ACRRM

Submission to Senate Select Committee on Australia's Disaster Resilience

College Submission
April 2024

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, and clinical practice standards; and support and advocacy services for rural doctors and the communities they serve.

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

The College 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.

Background

All disaster response and resilience planning should be underpinned by the principle that people living in rural and remote and Aboriginal and Torres Strait Islander communities should have timely and equitable access to safe, high-quality care which is appropriate to their needs and circumstances.

People in rural and remote Australia experience significantly higher rates of injuries and deaths resulting from emergencies and disasters, including transport and other accidents (occupational and recreational), envenomation, and climate-related adverse weather events. [1]

In recent times, Australia has experienced both natural and health disasters, in the form of bushfires, floods, droughts and the COVID-19 epidemic. Accidents and emergencies are also relatively common in rural areas.

In 2019–20, the likelihood of hospitalisation and death due to accident and injury increased sharply with remoteness. People living in outer regional areas were 32% more likely to be hospitalised and 56% more likely to die from an injury than people from major cities, while people living in Very remote areas, were: 2.3 times as likely to be hospitalised, and 2.0 times as likely to die from an injury. [2] Regional and remote road crashes accounted for 65% of Australia's fatal crashes from 2010-2018.[3]

Land transport accidents are a leading cause of death in remote and very remote areas, the death rate being nearly three times as high for remote areas and nearly four times as high for very remote areas

[1] Australian Institute of Health and Welfare. (2022). Rural and remote health. Retrieved from https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health
[2] BITRE (2020) Road Trauma Australia 2019 Statistical Summary: Bureau of Infrastructure, Transport and Regional Economics, Canberra: Commonwealth of Australia.
[3]Austroads (2019) National View on Regional and Remote Road Safety (AP-R603-19) Sydney: Austroads. 257 AIHW (2019).

compared with Australia overall.[4] People in rural areas are 3-4 times more likely to die in road accidents and twice as likely to be hospitalised, and twice as likely to die, from injury.[5]

Other hazards include agricultural and mining industry accidents, envenomations, wildlife-vehicle collisions, and environmental hazards.

The Role of the Rural Generalist

The increasing occurrence of natural disasters together with the COVID pandemic, has highlighted the importance of utilising the community knowledge, expertise and skill of rural and remote medical practitioners in disaster and emergency response and building and supporting community resilience.

Rural and remote doctors and their teams are critical players in emergency and disaster response efforts. As frontline responders they provide immediate care for their own patients and others. They are also the main providers of ongoing care following such events, including mental health services and support, and can lead or support community response and resilience initiatives.

With their connections into community, they can offer unique local insights during and in the aftermath of emergencies and disasters. They can also contribute their expertise into the operation of the health system more broadly, particularly in relation to how rural general practices and facilities can operate and integrate with secondary and tertiary care. Their skills and insights are particularly valuable, noting that support from metropolitan and regionally based emergency and retrieval services may be significantly delayed or compromised due to distance, weather, demand, or other factors.

Despite this, most States and Territories do not currently have policies and clinical management frameworks which formalise the role of the rural doctor in the pre-hospital emergency or disaster response. In some instances, the protocols instigated by centralised jurisdictional government retrieval agencies may not permit local doctors to respond to disasters in their own towns.

This creates the potential for the local practitioner and healthcare team to be bypassed in communication and coordination and engagement networks in the response to local emergencies, causing significant delays and failure to make the most effective use of valuable local knowledge and resources.

The Rural Generalist (RG)

ACRRM contends that the rural generalist model of care is key to the delivery of the best possible healthcare services in rural and remote communities, maximising the care that can be provided locally.

The Cairns Consensus definition of Rural Generalist Medicine describes the discipline as *the provision of a broad scope of medical care by a doctor in the rural context that encompasses the following:*

- *Comprehensive primary care for individuals, families, and communities*
- *Hospital in-patient and/or related secondary medical care in the institutional, home, or ambulatory setting*
- *Emergency care*

[4] MORT (Mortality Over Regions and Time) books: Remoteness area, 2013–2017. Cat. no. PHE 229. Canberra: AIHW. https://www.aihw.gov.au/reports/life-expectancy-death/mort-books

[5] AIHW (2019) MORT (Mortality Over Regions and Time) books: Remoteness area, 2013–2017. Cat. no. PHE 229 24

- *Extended and evolving service in one or more areas of focused cognitive and/or procedural practice as required to sustain needed health services locally among a network of colleagues*
- *A population health approach that is relevant to the community*
- *Working as part of a multi-professional and multi-disciplinary team of colleagues, both local and distant, to provide services within a 'system of care' that is aligned and responsive to community needs.*[6]

RGs are ideally placed to contribute to disaster response and planning and support community resilience, both at the frontline and in broader strategic planning initiatives.

Typically, RGs provide primary care services to their community along with emergency care through their local rural hospital. In addition to comprehensive core training, many will have advanced skills in anaesthesia and resuscitation, making them well-placed to assist in a disaster, both at initial response phase (with provision of early and advanced clinical care) and in subsequent phases.

ACRRM Fellows (FACRRMs) achieve a specialist general practice qualification and are trained to practise as RGs. FACRRM training, in addition to generic general practice education, includes mandatory training and assessment in obstetrics, emergency medicine, hospital inpatient care and population health. An additional one to two years of assessed Advanced Specialised Training (AST) in a selected field is also required. All rural generalist assessment measures capacity to apply skills within the clinical context of rural and remote settings.

College Fellows are required to complete Advanced Life Support (ALS) training in association with their attainment of Fellowship and must maintain ALS currency as evidenced through their continuing professional development reporting.

The joint application for recognition of Rural Generalist Medicine as a specialist field within general practice is now well advanced. Should this be successful, this would provide a consistent and clear basis for MBS item numbers and industrial awards which recognise the distinct training, assessment and professional development associated with the rural generalist scope. This could significantly add to the attractiveness of a rural generalist career and appropriately recognise and remunerate the rural generalist training and skill set.

The International Context

In countries such as New Zealand, Scotland, the UK, and Canada there are formal rural responder networks which incorporate the rural General Practitioner (GP) in their centralised emergency response protocols, in acknowledgement of the important role of local medical staff.

In contrast to these countries with comparable healthcare systems and resources, Australia has done little toward developing such networks. This is despite our continent being characterised by substantial challenges in in the form of vast distances, diverse remote populations, and vagaries of weather. When emergency care is needed outside of Australia's major centres, these factors in combination contribute to excessive retrieval times which are frequently exacerbated by transport delays and travel uncertainties.

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[6] Murray R (2014) Cairns Consensus: International Consensus Statement on Rural Generalist Medicine. Retrieved at: https://ruralgeneralist.qld.gov.au/wp-content/uploads/2017/07/Cairns-Consensus-Statement-fd.pdf

[6] Australian Institute of Health and Welfare. (2022). *Rural and remote health.* Retrieved from https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health

The Australian Situation

Australia's disaster response is characterised by siloed approaches, fragmented and inequitable funding, and convoluted arrangements, including the two-tiers of responsibility (Commonwealth and State/Territory). Poor interconnectedness, including between the Commonwealth and States/Territories; health services and social and community services; and emergency services, means that delivering the integrated responses needed during emergencies and disasters is challenging. Poor communication and mixed messages often exacerbate these challenges.

Likewise, there is little coordination in terms of developing and supporting community resilience programs. This often results in duplication of services; failure to make the best use of existing resources and a poor response at the community level.

Many response and resilience programs are designed for metropolitan or inner regional situations. They commonly rely on sub-specialised healthcare professionals who have little awareness of the rural and remote context, or of the local knowledge and clinical expertise of rural clinicians and how these can most effectively be utilised. This omission can lead to further inequities in terms of timely responses and access to appropriate care and an uncoordinated and 'ad hoc' response.

Training, Skills, and Support for RGs and Rural GPs

First Responder Networks **-** Rural doctors with current advanced skills in emergency medicine, anaesthetics, surgery, and mental health are particularly well equipped to provide emergency services in collaboration with ambulance and retrieval services. However not all practitioners are able to work at this advanced level. Initiatives such as First Responder Networks are useful in utilising volunteer RGs to attend emergencies and provide additional support to their colleagues. These doctors are already familiar with the rural and remote context allowing them to provide effective and appropriate support.

These Networks could fill an important role at both the national and state/territory levels, particularly if consistent credentialing and ongoing upskilling were supported, and if their role was recognised and integrated it disaster and resilience planning.

Equipment and Infrastructure **-** The 'gold standard' for safe, quality emergency care lies at the intercept of in-time access to services and adequate resourcing (in equipment, personnel, and skills) of rural emergency departments.

ACRRM has developed minimum standards for small rural hospital emergency departments. These aim to assist small rural hospitals and relevant jurisdictions to work towards being adequately equipped and resourced to initially manage any presentation to their Emergency Department (ED), bearing in mind that many factors will influence the need for additional resources to be incorporated into the design and function.

Standardised emergency bags should also be available for the use of rural doctors who are called to attend to accidents and emergencies in the pre-hospital environment. For example, The Sandpiper Bag aims to provide a standardised set of equipment to enable a first responder to perform a limited suite of

meaningful interventions on the pre-hospital scene[7]. Ideally such responses should not occur ad hoc but be part of a scheme with agreed call-out criteria, equipment, training, and clinical governance.

Practitioner Health and Wellbeing **-** The College recognises that the role of medical professionals dealing with emergency and disaster response can be highly stressful. In the rural and remote context, these issues are exacerbated through geographic isolation from professional colleagues and the closeknit nature of rural communities which commonly involves practitioners having ongoing social relationships with patients and their families. Feedback from our members suggests that these issues are major causes of practitioner burn out and workforce attrition.

Practitioner health and wellbeing must be supported at all times, but this becomes more vital during emergency and disaster response. We must ensure the rural and remote health workforce has access to personal mentoring and support structures to assist them maintain their physical and mental safety and wellbeing.

During the recovery phase the medical workforce will require ongoing support as they in turn work to support their patients and communities. Arrangements should be in place to ensure that they have access to locum relief and other leave arrangements so that they are able to refresh and recover. Their mental and physical health may also be affected, so access to appropriate support and services (including by telehealth) is readily available.

The importance of equipping our medical workforce with the necessary skills to monitor their professional and personal wellbeing and act on the results and allowing them in turn to respond to workplace challenges cannot be understated. Self-care promotes a higher quality of care for patients, enhances capacity for empathy and rational atonement, as well as modelling healthy behaviour.[8]

Summary of Recommendations

1. State and territory-wide retrieval services and other organisations responsible for emergency response and disaster management planning should formally recognise local rural doctor, hospital facilities and staff as important and integral components of the emergency and disaster response team and document their roles accordingly. The skills, expertise and community knowledge of the Rural Generalist and rural General Practitioner should be recognised and respected and incorporated into all levels and stages of disaster and resilience planning and response.
2. The Commonwealth, States and Territories should seek rural medical input in the development of their strategic plans and disaster response management strategies. Input should include recognition of ACRRM and other key rural stakeholders and accommodate their participation in the development and evaluation of any disaster response policies and plans.
3. Rural communities should be supported to develop local disaster management programs including for the mobilisation and coordination of local health care teams.
4. Rural doctors should be trained and supported so they can effectively respond to emergency situations. This includes specific training programs and/or curricular for rural doctors and ongoing Continuing Professional Development.

[7] https://sandpiperaustralia.org/index.php/sandpiper-bag-contents/
[8] Importance of self-care and professional quality of life, Dr Nathan Castle, APS website Feb 2023 https://psychology.org.au/for-members/publications/inpsych/2021/november-issue-4/psychologists-wellbeing-in-the-workplace

5. A nationwide Rural Emergency Responders' Network should be developed to identify and document the location of rural doctors with advanced emergency response and retrieval skills to provide an additional level of community resilience in the face incidents such as multi-trauma and State/Territory or national disasters. These doctors should be appropriately equipped and supported.

College Details

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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.