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

COLLEGE SUBMISSION

Provision of Primary, Allied and Private Health Care, aged care and NDIS Care Services and its Impact on the Queensland Public Health System

Background

The Australian College of Rural and Remote Medicine (ACRRM) welcomes the opportunity to respond to this inquiry.

The College submission provides comment on those issues which fall within its scope of operations and in both the Queensland and national context, in acknowledgement of the role of the Commonwealth in a wide range of areas which impact on the provision primary care and its intersect with the public health system. These include primary care funding and incentives; the Medical Benefits Schedule and Pharmaceutical Benefits Schedule; medical workforce policy and planning; general practice training and related medical education funding programs.

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. Its 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.

The College trains doctors towards Fellowship of the College (FACRRM). Award of FACRRM entitles doctors to national recognition as specialist GPs and the associated provision of Medicare supported services. The FACRRM also reflects doctors' skills in the Rural Generalist model of practice.

A Rural Generalist medical practitioner is a General Practitioner who has specific expertise in providing medical care for rural and remote or isolated communities and who can understand and respond to their diverse range of health care needs. This includes applying a population approach, providing safe primary, secondary and emergency care, culturally engaged Aboriginal and Torres Strait Islander peoples' health care as required, and providing specialised medical care in at least one additional discipline.

ACRRM's Fellowship model has unparalleled success in producing high-quality, long-term rural doctors.[i] Some 80% of College Fellows continue to practise rurally. ACRRM trainees are selected

based on their assessed capacity to become competent rural practitioners and have a training experience which reinforces their rural motivation and builds their skills for the rural practice context. Of the over 900 doctors trained to FACRRM over the past fifteen years, 75% have remained in rural practice five or more years after completion of training.

Rural and Remote Health Outcomes and Access to Primary Care 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, and especially primary care services is a key contributing factor to poorer health outcomes. Australian Institute of Health and Welfare (AIHW) research[ii] indicates that people living in outer regional areas are 2.5 times more likely to report having access to a General Practitioner 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.

The shortage of primary care services and resultant poor health outcomes place additional pressure on the public health system. Patients are more likely to present to hospital emergency departments if they cannot access primary care. Poor access to the preventative and longitudinal care that can be provided through primary care, can lead to earlier onset and increased severity of a range of chronic diseases including diabetes, heart disease and late-diagnosis cancer. These all place additional pressure in terms of cost, workforce and infrastructure, on the public health system.

Rural Underspend - AIHW research[iii] 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.

The Rural and Remote Medical Primary Care 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.
The situation becomes increasingly fragile as the workforce ages. The average age for a GP working in a rural or remote area continues to be over 50, with an increasing number in the over-60 age group who will be looking to retire or at least reduce their workloads over the coming years. College membership figures indicate lower numbers in the following cohort (40-49 yrs) and this is most likely due to changes in policy regarding medical school intakes during the relevant time period.

There are a much larger number of members who are in the younger age groups; however the challenge is to retain the experienced doctors who are either retiring or close to retirement within the workforce for some period of time so they can continue to provide health care services and train the next generation until more workforce gaps can be filled.

The workforce maldistribution extends beyond geography, to an increasing preference for careers in specialties other than general practice and the increasing trend towards sub-specialisation. Specialist services are expensive and usually located in larger centres. They do not facilitate the delivery of the services that are most needed in rural and remote communities in a cost-effective manner; nor do they take into account the importance of providing as many services as possible, as close to home as possible, for people living in rural and remote areas.

Changing expectations will also impact on workforce supply and distribution into the future. The younger generation of doctors has differing priorities and lifestyle expectations to their forebears. Many are less interested in running a private business; they place a higher priority on allocating time for family and to purse other interests. They are also aware that that private practice does not necessarily provide many of the benefits of public employment, including sick leave; designated holiday periods and time off; transferability of entitlements; and study and other professional leave . These issues need to be addressed if the current workforce maldistribution towards specialist rather than general practice/primary care is to be addressed.

Rural Generalism as Primary Care Solution

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.

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 cornerstone of the Rural Generalist approach is the creation of strong, sustainable, locally-based healthcare services. In rural communities this means that the interdependence between strong hospital services and strong GP services must be acknowledged and supported. The availability of rural generalist doctors with a broad scope of practice enables them to pivot across various elements of the healthcare delivery chain, with the result that GP clinics can be supported by strong local hospital and emergency services. It also provides those practices with a wider and better-skilled pool of potential business partners or employees.

It is critical to quality care for rural people that both the strength of both areas of services is maintained. Increasing trends to replace locally based hospital doctors with temporary and outreach services not only weakens hospital care but removes an essential layer of support to the local GP clinic and its doctors and healthcare workers.

The Role of Private General Practice

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.

There is strong evidence that when properly supported, general practices provide high-quality continuity of care in an efficient and cost-effective manner. However the impact of decades of under-funding and undermining of the role of private general practice has resulted in this specialty becoming less attractive to medical students and junior doctors and threatened the viability of existing practices.

General Practice Viability and Sustainability

The current rural workforce crisis reflects systemic failure over many years to build the value proposition for rural practice as a well remunerated, supported, and reliable long-term career path and to keep pace with the increasing costs associated with private general practice, particularly in rural areas.

In remote and rural areas, costs of operation can be high, in terms of resources, staff, accessing training, and locum support. These all affect business costs while the potential income in rural communities is limited to the size and socio-economic status of the local population. From a business perspective the size of the client base and their capacity to pay is constrained and vulnerable to small fluctuations in population and circumstances for local industries. Rural areas often have a low socio-economic profile and rely heavily on bulk billing. Medicare funding is commonly not sufficient to sustain general practice and the rural Practice Incentive Program (PIP) is generally viewed as critical to practice viability. Clinicians who invest in local practices must accept a considerable lack of capacity to grow their business and considerable vulnerability to small changes in the local population which may render their otherwise healthy business, unviable and unsellable. [iv]

Rural practice involves increasing levels of compliance and administration, associated with practice accreditation, clinical credentialling, and continuing professional development. These are taking up an increasing proportion of the work time of rural doctors who are already overworked. [v] Furthermore, meeting these requirements (for example travelling to cities for mandatory upskilling and backfilling with locums) all have higher costs in rural and remote contexts.

Rural general practices are increasingly struggling to find general practitioners to take over their businesses. They face increasing competition from FIFO/locum or telehealth practitioners that may have minimal or no local infrastructure or staff costs, and these visiting services typically do not have responsibility for after hours, continuing or emergency care, nor maintaining relationships with the local community and other health team members.

Funding under the Medicare Benefits Schedule (MBS)

Insufficiently funding Medicare disproportionately impacts the viability and attractiveness of providing medical services in rural and remote areas. Many practices have not recovered from the freeze on MBS rebates which commenced in July 2014 and was not completely lifted until 2020.

The viability of rural general practices is limited to the capacity of the patients within their geographic catchment to pay an out of pocket contribution to their care cost. They do not have the flexibility to grow their business by offering niche (cosmetic, sports medicine, skin cancer etc.) services to attract a broader pool of patients. They are also more likely to have a patient pool of low socio-economic status with less capacity or willingness to pay gap fees and who are more reliant on Medicare rebates to fund their health care costs.

Medicare is technically an insurance program for patients. The MBS rebate is paid to the patient and not the practitioner. Given that rebates have not kept up with increasing costs for patients and the increasing inability for practices to absorb the shortfall, this imbalance will eventually drive patients to cheaper options like an emergency department and overall this is poorer care for chronic health needs.

The recent introduction of rural loadings for a limited number of MBS items is a welcome, important and potentially game-changing innovation. The College would like to see these strengthened to ensure they can have impact.

Workforce Planning and Policy

Workforce 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.

Distribution Priority Area Policy

The College supports the Modified Monash Model (MMM) as an administratively efficient mechanism to proportionately support practice, and, compensate for the additional personal and financial costs associated with practice in isolated locations. The College acknowledges the considerable scholarship that underpins the model's validity and the significant input of rural doctors and communities who informed it. It is recognised that the MMM system will not perfectly reflect need and there may be need for additional mechanisms to accommodate exceptions.

The College is aware of anomalies that have led to communities not being conferred the Distribution Priority Area (DPA) status to enable them to recruit urgently needed doctors to their towns. ACRRM welcomes the recently announced review into this program toward building more flexibility to respond to the dynamic and diverse nature of rural and remote communities and their workforces.

The DPA as well as the Distribution of Workforce Area (DWA) program would both benefit from incorporating consideration not just of workforce need but also the appropriate model of care for each rural area. For example, areas seeking a general practitioner, may need a general practitioner with a specific skill set. Likewise, an area applying for a specialist obstetrician as a DWA may be better served by a Rural Generalist who can provide general practice services as well as obstetric services.

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.

The range of social issues which impact on the recruitment and retention of health professionals and trainees in rural and remote areas, should also be acknowledged. These include employment and

other opportunities for partners; education for children; and appropriate standards of accommodation. Innovative, community-lead and government-supported funding models are required to address these issues.

Increasing the General Practice Workforce: Rurally-based training

As previously outlined, 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.

In the view of the College, the current intake of medical students is adequate, and any move to increase these intakes, will simply result in more junior doctors remaining in later centres and either choosing a career in a speciality other than general practice, or looking to increase their income through over-servicing. There is strong evidence that medical students from a rural background are far more likely to return to rural practice, and that initiatives such as Rural Clinical Schools, longitudinal rural placements, and providing junior doctors with a positive exposure to rural general practice, will encourage these students and doctors to return to providing high-quality generalist care within rural and remote communities.

However, rurally based general practice training places financial and personal imposts on trainees not experienced by their urban counterparts. As well as the additional work hours and responsibilities of rural practice, it typically involves less access to in-person training events and peer support. The key nationally funded general practice training program (AGPT), mandates that 'rural pathway' trainees work in designated rural and remote locations usually requiring them to relocate away from family and support networks. Lack of recognition or support to cover the greater costs and imposts associated with Fellowship training outside major cities has disincentivised rural options.

This fuels perceptions among the prospective workforce that rural positions are lower-status, poorly valued options. Rurally based training is supported by the Federal government and to some degree by states and territories, but these costs and supports are not consolidated, not able to be clearly marketed, and not reliable over the length of the four-year training program.

Inter-Governmental Coordination and Collaboration

Coordination across all levels of health systems is imperative, and especially important for rural and remote communities who rely on cross-sector collaboration to maximise local capacity. There is need to establish a point of accountability and a proactive approach to ensuring the provision of an acceptable minimum level of service to all isolated Australians. The division of service responsibilities enables situations where no tier of government accepts accountability for service provision. This has facilitated long-term deterioration of resourcing for rural and remote health services at all levels.

From the general practice and primary care perspective, coordination between the public and private sectors is also important. This extends to robust and comprehensive communication systems between hospitals and GPs, to ensure comprehensive patient handovers and comprehensive continuity of care.

Where problems arise, they are often subject to blame shifting, with no level of government accepting responsibility. This includes accepting responsibility and assuming leadership to address the decline in general practice and downgrading of hospital and other facilities and subsequent loss of services in rural and remote communities.

Blame-shifting by tiers of government is especially felt by remote rural communities who lack visibility in centres of power and whose health services rely heavily on cross-sector cooperation. As Rural Generalists. ACRRM Fellows deliver the services their communities need irrespective of local/state/federal funding arrangements. This commonly involves some combination of work in GP clinics, Residential Aged Care Facilities, Aboriginal Community Controlled Health Organisations, hospitals, and retrieval services. As a result, their practice is especially vulnerable to lack of support, and bureaucratic roadblocks, and conflicts.

Long-term accountability lies typically at the whole-of-jurisdiction level, but immediate service accountabilities lie at the local or regional level. Vertical communication lines are often unclear and there is ample opportunity to blame shift. There is a prevailing tendency under these circumstances to favour short-term solutions over a commitment to strong, high-quality, sustainable local services. Over time this sees the erosion of rural services. Our members commonly report health services favouring ongoing expensive locum/FIFO or patient transports over the continuing responsibility of maintaining a local rural hospital service.

A systematic, proactive approach to ensuring all rural and remote communities are supported by adequate funding and resourcing should be adopted. This ideally would involve identification of minimum acceptable health service access standards across the diversity of models of care. This could build on the excellent work in this area by Wakerman, Humphreys and colleagues.[vi] Data based on these models could be actively monitored, and communities at-risk of not meeting minimum standards could be identified, referred for action, and subject to ongoing higher-level monitoring.

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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.

[i] 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 Health

[ii] 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.

[iii] 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.

[iv] ACRRM (2020) *Accessing Rural Health Care in Rural and Remote Australia: overview issues and solutions – Background Paper commissioned for the Primary Health Care Reform Taskforce.* Retrieved from: https://www.acrrm.org.au/docs/default-source/all-files/rural-and-remote-access-to-phc-background-paper-(2020).pdf?sfvrsn=22e70563_8

[v] Russell D (2016) *How does the workload and work activities of procedural GPs compare to non-procedural GPs?* Aust. J. Rural Health (2017) 25, 219–226

[vi] Wakerman et al (2008) Primary health care delivery models in rural and remote Australia – a systematic review **BMC Health Services Research** Vol.8:276.