Australian Health Ministers' Advisory Council

RURAL HEALTH STANDING COMMITTEE

Development of a National Strategic Framework for Rural and Remote Health

Template for written submissions

Thank you for requesting the template to make a written submission. As the covering email suggests, please save this document on your system with a title that includes your own name. This document is set up as a Word document with boxes that will expand to fit your content. When you have completed your submission, please attach it to an email addressed to melissa.williams@sigginsmiller.com.au. Alternatively, you can print it and post it, attention Melissa Williams, PO Box 1143, Kenmore Queensland, 4069.

The due date for written submissions is Friday, 19th March, 2010.

Project background

The Rural Health Standing Committee (RHSC) was established under Australian Health Ministers' Advisory Council (AHMAC) to provide advice on, and guidance to progress, national issues relating to improving health services in rural, regional and remote Australia. Membership of the RHSC comprises the Australian Government, and the governments of all states, the Northern Territory and New Zealand.

To progress national policy directions related to rural health, the RHSC identified the need to develop a new strategic approach for improving the health of rural, regional and remote Australians. This new strategic approach will replace *Healthy Horizons: A Framework for Improving the Health of Rural and Remote Australians. Outlook 2003-2007 ('Healthy Horizons 2003-2007')*.

In January 2009, AHMAC approved the development of a National Strategic Framework by the RHSC that will:

- define an agreed vision and direction for rural health;
- define an agreed set of national rural health priorities, reflecting common issues and challenges across jurisdictions;
- set out an agreed work program for the RHSC to support the new Framework;
- align with the timetable and directions of the national health reform agenda and process; and
- align with state and territory initiatives in regard to rural and remote health.

Objectives of the project

The project involves the development of a new National Strategic Framework for Rural and Remote Health. Once endorsed by AHMAC the framework will assist the Commonwealth, state and territory governments to improve:

- Access to health services
- Health outcomes in rural and remote communities
- Collaboration and integrated planning
- Flexibility of service delivery to better meet the needs of the community.

Project Team

Siggins Miller have been engaged by the Australian Government on behalf of the RHSC to undertake work including stakeholder consultations to inform the development of a National Strategic Framework for Rural and Remote Health.

Key themes for National Strategic Framework

To ensure the new national strategic framework targets activity towards the most urgent and pressing priorities for rural and remote health in the next five years, the RHSC has agreed to focus the overarching framework document on six key themes, including eight service priority areas. The National Strategic Framework will be developed around these themes.

The six agreed themes are:

1. Access
2. Service Models
3. Health Workforce
4. Sustainability
5. Collaborative Planning and Policy Development
6. Service Priorities are:
    - Maternity services
    - Aboriginal and Torres Strait Islander health
    - Emergency care
    - Health promotion and prevention
    - Chronic disease management
    - Drugs and alcohol
    - Mental health
    - Oral health

The written submission

In this written submission, we invite you to comment on aspects of the above-mentioned key themes.

We also welcome your comments on any other issues and any other suggestions you may wish to register.

Please note that we do not expect that everyone will want to make a comment on all themes and priority areas, so please feel free to comment only on those issues that are of interest to you or for which you have particular observations or suggestions.

Stakeholder details

To help us understand the views expressed through your written submission, we need to gather some basic information about you or your organisation (if you are responding as a representative). This will allow summary information to be presented to the RHSC about who has responded via a written submission.

If you are responding as an individual, none of the information requested will allow you to be identified. If you are responding on behalf of an organisation, we do invite you to provide us with details of your organisation so that summary information can be prepared on the range of stakeholder rural and remote health organisations that have responded via a written submission. This is the same process that will be followed in the face-to-face consultations for the development of the strategic framework.

Please complete the following:

In what capacity are you providing this written submission? (please tick or cross)

As an individual	
On behalf of your organisation	✓
Other (please specify)	

Name of stakeholder / organisation making this submission:

The Royal Australasian College of Physicians.

The Royal Australasian College of Physicians (RACP or 'the College') is a Fellowship of more than 10,500 specialist physicians and 4,600 trainees who practise in more than 25 medical specialties including paediatrics, cardiology, respiratory medicine, general medicine, neurology, oncology, public health medicine, occupational and environmental medicine, rehabilitation medicine, palliative medicine, sexual health medicine and addiction medicine. The College works to establish and achieve the highest standards of contemporary knowledge and skill in the practice of medicine and promote the health and well being of the community, and of its members. The College, in collaboration with affiliated Specialty Societies, is the provider of frameworks and standards of education for specialist physicians and trainees. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the well-being of patients.

The RACP governance structure includes Expert Advisory Groups in Aboriginal and Torres Strait Islander Health, Rural Health and Workforce, all of which have contributed to this submission. In addition, a number of past policies and submissions by the College have been drawn on in preparing this paper. These are available on the College website, here.

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Stakeholder interests

My comments or interests particularly concern the following in the rural and remote health context (please tick or cross those that apply):

Aboriginal health services	✓	**Health Promotion and Prevention services**	✓

Allied health services	✓	**Health Workforce**	✓
Ambulance services	✓	**Hospital services**	✓
Aged persons health services	✓	**Maternity services**	
Child and adolescent health services	✓	**Mental Health Services**	
Chronic Disease services	✓	**Non government health services**	
Consumers/carers		**Nursing Services**	
Dental Services		**Other medical practitioners**	✓
Drugs and Alcohol Services	✓	**Primary care**	✓
General Practitioners		**Rural and Remote Health (general)**	✓

Other comments: (please specify):

Points not addressed in the submission template:

- Commonwealth taking over outpatient costs (GPs) only – not for specialist services
- Specialist chronic disease management – the majority is undertaken on an ambulatory basis
- The *National Health and Hospitals Network* for Australia's Future (release by the Commonwealth early March 2010) and the crossover with this proposed strategy

Stakeholder Comments – Key themes

1. Rural and Remote Health (General)

For each section below, please include:

- Any comments and suggestions;
- Examples of good practice
- Case studies and/or evidence of activities that have not succeeded and any lessons learned.

1.1 Access

Access to care is dependent on the strength and dynamism of the health care service. Specialist care is a fundamental component of the health system, and access to this service is as vital in rural and remote regions as it is in metropolitan areas.

However, there is a well documented and dramatic decrease in the number of specialist services outside metropolitan areas. The decrease of specialist services in rural areas is positively correlated to a higher burden of disease and poorer health outcomes in these regions.

The current health reforms are predominantly centric to primary care and hospitals. The College recommends that strategic planning and resources should also be allocated to ambulatory and community health services.

Allocation of resources, infrastructure and funding should be allocated via logical geographical clusters and population catchments rather than by State and Territory boundaries.

There are many instances where, for rural and remote health, the most logical place of care is within another state. For example, it makes more sense for people in parts of eastern Western Australia to travel to Alice Springs than to travel to Perth.

For many Indigenous communities, there are travel and trade routes with natural linkages to centres that are not within the State. These must take precedence as appropriate relocation centres for health care over

those dictated by state boundaries. An example of this is in Central Australia where many patients from the border areas of South Australia and Western Australia will prefer to have treatment (e.g. renal dialysis) in Central Australia than in their own state.

These issues and many more may be addressed in the National Health and Hospital Reform Commission changes.

1.2 Service models

Optimal service models and the subsequent health outcomes of individuals, families and communities can vary. Establishing a rapport within a community and developing a relationship built on trust between clinician and patient takes time.

The College advocates for the establishment of regional centres of excellence to foster growth in the rural health sector. To ensure adequate training and education, specialist trainees require more than one specialist clinician to undertake their supervision. The College supports a service model framed on a commitment to a critical mass of three or more specialists in the rural/remote area. This allows a tenable roster to run and gives clinicians capacity for things inside and outside the job that satisfy their professional interests and benefit the local community, such as clinical research or community work. A reasonable roster, most importantly, guarantees adequate training and supervision of trainees and as such promotes ongoing sustainability of regional services.

The College supports team based specialist medical care. General Practitioners (GPs), allied health and specialist nurses play a vital role in the delivery of medical services; to provide specialist outreach consultations in the absence of these types of coordinating, follow up, rehabilitation and other support services may enhance access to a service per se, but outcomes are not necessarily improved.[1]

Successful service model examples:

Kimberley region service model

A unique model which has retained a stable paediatric staff team for almost five years

Currently the Kimberley has a group of four core clinicians working part-time in alternate time blocks (4 – 6 week rotations). In addition to the core clinicians, three or four regular locum clinicians work for short periods over the year to provide relief to the principle clinicians.

This model supports a sustainable health workforce and ensures that the primary clinicians do not suffer from burn out or the feeling of isolation.

Benefits also include:

- several clinicians with different areas of interest/expertise and a greater ability to share knowledge amongst the team
- increased opportunity to access and provide peer support/mentoring
- relief from on-call duties
- ability to establish regular outreach services and develop relationships within small towns and communities via other health workers and families
- Due to the rotating roster, clinicians have opportunities to pursue their own interests, including continuing professional development

The above model has strengthened relationships in towns and communities compared with previous models, and retained a stable team of clinicians for almost five years which is an anomaly in the Kimberley region.

[1] Gruen R, et al (2003) Specialist outreach clinics in primary care and rural hospital settings. Cochrane Database of Systematic Reviews, Issue 4. Art. No.: CD003798.

Cairns/Darwin

Many large regional centres have been able to develop a specialist physician workforce by attracting and retaining a workforce who have worked as generalists as well as sub-specialists. Cairns and Darwin are examples of this. Key components of the success have been: a critical mass of physicians, maintaining a strong emphasis on general medicine whilst developing sub-specialist services, developing registrar training programs. Both have been able to develop successful outreach programs. This underlines the benefits of dual trained physicians (general plus another speciality) to supply services to regional communities and the need to expand the training of this type of physician.

Unsuccessful service model example:

Mount Isa

Mount Isa has been unable to retain a specialist physician workforce and is dependant on international medical graduates (IMGs) and locums. A key reason for this has been an unwillingness to commit to a critical mass of physicians. On call ratios of one in one or one in two are unsustainable and lead to burn out and loss of staff. With no physicians with the FRACP qualification, the hospital can not be accredited for specialist training and so can not have rotating registrars.

1.3 Health workforce

It is essential that State and Federal Governments, all Colleges and tertiary hospitals commit to facilitating and supporting rural training. This is further addressed in section 1.5.

To encourage an increase in the rural and remote workforce the following proposals/future models should be considered:

- Implementing and supporting small core medical teams of clinicians to undertake 2-6 week rotations in rural and remote areas. This would be more effective in terms of community access, availability of services, and sustainability for clinicians. The current model (a one day fly-in visit from a visiting specialist from a tertiary hospital) does not encourage or build on current relationships between community and the health service.
- Additional salaried specialist positions in rural/remote areas.
- The financial incentives/resource funding would be allocated to the following areas:
    - Income support to ensure an incentive to rural practice and to reward tenure;
    - Additional funding for professional and personal development;
    - Relocation allowances;
    - Training scholarships for rural placements;
    - Subsidised child care;
    - Infrastructure e.g. for training and research.
    - Schooling for children,
    - Ensuring ability to get time off for Continuing Professional Development or holidays,
- Ensuring a critical mass of specialist clinicians in a regional area per population capita will not only encourage recruitment to regional areas, but to ensure long-term retention of these health professionals.
- Establishing social support networks for all rural and remote health professionals, particularly in terms of training and professional development, which may include a mentor scheme, online social network and the utilisation of training/professional development via videoconference (this is further addressed in section 1.5).

- Introducing a minimum income guarantee (via Medical Specialist Outreach Assistance Program or similar) for a non-salaried position to undertake outreach services in remote areas. This model would be useful in a clinic where patient influx is unpredictable, depending on local circumstances of the community.
- Encouraging the next generation of specialist clinicians to work in rural and remote areas. There are a large number of medical postgraduates who will pursue training positions in the very near future. The current training constructs; including the placement, resources and funding available require reassessment to facilitate training in rural areas.
- Establishment of clear financial incentives, similar to those currently offered to GP registrars training in rural areas will improve the prospects of long-term rural training and rotations of specialist registrars.
- Improving remuneration for generalist specialists. The relative value of the complex consultations and medical work undertaken by this group is not reflected in the Medicare schedule.
- Improving employment and accommodation conditions for rural/remote specialist clinicians will provide positive reinforcement and feedback to specialist trainees, and thus encouraging trainees to work in rural and remote areas. It is a disincentive for any trainee to be involved in placements or rural training where they are unable to find suitable accommodation, or where they are left to pay what can be expensive rural rents while concurrently paying rent or a mortgage at their primary location.
- Encouraging flexible employment contracts to facilitate employment retention and job satisfaction. For instance: The employment of health professionals on a 0.8FTE contract. Where there is the option to work 5 days a week and get paid for 4 days, and thus "purchasing" one day's extra annual leave each week, allowing for 16 weeks leave per year. Promoting this model encourages retention of the current workforce; as generally the five weeks of leave per year in a remote setting is not sustainable. This employment model successfully functions in the Kimberley region where the majority of the specialist clinicians have negotiated this arrangement.

1.4 Sustainability

Sustainability depends on having adequate personnel to ensure adequate on call arrangements, time for CPD, recreational activities and down time. As the extent of isolation increases so does the likelihood of required time away from practice. Where there is not enough local staff they must be supported by staff on a fly in fly out model. Ideally this should be done in an ongoing rather than ad hoc manner.

In reference to the Kimberley service model (section 1.2), there is an aspiration to coordinate staff from tertiary hospitals based in Perth, with a core group of clinicians from Perth to be based in the Kimberley region on a rotation basis throughout the course of a year. Consequently this model will not only consolidate the existing relationship between paediatricians and families, but also develop straightforward access to subspecialty services currently unavailable to these families/patients.

Primary benefits of a rotating roster:

- Firstly, drawing from the above (1.3); implementing a rotating roster for specialist clinicians who are reluctant to leave larger communities/metropolitan areas for a rural/remote setting, may prevent the need to relocate entire families or disrupt employment of partners/children's education or similar commitments. This structure would enable a wider group of specialist clinicians and specialist trainees to undertake rural/remote employment and training.
- Secondly, the patients and community will be treated consistently from the same group of specialist clinicians. Continuity of care is paramount, particularly in some Indigenous communities where clinical rapport can take more than one visit to foster and cultural competence of the clinician is honed locally, distinct to that community.

1.5 Collaborative planning and policy development

At present specialist clinicians are not eligible for the incentives offered to their GP counterparts. For instance, specialists are not entitled to relocation grants and/or practice incentive payments. However, specialists confront the same increased costs of rural/remote practices compared with metropolitan services.

As outlined in section 1.3, resource incentives are crucial to encouraging clinicians and trainees to seek employment in rural and remote areas as GPs.

For some years training has focussed on the major metropolitan centres. Although there are limitations to the conclusions that can be drawn,[2] a number of observational studies point to the fact positive rural and remote experiences in early years of training lead to doctors that are more inclined to return to provide services in those communities.[3,4]

Therefore the College promotes the inclusion of trainee specialists in the delivery of outreach services.

Whilst the College supports training in rural areas, it is important to ensure this is a positive experience such that the trainee is more inclined to consider working in a rural/regional practice as a result of the attachment.

Several factors are required to ensure these experiences are positive:

- Infrastructure, in terms of accommodation and online capabilities and hardware for teleconferencing.
- Training support. This includes appropriate level of supervision and oversight, ready access to consultants for advice, access to online delivery of training series and lectures, links to ground rounds at major tertiary centres and regular consulting with other specialists and/or medical education officers.
- A supported roster for teaching staff to enable adequate time off for specialists and trainees - a medical service cannot run with only one physician - at least three or four are required to sustain a service. Ongoing continuing education of the supervisors is also required to ensure they are adequately up-skilled and supported.

Example: Cairns base hospital endocrinology training
Cairns base hospital has had 3 of 4 endocrinology registrars return to establish themselves in Cairns as physicians. Anecdotally, this has been accredited to their positive experiences in during their training term in Cairns.

Example: Remote supervision
A number of examples of successful training via remote supervision are beginning to emerge:
In the Northern Territory, in recognition of the fact there is no Addiction Medicine specialist , but the highest rates of substance abuse, a remote training program has been established whereby a supervisor sees the trainee at least once a month formally, and more frequently (no less than weekly) via phone or Telelink.

Utilising technology:

The College has developed and supported the use of videoconferencing for training and education of specialist clinicians. Below are successful examples:

- Physician Education Program (45 per year) is videoconferenced to almost 80 sites and to 600 trainees across Australia and New Zealand.
  Currently, New South Wales and Victorian sites are funded by their state health jurisdictions.

[2] Grobler L et al (2009), Interventions for increasing the proportion of health professionals practising in rural and other underserved areas, Cochrane Database of Systematic Reviews, Issue 1. Art. No.: CD005314. DOI: 10.1002/14651858.CD005314.pub2.
[3] Woloschuk W &Tarrant M (2002) Does a rural education experience influence students' likelihood of rural practice? Impact of Student background and gender. Medical Education; 36:241- 7.
[4] Hodges B et al (2006), Factors predicting practice location and outreach consultations amongst University of Torronto psychiatry graduates, Canadian Journal of Psychiatry; 41(4):218-25.

The College advocates that other State and Territories should fund the delivery of this program to ensure equity of access to all specialist clinicians and trainees.

- The Rural Child Health Training Module has been formulated and is in operation in Victoria to ensure ongoing mentoring and online support to rural trainees. Ultimately this training program aims to change the experience of rural rotation among trainees. This module endeavours to change pessimistic perspectives and encourage trainees to have rural training as a priority when undertaking placements.

  There are two components to the Module:

  (1) Initial three day face-to-face meeting of trainees. Consists of hands on training

  (2) 20 x weekly 90 minute seminars delivered via GTH Events videoconference

The College also runs the following programs:

- Continuing education programs are quarterly and remote sites pay a fee of $210 + GST for videoconferencing set up and administration costs per site.
  The program covers updates in twelve specialties per year developed to further continued professional development of Fellows. The program can also be accessed by trainees.

- The Victorian Paediatric Further Education and Training Program (Vic FEAT) provides updates in various aspects of Paediatric Medicine in Victoria. There are five Vic FEAT programs per year, which are aimed at General Paediatricians, Paediatric Trainees and any other interested Fellows and healthcare professionals. Twenty regional sites and ten metropolitan sites are funded to join this program. Additional sites are $200+GST per site per event.

2. Maternity Services

For each section below, please include:

- Any comments and suggestions;
- Examples of good practice
- Case studies and/or evidence of activities that have not succeeded and any lessons learned.

Good maternal care also involves access to a physician with expertise in obstetric medicine and diseases of pregnancy. Currently these services are often not available in rural areas.

3. Aboriginal and Torres Strait Islander Health

For each section below, please include:

- Any comments and suggestions;
- Examples of good practice
- Case studies and/or evidence of activities that have not succeeded and any lessons learned.

3.1 Access

There are well known pressures for rural and remote people attempting to access health services (section 1 above, and section 6 below). For Indigenous Australians the following additional pressures apply, including:

- adverse socioeconomic conditions compared with non-Indigenous Australians, i.e. lower incomes and poorer educational outcomes;

- poor housing and infrastructure;
- high exposure to violence; and
- increased exposure to 'life stressors', e.g. death of close friends or family members, overcrowding, alcohol and other drug problems, serious illness and disability, long-term unemployment.[5]

Cultural issues

A recent study of a health service[6] indentified reasons for non-attendance at traditional medical services:

- No Aboriginal persons working within the centre
- Aboriginal people perceived staff as unfriendly and uncaring
- Staff took a patronising approach with patients ("make you feel shamed")
- Staff body language could be interpreted by Aboriginal people as unwelcoming
- Aboriginal people were treated poorly at reception e.g.: "Why are you coming in at 4.30 pm, we close at 5.00pm. Go home and come back tomorrow"
- Staff showed low tolerance to Indigenous child behaviour "keep them quiet"
- Long waiting times to see doctors
- There is "nothing" at the centre that Aboriginal people can identify with.

Reasons for attendance included:

- Convenience of location
- Satisfaction with doctors and staff

Aboriginal and Torres Strait Islander people will access mainstream health services if community consultation and participation is undertaken in forming and running that service, as described below.

Structural system issues

In addition to the issues above which are largely cultural, for rural and remote regions there is difficulty in providing specialist services on referral to those communities where there is no GP to provide the referral. The College encourages extending referral rights to physician assistants, nurses or health workers where there is no resident GP.

3.2 Service models

There is a need to look beyond traditional clinical solutions to resolve the poor health outcomes of Indigenous Australians.

The health service example above, the Inala Indigenous Health Service (IIHS), implemented a successful strategy to increase Indigenous access to the service. The suburb of Inala is a low socio-economic area with significant public housing, cultural diversity and a high proportion of Indigenous peoples. Approximately 8% (1063) of the total Inala population (13 284) is Indigenous, however, in 1994 only 12 patients were identified as Indigenous at the service. Today approximately 3,500 Indigenous clients are registered and 1,200 doctor consultations are completed monthly.

[5] Australian Institute of Health and Welfare. Chronic diseases and associated risk factors in Australia, 2006. Canberra2006 Contract No.: cat. no. PHE 81.

[6] Hayman NE, White NE, Spurling GK, Improving Indigenous patients' access to mainstream health services: the Inala; *MJA* 2009; 190 (10): 604-606.

Six basic strategies were employed to ensure improvement in access by the local Indigenous population:

Strategy 1
To employ Aboriginal or Torres Straight peoples as nurses, Aboriginal or Torres Straight Islander Health Workers, receptionists or liaison persons.

Strategy 2
To purchase culturally appropriate health posters and artifacts for the centre to help make Aboriginal and Torres Straight Islanders people "feel more at home". Also play Aboriginal radio "AAA Murri Country" on occasions. This will enable Aboriginal and Torres Straight Islander people to identify with the centre.

Strategy 3
To provide cultural awareness talks to all staff within the centre.

Strategy 4
To disseminate information into the Aboriginal and Torres Strait Islander community about what services are available.

Strategy 5
To promote intersectoral collaboration with local Indigenous business, health services and land councils.

Strategy 6 – Financial viability
In 2006 the IIHS was allowed to operate with an exemption from section 19(2) of the *Health Act 1973*. Bulk billing money has enabled the service to employ extra staff, including two doctors, two nurses and two administrative positions. In 2007, in conjunction with refurbishment of the general practice, the IIHS has moved to a stand-alone clinic with four consulting rooms, a large procedural area with two beds for minor operations and emergencies and a large non-clinical area for community-based staff. In the same timeframe, utilisation of Indigenous health checks and chronic disease Medicare item numbers contributed significantly to the employment of an extra doctor and registered nurse.[7]

The IIHS analysed 413 health checks using Medicare item 710. The study showed that the health check is a viable vehicle for evaluating health status, identifying chronic disease risk factors and for implementing preventive health care[8]. The IIHS has improved significantly the outcomes for all 11 indicators. For example, the average HbA1c for all diabetic patients was 9.6% in 2006-07 and 7.9% in 2008-09. This reduction is highly significant in reducing diabetes complications and cost to the community. Ninety percent of all diabetics had a HbA1c completed in the last six months compared to 44 percent nationally. Just over 90% of all diabetics had a blood pressure taken in the last six months. Only 25.3% of diabetic patients reached target blood pressure in 2006-07, this improved to over 50% in 2008-09.

This example is just one example of health services around the country that have shown how Indigenous partnerships combined with realistic investment in infrastructure, finance, data collection and cultural competence can make inroads to improving local Indigenous health outcomes.

Outreach

For rural and remote areas, the system is heavily reliant on the Medical Specialist Outreach Assistance Program (MSOAP) to deliver specialist services.

MSOAP is a valuable program through which many dedicated practitioners provide care to people that would otherwise never see medical professionals. It is, however, in dire need of better coordination. There has been at least one review of the MSOAP program that has made recommendations for reform. The Commonwealth has not released or commented on these recommendations.

A number of other factors have repeatedly been called for, which include the following:

- Outreach measures should focus on models that enhance regional health network building and capacity of local (and future) health practitioners. Hub and spoke models and backfilling of regional specialists are the preferred models. Hub and spoke promotes regional specialist capacity and service development rather than the 'fly in fly out' (FIFO) model of discrete instances of care.

Coordination of care for a chronic disease patient needs to be done locally, with the local GP (or nurse) being the centrepiece, working collaboratively with local or regionally based specialists.

- Regionally based specialists need to be supported, and their numbers increased in favour of flying people in from bigger centres. FIFO specialists should backfill regional specialists where possible to allow regional specialists to provide an outreach service. This relieves the local medical workforce so they may foster the development of networks in their region. The existence of these clinical networks enhances the experience of rural and regional practitioners, leading to greater likelihood of workforce retention. Pure FIFO services will remain important ways to provide access to specialist services for some communities. Where possible FIFO services should be on rotation, with regular visits by the same staff to enhance continuity (as at 1.4 above).
- Trainee medical staff should be able to participate in the program. This requires funding to the service that releases them for outreach work so to that they may be back-filled.
- The program should be complemented by significant investment in health technology and communications. For example, if the program allowed funding for nurses to train in performing certain tests, these results could be provided to specialist teams before they arrive to ensure they see those patients that require care upon arrival. Technology can also be used for follow up care and training with the local health team/nurse.
- Training and resourcing remote service delivery centres (capacity building) is essential. Community health service providers and facilities need to be adequately resourced and trained to plan and deliver specialist care. This includes access to appropriate infrastructure and information systems.

3.3 Health workforce

Colleges need to be supported to ensure that trainees develop cultural competency, but also that those existing Fellows are culturally competent themselves, in order to teach and assess those coming after them. Programs that provide Specialty Training through funded rotations to the Aboriginal Community Controlled Health Organisations and other culturally safe primary care facilities with a high Indigenous patient load should be expanded. This requires not only funding the training in these settings, but all the other aspects that facilitate training – such as:

- Incentives for specialist practice in these settings. General Practice and allied health have been heavily subsidised to provide certain Indigenous and chronic disease services through the Medicare system and this should be complemented by incentives for specialist intervention where required. Where specialist services go, training can follow.
- Ensuring there is adequate infrastructure for the community primary care centres to accommodate sessional specialist consulting, in terms of rooms, equipment and information systems. For the trainee, housing (or secondment accommodation) should be supported.
- Capacity building for administrative staff training to adequately plan support specialist service delivery in the community.
- See comments above about supervision etc

3.4 Sustainability

Systematic and sustained approaches combining prevention, primary and specialist care are needed to make lasting improvements to health in Indigenous communities. Programs must be long-term and complemented with follow up, education (of patients and clinicians), surveillance, funding, infrastructure, and staffing. Cessation of these features over time leads to a commensurate scaling back in any improved clinical outcomes.[7]

[7] Hoy, W et al (2005), *Clinical outcomes associated with changes in a chronic disease treatment program in an Australian Aboriginal community*, MJA 2005; 183(6):305-309.

Extra efforts in Indigenous health services, particularly specialist care, have sometimes been typified by ad hoc approaches. For example, the current MSOAP program runs on annual rounds, which means that there are sometimes gaps of up to six months in service delivery to some communities while application processes are completed. Funding has also been capped and has not allowed growth of services to meet need. Short term funding cycles with periodic uncertainty over ongoing funding do not facilitate sustained efforts to improve the health of a community. To ensure rural training posts are consistently filled they need long term investment that requires ongoing and consistent funding.

In addition, health measures must be accompanied by investment in education, housing, and increased rates of employment in order to achieve improved health literacy and sustained health improvement.

3.5 Collaborative planning and policy development

The most important aspect of policy development for Aboriginal and Torres Strait Islander Health is the need for involvement of Aboriginal people in decision making processes. A top down approach of imposed measures will not nurture the capacity of communities to reach and maintain acceptable levels of wellbeing, as evidenced recently in the Health Impact Assessment of the Northern Territory Intervention.[8]

Whilst the current Government has invested significant funding in Aboriginal and Torres Strait Islander Health and has made commitments to close the life expectancy gap between Indigenous and non-Indigenous Australians by 2030 and halve the infant mortality rate in 10 years, no long term plan exists with targets to achieve this.

The RACP, with other peak human rights and health agencies[9] has called for:

- A comprehensive, long-term plan of action, that is targeted to need, evidence-based and capable of addressing the existing inequalities in health services, in order to achieve equality of health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non- Indigenous Australians by 2030; and

- Ensuring the full participation of Aboriginal and Torres Strait Islander peoples and their representative bodies in all aspects of addressing their health needs. It is important that these programs are developed in partnership with Aboriginal in Torres Strait Islander people and are either controlled by Aboriginal and Torres Strait Islander people or include a plan for increasing ownership.

A full report is available here.

4. Emergency Care

For each section below, please include:

- Any comments and suggestions;
- Examples of good practice
- Case studies and/or evidence of activities that have not succeeded and any lessons learned.

4.1 Access

4.2 Service models

[8] Australian Indigenous Doctors' Association and Centre for Health Equity Training, Research and Evaluation, UNSW. Health Impact Assessment of the Northern Territory Emergency Response. Canberra: Australian Indigenous Doctors' Association, 2010.
[9] Shadow Report, Close the Gap Steering Committee for Indigenous Health Equality in February 2010

4.3 Health workforce

4.4 Sustainability

4.5 Collaborative planning and policy development

5. Health Promotion and Prevention

For each section below, please include:

- Any comments and suggestions;
- Examples of good practice
- Case studies and/or evidence of activities that have not succeeded and any lessons learned.

5.1 Access

The College provides training to its physicians to reduce the burden of chronic disease through the promotion of healthier lifestyles, particularly in relation to the prevention, identification and management of conditions associated with:

- obesity,
- excessive consumption of alcohol, and
- tobacco use

However, Australia's current fee for service funding arrangements do not support preventive health interventions at the point of service, nor does health funding prioritise prevention of disease sufficiently.

5.2 Service models

The College has outlined its own policies on chronic disease management and prevention in our submissions to the National Preventative Health Taskforce and the National Health and Hospital Reform Commission (available at www.racp.edu.au). These include how to address modifiable risk factors for chronic disease, focusing on interventions to combat obesity, tobacco use and harmful consumption of alcohol.

The establishment of the National Preventative Health Agency is essential to coordination and investment in preventative health services and strategies in Australia.

5.3 Health workforce

Unlike other medical specialties, there are limited funded training places for specialist training in Public Health (a few are becoming available in an ad-hoc fashion through the Specialty Training Program).

5.4 Sustainability

There is evidence that a drop off in public awareness or health literacy occurs when public education campaigns cease, e.g. when anti-smoking campaigns cease, a rise in smoking rates can be seen. Preventive health efforts must be sustained over the long term.

5.5 Collaborative planning and policy development

The College strongly supports evidence based interventions which directly impact on health literacy. There is a strong association between an individual's health related decisions and their level of education and literacy skills. According to the results of the Adult Literacy and Life Skills Survey[10], conducted by the Australian Bureau of Statistics, only 41% of Australians achieved skill level 3 and above – the level regarded as the 'minimum required' for individuals to meet the complex demands of everyday life and work in the emerging knowledge-based economy.[11] Around one-fifth (19%) of adults only had Level 1 health literacy skills, with a further 40% having Level 2. These people had difficulty with tasks such as locating information on a bottle of medicine about the maximum number of days the medicine could be taken, or drawing a line on a container indicating where one-third would be (based on other information on the container). Health literacy levels in Australia appear to further decrease after the age of 39, with 83% of those aged 65 to 74 not achieving Level 3 or above on the health literacy scale.

6. Chronic Disease Management

For each section below, please include:

- Any comments and suggestions;
- Examples of good practice
- Case studies and/or evidence of activities that have not succeeded and any lessons learned.

6.1 Access

Factors related to increased chronic disease occurrence and mortality in rural and remote locations include:

- socioeconomic disadvantages (including lower incomes and education levels)
- geographic isolation and attendant difficulties with access to health care
- shortage of health care providers and services
- greater exposure to injury
- greater difficulties in transport and communications
- sparsely distributed populations leading to diseconomies of scale.

Additional factors concerning general Rural and Remote Health are addressed in section 1, and Aboriginal and Torres Strait Islanders specifics are addressed at section 3 above.

Access examples of chronic disease patients – Queensland (excerpt from the RACP Submission to the Inquiry of the Social Development Committee of the Queensland Parliament on Chronic Disease in Queensland, August 2009. Available at www.racp.edu.au)

A key problem in Queensland is the poor access to services among for those in rural and remote communities, where a widely dispersed population means that often people are unable to access the best treatment for their chronic conditions. Chronic disease management funding and programs must be developed with consideration of such locational disadvantages. The situation in South West Queensland is a good example of this issue. The South West Health Service District covers an area of 320,000 km, with a population of 26,000, and has the following access to physicians in terms of management of chronic conditions:

[10] Australian Bureau of Statistics. Health Literacy, Australia. Canberra2006 Contract No.: 4233.0.

[11] Statistics Canada and OECD. Learning a Living: First Results from the Adult Literacy and Life Skills Survey. Ottawa and Paris2005.

Rheumatoid Arthritis

No rheumatologists visit South West Queensland. The nearest to this area is in Toowoomba (120km west of Brisbane), which patients from the South West may have to travel hundreds of kilometres to attend (Charleville is some 600km west of Toowoomba) even just to obtain biological agents for their arthritis.

Cardiovascular Disease

Most specialist cardiology services to remote communities are through the Commonwealth funded Medical Specialist Outreach Support Program (MSOAP). The College fully supports MSOAP, but feel it is limited by a lack of planning, funding, and needs analysis, leaving most of Queensland (Cape York is the exception) with patchy and unsatisfactory coverage.

Diabetes

Specialist diabetes services to the whole of South West Queensland are dependent on one private General Physician / Diabetologist (who is currently close to retirement) funded through MSOAP.

Oncology

There is minimal ability to access Medical Oncology services in South West Queensland. Roma hospital is the only hospital administering chemotherapy for an area the size of Victoria.

General

There are only three general physicians who visit the communities South West of Toowoomba, all of which are based in either Toowoomba or Rockhampton, a considerable distance from many communities.

6.2 Service models

Currently, primary care is heavily supported to provide chronic disease services through general practice, nurse practitioner and allied health funding. (e.g. through the Enhanced Primary Care or Practice Incentive Payments programs: see Allied Health items (Medicare items 813000 to 81360), Aboriginal and Torres Strait Islander – Health checks for children, adults and older persons (Medicare item 717), Chronic Disease Management (Medicare items 721 and 723), Health Kids Check (Medicare items 709 and 711), More Allied Health Services program, Cervical Cancer Incentive Payments (Medicare items 73053, 73055 and 73057) etc.)

Whilst the primary carer is the essential point of coordination and front line and ongoing management, specialist physicians act as leaders, educators and coordinators in the field of chronic disease.

They produce and provide the seminal clinical guidelines for chronic disease care.[12] The progressive nature of chronic disease and the associated increase in complexity in its management demands continuity of care, and specialist care.

Medicare data shows the converse relationship between lower access to specialist services in the Northern Territory and poorer health outcomes for those with chronic conditions.

[12] www.carpa.org.au.

Requested MBS category by group and subgroup processed from July 2008 to June 2009

1 Professional Attendances		State							
		NSW	VIC	QLD	SA	WA	TAS	ACT	NT
		Services per 100,000 population	Services per 100,000 population	Services per 100,000 population	Services per 100,000 population	Services per 100,000 population	Services per 100,000 population	Services per 100,000 population	Services per 100,000 population
A4 Consultant Physician (other than Psychiatry)	**1 No subgroup**	44,809	48,318	35,298	46,191	25,694	34,151	30,843	11,851
A28 Geriatric Medicine	**1 No subgroup**	98	41	18	78	24	11	57	1

RACP supports incentives for rural and remote areas to have functioning specialist services, as above (section 1.3).

Successful service model example:

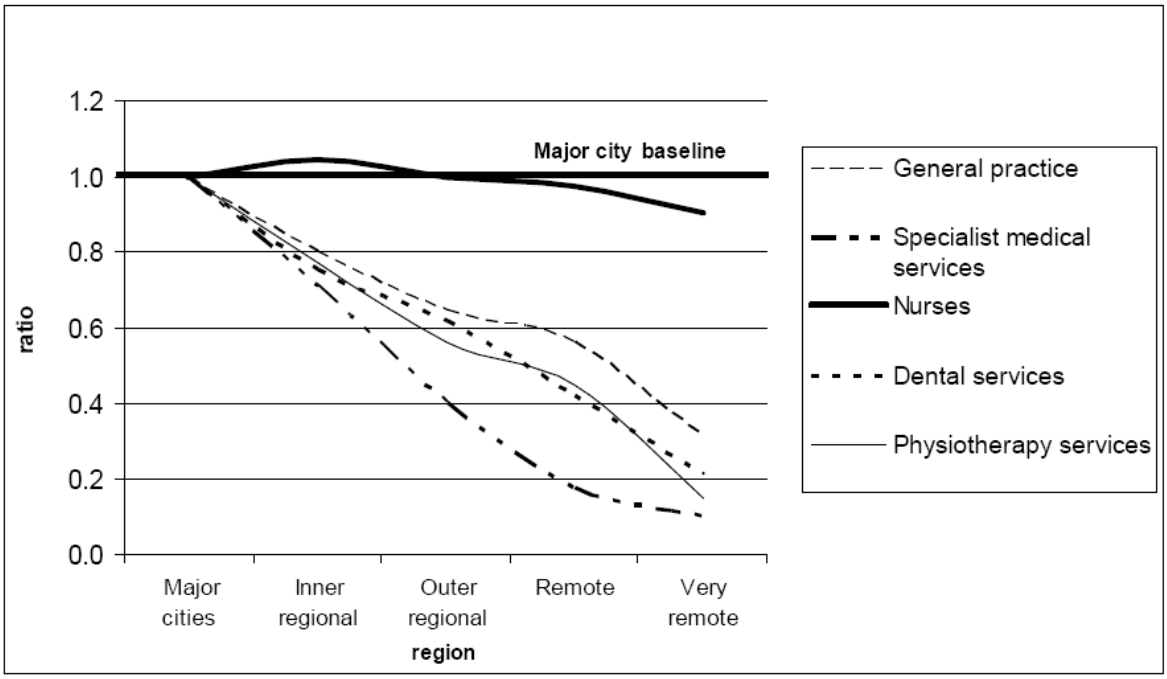
Specialist clinician residing in Broome, delivering outreach services

Specialist clinician residing in Broome, delivering outreach services throughout the Kimberley region to five hospitals, four Aboriginal Health Services and ten remote communities. This is a predominantly community based service; inpatient care on a day to day basis is not possible with only one specialist clinician. A minimum of four specialists would be required in order to maintain an inpatient unit at Broome Regional Hospital, thus at present this is an unsuccessful component of this model. Further drawbacks to the model are most locations require more frequent visits than the one specialist can provide.

Unsuccessful service model examples:
Less successful models of care are those rotating out of major metropolitan teaching hospitals, sometimes with a different specialist rotating each time. It is crucial that rural communities feel they have a relationship with their doctors. Spending hours and hours travelling to an appointment in the city, maybe waiting a couple of hours to be consulted for ten minutes, and then being asked to return in another month or two is far from ideal. Patient Assisted Travel Scheme (PATS) funding does not always cover the costs either; for example a patient going to Perth from the Kimberley will always be out of pocket for their accommodation costs (only $60 per day is reimbursed).

6.3 Health workforce

Access to specialist clinicians diminishes with increasing remoteness more than any other group of health professionals. See table below.



Data sources: AIHW (2003a; 2003b).

The College strongly advocates for measures to increase the numbers of general physicians across Australia and New Zealand, and particularly in Australia's remote and regional locations where a general physician can provide a comprehensive service. Generalist physicians are particularly advantageous where people suffer from multiple conditions, as is common in the case of chronic disease. Again this becomes even more important where access to physicians and other medical professionals is limited.

This position is laid out more in detail in the College's position paper 'Restoring the Balance'[13] available on the College's website, and in the College's submission to the Productivity Commission's 2005 Health Workforce Study, both available here.

General physicians participating in clinical outreach teams have the potential to play a major role in early intervention and chronic disease management services to geographically isolated areas. If used in conjunction with an expanded telehealth systems utilising digitally integrated support services, i.e. pathology and radiology, such a combination service has the potential to greatly expand the reach of health services.

Evidence based chronic disease protocols

Evidence based chronic disease protocols have been developed for the Kimberley region in addition to the Kimberley Standard Drug List (KSDL) (www.kamsc.org.au/content/resources/resourceguidelines.html) which have streamlined and simplified chronic disease management; it is still too early to have outcomes data at this stage.

The Central Australian Rural Practitioners Association (CARPA) manual is also a good example of specialist driven protocols aimed at improving chronic disease management. These protocols mean that a large extent of chronic disease management can be effectively delivered by the primary health care team (GP's, nurses and health workers), saving the time of the specialists for the truly difficult and complex cases. However, there are still inadequate specialist numbers in rural and remote areas, and succession planning needs to occur to ensure the whole system does not collapse when one or two key people leave a region.

[13] Royal Australasian College of Physicians. Restoring the balance. Sydney: RACP2005 (reprinted 2006).

6.4 Sustainability

Many chronic diseases relate to lifestyle factors, particularly tobacco use, harmful alcohol use, and the development of obesity, factors which have characterised recent discussion on chronic disease prevention. Across Australia, people living in regional areas are more likely than those in cities to have one or more of these risk factors.

There should be additional emphasis on the importance of ensuring resources are allocated to early intervention, particularly in the community health sector. It is also strongly recommended that smoking cessation clinics be established in community centres which can provide significant improvements in smoking cessation rates in targeted high-risk populations, such as the Indigenous. The evidence shows that the following are effective mechanisms for reducing smoking:

- Increasing cost, through taxation. Revenues should be redirected in to smoking cessation programs (hypothecation).
- Plain packaging.
- Nicotine replacement therapy (NRT).

For the Indigenous population, the drivers for change can be different. The Victorian Aboriginal Community Controlled Health Organization[14] is doing some work in this area and has recommended:

- Training for health workers to support smokers to quit.
- Creating environments within health services and communities to support quitting.
- Indigenous specific anti-smoking advertising and health promotion.

As mentioned throughout this submission, incentives for recruitment and retention of health professionals are vital to ensuring long term sustainability in rural and remote areas. Adequate infrastructure and an entire health workforce approach are crucial in rural and remote areas. Funding and resources needs to be adjusted to reflect the disease burden of the varying rural and remote communities of Australia.

6.5 Collaborative planning and policy development

Modifying and uniforming the Patient Assisted Travel Schemes (PATS) across Australia

Currently PATS is State and Territory based and many remote patients can not access their closest health service via PATS as it is based in a different State/Territory to which they reside. The College recommends that PATS are consolidated across Australia to allow the development of practical regional networks and travel between State and Territory boundaries.

In some instances, PATS support is limited to clients traveling over 100km. This is an arbitrary cut-off which disadvantages clients who may be within the 100km limit but for whom the cost of travel may be significant. For many Aboriginal communities transport options are limited, fuel is costly, roads may be challenging and/or impassible during the wet season, and accommodation options in the town where services are located may be limited and expensive. The College recommends that the 100km limit should not apply to patients living in rural and remote towns and communities who otherwise meet the criteria for PATS eligibility.

In addition to specialist and primary care services, preventive care must be a focus of comprehensive chronic disease service delivery. Prevention programs should be part of overarching and well resourced population health measures. Many chronic diseases relate to lifestyle factors such as tobacco use, harmful alcohol use and obesity. Interventions should occur in routine primary care as part of child and adult health

[14] http://www.vaccho.org.au/programs/programs_publichealth.asp

checks. These and other initiatives are outlined in the College's submission to the National Preventative Health Taskforce, here.

7. Drugs and Alcohol

For each section below, please include:

- Any comments and suggestions;
- Examples of good practice
- Case studies and/or evidence of activities that have not succeeded and any lessons learned.

7.1 Access

- There are high-quality drug and alcohol workers in rural areas; however, they are not sufficiently supported by medical professionals compared with their metropolitan counterparts.
- Currently, there are only a handful of Chapter of Addiction Medicine physicians working in rural areas. The rural specialists in Addiction Medicine will be crucial catalysts to encourage and empower GPs to undertake drugs and alcohol treatment work.

8. Mental Health

The College defers to the Royal Australian and New Zealand College of Psychiatrists for reform recommendations in this area.

9. Oral Health

Oral health is strongly linked with other systemic disease, particularly chronic disease. It is not uncommon to see patients that have become malnourished due to poor oral health. The College acknowledges the high disease burden associated with oral health in many rural and remote communities.

The College recommends that all dental services, both preventive and curative, are considered PATS-eligible services, with travel and accommodation costs covered for patients who are required to travel to access such services.

10. Do you have any other issues/comments/suggestions that you may consider relevant in the development of the new National Strategic Framework?

- The College recommends a formal regional health workforce data projections per regional centre. This data would be assessed to highlight the workforce shortages per regional centre and per capita. Such data projections could be used by specialist trainees to plan their training in advance, where they could potentially fill an area of need. Rural clinical schools would also benefit from workforce data projections by encouraging students to undertake training in the local area of need.
- Promotion and funding of ongoing mentoring and buddy systems in rural and remote regions: As mentioned throughout the above submission it is pivotal for rural and remote specialists to have regular and consistent contact with other specialist clinicians. This fosters further professional development, ongoing contact with major centres and social networking among peers. Ongoing mentoring and development of professional networks for rural students is also a key aspect of successful rural training, thus promoting recruitment and long term retention of health professionals in rural and remote regions of Australia.

Thank you for your time, thought and effort in preparing your written submission to this project. Please email your submission by Friday, 19th March 2010 to:

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