Rural & Remote Medical Services Ltd
An Australian Health Charity Est. 2001

SUBMISSION TO SENATE STANDING COMMITTEE ON COMMUNITY AFFAIRS INQUIRY INTO THE PROVISION OF GENERAL PRACTITIONER AND RELATED PRIMARY HEALTH SERVICES TO OUTER METROPOLITAN, RURAL, AND REGIONAL AUSTRALIANS

Thank you for the opportunity to make a submission to the Inquiry.

TERMS OF REFERENCE

The provision of general practitioner (GP) and related primary health services to outer metropolitan, rural, and regional Australians, with particular reference to:

a. the current state of outer metropolitan, rural, and regional GPs and related services;
b. current state and former Government reforms to outer metropolitan, rural and regional GP services and their impact on GPs, including policies such as:
    i. the stronger Rural Health Strategy,
    ii. Distribution Priority Area and the Modified Monash Model (MMM) geographical classification system,
    iii. GP training reforms, and
    iv. Medicare rebate freeze;
c. the impact of the COVID-19 pandemic on doctor shortages in outer metropolitan, rural, and regional Australia; and
d. any other related matters impacting outer metropolitan, rural, and regional access to quality health services.

WHY ARE WE MAKING A SUBMISSION?

Rural and Remote Medical Services Ltd (RARMS) was established in 2001 to support rural and remote communities in NSW that historically struggled to attract and retain medical services. As a charity, we work with local communities to establish or take over primary health care services and provide our expertise to recruit health and medical workforce and operate practices in disadvantaged towns.

RARMS Health operates in 8 rural and remote communities with 20,000 active patients, a quarter of whom are Aboriginal and/or Torres Strait Islander people.

RARMS delivers a comprehensive service encompassing health literacy and promotion, health education and training, community consultation, service coordination and primary health care delivery.

To help fund our activities RARMS operates 3 social enterprises:

1. Village Health – a practice operating in metropolitan areas to deliver high quality care and generate surpluses to cross-susbidise rural and remote health care;
2. Consule – a rural and regional social, health and economic consultancy that supports communities, local government, health organisations and others to align strategies to address the social determinants of health and improve health and human service delivery.
3. HealthAccess – a primary care telehealth service that delivers workforce support and health access services to a catchment of more than 300,000 people across 33 towns,

and a hybrid aged care service to support Residential Aged Care Facilities that lose regular GP services.

We also apply for grants and tenders to augment income and build sustainable rural and remote practices.

RARMS is unique in that it is a charity (100% of everything we make goes back into improving rural health) and has been successful over 20 years in supporting rural recruitment and retention.

As a Geographic Opportunity Employer our non-clinical specific staff can live and work in any part of Australia with preference given to candidates who live and work in rural and remote communities. This ensures our practice and strategies are informed by the needs and priorities of our communities.

We are writing this submission to ensure the Committee has the benefit of the views of rural and remote people.

INTRODUCTION

While each rural and remote town is unique, they share common characteristics including:

1. high rates of poverty and lower socioeconomic households
2. high rates of household residents who are unemployed
3. high rates of single parent families, and in families where the mother has a low educational attainment
4. low levels of educational attainment
5. low levels of health literacy

These characteristics contribute to:

1. high rates of chronic disease and preventable illness
2. high rates of teenage pregnancy
3. high rates of developmental vulnerability in children
4. high rates of avoidable hospitalisations

Access to health and human services also declines with increased remoteness. This is of concern because it limits the ability to address and prevent the onset of preventable illness and avoidable hospitalisations, and resultantly the long term social and economic impact of disease in rural and remote Australia.

A range of barriers have been identified for GPs, nurses and other health practitioners to take up residence and work in rural and remote communities:

- Isolation
- Lack of professional development
- Inability of spouse to gain employment
- Lack of educational options for children
- Lack of social amenity
- Perceived workload
- Comparatively lower remuneration for rural and remote GPs and health workers

We have known about these barriers to rural and remote workforce recruitment and retention for decades. Over the last 20 years the Commonwealth and State/Territory governments have invested billions of dollars to address them.

But according to recent evidence from the NSW Rural Doctors Network to the NSW Inquiry into rural and remote health there has been a dramatic decline in the number of procedural GPs in rural and remote NSW from 800 to 200 over the last decade.[1]

Data from the Medical Deans of Australia and New Zealand has found that despite significant public investment in rural and remote medical education and training, the proportion of medical students who intend to work in rural and regional areas has fallen between 2015-2019 and the first preference for practice as a GP has fallen from 17.8% in 2015 to 15.2%.[2]

Australia has not filled all funded GP training places in the Australian General Practice Training Program since 2017.[3]

The response has not been to fundamentally reconsider the approach to rural workforce development and health service access, but to expand current approaches.

We have funded more Bonded Medical Places (BMP) despite an independent report finding that for many BMP recipients view the program as a "low cost or interest free loan that can relatively easily be repaid once fully qualified" without a requirement to engage in the return of service obligation in a rural or remote town.[4]

We have adjusted distribution priority areas even though this forces rural and remote towns like Goodooga to compete with large cities like Geelong.

We have funded more rurally based GP training places even though we know that rural and remote towns do not have the funding to provide the clinical supervision needed, and trainees do not remain in rural or remote areas at the completion of their training in any case.

There must be accountability to rural and remote communities for why, after the investment of so much time and effort by rural and remote people in supporting these various initiatives, that the situation on the ground has not changed (and in many cases is worse).

We need to reframe the question from "how to repair what is not working" to "what is working, and how can we strengthen investment in these approaches".

For this discussion to occur, we need to challenge and change the 'rural deficit discourse' that pervades our thinking: 'rural communities are unattractive places for professionals to live and work'; 'rural populations are in morbid decline'; 'rural people bring it on themselves by living so far away from major cities'; 'rural people are responsible for their own health like everyone else'; 'if only they would get a job they would not be so unwell'; 'if they didn't get pregnant at 16 years old things would be different'; 'rural people must accept limitations on

1 https://www.parliament.nsw.gov.au/lcdocs/transcripts/2514/Transcript%20-%20RRR%20health%20outcomes%20-%2019%20March%202021%20-%20CORRECTED.pdf
2 https://medicaldeans.org.au/md/2020/08/2020-MSOD-National-Data-Report_2015-2019-Full-report.pdf
3 https://medicalrepublic.com.au/a-little-boost-to-sliding-agpt-numbers/44715
4 https://www1.health.gov.au/internet/main/publishing.nsf/Content/D26858F4B68834EACA257BF0001A8DDC/$File/Review%20of%20Health%20Workforce%20programs.pdf

access to the right to health because of they choose to live away from where services are located'.

This idea that rural and remote people are primarily responsible for the state of local health, without adequate acknowledgment of the impact of social and economic policies on these communities, has impeded our ability to engage with evidence-based solutions to improve the workforce and health access situation for rural and remote people. We need to shift our outlook from deficits to strengths.

We have considerable evidence for what works in rural and remote towns. Wakerman and Humphries systematic review of primary health care delivery models in rural and remote Australia sets out the models and the elements that make them sustainable.[5]

Services like Rural and Remote Medical Services Ltd (RARMS) (walk-in, walk-out) and the Aboriginal Community Controlled Health Organisations (ACCHOs) are examples of sustainable models that have demonstrated how a collaborative funding approach between the States and Commonwealth can overcome many of the barriers to rural and remote health care delivery in disadvantaged communities.

Across the States and Territories there are thoughtful and well-designed policy frameworks and programs that build on the strengths of rural and remote communities including:

1. The Tasmanian Health Literacy Framework[6]
2. The NSW Human Services Outcomes Framework[7]
3. The RARMS Community and Patient-Centred Care Framework[8]
4. The RARMS Rural Health Equity and Social and Economic Equity Framework[9]
5. The Victorian Care Coordination Program[10]
6. James Cook University Rural Medical School[11]
7. Rural and Remote Medical Services Ltd Easy Entry, Gracious Exit model[12]
8. The Queensland Rural and Remote Health Services Framework[13]
9. The South Australian Rural Doctors Workforce Agency GP Locum Support Program[14]
10. The South Australian 'Health in All Policies' Framework[15]

The problem is not that we don't know what needs to be done, it is that we lack of a clear policy driver for change.

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5 https://rsph.anu.edu.au/research/projects/systematic-review-primary-health-care-delivery-models-rural-and-remote-australia

6 https://www.dhhs.tas.gov.au/publichealth/health_literacy

7 https://www.facs.nsw.gov.au/resources/human-services-outcomes-framework

8 https://www.ruralandremotehealth.org.au/patient-community-centre-care

9 https://www.ruralandremotehealth.org.au/rural-health-equity and https://www.ruralandremotehealth.org.au/social-economic-equity

10 https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/rehabilitation-complex-care/health-independence-program/care-coordination

11 https://researchonline.jcu.edu.au/40777/1/JCU%20rurally%20orientated%20selection%20process.pdf

12 https://www.ruralandremotehealth.org.au

13 https://www.publications.qld.gov.au/dataset/rural-and-remote-health-service-planning/resource/0d627e3a-1a38-443a-80e5-6b60fd837b8f

14 https://www.ruraldoc.com.au/rural-gp-locum-support?ref=promobox

15 https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/about+sa+health/health+in+all+policies/health+in+all+policies

These problems are only going to get worse, particularly following the interruptions to International Medical Graduates supply during COVID on which our communities rely to staff our health and medical services. Without a fundamental and immediate investment in new service delivery models, and redesign of our workforce education and training, there is a serious risk that the decline of rural and remote health services will accelerate over the next 12 months.

The purpose of our submission, as an organisation that lives and works 365 days a year in rural and remote communities, is to challenge the deficit discourse that in our view has prevented genuine systemic reform of rural and remote health and to call for evidence-based action to address the maldistribution of workforce and services in Australia.

Below we will outline what we see as some of the key systemic challenges for policy reform.

The Funding Problem

A central problem for rural and remote communities is Australia's one-size-fits-all health system.

Rural and remote towns are not like capital or regional cities, and health service and workforce models designed for our cities do not work in rural and remote towns.

Rural towns do not have a myriad of GP practices and pharmacies in every town centre, specialists within easy access using public transport, multiple allied health and dental care services and access to comprehensive and well-funded acute and emergency care.

In rural and remote towns there is generally a local GP and pharmacist who work collaboratively with community organisations to connect patients with human services to address the causes of poor health, organise drive-in, drive-out allied health and dental care services, and run the local hospital emergency department to stabilise patients for transportation to larger referral hospitals.

But our health system has been designed for people who live in high-density health markets. It incentivises and rewards activity rather than better health and community outcomes. Our funding model drives doctors, nurses and other health professionals to where the largest number of patients reside, rather than supporting the alignment and coordination of health and human care around individual patients where the health need is greatest.

The activity-based funding model is an important part of how we incentivise the sort of behaviours and outcomes we seek from our health care system. But on its own it does not work in thin rural and remote markets where patients have complex chronic diseases which requires an investment of time in integrated team-based care to prevent the escalation of disease and intervene to ameliorate its impact.

Our inability to appropriately adapt this model to the needs and circumstances of all vulnerable communities is at the heart of why rural and remote communities cannot access health care equitably in Australia.

The Integration Problem

Research suggests that 80% of health outcomes can be attributed to social determinants, while 20% is attributable to access to health care.[16]

Healthcare largely comprises primary health and hospital services. According to the Australian Institute of Health and Welfare, in 2018–19 83% of Australians aged 15 and over reported seeing at least one GP in the previous 12 months while 14.4% visited a hospital emergency department.[17]

We estimate that hospital care accounts for around 2% of modifiable contributors to healthy outcomes for a population (emergency care, acute care), while primary health care contributes around 18% (promotion, prevention, early intervention).

Research suggests that the greatest health and economic gains can be made in Australia by addressing the reasons people get sick (poverty, poor educational attainment, unemployment, intergenerational trauma, domestic violence, health illiteracy) and preventing the onset of chronic diseases through improved integration of primary health care and human services.

In our fragmented care system, however, we are very poor at coordinating services and pooling funding to join-up services to maximise economic and social gains in rural and remote areas. Our communities end up with a range of short-term, fragmented programs that does not address the need for sustainable organisational and community capacity.

Funding and program design too often ends up centralised in our cities with services delivered remotely, reducing the capacity of rural and remote communities to sustain local services, influence priorities and costing rural and remote jobs.

Centralisation of rural and remote services in the hands of a few remote corporations located in our cities reduces the effectiveness of health service delivery and paradoxically increases the cost of health and medical care because of the inevitable rise in avoidable hospitalisation and long-term preventable disability.

The ability to achieve effective integration of health and human services is limited due to: (1) funding and delivery by different tiers of government; and (2) a health funding framework that gives priority to organisational integration of acute and emergency care over patient-centred integration of health promotion, prevention, and access.

This is a key challenge for rural and remote towns. Most small towns of 500-1000 people cannot sustain individual primary health care services, legal aid centres, domestic violence services, women's shelters, disability services, aged services, drug and alcohol services etc etc because of the overhead costs of serving comparatively thin populations over large geographic distances.

The fragmented way in which we deliver health and human services in rural and remote communities means that we are required to fund the overhead costs of 15-25 organisations that are all working on the same or similar problems, rather than coordinating funding locally

16 https://www.pwc.com.au/health/health-matters/social-determinants-in-health-australia.html
17 https://www.abs.gov.au/statistics/health/health-services/patient-experiences-australia-summary-findings/latest-release

to create more sustainable models that enable organisations to meet overheads and attract workforce.

In our view, a sustainable model of health and human care for rural and remote communities would be designed to align with the integrated way rural and remote communities currently work.

Creating community-led organisations to support coordinated service delivery across primary health, human, aged care, disability and community services in rural and remote towns would ensure services were designed around local needs, create jobs, grow economic activity, improve service coordination and access, support better health and social outcomes and address the diseconomies of scale that reduce the capacity of rural and remote towns to attract and retain professional staffing.

This model has been delivered successfully in part by Rural and Remote Medical Services Ltd (RARMS) for 20 years by pooling various funding streams to create a work environment and remuneration framework that attracts permanent workforce. Another successful model is the Aboriginal Community-Controlled Health Services (ACCHOS).

A key strategy to address the gaps in service access for rural and remote communities would be to reverse our current approach of centralising services in our cities and support the centralisation of community-responsive, sustainable, and attractive employment opportunities in rural and remote towns.

The Workforce Problem

We do not do well in attracting doctors, nurses and other health professionals to rural and remote communities. It is a source of constant frustration for rural and remote people that the marketing of their town, and recruitment of doctors, nurses and other health professionals is done with little consultation or engagement with local people and without support for rural and remote practices to build the capacity to deliver high quality local training.

There is also concern that the increasing focus on proceduralism is competing with the need for generalists to the detriment of community primary health care. Primary health care is a whole-person, patient-centred system built around a trusting and continuous therapeutic relationship between a GP/health practice team and the patient.

While there is a recognition that the priority is to address the geographic maldistribution of the primary health care workforce in rural and remote areas, the lack of funding support for clinical supervision in rural and remote towns has produced an over-reliance on the regional and peri-regional State hospitals and medical services which can provide more consistent experiences and supervision.

This has three impacts:

1. Graduates do not gain an appropriate length of exposure in rural and remote communities, or within homogenous regions, to build a sustainable career intention for rural practice and establish networks in rural and remote communities.
2. The training of doctors in hospitals has increased the drift away from community general practice to hospital-based practice.

3. The increased concentration of training in cities and peri-regional centres that are proximate to cities reduces the economic and employment flow-on benefits to rural and remote towns, as well as the capacity of rural and remote practices to address funding shortfalls under Medicare.

At RARMS we began by training the next generation of permanent rural and remote GPs using a team of highly skilled rural generalist in our local communities. The ageing of the rural and remote GP workforce has resulted in a decline in rural and remote practitioners who are able to undertake the clinical supervision of new GPs locally to attain accreditation for independent practice in our communities.

We need to go back to strengthen the capacity of rural and remote general practices to train medical graduates locally in communities by directly funding them to buy-out, or buy-in, time for clinical supervision, provide retention incentives, secure adequate housing and designing local, flexible (and less rigid) training programs.

RARMS has recently submitted a proposal to the government to establish a community-based Rural and Regional Health Training program to build clinical supervision capacity and train more doctors, nurses and other health workers in rural and remote towns. It is currently establishing a Rural and Remote Health Careers Hub to provide rural and remote school kids (Years 10-12) with exposure to an operating health service environment and access to mentoring and support to build interest in rural and remote health careers. We are establishing a Health Literacy and Learning program for children to support our schools to help children engage in learning about their health, body and health system to engrain health literacy in child development.

In our view, we need to support rural and remote practices to engage kids in medical and health education to grow aspiration for local careers and remove the barriers to doctors training in rural and remote communities by actively supporting and encouraging doctors who can demonstrate to local communities and clinicians that the potential to become competent and capable rural GPs.

The Intermediary Problem

Part of the national response to the rural and remote health crisis has been the creation of a variety of intermediary bodies that sit between government and rural and remote communities dealing with workforce, services, policy and primary health care. The aim of these bodies was to bring policy making closer to the communities they serve but it is not clear if this has been successful.

The substantial number of submissions from rural and remote people to the NSW Inquiry into rural health suggests a growing sense of disconnect between the expectations of rural and remote people, and the advice being provided by intermediary bodies to inform public policy.

As is increasingly typical of rural and remote services generally, these bodies have tended to centralise services and jobs in cities for administrative efficiency and to attract skilled staff.

The flow-on impact of the centralisation of policy and funding control in cities is a growing remoteness from the lived experience, issues and priorities of rural and remote communities.

Further, rural and remote funding that might have gone to create jobs and economic activity in rural and remote towns ends up generating jobs and economic activity in the cities.

As rural health decision making moves further away from rural and remote communities, there is a risk that we will embed higher transaction costs to achieve future reform.

It is doubtful that we will fix the systemic problems of rural and remote health unless decisions are made with the knowledge, insight, and experience of rural and remote people living in rural and remote communities.

The Voice Problem

This leads to the need to acknowledge the lack of a national voice for rural and remote people in policy and planning for rural and remote health. Rural and remote health policy is largely determined by organisational and industry interests – rural doctors, rural health workers, rural lobbyists – in the absence of a dedicated voice for rural and remote people and communities. This is not to say that these organisations do not consult rural and remote communities, but their priorities and interests are typically broader than those of our communities and therefore the nature of contributions will inevitably be influenced by these objectives.

Without direct input of rural and remote people, and accountability back, we cannot reasonably expect to deliver a sustainable solution that reflects the unique needs and priorities of different rural and remote communities.

RARMS is working with several communities on the formation of a Rural and Remote Communities' Health Alliance which aims to bring together people who live in rural and remote towns across Australia to share knowledge, advocate for policy reform and to act as a vehicle for policy makers to gain the direct views of rural and remote people. The Alliance will be comprised of local branches to improve two-way information sharing. It will be headquartered in a rural or remote town. Over time, it is hoped that this new Alliance will be able to participate in policy discussions to bring a community voice to the national discussion and the health needs of rural and remote people.

RECOMMENDATIONS

1. Establishment of Rural and Remote Community Health Organisations (RRCHO)[18] governed by rural and remote communities. These organisations would be funded to be sustainable and to plan, co-ordinate and deliver health and human services in rural and remote communities and drive workforce development.
2. RRCHOs would not be service providers. RRCHO Boards will be responsible for monitoring performance against locally developed plans and priorities to delineate responsibility for strategic direction and oversight, and the operational design and delivery of clinical and social services. Services would be contracted to third party local NGO health organisations to maximise economic flow-on benefits in rural and remote communities.
3. The overheads of RRCHOs (clinical governance, accreditation, ICT, HR, finance, operations, insurances etc) would be funded under a block funding arrangement by the Federal Government initially using savings made by Medicare resulting from

[18] https://www.ruralandremotehealth.org.au/post/opinion-out-with-the-new-in-with-the-old

under-servicing, with negotiations to occur with the States to progressively co-locate and coordinate human and community services through RRCHOs.

4. Primary health services would be funded under Medicare on an activity basis and other programs such as aged care through existing funding arrangements to ensure an appropriate balance between financial sustainability and certainty (block funding), and performance incentivisation (activity and outcomes funding).
5. Medical and health training places and funding would be allocated to RRCHOs to re-engage local communities in workforce training and development and to enable RRCHOs to buy-in, or buy-out, clinical supervision time for training purposes.
6. RRCHO-led training programs for community-based general practice would be approved under agreed guidelines by an appropriate oversight body such as the RACGP.
7. RRCHOs would be funded to pay local health districts to provide access to procedural training that the RRCHO needs based on a competency framework to ensure hospital training is focussed on the skills required for rural and remote primary health care and to meet community need.

RARMS would welcome the opportunity to address the Committee on its views and provide any further information that may support systemic change in our approach to rural and remote health service access and outcomes.

Yours sincerely

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Chief Executive Officer
6 October 2021