatric SOS (Services on Screen) program** provides isolated rural and remote clinicians with the support of a virtual multidisciplinary psychogeriatric team, to assist them to manage their older patients with mental health problems and dementia locally, and as the lead clinicians via web conferencing. The Psychogeriatric SOS model meets a significant need for high quality psychogeriatric services in rural, remote and under-resourced areas in NSW by supporting local clinicians to lead the assessment and management of their patients, guided by the expertise of the multidisciplinary clinicians from the St Vincent's Psychogeriatric team. The outcomes of Psychogeriatric SOS are varied and diverse. At the clinician level, they will be up-skilled through advice, education, and supervision, creating a greater sense of empowerment, a stronger sense of being supported, and an improved sense of job satisfaction. Their relationships with their patients should be strengthened through achieving better outcomes, and by remaining fully engaged as the lead clinicians. And their professional confidence should be bolstered by enhancement of their knowledge and skills in dealing with a broad range of psychogeriatric issue. At the LHD level, the provision of previously in-accessible psychogeriatric expertise should enhance local resources in an efficient and cost-effective manner. In the longer term, access to such support could facilitate improved recruitment and retention of local clinicians in rural and remote regions

CASE STUDY: Geriatrician in the Practice: a shared care approach to dementia care linking hospital specialist dementia teams with general practice staff and patients
The Shoalhaven region has an ageing population and a high prevalence of dementia; and insufficient geriatricians available, which has resulted in long waiting lists for local hospital clinics. Dementia is a serious chronic condition that requires expert clinical assessment, diagnosis and management. The Geriatrician in the Practice program is an innovative model of shared care where the specialist hospital dementia care team and the general practice team conduct joint consultations in the GP clinic, rather than the traditional approach whereby the patient would be seen by the specialists in the hospital outpatient clinic. The aim of the program is to improve patient care, upskill GPs and practice nurses in diagnosing and managing their own patients with dementia, while also reducing the waiting lists for hospital outreach clinics – which will only be required to see the more complex patients. Overall, the Geriatrician in the Practice program aims to improve care coordination, communication and linkages between specialists at Shoalhaven hospital and local general practices, while involving people who may have dementia and their carers in the care and management of their condition The program is conducted collaboratively with the aged care services based at the Illawarra Shoalhaven Local Health District, COORDINARE (the South Eastern NSW PHN), and general practices in the Shoalhaven area. The initiative is funded through the NSW Ministry of Health Integrated Care Planning and Innovation Fund. A formal evaluation of the GIP program found that the level of patient satisfaction was very high, GPs were able to identify dementia patients with greater confidence and accuracy and showed a significant decline in the likelihood of emergency department attendance, and a decline in the number of patient reviews required to be performed by the hospital team. One year after receiving the GIP program intervention, patients in the initiative attended an emergency department with a frequency 44% lower than in the year immediately prior to the intervention.

RECOMMENDATION 1: NSW Health to work with the Federal Government and PHNs to provide incentives that increase the supply of the primary care workforce in rural areas as a matter of urgency to ensure that access to appropriate, cost-effective healthcare is a reality for those who live outside urban areas.

RECOMMENDATION 2: NSW Health to amend its Rural Medical Generalist Training Program to incorporate the missing critical elements of "quarantined and adequate" number of GP intern positions in the regions, adequate resourcing for program support, regionally focussed workforce and training plans, and industry recognition of the rural generalist qualification.

RECOMMENDATION 3: NSW Health and LHDs to maintain procedural services in rural hospitals, i.e. obstetric, anaesthetics and emergency services including birthing services.

4. ACCESS TO MENTAL HEALTHCARE IN RURAL AREAS

One in five Australian adults experience a mental disorder in any one year. According to national surveys, the rates of common mental illnesses were similar across metropolitan and rural areas.[19]

However, the *impact* of mental health is worse in rural areas, due to lack of **access** to treatment, and also due to **lower utilisation of services**, possibly due to perceptions of stigma surrounding mental illness. According to the Productivity Commission 2020 report,[20] following its inquiry into mental health, poor access to communications and services (due to issues with broadband, mobile coverage and public transport) and environmental challenges (such as droughts, floods, and bushfires) compounds the issues regarding access to mental health services in rural Australia. The Commission also noted that particular groups in the community such as Aboriginal and Torres Strait Islanders, face additional barriers to care because of a lack of culturally capable services and experiences of discrimination (see section on Aboriginal health below).

4.1. Access to GPs and specialist mental health services

GPs account for the bulk of mental health services across Australia; the Productivity Commission estimated that at least 5 million people had a consultation with their GP about their mental health in 2018-2019. This equates to about 20 million consultations a year.[21]

The Centre for Rural and Remote Mental Health (University of Newcastle) has estimated that in major cities there were **twice as many GP mental health encounters per capita** in one year (708.5 GP mental health encounters per 1,000 people in major cities; compared to just 339.2 encounters in rural and remote areas).[22] GPs in rural and regional areas have fewer referral options regarding mental health and other services than their metropolitan counterparts.[23]

The Productivity Commission report noted that **access to psychiatrists** is particularly difficult across Australia, with high costs and long wait times in some areas. Access to psychiatric services for children and adolescents, people in aged care and people in rural, regional and remote areas is a particular issue. People who live in major cities were **two times more likely to have accessed a psychologist or psychiatrist** in the previous year compared to those in other areas. The Productivity Commission report[24] found that for MBS-rebated services in 2018-19:

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[19] Australian Institute of Health and Welfare (2019). *Rural & Remote Health. Cat. no. PHE 255*. Canberra: AIHW. https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health. Note: mental and behavioural problems were higher in Inner regional areas (26%) compared with Outer regional and remote areas (22%) and Major cities (21%)

[20] Productivity Commission (2020). *Mental Health: Productivity Commission Inquiry Report*. No. 95, 30 June 2020. Canberra: Australian Government. Overview, pg 30. https://www.pc.gov.au/inquiries/completed/mental-health/report.

[21] Productivity Commission (2020). Chapter 10.2 pg 455

[22] Hazell T, Dalton H, Caton T, Perkins D (2017) *Rural Suicide and its Prevention: A CRRMH Position Paper*. Centre for Rural and Remote Mental Health (CRRMH), University of Newcastle, Australia. www.crrmh.com.au/content/uploads/RuralSuicidePreventionPaper_2017_WEB_FINAL.pdf

[23] Productivity Commission (2020). Section 16.2: Workforce planning.

[24] Productivity Commission (2020). Locational mismatch, pg 532.

- for psychological therapy, roughly 5% of people in major cities and 'inner regional' areas had at least one session in a year, compared with less than 2% of people in remote and very remote areas
- for psychiatry, roughly 2% of people in major cities and inner regional areas had at least one session in a year, compared with less than 1% of people in remote and very remote areas.

The Productivity Commission 2020 report recommended strengthening workforce programs in rural and regional areas, bolstering mental healthcare provided through ACCHOs, as well as enabling the use of technology (e.g. telehealth, on-line or telephone psychiatric advice for GPs, clinician supported on-line models) to overcome workforce shortages and availability issues.[25]

4.2. Suicide and self-harm

The rate of deaths by suicide in rural areas has been rising over the past years, and is expected to rise further in the wake of the coronavirus pandemic. In every state in Australia, the rate of deaths by suicide among those who live outside the capital cities is over 50% higher than for residents of the capital city.[26]

Disturbingly, the discrepancy between suicide rates in the capital city and the rest of the state is even higher in NSW. The CRRMH found that the rate of suicide in rural NSW was nearly 90% higher than that of the Greater Sydney area (14.9 deaths per 100,000 people in the rest of state, compared to 7.9 deaths in the capital city).[27] The rates of suicide and self-inflicted injuries increases the further away people live from the capital city.

In 2016, the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project released its final report (ATSISPEP Report), which highlighted that efforts to reduce suicide in our First Nations people must address social and economic disadvantage, as well as promote the strengthening of social and emotional wellbeing, lead to cultural healing and building the resilience of families and communities.[28] Further issues regarding mental health and suicide in Aboriginal communities is discussed below.

Suicide is complex and no single intervention can prevent it. All levels of government (federal, state and local) must continue to invest in suicide prevention and work in conjunction with the community to design and implement uniquely tailored situations for local regions.

CASE STUDY: Supporting families and communities impacted by suicide
To ensure communities are aware of services and to support a timely and coordinated response for individuals and communities following a suicide or critical event in the Murrumbidgee region, a Local Response Group comprising Murrumbidgee PHN, Wellways Australia, the Riverina Police District, and the Murrumbidgee Local Health District was formed. A communications and response protocol was developed by the group with the support of the Murrumbidgee Suicide Prevention and Postvention Roundtable group. This protocol is the framework for the engagement of the Local Response Group when a formal response is required. The protocol is reviewed periodically to ensure it works in practice, including incorporating Local group focusses on suicide prevention and aftercare feedback from people who have received supports initiated by the group. The population is experiencing combined trauma from bushfires, drought and COVID-19, and the health services are seeing early indications of mental health concerns within communities. The Local Response Group aims to increase public awareness of the support mechanisms available in the region, to encourage people to seek help when they need to, and to give people opportunities to build and support suicide safe communities.

[25] Productivity Commission (2020). Overview: pg35.

[26] CRRMH position paper (2017), using Australian Bureau of Statistics data from 2016.

[27] CRRMH position paper (2017).

[28] P Dudgeon, J Milroy, T Calma et al., (2016) Solutions that work: what the evidence and our people tell us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report (ATSISPEP Report). Perth: University of Western Australia. www.atsispep.sis.uwa.edu.au

4.3. Integration and coordination of rural mental health care services

The Productivity Commission 2020 Report concluded that a factor resulting in poor access to mental health care is that the services that are available are fragmented and poorly coordinated.[29]

The Commission recognised that new approach to mental health funding and reform is underway, which aims to move to new models of care to a flexible and joined-up system focused on the needs and views of consumers and which maximises their potential to participate. The focus of current mental health reform is also aimed at shifting the mental health care model from bed-based services to a community-based approach that emphasises recovery. Several national plans describe a new system that will encompass moving from fragmentation, duplication and service gaps to one that is planned, integrated, coordinated and delivered all at a regional level.[30]

For instance, the *Fifth National Mental Health and Suicide Prevention Plan* was endorsed by the COAG Health Council in August 2017.[31] The Fifth Plan represents commitment from all governments to work together to achieve integrated planning and service delivery of mental health and suicide prevention related services. The Fifth Plan recognises that the *regional level* is where practical, targeted and locally appropriate action can be taken and strong community collaborations and partnerships can be formed. The Productivity Commission supported the approach of the Fifth Plan towards planning, commissioning and implementation of services occurring at a regional level, in order to accommodate the different and unique needs of each area.[32]

In response to the Fifth Plan, NSW LHDs and PHNs are undertaking joint, integrated regional planning for mental health and suicide prevention services, to overcome the traditional funding approaches that have resulted in the separate and fragmented model of service delivery. At a regional level, PHNs also work together with LHNs to analyse community needs and map providers across the service system, develop stronger referral pathways and build community knowledge of the range of available services and how to access them. Most PHNs are either ahead of schedule or on track to meet these targets.[29] The plans have been developed on the understanding that that this reform is significant, wide-ranging and involves change at almost every level of the system. This reform involves the adoption of new models of care (within the constraints of the current funding arrangements), upskilling and new modes of working by all segments of the workforce, new IT and data sharing platforms, a move towards healthcare delivery in the community and away from acute care settings, new methods of data collection, evaluation and reporting of processes and outcomes, all while ensuring consumer involvement and empowerment and ensuring the highest commitment to privacy and ethical standards. A longer timeframe for the implementation of these plans is understandably necessary.

The first joint *Mental Health and Suicide Prevention Health Plan* to be released was produced by the South Eastern NSW PHN (COORDINARE) and its two partner LHDs in Illawarra/ Shoalhaven and Southern NSW; and is a recognised example of best practice in collaboration.[33] The reforms described above are part of a broader move towards person-centred, integrated and coordinated care that is taking place across the healthcare spectrum (see Health Reform sections below).

Overall, a significant increase in investment in the mental health and suicide prevention funding is needed, including a commitment to fast-tracking plans to increase the availability of the primary care and mental health workforce, including the Aboriginal health workforce, in rural areas.

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[29] Productivity Commission (2020). Appendix *G.4 Current approach to managing split government roles*.

[30] Australian Government (2015). *Australian Government response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services*. Canberra: Commonwealth of Australia.

[31] Australian Government (2017). *Fifth National Mental Health and Suicide Prevention Plan*. Canberra: Commonwealth of Australia. www.mentalhealthcommission.gov.au/Monitoring-and-Reporting/Fifth-Plan/5th-National-Mental-Health-and-Suicide-Prevention

[32] Productivity Commission (2020). Appendix *G.4 Current approach to managing split government roles*.

[33] https://www.coordinare.org.au/assets/Main-Site/Uploads/Resources/publications/SENSW-Regional-Mental-Health-and-Suicide-Prevention-Plan.pdf

The Productivity Commission recommended that governments consider trialling alternative funding models in order to better incentivise appropriate care. The Commission recommended piloting bundled payments or capitation models regarding mental healthcare services; these models have been adopted in several countries regarding physical healthcare, but have not been explored thoroughly for mental healthcare services. Other funding reform measures could include outcome-based payments, including incentivising LHDs for treating people in the community and avoiding unnecessary hospitalisations. Co-funding and co-commissioning options are already being explored by PHNs and LHDs regarding a variety of health initiatives.[34]

RECOMMENDATION 4: NSW Health to continue to support and encourage LHDs and PHNs to complete and implement their joint regional mental health and suicide prevention plans. The joint plans will describe one overall planned and coordinated approach to mental heath and suicide prevention services, tailored to meet the unique needs of the local region..

RECOMMENDATION 5: NSW Health to consider trialling new funding models regarding mental healthcare and suicide prevention services that could include bundled payments, outcome-based payments, as well as co-funding and co-commissioning of services to better incentivise more appropriate treatment and better health outcomes.

[34] Productivity Commission (2020). Section 23.4, pg.1171

TOR 1K. Impact of health and hospital services in rural NSW on indigenous communities

5. IMPROVING ACCESS TO HEALTH SERVICES for the ABORIGINAL COMMUNITY

Measures of Aboriginal Australians' health status and outcomes drawn from the *Aboriginal and Torres Strait Islander Health Performance Framework 2020* shows mixed results over the last decade. While there have been some improvements, in other cases progress has stalled or outcomes have become worse.[35] The health issues in the Aboriginal community are often triggered by different and more complex symptoms and barriers than non-Aboriginal Australians and has resulted in some of the treatment options that are successful for the broader community are neither effective nor appropriate for the Aboriginal population. For instance, in Western NSW PHN there are 15 different Aboriginal nations, each with unique culture, lore, languages and history, and experiences of colonisation. The history of the trauma of colonisation and the dispossession of Aboriginal people from their families, homes and lands is central to understanding contemporary relations between Aboriginal and non-Aboriginal people and institutions today. There is also so much to celebrate and learn from Aboriginal people on how to engage with community and support the development of Aboriginal health services.

A one size fits all approach for a health system designed by non-Indigenous Australians, is not achieving the outcomes needed for Aboriginal people. Aboriginal-led health service planning at all levels is necessary in order develop culturally safe health services.

5.1. Improving Aboriginal-led health service planning

Lower access levels to health services has contributed to inequality in health outcomes, with the burden of disease among Aboriginal and Torres Strait Islander people 2.3 times that of non-Indigenous Australians.[35] Key barriers identified in the *Health Performance Framework 2020*, include cost and lack of accessible or culturally appropriate health services as impediments to access. Social and cultural determinants of health play an important role, and will be covered in greater detail further in this section. There are numerous initiatives and strategies aimed at improving access to health services for the Aboriginal community, however two evidence based enablers that will improve access in regional, rural and remote NSW includes Aboriginal-led health service planning, design and commissioning; and embedding cultural safety as a quality standard within NSW Health.

Health service planning, design and commissioning across the care continuum, needs to be Aboriginal-led. An example of an Aboriginal designed and developed health service is the Waijungbah Jarjums Midwifery Service (see case study below). As part of the original pilot, a formal evaluation identified that having a culturally appropriate service developed and designed by the Aboriginal community had not only contributed to improved access, attendance of service, however improved overall antenatal health outcomes. PHNs are working to support Aboriginal Medical Services via an appropriately resourced Aboriginal workforce.

To improve access to health services for the Aboriginal and Torres Strait Islander community, embedding cultural safety as part of quality standards is essential. *Respecting the Difference* is an initiative developed by Aboriginal Workforce and NSW Health aimed at increasing cultural competencies and promoting a greater understanding of the processes and protocols for delivering health services to Aboriginal people.[36] The Framework is an important initial step that has improved cultural awareness, however in order to align to national standards such as the National Safety and Quality Health Service Standards,[37] it is recommended that NSW Health adopt cultural safety to be

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[35] AIHW, (2020). Aboriginal and Torres Strait Islander Health Performance Framework 2020. Canberra: Australian Government. https://www.indigenoushpf.gov.au/getattachment/744a8cf6-8eb3-4bb3-8d12-474a65bc1aa6/attachment.aspx

[36] NSW Health (2011). Respecting the Difference: An Aboriginal Cultural Training Framework for NSW Health. Policy Directive PD2011_069 www.health.nsw.gov.au/workforce/aboriginal/Pages/respecting-the-difference.aspx

[37] The Wardliparingga Aboriginal Research Unit of the South Australian Health and Medical Research Institute (2017). *National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander health.* Sydney:

mandated as part of their quality standards. A key principle that underpinned the development of the standards by the Australian Commission on Safety and Quality in Healthcare, is that the safety and quality of care for the Aboriginal and Torres Strait Islander people can only be improved when everyone who works in the health service recognises that they are responsible for providing equitable care - it is not solely the responsibility of Aboriginal and Torres Strait Islander employees and services.[38] Embedding cultural safety into quality standards will result in improved access to health services for the Aboriginal and Torres Strait Islander community through the provision of equitable, culturally appropriate services.

CASE STUDY: Waijungbah Jarjums Midwifery Service: a maternity health service designed and developed by the Aboriginal Community of the Gold Coast strengthens cultural connection and improves health outcomes
The Aboriginal Community on the Gold Coast had significantly adverse antenatal outcomes such as premature births, low birth weight, high Neonatal Intensive Care Unit (NICU) rates and low antenatal attendance appointments. The Waijungbah Jarjums Midwifery Service is an innovative model as it is one of the only services in the Gold Coast Health that has been built from the ground up alongside the Aboriginal and Torres Strait Islander community of the Gold Coast. The service connects Aboriginal and Torres Islander parents with an Aboriginal and Torres Islander midwife, child health nurse and health worker from conception to the first 1000 days. It encompasses social and emotional health as well as the health and wellbeing of the individual and the community. Beyond strengthening cultural connections, the service has changed families' experiences with Gold Coast Health and improved outcomes for Aboriginal and Torres Strait Islander mothers and babies. The service is still in the early stages, however after the first 6 month pilot there was significant improvement in women attending antenatal appointments because of the engagement they had with an Aboriginal and Torres Strait Islander midwife. Six times less likely to have their baby prematurely, 11 times less likely to have low birth weight baby and less likely to have a baby admitted to the NICU which saved more than 400 beds days and $1.5 million for the health service (Source QLD Government Gold Coast Health.[39]

RECOMMENDATION 6: NSW Health to support and enable increased Aboriginal-led health service planning, design and commissioning.

RECOMMENDATION 7: NSW Health to embed Aboriginal cultural safety as part of their quality standards.

5.2. Overcoming disparities in cultural and social determinants of health

A large part of the differences in health outcomes between Aboriginal Australians and non-Aboriginal Australians is explained by disparities in social determinants of health, in particular income, employment and education.36 Increasingly, more evidence is becoming available on the significance of cultural factors such as country and caring for country, knowledge and beliefs, language, self-determination, family and kinship and cultural expression, which can positively influence Aboriginal and Torres Strait Islander people's health and wellbeing.[40,41]

In 2017, the Australian Government released *My Life My Lead - Opportunities for strengthening approaches to the social determinants and cultural determinants of Indigenous health: Report on the*

ACQSHC. www.safetyandquality.gov.au/sites/default/files/migrated/National-Safety-and-Quality-Health-Service-Standards-User-Guide-for-Aboriginal-and-Torres-Strait-Islander-Health.pdf

[38] National Aboriginal and Torres Strait Islander Health Standing Committee of the Australian Health Ministers' Advisory Council (2016). *Cultural respect framework 2016–2026 for Aboriginal and Torres Strait Islander health*. Canberra: AHMAC

[39] www.goldcoast.health.qld.gov.au/about-us/news/service-strengthens-cultural-connection-and-improves-health-outcomes

[40] Bourke S, et al. (2018). Evidence review of Indigenous culture for health and wellbeing. International Journal of Health, Wellness, and Society **8**(4), 11-27

[41] Jones R, Thurber K, Chapman J, on behalf of the Mayi Kuwayu Study team et al. (2018). Study Protocol. Our Cultures Count, the Mayi Kuwayu Study, a national longitudinal study of Aboriginal and Torres Strait Islander wellbeing, BMJ Open. **8**(6):e023861

national consultations. [42] In this report, evidence suggests that 34.5% of the health gap for Aboriginal and Torres Strait Islander people is linked to social determinants and increases to over 53% when combined with behavioural risk factors. These consultations contributed to a refresh of the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023*. Additional reforms were included such as racism within health and other systems must be addressed to remove barriers and achieve better outcomes in health, education, and employment; and that Governments need to support long-term, coordinated, placed-based approaches that honour community-determined priorities and embed participation.[43]

RECOMMENDATION 8: NSW Health to increase funding to support long-term, coordinated, placed-based approaches aimed at improving the social determinants of health, and strengthening the positive cultural determinants of health for the Aboriginal community.

RECOMMENDATION 9: NSW Health to work collaboratively to overcoming social determinants of health disparities with stakeholders including the Aboriginal Community Controlled Organisations (ACCOs), primary health and community care sector, other non-health government departments, and PHNs.

5.3. Reducing the burden of disease

The burden of disease among Aboriginal and Torres Strait Islander people is almost two and a half times that of non-Indigenous Australians. Chronic diseases such as cancer, cardiovascular disease, respiratory diseases, diabetes and kidney disease are areas of particular concern.[43]

CASE STUDY: Integrated Aboriginal Chronic Care program
An example of an effective Aboriginal-led program on the North Coast of NSW is the *Integrated Aboriginal Chronic Care* program, a partnership between the Northern NSW Local Health District, North Coast Primary Health Network, local Aboriginal Medical Services and general practice has been developed as a culturally appropriate service delivery model to streamline and simplify access to all Aboriginal specific chronic disease services and rehabilitation programs within the Northern NSW region. The program has had a significant positive effective on both improved access to services and health outcomes.

Access to comprehensive, affordable and culturally appropriate primary healthcare is critical for closing this gap between health outcomes in the Aboriginal population and the non-Aboriginal population.[44] The **Integrated Team Care (ITC) Program** aims to strengthen a team-based approach for the provision of coordinated, multidisciplinary care. This requires collaborative working relationships between patients, general practices, AMSs and other service providers. Funding for the ITC Program is directed through PHNs, who commission organisations to provide services under the Program. The program was developed to improve health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through better access to coordinated and multidisciplinary care; and contribute to closing the gap in life expectancy by improved access to culturally appropriate mainstream primary care.[45] A formal evaluation of the project was conducted by Health Policy Analysis in 2018, however no quantitative data was available on patient outcomes resulting from the ITC

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[42] Department of Health (2017). *My Life My Lead - Opportunities for strengthening approaches to the social determinants and cultural determinants of Indigenous health: Report on the national consultations*. Canberra: Commonwealth of Australia. www1.health.gov.au/internet/main/publishing.nsf/Content/D2F6B905F3F667DACA2580D400014BF1/$File/My%20Life%20My%20Lead%20Consultation%20Report.pdf

[43] AIHW (2020) *Aboriginal and Torres Strait Islander Health Performance Framework 2020. Key health indicators NSW.* Canberra: Australian Government. https://www.indigenoushpf.gov.au/getattachment/744a8cf6-8eb3-4bb3-8d12-474a65bc1aa6/attachment.aspx

[44] Davy C et al., (2016) Access to primary health care services for Indigenous peoples: A framework synthesis. International Journal for Equity in Health. **15**, Article number: 163

[45] The Department of Health, Funded Activities – ITC https://www1.health.gov.au/internet/main/publishing.nsf/Content/indigenous-funding-lp

Program. Therefore, the approach used to obtain information about outcomes was to interview the ITC workforce and other key stakeholders about patients' uptake and experiences of the Program.[46]

The findings from the review are immensely positive and significant. These include improved capacity of mainstream primary care and uptake of Aboriginal and Torres Strait islander-specific MBS items, improved navigation of the healthcare system, reduced barriers to accessing services and medical/ health aids, improved continuity and communication between providers and patient, improved patient self-efficacy and self-management and improved impact on outcomes and quality of life (reported by stakeholders through personal stories, patient experience and anecdotes). The formal evaluation found that care coordination plays an integral role in improving access and outcomes for Aboriginal and Torres Strait Islander people. A key limitation to overcome for both programs is ensuring that data collection is efficient but informs the outcomes of the Program.

RECOMMENDATION 10: NSW Health to develop and enhance culturally appropriate system-wide Aboriginal integrated care programs to reduce disparity in health outcomes.

RECOMMENDATION 11: NSW Health to enable appropriate and curated evidentiary support for the contribution made by Aboriginal models of care, including by local employment opportunities.

RECOMMENDATION 12: NSW Health to work with the Aboriginal community to improve collection of Aboriginal status in health data sets, in order to improve data collection and to assist with appropriate care pathways.

5.4. Reducing mental health burden in the Aboriginal community

Aboriginal Australians are more likely to experience mental health problems than non-Aboriginal Australians.[47] Multiple factors can adversely affect mental health including biological, environmental and social factors. Mental ill health can be founded in trauma and stress, potentially from early childhood. In 2018-19, around 3 in 10 Aboriginal Australians in NSW had high to very high levels of psychological distress (31%). This figure has not changed significantly since 2008, and can be compared to the rate of 13% of non-Indigenous Australians who experience very high levels of distress.[48]

The Productivity Commission F*inal Report into Mental Health* (2020) identified a significant number of barriers that need to be addressed to improve the mental health burden and a disproportionate number of these directly impacted upon the Aboriginal community. For example, disparate focus on clinical services — overlooking other determinants of, and contributors to, mental health, including the important role played by family, kinship groups and carers in facilitating a person's functional recovery within their community, stigma and discrimination; and difficulties in finding and accessing suitable support. A key recommendation from the report is to empower Aboriginal communities to prevent suicide.

RECOMMENDATION 13: NSW Health to work with the Federal Government to fast-track development of the Aboriginal and Torres Strait Islander mental health work-force program to address the specific needs of their local communities. This recognises the distinct needs of, and obstacles faced by these communities as well as their holistic cultural approach to matters of social and emotional wellbeing.

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[46] Review of Care Coordination within the Integrated Team Care Program, Summary Report 2018. https://www1.health.gov.au/internet/main/publishing.nsf/Content/D2046EAB2B87A70DCA257F370017F288/$File/ITC-Review-Summary-Report.pdf

[47] Productivity Commission (2020). *Mental Health: Productivity Commission Inquiry Report*. No. 95, 30 June 2020. Canberra: Australian Government. Volume 1. https://www.pc.gov.au/inquiries/completed/mental-health/report

[48] NSW - Aboriginal and Torres Strait Islander Health Performance Framework summary (2020). https://www.indigenoushpf.gov.au/getattachment/744a8cf6-8eb3-4bb3-8d12-474a65bc1aa6/attachment.aspx

TOR 1L. Other related matters: Health reform & Digital health

6. HEALTH REFORM UNDER THE NATIONAL HEALTH REFORM AGREEMENT

Australia's health system is large, fragmented and complex, and no single organisation has full responsibility for health. In many areas funding and accountability overlap. As such, the responsibility and accountability for population health is shared across different levels of government, private and public healthcare providers and non-government organisations. Transitioning to a person-centred model of healthcare based on integration and collaboration represents a substantial cultural shift away from the siloed nature of existing services. The Federal Government and NSW Health are in alignment as this is clearly enunciated within the National Health Reform Agreement (NHRA).

All Australian governments (Commonwealth, state and territory) signed the new 2020–25 NHRA on 29 May 2020.[49] The NHRA commits to improving health outcomes for Australians, by providing better coordinated and joined up care in the community, and ensuring the future sustainability of Australia's health system. The reform agreement covers public hospital funding as well as the funding and governance of Primary Health Networks and Local Health Districts (LHDs), and commits them to working together to find local solutions to gaps in service provision.

Compared to the previous NHRA, the 2020 NHRA makes a stronger commitment to mental health, closing the gap regarding Aboriginal and Torres Strait Islander health and wellbeing, and joint planning by State and Commonwealth governments. The latest NHRA importantly includes a commitment that the role of LHDs is to *decentralise public hospital management and requires them to work with PHNs to enable health system reform.*

6.1. Role of Primary Health Networks in Health Reform

PHNs have been specifically established and funded by the Federal Government as a key enabler integrating health services at the local level, supporting GPs and primary care, and commissioning services to meet identified local health needs PHNs act as local agents of change in Australia's health system and act as the principal link between primary care and the hospital-based system. We partner with clinicians, Local Health Districts, local governments, non-government organisations and communities to implement innovative models of care aimed at improving integrated, co-ordinated, team-based care with patients at the centre of focus. Last summer's bushfires as well as the coronavirus pandemic have demonstrated the ability of PHNs to rapidly implement flexible, place-based programs targeted to the needs of the community, such as increasing mental health services and awarding community resilience grants in the wake of the bushfires and working with the Department of Health to establish GP Led Respiratory Clinics during the pandemic.

As our population ages and rates of chronic disease continue to rise, Australians will increasingly find themselves in need of multiple types of care with multiple providers. Complex, chronic conditions require person-centred care that is **integrated and coordinated** across multiple health settings and systems. Person-centred and integrated care has become a central part of policy initiatives across the world to improve the access, quality, continuity, effectiveness and sustainability of healthcare systems.[50] There is also an ideological shift towards providing care in the community, closer to home and away from the acute care system where appropriate.[51]

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[49] Australian Government (2020), National Health Reform Agreement Addendum 2020-25 (Consolidated agreement). http://www.federalfinancialrelations.gov.au/content/npa/health/other/NHRA_2020-25_Addendum_consolidated.pdf

[50] Timmins, N and Hamm, C. (2013). The quest for integrated health and social care. A case study in Canterbury, New Zealand. London: The Kings Fund. https://www.kingsfund.org.uk/publications/quest-integrated-health-and-social-care Also Dorling G, et al. (2015) The Evidence for Integrated Care. McKinsey and Company. https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/the-evidence-for-integrated-care

[51] KPMG (2019), Delivering healthcare services closer to home. An international look at out of hospital, community-based healthcare services. KPMG International. https://assets.kpmg/content/dam/kpmg/xx/pdf/2019/10/out-of-hospital-care.pdf

Integrated care can take different forms based on different settings and models. What is essential is a commitment to overcoming fragmented care, and to meeting complex care needs through ongoing and productive partnerships and networks. Fragmentation of care has been associated with communication gaps, poorer patient outcomes, and higher rates of emergency department visits and hospital admissions.

Implementing integrated models of care requires cooperation and collaboration across the health system. GPs and other primary care stakeholders play a key role in the management and coordination of care of people with chronic or complex conditions in the community. **However, primary care organisations require the support and leadership of their PHNs in order to implement innovative approaches and systems designed to integrate and coordinate health services across the different healthcare settings.** PHNs are funded to support primary care to implement new models of care delivery (e.g. shared care models, person-centred healthcare homes model or medical neighbourhood model) and new modes of working (e.g. virtual care platforms and telehealth during COVID-19 pandemic, the My Health Record platform).

CASE STUDY: Supporting complex chronic disease management
The Integrated Care Coordination (ICC) program, delivered by Marathon Health, supports clients with complex and chronic health issues and their families to effectively navigate the health system to achieve better health outcomes through improved self-management and integration with general practice and other relevant healthcare services. Care coordinators work closely with general practitioners and provide linkages to other appropriate health services. The ICC program is delivered jointly with the Murrumbidgee LHD care coordination program to ensure access across the region. The Health Navigator Support Service provides additional support for ICC clients where complex social needs impact on health and wellbeing. The Health Navigator Support Service uses social prescribing to enhance the effectiveness of health based care coordination. Established in November 2019 as a pilot program, the Health Navigator Support Service is intended to complement health focused care coordination by supporting people with a range of social, emotional or practical supports. The support is non-clinical and addresses barriers to a client's wellbeing which may include safety, housing, financial, legal, employment, mental health, fitness and spirituality. The Health Navigator in action: A client was referred to the ICC program after multiple unplanned presentations to hospital. The client was supported with a coordinated approach which involved the Murrumbidgee LHD occupational therapist and social worker, the client's GP, a care coordinator and the health navigator. The team contributed to developing an NDIS application, which was successful. The client now has funding to secure long-term support and the Health Navigation Support Service is supporting the client to achieve their goals which include shopping, domestic assistance, participating in social activities and accessing mental health support.

Better integration can be achieved at the simplest level through the implementation of linked digital information systems and patient referral pathways (e.g. mapping local referral pathways via the HealthPathways portal). More sophisticated integration involves 'system level' thinking and approaches in order to foster improvements in organisational structures and functions encompassing improved relationships among stakeholders, and new approaches to IT systems, governance and especially funding reform. Healthcare integration includes comprehensive and multifaceted models of care that require agreements, cooperation and co-funding between general practices, PHNs, LHDs and other local care providers. An example of care coordination and navigation services that encompass health and social care is outlined in the case study below.

Even simple aspects of care integration, such as providing hospital discharge summaries regarding ongoing patient treatment and care are still inconsistent; observations from the Southern NSW PHN region has shown that only 65% of discharge summaries are reaching their target primary care providers. This issue may be solved by improving the IT systems that connect the different levels of health services. It is in the interests of NSW Health to continue to work with PHNs to enable primary

care practices to lead team-based care in the community setting, as this can encourage person-centred care, provide continuity of care, decrease fragmentation of services and ultimately improve health outcomes and decrease the number of preventable hospitalisations.

7. HEALTH REFORM in NSW

A person-centred, integrated care approach that addresses local needs will require buy-in from a wide range of stakeholders. Incentives will be required to align the motivations and outcomes across the care settings. The improvement of healthcare outcomes in NSW will only be achieved by working together across the state/ federal boundaries and by including the NSW Ministry of Health and LHDs, the primary care sector, PHNs, other organisations, and the community to provide the best value care.

In alignment with the current and previous National Health Reform Agreements and the Bilateral Agreement on Coordinated Care and other related health reform agreements, NSW Health has implemented several health reform policy initiatives in partnership with the NSW PHNs. These are aimed at incentivising access to appropriate care closer to home as well as improving chronic disease prevention and management. In NSW, the alignment of PHN and LHD boundaries is a key enabler of positive working relationships.

As discussed in a previous section, NSW LHDs and PHNs are undertaking joint, integrated regional planning for mental health services which included the *Mental Health and Suicide Prevention Health Plan* between South Eastern NSW PHN (COORDINARE), Illawarra/ Shoalhaven LHD and Southern NSW LHD.[52] This proved to be a key enabler in the joint mental healthcare response to the 2019/2020 summer bushfires. PHNs and LHDs around the country have also now developed or are developing their joint regional mental health plans, as part of the requirement of the *Fifth National Mental Health and Suicide Prevention Plan*.[53]

NSW Health has completed its **Integrated Care Strategy** trial at four demonstration sites[54] which included Western NSW as well as metropolitan sites. The Integrated Care Strategy helped test and develop the enablers of integrated care, including IT platforms (to capture Patient Reported Measures and to link GP and NSW Health medical records) is now considering how to upscale these into a systems based approach (see Appendix).

Currently, NSW Health is working with the PHNs to continue the integrated care approach by formulating a *Joint Statement on Working Together to Deliver Person-Centred Healthcare* as well as developing a Collaborative Commissioning program.[55]

Many approaches to integrated care as part of the above strategies have already begun in local PHN-LHD areas; there is no one-size-fits-all solution, and each region will co-design and co-commission various models that are suited to their particular needs. However, we acknowledge that some regions are further ahead regarding integrated care whereas others may require some assistance to overcome barriers and workforce issues in their region.

RECOMMENDATION 14: NSW Health to continue to work in collaboration with PHNs in progressing their commitment to developing, trialling, funding and implementing new models of person-centred, integrated and coordinated care, which are tailored to meet the assessed needs of the local communities.

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[52] https://www.coordinare.org.au/assets/Main-Site/Uploads/Resources/publications/SENSW-Regional-Mental-Health-and-Suicide-Prevention-Plan.pdf

[53] Australian Government (2017). *Fifth National Mental Health and Suicide Prevention Plan*. Canberra: Commonwealth of Australia. www.mentalhealthcommission.gov.au/Monitoring-and-Reporting/Fifth-Plan/5th-National-Mental-Health-and-Suicide-Prevention

[54] https://www.health.nsw.gov.au/integratedcare/Publications/strategic-framework-for-integrating-care.PDF

[55] https://www.health.nsw.gov.au/Value/Pages/collaborative-commissioning.aspx

7.1. NSW Health and PHN Joint Statement re Person-Centred Healthcare

NSW Health and PHNs have agreed to a **Joint Statement,** *Working Together to Deliver Person-Centred Healthcare*, that guides how to work together at the regional, state and federal level, inform shared governance arrangements and agreements, and facilitate shared ownership; initiation, implementation and evaluations of programs, projects and services. Importantly, the Joint Statement (about to be finalised) recognises the barriers to optimising healthcare in our current system, such as:

- Funding sources and models are varied and fragmented
- Payments reward volume rather than value
- Differences in how we define health outcomes
- Limited data sharing and data governance
- Lack of communication about care planning, referrals and treatment
- A training focus on specialisation, rather than multi-disciplinary, team based care
- Different organisational structures, boundaries, goals, business models, value propositions and working practices
- Different professional cultures and values, including in relation to quality, safety and risk.

The Joint Statement demonstrates a commitment from NSW Health, the 15 LHDs and 3 Specialty Health Networks, the Commonwealth Department of Health and the 10 NSW PHNs, to working in partnership to deliver person-centred healthcare at a local level, enabling local autonomy, decision-making and accountability. As such there is recognition that person-centred care requires collaboration between, and integrating care across, the primary, community, hospital and social care areas. The Joint Statement can be used to guide the parties to work together at the regional, state and federal level, inform shared governance arrangements and agreements, and facilitate shared ownership, initiation, implementation and evaluations of programs, projects and services in order to overcome the structural barriers in our healthcare system. The use of collaborative commissioning and shared care approaches to achieve these outcomes will build on existing LHD/PHN partnerships.

7.2. NSW Health Collaborative Commissioning Project

Collaborative Commissioning is considered by the NSW Ministry of Health to be central to the transformation of the health system in NSW. The **Collaborative Commissioning Project** is a core partnership between PHNs and LHDs in order to lead change at the local level, by identifying and prioritising local health needs and embedding local accountability for improving patient and community outcomes.

The reform plan involves the formation of **Patient Centred Co-commissioning Groups** which will be tasked with developing new ways of working to achieve better patient outcomes more efficiently. Several Patient Centred Co-commissioning Groups are in the process of being established with a goal of having state-wide coverage in all ten NSW Primary Health Network regions. Populations to be serviced are diverse. For example, **Western NSW** is focussing on improving quality and access to care for people with diabetes at high risk of complications. The Collaborative Commissioning Project will take time to come to fruition, with some PHN / LHD collaborations further ahead in progress than others.

RECOMMENDATION 15: NSW Health to continue to support, monitor and evaluate the progress of the Collaborative Commissioning Project and ensure that each region, particularly rural regions, are given every assistance to achieve their goals and overcome barriers.

7.3. Whole-of-government approach: integrating health with other sectors

Governments also need to give greater priority to the prevention of ill health by working together with healthcare and other agencies to tackle the wider determinants of health and wellbeing. As well as integrating the healthcare sectors, healthcare reform agendas have emphasised a whole-of-government approach to achieve improved population health.[56] Applying resources from other sectors (such as housing, justice, education and the private health sector) would have a substantial multiplying factor on Australia's health investment.

Shared investment (which includes pooled funding or co-commissioning approaches to funding) is a way to leverage cross sectoral action on shared health determinants and outcomes. For example, the North Coast Collective was developed as a cross-sectoral approach to optimising health outcomes the our region. The Collective is initially a partnership between Healthy North Coast Ltd (the North Coast PHN) and both Mid North Coast LHD and Northern NSW LHD (see case study below). This shared approach involves joint planning and priority setting, joint governance, shared resourcing, and a commitment to pursuing the best return on investment for health outcomes and recognises that the health of our communities cannot be determined by the healthcare sector alone, particularly in regional, rural and remote areas.

CASE STUDY: Mental Health & Other Drugs Strategy – an LHD/ PHN collaboration to determine needs in the North Coast
Part of a strategic response to improving health outcomes on the NSW North Coast, Mental Health & Alcohol and Other Drugs was the first strategy of the North Coast Collective. We expect that within our region, over 100,000 people will suffer a mental health disorder in the next 12 months. Despite North Coast LHDs and Health North Coast spending more than $200 million per annum, this region has more adverse outcomes for those with mental health and addiction issues than the state averages. The North Coast Collective explored potential ways they might more prudently and efficiently apply resources in the pursuit of better health outcomes, through systems dynamic modelling (SDM). SDM is a tool that assists decision-makers determine where to best target investments for complex problems, and at what intensity, so that limited resources can be optimised and locally tailored strategies can be theoretically tested prior to implementation. The Collective used SDM to simulate the way in which different determinants of health (healthcare and social) interact to produce MHAOD outcomes. This approach identified technology-enabled care, social connectedness and post-attempt care as the most optimal interventions. Healthy North Coast have since redesigned existing services to incorporate these outputs into delivery. Performance of the selected suite of interventions will involve monitoring the selected metrics and KPIs over time to measure estimated outcomes against the actual measured outcomes.

8. DIGITAL HEALTH

The use of digital technology in health can bring improvements in service quality, efficiency and equity. This creates opportunities for a health system that is seeking to enable individuals, families, and communities to maintain and improve their health through timely access to quality services. Australia's National Digital Health Strategy reinforces that digital information is the bedrock of high-quality healthcare, highlighting that the benefits to patients are significant and compelling, inclusive of hospital admissions avoided, fewer adverse drug events, reduced duplication of tests, better coordination of care for people with chronic and complex conditions, and better informed treatment decisions.[57]

[56] Government of Canada (web-page). (2012) *What is the population health approach?* www.canada.ca/en/public-health/services/health-promotion/population-health/population-health-approach.html

[57] Australia's National Digital Health Strategy | NATIONAL DIGITAL HEALTH STRATEGY:

8.1. Barriers to the provision of digital health services

Across regional and remote NSW during COVID-19, many consumers embraced the improved access to digital mental health. However, consumers expressed frustration as some service providers were slow to take up or offer digital health services such as telehealth. A known barrier to the delivery and uptake of digital services is reluctance or hesitation from a service delivery perspective. To support increased delivery and uptake of digital mental health services, significant work will have to be undertaken with the existing workforce to understand the potential for this treatment modality and to include it in the service offering. Addressing provider concerns regarding interoperability and integration will also assist in removing barriers for service providers to increase their digital service offering.

Another aspect is the digital divide: in rural areas such as Murrumbidgee and Western NSW, approximately 23% of households report not having access to the internet. When designing digital health services, the lack of access to home internet or computer facilities must be taken into account. Improving NBN access to Australia's more remote regional areas is one obvious solution. Assisting general practices or public libraries to have dedicated rooms with free access to computers and the internet in a private area could be another shorter-term solution.

From a primary care perspective there still remains a gap in the adoption of interoperable clinical information and technology (ICT) systems across most regional NSW PHNs. This needs to build on compatibility with both the My Health Record and the upgrade of the Cerner based electronic medical record system used in NSW hospitals. Despite ongoing commitment between the LHDs and PHNs to jointly pursue ICT interoperability, adoption and diffusion has been too slow, impeded by cost, regulatory and bureaucratic barriers at the level of eHealth NSW. The opportunity cost of the failure to exploit this regional commitment will be reflected in care delays, errors, waste and clinical variance because key data is not being shared in real time.

RECOMMENDATION 16: NSW Health to work with PHNs to provide training and support to service providers and consumers in utilising digital health platforms.

RECOMMENDATION 17: NSW Health to improve access to computing facilities and the internet for rural areas.

RECOMMENDATION 18: NSW Health to continue to improve interoperability between data systems, including between primary care, hospital care and aged care systems.

RECOMMENDATION 19: eHealth NSW to enable investment in interoperable information and communication technology to be fast-tracked in order to optimise clinical workflows and patient care pathways across sectors.

8.2. Integration of lived experience perspective in digital health services

For true person-centred care, lived experience working groups must be utilised to advise on the design, delivery and evaluation of services as part of an ongoing process, not simply on an *ad hoc* basis. For example, central to the North Coast Collective (NCC) approach to the development of a mental health service strategy is the use of participatory design. Participatory design is based on the premise that 'the people destined to use the system play a critical role in designing it.[58]

RECOMMENDATION 20: NSW Health to continue their support of integrating the Lived Experience perspective into the design and delivery of digital health services. The Lived Experience perspective should be consistent, authentic, and inclusive across low, moderate or high intensity mental health consumer experiences.

[58] Robinson, J, Bailey, E, Browne, V, Cox, G, & Hooper, C. (2016) Raising the bar for youth suicide prevention. Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health.

9. PANDEMIC, DISASTER AND EMERGENCY RESPONSES

The issues of drought, bushfires and the COVID-19 pandemic over recent years have led to significant demands of rural primary care providers and PHNs. At the same time, these responses have not been included in NSW emergency and pandemic response plans. The essential role of GPs and primary care was noted in the recent Royal Commission inquiry into the bushfires.[59] The lack of inclusion of GPs and their coordinating PHNs in disaster planning meant that there were situations in which people were without medical care during the Black Saturday bushfires, and some general practices did not have the correct equipment to properly treat people with burns and smoke inhalation.

PHNs are now working towards ensuring there a more co-ordinated and integrated approach towards embedding GPs into disaster planning processes and ensuring they are compensated for their time when participating in disaster planning.

During COVID-19, the key areas of external facing work that were undertaken by PHNs included coordination of general practice and primary care emergency support, rapid distribution of Personal Protective Equipment, establishment of GP-led Community Respiratory Clinics (COVID-19 testing clinics), comprehensive information and education campaigns, development of clinical Health Pathways referral systems, capacity tracking in primary care, and focused general support across General Practice, Aboriginal Medical Services, Commissioned Services, Allied Health and supporting General Practice into Aged Care.

Alongside these new and increased responsibilities, PHNs were working to support large numbers of commissioned services. A key strength of the PHN model emerged throughout the pandemic which was the ability to provide localized primary care coordination, support and advice to suit local conditions. Established and strengthened relationships with frontline providers enabled PHNs to gain knowledge at a granular local level to really understand the impacts in rural communities. The agility of PHNs throughout the time period highlighted the value of localised non-government response agencies. Through strengthened relationships, increased stakeholder engagement, acknowledgement of PHNs as a central source of truth for primary care.

At the same time, there were not always clearly defined and legitimised relationships with other agencies (such as Local Health Districts) during the pandemic response. PHNs had strong relationships but not always with the right area or person, and these had to be developed rapidly.

PHNs were not a part of established Commonwealth and state pandemic response plans. The legitimacy of the role of the PHN played within emergency response was not always clear, and resulted in tension at times (particularly in areas such as aged care and surge workforce). This cascaded into similar tension around the roles and coordination of GPs. In some situations, this resulted in a disastrous lack of availability of GPs of COVID-19 cases in the community and in aged care settings.

RECOMMENDATION 21: NSW Health to include the general practice and PHN roles in emergency and pandemic plans, and to clarify roles in relation to Local Health Districts and residential aged care sector. Jurisdictional responsibilities to be clarified for all agencies and stakeholders.

[59] Binskin, M (2020). *Royal Commission into National Natural Disaster Arrangements Report* (Tabled in Parliament on 30 October, 2020). Chapter 15, pg 340. https://naturaldisaster.royalcommission.gov.au/

10. SUMMARY OF RECOMMENDATIONS

The Hunter New England and Central Coast PHN, Murrumbidgee PHN, North Coast PHN, South Eastern NSW PHN and Western NSW PHN present the following list of recommendations to the inquiry.

	RECOMMENDATIONS
TOPIC	**3. ACCESS TO PRIMARY CARE IN RURAL AREAS**
RECOMMENDATION 1	NSW Health to work with the Federal Government and PHNs to provide incentives that increase the supply of the primary care workforce in rural areas as a matter of urgency to ensure that access to appropriate, cost-effective healthcare is a reality for those who live outside urban areas
RECOMMENDATION 2	NSW Health to amend its Rural Medical Generalist Training Program to incorporate the missing critical elements of “quarantined and adequate” number of GP intern positions in the regions, adequate resourcing for program support, regionally focussed workforce and training plans, and industry recognition of the rural generalist qualification.
RECOMMENDATION 3	NSW Health and LHDs to maintain procedural services in rural hospitals, i.e. obstetric, anaesthetics and emergency services including birthing services.
TOPIC	**4. ACCESS TO MENTAL HEALTHCARE IN RURAL AREAS**
RECOMMENDATION 4	NSW Health to continue to support and encourage LHDs and PHNs to complete and implement their joint regional mental health and suicide prevention plans. The joint plans will describe one overall planned and coordinated approach to mental heath and suicide prevention services, tailored to meet the unique needs of the local region.
RECOMMENDATION 5	NSW Health to consider trialling new funding models regarding mental healthcare and suicide prevention services that could include bundled payments, outcome-based payments, as well as co-funding and co-commissioning of services to better incentivise more appropriate treatment and better health outcomes.
TOPIC	**5. IMPROVING ACCESS TO HEALTH SERVICES for the ABORIGINAL COMMUNITY**
RECOMMENDATION 6	NSW Health to support and enable increased Aboriginal-led health service planning, design and commissioning.
RECOMMENDATION 7	NSW Health to embed Aboriginal cultural safety as part of their quality standards.
RECOMMENDATION 8	NSW Health to increase funding to support long-term, coordinated, placed-based approaches aimed at improving the social determinants of health, and strengthening the positive cultural determinants of health for the Aboriginal community.
RECOMMENDATION 9	NSW Health to work collaboratively to overcoming social determinants of health disparities with stakeholders including the Aboriginal Community Controlled Organisations (ACCOs), primary health and community care sector, other non-health government departments, and PHNs.
RECOMMENDATION 10	NSW Health to develop and enhance culturally appropriate system-wide Aboriginal integrated care programs to reduce disparity in health outcomes.
RECOMMENDATION 11	NSW Health to enable appropriate and curated evidentiary support for the contribution made by Aboriginal models of care, including by local employment opportunities.
RECOMMENDATION 12	NSW Health to work with the Aboriginal community to improve collection of Aboriginal status in health data sets, in order to improve data collection and to assist with appropriate care pathways.

RECOMMENDATION 13	NSW Health to work with the Federal Government to fast-track development of the Aboriginal and Torres Strait Islander mental health workforce program to address the specific needs of their local communities. This recognises the distinct needs of, and obstacles faced by communities as well as their holistic cultural approach to matters of social and emotional wellbeing.
TOPIC	**7. HEALTH REFORM in NSW**
RECOMMENDATION 14	NSW Health to continue to work in collaboration with PHNs in progressing their commitment to developing, trialling, funding and implementing new models of person-centred, integrated and coordinated care, which are tailored to meet the assessed needs of the local communities.
RECOMMENDATION 15	NSW Health continue to support, monitor and evaluate the progress of the Collaborative Commissioning Project and ensure that each region, particularly rural regions, are given every assistance to achieve their goals and overcome barriers.
TOPIC	**8. DIGITAL HEALTH**
RECOMMENDATION 16	NSW Health to work with PHNs to provide training and support to service providers and consumers in utilising digital health platforms.
RECOMMENDATION 17	NSW Health to improve access to computing facilities and the internet for rural areas.
RECOMMENDATION 18	NSW Health to continue to improve interoperability between data systems, including between primary care, hospital care and aged care systems.
RECOMMENDATION 19	eHealth NSW to enable investment in interoperable information and communication technology to be fast-tracked in order to optimise clinical workflows and patient care pathways across sectors.
RECOMMENDATION 20	NSW Health to continue their support of integrating the Lived Experience perspective into the design and delivery of digital health services. The Lived Experience perspective should be consistent, authentic, and inclusive across low, moderate or high intensity mental health consumer experiences.
TOPIC	**9. PANDEMIC, DISASTER AND EMERGENCY RESPONSES**
RECOMMENDATION 21	NSW Health to include the general practice and PHN roles in emergency and pandemic plans, and to clarify roles in relation to Local Health Districts and residential aged care sector. Jurisdictional responsibilities to be clarified for all agencies and stakeholders.

11. ABOUT PHNs

The Federal Government established 31 PHNs as independent primary health care organisations, in July 2015. The Federal Government has supported the role of regional primary health care organisations for many years, starting with Divisions of General Practice in the 1990s. From 2011, Divisions were replaced with Medicare Locals which were charged with encouraging collaboration between health care professionals, undertaking population health planning and, in many cases, providing services. The main role of PHNs is to commission, rather than provide services. It is the key difference between Medicare Locals and PHNs, and represents a fundamental shift in the way primary health care services are planned for and funded at the regional level. PHNs make decisions independent of government and are operated by not-for-profit companies. They decide which services or health care interventions should be provided and who should provide them. They also work closely with providers to monitor performance and implement change.

PHNs have three main roles:

- Commission health services to meet the identified and prioritised needs of people in their regions and address identified gaps in primary health care. This may include working with others in the community to plan and deliver innovative services that meet specific health needs.
- Through practice support, PHNs work closely with general practitioners (GPs) and other health professionals to build health workforce capacity and the delivery of high quality care.
- Work collaboratively within their regions to integrate health services at the local level to create a better experience for patients, encourage better use of health resources, and eliminate service duplication.

12. APPENDIX: NSW Integrated Care Strategy and Framework

In 2014, the NSW Government committed $180 million over six years towards the Integrated Care Strategy which aimed to implement new, innovative locally-led models of integrated care across the state in order to deliver person-centred, seamless, efficient and effective care for people with complex, long-term conditions. This includes state-wide strategies coordinating better communication and connectivity between healthcare providers in primary care, community, and hospital settings, and providing better access to community-based services closer to home. The strategy involves building the enablers of integrated care – such as improving IT systems (e.g. by implementing integrated medical records systems and platforms to capture Patient Reported Outcome Measures) and care coordination.

After the completion of three pilot sites, all PHNs are now working with their partner LHDs in each region to formalise and implement agreements to work collaboratively with a focus on joint planning and investment across care settings.

Western NSW was part of the integrated care 'demonstrator sites' in NSW. For example, the **Western NSW Integrated Care Strategy** is a ground-breaking approach to implementing locally-driven, regionally-enabled integrated care across a large rural health district, with a particular focus on Aboriginal Health. The strategy was implemented collaboratively through a jointly governed partnership between Western NSW LHD, Western NSW PHN and Bila Muuji Aboriginal Health Services.

The integrated model of care involved identification and enrolment of high risk patients with complex needs, managed by a care team overseeing individual care plans addressing both health and social needs. The strategy has achieved significant improvements in how local communities address the care of people with complex care needs. The strategy has successfully demonstrated that a place-based, general practice-led, locally driven strategy can work in the rural setting. The lessons have successfully been applied to additional sites with the integrated model of care applied to additional priority areas (antenatal care, the first 2000 days of life, as well as expanding chronic and aged care to include asthma, dementia and mental health).