# Accessing Primary Health Care in Rural and Remote Australia: overview, issues and solutions

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# Content



*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. Introduction

All Australians should have access to high quality health care. It is not expected that the nature of health care access for people in rural and remote Australia will be the same as that for people in cities, it is appropriately expected however that the service experienced should deliver the same high standard of quality and safety of care.

The vast bulk of specialist resources, facilities and staff are clustered in major cities. People living in cities not only have access to the services in their immediate locale, but also have easy access to those in the neighboring suburbs, and more substantial and specialised resources within a reasonable geographic radius. Even where there is a degree of distance involved in accessing these facilities, public transport is available and subsidized.

People in remote areas are separated by considerable geographic distance from the resources of cities. Their local services may be limited or stretched, and as on average they have lower socio-economic status compared to people in cities, geographic isolation from services may often present a significant financial as well as a physical barrier to access.

The implications of these distinctions for the health, mortality and service access recorded by remote Australians relative to their urban counterparts are stark. On average, Australians living in rural and remote areas have shorter lives, higher levels of disease and injury and poorer access to and use of health services[1]

It is worth noting that the communities of regional, rural, and remote Australia are estimated to produce approximately 67% of the value of Australia's exports[2] and many communities support a connection to land and its associated traditions for Indigenous Australians unbroken for over 10,000 years.

The current health inequities merit a sense of urgency from policy makers in recognising systemic policy failure and in finding effective solutions. While there is an underspend by governments on the health care of people in remote areas which should be addressed, it is imperative that any efforts to improve remote care consider the underlying structures and any misplaced policy assumptions that have allowed these inequities to become ubiquitous across our health systems and an accepted status quo.

At this time when the rapid emergence of information technologies is bringing transformative change to how we receive health care, and as society adjusts to the new paradigm and many Australians are rediscovering the potential for working outside of the cities, there is opportunity to ensure that new frameworks that emerge view rural and remote models of care, not as an afterthought or an add-on but as part of the DNA of their design.

# 2. Access equity and health status

By virtually all indicators remote Australians are grossly underserved and this underservice occurs in tandem with this sector of the population recording much greater disadvantage by health, mortality, and morbidity measures as well as by most measures of social determinants of health.

[1] AIHW (2019) Rural and remote health. Cat. no. PHE 255. Canberra.
[2] NRHA Little book of numbers Economic contribution or regional, rural and remote Australia. Last updated March 2018.

## Health Status

The burden of disease increases with remoteness and for people in very remote areas is 1.7 times that of people in cities.[3] The median age at death decreases with remoteness from 82 years for people in major cities to 69 years for people in very remote areas.[4] In 2015, people living in very remote areas recorded potentially avoidable death rates over 2.5 times as high as people living in major cities with rates overall increasing with remoteness. In particular, compared to the Australian average, people in remote areas are 3 times more likely to die from road accidents and people in very remote areas are 4 times more likely.[5]

People in rural and remote areas have higher rates of mental health disorders and risk of suicide than other Australians.[6] In 2016, the number of suicides in rural and remote Australia was 50% higher than in the cities with the rate increasing with remoteness. The rate in rural and remote Australia has also been growing more rapidly than in the cities and the rate for Aboriginal and Torres Strait Islander people is twice that for non-Indigenous people.[7] Despite this it is estimated that remote communities have access to less than a third of the support services available in cities.[8]

Drug and alcohol addiction is a major cause of rural morbidity, mortality and social breakdown. Crystal methamphetamine 'ice' use has been particularly destructive and is significantly more prevalent among rural Australians than other Australians.[9]

The disparities of the health status of Indigenous Australians and those of remote Australians are intertwined. Aboriginal and Torres Strait Islander people represent a far greater proportion of remote communities than of urban communities and there are many of the country's most isolated communities which are almost entirely composed of Indigenous people. 65% of Indigenous Australians live outside of major cities and 32% live in remote areas whereas 71% of non-Indigenous Australians live in major cities.[10] The health impacts of lack of service access for all people based in remote areas are likely to be exacerbated for Aboriginal and Torres Strait Islander peoples living in these areas by the well-documented negative health impacts of colonization and intergenerational trauma.[11]

Social determinants of health also provide an important lens for understanding rural and remote people's health status. People living outside of capital cities have higher rates of unemployment and 19% lower weekly incomes per household.[12,13] Year 12 completion rates decrease with remoteness from 75% in urban areas to 55% in remote and very remote areas[14] and the rate of bachelor degree completions drops from 37% in cities to 20% in outer-regional, remote and very remote areas.[15]

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[3] AIHW (2016) Australian Burden of Disease Study: impact and causes of illness and death in Australia 2011. Australian Burden of Disease Study series no. 3. BOD 4. Canberra.
[4] ABS (2017) *Labour force, Australia, detailed—electronic delivery, Dec. 2017*. ABS cat. no. 6291.0.55.001. Canberra.
[5] AIHW (2019) MORT (Mortality Over Regions and Time) books: Remoteness area, 2013–2017. Cat. no. PHE 229.
[6] AIHW (2010) A snapshot of men's health in rural and remote Australia. Cat No. PHE 120. Canberra.
[7] ABS (2017), 3303_0 Causes of Death, Australia, 2016.
[8] Meadows G et al (2015) Better access to mental health care and the failure of eth Medicare principle of universality. *Med. J. Aust*. 202:190-194.
[9] Roche A et al (2017) Ice and the Outback. Ice and the outback: Patterns and prevalence of methamphetamine use in rural Australia. *Aust. J. Rural Health.* Vol(1) 25:202-209.
[10] AIHW (2019). *Australia's Health 2018* Australia's health series no. 16. AUS 221. Canberra.
[11] Griffiths K et al (2016) How colonisation determines social justice and Indigenous health—a review of the literature. *Journal of Population Research.*33:9-30.
[12] AIHW (2019) Rural & remote health. Cat. no. PHE 255. Canberra.
[13] ABS (2019) Household income and wealth, Australia, 2017–18. ABS cat. no. 6523.0. Canberra.
[14] ABS (2019) Education and work, Australia, May 2019. ABS cat. no. 6227.0. Canberra.
[15] AIHW (2019) *Australia's Health 2018* Australia's health series no. 16. AUS 221. Canberra.

## Services Provision

There is a substantial national underspend in rural people's health care relative to expenditure on people in cities. Based on AIHW research in 2007[16], it was estimated that the government would need to spend an additional $2.5 billion annually on health care for rural Australians, to bring national expenditure on them, into parity with the per capita health spend on people in cities. The analysis, further estimated that this underspend reflected, 25 million fewer MBS services and 11 million fewer PBS scripts used that year by rural people, than would have been the case if they had the same health care usage rate as people in cities.[17] 2019 figures showed people in remote areas on average making half as many MBS billed visits for primary care services than people in major cities.[18]

When compared to major cities, the rate of people reporting not having a general practitioner nearby as a barrier to seeing one was 6 times as high for people in remote and very remote areas. The rate of people reporting not having a specialist nearby as a barrier to seeing one, was 9.7 times as high.[19] The health impacts of barriers to access can also be assumed to contribute to the almost doubling of the likelihood that people living in remote areas will have been to an emergency department because no general practitioner was available when needed.

There are clear indicators of the link between these barriers to access and poor health outcomes. For example, people living in remote areas have lower rates of bowel, breast and cervical cancer screening[20,21] and people living in remote and very remote areas for example have respectively 1.7 and 2.5 times higher rates of potentially preventable hospitalizations and these rates increase with remoteness.[22]

### Workforce Shortages

While health services for remote communities are by definition limited and small in scale, this issue should not be confused with the broader policy issue of the persistent workforce shortages and the increasing difficulties in retaining permanent staff in remote areas.

There is a well-documented maldistribution of medical practitioners in rural and remote 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 doctors' shortages for Australians living in rural and remote areas.[23] Australian trained medical graduates today are less likely to work either as general practitioners or in rural communities compared to graduates of the 1970s–1980s and rural areas continue to remain substantially dependent on International Medical Graduate doctors, that comprise 36-38% of all general practice doctors in small rural centres.[24]

The impacts of the geographic maldistribution of the primary care workforce translates to fewer staff in rural areas and also to issues of lack of continuity of care as rural and remote communities are increasingly serviced by short-term, temporary or locum practitioners. The provision of reliable health care services needs is a cornerstone to community resilience, and the loss of services, or loss of trust in

[16] 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.
[17] NRHA (2011) *Australia's Health System Needs Rebalancing*: a report on the shortage of primary care services in rural areas. https://www.ruralhealth.org.au/document/australias-health-system-needs-re-balancing-report-shortage-primary-care-services-rural-and
[18] Aust Govt Dept of Health (2019) Annual Medicare statistics Canberra.
[19] AIHW (2018) Survey of Health Care: selected findings for rural and remote Australians. Cat. no. PHE 220. Canberra.
[20] AIHW (2019) National Bowel Cancer Screening Program: monitoring report 2019. Cancer series no. 125. Cat. no. CAN 125. Canberra.
[21] AIHW (2019) BreastScreen Australia monitoring report 2019. Cat. no. CAN 128. Canberra.
[22] AIHW (2019) Admitted patient care 2017–18: Australian hospital statistics. Health services series no. 90. Cat. no. HSE 225. Canberra.
[23] Aust Govt Dept of Health (2019) *National Medical Workforce Strategy: Scoping Framework, July 2019.* P.26. https://www1.health.gov.au/internet/main/publishing.nsf/Content/Health%20Workforce-nat-med-strategy.
[24] O'Sullivan B et al (2019) Reviewing reliance on overseas-trained doctors in rural Australia and planning for self-sufficiency: applying 10 years' MABEL evidence *Hum Resour Health* 17: 8.

service provision can lead to population loss which creates a downward spiral in terms of establishing sustainable local staff and resources.

# 3. Defining features of remote primary health care

**How is primary health care defined in rural and remote contexts?**

There is a tendency to view primary health care as unreferred care provided within general practice clinics and this is appropriately a cornerstone of primary care. Particularly in the context of rural and remote areas however, a more nuanced, outcome focused definition is called for. It should reflect the provision of all essential health care needs and the contribution to, and facilitation of as much as practicable of people's secondary and tertiary needs in the most accessible possible way. In remote contexts this involves a blurring of the distinctions between private and public health services, hospital and private clinics, and between the traditional roles of medical, nursing and allied health professionals.

Despite the diversity across rural and remote Australian communities there are common recurring themes that set them apart from the urban context. These all have significant implications in terms of service and workforce design for the best possible health care provision.

From the service provider perspective, health professionals working in cities, have access to a broad patient pool with diverse socio-economic circumstances. They may choose to broaden or shift their patient pool to align with their interest or improve their business model. These health professionals, can assume that there are alternative professional services available to their patients, should they be unable to provide services or choose to only address niche patients, or patient needs. In contrast, health service business models in rural and remote areas are constrained by the size of the local population the socioeconomic status and capacity to pay of their local community and are required to focus their practice on the specific service needs and priorities of that population. The shape and capacity of the practice will be strongly dependent on the locally available resources and supporting staff and expertise. This interdependence and the smallness of the team overall, means that even thriving rural services are inherently vulnerable, and only ever a few resignations away from a local workforce crisis.[25]

Taking a strengths-based approach, rural health care services can relatively easily create strong communications across systems and health care settings to provide well-coordinated, patient centred care, particularly where individuals such as rural generalists work across a range of work settings. Rural health professionals can provide excellent continuity of care and build trusting and strong relationships with their patients. Rural health careers can provide practitioners with the opportunity to have a job characterised by high levels of practice variety and strong relationships with patients which are a common source of attraction and job satisfaction.[26] All these positive features can be promoted and supported by health care policy and planning which is built to support best practice rural models of care. Remote communities are often early adopters of technologies and innovative models of care. Remote health care services are often much better places than their urban counterparts to leverage highly motivated local champions and the connectedness of their communities to build strong community partnerships and benefit from local advocacy, stewardship and volunteer-based support.

**Key defining features**

A closer look at the key distinguishing features of health care services in the rural and remote context highlights some of the strengths, challenges and issues for consideration in policy reform.

[25] Worley P (2004) Always one doctor away from a crisis! *Rural and Remote Health* 4:317(online)
[26] McGrail M et al (2010) Professional satisfaction in general practice: does it vary by size of community? *MJA* 193(2):94-98.

## 1. Local health care teams

> *" … Not so long ago there were three totally committed GPs managing a remote practice in Malacoota. The number was about right for a town of around 1,000. Now that remote community always assumed it would be that way. It came to pass that two of the GPs decided to leave for personal reasons."*
>
> Resident of Malacoota, Victoria, Nov. 2020

A key feature of remote practice is the interprofessional teamwork commonly involved in local health care delivery. Far from the highly specialised workforce options available in cities, in small and isolated towns, a small number of people are called upon to work to a broad scope of practice and ensure provision of the spectrum of primary care needs. This can involve various members of the health care team playing multiple roles in multiple workplaces including across hospitals, private general practices, Aboriginal and Torres Strait Islander Community-Controlled Health Service (ACCHSs) and aged care facilities. It commonly also leads to scenarios where all the practitioners may be called upon to work at the top of their scope and take on roles that may normally be handled by the clinician at the next stage in the specialisation chain. This raises important issues for patient care of facilitating effective interprofessional relationships, maintaining professional skill sets and defining the appropriate limits of scope of rural practice and enabling practitioners to work to the extent of these limits.

The rural generalist concept as described in the International Statement on Rural Generalist Medicine (Cairns Consensus)[27] has emerged as part of a global movement to define the scope, standards and training needs of this model of practice as it pertains to general practice trained doctors. This a positive area of development supported by the Commonwealth Government for national implementation and has potential for broader adoption across the primary health care professions.

## 2. Local-Distal Systems of care

Additional to the complex interaction of members of the local health care team a major feature of rural and remote practice is the complex interaction with professionals and support services that are not locally-based. This may take the form of digital health, fly-in fly-out (FIFO) specialists, aero-retrievals and patient transport. The effectiveness and cohesion of these systems has major implications for the quality of care received by rural and remote communities. Many outreach services to rural and remote areas while highly valued, are based on specialist models or are restricted to particular needs groups, it is important that services delivered in remote locations are accessible to the community as a whole and connected in to patients' continuing primary care. Of note, patient surveys have found that the likelihood that patients will not see a specialist due to access difficulties increases with remoteness, as does the likelihood of a general practitioner not having been informed of care received by specialist.[28]

## 3. Dynamic and Fragile

The smallness of scale of health services in rural and remote areas means that they have little buffer in terms of funding, resources and staff and minimal capacity to absorb the health service impacts of small changes. The impact of this is that the gain or loss of funding for a health service of one or two key staff members can be transformative to health service capacity and systems. While minor budget reductions or loss of a few staff have had devastating effects on services, the reverse can also be true. Another common feature of many rural and remote communities which is symptomatic of persistent workforce shortages, is a high-turnover workforce including regular FIFO

[27] International Statement on Rural Generalist Medicine (Cairns Consensus). 2014. https://www.acrrm.org.au/docs/default-source/all-files/cairns-consensus-statement-final-3-nov-2014.pdf?sfvrsn=f13b97eb_16
[28] AIHW (2016) Survey of Health Care: selected findings for rural and remote Australians. Cat. no. PHE 220. Canberra.

locums and young trainees. This creates major barriers to patients' continuity of care which is a recognised key contributor to patient safety and health outcomes.[29]

Ultimately systems resilience comes from each local health team being prepared to be resourceful, innovative and adaptive to change. This inherent fragility even to the strongest rural health services needs to be recognised within the wider policy framework and rural communities' capacity for resilience needs to be facilitated and enabled.

*" …(Careflight) recently announced that there were a number of strips they would not attend at all and a further list they would not land at night unless upgrades were made. …As a result of these issues there has been a patient with a snakebite who nearly died due to a delay in accessing treatment (road extraction wasn't possible due to rain). Furthermore, the Timber Creek strip is not deemed adequate. This is the closest strip to the local clinic and has all weather access. The closest strip that is approved is at an Aboriginal community approximately 80km away down an extremely rough dirt track. Transporting a patient from the clinic to this strip risks further complications due to the challenge of monitoring and treating a patient in a bouncing ambulance."*

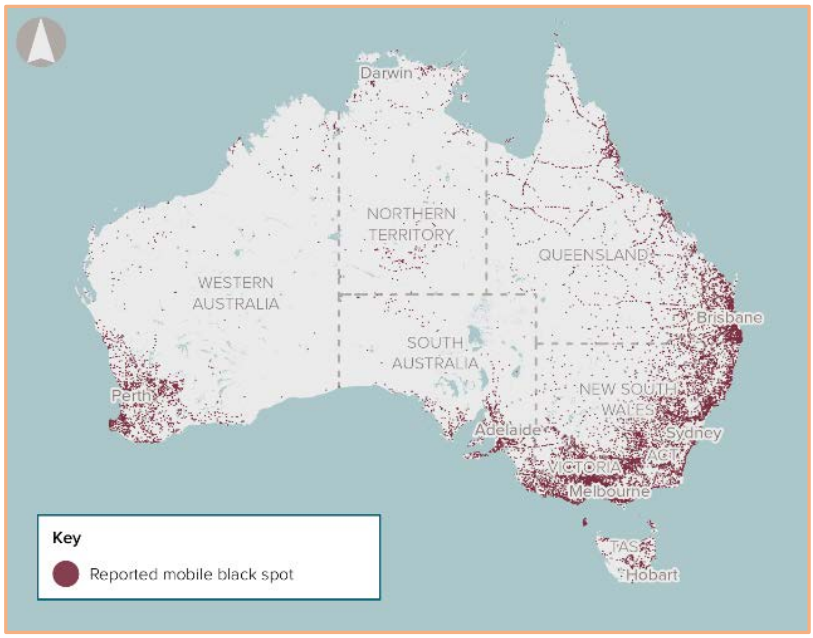
Resident of farm near Katherine, NT (pop. approx. 10.000). Nov. 2020

## 4. Localised Models

People living in major cities have relatively easy physical access to the full gamut of primary health care services. Rural and remote populations do not - and their access will differ greatly in terms of the range, scope and scale of accessible services, and the different ways that they are able to access them. Some communities have strong private practices with no hospital facilities, others may have neither of these but a strong ACCH. Some remote communities may have a remote area nurse and access to general practitioners by telehealth, while others may have strong hospital facilities but limited general practice services. Some may rely heavily on regular aero-medical visits and specialist outreach with limited access to any general practitioners. These diverse, cooperative models of care that emerge to deliver needed capacity to remote communities are based on a range of organisations accepting joint responsibility for a localized set of needs. A downside of this blended nature of remote health care delivery is that when services fail - no one government instrumentality need accept ultimate accountability. There is impetus for state and local governments to withdraw essential services and thus pass on the financial costs, risks and legal liabilities of accessing health care to the families in remote communities. While Commonwealth Government support which is directed principally through private practice can take a hands-off approach, leaving remote services provision to the uncertainties of market forces.

For service planners the resource and infrastructure base of each community bears specific consideration. The quality of roads, the availability of appropriate air strips remain life and death issues for many people. An increasingly key equity issue is the lack of telecommunications technology which for many remote communities prevents even mobile phone communications, and commonly prevents any meaningful video consultation. The figure below shows the extent across rural Australia of mobile black spots where unreliable or no smart phone coverage exists.

[29]Pereira Gray D et al (2018) Continuity of care with doctors—a matter of life and death? A systematic review of continuity of care and mortality. *BMJ* Open. 8(6)




Source: Australian Government, Infrastructure Australia website, Downloaded Nov, 2020.

These localized distinctions underscore the inappropriateness of adopting a blanket approach to national remote health care policy solutions. The former National Rural Health Commissioner, Prof Paul Worley has emphasized the importance to both recognising the distinctive nature of each rural community, but identifying a range of discernable models and typologies in order to create policies scalable for national implementation.[30] Humphreys et al. have constructed one such framework which defines common typologies of practice associated with certain context characteristics which can provide a basis for policy and planning[31]. Another useful approach is to create structures which can identify and enable the upscaling or translation to new settings of successful models.

## 5. Community responsibility

Each rural community must rely heavily on their locally-based health care professionals to address their needs if and when they arise. There is considerable pressure on rural professionals to provide after-hours and relief work, to upskill to provide the widest possible skill set particularly to align with the needs of patients, and to manage their patients' progress through the health care system. Many doctors gain skills in areas such as Point of Care Testing (POCT), cancer screening, population health, and health promotion. The pandemic and the recent bushfires have highlighted the extended roles that health professionals are called upon to play for their communities. One especially important area of community responsibility is in emergency care provision. Primary care doctors and nurses in rural and remote areas must be able to provide emergency response care and commonly also need skills in patient transport, retrievals and advanced clinical management. It is essential that every town has health

> *" …Earlier this year we had to call on the local Ambulance (voluntary driver with Nurse from clinic) out to our property, 50km from town, following a motor bike accident. We could not speak highly enough of the care received between the paddock and Charleville Hospital, then to Toowoomba via the RFDS. The Volunteer Ambulance driver positions and the full time staffing of our clinic is vital to our community."*
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> Resident of farm near Morven, Qld, (pop. approx. 200). Nov. 2020

[30] Worley P, Keynote address to NRHA 6th Rural and Remote Health Scientific Forum, April 2018. https://www.ruralhealth.org.au/rrhss
[31] Wakerman et al (2008) Primary health care delivery models in rural and remote Australia – a systematic review *BMC Health Services Research* Vol.8:276.

professionals with these skills sets, that these skill sets are kept current, and that there are sufficient of these personnel to be available as and when needed.

It is also noteworthy that rural community members are themselves key providers of essential services filling vital voluntary roles such as ambulance services. They also play an essential role in health advocacy and leadership of local health care community facilities particularly within the Aboriginal and Torres Strait Islander communities. The Men's Shed movement for example is entirely community-led and has become an important part of men's health and well-being strategies across rural Australia.[32]

> *"… staffing at the hospital has changed a little since then. While there are still permanent staff, some have left and agency staff used to fill the void (as I understand it). I do not know if this is because of availability issues, or the government not wanting to put on permanent staff."*
>
> Resident of Nannup, WA (pop. approx. 1000). Nov. 2020

## 6. Rural Business Viability

The value proposition from a financial point of view of becoming a permanently based remote private practitioner is often not strong. Each remote community has a confined patient base and associated socio-economic status. 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. For the more specialised primary health care providers including most fields of allied health, dentistry, specialist nursing and specialised medical practice permanent locally-based practice may not be viable at all and workforce figures show a sharp decline in all these fields as remoteness increases.[33]

It is important to recognise the value to communities of private, locally-based practitioners. These practitioners are part of the community with a shared interest in the issues of importance to their patients and practice ownership is a strong predictor of practitioner retention.[34] Clinicians that 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. These factors challenge the business proposition of becoming a private business owner in general practice and other health care professions, putting further pressures on remote primary care services. Many communities fear that the closure of private practices will lead to a permanent loss of local doctors and trigger a viscous cycle as population abandons towns without adequate health care services.

This context also creates an impetus to both governments and entrepreneurs to promote arrangements such as FIFO, outreach and locums as a permanent solution to remote service provision. The trend to a non-locally based workforce, is exacerbated by the relatively high rates of pay for locum services relative to what is available to staff based permanently in the local area whether it be through the private or public services. The increasing use of locum-based models of care in rural and remote areas represents a poor health care outcome for rural communities who lose their access to continuous care and creates an unduly expensive service option for jurisdictions. These issues have been acknowledged by the National Medical Workforce Reform Advisory Committee.[35] The trend toward and increasingly transient workforce is commonly leading to a situation where the predominant model of primary care from people in rural and remote Australia is fragmented and discontinuous.

[32] Wilson N et al (2013) A narrative review of Men's sheds literature. *Health and Social Care in the Community*. 21(5) 451-463.
[33] Aust Govt Dept of Health (2019) Annual Medicare statistics. Canberra.
[34] Russell D et al (2012) What factors contribute most to the retention of general practitioners in rural and remote areas? *Aust J. Primary health* 18(4):289-94.
[35] Aust Govt Dept of Health (2019) *National Medical Workforce Strategy: Scoping Framework July 2019*.

## 7. Rural and Aboriginal and Torres Strait Islander cultural context

> *"In 2014 the Bega Valley suffered the tragic loss of three or four teenagers to suicide. Our whole community was devastated. After a great deal of heart searching and discussion with teenagers and the local high school welfare officer, we established a Nurse Led drop in clinic two afternoons a week for high school kids and called it Teen Clinic. …We have done a lot of ground work and development to support this model of care which we feel has been incredibly rewarding and life changing. The model upskills the practice nurse as part of the GP team, who acts as a soft entry point and conduit for Teens to enter health care system. Rotary has been an avid supporter of the Teen Clinic model, and local service club by-in a critical component to community ownership and acceptance."*
>
> Resident of Bega, Vic (pop. approx. 4000). Nov. 2020

Notwithstanding the cultural diversity across rural and remote communities, there are some recurring themes that have implications for health care access.

The well-documented 'stoicism' of farming communities is noted as a barrier to many current policies to address poor mental health and high rates of self-harm. Establishment of trust and rapport and incorporating mental health care into a program of continuing care have been seen as important approaches.[36]

Rural and remote communities are known for their capacity for connectedness. There is some scholarship to suggest that rural people have a more 'giving culture' than their urban counterparts and they are considerably more likely to contribute as volunteers.[37]

By virtue of their smallness remote communities are characterized by their interconnectedness and by the familiarity health practitioners, patients and their families alike have with each other. This creates challenges for practitioners in managing professional boundaries and for patients in seeking help with confidence that their privacy will be upheld.

Aboriginal and Torres Strait Islander people represent a far greater proportion of rural and remote communities than they do of urban centres and many remote communities are comprised entirely of Indigenous people. Aboriginal and Torres Strait Islander culture is diverse reflecting several hundred different kinship and language groups and varying levels of connectedness to western and traditional cultures. This diversity notwithstanding, health care outcomes for Aboriginal and Torres Strait Islander people are known to be much stronger where there is a sense of community ownership, where trust has been established with health care providers over time, and where care is aligned with Indigenous people's various traditions and cultural norms in a culturally safe way.[38]

## 8. Practitioner Safety and Support

Any analysis of remote access to health care must consider the employment value proposition for remote health and medical workforces. Remote access is perennially impacted by workforce shortages, from a policy point of view their persistence is concerning in a context in which the national medical workforce is moving toward oversupply.[39] Over and above issues of remuneration of health care workers in remote areas, there are many aspects of work in these locations which must be adequately addressed in order to deliver the needed workforce to remote communities.

Practitioner's personal safety is an issue particularly for remote area nurses and health care workers called up to visit patients in their homes or in clinics with few if any support staff.[40]

[36] Varyo C et al (2020) "Don't …break down on Tuesday because the mental health team are only here on Thursday": a qualitative study of service provision Related Barriers to, and Facilitators of Farmers' Mental health help-seeking. *Administration and Policy in Mental Health and Mental Health Services Research.*
[37] ABS (2010) *Voluntary Work, Australia, 2010*. 4441.0 Canberra.
[38] NACCHO (2013) *Health Futures 2013-20130: NACCHO 10 point plan.* Canberra.
[39] Aust Govt Dept of Health (2019) *National Medical Workforce Strategy: Scoping Framework, July 2019.* P.26.
[40] CRANAplus 2017. Remote Health Workforce Safety and Security Report: Literature review, Consultation and Survey report. CRANAplus, Cairns

For health care professions in remote areas, professional isolation is a major factor impacting their health and well-being and ultimately their rates of retention in the area. Unlike doctors in hospitals and urban general practice, remote area based practitioners are geographically isolated from their professional peers and mentors. Doctors and health professionals often relocate and leave their family and social support networks to take up remote practice. Establishment of personal and professional support arrangements within the local community is important and appears to contribute to decisions by doctors to remain in rural practice.[41]

Professional isolation undermines practitioner retention and can compromise the safety of both the practitioners and their patients as the elevated responsibilities of being accountable for their care with minimal support can be overwhelming. It can lead practitioners to situations where they are called upon to work outside or at the limits of their scope. Work stress, lack of clinical confidence and professional isolation have all been recognised as reasons why doctors leave rural practice.[42,43] To improve practitioner confidence, competence and personal well-being, strong supervision and mentoring, access to upskilling, locum relief and time-off when needed, and, strong professional peer networks (even where these may be digitally enabled rather than in person) are important strategies.

A pivotal issue is the provision of medical and health professional training from university through to professional qualification which incorporates learnings, experience, and assessment on capacity to perform clinical services in the rural and remote context. In the context of general practitioners and rural generalists, specific, rurally-oriented collegial support, rural curricula and support to gain and maintain advanced skills including procedural and emergency skills is strongly linked to rural retention.[44,45]

# 4. Case studies of effective models of care for remote communities

The headline picture of insufficient and ill-fit health workforce and resourcing in rural and remote areas does not reflect the many fit-for-purpose models of health care provision that are able to overcome the challenges of geography and provide excellent services to rural and remote people.

**Case Study 1: Digitally-enabled care at Laynhapuy Aboriginal Community Controlled Health Services, East Arnhem Land [46]**

Laynhapuy Aboriginal Community Controlled Health Service (LHS) supports 30 extended traditional kinship groups known as 'homelands'. These communities are about 750 km east of Darwin and 200 km southwest of Nhulunbuy (their nearest major centre, population approx. 4000). Each community has a population of about 100. Travel to these sites is via non-sealed road and can take 3–4 hours from Nhulunbuy depending on the conditions. The roads are often closed in the wet season and charter flights take 20–30 minutes.

The clinics are staffed by one to three Aboriginal health workers who typically hold a Certificate II in Aboriginal and/or Torres Strait Islander Primary Health Care. Nursing teams travel in pairs to provide

[41] Hays et al (2008) Getting the balance right: GPs who choose to stay in rural practice. *Aust J. Rural Health. 11:4(193-8)*
[42] Gardiner et al (2005) The role of psychological well-being in retaining rural general practitioners. *Aust J. Rural Health. 13:3(149-55)*
[43] Buykx et al (2010) Systemic review of effective retention incentives for health workers in rural and remote areas: Towards evidence-based policy. *Aust J.Rural Health. 18:102-109*
[44] McGrail M et al (2017) *Solving Australia's rural medical workforce shortage*. (Policy Brief: Centre for Research Excellence in Medical Workforce Dynamics. Issue 3). University of Melbourne.
[45] McGrail M et al (2020) Faculties to support general practitioners working rurally at broader scope: a national cross sectional study of their value. *Int. J. Environ. Res. Public Health. 17:4652.*
[46] St Clair M et al (2019) Telehealth a game changer: closing the gap in remote Aboriginal communities. *MJA 210 (6 Suppl)* S26-7

weekly visits to the homelands clinics and a general practice registrar attends periodically. Most weeks they travel up to 220km, usually by 4WD. Most staff stay one to two nights because there are so many places to cover. A full-time senior rural generalist doctor provides clinical oversight and patient consultations predominantly by telehealth. The doctor had been previously based on site and despite relocating has remained with the LHS and developed a long-term relationship with staff and patients. It is believed that this established relationship is a key factor in the successful implementation of the model.

Consults in the homelands often include the patient, members of the patient's family, a nurse and an Aboriginal health practitioner in the clinic, and a general practice doctor and possibly even a specialist consultant all together in a single discussion. This reflects a delivery of care that is culturally appropriate enabling family group decisions, and which facilitates communication across the care spectrum.

As with many remote Aboriginal health services there is a lack of doctors and greater reliance on the expertise of Aboriginal health workers, nurses and trainee doctors to deliver effective health care. This includes the challenges of providing adequate supervision of trainee doctors. Given the small population sizes of homelands there are also the challenges of keeping the day to day primary health care cost effective and sustainable. In addition, there are the significant costs of sending patients into hospital and specialist services.

The senior doctor uses telehealth and videoconferencing to provide remote clinical oversight and advice to Aboriginal health practitioners, nursing staff, or trainee doctors. This includes weekly staff debriefs and mentoring and more structured training supervision sessions with the registrars. In this way all staff are upskilled, medically guided and personally supported while patients receive coordinated, culturally safe, continuous care.

**Case Study 2: Fitzroy Valley Community Partnership for integrated acute and primary care services[47]**

The Fitzroy Valley in the Kimberley region of Western Australia covers over 30 000 km2 with a population of around 3500 people dispersed across over 40 communities. Over half of the population in the area are Aboriginal people. The largest town is Fitzroy Crossing (population 1600), which includes a state government-funded hospital and community clinic, and the Commonwealth-funded Aboriginal community-controlled health service – Nindilingarri Cultural Health Service (NCHS).

Western Australian Country Health Service (WACHS) entered an agreement with NCHS to partner to provide integrated primary and secondary health care in the region. This enabled structural changes to the organisations respective roles and responsibilities in service delivery.

NCHS relinquished their primary care clinics (staff and buildings) so they could focus on their areas of strength – environmental health, health promotion, cultural safety and advocacy. This more strategic focus resulted in significant achievements, including a smoking cessation program and the implementation of community-led alcohol restrictions and support for the first Foetal Alcohol Spectrum Disorder (FASD) prevalence study in Australia.

The consolidation of clinical resources increased primary care access across the valley through increased outreach services. Community nursing clinics became available 4 days a week in three smaller Fitzroy Valley communities with populations of more than 160 people – Bayulu, Noohkanbah and Wankajungka, and monthly services were also available to even more distant satellite communities. In addition, key changes in the hospital included a primary care clinic where non-urgent emergency department patients are seen in a much more comprehensive manner, with a follow up and recall

[47] Reeve C et al (2015) Community participation in health service reform: the development of an innovative remote Aboriginal primary health-care service. *Australian Journal of Primary Health* 21:409–416

system and regular doctor visits to the community clinics, particularly for the management of complex chronic disease.

The partnership also enabled access to medications for people in the Valley where there are no pharmacies. Analysis of local service delivery data showed increases in primary care clinic availability across the Fitzroy Valley, particularly in the smaller satellite communities, an increase in Aboriginal staff employed, an increase in the proportion of the budget invested in primary care and increased allied health services and follow up of patients for primary care.

**Case Study 3: Single Practice Model, Central West Health and Hospital Service, Qld[48]**

The Central West Health (CWH) and Hospital Service district covers an area of 385 000 km$^2$ serving a population of around 12 000 living in small towns and on isolated pastoral properties. The district is served by a small acute hospital located in Longreach (pop. 3400) and smaller hospitals are located in Barcaldine, Alpha, Blackall, and Winton all managed directly by the Central West Health and Hospital Service. General Practices are located in Longreach, Barcaldine, Winton, Alpha and Blackall. The town General Practices operate as private General Practice services, though in the cases of Winton and Blackall and Alpha, they are owned by CWH. Community Health services are provided by CWH in Longreach and remote area nurse led Primary Health Clinics are proved in Aramac, Birdsville, Bedourie, Boulia, Isisford, Jericho, Jundah, Muttaburra, Tambo and Windorah. Longreach General Practice provides outreach medical services to Isisford: Blackall General Practice to Tambo; and Barcaldine General Practice to Alpha, Aramac, Jericho and Muttaburra Primary Health Clinics. RFDS doctors service Jundah, Windorah out of Charleville and Birdsville Bedourie and Boulia out of Mt Isa.

The Central West Single Practice Service model evolved in response to an ongoing series of crises in supplying necessary health care services in the area. When in 2009 it became apparent that both the private and hospital services may not be sustained the state health service recognised the need to take decisive action. A contract was established between the health department and a management company which was established to run the local general practice clinic. The experienced senior clinician who was the former owner of the private general practice returned to the hospital as a Senior Medical Officer and took responsibility for the management of all medical service. The management company operated as a separate legal entity to provide the practice management and back of house services required to manage a successful private practice.

The Single Practice Model addresses the availability of workforce for primary health care as well as secondary treatment and acute inpatient care and has allowed CWH to pursue an integrated care model across both tiers of services. As such, continuity of care for patients across the care continuum is enhanced and the potential for adverse events associated with problems in communication and handover has been reduced.

By combining the medical presentations for both public and private medical services and the associated revenue for both a critical mass of activity is achieved, and the viability and sustainability of both public and private services is enhanced. This has been critical in maintaining a district hospital and also a viable primary health care service based on general practice.

For complex patients and those with chronic diseases, continuity resides in the system rather than in the individual doctor who may have been the sole care provider for many years. Clinicians have access to both general practitioner and hospital records which improves continuity of care and reduces opportunities for error associated with clinical handovers.

[48] Rimmer D et al (2015). *Central West Single Practice Service Model* Paper presented to the Rural Medical Australia Conference, October, 2015.

Medical staff are flexibly deployed across the primary health care and acute care sectors dependent upon their skill sets and the service requirements. The model optimises the skills of rural generalist registrars being trained in association with the Queensland Rural Generalist Program who have advanced skill training (AST) to supply the extras skills needed by rural GPs to manage patients as close to home as possible. The focus has been on registrars undertaking AST training in obstetrics and anaesthetics given the absolute imperative to maintain birthing services at Longreach. Under the model, all ASTs held by any doctor in the district are made available across the district. CWH employs all medical staff on a "whole of district" basis such that doctors have a district wide responsibility as well as their responsibility to their individual locale. Telehealth allows application of an AST across the district and the doctor with that AST has a responsibility to share that extra knowledge. In order to facilitate free movement of doctors with the focus on the work most needing to be done there is a strong preference for an all Salaried Medical Officer model.

Appling a rural generalist approach, residents of Central West Region have access to patient centred clinical care delivered by appropriately skilled clinicians, in a timely fashion, as close to home as is safe. "As close to home as is safe" is defined by the service capability of the most appropriate facility closest to the patient's home. Clinicians are challenged to deliver services closer to the patient's home by the use of current and evolving technologies and workforce models. The Clinical skills are assessed and normed against published national standards.

# 5. Guiding Principles for policy reform

Based on the issues that have been overviewed the following are proposed as some useful guiding principles for primary health care policy that incorporates appropriate consideration of the needs of people living in rural and remote areas:

1. **The gold standard for primary health care should remain locally-based practitioners providing continuous care**
   It is understood that continuous care is essential to quality care, this should ideally come from practitioners based locally that can know and empathize with patients and their families about the problems associated with their broader context.

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**
   It must be consistently reinforced to policy makers that any definition of a level of care that meets a minimum provision standard for all Australians needs to incorporate a measure of an acceptable level of practical access to care or at least some reasonable mitigation of any associated costs.

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 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.**
   Rather than worsening the existing problem, appropriate solutions such as systems review, enhanced practitioner training, better resourcing, enhanced staff support and mentoring should always be considered.

6. **Policy frameworks should seek to enable service delivery solutions that emerge from remote and rural communities to be supported in their development with a view to creating models with long-term sustainability and to creating models for broader implementation**

7. **National policy infrastructure should ensure that it is able to be at all times receptive to continuous meaningful input from rural and remote communities into all planning and decision-making**
   It should be explicitly recognised that decision-making ultimately is vested in people based in major cities whose personal context inevitably influences their perspectives. This needs to be proactively mitigated against through transparent processes and structures. 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.

# 6. Policy approaches

- **Fit for purpose rural and remote health care provision**

  It should be recognised that the current fee-for-service system is a flawed instrument for reflecting and appropriately rewarding rural and remote practice. It is not well-equipped to capture many of the features that characterise much of rural general practice and rural generalist practice, including,
  - the unpredictability and variability of rural practice
  - the community responsiveness of practice scope and activity
  - its common propensity to require practitioners to work to top of scope, and
  - the interdisciplinary teamwork based approach.

  ➢ Models could be developed which enable place-based care whereby practitioners or practice teams can structure their services to meet specific population health issues of concern to their community. These might take the form of pooled funding models that address health and preventative outcomes.

- **Primary Care Infrastructure Development**

  There needs to be a more focused approach to supporting and rewarding doctors and health professionals that establish a permanent base in remote communities. In doing so, this would incentivize continuity of care, long-term retention and typically higher degrees of service which is often not possible for non-resident practitioners. Currently there is considerable incentive to opt for non-permanent positions - locums, temporary and FIFO staff typically are better remunerated than permanent staff and without the administrative burdens of running a business.

  ➢ Policy instruments should be designed that provide infrastructure support for primary care in rural and remote communities. This should promote an easy entry and graceful exit for health professionals who choose to stay in regional, rural and remote services.

- **Enabling the traditional model of the GP within the broader roles and responsibilities of the health care team across primary, secondary and tertiary care teams**

  The prevailing systemic pressures toward specialised models of care need to be actively prevented from diminishing the services that primary health care teams in rural and remote areas can provide or for which they can facilitate provision. At the same time positive strategies should be engaged to encourage the local provision of the broadest possible scope of safe, quality care by locally based heath care teams which include a general practice qualified doctor providing the essential medical guidance and coordination.

  A range of strategies could facilitate this.

  - This could be supported through a redistribution of resources (including human, financial, data and infrastructures) to better meet community needs and to site practices with the appropriate part of the sector. For example, the general practitioner may be supported to provide wound care services or hospital in the home. This would involve changing the current system of parallel (federal and state) service delivery structures.

  - Blended payments could be introduced for aspects of primary care that may include nursing services, palliative care, chronic disease care, antenatal care and preventative health.

  - Fee for service could remain in place for episodic care and could include appropriate loadings for rurality.

- **Engagement with businesses and jurisdictional health services toward innovative solutions**

  There is an opportunity to establish structures that can operate at a national level which can facilitate positive, collaborative development to be implemented in rural and remote areas in a manner which is in alignment with national priorities and such that the developments can be accommodated within broader government systems and planning.

  - National frameworks could facilitate interaction between local primary health care businesses and health services toward redistribution of skills to support top of scope high quality clinical care that is respectful and collegiate. This would include for example cooperative arrangements balancing the role of the rural generalist obstetricians in nurse led models of midwifery care across private/public sectors.

  - National frameworks might also be used to canvas opportunities for investment focused on state/federal partnerships inclusive of the role of Primary Healthcare Networks/Health and Hospital Services and National Cabinet. These investments would focus on validating the role of primary care in the health of our regions.

# 7. Note on consumer statements

The College has an informal network of people who live in diverse locations across rural and remote Australia with a common interest in progressing the College vision of *the right doctors, with the right skills, in the right places providing rural and remote people with excellent health care*. The group's members were asked to provide their comments on some of their seminal experiences of remote health care. Selected comments have been included in this paper so that the analysis provided is presented in the context of authentic rural and remote community voices and lived experience.

# Acronyms

| | |
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| ABS | Australian Bureau of Statistics |
| ACRRM | Australian College of Rural and Remote Medicine |
| ACCHS | Aboriginal and Torres Strait Islander Community-Controlled Health Service |
| AIHW | Australian Institute of Health and Welfare |
| AST | Advanced Specialised Training |
| CPD | Continuing Professional Development |
| CWH | Central West (Queensland) Health |
| FACRRM | Fellowship of Australian College of Rural and Remote Medicine |
| FASD | Foetal Alcohol Spectrum Disorder |
| FIFO | Fly-In, Fly-Out |
| GP | General Practitioner |
| HHS | Hospital and Health Service |
| IMG | International Medical Graduate |
| LHN | Local Health Network |
| LHD | Local Health District |
| MBS | Medical Benefits Scheme |
| NCHS | Nindilingarri Cultural Health Service |
| NRGP | National Rural Generalist Pathway |
| NRHA | National Rural Health Alliance |
| PBS | Pharmaceutical Benefits Scheme |
| PHN | Primary Health Networks |
| POCT | Point of Care Testing |
| RFDS | Royal Flying Doctors Service |
| RWA | Rural Workforce Agency |
| WACHS | Western Australian Country Health Service |