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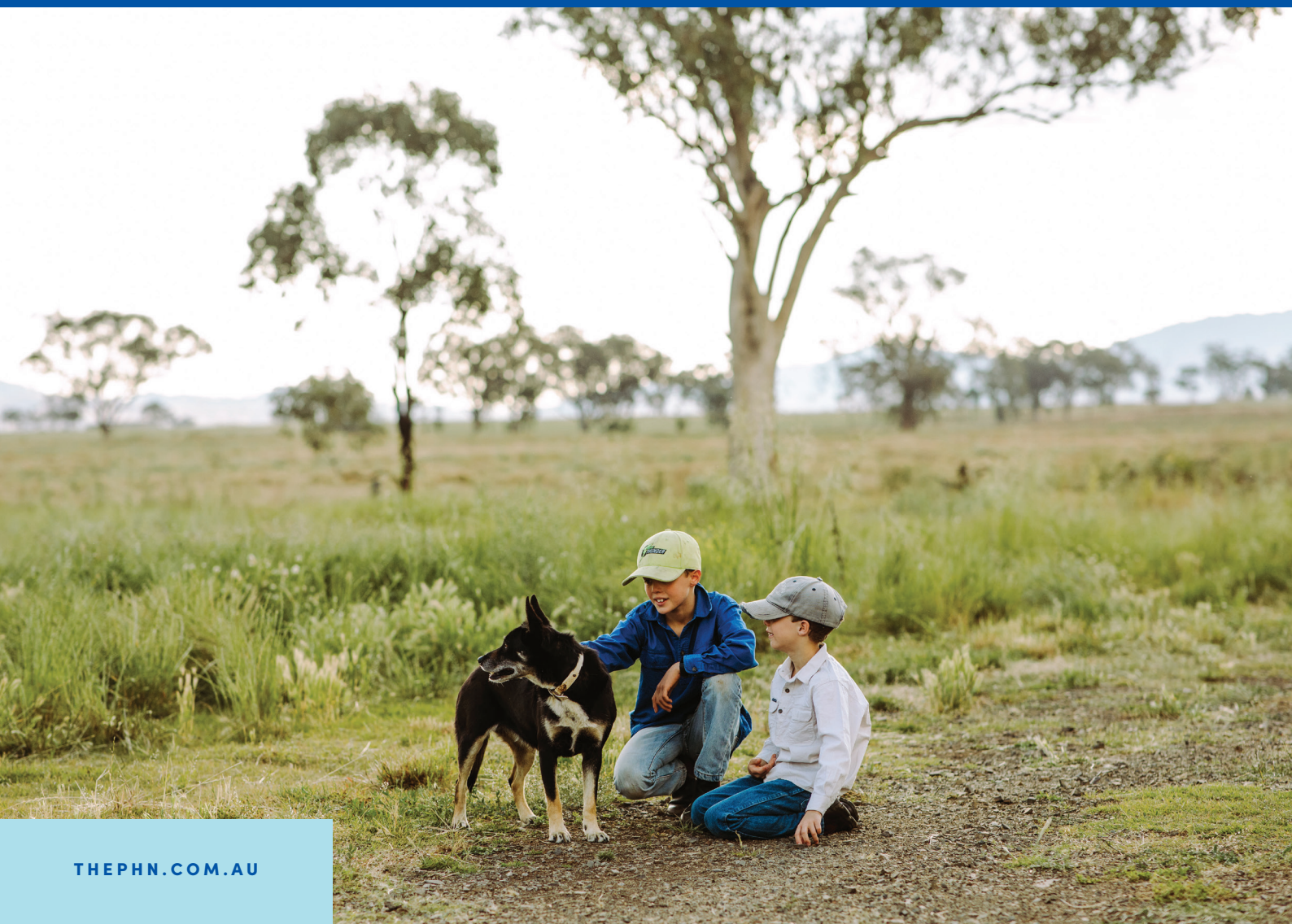
HUNTER NEW ENGLAND AND CENTRAL COAST
An Australian Government Initiative

PRIMARY HEALTH NETWORK

Better Health for the Bush

We're listening to and engaging with our communities around their health needs and the available support services.

We propose to work and collaborate with communities to identify new approaches for innovative workforce solutions.



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Hunter New England and Central Coast (HNECC) PHN acknowledges the traditional custodians of the lands we walk, live and work upon, and respect First Nations continuing culture and the contribution they make to the life of this vast region.

Aboriginal Nations within our region include: Anaiwan and Nganyaywana; Awabakal; Biripi; Darkinjung; Dunghutti; Geawegal; Kamilaroi; Kuring-gai; Ngarabal; Wonnaru; Worimi.

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FIRST NATIONS HEALTH

What is the Better Health for the Bush model?

The Better Health for the Bush (BHFTB) model was developed by the Hunter New England Central Coast PHN (HNECC PHN or the PHN) to pursue our vision of Healthy People and Healthy Communities by finding solutions to improve how we attract and retain healthcare providers, working with communities and health professionals to ensure that the solutions fit and work locally.

In the short term BHFTB will continue to pursue the goals of:

- establishing a multisector networked rural health model for Glen Innes, Inverell, and Tenterfield, which includes technology-enabled healthcare to link teams around the patient
- developing localised recruitment packages that attract GPs and allied health workers to vacant roles in targeted locations – using evidence to increase incentives and address disincentives.

In each sub-region BHFTB wants to start building a network of:

- medical, nursing and allied health practitioners
- key community members
- health providers
- education and training providers
- local government, and
- non-government agencies.

The network will focus on:

- ✓ identifying service gaps
- ✓ supporting the development and implementation of new approaches to the coordinated delivery of healthcare across teams and agencies
- ✓ providing welcome and connection for new clinicians and their families
- ✓ helping communities and individuals navigate their way through the health system.

OPTIONS FOR THE MODEL WILL BE TO:

Attract and retain GPs – possibly by establishing and commissioning a not-for-profit Primary Health Service (clinic) in one of the three major sub-regional towns.

"A significant number of our registrars are IMGs (International Medical Graduates). They have often formed relationships in the city. If we don't provide the cultural supports they need, they can be pulled back to the city" – Health Professional

The commissioning approach will ensure that the successful tenderer delivers outcomes aligned with local community needs and will have community and PHN nominees on the governance board.

"Sometimes we can focus too much on GPs and forget about the rest of the health workforce that can make a real difference" – Health Professional

Increase the workforce - develop and implement strategies to attract a skilled workforce to communities across the Tablelands sub-region (GPs, nurses and allied health staff).

This includes the use of incentives and creation of positive environments such as:

- promotional and marketing activities
- establishing and ensuring clinical, infrastructure and educational support
- opportunities for continuing professional development (CPD) through networks, research, education and participation in achieving local solutions
- lifestyle and family support that include social activities for community integration, safety initiatives, quality schooling, and opportunities for partners to engage in meaningful employment
- campaigns promoting the opportunities in a rural placement
- supporting registrars and their families with accommodation, education, employment and transport opportunities.

Support the workforce - establish a GP Clinical Lead position including:

- liaise with local clinicians to develop coordinated care approaches
- lead strategies to make these communities desirable professional environments
- offer mentoring and clinical guidance to new clinic teams.

"I feel like I carry the expectations of the community and when I can't find the resources or staff, I feel responsible" – Health Professional

Navigate the system – commission the Community Innovation Coordinator initiative to respond to community needs and enable better navigation and coordination of services in major towns and communities across the Tablelands sub-region.

"There are so many different services and health providers. It's confusing and the people who need the services don't know what's actually available" – Consumer

Digital solutions - develop telehealth and technology enabled health services to enhance and supplement the delivery of primary health and other health services.

MODEL CONSIDERATIONS

Continuing to deliver the same primary healthcare service model is like doing nothing in the face of shrinking primary healthcare provision. In the bush this means a far greater risk that the situation continues to decline exponentially. Key foundations to effectively ensure that this deterioration does not continue to occur means:

- establishing effective governance across the sub-region that includes GP, community, and local government representation
- significant, consistent and sustained engagement and partnerships with local GPs
- significant, consistent and sustained engagement and partnerships with local communities (including local government and other community representatives).

WHY DO WE NEED A NEW MODEL?

Communities in the New England region have poorer health outcomes and access to healthcare compared with New South Wales and Australia. On average, Australians living in rural and remote areas have shorter lives and higher levels of disease and injury. They have poorer access to, and use of, health services compared with people living in metropolitan areas.

The shortage of GPs and other health professionals in the Tablelands sub-region (Glen Innes, Inverell and Tenterfield) creates barriers to timely health service access.

2019 GPS PER 100,000 RESIDENTS	
New England (excluding Tamworth and Armidale)	96
Rural and Remote	110
Urban	125

When GP practices close in rural communities it reduces the opportunities to recruit more GPs and registered health professionals. The local population is forced to access a shrinking number of health providers.

"In my town, we have three GP practices. There is a six week wait to see the GP when you book an appointment. Two of the GP practices are going to close in the next six months because the doctors are retiring. What are we going to do?!" – Consumer

The shortage of GPs in regional communities is mirrored by a shortage of other registered health professionals. For all registered health professions, the number of employed full-time employed (FTE) clinicians working in their registered professions decreases with distance from major cities.

2018 CLINICAL FTE PER 100,000 PEOPLE	
Inner regional areas (Tamworth and Armidale)	1,679
Outer regional areas (Glen Innes, Inverell and Tenterfield)	1,550
Urban	1,927

As care coordination and network building activities reduce, the health system becomes increasingly difficult to navigate for consumers. Communication and collaboration between primary health, community providers, hospital services and specialist medical services decreases.

"Lots of organisations are doing things but there's not a lot of coordination" – Consumer

Communities struggle to have their concerns heard and their needs met by an increasingly challenged health service delivery environment. There is little time to engage in planning for shared initiatives and the delivery of services that are responsive to the needs and concerns of local communities.

In rural Australia, the prevailing models of primary health care struggle to respond to reduced access to GPs, poorer quality care and poor outcomes. The models are not flexible and efficient enough to:

- service the growing caseload of primary, secondary, and tertiary prevention work associated with chronic disease
- meet the needs of a more dispersed, older population
- support GPs to contribute to the delivery of tertiary hospital-based services such as emergency and procedural work.

"We need to demonstrate that GPs can come to the country and have the academic appointments and opportunities for research that they can get on the coast" – Health Professional

The existing GP remuneration model (prior to the COVID-19 pandemic) disincentivises the use of telehealth and digital remote consultation tools. This deepens inequities arising from low levels of GP availability in rural settings.

"We have been talking about this for 30 years. Rural people are sick of being told that they need to accept worse health outcomes" – Consumer

Medical practices and practitioners operate within an environment where service delivery is challenged by distance, socio-economic conditions and the sufficient availability of a range of health practitioners. Several factors impact GPs' capacity to thrive in smaller locations including:

- insufficient availability and high cost of locum relief
- high on-call responsibilities and insufficient down-time
- GP training pipeline that fails to deliver the required medical workforce where they are needed most
- a lack of time and opportunities for generalist procedural training and support

"The pipeline isn't being filled from the tank - there are not enough GPs in the pipeline" – Health Professional

- minimal supplementation of generalist procedural practice with registrar, medical and allied health student placements
- lack of access to learning opportunities and support for careers or personal development
- limited opportunities (and time) to participate in broader health networks with LHD colleagues, other local primary health providers, Aboriginal medical services and education providers in the health sector.

"How good would it be if we could get everyone working together? Maybe have more services operating together under one roof" – Consumer

New England communities use fewer general practitioner (GP) services compared with New South Wales and Australia.

PERCENTAGE OF PEOPLE WHO ACCESSED A MEDICARE SERVICE BILLED GP ATTENDANCE, 2018-2019	
New England	85.8%
New South Wales	88.1%
Australia	87.8%

WHAT HAVE WE BEEN DOING SO FAR WITH THE BHFTB MODEL?

In November 2019, consultants were engaged to undertake initial consultations during 2020 with a wide range of general practices in the Mehi, Tablelands and Plains sub-regions, medical organisations, community members, allied health and the PHN New England North West Clinical Council and Community Advisory Committee.

The consultations identified key areas for further exploration and elaboration as the collaborative developed the BHFTB initiative:

- the critical role of general practitioner (GP) clinical leadership and care navigators
- attracting registrars, GPs and Rural Generalists to the regions
- recruiting allied health and nursing clinicians to the regions

"It's about showing young doctors that they can have an amazing lifestyle in the country" – Consumer

- working with and leveraging existing programs and frameworks such as the Rural Generalists procedural program
- utilising the strengths of local communities and health services.

In 2021, consultants undertook and utilised codesign principles to explore, plan and determine how the program could be implemented locally. It is acknowledged that due to the COVID-19 pandemic, engaging with local GPs was problematic due to their high caseloads. There is general acknowledgement that the traditional model of delivering general practice care is no longer acceptable for emerging GPs i.e., where the GP establishes their own business, is available on call, and works as a VMO for the local hospital.

A number of implementation themes have emerged during that process:

1. optimising the supply chain/pipeline of GPs to rural communities
2. building the right conditions that will attract and retain health workers
3. business models for BHFTB primary health service(s)
4. building a networked health service model tailored for local communities

"There are enormous numbers of players, and no one communicates with each other, I work in this environment, and I still get confused! How's a community member expected to understand what's going on?" – Health Professional

5. balancing regional, sub-regional and local solutions
6. utilising new technologies as a service enhancement
7. building working partnerships.

EXISTING BUSINESS MODELS FOR PRIMARY HEALTHCARE

"There are models that we know can work in rural communities. One example is Aboriginal Medical Services. Another example is rural clinics with mixed funding" – Health Professional

- Partner-based practices that operate as small businesses.
- Corporate entities: The practice operates under a structured business model and practice profits are shared between business owners and/or shareholders.
- "Benign" corporate entities: There is a structured business model, however practice profits are reinvested in the practice itself.
- Not For Profit practices that often operate as charities with a particular mission to deliver services to specific communities.
- Community controlled primary health services.

Examples of different types of current models include:

- RARMS (Rural and Remote Health Services)
- ACCHOs (Aboriginal Community Controlled Health Organisations) or AMS (Aboriginal Medical Services)
- RACCHO (Rural Area Community Controlled Health Organisations).

EXISTING WORKING PARTNERSHIPS

- Local Health Advisory Committees (convened by the LHD)
- A regional GP Succession Planning meeting (that is attended by the Rural Doctors Network and the PHN)
- Regional clinical councils.

"The concept of 'cradle to grave' rural GP roles is no longer attractive. Young people want a broad range of experiences across their careers. BHFTB needs to develop attractive entry and exit strategies for GPs and allied health workers. To retain health workers for longer periods of their lives and careers, not just when entering or exiting a town. To retain health workers, BHFTB needs to pitch to lifecycles" – Health Professional

WHO WAS INVOLVED?

A collaborative of organisations led by Hunter New England Central Coast Primary Health Network and including Hunter New England Local Health District and the University of New England School of Rural Medicine are undertaking the BHFTB project in the New England region.

Specifically, BHFTB is being developed and piloted in the Tablelands sub-region (covering Glen Innes, Inverell and Tenterfield).

A BETTER HEALTH FOR THE BUSH COLLABORATIVE

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une University of New England

NSW GOVERNMENT Health Hunter New England Local Health District

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