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

College Submission
October 2022

Feedback on the NSW Regional Health Plan 2022-2032

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 face-to-face specialist and allied health services.

ACRRM has more than 5000 rural doctor members with1000 doctors in training, who live and work in rural, remote, and indigenous 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

The College welcomes the opportunity to provide feedback on the New South Wales Regional Health Plan.

As one of two professional Colleges recognised by the Australian Medical Council to provide vocational training towards Fellowship in the specialty of general practice, ACRRM's programs are specifically designed to provide its Fellows with the extended skills required to provide the highest quality care in rural and remote communities, which often suffer from a dearth of face-to-face specialist mental health services.

The ACRRM Fellowship (FACRRM) describes the professional skillset for the Rural Generalist model of practice. This is designed to train doctors with a broad and responsive skill set to provide the services that best fit the needs of their rural community.

"A Rural Generalist is a doctor who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care and required components of other medical specialty care in hospital and community settings as part of a rural healthcare team"[1]

ACRRM is encouraged to read that promoting Rural Generalism for doctors, nurses and allied health professionals is a key objective of the Plan. Given the important role of Rural Generalists, it is important that their input is considered at all stages of development of the Plan and the resultant implementation, monitoring, and evaluation frameworks.

General Comments

Further comments relating to each of the six strategic priority areas and key objectives:

1. Priority One

Strengthen the regional health workforce: *Build our regional workforce; provide career pathways for people to training and stay in the regions; attract and retain healthcare staff; address culture and psychological safety, physical safety, and racism in the workplace*

The Plan should aim to support the development of an appropriately skilled health workforce of sufficient size, which is suitably deployed to be able to meet the support and treatment requirements of patients at a time and in a way which best meets their needs. It is of paramount importance that the Plan specifically considers rural and remote perspectives and the unique needs and circumstances of people living and working in those communities, including health professionals.

Developing and supporting a skilled health workforce which can provide as many services as possible, as close to home as possible, with the local Rural Generalist/General Practitioner integral to the process, either as part of a team or via solo practice is key.

Promote Rural Generalism

ACRRM welcomes the first key objective in this priority area: Promoting rural generalism for allied health professionals, nurses, and doctors.

Our College supports doctors to become specialist General Practitioners (GPs) trained to work in the rural generalist model of practice. As such they are purpose-trained through the ACRRM Fellowship (FACRRM) to provide comprehensive primary care, secondary care, population and public health services and emergency care within the clinical context of rural and remote locations.

RGs and other GPs are often the only provider of medical services in rural and remote areas, and in areas where health services do exist, are often the first point of contact for patients. Rural and remote GPs work under unique circumstances and with a scope of practice and working environment which can be very different to urban practice. These doctors are often the only readily available health care practitioners and as such, they may need to take on a range of roles which would ordinarily fall to specialists, allied health professionals, or health care teams in larger areas.

[1] Collingrove definition of Rural Generalism 2018

These doctors work across a range of settings including clinics, to in hospital and facilities, and in emergency situations. They must be adequately funded and supported to continue to deliver these services across rural and remote New South Wales. Likewise, if they are to work to a broad scope of practice and meet as many community needs as possible, they must be supported by adequate facilities, infrastructure, and equipment.

These practitioners are critical to the successful implementation of the Plan in rural and remote areas, as they provide continuity of care for patients at all stages of their treatment and have the necessary skills and training to provide early intervention to those in need.

RGs and GPs are in a unique position to provide holistic care, crossing the siloes of primary, secondary, and tertiary health care and providing care across the illness spectrum and the lifespan, and working with an extended scope of practice in relatively low resource settings.

The Rural Generalist model is designed to train doctors with a broad and responsive skill set to provide the services that best fit the needs of their rural community. Collaborative healthcare team models are a cornerstone of this approach.

It is acknowledged that the training and practice of this workforce is inhibted due to the failure of employers and healthcare systems to appropriately recognise these doctors' training and credentials. Through the Rural Generalist Recognition Taskforce a joint application for recogntion of Rural Generalist Medicine as a specialised field within general practice has been made by ACRRM and RACGP in association with the National Rural Health Commissioner. The application has completed an initial assessment and will be subject to a national consultation as part of the second stage (detailed) assessment. The support of the New South Wales Government will be important in the national consultation and ulitmately in the success of this process and this should be recognised in the strategic plan.

The Federal government is also committed to establishing a supported career pathway for a range of rural generalist allied health practitioners able to take a rural generalist approach within their respective professional scopes. This will support important complementary workforce development to strengthen the efficacy of health care services built around rural generalist models of care.

Prioritise attraction and retention

The trend by state health departments toward increasing use of locum and FIFO workforces as well as telehealth services has been widely reported by our members and in a range of recent inquiries.[2] Locums and FIFO staff are paid at higher rates than permanent locally based staff and do not offer continuity of care or the out of hours or emergency response capacity of permanently based staff. It is important that the Workforce Strategy explicitly recognises the importance of systematically building strong and sustainable health systems within local communities and prioritising investment in solutions which provide long-term security to rural services over stopgaps.

Tailor career pathways for Aboriginal health staff

Recruitment, training, and support of more Aboriginal and Torres Strait Islander healthcare professionals is a component of the Close the Gap effort, and the Plan should aim to increase workforce numbers from this population. Engaging with the implementation of the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031* and the

[2] New South Wales Parliamentary Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales. https://www.parliament.nsw.gov.au/committees/inquiries/Pages/inquiry-details.aspx?pk=2615
And Tasmanian Legislative Council Rural Health Services Inquiry (2021)
https://www.parliament.tas.gov.au/ctee/Council/GovAdminA_RuralHealth.htm

corresponding Sector Strengthening Plan will be of importance to ensure alignment with both plans and collaboration/partnerships with Aboriginal and Torres Strait Islander peak bodies.

The contribution that ACRRM can make in building the rural and remote workforce, particularly the Aboriginal and Torres Strait Islander doctor workforce, and supporting these doctors to provide the best possible services to their patients should be considered.

ACRRM members have an important role in contributing to the care of Aboriginal and Torres Strait Islander peoples in Australia particularly those based in rural and remote areas.

It has been a founding principle of the College that advancing the health of Aboriginal and Torres Strait Islander peoples is inextricable from its essential purpose to improve the health of rural and remote communities. The College's curricula, standards and structures have all been designed to reflect this position. Most ACRRM members as remote and rural doctors have many Aboriginal and Torres Strait Islander peoples among their patients and over a hundred ACRRM members are working in the ACCHO sector. As doctors trained to work across community-based, hospital, and retrieval services they can provide an important point of continuity for Aboriginal and Torres Strait Islander peoples as they navigate these systems. We are also proud to say that increasing numbers of our Fellows and trainees are themselves Aboriginal and Torres Strait Islander peoples.

Expand training and upskilling opportunities

GP training places need to be fit for purpose and adequately funded. Rural Generalist practice reflects a scope of practice for primary health doctors which is essential to meeting the needs of rural communities and this requires to be recognised and funded through the primary training framework.

Our members welcome programs such as the New South Wales Rural Generalist Program and John Flynn Prevocational Doctor Program, however these programs require increased funding for expansion and the security of long-term funding.

It is also critical that RGs and rural GPs, particularly in under-served communities, can access the training they need to maintain and upgrade the skills they need to be able to continue to deliver high-quality care.

Rural GPs have significant needs in terms of training and upskilling and many struggle to meet these needs. The Strategy needs to address how GP's wishing to upskill or undertake training can access appropriate incentives, funding, and support to do so.

There is a need for structured programs to facilitate participation in training programs in larger centres, including funding and accommodation attached to these programs to allow GPs to access them. Alternatively, increased delivery of onsite training should be considered.

Nurture culture, psychological and physical safety

The College considers that protecting the health and wellbeing of our rural and remote health professionals needs to be robustly addressed in the Plan. Strategies should be designed to cover the following: improved workplace culture, reduction in bullying and discrimination, reduction in work overload, provision of adequate rest periods and breaks (and spaces/places in which to take those rests and breaks), and senior leaders setting the example by prioritising self-care as role models should all be built into the Plan.

The College recognises that the role of all healthcare professionals working within an overstretched system can be highly stressful. These issues are exacerbated through geographic isolation from professional colleagues and through the nature of rural communities which commonly involves practitioners having ongoing social relationships with patients and their families. Feedback from our members suggest that these issues are major causes of practitioner burn out and workforce attrition in rural communities.

Many of the factors which make rural communities attractive and rewarding places to live and work, are also those that can present the biggest challenges for health professionals. Rural health professionals are affected by the social and economic issues which impact on the communities in which they live and work. Like their counterparts in the wider community, they feel the economic and social impacts of vagrancies of climate and a reduced range of services.

In addition to their professional capacity, these people and their families are also community members who have several other roles within their community. They will meet their patients in a range of other capacities and the separation of roles can be difficult for both patient and practitioner and create another barrier to seeking treatment.

The College recognises the importance of practitioner health and wellbeing and is committed to caring for and supporting a rural and remote workforce which is geographically dispersed and often working in more challenging circumstances than their urban counterparts. It will continue to take a lead role in setting quality standards and develop innovative models of care to support practitioners at all stages of their career and enable them to 'thrive' in rural practice, however this Plan must contain the necessary policy levers to ensure that practitioner wellbeing is a focus across the health system.

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.

Enable and empower staff to work to their full potential

Sustainable, high functioning and reflexive multidisciplinary teams form when team members work effectively across their broadest scope of practice, skills and experience and are drawn together as a team with common purpose, governance structures and goals.[3]

All disciplines should aim to adopt a Rural Generalist approach to service delivery, including the identification of appropriate, safe scopes of practice whereby each practitioner can work to a broad scope of practice with a view to providing as much in-person continuous care as possible in the local setting and across as many disciplines as possible.

2. Priority Two

Enable better access to safe, high quality and timely health services: *improve transport and assistance schemes, deliver appropriate services in the community; continue to embed virtual care as an option to complement face-to-face care and to provide multidisciplinary support to clinicians in regional settings.*

Our members report that services such as oncology, palliative care, allied health, ambulance services and telehealth do not always accord with community need: issues which were also identified in a recent parliamentary Committee report.[4] More must be done to ensure that regardless of postcode, services can be viably run in rural, regional, and remote areas so residents can seek, access, and receive treatment in a timely and cost-effective manner.

Deliver appropriate services in the community

The College supports the principle that health services should be delivered by a skilled local workforce, supported by technology and comprehensive governance arrangements, to ensure that they are responsive to local needs and can be readily ramped up and down as needs change.

[3] Draft Ngayubah Gadan Statement Part 1, Page 4
[4] NSW Legislative Council Portfolio Committee No.2 Health outcomes and access to health and hospital services in rural, regional, and remote New South Wales, Findings 2,3 and 7

In rural and remote areas, this necessitates developing and supporting a skilled health workforce which can provide as many services as possible, as close to home as possible, with the local General Practitioner/Rural Generalist being integral to the process either as part of a team or working in solo practice. The provision of appropriate services for patients and support for practitioners and caregivers via telehealth and other mechanisms to complement face-to-face services are an important component of workforce support.

Leverage virtual care

The provision of appropriate services for patients and support for practitioners and caregivers via telehealth and other mechanisms to complement face-to-face services are an important component of workforce support, and when implemented alongside appropriate on-the-ground services, can provide additional access to services for rural and remote communities.

General practice telehealth, which is clearly linked to a continuous care relationship, has played an extremely important role in enabling triage, assessment and follow up of patients in rural and remote communities and it is important that it be supported to continue. Other models such as those involving the patients primary care doctors and their specialist consultant or the patient, their general practitioner and their remote care nurse have clear capacity to improve rural and remote mental health care. These should be supported by appropriate funding mechanisms.

3. Priority Three

Keep people healthy and well though prevention, early intervention, and education: *Prevent some of the most significant causes of poor health by working across government, community, and other organisations to tackle the social determinants of health; prepare and response to threats to population health.*

Address the social determinants of ill health

There is currently an estimated annual national health underspend on rural and remote Australians of around $2.1b arising from lack of access to services. This underspend reflects the money saved through an estimated 25 million health care services each year, that rural and remote people do not receive that they would be expected to receive if they lived in a city.[5]

There continues to be a reliance on locum and FIFO workforces in rural and remote areas. These staff are paid at higher rates than permanent locally based staff and may not offer the continuity of care or out of hours, emergency response capacity of permanently based staff. The National Rural Generalist pathway has the potential, if properly implemented, to address barriers such as lack of recognition and decrease reliance on FIFO workforces.

People living in rural and remote communities should have equitable access to high quality, safe and sustainable healthcare services. This requires a structured, systematic, and person-centred and team-based approach to service delivery which properly reflects the distinctions of the rural and remote clinical context. Improved integration of levels of care is especially important to improving healthcare for rural and remote communities that are geographically isolated from many secondary and tertiary care services and rely on collaboration to maximise local capacity.

[5] National Rural Health Alliance (2016). *The Extent of the Rural Health Deficit.* https://www.ruralhealth.org.au/sites/default/files/publications/fact-sheet-27-election2016-13-may-2016.pdf

Invest in mental health

Funding - in the view of the College, the current funding models do not adequately reflect the important role played by GPs and Rural Generalists in providing mental health services. These doctors may experience layers of financial disadvantage: they have limited access to subsidised courses (noting that mental health emergency training has now been approved under the Rural General Practice Procedural Grants Program); they earn less per hour, and the patients they manage generally experience high levels of disadvantage so GPs tend to bulk-bill these patients in order that they can access care. Despite this, GPs continue to provide mental health care in some of the most disadvantaged areas of Australia.

Feedback from College members indicates that the current Medicare Benefits Schedule (MBS) rebate structure for GP mental health consultations is completely inadequate and does not reflect either the degree of skill involved or remunerate effectively for the time taken for these consultations, which are often of a long and complex nature.

This poor rebate structure does not recognise the level of mental health services provided by rural and remote GPs, nor the circumstances under which they are delivered. It also means that they are less able to afford additional training and upskilling.

Given the disparity in access and the greater demand for services in rural and remote areas, the College recommends that more weight be given to allocating funding for these communities, with a priority given to supporting local services and training and supporting a local health workforce wherever possible.

Training - the ACRRM primary curriculum for registrar training is designed to equip them to deal with a wide range of patient presentations, including acute, non-acute, occupational, and preventative mental health presentations, and in rural and remote setting where limited resources and referral supports are available.

In addition to the extensive generalist training provided to all College registrars through the primary curriculum, each registrar must undertake an additional year of advanced specialised training (AST) with a choice of one of nine disciplines. Mental health is included as an AST option.

The Advanced Specialised Mental Health Training Curriculum sets out the advanced competencies required upon completion of an Advanced Specialised Training year in mental health. Following completion of this AST, registrars will have developed higher level diagnostic skills and greater competency in management of complex and chronic mental health conditions.

While this is a challenging AST, it is encouraging that there are increasing numbers of College Fellows with advanced skills in mental health who are working to fill a pressing community need.

The Rural and Remote Context - The Plan must therefore take cognisance of the differences between delivering mental health services in rural and remote settings, and in Aboriginal and Torres Strait Islander communities as compared to urban settings. The delivery of support and treatment, and who is best placed to deliver it can be different in the rural and remote context. Likewise, in defining the mental health workforce, it is important to note that the needs of Australians in rural and remote areas, and the barriers to accessing treatment for mental health disorders can differ from the urban experience.

Rural Generalists and General Practitioners are in a unique position to provide holistic care, crossing the siloes of mental health care and providing care across the illness spectrum and the lifespan, and working with an extended scope of practice.

Employment insecurity is a particular issue for rural and remote area mental health, with many State and Federally funded mental health programs being funded on an annual or contractual basis. This further hinders recruitment and retention of staff to mental health programs in rural and remote areas.

As previously outlined, Rural Generalist practitioners and especially those with advanced skills in mental health, will be in the best position to deliver and coordinate a range of services, especially in those

communities which lack the critical mass to employ a full health care team, including psychiatrists and mental health workers.

Invest in maternity care and early childhood

Over the past three decades, there has been a progressive decline in rural and remote maternity services and in particular, birthing services. With over 34,000 babies born each year in locations classified as outer regional, remote, and very remote, lack of access to appropriate services impacts women and their families. One of our members recently reported an instance where a pregnant woman in New South Wales had to travel over 400kms to have her baby delivered.

The loss of maternity services in rural towns has wider community impacts. It is usually associated with a progressive de-skilling of the medical workforce, a downgrading of facilities and overall level of services. Access to a wider range of healthcare services becomes poorer as a result.[6]

Promote early intervention and prevention

Supporting Australians to be physically well is no longer restricted to those experiencing ill-health, but also encompasses education, preventive measures, and early intervention to promote wellbeing, taking a proactive role in your own healthcare and assisting people at risk.

Literacy and consumer engagement initiatives must be designed to ensure they can be easily adapted to the rural and remote context. Health promotion and education activities need to be tailored to the specific needs of each community, particularly high-risk communities, and need to be culturally responsive and safe for those from Aboriginal and Torres Strait Islander or culturally and linguistically diverse backgrounds. The role of rural General Practitioners and Rural Generalists as leaders in rural and remote communities should be leveraged to ensure effective engagement.

Prevent, prepare for, respond to, and recover from the health impacts of epidemics, pandemics, natural disasters

Rural doctors are at the frontline of the emergency and disaster response in rural and remote areas. They are often called to assist the ambulance and retrieval services at the roadside; supervise transport to the local hospital; and stabilise the patient for retrieval. Many have on-call responsibilities to their local rural hospital. This local involvement is important and can save lives.

It is important that these rural doctors have the necessary training, skills, and support to be able to provide an effective response to a wide range of emergency situations.

Local support in emergency situations can be limited in rural and remote areas. Ambulance services may be available; however, many have limited staff or rely on volunteers with only Basic Life Support (BLS) skills. These services may also be constrained by staffing and fatigue issues. Metropolitan and regionally based emergency and retrieval services support rural areas. However, at times their response may be significantly delayed due to distance, weather, or other factors.

The role of the Rural Generalist/rural General Practitioner in pre-hospital emergency and disaster response needs to be formalised with the necessary policies and clinical management frameworks. Lack of rural GP involvement in formal coordination and communication networks can cause significant delays and fails to make the most effective use of valuable local knowledge and resources. The Plan should ensure that they key role of local health practitioner in disaster, emergency and epi/pandemics is recognised, factored into planning and utilised.

[6] ACRRM Position Statement Rural Maternity Services, November 2019

4. Priority Four

Keep communities informed, build engagement, seek feedback: *Provide more information to communities about what health services are available ad how to access them; empower the community to be involved in how health services are planned and delivered; increase responsiveness to patient experiences.*

Support culturally appropriate care and cultural safety

Service delivery models should be flexible and responsive to the needs of communities where they operate, and co-design of models with input from key partners and stakeholders across communities is welcomed. The Plan should recognise that tailored models may be required for rural and remote and Aboriginal and Torres Strait Islander communities. Services also need to be culturally responsive and safe for those from Aboriginal and Torres Strait Islander or culturally and linguistically diverse backgrounds. The role of Rural Generalists and rural General Practitioners as leaders in rural and remote communities should be leveraged to ensure effective engagement.

5. Priority Five

Expand integration of primary, community and hospital care: *Roll out effective, sustainable integrated models of care through collaboration between Federal and NSW Government to drive improved access, outcomes, and experiences.*

Address the employer model

Rural Generalists serve communities by being able to pivot between the hospital and the GP clinic to provide services. To gain this skill set they need to transition from hospital and general practice settings over their four to five years of training however, when trainees move between the two systems, they lose their workplace entitlements including parental leave. The Murrumbidgee Rural Generalist pilot program is one effective model that enables trainees to maintain entitlements by providing continuous employment. Under this arrangement, a collaboration between local GPs and health service, the health service as a single employer, salaries trainees through the duration of their Fellowship program.

Improve access and equity of services for Aboriginal people and communities

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

The disparities in the health status of Indigenous Australians and those of remote Australians are intertwined, and it is imperative that in addressing rural access that this includes providing access to culturally safe and responsive health care for Aboriginal and Torres Strait Islander peoples.

Therefore, the success of the Plan will be contingent on its interaction with the *National Agreement on Closing the Gap, National Medical Workforce Strategy*, *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031,* the *Primary Healthcare 10 Year Plan* and the *National Preventive Health Strategy*, coupled with adequate funding for services in rural and remote areas and the extent to which focus is centred on substantive, immediate intervention in support of rural healthcare.

6. Priority Six

Priority six: Harness and evaluate innovation to support a sustainable health system: *Continue to transform health services through aligned funding and resourcing models, digital and health technologies, research, and environmental solutions.*

Align funding and resourcing models

There is the need for a national approach to ensure all rural and remote communities are systematically supported by adequate funding and resourcing. Coordinated oversight at the national, regional, and local level, and a commitment to establishing benchmarks for minimum standards of access to primary and essential care for every Australian are key.

Accountability - there is need to establish a single point of accountability and a proactive approach to ensuring the provision of an acceptable minimum level of service to all isolated Australians. The division of service responsibilities enables situations where no tier of government accepts accountability for service provision. This has facilitated long-term deterioration of resourcing for rural and remote health services at all levels.

Coordinated and systematic approach - coordination across all levels of health systems is imperative, and especially important for rural and remote communities who rely on cross-sector collaboration to maximise local capacity. A systematic, proactive approach to ensuring all rural and remote communities are supported by adequate funding and resourcing should be adopted, alongside a commitment to cross-sector collaboration to maximise local capacity.

Minimum acceptable standards - ideally this would involve identification of minimum acceptable health service access standards across the diversity of models of care. This could build on the excellent work in this area by Wakerman, Humphreys and colleagues.[7]Data based on these models could be actively monitored, and communities at-risk of not meeting minimum standards could be identified, referred for action, and subject to ongoing higher-level monitoring.

Implement digital health investments

There are still areas of Australia where limited access to adequate internet bandwidth and mobile phone coverage are significant impairments to the delivery of telehealth services. These deficiencies should be addressed urgently as part of the broader digital health policy agenda. Significant and ongoing investment is required in programs such as the mobile blackspot and regional connectivity programs, to enable expansion of the mobile network and guarantee access to affordable voice and data services which meet minimum standards of reliability.

This is particularly important given the telehealth funding levers which support the use of video consultations.

Undertake research and evaluation

There is urgent need to develop better, nationally consistent health service data on the provision of primary care in rural and remote Australia. The three main sources of national data on rural medical workforces Bettering the Evaluation and Care or Heath (BEACH), Medicine in Australia – Balancing Employment and Life (MABEL), and the Rural Workforce Agencies (RWAs) National Minimum Datasets have all been discontinued. The Australian Institute of Health and Welfare (AIHW) data sets have significant gaps in rural and remote areas. PHN and RWA needs analyses are not nationally

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

consistent and of limited benefit for national benchmarking. Furthermore, less than three percent of National Health and Medical Research Council (NHMRC) grants funding was directed to rural health research projects of the ten years from 2005 to 2014. [8]

The development of evidence-based policy appropriate to rural community needs is not possible without an evidence base. In the absence of this, evidence of workforce models and approaches that have proved effective in urban settings is typically used as proxy evidence for programs implemented rurally often with negative outcomes. Furthermore, there is no reliable dataset to demonstrate program ineffectiveness across rural and remote communities. Appropriate national datasets should include establishment of benchmarks for minimum standards of access to primary and essential care for every Australian which could be used as a proactive planning tool to ensure maintenance of services across rural and remote Australia.

Commit to environmental sustainability footprint

The College believes that a key strategy in improving rural health outcomes involves providing as many services as possible, as close to home as possible. Urgent and priority action should be taken to improve access to a skilled and sustainable rural and remote primary healthcare workforce, acknowledging the specific challenges facing clinicians working in rural and remote communities.

The importance of the Rural Generalist approach should be recognised, and strategic work is required to support this as an enabler to innovative workforce models and workforce capacity building. Priority should be given to supporting local services and training and growing a local health workforce wherever possible.

The Plan should be developed, implemented, and evaluated in detailed consultation with representatives from rural practitioners, community representatives and stakeholders, and should include a 'rural and remote proofing' protocol.

[8] Barclay, L et al (2018), Rural and remote health research: Does the investment match the need? Aust. J. Rural Health, 26: 74-79. https://doi.org/10.1111/ajr.12429

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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.