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

College Submission
September 2023

Feedback to Standing Committee on Health, Aged Care and Sport - Inquiry into Diabetes and Obesity

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 provides a quality Fellowship program including training, professional development, clinical practice standards; and support and advocacy services for rural doctors and the communities they serve.

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

Fellowship of the College (FACRRM) entitles doctors to national recognition as specialist General Practitioners (GPs) and the associated patient access to the Medicare Benefits Schedule (MBS). 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 has more than 5000 rural doctor members including 1000 registrars, who live and work in rural, remote, and Aboriginal and Torres Strait Islander communities across Australia. Our members provide expert front line medical care in a diverse range of settings including general practices, hospitals, emergency departments, Aboriginal Medical Services, and other remote settings such as RFDS and Australian Antarctic Division.

Initial Comments

Diabetes is a chronic, metabolic disease characterised by elevated levels of blood glucose which leads over time to serious damage to the heart, blood vessels, eyes, kidneys and nerves. Type 1

diabetes cannot currently be prevented, and type 2 diabetes is more common, usually in adults, and occurs when the body becomes resistant to insulin or does not produce enough insulin.

The World Health Organisation Reports that in the past 3 decades the prevalence of type 2 diabetes has risen dramatically in countries of all income levels.[1] Early diagnosis and early intervention and treatment are crucial to enable patients to live well with diabetes. The longer a person lives with undiagnosed and untreated diabetes, the worse their health outcomes are likely to be.[2]

Diabetes Australia reports there are 1.5 million Australians living with diabetes, and over 400,000 at risk of the onset of type 2 diabetes.[3] Those living with diabetes must be supported to effectively manage their condition through education, care and support, and those at risk must be supported to prevent or delay the onset.

ACRRM supports the globally agreed target to halt the rise in diabetes and obesity by 2025. The pivotal role of Rural Generalists across Australia's rural, remote and Aboriginal and Torres Strait Islander communities can be leveraged to provide screening, early diagnosis, treatment and support for diabetes in primary care settings.

Response to key issues

The causes of diabetes (type 1, type 2 and gestational) in Australia, including risk factors such as genetics, family history, age, physical inactivity, other medical conditions and medications used.

Diabetes is a major cause of illness and disability in Australia. It is a leading cause of blindness and lower limb amputation and can lead to pregnancy related complications for both the mother, foetus and newborn child. Diabetes is an important risk factor for other chronic diseases including heart disease, stroke, and renal disease.[4] Risk factors for diabetes include genetic factors, obesity, low birth weight, increasing age, physical inactivity, poor diet and smoking.

Social determinants of health and population demographics contribute significantly to risk factors for diabetes and associated chronic conditions, particularly in rural and remote and Aboriginal and Torres Strait Islander communities. When compounded by poorer access to primary and preventative health care and subsequent challenges in accessing secondary care, the impacts of diabetes can be far more significant in these areas.

Prevention and early intervention are key to changing the trajectory of the diabetes epidemic[5] and ACRRM supports the goals of Diabetes Australia's Strategic Plan:

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[1] https://www.who.int/health-topics/diabetes#tab=tab_1
[2] https://www.who.int/health-topics/diabetes#tab=tab_3
[3] https://www.diabetesaustralia.com.au/
[4] AIHW Regional, Rural and Remote Health, A Study on Mortality, 2nd edition, page 260
[5] Diabetes Australia Group Strategic Plan 2023-27

We have four goals:

GOAL #1

Prevent diabetes

We want fewer people developing type 2 diabetes – achieved through greater investment and better coordination of national and state prevention, risk assessment and screening programs for Australians at risk, as well as enhanced whole of population prevention strategies.

GOAL #2

Live well with diabetes

We want people with diabetes to be empowered to self-manage their condition – connected to the right supports – and not just surviving but thriving.

GOAL #3

Reduce health and financial impacts

We want to minimise the incidence and impact of diabetes on people through early diagnosis, better management and access to information and services that are person-centred, integrated and coordinated. We want to improve the quality of life, outcomes and experiences of people with diabetes – and to reduce avoidable complications, hospitalisations and associated costs to the health system and society.

GOAL #4

Find a cure

We want more people with diabetes benefitting – now and in the future – from research, data and evidence to prevent and treat diabetes. We ultimately want to find a cure for diabetes.

Source: Diabetes Australia Group Strategic Plan 2023-27

Early intervention can improve outcomes through a combination of blood glucose control, diet, physical activity, medication and regular screening for damage to eyes, kidneys and feet. Rural Generalists can play a key role across Australia's rural, remote and Aboriginal and Torres Strait Islander communities in leading health care teams and providing early diagnosis, treatment and support for both types of diabetes in primary care settings.

Prevention strategies for rural and remote communities should also encompass supporting healthy lifestyles by ensuring provision of community sports and leisure infrastructure and activities, and also through ensuring access to affordable healthy food options. These two factors while key to promoting cultures of healthy lifestyles, are often not the case in many rural and remote towns and communities.

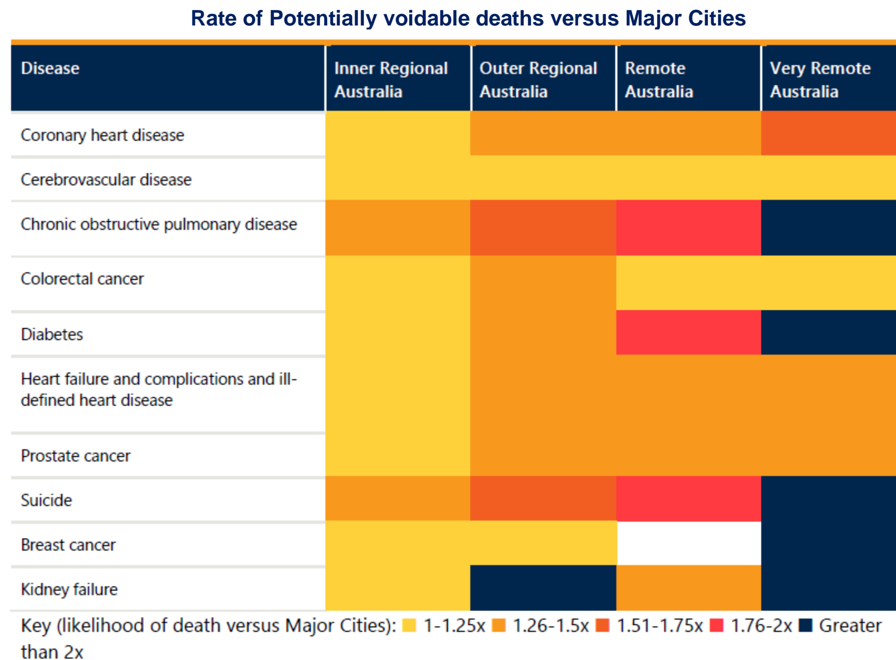
The broader impacts of diabetes on Australia's health system and economy

Burden of disease – rural and remote Australia

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.

Studies demonstrate that the burden of disease in remote areas is 1.4x that of major cities, and potentially avoidable deaths[6] are 2.3x higher in males and 3x higher in females in very remote areas.[7] Figures for death rates from diabetes are 3.8x as high in very remote settings. A recent report has demonstrated the overrepresentation of remote communities in potentially avoidable deaths, with very remote areas experiencing more than two times the rate of death for several chronic conditions, including diabetes.[8]

Rate of Potentially voidable deaths versus Major Cities



Source: NRHA Report, June 2023

Diabetes and poor mental health and wellbeing

Australians with diabetes have a higher prevalence of poor mental health and wellbeing than those without diabetes[9]. Once again, the health, social and economic impacts of poor mental health can be greater in rural and remote communities where it is more difficult to access services and people are less likely to seek intervention due to a range of social and economic factors.

- Adults with diabetes had a significantly higher prevalence of medium, high or very high psychological distress than those without diabetes (43.4% and 32.2% respectively), after adjusting for age differences in the groups, based on the 2007–08 National Health Survey.
- In 2007–08, diabetes hospitalisations were more likely to also have a mental health condition recorded than other hospitalisations (age-standardised rates of 8.4% and 7.5% respectively). Substance use, dementia/Alzheimer disease and depression were the most common mental health conditions.
- The proportion of people who claimed a mental health-related service from the Medicare Benefits Schedule (MBS) in 2008 was twice as high for those with a diabetes-related MBS

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[6] Defined as deaths under 75 years from conditions considered preventable
[7] Mortality Over Regions and Time (MORT) books Australian Institute of Health and Welfare June 2022 https://www.aihw.gov.au/reports/life-expectancy-death/mort-books/contents/mort-books
[8] National Rural Health Alliance, Evidence base for additional investment in rural health in Australia, June 2023 https://www.ruralhealth.org.au/document/evidence-base-additional-investment-rural-health-australia
[9] AIHW Diabetes and poor mental health and wellbeing: an exploratory analysis, June 2011, accessed August 2023 https://www.aihw.gov.au/reports/diabetes/diabetes-poor-mental-health-wellbeing-analysis/summary

service than for those without a diabetes-related MBS service (age-standardised rates of 13% and 6% respectively).

The effectiveness of current Australian Government policies and programs to prevent, diagnose and manage diabetes

Improving access to Primary Care

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.

Poor access to services, and especially primary care services, is a key contributing factor to poorer health outcomes. Research 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.[10] The shortage of primary care services and resultant poor health outcomes place additional pressure on the public health system, as patients are more likely to present to hospital emergency departments if they cannot access primary care.

Lack of preventative and longitudinal primary care can lead to earlier onset and increased severity of a range of chronic diseases including diabetes, which in turn places additional pressure on the public health system in terms of cost, workforce and infrastructure.

Health outcomes, particularly for people living in rural and remote and Aboriginal and Torres Strait Islander communities, can be significantly improved through better access to primary care and the high treatment costs involved when conditions escalate to requiring secondary or tertiary care can be significantly reduced.

Rural and remote general practice is integral to improving health outcomes for rural and remote Australians but is currently grossly underfunded and needs to be subsidised to remain viable.

The College strongly supports increased investment in Rural Generalist practice. RGs are often the only, or one of few providers of medical services in rural and remote areas. The broad scope, community responsive work of RGs and their local healthcare team colleagues where applicable, is essential to providing accessible care for people in rural and remote areas. These doctors are uniquely placed to minimise the incidence and impact of diabetes through early diagnosis, better management, and access to information and services, and must be adequately funded and supported to continue to deliver essential diabetes services across rural and remote Australia. RGs commonly also provide inpatient, emergency and retrieval care for patients in rural and remote areas. They can thus facilitate integrated patient care across the primary, secondary and tertiary spaces as required.

Supporting Rural Generalist Practice

If rural generalist practice is to be appropriately funded and supported, a broad range of mechanisms which recognise the unique circumstances and challenges of rural and remote practice must be considered.

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[10] AIHW Survey of Health Care: selected findings for rural and remote Australians https://www.aihw.gov.au/reports/rural-remote-australians/survey-health-care-selected-findings-rural-remote/contents/summary

Financial challenges may include a limited patient population and thus limited capacity to generate income, difficulties in finding work for partners, the cost of accessing professional development and training to work to a broad rural scope, and costs associated with travel to city centres for work and lifestyle reasons.

In addition to realistic MBS patient rebates which reflect to cost of services in rural and remote areas, blended funding models would provide a funding source particularly for the management of chronic and complex diseases such as diabetes. Funding should incentivise provision of care by a locally based practice and locally based practitioners able to provide in-person care as required, and support continuity of doctor-patient relationships. It is noted that the announcement of the MyMedicare initiative in the 2023 Federal budget recognises the need for new models to fund effective care for chronic and complex conditions within the general practice setting.

Flexible funding should be available to specifically support rural and remote, locally based services. This funding must be fit-for-purpose and proportionately recognise and reward the effort and skill of medical/health care providers in meeting their patients' needs. To lend resilience, there needs to be a range of potential funding sources and policy levers. These would enable practices to adopt viable models of care appropriate to community needs and circumstances.

Policies should ensure remuneration structures reflect the higher costs associated with working in rural and remote areas. They should also appropriately incentivise and remunerate the clinical complexity and heightened responsibilities associated with working in these environments. Finally, they should reflect the value of the services that these professionals provide to some of the country's highest needs populations.

Other challenges include working with minimal local resources and facilities, the weight of responsibility for patients who have limited access to alternative care, professional and personal isolation, and the professional stress associated with caring for high-needs, low socio-economic patient populations.

If government policy is to successfully improve access to healthcare for rural and remote people, it must address training, resourcing and personal support for the health and medical professionals who choose to work in rural and remote areas, in addition to ensuring that they are adequately remunerated.

Collaborative, team based models of care - Rural and remote healthcare is best served through team-based models with appropriate collaborative arrangements in place. People in rural and remote areas should have easy access to a general practitioner as their first point of contact and the key person in their continuum of care.

The College supports models of care that involve a collaborative and team-based approach where possible. This includes adopting a distinctive, flexible, and broad scope of practice within each practitioners' safe scope to deliver the fullest and best possible local care in rural and remote areas. It is noted that there is already a broad range of excellent rural and remote nursing and allied heath models involving remote area nurses, midwives, Aboriginal and Torres Strait Islander health professionals and others which reflect this rural generalist approach to rural healthcare.

Any interrelated health issues between diabetes and obesity in Australia, including the relationship between type 2 and gestational diabetes and obesity, the causes of obesity and the evidence-base in the prevention, diagnosis and management of obesity

Obesity is a chronic disease with multiple health consequences, and comorbidities associated with obesity can lead to a reduction in quality of life and can ultimately be life-limiting.[11] Obesity increases the risk of type 2 diabetes and many other non-communicable diseases such as cardiovascular disease and cancer.

People dealing with obesity must be supported to manage their condition and its consequences, and to optimise the1.ir health regardless of their weight. Obesity disproportionately affects Aboriginal and Torres Strait Islander populations in Australia, and this is associated with the conditions under which people are born, grow, live, work and age. Interventions and education to address obesity must be co-designed with priority populations to increase engagement and maximise outcomes.

In aiming to create a person-centred health system which takes a holistic approach to health and wellbeing, there is the need to recognise that the delivery of support and treatment, and who is best placed to deliver it can be different in the rural and remote context. The needs of Australians in rural, remote and Aboriginal communities, and the barriers to accessing treatment for mental health disorders can differ from the urban experience. Rural Generalists are in a unique position to provide holistic care, crossing the siloes of both physical and mental health care and providing care across the illness spectrum and the lifespan.

It is important to note that Australia's rural, remote and Aboriginal and Torres Strait Islander communities experience food insecurity in conjunction with a range of other health risk factors already mentioned in this submission. Many people do not have access to affordable, healthy nutritious food. Addressing food insecurity in pregnancy and early childhood can make lasting improvements in the health status of our Aboriginal and Torres Strait Islander children.[12]

Conclusion

Addressing and managing the causes and treatment of diabetes in rural and remote and Aboriginal and Torres Strait Islander Communities requires recognition of the unique circumstances and challenges that are faced by these communities in accessing health care, and the need for targeted funding and other support for the health care professionals who work in those communities.

ACRRM believes that its Fellows (FACRRMs) can play a key role in supporting public health initiatives and working across both the primary and secondary care sectors to deliver a wide range of health care services within the communities where these services are most needed. Through their broad scope of practice and community involvement, they can contribute to the prevention, early intervention and management of diabetes with significant benefits to patients, communities and the national economy.

Rural Generalists, together with other healthcare professionals, must be appropriately supported, recognised and remunerated in order to be able to continue this important work.

At a broader level, a range of strategies are required to address social determinants of health and other causative factors for diabetes. Coordination across all levels of the health system is imperative, and especially important for rural and remote communities who rely on cross-sector collaboration to maximise local capacity.

[11] RACP Obesity Position Statement, May 2018 https://www.racp.edu.au/docs/default-source/advocacy-library/racp-obesity-position-statement.pdf?sfvrsn=6e3b0b1a_5
[12] Food Security and Health in Rural and Remote Australia, October 2016, https://agrifutures.com.au/wp-content/uploads/publications/16-053.pdf

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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.