Australian Government

National Rural Health Commissioner

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Communique 1

July 2018

This is first in a series of communiques from the National Rural Health Commissioner

Dear Colleagues

We have a problem - and an opportunity.

As I have travelled across our vast country, many communities across regional, rural and remote Australia have told me that they are still deprived of equitable access to medical services. This is despite decades of investment in rural health reform, and despite the commitment of overseas trained doctors who have moved to regions where most domestic graduates have refused to venture. Many practitioners that remain in rural areas, both domestically and internationally trained, are working under unsustainable strain. As a result, the health and wealth of rural Australians is suffering.

I have also seen examples of great progress, success stories and evidence to inform sustainability. So why do we still have this evident disparity?

In significant part, this disparity persists because the underlying drivers of the medical profession have not changed – training and remuneration are based around specialty models of care in urban centres of excellence. Whilst this may have had some justification in the mid-20th century, this is no longer the case. The evidence base for primary care to be valued and integrated as an equal leader in both training and practice, and the positive outcomes for communities, clinicians and students of rurally based medical education, are now undeniable. City excellence must now be matched by rural excellence – one not diminished by the other, and neither being dependent on the other.

What is needed is a circuit breaker, a paradigm shift. This is the genesis of the National Rural Health Commissioner and the initial legislated priorities for this role. The Rural Generalist model and the National Rural Generalist Pathway, by integrating primary, secondary and tertiary care skills in each practitioner and establishing self-sustaining rural training networks across the country, are game changers: disruptive technologies that can enable the creation of cost-effective rural health services that underpin vibrant, safe and robust rural communities.

The Office of the National Rural Health Commissioner was established under Section 79AB of the *Health Insurance Act (1973)*. The Act sets out the functions the Commissioner is required to undertake in order to establish a Rural Generalist Pathway. These include:

a) defining what it means to be a rural generalist;
b) developing a National Rural Generalist Pathway; and
c) providing advice to the Minister on the development and distribution of the rural workforce and on matters relating to rural health reform.

In performing these functions, the National Rural Health Commissioner must:

a) consult with health professionals in regional, rural and remote areas;
b) consult with States and Territories, and with other rural health stakeholders as the Commissioner considers appropriate;
c) consider appropriate remuneration, and ways to improve access to training for rural generalists; and
d) consider advice of the Rural Health Stakeholder Roundtable and the Rural Health Workforce Distribution Working Group.

I was appointed to the role on November 11, 2017. Since then I have had the honour and the pleasure of meeting and listening to many stakeholders across the country. The enthusiasm that has greeted me underscores the fact that the role of the Commissioner has been called for by the sector for many years and is in fact the result of decades of advocacy.

In the first few months of my appointment I have been developing processes to meet the functions set out in the legislation. In this communique I will outline two of these initial steps.

It should be noted that while the legislation has directed me, as a first task, to develop a pathway for Rural Generalists in medicine, I will in time be supporting the development of similar pathways for other medical specialities and Dentistry, Nursing and Midwifery, Allied Health and Aboriginal and Torres Strait Islander Health Practitioners.

There is strong support from the Minister for Rural Health, Senator the Hon Bridget McKenzie, the Minister for Health, the Hon Greg Hunt MP, and staff in the Australian Government Department of Health, as evidenced by the significant enhancements announced in the Stronger Rural Health Strategy in this year's budget. I am also grateful for the clear bipartisan and cross bench support in the Commonwealth Parliament, and extensive interest shown by State and Territory Governments. I also see evidence of leaders in our profession collaborating to progress initiatives for the benefit of rural communities. In this environment we have a unique national opportunity to together make a transformational change towards a sustainable rural health workforce.

The Collingrove Agreement

The concept of rural generalism has gained increasing currency over the last decade. It is used in a wide variety of contexts and has multiple meanings. What has eluded us is a common definition that can be applied consistently to Rural Generalists in medicine in Australia and the development of the National Rural Generalist Pathway.

In early January 2018, representatives from the Royal Australian College of General Practice (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) came together at my invitation to develop the Collingrove Agreement. This Agreement sets out the shared commitment by both Colleges to work together in the development of a national framework for the National Rural Generalist Pathway. As a first step, and articulated in the Agreement, the Colleges defined what it means to be a Rural Generalist doctor:

> A Rural Generalist is a medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a sustainable and cost-effective way by providing both comprehensive general practice and emergency care and required components of other medical specialist care in hospital and/or community settings as part of a rural healthcare team.

The significance of this definition is two-fold. It not only ensures that context and geography define the nature of the role, it also places the needs of the community at the centre.

We now have an agreed language that enables us to describe the variety of doctors and models of practice that are required in different rural and remote communities. We need great General Practitioners in our regional centres. We need great Specialists serving our regional, rural and remote communities. And we need great Rural Generalists. One is not better than the others, but they are needed in different settings to support optimal rural healthcare that is sustainable and cost-effective.

Some regional cities with large populations, in Modified Monash 2 for example, require teams of Specialists and multiple General Practices. Other larger rural centres in Modified Monash 3 and 6 require an integrated balance of Rural Generalists, General Practitioners and resident and visiting Specialists. The majority of rural and remote communities, those in Modified Monash 4-7, will be best served by teams of Rural Generalists supplemented by visiting Specialists.

As many communities around our country know, if the balance between these types of doctors is wrong, then just adding more doctors does not solve the problem. A small town where only a minority of doctors provide the broad range of services needed by the community will remain in crisis despite adding further 9-5 clinic doctors. The National Rural Generalist Pathway will train doctors to provide the broad range of GP, emergency and other specialist services required by their communities, and will include ways for existing rural doctors to either be recognised as Rural Generalists if they are already practicing as such, or, if they wish, to broaden the range of their skills to meet the same needs.

The variety of specialities required by Rural Generalists have historically emphasised procedural skills in Obstetrics, Anaesthetics, Emergency and Surgery. Increasingly in the future, skills in Psychiatry, Internal Medicine, Aboriginal and Torres Strait Islander Health, Palliative Care, Geriatrics and others will be needed, according to community need. In all of

these areas of practice, medical practitioners need to work as part of multidisciplinary teams. Integration between community practice and acute care will also be paramount.

The Collingrove Agreement was formally announced at the Rural Health Stakeholder Roundtable on 9 February 2018 by Senator the Hon Bridget McKenzie, Minister for Rural Health. It was enthusiastically endorsed by members of the Rural Health Stakeholder Roundtable who recognised its historic significance.

The National Taskforce

The work of the National Rural Health Commissioner concerns reforms for the future workforce. By this I do not mean the workforce a generation away from today, but the workforce that is currently enrolled in medical schools and training programs. We do not have a supply issue – we have a workforce maldistribution. There is an urgency about this situation – a need to channel this future workforce into the locations where they can pursue high quality training and base their lives – rural Australia. We cannot remain one doctor away from a crisis.

Fortunately we are not working with a blank page. Most of us know the problems and many of the solutions. My intention is to work quickly and effectively by harnessing the expertise, commitment and good will of those around me to ensure that the required reforms are appropriate and workable and most importantly, will provide a benefit to rural communities.

The Collingrove Agreement is the first definitive step in developing the National Rural Generalist Pathway. It is the foundation and around it must be placed the scaffolding of various pieces of work that the Pathway will be built on. These include developing common standards, curriculum and assessments for training Rural Generalists in the Pathway; a process for national professional recognition; remuneration and support arrangements for Rural Generalist trainees and practitioners; and an evaluation framework that can measure the impact these reforms will have on rural communities and Rural Generalist training and practice into the future.

This is a complex set of tasks that will need expertise of many stakeholders working at multiple levels across the rural health sector. In order to guide this work I am establishing a series of working groups and expert reference groups. These groups and the work they produce will be led by a National Taskforce that will oversee the development of a National Rural Generalist Training Framework and ensure a consistent approach by, and collaboration between, each group. In addition I will work with the expertise of established groups such as the Rural Jurisdictional Workforce Forum, the Distribution Working Group, and the Rural Health Stakeholder Roundtable.

All aspects of the work will be undertaken according to the following principles:

- The Pathway will be framed around the Collingrove Agreement.
- The Pathway will commence at entry to medical school and link seamlessly to junior doctor and registrar training with flexible exit and entry points.
- The Pathway will be most effectively based and delivered in networks of regional/rural/remote health services.

Current appointments to the Taskforce are:

- Dr Yousuf Ahmad
- Professor David Atkinson
- Professor Amanda Barnard
- Dr Mike Beckoff
- Mr George Beltchev
- Dr Kaye Atkinson
- Associate Professor David Campbell
- Dr Dawn Casey
- Dr Hwee Sin Chong
- Dr Adam Coltzau
- Dr Melanie Considine
- Ms Marita Cowie
- Mr Mark Diamond
- Dr Rose Ellis
- Dr Sam Goodwin
- Mr Dave Hallinan
- Dr Kali Hayward
- Dr Sandra Hirowatari
- Dr Tessa Kennedy
- Mr Martin Laverty
- Mr Jeff Moffet
- Dr Belinda O'Sullivan
- Ms Carolyn Reimann
- Dr Mark Rowe
- Associate Professor Ayman Shenouda
- Dr Kari Sims
- Associate Professor Ruth Stewart
- Professor Ian Symonds
- Dr Allison Turnock

Future Communiques

My intention is to provide regular updates about the progress of my work. I welcome your feedback through my Office. In the near future, I will discuss the implications of the proposed pathway model and the concept of regionally-based training networks to ensure that the locus of Rural Generalist training is placed where it belongs – in rural communities.

By investing in the rural and remote workforce, we strengthen rural health systems. By strengthening rural health systems, we bring safety and hope and enrich rural and remote communities. When we enrich these communities, the whole of Australia prospers.

Emeritus Professor Paul Worley

National Rural Health Commissioner