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

**College Submission**
June 2023

# Mid-term review of the National Health Reform Agreement (NHRA) Addendum 2020-25

## 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.

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

ACRRM welcomes the opportunity to provide feedback to the National Health Reform Agreement (NHRA) Addendum 2020-25 Mid-term Review (the review).

The NHRA aims to achieve a sustainable, connected, and equitable health system that delivers the best outcomes for Australians. Clause 18(4) of the NHRA states "*All Australians should have equitable access to high quality health care, including those living in regional and remote areas*".

Whilst the objectives of the Addendum are commendable, in reality the current funding arrangements are failing to deliver equitable access to care particularly for people living in rural, remote and Aboriginal and Torres Strait Islander communities.

There is an unacceptable burden of illness, injury and death experienced by rural and remote Australians. The burden of disease increases with remoteness and for people in very remote areas is 1.7 times that of people in cities.[1] The median age at death decreases with remoteness from 82 years for people in major cities to 69 years for people in very remote areas.[2]

Rural and remote Australians face unacceptable obstacles to accessing healthcare and there are clear indicators of the link between these barriers to access and poor health outcomes. People living in remote and very remote areas have respectively 1.7 and 2.5 times higher rates of potentially preventable hospitalisations and these rates increase with remoteness.[3]

The division of service responsibilities and funding arrangements has created a situation in rural and remote Australia where no tier of government has total accountability for ensuring service provision across the primary care and hospital sectors. This results in poor coordination and inefficient use of resources, leading to gaps in service delivery and frustration on the part of communities and the medical practitioners who work in them.

The NHRA would benefit from the rigorous application of a rural-proofing lens to ensure it is meeting its commitment to deliver the best outcomes for all Australians.

# Rural Generalism and the Rural & Remote Context

ACRRM 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 and emergency care, population and public health services within the clinical context of rural and remote locations.

Rural Generalists (RGs) are often the only providers 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. RGs 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.

They 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.

As such, many RGs often work under both state and territory and federal funding arrangements and sometimes also under funding arrangements in different states and territories. The discrepancies in these arrangements were highlighted during the COVID pandemic, when many RGs were subjected to a range of sometimes conflicting policies and funding arrangements from the Commonwealth and one or more state or territory.

**Rural Generalist Medicine and the National Rural Generalist Pathway**

ACRRM together with the Royal Australian College of General Practitioners (RACGP) has submitted a joint application to the Medical Board of Australia for recognition of Rural Generalist Medicine as a specialist field within general practice. This will provide a protected title and quality assure the training

[1] AIHW (2016) Australian Burden of Disease Study: impact and causes of illness and death in Australia 2011. Australian Burden of Disease Study series no. 3. BOD 4. Canberra.
[2] ABS (2017) *Labour force, Australia, detailed—electronic delivery, Dec. 2017*. ABS cat. no. 6291.0.55.001. Canberra.
[3] AIHW (2019) Admitted patient care 2017–18: Australian hospital statistics. Health services series no. 90. Cat. no. HSE 225. Canberra.

and skill set of RGs working across a broad spread of geographic locations and health facilities throughout Australia.

This recognition will remove some current roadblocks to training, skills certification, recruitment, employment and resource planning, together with a career pathway which ends with a recognised title and associated recognition.

These developments are associated with the National Rural Generalist Pathway concept which is identified as an action for implementation in the National Medical Workforce Strategy. This is overseen by the National Rural Generalist Strategic Council which includes a Jurisdiction Implementation subcommittee and includes the network of state and territory government funded Rural Generalist training coordination units in every jurisdiction.

With its key components of a supported training pathway and increased national recognition for the Rural Generalist model of practice, the National Rural Generalist Pathway has the potential to make a significant contribution to the sustainability of Australia's rural and remote medical workforce; minimise the reliability on locum services; and increase and the range of services which can be delivered safely and effectively in rural and remote areas.

To build a strong Rural Generalist network across rural and remote Australia will require not only a strong training pathway but strong local rural health and hospital services and employment opportunities for Rural Generalists in hospitals as well as in community-based clinics. It is important that the importance of these elements of the pathway are also recognised by the review.

# Response to Elements of Clause 21

We have responded to the elements of Clause 21 and factors arising since implementation of the Addendum, pertinent to the work of the College.

## a) Implementation of the long-term reforms and other governance and funding arrangements, and whether practice and policy in place delivers on the objectives of the NHRA and the Addendum

### Medical Workforce

***The College believes that there is potential for the NRHA to be more proactive in terms of addressing the current maldistribution of skills and location of the medical workforce, and in particular where funding and governance issues are barriers to rural and remote medical workforce recruitment and retention.***

There is need for urgent and significant action to support the nation's rural and remote health services. The general practice workforce is ageing, and a large proportion is approaching retirement with 15% aged over 65.[4] There is risk of rural service closures without generational transfer of their practices or their knowledge and skills. Without immediate action an irreversible loss of rural/remote workforce/capacity is likely to occur

Australia's overall doctor to population ratios is among the highest in the OECD and many areas of medical practice are in plentiful supply or even over-supply.[5] Maldistribution of the medical workforce

[4] Cth Dept of Health (2021) General Practice Workforce providing Primary Care services in Australia: 27 Sept 2021. Based on the National Medical Workforce Data Set.
[5] Cth Dept of Health (2021) National Medical Workforce Strategy: 2021-31 Investing in our medical workforce to meet Australia's health needs.

however, both in terms of location and specialisation, continues to result in pervasive workforce shortages across rural and remote Australia. These shortages are contributing to unacceptable inequities in terms of healthcare outcomes for the people affected by them.

***Addressing workforce maldistribution -*** Geographic maldistribution, the imbalance between specialist disciplines, subspecialisation and generalism and the need to move away from reliance on locums and international medical graduates are all documented in the National Medical Workforce Strategy 2021-2031. These issues persist despite increased domestic graduate numbers.

Australia's overall doctor to population ratios is among the highest in the OECD and many areas of medical practice are in plentiful supply or even over-supply.[6] Maldistribution of the medical workforce however, both in terms of location and specialisation, continues to result in pervasive workforce shortages across rural and remote Australia. In terms of the maldistribution of skills, Australia is now training more non-GP specialists than GPs and Rural Generalists. Studies based on the MABEL (Medicine in Australia: Balancing Employment and Life) dataset have found that Australian trained medical graduates today are less likely to work either as General Practitioners (GPs) or in rural communities compared to graduates of the 1970s and 1980s.[7]

Workforce shortages translate to longer patient wait times, lack of emergency care, and fragmentation of care as rural and remote communities are increasingly serviced by short-term, temporary or locum practitioners. Reliable healthcare services are a cornerstone to rural community resilience, and the loss of services, or loss of trust in service provision can lead to population loss which creates a downward spiral in terms of establishing sustainable local staff and resources.

ACRRM believes that the best health outcomes and efficient use of funding resources particularly for rural and remote communities, will be achieved by a shift in focus from the current reliance on consultant specialists and subspecialists to a greater focus on rural and regionally based RGs who can provide integrated primary, secondary and emergency care working in both GP clinics and hospitals as required by local patient need. Mechanisms to support this model of care are required at both the federal and state and territory levels, preferably through collaborative and coordinated arrangements.

The Distribution Priority Areas (DPA) scheme provides a recent example of changes to government policies having severe perverse impacts on rural workforce. The DPA program facilitates employment of International Medical Graduations (IMG) doctors in the most hard-to-recruit areas in MM3-7 by conferring exemptions to them to provide MBS billable services. To address relatively minor workforce shortages in MM2 and outer urban areas, the scheme was extended last year to support employment in these areas. Within a short space of time, this triggered significant movement of IMG doctors out of MM3-7 to take up positions in MM1-2 and has made it substantially harder to recruit to MM3-7 vacancies.[8]

The College would support the implementation of clear national benchmarking and workforce KPIs to monitor workforce maldistribution at the state and territory, and national level across both the primary care and hospital sectors.

***Funding the Rural and Remote Primary Care Medical Workforce -*** Rural and remote primary care requires a separate funding model which acknowledges the unique characteristics of non-urban contexts including teams-based care, and the broad practice scope and complex employment arrangements of Rural Generalists. In particular, it must be recognised by all jurisdictions that the

[6] Cth Dept of Health (2021) National Medical Workforce Strategy: 2021-31 Investing in our medical workforce to meet Australia's health needs.
[7] O'Sullivan, B., Russell, D.J., McGrail, M.R. *et al.* Reviewing reliance on overseas-trained doctors in rural Australia and planning for self-sufficiency: applying 10 years' MABEL evidence. *Hum Resour Health* **17**, 8 (2019). https://doi.org/10.1186/s12960-018-0339-z
[8] Sparke C (2023) '800 open job ads 'a sign of rural doctor crisis' *Australian Doctor.* 21 Feb 2023 https://www.ausdoc.com.au/news/800-open-job-ads-a-sign-of-rural-doctor-crisis

current rural and remote general practice funding models are inadequate in terms of sustainability and viability.

There has been a systemic failure 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. The general practice sector, and particularly the rural general practice sector in Australia, is grossly underfunded.

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***

***Visiting Medical Officer Funding Models –*** the College supports appropriately remunerated and supportive contractual and employment arrangements for the GP VMOs providing services to rural and remote hospitals and health care facilities. VMO arrangements should not rely on MBS billing to fund a heath service which the state is required to provide. In the view of the College, the employment arrangements for RGs working in small rural and remote health services requires a nationally coordinated review. This is particularly relevant given the current application to the MBA for the national recognition of Rural Generalism as a specialised field of general practice.

## Single Employer Models

Single Employer Models (SEMs), when appropriately designed, are a positive development toward building a strong Rural Generalist workforce. ACRRM is committed to progressing initiatives to implement appropriately designed SEMs and to contribute to their development and delivery at all stages, noting that they are not the only or whole solution to addressing workforce issues.

Rural Generalist registrars in particular, face challenges in attaining Fellowship which require bespoke solutions, given that RGs provide broad scope services to meet the needs of people without easy access to the specialised services available in cities. To attain this scope involves training in multiple workplaces and a longer and more complex training journey than that requisite for general practice Fellowship.

To incentivise the growth of this critical workforce, Rural Generalist registrars must have access to pay and conditions that recognise these circumstances and fairly reward their services. The SEM approach provides a mechanism for addressing a key disincentive to attaining the Rural Generalist scope of practice, namely the inability to accumulate job entitlements for the duration of training. It potentially has broader benefits such as streamlining training and contributing to better integrated patient care.

To be effective, SEM models must:

- Consider the longer-term imperatives for workforce development
- Include strong cooperation between participating doctors, practices, and health services in design and delivery
- Build in sufficient flexibility to be compatible with Rural Generalist training needs

- Involve ACRRM as part of the planning and roll out as the leading arbiter of professional standards for Rural Generalist training and practice.

The College supports SEMs as part of a range of employment options available to Rural Generalist registrars. However, there must be a range of options which are fit for purpose for the diversity of contexts in which Rural Generalist training occurs and the varied training journeys that Rural Generalists pursue**.**

To be effective, employment models for the training workforce must then be transferred to complementary frameworks in which careers in rural practice beyond Fellowship can also be appropriately remunerated and incentivised.

## Urgent Care Centres (UCCs)

The introduction of Urgent Care Centres (UCCs) at both the state and territory and Commonwealth levels, provides another example of the failure of the NRHA to support equity of access to health care services and inadequate funding for RGs working under some jurisdictional arrangements.

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 intent UCCs is to make it easier for patients to see a doctor or nurse when they have an urgent, but non-life-threatening need for care. However, UCCs at both the Commonwealth and state and territory levels, operate under a range of different funding models.

For example:

- The model referred to as “Urgent Care” in the Australian Capital Territory involves the Centres and their staff being wholly funded through the territory government, with staff being paid on salaried arrangements.
- An Urgent Care Centre in Queensland would be referred to as a small state government owned Rural Hospital Emergency Department, where all facilities and equipment and staff salaries would be paid through the state funding arrangements.
- The Victorian Health Department’s UCC model involves the Centres functioning as Emergency Medicine Departments with facilities and equipment being funded by the state. However, staff salaries are not funded by the state and must either be paid through patient billing to MBS or charging patients privately.

The situation is further complicated by the federal government commitment of $358.5 million over 5 years to fund 58 Medicare-funded Urgent Care Centres

Of particular concern to the College, is that some states base some rural and remote emergency services on an MBS billing arrangement. This requires the treating practitioner who is usually and RG or specialist GP, working under Visiting Medical Officer (VMO) arrangements to bill the presenting patients. This requires presenting patients to pay a gap fee or the providing practitioner not being adequately remunerated by accepting the MBS rebate, given that it is widely accepted that MBS does not reflect the essential costs of medical care.

This is a systematic framework which results in people living in rural and remote areas receiving less funding support for their emergency care than their counterparts in cities. Given the estimated $4 billion national underspend on people in rural and remote areas due to their lower use of government funded health services that already exists, this inequity is particularly unacceptable.

It is also worth noting that these inequities for people living in rural and remote areas are exacerbated and that private health cover is also not available to support them in accessing the services provided by these Centres. Ambulance cover is also charged to patients, and many choose to drive themselves often at considerable personal risks as the costs may be prohibitive or to use services run by volunteers who are themselves members of the local community.

***ACRRM recommends that the review reconsiders its approach to providing emergency care for people living in rural and remote areas. 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.***

## b) The impact of external factors on the demand for hospital services and the flow-on effects on Addendum parameters

**Ageing population**
The population is ageing and people are living longer, with a resultant increase in demand for a wider range of both primary and secondary care and associated challenges in service design, funding, and delivery. Over one in four Australians in the aged care target population live in rural or remote communities, and there are fewer aged care services in rural and remote Australia than in metropolitan regions.[9] Compared with rural areas, people who use residential aged care in remote areas tend to be younger and comprise a greater proportion of men and Aboriginal and Torres Strait Islander people.[10]

Aged care is critically important for rural and remote communities and an integral part of rural and remote medical practice. Rural Generalist doctors are involved in the full spectrum of aged care – through general practice-based primary care, home visits, nursing home attendances, secondary care in the local hospital, coordination of team-based care and referrals, support for family and carers, and palliative care.

The optimum model of aged care is to enable the elderly to continue to live within their community where they can be supported by family and their wider networks and receive ongoing, coordinated, and collaborative care from a well-trained, skilled and supported health care team led by their local medical practitioner. Patients benefit the most from a lifelong relationship with a "usual GP".
The Addendum must consider how it will manage the projected increase in hospitalisations from an ageing population and provide tailored solutions to support rural and remote older Australians[11].

***Funding for rural and remote aged care services and facilities must be cognisant of the rural and remote context and circumstances in which these services are provided. Funding models would benefit from greater flexibility to enable these communities to make the most effective use of locally available resources and tailor services to meet local needs. This includes supporting multi-purpose services and recognising the role of small rural hospitals in catering for long-stay aged care patients.***

[9] AIHW Factsheet Aged Care in Rural and Remote Areas Factsheet 2020 https://www.gen-agedcaredata.gov.au/www_aihwgen/media/2020-factsheets-and-infographics/Aged-care-in-rural-and-remote-areas-factsheet_2020.pdf?ext=.pdf
[10] Ibid.
[11] ACRRM Position Statement, Rural and Remote Aged Care Services May 2022 https://www.acrrm.org.au/docs/default-source/all-files/college-position-statement---rural-and-remote-aged-care-services.pdf?sfvrsn=6eda3b3_4

**Mental Health**

Australians living in rural and remote areas are impacted by mental disorders at the same rate as people living in major cities, however research shows that suicide and self- harm rates are higher, with residents of very remote areas twice as likely to die from suicide as city residents.[12]

Rural and remote Australians experience several unique barriers to receiving care. Poor service availability and access means rural and remote health services are less able to intervene in response to signs of known risk factors, with the consequence that suicide rates are significantly higher than those in major cities.[13] They are less likely to access MBS funded primary mental healthcare services than their city counterparts, yet more likely to utilise state and territory funded community mental health services. They are also more likely to present to an emergency department with a mental health concern, and in remote and very remote areas, more likely to be admitted to hospital for a mental health problem.[14]

The lack of coordination between federal and state and territory funded services leads to a disjointed mental health system which is confusing for both patients and practitioners to navigate.

The College notes and supports the Productivity Commission statement that "*Services should be delivered by a skilled 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 mental 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 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.

Rural Generalists with an AST in mental health can lead the development of unique and innovate models of mental health care which are appropriate for rural community needs and contexts. This includes the current and future challenges of natural disasters, pandemics and extreme seasonal conditions which are becoming increasingly prevalent. Models of care can be based on collaboration with other available health care professionals including allied health workers and Nurse Practitioners, to support the evolution of services to prepare for, and meet challenges as they emerge.

[12] Bishop, Ransom, Laverty and Gale, *Mental Health in Rural and Remote Communities*, Royal Flying Doctor Service, March 2017)
[13] Ibid.
[14] National Rural Health Alliance Partyline Issue 81 *Mental Health in Rural Australia*, December 2022

***The review should leverage the existing role of RGs in rural and remote communities to facilitate better access to locally-based primary mental health care. The development of innovative service delivery models, which are flexible and responsive to the needs of the communities where they operate, and co-design of models with input from key partners and stakeholders across communities will be key to avoiding a "one size fits all" approach.***

## c) For small rural and regional hospitals, whether they continue to meet the block funding criteria determined by the Independent Health and Aged Care Pricing Authority (IHACPA)

Rural hospitals continue to face significant challenges to service provision, including higher running costs, increased reliance on costly locum services, and the continuing impact of natural disasters, including fires, flooding, and drought.

Block funding arrangements have failed to keep up with the actual cost of providing services in rural hospitals, together with increased accreditation and compliance costs. Being based on past activity, they have failed to accommodate situational change or facilitate readiness to meet future trends, including increased public health demands. This is particularly significant in regions which have seen a significant population influx post-COVID.

Workforce constraints in smaller regional and rural hospitals often results in the full demand for services not being met and patients either being forced to travel to other facilities, or to forgo care. This in turn means that demand is not accurately captured to inform funding. This results in discriminatory and compromised funding models.

Place based models must be supported by equitable funding, and robust, equitable collaboration between state and territory and federal governments to address funding gaps.

### Training, Teaching and Research

***Training and teaching -*** There is an increasing body of research which identifies rural-and-regionally based training as a determining factor in whether a medical student/junior doctor will progress to a rural medical career; and a key component of the proposed National Rural Generalist Pathway is a coordinated training pathway with provides a seamless transition from medical school, through prevocational training and finally to Fellowship and beyond.

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. They also face uncertainty and lack of security as they transfer from one workplace training setting to another during their training journey. The Single Employment Model is one initiative which aims to address these issues.

Funding for, and allocation of hospital placements for RG trainees is problematic from a number of perspectives. Block funding arrangements do not necessarily support training placements, or funding is not appropriately used for this purpose. RG trainees who require hospital placements to complete their Advanced Skills Training are often in competition with trainees from other non-GP specialities who may be funding through the Specialist Training Program or other initiatives.

RG trainees undertaking their AST terms should not be disadvantaged as is often currently the case, by a system which disproportionately advantages non-RG trainees.

The College supports flexible and coordinated funding models for teaching and training which provide strong personal and professional support for both trainees and supervisors; adequate resources to both hospital and community settings; strong collaboration between other services such as allied

health, pharmacy and nursing; and where programs can be tailored to the needs and circumstances of communities and the health care facilities within those communities.

This may include innovations such as a revised approach to 19.2 exemption arrangements so that 19.2 exemptions are tied to the registrar in rural and remote locations, rather than assigned to a specific practice or facility.

***Research –*** The College contents that, in addition to teaching and supervision, support for a strong academic and research agenda is an essential support to sustainable rural generalist practice. However, there are currently no KPIs or reporting requirements within block funding agreements which require rural hospitals to invest in this area.

There is an urgent need to provide robust and equitable levels of funding to promote rurally relevant research, data collection and benchmarking, particularly with the increased recognition of rural generalism as the preferred model of service delivery in rural and remote areas. This will promote and sustain the RG model and the delivery of appropriate care to rural and remote and Aboriginal and Torres Strait Islander communities more broadly.

Initiatives which ensure an accountable, equitable distribution of the teaching, training and research funding pool to regional and rural hospitals are needed to underpin sustainable RG and GP training.

Once again, applying a rural-proofing lens to policy would reflect a broader range of settings of health care delivery, and allow for a focus on the wide range of appropriate learning experiences. Distributed teaching and research models, which are not only focused in urban centres, are required.

**General Practice Training**

***Australian General Practice Training*** - the Commonwealth Government currently supports GP training predominantly through the Australian General Practice Training (AGPT) program and the smaller Remote Vocational Training Scheme (RVTS). AGPT training has been managed directly by the two GP Colleges under College-led Training since February 2023.

ACRRM currently receives additional funding for up to 400 places per year for four years under its Rural Generalist Training Scheme (RGTS) and the College also autonomously delivers self-funded, AMC accredited training through its Independent Pathway.

***Training places -*** Government policies currently limit the capacity of the College to continue to grow its number of registrars. Under current arrangements, ACRRM continues to be capped at 10% of GP places through the Australian General Practice Training Program (AGPT).

This is in spite of the fact that GPs are the only Australian medical specialists currently becoming more urbanised.[15] Over 80% of ACRRM-trained GPs remain rural, but of 1600 annual AGPT funded registrar places, ACRRM is capped at 150, which is then divided into regional quotas.

These restrictions are a deterrent to many registrars applying to join the ACRRM program, due to perceived competition for training places.

The College has strong support for its Independent Pathway training which is self-funded and independent of the AGPT and also through the Rural Generalist Training Scheme (RGTS) where this is strong interest in spite of the general downturn in GP registrar numbers.

With the implementation of the new training arrangements and consequent transition to College-led training, there is an opportunity to review the current funding arrangements so that funding allows the

[15] Scott, A.(2021) ANZ- Melbourne Institute: Health Sector Report. The Evolution of the Medical Workforce

College to broaden and consolidate its training footprint in support of the current and future rural and remote medical workforce.

## d) Whether any perverse consequences such as cost shifting, perverse incentives or other inefficiencies that impact on patient outcomes have arisen, and the capacity of the Parties to adopt and deliver innovative models, as a result of financial or other arrangements in the Addendum

There can be a lack of overarching authority at the jurisdictions level to translate state-level strategic commitments to on-the-ground operational outcomes and conversely to ensure state funding frameworks are sufficient to meet local needs. Over time, this sees the erosion of rural services.

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, together with 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. The Addendum needs to adopt a robust approach to addressing these accountability issues, otherwise, the deterioration of rural services will continue.

***Coordinated and a 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.[16]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.

## e) The performance of the national bodies against their role, functions and abilities

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.

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

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

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 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.[17]

***A framework defining minimum acceptable standards for service provision and appropriate national datasets should be developed, including 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.***

# Impact from factors since the Addendum came into effect

## The COVID-19 pandemic, including the response to the pandemic and ongoing implications for the health service

Even before the pandemic, access to medical and healthcare services was a critical issue for rural and remote Australians. Those living outside metropolitan areas experience poorer health outcomes, often having shorter lives and higher incidence of disease. This placed people living in rural and remote areas at greater risk of health complications arising from COVID 19.

The impact of the pandemic was more severely felt in rural and remote practices, where the local practitioners and health care teams were solely responsible for the provision of screening, treatment and vaccination services. Health professionals were called on to take additional responsibilities including establishing and maintaining federally funded GP Respiratory Clinics in addition to their normal daily workload and areas of operation.

***Coordination and Communication –*** the differing rights, responsibilities and policies between the Commonwealth and states and territories, resulted in sometimes conflicting approaches. Once again, rural practitioners and practices tended to be more severely impacted, given that these doctors often work in both the public (funded by states and territories) and private (funded by the Commonwealth) settings and often across a number of facilities, including Residential Aged Care Facilities.

***Vaccination Rollout -*** the College was one of several peak medical organisations who were regularly consulted by the Commonwealth Department of Health regarding the rollout of the COVID vaccination. This provided ACRRM with the opportunity to highlight issues pertaining to the rural and remote context and the challenges of vaccination distribution in rural and remote communities.

There were widespread concerns, particularly in the early stages of the vaccination program, that many rural and remote areas lagged behind their urban counterparts regarding vaccination rates. In some instances, vaccines were diverted from rural and remote areas to larger COVID 'hotspots'. With larger percentages of metro populations vaccinated, state-wide targets were not always representative of the situation in our most vulnerable rural and remote communities.

Of particular concern was the decision of the Commonwealth Department of Health to delegate responsibility for the administration of vaccines in rural and remote residential aged care facilities (RACFs) to a number of private entities. This did not always lead to best results in rural and remote communities. Feedback from communities and practitioners indicates that there was limited communication and advance warning of the vaccination visits in some areas; that those who were

[17] 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

administering the vaccine had little understanding or appreciation of the issues and circumstances; and that because of the limited nature of the requirements; many opportunities to vaccinate other community members (including facility staff) were missed.

***Public education and media campaigns -*** initially, governments at all levels failed to coordinate an effective public education campaign and messaging conducive to instilling confidence in the general population towards vaccination. Lack of, inconsistent, or poorly considered and targeted messaging from state/territory and federal governments led to confusion, and in some areas, complacency, surrounding the vaccination decision-making process. Historians have declared the vaccine rollout "the worst public policy failure in modern Australian history.[18] The program was significantly challenged by differences in policies and approaches from the Commonwealth and states and territories and lack of communication and coordination between these jurisdictions.

While there were a number of other factors initially impacting on public confidence in the vaccines and vaccination process, this would have been considerably improved by a more professional and coordinated campaign initially, including campaigns targeted at Aboriginal and Torres Strait Islander and migrant and refugee communications.

# Summary of ACRRM Recommendations

1. ***NRHA to be more proactive in terms of addressing the current maldistribution of skills and location of the medical workforce, and in particular where funding and governance issues are barriers to rural and remote medical workforce recruitment and retention***

2. ***Facilitate innovative funding pools which 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.***

3. ***Redesign the approach to providing emergency care for people living in rural and remote areas through alternative models of care that support affordable access to emergency care services and appropriately remunerate the rural medical practitioners who are providing this care. Fund rural and remote aged care services and facilities cognisant of the rural and remote context and circumstances in which these services are provided.***

4. ***Funding models would benefit from greater flexibility to enable these communities to make the most effective use of locally available resources and tailor services to meet local needs. This includes supporting multi-purpose services and recognising the role of small rural hospitals in catering for long-stay aged care patients.***

5. ***Leverage the existing role of RGs in rural and remote communities to facilitate better access to locally-based primary mental health care. The development of innovative service delivery models, which are flexible and responsive to the needs of the communities where they operate, and co-design of models with input from key partners and stakeholders across communities will be key to avoiding a "one size fits all" approach.***

6. ***Develop a framework defining minimum acceptable standards for service provision and appropriate national datasets, including 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.***

[18] Bongiorno, Frank – "A little jab now and then" Inside Story 9 July 2021

# 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.***