New South Wales

Special Commission of Inquiry into Healthcare Funding

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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 (RG) model of care in rural and remote communities, which often experience a shortage of local consultant specialist and allied health services.

The College has more than 5000 rural doctor members including over 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

Thank you for the opportunity to meet with Commissioner Beasley and to provide feedback to the Special Commission of Inquiry. This submission addresses the Terms of Reference where these have particular relevance to the work of our College and its members.

ACRRM is dedicated to building a national rural and remote workforce with a RG skill set, and the provision of a network of RGs would ensure rural and remote communities in New South Wales (NSW) can deliver high-quality, locally based, sustainable health services. ACRRM sees need for the state's overall approach to rural health policy and management to pivot away from preoccupation with localised crises responses, to a strengths-based approach that commits to the long-term strength and thriving of rural services and supports and assures this commitment at the highest levels. When properly funded and intelligently designed using rural-centric models, rural health services can provide excellent health care which meets community need and a substantial longer-term return on investment. A strong RG workforce is a key solution to restoring sustainable health care services to remote, rural and regional areas of NSW.

Recommendations Summary

1.	Support the continuation of the SEM trials for RG Fellowship training. These should be opt-in, flexible, college-aligned, and coordinated and delivered collaboratively with practices, colleges, and communities.
2.	Exploration of the potential for RG SEM models for Fellowed doctors where these can restore locally-based rural and remote medical services
3.	Review the VMO model and explore the potential for Employment Awards that align with a registered RG qualification should this be established.
4.	Implement jurisdictional policies to recognise and value the particular importance of rural private practices and support these services wherever practicable.
5.	Greater system-wide recognition of the RG skillset and employment of these skilled services to meet emergency, obstetric, anaesthetic, and other key rural health service needs
6.	More MRI facilities made available in rural health services and paired with local practitioner upskilling to utilise these
7.	Implement government structures to partner with local governments and other stakeholders to support them to address lifestyle factors in rural communities and make them attractive places for rural doctors and their families to live.
8.	Reframe rural facing programs including the NSW RGTP and the NSW SEM trials to enable localised/regionalised autonomy while establishing a single, central coordination and accountability point at the Ministry level to ensure their effectiveness and cross-programs support.
9.	Locum workforces are engaged only as a workforce of last resort where no alternative locally-based services are available including local Rural Generalists working to full scope.
10.	Specialists engaged to provide rural outreach services that are not locally available should also be contracted to provide local upskilling and comprehensive patient handover to locally based practitioners
11.	Rural funding structures commit to long-term strength of local services, always prioritising investment in locally-based services, and assigning funding based on a quantum necessary for sustainable services not based on historical underfunding.
12.	Rural funding models invest in, and enable context appropriate innovative models of care

Response to Terms of Reference

A. The funding of health services provided in NSW and how the funding can most effectively support the safe delivery of high quality, timely, equitable and accessible patient centred care and health services to the people of NSW, now and into the future

Sufficient Funding

It is essential that funding arrangements for rural and regional hospitals reflect the actual cost of providing services in rural hospitals, together with increased accreditation and compliance costs. Funding should not be based on past activity and must accommodate situational change and 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.

Additional to covering operational costs pricing frameworks should be cognisant of the much broader role rural and remote hospitals have to play in providing essential access to healthcare for people in rural and remote areas. There is comprehensive evidence that people in these areas have poorer heath status yet receive far fewer healthcare services than people in cities. This reflects among other things, their lack of easy access to the gamut of health and social services in cities. Hospitals are the key health infrastructure in place in many of these communities and it behoves them to be contributing wherever possible to addressing this inequity.

In particular, it is vital that pricing frameworks enable and incentivise forward-looking resource planning committed to maintaining robust locally-based services. These should ensure that "rural" funding makes its way to "rurally-based staff and resources" and should lend confidence in their future rural and remote doctors, staff, and communities.

The College also recommends greater transparency in terms of the way in which funding for rural hospitals is determined, together with the specific allocations for these hospitals in each state and territory. ACRRM would support making funding data publicly available to support this transparency and provide accountability to communities, doctors, and patients.

Rural Generalist Services

RGs and GPs are in a unique position to provide holistic care, crossing the siloes of primary, secondary, and tertiary health care and providing care across the illness spectrum and the lifespan, and working with an extended scope of practice in relatively low resource settings. The RG model is designed to train doctors with a broad and responsive skill set to provide the services that best fit the needs of their rural community. Collaborative healthcare team models are a cornerstone of this approach.

- ***RG Employment Awards***

  The joint application for recognition of Rural Generalist Medicine as a specialist field within General Practice is now well advanced and a final determination by the Health Ministers' Committee is likely to be made in 2024.

  Should this be successful this would provide a consistent and clear basis for industrial awards which recognise the distinct training, assessment and professional development associated with the RG scope. For the ACRRM Fellowship, additional to the generic General Practice education standards, this includes mandatory training and assessment hurdles related to obstetrics,

emergency medicine, hospital inpatient care, and population health, and an additional one to two years of assessed advanced specialised training in a selected field. All RG assessment measures capacity to apply skills within the clinical context of rural and remote settings.

Should recognition and protected title be awarded, this will provide an opportunity for all jurisdictions, to take a consistent approach to remunerating nationally registered specialist RG doctors in their services. This could significantly add to the attractiveness of this rural career and would simplify employment and credentialing arrangements for systems managers.

- ***Single Employer Models***

Single Employer Models (SEMs) are a positive development toward building a strong RG 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.

RG registrars 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. Additionally, rural workforce shortages, limited training capacity, and geographic distances all add further complications to navigating the training journey.

The SEM approach provides a mechanism for addressing the inability to accumulate job entitlements for the duration of training and has broader potential benefits such as streamlining training and contributing to better integrated patient care.

Under SEMs, registrars maintain one employer for the duration of Fellowship training usually a jurisdictional health service. The Single Employer provides the participating registrars' salary and work entitlements, and secondment arrangements are established with the additional workplaces in which the registrar may train. In the ideal under these arrangements, training toward a Fellowship qualification as a specialist GP and RG would provide a seamless movement between hospitals, general practices and other work settings such as Aboriginal and Torres Strait Islander Medical Services or Retrieval Services.

For the rollout of SEM in NSW to be successful, there is value in this being overseen by the Department, enabling Local Health Districts (LHDs) to develop local solutions, while establishing state-wide structures and frameworks which will allow NSW to work cooperatively across LHDs towards shared workforce goals. The rollout is best managed centrally to ensure the implementation of a robust and predictable model which will apply wherever a registrar chooses to train in NSW.

The College supports SEMs as an opt in model, part of a range of employment options available to RG registrars as befits the diversity of contexts in which RG training occurs and the varied training journeys that RGs 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. There may be contexts particularly in rural and remote communities that have not been able to sustain private practice clinics, where SEMs for Fellowed doctors are implanted as a policy level for rural workforce development.

- ***Supporting Private Practice***

Many rural general practices across NSW are concerned about the ongoing viability of their business and look to the GP training system to facilitate their recruitment of doctors to take over their practice. It is important that SEMs and other workforce models do not undermine the potential for registrars and junior doctors to gain skills and experience and build professional relationships with these rural GPs.

In private practices that are locally run, and in which doctors have a direct interest, the doctor is invested in the community, and patients benefit from the innate sense of accountability for quality care that the doctor (who is also a business manager) holds toward their patients' welfare that is a natural consequence of the doctor - patient relationship.

ACRRM does not expect that the GP private practice model will be a good fit for every context and supports an approach which enables diversity and accommodates the needs and exigencies of every community. We would however recommend that the particular value of the private practice model to rural and remote communities be given due recognition by jurisdictional policy makers in developing their policy frameworks.

- ***VMO Model and Hospital Staffing***

The VMO model by which RGs, who work in GP clinics are able to also provide services in their local hospital involve unduly onerous administrative requirements and credentialing policies. These represent a significant deterrent to many rural practitioners, particularly experienced practitioners, to offering locum and hospital services. Much of the documentation required appears to be either irrelevant or has previously been submitted to NSW Health and takes a significant amount of time to complete. Consequently the lack of locums deprives communities of much-needed services and affects those doctors who are working full-time in those communities by reducing their access to locum support so that they can work reasonable hours or take leave. This then makes recruiting and retaining a sustainable workforce even more challenging.

Additional to the administrative burdens, the employment arrangements tend to offer insufficient financial incentivisation for the considerable skills training and maintenance, and time and stress challenges that they engender. VMO terms and conditions appear to be dissuading RGs from providing hospital services. Members have reported for example, ceasing to provide hospital services in addition to their clinic-based work when they moved to NSW noting that this would have involved being on a permanent on-call roster without any financial remuneration for this commitment.

At least partially as a result of these issues, many facilities continue to rely on locum and fly-in, fly-out staff which impacts on continuity of care and increases the cost of service provision.

Recommendations:

- *Support the continuation of the SEM trials for RG Fellowship training. These should be opt-in, flexible, college-aligned, and coordinated and delivered collaboratively with practices, colleges, and communities.*
- *Exploration of the potential for RG SEM models for Fellowed doctors where these can restore locally-based rural and remote medical services*

- *Review the VMO model and explore the potential for Employment Awards that align with a registered RG qualification should this be established.*
- *Implement jurisdictional policies to recognise and value the particular importance of rural private practices and support these services wherever practicable.*

Case Study - Murrumbidgee Single Employer Model (SEM)

The Murrumbidgee Model trial was established in 2020 through an agreement with the Commonwealth health department and the NSW Murrumbidgee Local Health District (MLHD). The agreement grants a limited exemption to Section 19(2) of the Health Insurance Act 1973, which prohibits the payment of Medicare benefits where other government funding is provided for that service. The exemption allows the jurisdictional health service to be the employer of doctors who provide Medicare billed services.

Under this model, doctors enrolled on a FACRRM or FRACGP Fellowship pathway can apply under the program. In joining the program, they are also enrolled in the NSW RG Training Program and commit to training in locations in the Murrumbidgee region. They are employed under the state award by the MLHD. The MLHD enters an agreement with each of the participating general practices. Under these agreements, registrars' services within practices are billed to Medicare and the MLHD invoices the practice for the billable hours worked in the practice by the registrar.

The model has excited considerable interest particularly with our medical students and early career doctor members.

Over and above, the improved payments arrangements for registrars, keys to the success of this model that need to be supported and expanded going forward, have been:

- its capacity to take a more long-term and wider view of workforce development in the region and creating training opportunities that can align with long-term career/training/life planning by participating registrars.
- allowance for flexibility to accommodate registrars' diverse circumstances, and the dynamic and unpredictable nature of training capacity in rural and remote areas,
- ensuring that participating practices and health services, community, and colleges, are able to have a strong input into decision making, recognising a shared-interest in the long-term strength of the rural medical workforce.

A potential weakness lies in the lack of flexibility in the rural locations in which participating registrars can practice due to the Section 19(2) contractual obligations. These issues continue to be worked through.

Emergency Departments

In order to facilitate the best possible emergency care for people in rural and remote locations, the special skillset associated with the ACRRM Fellowship and particularly that of FACRRM's with Emergency Medicine Advance Specialised Training (AST) should be leveraged. The ACRRM RG Fellowship Program is an AMC accredited specialist training program. It includes mandatory training terms and summative assessment at the Core Generalist level in Emergency Medicine as well an option to complete an additional twelve months of Advanced Specialised Training (AST) with an associated education and

assessment program in RG Emergency Medicine. Both the training and assessment are specifically designed to assure competency for practice in a low-resource, clinically/geographically isolated context.

- ***Urgent Care Centres***

The College would caution against UCCs being deliberately built on workforce planning which utilises unsupervised non-VR doctors or even by Fellows of other specialties who are not also FACRRMs/FRACGPs. That would indicate a lower standard of care than general practices or most hospitals where senior supervision would provide a safety net for patient care.

- If UCCs are to be classified as primary care settings, then their staff and facilities should be expected to meet the same minimum standards as general practices do.
- If they are classified as equivalent to small hospital settings, then they should meet those standards.
- If they are to establish a new classification that integrates both then that requires new standards, and it should reflect the scope of practice that is RG - and ACRRM should have a pivotal role in the formulation of those standards.

Managing rural emergency departments involves a unique and complex set of competencies and the College Fellowship has been specifically designed to reflect these. Rural management involves capacity for service delivery in an isolated, low-resource environment, it requires broad scope generalist care, strong skills in patient stabilisation and transport, capacity to manage undifferentiated patient presentations, and often also, the capacity to manage in-patient and follow-up care.

- ***Virtual Models of Care***

In the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023–24*, IHACPA outlined its intention to investigate innovative models of care and services related to virtual care, with an initial focus on virtual care delivered by emergency departments.[1]

ACRRM acknowledges that telehealth is an important component of RG practice noting that it is not an acceptable 'replacement' for face-to-face services and instead should be viewed as a tool to support and strengthen in-person care.

Telehealth can improve health outcomes by facilitating timely access to essential specialist services and advice. It can further extend the scope of practice of RGs to provide comprehensive care for patients in the local community in consultation with other specialists if required. There is particular value for both patients and practitioners in shared care arrangements which facilitate quality models of care involving the patient-end clinicians (RGs) and remote-end specialists/consultants.

Our members in NSW are increasingly concerned about the trend towards replacing vital face to face emergency services with virtual FACEM consultations. As one member succinctly puts it "the camera cannot cannulate".

[1] IHACPA Consultation Paper, page 27

Any solutions to the provision of emergency care in rural and remote areas must put local RGs and GPs at centre if they are to support rural people's access to local emergency care. Most small rural hospitals do not have specialist emergency physicians on staff and rely on the services of local GPs and particularly RGs which have advanced training in emergency medicine.

It is important to recognise that the UCC workforce is likely to require the same skills and scope as the RG workforce, and RGs therefore present a logical solution to the workforce crisis in Emergency Departments. FACRRMs are already trained to operate in EDs and are arguably better equipped to assess, treat, and manage patients across the full range from Category 1 immediately life-threatening conditions, though to Category 5 chronic or minor conditions requiring assessment and treatment.

- ***Patient transfers***

Timely transfer to definitive tertiary hospital care can be limited by factors such as lack of available aircraft and pilot hours. This is especially an issue with an increase in bariatric cases who cannot be treated locally due to risk - intra-operative and post-operative, due to lack of ICU services.

- ***Retrieval Protocols***

Retrieval services are an essential support system for RGs. Unfortunately it is increasingly apparent that rather than transporting patients from the scene of an accident to hospital for initial assessment and stabilization, metropolitan-based retrieval services are ordering that patients stay on scene and wait for the chopper. There are increasing examples where patient assessment and initial management is delayed in order that the chopper is on the ground. This leads to worse and possibly fatal outcomes for patients, sometimes unnecessary activations of retrieval services and a waste of the skillset that is often present in a nearby town. Early patient assessment and care with possible retrieval saves lives. Lifting the retrieval silo is imperative to improve the outcomes for rural and remote patients. These decisions commonly are borne out of ignorance of the RG services that are available locally and the skills and training that underpin them. Not only are these available skilled services being withheld from rural patients, but local RGs and other skilled support staff are demoralised, and future staff disincentivised from basing themselves in rural communities, where their skills will not be employed or respected.

Maternity care

Over the past three decades, there has been a progressive decline in rural and remote maternity services and in particular, birthing services. One of our members has reported an instance where a pregnant woman in NSW had to travel over 400kms to have her baby delivered. The loss of maternity services in rural towns has wider community impacts. It is usually associated with a progressive de-skilling of the medical workforce, a downgrading of facilities and overall level of services. Access to a wider range of healthcare services becomes poorer as a result.[2] All ACRRM Fellows complete training and assessment in antenatal and postnatal care, obstetrics core skills and emergency obstetrics. Additionally, a percentage of ACRRM's annual Fellowing cohort, (approximately 20%), have completed a full year or more of assessed advanced specialised training in obstetrics which qualifies them for the Advanced Diploma of the Royal Australasian College of Obstetrics and Gynaecology (DRANZCOG Adv).

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

Diagnostic Imaging

Improved access to MBS-supported MRI facilities would be of significant benefit particularly in areas where there is significant travel time involved and for a range of acute and subacute issues including brainstem stroke; ligamentous C-spine injury; orthopaedic injuries; and osteomyelitis. For acute issues, this may reduce the need for emergent transfer. For subacute issue, it would reduce travel for patients who just needed the imaging and could access care closer to home. Where MRI services are available, they are often in the private system and result in higher costs per service compared to the same imaging in larger, typically costal regional cities.

Recommendations:

- *Greater system wide recognition of the RG skillset and employment of these skilled services to meet emergency, obstetric, anaesthetic, and other key rural health service needs*
- *More MRI facilities made available in rural health services and paired with local upskilling to utilise these.*

Case Study - Virtual RG Service

ACRRM Fellow, Dr Shannon Nott has designed and leads the Virtual RG Service (VRGS) through the Western NSW Local Health District (Australia). The service was established to support rural clinicians in providing safe and high-quality care. The service is designed to supplement and support face-to-face care in rural and remote communities. It leverages the unique RG skillset to provide hospital-based clinical services in communities without a local doctor or where local doctors request additional support. In its first two years, VRGS has provided over 40,000 patient consultations across 30 rural communities. The service has been COVID-19 resilient during a period where existing fly-in-fly-out workforce has been unable to travel due to border restrictions in Australia.[3]

Key to the success of this model which provides a basis for broader adoption, are:

- the emphasis on supporting rather than replacing locally-based care, and,
- (instead of urban specialists), engaging the knowledge and skills of professional colleagues that understand the context of care, i.e., low resource, broad scope, geographically isolated (i.e. RG) care.

B. The existing governance and accountability structure of NSW health

i. the balance between central oversight and locally devolved decision making, including the current operating model of Local Health Districts

[3] Nott S. (2023) The Virtual Rural Generalist Service - a COVID-19 resilient support service for rural and remote communities. *Rural and Remote Health.* Jan 23(1):8131. DOI: 10.22605/rrh8131. PMID: 36802813.

A recurring theme in issues raised by our members in NSW is a lack of high-level support or connectedness to regional level decision-making in the interests of rural people's health services. ACRRM acknowledges the necessary tension between local autonomy and central coordination that impacts the LHDs networks. The complexity of local issues requires flexibility and localised solutions, these however need to be articulated to strong committed leadership at the whole of state level. This is necessary to ensure that financial support and services makes their way to where they are needed, and also to provide the system coordination and engagement, to ensure that what works for rural people at the local level is not being undermined by conflicting priorities and initiatives at the regional or state level.

Above all, regional, rural, and remote communities need to have confidence that there is long-term governmental commitment to the sustainability of their local health services, without this, people in these communities cannot themselves commit to the future of the community. This triggers a downward spiral, as the loss of population, justifies further diminution of facilities.

Rural health programs such as the NSW Rural Generalist Training Program, or the NSW SEM trials would benefit from strong overarching coordination and support at the Ministry level. RG registrars commonly report facing difficulties in completing their Advanced Specialised Training in regional and rural hospitals. The reported barriers include rural and regional hospitals losing their accreditation as training facilities due to lack of staff or resources, together with the limited pool of rural training places being prioritised for trainees with other specialist colleges. These problems reflect the scarcity of funding and ongoing workforce shortages but are compounded by a lack of strong leadership and support for RG training and practice scope in wider decision forums. To successfully meet its potential, the program requires strong state-wide cross-system support. In the ideal this would come from a single point of coordination, directly answerable to the Minister.

Recommendation:

- *Rural facing programs including the NSW RGTP and the NSW SEM trials should enable localised/regionalised autonomy but have a single, central coordination and accountability point at the Ministry level to ensure their effectiveness and cross-programs support*

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ii. the engagement and involvement of local communities in health service development and delivery

Service delivery models should be flexible and responsive to the needs of communities where they operate, and models co-designed with input from key partners and stakeholders across communities. Tailored models may be required for rural and remote and Aboriginal and Torres Strait Islander communities to ensure they are culturally responsive and safe for those from Aboriginal and Torres Strait Islander or culturally and linguistically diverse backgrounds.

Key to delivering on equitable funding of services in rural and remote areas will be the inclusion of rural perspectives at all levels of decision-making and this should include people from rural and remote communities. The role of RGs and rural GPs as leaders in rural and remote communities should be leveraged to ensure effective engagement with communities.

Training and employment in rural communities which are poorly resourced, offer a poor standard of living, and provide a poor personal experience for the doctor during their time in the community, are unlikely to entice trainees to return, or doctors to stay. Local governments have a strong incentive to ensure a positive experience for medical students, registrars, and new doctors, and are well positioned to

engage proactively in ensuring they have one. This might include addressing local disincentives such as inadequacy of housing, schooling, childcare, or partner employment opportunities. Jurisdictional policy frameworks should support and provide mechanisms to enable local communities to be proactive in these ways.

Recommendation:

- *Implement government structures to partner with local governments and other stakeholders to support them to address lifestyle factors in rural communities and make them attractive places for rural doctors and their families to live.*

iv. the impact of privatisation and outsourcing on the delivery of health services and health outcomes to the people of NSW

There is risk that these processes may lose sight of the interests of rural and remote communities. Any privatisation or outsourcing of services must be strongly articulated to policies which are committed to the continuing strength of services in rural communities. Any delegated authorities would need to be held accountable not only for their outcomes in providing high-quality services to rural and remote communities over the immediate term but also for maintaining strong locally-based services and capacity over the longer-term.

The trend towards increasing use of locum and FIFO workforces as well as telehealth services has been widely reported by our members and in a range of recent inquiries.[4] Locums and FIFO staff are paid at higher rates than permanent locally based staff and do not offer continuity of care or the out of hours or emergency response capacity of permanently based staff. It is important that NSW systematically builds strong and sustainable health systems within local communities and prioritises investment in solutions which provide long-term security to rural services over stopgaps.

Where urban-based FIFO and digitally-linked services are deployed these should be oriented toward supporting and strengthening the continuous care by locally based services and minimising ongoing reliance upon them. Paid services to local patients, should involve local upskilling and strong handover information to locally based care providers who will be responsible for follow-up and ongoing care. RGs and other locally based health professionals should be trained to maximise the care they can provide locally in between visits by a FIFO specialist, or where safely possible, trained to provide these services themselves.

Recommendations:

- *Locum workforces are engaged only as a workforce of last resort where no alternative locally-based services are available including local Rural Generalists*
- *Visiting specialists engaged to provide rural outreach services should also be contracted to provide local upskilling and comprehensive patient handover to locally based practitioners.*

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

v. how governance structures can support a sustainable workforce and delivery of high quality, timely, equitable and accessible patient centred care to improve the health of the NSW population

Supported Training

GP and particularly RG training places need to be fit for purpose and adequately funded. RG practice reflects a scope of practice for primary health doctors which is essential to meeting the needs of rural communities. Our members welcome programs such as the NSW RG Program and John Flynn Prevocational Doctor Program and see opportunities to expand and build upon these with the support of the state government.

It is critical that RGs and rural GPs, particularly in under-served communities, can access the training they need to maintain and upgrade the skills they need to deliver high-quality care. Rural GPs have significant needs in terms of training and upskilling and many struggle to meet these needs. The Strategy needs to address how GP's wishing to upskill or undertake training can access appropriate incentives, funding, and support to do so.

Practitioner Wellbeing

The College considers that protecting the health and wellbeing of our rural and remote health professionals needs to be robustly addressed in the Plan. Strategies should be designed to cover the following: improved workplace culture, reduction in bullying and discrimination, reduction in work overload, provision of adequate rest periods and breaks (and spaces/places in which to take those rests and breaks).

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

Rural Generalist/Full Scope Practice

To maximise the care that rural and remote communities can access, raining should support rural doctor and health practitioner training in the Rural Generalist/full scope approach to practice.

At the core of any rural and remote health policy must lie the commitment that people in rural and remote areas warrant the best possible care that can be provided. ACRRM believes this can and should be care to the highest clinical standards but may not take the same form as best practice care in citites.

Rural Generalist Medicine is rooted in the concept of context-appropriate service that maximises the care that can be accessed locally. Expanded and full scope practice has particular value in conditions of relative professional and geographical isolation and limited clinical resources such as occurs in rural and remote areas including Aboriginal and Torres Strait Islander communities. In these contexts, the economies of a highly specialised staff and resource system of care that can occur in major centres do not apply. The absence of scale economies can be offset however through a fit for context skilled workforce and the benefits of strongly integrated care.

Due to relatively small patient catchments, it is unlikely that private practitioners and services, nor governments, will ever establish the breadth and depth of medical, nursing, and allied healthcare services that exists in metropolitan areas in rural or remote areas. Geographic distances will continue to create a substantial barrier to these people accessing many of these services. This being the case alternative (non-urban) models of practice and service delivery are required to optimise the services that can be accessed locally.

The healthcare services that people in rural and remote communities are physically able to access remain critical to their health and well-being. Thus, models of care appropriate for rural and remote contexts, need to put the community and its needs at centre, and the role and scope of all members of the local healthcare team including their relationships with outreach and telehealth providers need to be defined responsively to these needs.

ACRRM supports the expanded/full scope approach across all healthcare professions in rural and remote settings, where it is appropriately applied. The concept of Rural Generalism has always relied on a team-based approach to care, with all health professionals cooperating, not competing. This requires not just RGs working to the top of their scope, but also rural nurses and rural allied health professionals working to the top of their scope in management of chronic illness, palliative care, mental health care, maternity and other services which would be performed by specialists in larger centres. These positions are articulated in the Ngayubah Gadan Consensus Statement of which the College is a signatory.

C. The way NSW Health funds health services delivered in public hospitals and community settings, and the extent to which this allocation of resources supports or obstructs access to preventative and community health initiatives and overall optimal health outcomes for all people across NSW

Funding models must be supported by equitable funding, and robust, equitable collaboration between state and federal governments to address funding gaps and keep up with actual service costs going forward. Workforce constraints in smaller regional and rural hospitals often result 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 models.

Training and teaching

An increasing body of research 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 RG Pathway is a coordinated training pathway with provides a seamless transition from medical school, through prevocational training and finally to Fellowship and beyond.

Funding for, and allocation of hospital placements for RG trainees is problematic from a number of perspectives. 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 can be tailored to the needs and circumstances of communities and the health care facilities within those communities. As outlined above the SEM is one policy approach which can address many of the challenges and barriers to attaining the RG skill set.

Future funding models

Best practice medical service delivery in the rural and remote community paradigm involves distinctive models of care. Rural and remote communities are defined by their geographic distance from a full complement of medical and other health services, resources, and specialist staff. These special circumstances need to be integrated into the costing framework.

In these contexts, attempting to apply principals of fairness via a "same price for the same service" can lead to perverse consequences. Services are delivered on a much smaller scale in rural hospitals, this scale together with the logistical challenges of distance, the typically higher burden of illness, the pervasive workforce challenges, and the relative paucity of supporting local healthcare services create fundamentally different economic structures to their urban hospital counterparts. Minor changes in financing have the potential to disproportionately affect both the services viability and the provision of services for the community. In addition, rises in fuel prices, the increasing cost of food and freight and general cost of living issues combined with smaller cohorts, a considerably smaller pool of staff and resources to draw upon, and the real costs of running a viable business in rural and remote areas, make the financial imposts upon the rural hospital greater.

Too often, systems of care have been designed to fit the funding models rather than communities needs. The separation of hospitals and private sector/primary care in Australia does not reflect the integrated way that care is provided in rural and remote locations and has enabled blame shifting and ultimately neglect of many rural and remote communities health service needs. The state government needs to hold itself accountable for communities access to care and its funding frameworks need to have the intrinsic flexibility to offer solutions to accommodate the diverse and dynamic circumstances of rural communities.

Given the need to tailor funding models to these unique needs and challenges, it is important that the rural and remote sector is strongly represented in policy and decision-making processes. This representation should be reflective of the wide variety of rural hospital facilities and services. ACRRM also recommends that a rural-proofing lens is applied to all decisions which have the potential to impact on rural hospitals.

Alongside revision of pricing metrics to ensure sufficiency of funding, funding models should be constructed to enable and incentivise approaches to rural health resourcing which will deliver robust rural health services sustainable over the long term.

These structures should:

- **Incentivise future-focused expenditures** to build a strong future workforce and signal a strong long-term commitment to maintaining rural capacity and resources. They should encourage investment in rurally-based training. They should also incentivise the building of local services sustainability. This should include preferentially funding permanent rural positions over short-term or locum appointments. Investments in appropriately trained staff that stay in rural areas and become part of the fabric of those communities, present a much greater return on investment than reliance on locums and other expensive stop gap solutions. Most critically funding structures should strongly signal to rural communities that their health services are there to stay, and that they can build their lives there, in the knowledge that they will continue to have access to care when needed.

- **Direct 'rural' funding to staff and resources that are based in rural areas -** rural funding to urban-based FIFO specialists, telehealth providers, and administrators incrementally drains resourcing away from the rural point of care where it can be most effective. It also serves to undermine the fragile critical mass in each community necessary to sustain local services.

- **Incentivise investment in models of care and resourcing** that can maximise quality services within each rural context. These approaches would include training staff with an appropriate scope of practice for the rural context such as RG doctors, and nurses and other professionals with a broad RG scope. It would also involve resourcing hospitals in a manner complementary to the rural model of care.

  Recommendations:

  - *Rural funding structures commit to long-term strength of local services, always prioritising investment in locally-based services, and assigning funding based on a quantum necessary for sustainable services not based on historical underfunding.*
  - *Rural funding models invest in, and enable context appropriate innovative models of care*

College Details

Organisation	Australian College of Rural and Remote Medicine (ACRRM)
Name	Marita Cowie AM
Position	Chief Executive Officer
Location	Level 1, 324 Queen St, PO Box 2507 Brisbane Qld 4001
Email	[redacted]
Phone	[redacted]

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.