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

Organisation: Australian College of Rural and Remote Medicine (ACRRM)

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WORLD LEADERS IN RURAL PRACTICE

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

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College Details

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ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the traditional owners of lands across Australia in which our members and staff work and live and pay respect to their elders past present and future.

About the Australian College of Rural and Remote Medicine (ACRRM)

ACRRM's vision is *the right doctors, in the right places, with the right skills, providing rural and remote people with excellent health care.* It progresses this through the provision of quality vocational training; professional development education programs; setting and upholding practice standards; and through the provision of support and advocacy services for rural doctors and the communities they serve.

ACRRM is accredited by the Australian Medical Council to set standards for the specialty of general practice. The College's programs are specifically designed to provide Fellows with the extended skills required to deliver the highest quality Rural Generalist model of care in rural and remote communities, which often experience a shortage of face-to-face specialist and allied health services.

Background

For ease of reference, this submission will use the term 'rural', to encompass regional, rural and remote communities, noting that in addition to a set of common issues, each of these communities has its own unique needs and circumstances.

The Rural Context

Health Professionals in rural areas work under circumstances and working environments, and with a scope of practice which can very different to urban practice. They are often the only readily available health care professionals and as such may need to take on a range of roles which fall to more specialised services or larger health care teams in larger centres. The degree of responsibility for the complete care of the patient borne by the local practitioner/s will be influenced by their skill set; the available health support services, staff, and resources in each locality; and, the geographical distance and/or transport options available to and from needed services.

These differing circumstances require practitioners to provide a varying and typically broader and more complex suite of services than their urban counterparts. These extended services are often delivered in ways that differ from typical urban practice models due to the limited resources and clinical teams in the local rural setting.

Rural Health Outcomes and Access to Services

It is well documented that people living in rural areas have poorer health outcomes across a wide range of measures. On average they have shorter lives, higher levels of disease and injury, poorer access to and use of health services and receive less government funding towards their healthcare and services.

Very remote people's premature death rate is 2.5 times that of people in major cities. Mortality increases with remoteness by 13 years (Major cities=82; Remote=76 years; Very Remote=69 years), while in cancer care, regional people have a 7% higher mortality rate.

Poor access to services is a key contributing factor to poorer health outcomes. AIHW research[1] indicates that people living in outer regional areas were 2.5 times more likely to report having a General Practitioner nearby as a barrier to accessing care compared with their urban counterparts, and residents in remote and very remote areas up to six times more likely to report this as a barrier.

There is a similar situation with respect to other specialist care, with rural residents (5 times higher) and remote residents (10 times higher) reporting that not having a specialist nearby as a significant barrier to seeking specialist care.

In terms of preventative care, rural people have lower rates of bowel, breast and cervical cancer screening and higher rates of potentially preventable hospitalisations.

AIHW research[2] indicates that lack of access is leading to people presenting when conditions have escalated, or when they are unable to seek appropriate primary care through their local GP. The rate of potentially preventable hospitalisations doubles in rural areas, leading to poorer health outcomes and consequent increased health care costs, losses in economic productivity and poorer quality of life.

AIHW research[3] also indicates that there is a massive underspend on health care in rural areas. It is estimated that governments would need to spend an additional $2 billion per annum on healthcare for rural Australians to bring national expenditure into parity with the per capita health spend on people in cities. This difference is largely due to the fact that rural people access significantly fewer MBS services and PBS scripts. Access to services is clearly a key factor accounting for this difference. For example, nine out of ten psychiatrists are in major cities and for every Government dollar spent on psychiatrist services in a remote area, $7.70 is spent in advantaged metropolitan areas.[12]

The Rural Medical Workforce

There is a well-documented maldistribution of medical practitioners in rural Australia. The doubling of the number of Australian medical graduates has led to an oversupply of doctors in urban areas but has done little to address shortages in rural Australia. Australian trained medical graduates today are less likely to work either as general practitioners or in rural communities compared to graduates in previous decades and rural areas continue to remain substantially dependent on International Medical Graduates doctors, who comprise almost half of the general practitioner workforce in rural areas.

This maldistribution translates to fewer staff and also lack of continuity of care where communities rely on short-term, temporary or locum practitioners. Reliable and sustainable heath care is a cornerstone to community resilience and the loss of services, or loss of trust in service provision, can create a downward spiral in terms of establishing sustainable local staff and resources.

Rural Generalism and the National Rural Generalist Pathway

The Rural Generalist (RG) is a medical practitioner who is trained to meet the specific current and future health care needs of Australian rural and remote communities in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care and required components of other medical specialist care in hospital and community settings as part of a rural healthcare team.

RGs work in a range or combination of settings including private general practice, primary health care clinics, hospitals, Aboriginal Community-Controlled Health Organisations (ACCHOs), and retrieval services. They will have an advanced skill on one of a range of areas such as obstetrics, emergency care, mental health, palliative care or anaesthetics.

Social and economic benefits of rural generalist practice include:

- Improving local access to procedural, emergency and other advanced skills which are most needed in rural communities including mental health, indigenous health and palliative care.
- Reducing health care costs for both governments and patients
- Reducing need for patients and their carers to travel with an associated reduction in costs and risks; social dislocation; and enabling patients to access local social and other support from their families and communities

[1] Australian Institute of Health and Welfare (2020). *Medicare-subsidised GP, allied health and specialist health care across local areas: 2013–14 to 2018–19*. Cat. no. PHC 4. Canberra.
[2] National Health Workforce Data Set (2020)

- Maintaining social capital and a range of medical and other skills within the community
- Increasing retention of a skilled medical workforce and the associated infrastructure and support services within the communities where they are needed
- Reducing the risk of a spiralling loss of services which results from a declining scope of practice; reduced skill sets; and consequent loss of workforce and infrastructure

There is widespread support for the implementation of a National Rural Generalist Pathway (NRGP). With the support of the Commonwealth and under the auspices of the National Rural Generalist Taskforce, an application has been submitted to the Medical Board of Australia for recognition of Rural Generalist Medicine as a specialist field within general practice. This would result in doctors with appropriate Rural Generalist qualifications being registered as such with the Australian Health Practitioner Regulation Agency within the discipline of general practice.

With its key components of a supported training pathway and increased national recognition for the Rural Generalist model of practice, the NRGP has the potential to make a significant contribution to the sustainability of the rural and remote medical workforce; minimise the reliability on locum services; and increase and the range of services which can be delivered safely and effectively in rural and remote areas.

ACRRM is a longstanding champion of Rural Generalism in the state/territory, national and international arenas and College Fellows are trained to the scope of RG practice. The College is strongly committed to building a national rural and remote workforce with a Rural Generalist skill set, in the belief that provision of a national network of Rural Generalists will significantly contribute to providing rural and remote communities with sustainable, high-quality health services.

The success of the ACRRM approach of a rurally-focussed College providing rural generalist training is unparalleled in addressing key rural workforce goals. Studies based on the MABEL dataset have found ACRRM Fellows are the most likely to become long-term rural doctors and the most likely to provide rural procedural such as obstetrics, surgery and anaesthetics, even compared to general practice doctors awarded Fellowship in Advanced Rural General Practice through the RACGP. They have found ACRRM Fellows (compared to Fellowed GPs without FACRRM) were 3.24 times more likely to be working in a rural area, and 4 times more likely to be working in a remote area.[3, 4]

ACRRM Fellowship is single best predictor of a long-term rural and remote medical practitioner outcome. In turn, there is a positive correlation between rurally-based training and exposure to rural practice, and enrolment in the College Fellowship program. Increased numbers of FACRRMs make a significant and long-term contribution to the rural medical workforce, given that College Fellows are trained to a Rural Generalist skill set to practise safely and confidently in rural and remote areas.

Service Reform in Regional, Rural and Remote Areas

When properly funded and intelligently designed using rural-centric models (rather than super-imposing urban-centric models), rural health services provide excellent health care which meets community need and a substantial longer-term Return on Investment.

This is supported by ample evidence that well-funded, intelligently designed, rural services which are led and staffed by Rural Generalists, are safe and of high quality. A study of Rural Generalist-led hospitals in rural locations found no quality and safety outcomes variance between rural these hospitals and state public hospital averages including for higher risk births. It is worth

[3] Islam A. (2017) *What are FACRRM's doing now? A look at the 2014 Mabel data.* Conference Proceedings. 5th Mabel Research Forum, May 2017, Melbourne

[4] McGrail M, O'Sullivan B. (2020) *Faculties to Support General Practitioners Working Rurally at Broader Scope: A National Cross-Sectional Study of Their Value.* International Journal of Environment Research and Public Healt

noting that four of the rural birthing units reviewed had been re-opened under an RG program.[4] This is supported by studies in WA[5], Australia-wide[6], and Canada[7]

Extensive literature records good of better health outcomes being achieved by rural health services relative to urban in:

- surgery,[8,9,10,11,12]
- cardiovascular medicine,[13,14,15]
- obstetrics,[16,17,18]
- anaesthesia,[19,20] and
- chronic disease management.[21]

The NSW Context – feedback from NSW members

While this submission has focussed on rural health issues within the national context, the College has also received some specific feedback from NSW members, as documented below:

- *Patient transfers:* Timely transfer to definitive tertiary hospital care can be limited by factors such as lack of available aircraft and pilot hours. This is especially an issue with an increase in bariatric cases who cannot be treated locally due to risk - intra-operative and post-op due to lack of ICU services.

- *Retrieval Protocols:* Retrieval services are an essential support system for rural generalists. Unfortunately it is increasingly apparent that rather than transporting patients from the scene of an accident to hospital for initial assessment and stabilization, metropolitan-based retrieval services are ordering that patients stay on scene and wait for the chopper. There are increasing examples where patient assessment and initial management is delayed in order that the chopper is on the ground. This leads to worse and possibly fatal outcomes for patients, sometimes unnecessary activations of retrieval services and a waste of the skillset that is often present in a nearby town. Early patient assessment and care with possible retrieval saves lives. Lifting the retrieval silo is imperative to improve the outcomes for rural and remote patients.

- *Staffing:* Many facilities continue to rely on locum and fly-in, fly-out staff which in turn can impact on continuity of care and increase the cost of service provision. Inflexible shift arrangements in some facilities result in fatigue and overwork and consequently more practitioners are reluctant to work these hospitals or provide VMO services.

- *Onerous administrative requirements and credentialing policies* represent a significant deterrent to many rural practitioners, particularly experienced practitioners, to offering locum and VMO services. Much of the documentation required appears to be either irrelevant or has previously been submitted to NSW Health, and takes a significant amount of time to complete. Consequently the lack of locums deprives communities of much-needed services, and affects those doctors who are working full-time in those communities by reducing their access to locum support so that they can work reasonable hours or take leave. This then makes recruiting and retaining a sustainable workforce even more challenging.

- *Training and support:* In many rural facilities there is potential to increase training and support for both medical and nursing staff, and in particular to allow trainees to be supernumerary for periods of time to facilitate learning and relieve staffing pressures.

- *Diagnostic Imaging:* Improved access to MBS-supported MRI facilities would be of significant benefit particularly in areas where there is significant travel time involved and for a range of acute and subacute issues including brainstem stroke; ligamentous C-spine injury; orthopaedic injuries; and osteomyelitis. For acute issues, this may reduce the need for emergent transfer. For subacute issue, it would reduce travel for patients who just needed the imaging and could access care closer to home. Where MRI services are

available, they are often in the private system and result in higher costs per service compared to the same imaging in larger, typically costal regional cities.

The Case for Reform

Unfortunately there is a tendency for over-stretched services to be made scapegoats for a system that is not necessarily fit-for-purpose. This undermines community and practitioner confidence and makes it more difficult to attract and retain an adequate health workforce.

As evidenced by recent inquiries, rural hospital, emergency and primary care services have reached a point where rebuilding is a matter of urgency. While other workforce projects and innovations are currently under way, these should not preclude a strong focus and substantive progress on this work, which needs to take place at the state and regional level as well as through Commonwealth planning and processes, and with coordination and collaboration at all levels.

Rebuilding and reformation should foster sustainable healthcare services within each rural and remote community, noting that this will require considerable policy flexibility and/or variability to reflect the fact that employment models may support doctors working across the private and public sector in different ways. These models should recognise the ultimate goal to provide each community with a high-quality, locally-based system of medical services supported by a sustainable number of in-situ medical practitioners and a strong health care team.

The College recognises that the viability of local healthcare services rests on having a sufficient number of doctors and other healthcare providers in the community. While there are a broad range of factors that encourage people to settle in a rural or remote location, attractive employment remuneration and conditions, personal and professional support (including a supportive workplace culture) and sustainable practice models are key determinants.

Telehealth

ACRRM acknowledges that telehealth is an important component of rural generalist practice noting that it is not an acceptable 'replacement' for face-to-face services and instead should be viewed as a tool to support and strengthen in-person care.

Telehealth can improve health outcomes by facilitating timely access to essential specialist services and advice. It can further extend the scope of practice of Rural Generalists to provide comprehensive care for patients in the local community in consultation with other specialists if required. There is particular value for both patients and practitioners in shared care arrangements which facilitate quality models of care involving the patient-end clinicians (Rural Generalists) and remote-end specialists/consultants.

It can also improve the professional relationship and mutual respect between rural practitioners and their urban-based colleagues and promote communication and collaboration to achieve high-quality patient care.

However the College is aware of unintended perverse telehealth outcomes which include a reduction in the provision of face-to-face visiting specialist services to rural communities and more importantly, a reduction in the levels of equipment, staffing and skills in rural facilities and services. The College views with concern, this increasing trend to install videoconferencing and other telehealth equipment and consider these as an adequate staffing and service level for rural hospitals and health care facilities. For example, a doctor on a screen can't insert a difficult cannula; suture a wound or intubate a critically unwell child with asthma. Telehealth must only ever be regarded as a support, never a replacement for rural communities and their health workers.

Any use or expansion of telehealth services must be done within a policy context that recognises that telehealth should complement rather than replace face-to-face care; support high quality continuity of care with the patient's usual GP or practice; and minimise the potential for telehealth services to undermine both the quality of care and overall sustainability of rural and remote practices and primary care services in particular.

Policy Reform – Guiding Principles

ACRRM recommends that service and policy reform should be based on the following principles:

1. *The gold standard for primary health care should remain locally-based practitioners providing continuous care* – Continuity is essential to quality care. Ideally this should be provided by practitioners based locally who know and empathise with patients and their families about the problems associated with their broader context. Rural patients are entitled to the same level of care as their urban counterparts.

2. *Equitable standards for government provision of health care services should incorporate not just the provision of the service but also the accessibility of the service* - Any definition of a level of care that meets a minimum provision standard needs to incorporate a measure of an acceptable level of practical access to care or at least some reasonable mitigation of any associated costs where patients are forced to travel to access services.

3. *The quality and safety of provision of procedures, services or resources in rural and remote clinical settings should always be considered in the rural and remote context If enforcing quality or safety compliance measures will worsen access to health care in a community either the measures should be reviewed, or positive risk mitigation strategies should be implemented.*
   Standards are commonly set with an apparent presumption that patients are within an urban context of relatively easy access to the full range of secondary and tertiary facilities. Failure to identify the implications of access to the health and safety of patients in rural and remote locations is likely to lead to further restrictions on their access to needed services.

4. *Digital health and other technologies should only ever supplement on-ground health care. They can be embraced to supplement and strengthen locally-based care but should never be viewed as an acceptable replacement for in-person services* - Digital communications technologies are enhancing quality care in remote areas. Without a clear policy position however, there is considerable risk that over time, pressure from governments to make budget savings, and opportunism from entrepreneurs to provide substandard, low cost care through telecommunications may lead to a gradual acceptance of the sufficiency of telehealth as a replacement to locally-based practitioners.

5. *Removal of services to people in rural and remote areas should never be seen as an appropriate response to poor health service events in those areas* - Appropriate solutions such as systems review, enhanced practitioner training, better resourcing, enhanced staff support and mentoring should always be considered. There is an expectation that clinicians practice in an evidence-based manner. Changes to health service supply must also include evaluation of the broad range of health outcome and cost implications for the State and for patients.

6. *Policy frameworks should foster innovation and support community-based solutions with a view to creating models with long-term sustainability and to creating models for broader implementation* – noting that flexibility should be maintained in order to accommodate the varying needs and circumstances of rural communities

7. *Rural communities should be meaningfully involved in all planning and decision-making* – This is especially important where there is service failure in a community and there is no definitive tier of government with accountability for the problem.

Conclusion

Given the continuing disparity in health outcomes and access to health care services between the residents of rural and remote communities and their urban counterparts; strong evidence that many rural health care facilities over understaffed and overstretched; and the ongoing challenge of addressing the maldistribution of the medical practitioner workforce and rural medical workforce more generally, urgent action is needed.

From the College perspective the Rural Generalist model of practice as espoused by ACRRM has the potential to significantly improve access to a wider range of services to rural communities. It must be supported by clear and well supported training pipelines; viable employment models which include appropriate remuneration and recognition; skilled support staff and healthcare teams; and well equipped and maintained health care facilities.

Issues and reforms must be addressed through a system-wide approach where both state and Commonwealth jurisdictions prioritise rural health care and incorporate clear lines of responsibility and accountability, in addition to supporting innovation and community-based models of care.

Above all, urgent action is required with sustainable planning and investment as a high priority. As a leader in Rural Generalist training with demonstrated retention outcomes and with its significant experience in rural workforce policy and planning and community advocacy, ACRRM can work with the government and other stakeholders to build high-quality, sustainable health care services in New South Wales.

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