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

College Submission
September 2022

Feedback on the Draft Victorian Health Workforce Strategy

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 with around1000 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 Victorian Health Workforce Strategy, and the commitment to "outlining an approach to long term workforce recovery, development and growth, and identifying immediate actions to support the health workforce now".[1]

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

[1] https://www.health.vic.gov.au/strategy-and-planning/health-workforce-strategy

quality care in rural and remote communities, which often suffer from a dearth of face-to-face specialist health services.

The ACRRM Fellowship (FACRRM) describes the professional skillset for the Rural Generalist (RG) 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" [2]

The Strategy 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 Victorians at a time and in a way which best meets their needs. It is of paramount importance that the Strategy specifically considers rural perspectives and the unique needs and circumstances of people living and working in those communities, including health professionals.

Given the important role of Rural Generalists (RGs), it is important that their input, along with the that of their communities, is considered at all stages of the development of the Strategy and the resultant implementation, monitoring, and evaluation frameworks.

General Comments

1. Workforce supply and distribution

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.

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.

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.[3] 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 stop-gaps.

Better access to an appropriately skilled and locally based primary care practitioners would moderate some of the need for patients and caregivers to travel to seek services, thus minimising resultant economic and social imposts.

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[2] Collingrove definition of Rural Generalism 2018
[3] 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

Evidence demonstrates that high quality primary care reduces hospital costs. There needs to be a focus in the Strategy on making primary health care sustainable.

Recommendation 1: the Strategy should recognise that urgent action is needed to address the lack of rural and remote health workforce. While long term planning is essential, this does not obviate the need for significant, immediate action to address the disparities in access to health services for rural and remote and Aboriginal and Torres Strait Islander communities across Victoria.

2. The Role of Rural Generalists in Health Service Delivery

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.

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 Victoria. 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 Strategy 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.

Recommendation 2: the Strategy should clearly identify the local General Practitioner/Rural Generalist as a key health professional in the continuum of care. Training, retaining, and supporting a locally-based, skilled and sustainable rural generalist workforce is the key to improving access to health services and consequently improving health outcomes for rural and remote Victorians.

3. Building the Generalist Capability of the Workforce

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.

Victoria has invested in a strong and mature Rural Generalist Program which facilitates and supports the training available from medical graduation through to Fellowship, and lines up a range of government programs to facilitate a seamless experience to a Rural Generalist career. The program has assisted our College's training program in Fellowing around 10 to 15 doctors each year as qualified RGs and GPs who provide broad scope services across rural Victoria.

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 Victorian 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.

Given these developments, the Strategy should recognise the importance of the rural generalist approach and strategic work to support this, as an enabler to innovative workforce models and workforce capacity building. There needs to be statewide recognition of RG's and rural and remote GPs as specialists.

Currently, each individual health service (around 80 in total) is at liberty to form their own opinion as to the role of the RG, whether they are classified as a "specialist" and how they are credentialled.

Statewide recognition would clearly delineate and identify the role of RGs within rural, remote, and regional health service delivery, and assist Hospital and Health Services in adopting the RG model and recognising its value. This could be achieved in a similar way to Queensland, Northern Territory and Tasmania.

Member comments:

"Health services need to be "told" from the top down that RG's are an important part of the medical workforce and they need to be treated as specialists. Currently because of the way RGs are contracted (as VMO) they sit outside the AMA specialist award meaning that health services can really treat them any way they want".

"RGs and GPs are still being told that they are "not specialists", yet we are a workforce solution. If the Department of Health and Aged Care recognised us then this would require Health Services to do so as well."

Recommendation 3: the Strategy should support the full implementation of the National Rural Generalist Pathway including specialist recognition of Rural Generalist Medicine and recognise the importance of the Rural Generalist approach and strategic work to support this, as an enabler to innovative workforce models and workforce capacity building.

Recommendation 4: the Strategy should recognise Fellowship qualifications for the Rural Generalist scope of practice as a basis for employment in hospitals. This could be done at a state or national level.

4. Workforce Wellbeing and Support

The College considers that protecting the health and wellbeing of our rural and remote health professionals needs to be robustly addressed in the Strategy. Members report having attended the recent consultation session on the wellbeing of the health workforce and being disappointed by the continued focus on resilience.

Whilst building resilience is important, this focus fails to tackle the root causes of the problem. Strategies to improve workplace culture, reduce bullying and discrimination, reduce work overload, provide adequate rest periods and breaks (and spaces/places in which to take those rests and breaks), and senior leaders prioritising self-care as role models should all be built into the strategy.

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 strategy 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.

Recommendation 5: the Strategy should address the specific challenges of working in rural and remote communities and the need for additional and tailored support programs and treatment access mechanisms for health professionals working in those environments.

5. Workforce Training and Skill Maintenance

Training **–** 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 Victorian Rural Generalist Program and John Flynn Prevocational Doctor Program, however these programs require increased funding for expansion and the security of long-term funding.

- Universities should be accountable for demonstrating long term rural outcomes, and not measured simply by the number of rural placements or rural internships they offer.
- Rural placements should be rural. In many cases, "rural" placements are in regional areas.
- There needs to be increased support for supervision capacity in primary care.
- There needs to be a framework that appropriately supports the more costly and arduous path that rural training presents for rural general practice and RGs. For example, the cost of supporting two rents during a rural placement can often be a barrier for many registrars.

Skill maintenance - it is 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 e.g., bringing Advanced Life Support and other courses to smaller towns, and allowing VMOs to participate.

Member feedback:

"When we asked our local health service if the GPs could attend the ALS day they were running, we were told no as the funding was only for nurses not VMOs. Yet the benefits of doing these courses on your own site with your own team is enormous."

Recommendation 6: designated state funding should be provided to enable and encourage RGs and rural and remote GPs to maintain and enhance their training and skills.

6. GP funding and employment models

The current rural workforce crisis reflects systemic failure over many years to build the value proposition for rural general practice including Rural Generalist practice as a well remunerated, supported, and reliable long-term career path and sustainable business model.

Primary care should provide essential healthcare services to all Victorians, however, in reality, the general practice sector, and particularly the rural general practice sector, is grossly underfunded.

This in turn impacts negatively on access to primary care for people living in rural communities, including Aboriginal and Torres Strait Islander people. Consequently, their health outcomes are poorer, with lack of primary care also resulting in higher treatment costs as conditions escalate to require secondary or tertiary care.

Innovative funding solutions: consideration should be given to providing public funding for private clinics in small towns when the private clinic is providing what would be a public funded service in a regional centre. Our members report the following example:

"Our clinic in Mt Beauty has been running a respiratory clinic in a demountable building. This is entirely self-funded at significant cost for PPE etc. When the clinic asked for some of the funding that the regional centre respiratory clinics were getting, we were told no and that we should be advising our patients to drive to the regional clinic. (Yes, we were told to tell our patients to drive a 2.5hour round trip while symptomatic with covid symptoms). So naturally our clinic does it anyway at either an out of pocket to us, or to the patient."

GP funding models - the method of employing doctors in small rural health services needs a complete rethink/overhaul:

- The current fee for service and funding doctors in Urgent Care through the MBS is not working and is unsustainable. It rewards elective procedural disciplines like anaesthetics yet provides no avenue for RGs with non-procedural skills to work across full scope in the public sector in small services.

  "How does an RG-Mental Health provide a mental health clinic in a small rural health service? They can't at present, there is no funding unless billing through MBS which is currently insufficient to cover the cost of the service."

- Salaried or sessional pay arrangements rather than fee for services are an attractive option and preference for many doctors. This is working well in some sites like Mansfield and Yarrawonga, yet the Department of Health and Aged Care is only funding this on a case-by-case basis. Some health services are requesting funds to set up similar programs and being refused.

- In many locations the VMO contract lies with a local GP clinic. This means that unless the doctor works at that clinic they have limited/no access to working at the hospital. This is unduly restrictive and an approach which maximises the options available to rural doctors will have far better outcomes in terms of rebuilding the rural workforce. There needs to be options at every site for doctors to be employed directly by the health service. The clinic could still be outsourced the roster, if necessary, but doctors should not be forced to work in a private setting to be able to work in a public hospital.

  "I know of doctors who live in a town but can't work at the hospital due to these arrangements as for various reasons they don't want to work at the local clinic yet are happy to work in Urgent Care or do on-call for the hospital."

- All health practitioners should be encouraged and supported to practice to a broad scope.

  "If we had more RIPEN nurses or nurse practitioners, then this would reduce the afterhours call burden on GP's. If RGs are allowed to practice full scope (e.g., ASTs funded employment options) then this reduces the need for visiting services etc. Current fee-for service does lead to "turf wars" in some places e.g., visiting specialists not wanting to let the local RG do the simpler procedures as the visiting specialist will lose money."

- Health services are outbidding each other in a locum war. High locum pay rates punish those who are committed to working locally.

  "Why would I be a poorly paid regular, if I could do exactly the same job and be paid high locum rates and get free accommodation and travel? We need to reward local staff too by paying them properly."

Diversified and Flexible Funding Sources – 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.

The College supports further consideration of innovative funding pools which also support the delivery of infrastructure and training; foster partnerships between a range of local and regional entities including local government; and maximise the potential of existing community skills, infrastructure, and resources.

Blended Funding Models - ACRRM supports the principle of blended funding models which provide supplementary funding sources to the Medicare system. This is particularly relevant for management of complex and chronic disease which is more prevalent in rural and remote areas, and which is currently underpaid and clearly undervalued compared with the income which can be generated by a high-volume throughput of patients.

Recommendation 7: the Strategy should review and implement funding models across all components of the health workforce and the important role played by GP's and Rural Generalists in providing health services.

Recommendation 8: General Practice funding models should be reviewed in consultation with rural and remote practitioners, to better support the delivery of health services in these communities.

7. Urgent Care Centres and Pre-hospital care

It is a core principle of the national health care system that every Australian irrespective of where they live should have free access to emergency medical care. State governments, through national funding arrangements, are delegated responsibility for ensuring this access.

The College understands that the vision for UCCs is in theory to make it easier for rural Victorians to see a doctor or nurse when they have an urgent, but non-life-threatening need for care. However, in the view of our members, the current UCC model in Victoria represents a fundamental abrogation of the State government's responsibility to provide this care free of charge to rural and remote Victorians.

The funding model also fails to appropriately acknowledge and remunerate the medical practitioners who are providing these services. It exacerbates the existing inequities in healthcare funding and access which are already experienced by rural Australians.

Member feedback:

"The inequalities across different sites are appalling. Why does Mt Buller provided a publicly funded medical centre to tourists, yet down the road in Mansfield locals have to pay to attend the urgent care centre. This is complete discrimination by location. Similarly, if you ski at Buller yet get free health care but have to pay at Hotham or Falls Creek."

"Rural has not benefited from the new state run after hours primary care centres. If anything, I think these new centres will encourage GPs to go and do a shift in them rather than do the on-call in their own town (more pay, set hours etc) potentially draining small towns of their doctors. Small town clinicals and hospitals are providing after hours services yet are not getting the funding to pay GPs properly. How about while also doing these clinics in regional centres, propping up small-town after-hours funding to match?"

In addition, our members report that pre-hospital care in Victoria is currently in chaos, quoting examples such as long wait times for ambulances:

"Our small-town ambulances get "stuck" in town either ramped at the hospital or re-deployed once in town. Often not returning for hours. Then when they do return staff have to take breaks and are not covered."

The Strategy needs to consider how local RGs and other trained staff such as rural nurses can be integrated into the pre-hospital system. Recent inquests into the Mallacoota bush fires and Kerang train accident both found that local GP services were overlooked yet could have been utilised in both disasters. GPs should be given a greater role in planning and responding to floods, fires, and other disasters.

The *GoodSAM* app[4] is an example which could be adapted to add a feature to the system to dispatch doctors, however a remuneration structure would need to be built into this service.

Our members also report that the Virtual Emergency Department (VED) is being disruptive in some rural areas:

"Ambos are told they have to call VED for advice, yet it would make more sense to be able to call the local on-call GP. For example, we had a covid patient call 000. VED determined that they needed antivirals and the VED doctor wrote a script on a weekend and told the patient's family member to drive 2.5hr round trip to go to the after-hours chemist in the regional centre to get the script. If the local GP was involved, they would have known that the medication was available at the local hospital for after-hours dispensing (10min trip). Plus, turns out that the medication prescribed by VED was contraindicated in that patient (GP knew this). Two days later the patient is transferred to the local regional centre with complications. All this could have been avoided if the ambos were allowed to call the local doctor. Why are they bypassing us when there is a local doctor available?"

Recommendation 9: the Victorian Government should review its approach to providing emergency care for people living in regional and rural areas of the State. The College would be happy to contribute to the development of alternative models of care that support affordable access to emergency care services and appropriately support the rural medical practitioners who are providing this care.

[4] https://www.ambulance.vic.gov.au/goodsam/

8. Telehealth

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.

Recommendation 10: the Strategy should specifically identify the complementary role of telehealth in the continuum of care, and designated funding should be provided for rural and remote area health telehealth services.

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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.