Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

COLLEGE SUBMISSION

Inquiry into Rural Health Services in Tasmania

March 2021

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.

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. 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 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) 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.

The Rural Medical Workforce

There is an acknowledged maldistribution of medical practitioners in 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
- 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

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.

ACRRM Fellowship is single best predictor of a long-term rural 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 areas.

Workforce Planning and Policy

When properly funded and intelligently designed using rural-centric models rather than urban-based planning, rural health services provide excellent health care which meets community need and a substantial longer-term Return on Investment. This is particularly the case with the Rural Generalist model of practice.

Planning and policy should be designed with the ultimate goal of providing 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.

Unfortunately, where services are over-stretched, they can be made scapegoats for a system that is not necessarily fit-for-purpose. There is also a tendency for services to be closed or downgraded where there are concerns about quality and safety, rather than prioritising the retention of the service and proactively working to improve capacity. Both scenarios reduce access and undermine community and practitioner confidence, making more difficult to attract and support a skilled and sustainable health workforce.

Implementing Rural Generalism in Tasmania

ACRRM strongly commends the Rural Generalist model as providing a rural-centric model which can meet the health care needs of communities in Tasmania, improving access to health care services and minimising the need for people to travel to larger centres for treatment. This is particularly important given that roads can become impassable in winter, making travel difficult, and socio-economic factors which mean that many people may not be able to afford the cost of travel and accommodation away from home.

The College notes the Rural Generalist training initiatives that are already under way within the state and recommends that training initially focusses on the Mersey hospital as a training hub. This would provide much-needed procedural services in this section of the state and serve as a springboard for the rollout of services to other areas and facilities.

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 there can be perverse outcomes to a reliance on telehealth. These include a decline 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. 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.

Promoting a Teams-Based Approach

While the College strongly supports building the Rural Generalist workforce as a key strategy to increase access to health care services, there is also a need to invest in strategies to build strong and sustainable rural health teams throughout the State. Working with Rural Generalists, these teams, which include nurses, allied health professionals and referred services, can promote coordinate care to their local communities through a range of services including inpatient care, palliative care, pain management and mental health support.

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.

Guiding Policy Principles

ACRRM recommends that workforce planning and policy be based on the following principles:

1. *The gold standard for primary health care should remain locally-based practitioners providing continuous care, based on the Rural Generalist model of practice* – 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. *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.

3. *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.

4. *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

5. *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

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 in Tasmania. As previously outlined, ACRRM recommends that an initial Rural Generalist training hub be established at the Mersey hospital and expanded following consolidation of this service.

As consistent with the principles of the National Rural Generalist Pathway, Rural Generalist training should 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.

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 for rural Tasmania.

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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.

[1] AIHW Australian Institute of Health and Welfare 2018. Survey of Health Care: selected findings for rural and remote Australians. Cat. no. PHE 220. Canberra: AIHW.

[2] AIHW Australian Institute of Health and Welfare 2018. Survey of Health Care: selected findings for rural and remote Australians. Cat. no. PHE 220. Canberra: AIHW.

[3] AIHW 2011. Australian health expenditure by remoteness: a comparison of remote, regional and city health expenditure. Health and welfare expenditure series no. 50. Cat. no. HWE 50. Canberra: AIHW.