



Consumers Health
Forum OF Australia



National
Rural Health
Alliance

Final report

Rural, regional and remote roundtable on health service access report

February 2022

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Acknowledgements

CHF and the NRHA acknowledge the Traditional Custodians of country throughout Australia where the participants of the rural, regional and remote roundtable on health service access work, live, and met to produce this report. We recognise the Traditional Custodians' continuing connection to land, waters and community and pay our respects to them and their cultures, and to Elders both past and present.

We acknowledge the ongoing contribution Aboriginal and Torres Strait Islander people make to the health and wellbeing of our communities and our environment and recognise the importance of self-determination and community-centred services for good health outcomes for all Australians, including Aboriginal and Torres Strait Islander people.

Foreword

Access to health services and health care is one of the seven 'healthcare rights' as noted in the Australian Charter of Healthcare Rights published by the Australian Commission for Safety and Quality in Healthcare. Access to healthcare should be available to everyone, including access to healthcare services and treatment that meet their needs.

Health equity is a reasonable expectation for all members of the community and access to health services should not be a factor that influences where we choose to live. Move away from the urban sprawl of the big cities and access becomes more challenging the more remote you live. It is unacceptable that between city and rural there is a great divide in health service availability, choice, access, safety and quality. This is evidence based, and yet, the issues still impact health consumers across the country on a daily basis and remain unresolved.

CHF initiated a Rural and Remote Special Interest Group (SIG), in 2018. As the co-facilitator of that group, I have been privileged to work with, listen to, engage with, and collaborate with consumer representatives from all around Australia. The range of topics discussed and considered during the bimonthly meetings has been extensive; however, in 2021, access to health services remained a dominant topic. The ongoing issues regarding reasonable access to health services created a need to act. To address these critical issues, a roundtable was undertaken with the support of the NRHA.

This initiative has been driven by consumer concerns, experiences, and the need to address the genuine disparity in access to healthcare services across the nation. Key areas were identified through our consumer network. These included allied health, dental services, mental health, obstetrics, specialist medical services and telehealth. While other aspects of primary and secondary health care were also identified as problematic, the diversity of the six subjects selected embraced the range of issues for residents of rural, regional, and remote Australia.

In the interests of highlighting the poor access to rural health services from the health consumer perspective, the Roundtable was developed to include short presentations, followed by breakout room discussions related to the six topics, with issues and solutions identified. While subject matter experts participated to comment and answer questions in each breakout room, the initiative has essentially been driven by health consumers and their needs, experiences and perceived issues, and possible solutions.

The barriers to be overcome to access to healthcare services were more far reaching than the physical 'getting to an appointment'. The consumer voice has identified the extent to which access is denied or limited. The significance of these matters cannot be discounted.

Consumer driven solutions proved to be enlightening and constructive with reasonable, realistic ideas to combat some of the problems that continue to escalate with health service access. Including the people at the coalface of these rural health issues provided a powerful opportunity to drive creative thinking that, hopefully, can lead to progress in this seemingly never-ending area of health service prejudice.

Thank you to the CHF and NRHA for listening and acting on this matter. For the 7 million Australians living in rural, regional, and remote Australia, this is a positive way forward.

Linda Beaver
Co-facilitator (health consumer representative)
Rural and Remote Special Interest Group Consumers Health Forum

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About this report

The Rural, Regional and Remote Roundtable on Health Service Access was a virtual event held on 1 December 2021. The roundtable was hosted by the CHF in partnership with the NRHA.

The roundtable was instigated by CHF's Rural and Remote SIG, a volunteer group of consumer health leaders. The SIG highlighted that access to specific services outside metro areas are problematic and a priority. They expressed a desire to be proactive in tackling these problems with consumer-led, consumer-driven and consumer-focused solutions.

CHF vision and mission

CHF is the national peak body representing the interests of Australian healthcare consumers. CHF works to achieve safe, quality, timely healthcare for all Australians, supported by accessible health information and systems.

CHF does this by:

- advocating for appropriate and equitable healthcare
- undertaking consumer-based research and developing a strong consumer knowledge base
- identifying key issues in safety and quality of health services for consumers
- raising the health literacy of consumers, health professionals and stakeholders
- providing a strong national voice for health consumers and supporting consumer participation in health policy and program decision making

CHF values:

- our members' knowledge, experience and involvement
- development of an integrated healthcare system that values the consumer experience
- early intervention, prevention and early diagnosis
- collaborative integrated healthcare working in partnership

CHF member organisations reach thousands of Australian health consumers across a wide range of health interests and health system experiences. CHF policy is developed through consultation with members, ensuring that CHF maintains a broad, representative, health consumer perspective. CHF is committed to being an active advocate in the ongoing development of Australian health policy and practice, including through the hosting of thought leadership roundtables on a range of emerging topics.

The National Rural Health Alliance

The National Rural Health Alliance comprises 42 national organisations committed to improving the health and wellbeing of the 7 million people in rural and remote Australia. Their diverse membership includes representation from the Aboriginal and Torres Strait Islander health sector, health professional organisations, health service providers, health educators and students.

The Alliance provides a united voice for people and health professionals living and working in rural communities and advocates for sustainable and affordable health services. Their most important role, underpinned by their broad representative base, is listening to the people of rural, regional and remote Australia and taking their views to government.

Introduction

The right to health and access to health facilities, goods, essential medications and services is a fundamental right in Australia.ⁱ Despite this, the Australian Institute of Health and Welfare reports that those living in rural and remote areas have poorer health outcomes and shorter lives compared to those in metropolitan areas.ⁱⁱ While social cohesiveness, more home ownership and a better work-life balance are positive social determinants of health in rural and remote areas,ⁱⁱⁱ the poorer internet access and mobile phone reception, higher levels of unemployment, lower incomes, lower education levels and increased homelessness all contribute to a decrease of up to five years in life expectancy for men and four years for women in rural and remote areas.^{iv}

The burden of disease in remote areas is 1.4 times that of major cities; the coronary heart disease burden in remote areas is twice that of major cities; the disease burden due to suicide and self-inflicted injuries in remote areas is 2.2 times that of major cities. When compared to the rate in major cities, potentially avoidable deaths in very remote Australia are 2.3 times higher in males and 3.0 times higher in females; 13.4% of babies born in very remote areas are pre-term, compared with 8.5% of babies born in major cities; Australians outside major cities are three times more likely to rate access to general, specialist and mental health services as poor and utilise Medicare up to 40% less than those in major cities.^v

Rural communities have fewer registered nurses, midwives, pharmacists, dentists, optometrists, psychologists, physiotherapists, podiatrists, occupational therapists and other allied health workers. Rural areas need an additional 21,357 FTE of personnel in these professions to match major cities on a per-population basis.^{vi}

As recorded in 2020, 7,111,203 people were spread across 12,670 rural, regional and remote localities, spanning 99.3% of Australia's land surface and contributing two-thirds of Australia's export earnings, including \$400 billion yearly in resources and agricultural exports.^{vii}

At the roundtable, participants were asked to consider elements of access other than distance and travel, such as:

1) Monetary costs

For travel such as incidentals and accommodation; the costs for tests, specialist appointments, transport; arrangements for children, pets and those left at home and the additional costs for carers, frequent and regular trips for those with acute and/or chronic conditions; lost income, planning time and delays.

2) Emotional costs

Uncertainty; lack of information causing confusion; personal concerns about health and outcome; the anxiety of travel without family support; isolation; personal and physical issues; lack of information or communication with health professionals and/or family; the requirement to make difficult decisions under distressing circumstances; exhaustion.

3) The broad range of issues impacting on access

Negative interactions with medical administration staff; automated telephone answering services; online booking limitations and frustrations; lack of orientation mediator in large hospitals; lack of knowledge or advice about parking, directions or accommodations regarding appointments at large hospitals; lack of respect for the needs of a person under duress, having to negotiate the complexities of the

health system; lack of recognition of all that is required to organise and manage appointments when distance underpins the first factor for consideration.

4) Medical access issues

Whether or not you were offered a choice when being referred to a specialist; whether or not the referrer explained the reason for referral; whether or not the consumer was given the opportunity to conduct their own inquiries into a preferred service or consultant; whether or not you needed more information about the process or procedures about to be undertaken; whether or not you know they are not obliged to see the specialist who visits their area on a regular basis; knowing that if you choose to see another specialist, whether or not travel benefits are still available; understanding you have a right to choose the specialist you see, not just one directed by the referrer; refusing a referral is an option; understanding the benefit the referral will provide to your health management and outcome.

5) Communication issues

Whether or not options are provided by your medical provider for questions to be asked; understanding that you can have a discussion with your medical provider about personal choices; knowing that if instructions are not clear you can ask for clarity; consider whether or not you are comfortable discussing your personal health issues; consider whether or not you feel respected and listened to; make sure you feel safe and assured of the best health care; consider whether or not information is provided to you in a way that is easy to understand, and whether or not you receive information to consider before making a decision.

6) Safety and quality issues

Pay attention to whether or not you feel an openness or a hesitation regarding disability, gender identification, ethnicity or religion, and if you feel safety and quality are impacted by the lack of access.

Aims

There were two core aims of the roundtable:

- 1) For consumers to name the core problems of each theme and to discuss potential solutions for better access to health care for those who don't live in urban environments
- 2) To draft those suggestions and solutions into a report that will add value to consultations and priorities sought from government and other related policy organisations, before and after the next federal election, and in the coming years of policy development around access to health services in regional, rural and remote Australia.

Background

In February 2021, the CHF Rural and Remote SIG ran its first meeting for the year. CHF CEO Leanne Wells was invited to facilitate a discussion about refreshing and renewing the SIG's interests and in getting wider engagement in the SIG. The SIG members were asked for their thoughts on "what they wanted, what their priorities were and how they might want things to change". As the big issue that was mentioned repeatedly was access, it was decided that a roundtable be organised for consumers to voice the problems around access and to be able to offer their own solutions, with the help and advice of specialists in the field.

The format

Due to the ever-changing nature of COVID-19 social distancing measures, the roundtable was held on Zoom. The discussion was co-facilitated by CHF CEO Leanne Wells and NRHA CEO Gabrielle O’Kane. The National Rural Health Commissioner Professor Ruth Stewart provided the opening address.

In the spirit of a consumer-driven collaborative day, consumers were asked if they would be willing to be facilitators for the themed groups. To allow as many consumers as possible to be part of the main discussions, CHF and NRHA staff were recruited as notetakers for all breakout rooms, and as facilitators for two rooms. Four participants, including the National Rural Health Commissioner presented five-minute talks on examples of successful improvements to health service access in rural, regional and remote areas.

The discussion

Six themes were chosen for discussion by the Rural and Remote SIG, with input from individuals in CHF’s other consumer groups. Dental health was a major concern in the February SIG meeting. This was reiterated at the June meeting after a talk by one of the SIG’s members on oral health care in Australia. Mental health and telehealth (digital health) were specific concerns raised in the SIG’s April meeting, which included members of the Youth Health Forum. These topics were raised again at the August meeting and so were added to the breakout room discussions list. Obstetrics, allied health and other specialists were called for by consumers in the Rural and Remote SIG and members of the CHF Primary Health Care SIG who lived in rural areas.

The participants

An online Expression of Interest (EOI) was emailed to all CHF Special Interest Groups, CHF members, and via CHF online publications. The event attracted many consumers who were unknown to CHF, which was surprising and positive.

In the interests of time, organisational capacity and potential numbers of participants in zoom meeting breakout rooms, the number of themes was limited to six. This would allow for six to eight consumers per room, plus a facilitator, a notetaker and a health expert in the given field. A total of 48 people were involved, resulting in six participants in each breakout room theme, which was manageable. The participants were from rural, regional and remote Western Australia; South Australia; the Northern Territory; the Australian Capital Territory; New South Wales; Queensland; and Victoria.

The experts

The NRHA invited experts from their membership base to provide advice to consumers in their discussions on the issues and potential solutions to their themed breakout rooms. Those experts are collectively affiliated with the National Rural Health Alliance; Royal Australian and New Zealand College of Obstetricians & Gynaecologists; University of Papua New Guinea; Tasmanian Dental Service; Australian Graduate Dental Year Program; Rural Flying Doctor Service; Papua New Guinea Dental Association; APHCRI Centre for Research Excellence in Primary Oral Health Care; [WA Country Health Service](#) Department of Psychiatry; the Australian Psychological Society; Rural and Remote Interest Group, College of Health Psychologists; La Trobe University; University of Tasmania; Australian Research Centre for Population Oral Health; Services for Australian Rural and Remote Allied Health; Western NSW Primary Health

Network; Umbo (national online speech pathology and occupational therapy organisation); Royal Australian College of Surgeons; The Australian Society of Otolaryngology and Head and Neck Surgeons; the Australian Medical Association; and Business and Professional Women Australia.

Gaps in rural, regional and remote health care access

“The system is not fit for purpose out here.”

The following story of one rural patient and their family illustrates the complexity of a health emergency and all the elements that must be considered and managed when attempting to gain access to life-saving health care, from advocacy and childcare, to losing work, communication issues and ambulance limitations.

“My husband has five different specialists all in Sydney. We live out of Parkes [central west New South Wales]. We can’t organize appointments at the same time. It’s two or three days out of work. We need childcare. Limited Western Area health is diabolical. We can’t keep GPs here for continuity of care. We kept one. An injury was mismanaged locally but we don’t go to the GP surgery. I’m a strong advocate. Because of his [husband’s esophageal] tear they wouldn’t take him by helicopter. He was expected to go via ambulance to Orange, then to Bathurst, then to Sydney. In the end I had to drive at 110km all the way to Sydney. Telehealth has never been offered. It’s like [there’s an attitude of] “you’ve chosen to live rurally” so we’re second-class citizens. It’s five hours to get to the city. We had three-days to get a covid test [prior to an operation]. No one’s open on Saturday and won’t get results back for pre-op tests. We had to go to Sydney. So, access around COVID tests as well as health problems!”

The discussions among the themed groups spanned ideas about improving physical experiences related to clinical care; infrastructure and system changes; rural and remote outreach; making more use of existing support structures; and improving consumer and clinician relationships with each other, with technology and with external support services.

The following are the common elements that were revealed as gaps in health care access.

Transport

The distance to travel is an added inconvenience making people less likely to get the preventive and urgent care they need, whether it is dental, allied health, mental health, obstetrics or other specialists.

The lack of viable public transport within small towns, between rural and regional towns, and to larger metro areas makes it difficult for people to get to health services, particularly for those in greater financial need. Where transport may be available, the time needed to get to and from those services is another barrier for safe and quality health care. Added barriers include having to organise childcare; the stress on children who need to be taken to specialist care; older people who may not be able or willing to drive; those with chronic conditions who may not be suitable for public transport or who cannot drive themselves; and those with disability.

Timely care

In line with the National Preventive Health Strategy, all health care must be timely or there is a risk of harm caused by the gaps in the health system itself.^{viii} Waiting six months for mental health support is unacceptable and is likely to compound psychological distress and compromise clinical outcomes. When the need is there, the service must be available. Telling somebody to call Lifeline is not an alternative when the consumer is faced with an automated phone answering system, needs face-to-face sessions with a professional, not just a volunteer, may need medication support, may need hospitalisation, needs continual care and may otherwise be averse to using telephones. When somebody tears a muscle and requires allied health services, they must be accessible; when a woman needs pre or postnatal support she must have access immediately to obstetrics and/or birthing services; when a person needs emergency access to their specialist in a city that may be five hours drive away and based in a hospital other than their local hospital, they must have reasonable access and communications with that specialist in a timely manner.

Timely health care saves lives and reduces the burden on the health system. The National Preventive Health Strategy recognises that “38% of the chronic disease burden could be prevented through a reduction in modifiable risk factors...This figure rises to be 49% for Aboriginal and Torres Strait Islander people”.^{ix}

The Strategy states that preventive action “must focus on all the influencing factors that impact on health to ensure health equity is achieved...”.^x

Access to timely health care also affects potentially preventable hospitalisations (PPH). PPH are conditions where hospitalisation could have potentially been prevented through the provision of appropriate individualised preventive health interventions and early disease management, usually delivered in primary care and community-based settings. In 2017-18, the PPH rate increased with increasing remoteness. When compared with major cities, the rate for those in very remote areas was 2.5 times as high and in remote areas was 1.7 times as high. Rates for regional areas are also higher than for major cities.^{xi}

Staffing/staff retention

One of the most common messages at the roundtable was the difficulty in getting and retaining clinical staff in rural, regional and remote areas. Staff turnover in these areas remains high.

The average allied health professional’s rural stay is three years, and this reduces further in remote areas.^{xii} In remote Northern Territory, turnover rates are extremely high with annual rates of 66% no longer working in any remote clinic and 128% movement between clinics. Only 20% of nurses and Aboriginal Health Practitioners remained after 12 months at a specific clinic. Half left within four months.^{xiii}

People cannot access health services when those services do not exist because there is no staff to operate them. The shortfall in health providers and services means that there is an underspend on health services in rural Australia. The NRHA has estimated that this rural health expenditure deficit is \$4 billion per annum. This means \$4 billion every year that governments should be spending on health services for rural communities which is not being invested. This government saving comes at the expense of the health outcomes of rural communities.^{xiv}

Rural areas have up to 50% fewer health providers per capita than in major cities. This includes general practitioners, physiotherapists, psychologists, dentists, pharmacists, optometrists and podiatrists.^{xv}

Digital health

While the benefits of digital health are increasingly being recognised, there is still confusion about its use for service providers and consumers, because of a lack of confidence around technology. The following feedback confirms this and other issues:

- There is currently too much focus on technology and not enough focus on people.
- There is a lack of understanding by the general population about privacy related to digital health care.
- Digital health is not being sufficiently harnessed by clinicians.
- The current Digital Health Strategy focuses too much on general practice and My Health Record. It is not clear to people what this means for them.
- The lack of consistency in online platforms when moving around the health system is anxiety-inducing and causes confusion.

Communication

The lack of clear and appropriate communication by healthcare clinicians and reception staff is not specific to rural, regional and remote areas. However, it is worth mentioning here due to the strong response to this issue.

Good practice and general health literacy affects patient health and care.^{xvi} The general reading literacy ability in Australia shows that about 44% of adults read at literacy level 1 to 2 (primary school to lower secondary education reading level, ages 12-14).^{xvii} The high rate of low literacy levels in Australia will have a direct impact on the health literacy of the general population, not to mention more vulnerable groups. The social determinants for general health and health literacy equally apply to dental health,^{xviii} which is linked with diabetes, heart disease, respiratory disease particularly aspiration pneumonia, arthritis, gastrointestinal disease, pre-term births, low birthweight babies and much more.

This is all relevant to rural, regional and remote when it comes to the unique challenges of communication by distance and the capacity for specialists and/or hospitals to address those communication needs. The Australian Health Practitioner Regulation Agency (AHPRA) codes of conduct for health professionals include “effective communication” and “informed consent”,^{xix} yet communication is often provided in a way that is not appropriate to address the literacy and numeracy capacity of the community.

Lack of coordination and support

Every themed discussion at the roundtable brought up the need for peer support services; a lack of support groups; the need for service coordination; the need for a rural and remote patient liaison in larger hospitals; and the need for carer support.

According to the feedback at the roundtable, patients in rural, regional and remote areas are often unaware of which allied health or other specialist might be visiting their community. They are faced with added complications compared to their metro counterparts when it comes to understanding the issues around accessing health services. This makes scheduling and coordination with visiting clinicians and external visits to specialists more challenging.

The call for multidisciplinary medical hubs in communities has come from several sectors: obstetrics; mental health; other specialists; allied health; and digital health. Support for the use of telehealth services is across the board. The problem of health specialisations creating 'silos', even within the same hospital setting, can cause harm to patients due to mistakes made in clinical handovers, time delays, confusion, lack of communication and other issues such as the need for referrals, repetition of stories and administrative paperwork, further negotiating with administrative staff which adds to exhaustion. This is not specific to rural, regional and remote patients. However, it is exacerbated due to the need for greater coordination, preparation and travel for those not within easy reach of multiple services or where choice is not a given when doctors write referrals.

Costs

"The patient travel subsidy scheme is a joke."

Patient subsidies do not cover travel costs. Those with chronic conditions (in particular), travelling to other towns or cities for health care incur regular costs that far outweigh any available subsidies. It is not just the cost of travel. It is the cost for those who lose income when they must give up work for any number of hours or days to reach their destination. It is the cost of childcare and the need for replacement carers for those caring for older relatives or friends. It is the cost of the actual appointment, accommodation, parking and food. It is the cost of exhaustion, for some, in navigating multiple appointments on a regular basis, of the paperwork, the actual drive, of repeating your story over and over. It is the cost of family members who must accompany an older relative or friend with dementia. It is the cost of energy in trying to make yourself heard, or being the expert on your chronic condition when nobody in the emergency department will listen to you; and it is the cost of preparation, organisation and coordination. It is the human cost of miscommunications and the need to advocate for yourself.

Attitude/culture

"There's an attitude that you've chosen to live outside the city so you have to live with that choice."

A common theme from the roundtable discussion was the attitude of having to accept sub-optimal health care, which often begins with the administration staff—the people with whom most consumers have first contact with the health system. The anecdotes of the common lack of care, communication, and clarity from administration staff could fill volumes.

As of 2020, 7,111,203 people were spread across 12,670 rural, regional and remote localities, spanning 99.3% of Australia's land surface and contributing two-thirds of Australia's export- earnings, including \$400 billion yearly in resources and agricultural exports.^{xx} These Australians who live and work rurally do not expect the same access to health services as people living in major cities. They do, however, expect access to a reasonable range of health services that are accessible and affordable, to ensure that their health and wellbeing is not adversely affected by their location.

Medicare

For rural, regional and remote people visiting other towns or cities for health care, the feedback at the roundtable revealed that people will try to organise all health-related appointments on the same day to minimise time away from work, home, income etc. Current complaints include:

- Not being able to get multiple rebates to see more than one specialist or procedure.
- The added costs involved in just getting to another town or city for health care makes the whole experience much more costly for rural, regional and remote people than for those in metro areas. There must be equity in health care.
- The, often exorbitant, cost of psychiatrist and psychologist appointments and dental care.
- There is only one MBS item for obstetric visits. This hasn't changed despite the range of investigations that obstetricians need to do for pre-natal checks increasing significantly in terms of time and complexity in recent decades.

Ambulances

Ambulances are often unavailable in rural and remote areas and often can't access rural and remote places when they are available. Other problems include:

- It can be difficult to direct ambulances where to go because of the address system in rural areas where the mailbox numbering system may not identify the best access route.
- Ambulances are often not equipped, for example, to drive on particularly muddy or washed-out dirt roads.
- Mobile phone connectivity can be tenuous.

Dental health

- Smoking continues to contribute to the prevalence of periodontal disease.
- Betel nut chewing is a major cause of oral cancer and its use is occurring in the ethnic groups who used in their home countries.

Solutions

Reception staff training

Front-of-house staff must have the capacity to deal with frightened, angry and/or confused patients and they need the resilience to do this on a daily and hourly basis. This is their job. On top of administrative and organisational skills, they need the capacity to counsel patients regarding processes and procedures. There should be strategies in place for staff in these consumer-facing roles to deal with the ongoing stress of supporting highly distressed patients. If they do not have the capacity to do this, there are three options:

- 1) Move them out of consumer-facing roles
- 2) Their shifts should not be long, all-day shifts. Frontline health workers need sizeable breaks from the needs and demands of patients who may be in a heightened emotional state. It is unsustainable to expect front-of-house staff to provide that level of emotional support all day, every working day
- 3) They need regular training to cope with their role, such as regular active listening and negotiating skills; they need specific training to be aware of the needs of people with disabilities, mental health issues, LGBTQI+ and cultural needs.

Multidisciplinary health hubs/RACCHOs

The NRHA is developing a new model of rural health care that will benefit both health professionals and communities in rural, regional and remote Australia: Rural Area Community Controlled Health Organisations (RACCHOs).^{xxi} RACCHOs are an evidence-based policy solution to overcoming the barriers to attracting and retaining a rural health workforce. Currently there are professional, financial and social barriers to deciding to work rurally. RACCHOs provide a model of multi-disciplinary care aimed at addressing these key barriers to attracting a rural workforce. The RACCHO model is an employment-based model which would pay a salary to employees to support early career health professionals, thus avoiding the need for health professionals to establish their own small business practice in order to work rurally.

Staffing/clinician retention

Recruiting staff to work and settle in rural, regional and remote communities is a challenge. However, some solutions discussed include:

- Work to increase numbers in rural generalist training across primary health service provision. While GP rural generalist studies have only just begun, consider specific training for other rural specialists.
- Subsidise a concierge model that helps health professionals move to rural, regional and remote areas – helps with the move, finding somewhere to live, finding jobs for spouses, and finding schools for children etc.
- Consideration to be given for remuneration as a salary rather than a case-by-case payment for specialists/consultants in rural, regional and remote hospitals.
- Include at least 12 months in a rural, regional or remote area for those in medical school and/or once the required study has been completed.
- Liaise with local councils to increase community support for regional doctors. Communities must be desirable places for clinicians to move to and remain in.
- Metro specialist hospitals could be responsible for supplying specialists to clinics in rural, regional and remote areas. Include regular rural visits as part of the metro

specialist's role. A rotation system would work well, staying for several working days or up to one working week at a time.

Support workers

Allied health assistants

- Utilise the capacity for allied health assistants to be integrated into holistic health care management or service provision under the direction of the relevant health professionals. Allied health assistants are qualified to provide treatment as well as service support.

Patient liaisons/care coordinators

- Patient liaison coordinators are needed for people from rural, regional and remote communities to assist in navigating the challenges of health service provision in hospitals or private care facilities in metropolitan areas; to assist in the use of telehealth as a complementary option. Patient liaison coordinators are essential in all aspects of health service navigation, be it in metropolitan, rural, regional or remote facilities.
- Develop a national vocational qualification in healthcare coordination that incorporates peer workers and/or patient liaison roles, as well as advocating for and coordinating care specifically for rural, regional and remote patients. This could include responsibilities in their community, general practice, and/or with external hospitals and specialists. These are people with an existing broad knowledge of how the health system works, an understanding of social prescribing, person-centred care and patient management protocols.
- Training support and recognition for long-term carers, to acknowledge their expertise and potential contribution to the broader community.

Medicare

- Medicare to allow for multiple rebates for more than one specialist visit or procedure per day for those from rural, regional or remote areas.
- Medicare to pay double Medicare rebates to see specialists privately for those in rural, regional and remote places.
- Increase the Medicare rebate for access to mental health.
- Targeted approach through subsidies: Extending the Child Dental Benefit Schedule (CBDS) or the Seniors Dental Benefits Schedule to other adults on welfare or pension payments, allowing them to go to the dentist of their choice and having their appointments rebated through their Medicare card.
- Provide greater healthcare subsidies related to costs for digital health access for rural, regional and remote consumers.
- Consult with the Royal Australian and New Zealand College of Obstetricians and Gynecologists to add and update MBS items for obstetric visits.

Digital health

- Focus on increasing equity.
- Identify priority areas for improvement and consider universal obligation service agreements.
- Create awareness of NBN Locals, to include community leaders.
- Run awareness campaigns regarding digital health to include responding to privacy concerns.

- Run awareness campaigns to increase digital literacy in line with the development of a national health literacy framework.
- Health care subsidies for costs related to digital health, for example, in delivering community WIFI.
- Involve consumers at all levels of digital health development: The system must be fit for purpose, focus on clear, simple English communication and easy-to-navigate platforms.
- Fix the disjointed rural health system by developing interoperability between digital platforms.
- Embed digital health training in clinician curriculum.
- Relevant compliance and enforcement of privacy legislation and principles should be updated as digital health progresses.
- Devise a digital health blueprint that takes into account opportunities and structural barriers in rural, regional and remote areas. This could be alleviated with a health care coordinator role.
- Funding for local community groups to support their communities in improving digital health literacy.
- The National Farmers' Federation has been funded to operate Regional Tech Hubs which provide independent, free advice about telecommunications services for rural, regional and remote Australians. These should be promoted more broadly.

Ambulances

- For those living in rural, regional and remote and with serious chronic health conditions, introduce push notifications going from mobile phones or other alert systems to emergency callouts stating what's required for the patient.
- Push notifications for patients to send to ambulances for directions in rural and remote areas.
- Wristbands or other easily carried digital cards attached to a QR code for those with serious chronic health conditions in rural, regional and remote areas. A scan by another phone could access information from specialists and patient history more quickly and more easily than My Health Record which relies on a single, external individual (GP) to upload information and which may be incomplete or inadequate.

Other specialised suggestions

Obstetrics

- Hospitals that provide birthing facilities also need to be able to provide pediatric support equipment if they are delivering babies.

Mental health

- For telehealth in mental health, there must be an option for rural and remote 'warm lines' (a person at the end of a phone line rather than an electronic prompter)
- Consider the possibility of providers of psycho-social issues being included for those in the NDIS.

Dentistry

- Universal dental schemes result in those people who already access care receiving more dental care while those now not receiving dental care to still not access care.^{xxii} Increase funding to the Royal Flying Doctor Service Dental Programs. Put conditions

on the funding to be directed specifically to rural, regional and remote people so it does not impact on existing public or private dental services.

- Water fluoridation is a cost-effective way of reducing the need for dental care, especially in rural and remote areas. We suggest that any funding supplied to state governments for dental service delivery (such as the program to reduce public sector dental waiting lists) include a condition that the state government has, or is in the process of, fluoridating the water supplies of all rural towns with a reticulated water supply for populations of 1,000 people or more.
- Water fluoridation, along with twice-daily use of fluoride toothpaste, are the closest we have to a “golden bullet” for improving oral health independently of the social determinants for rural oral health.
- Triage using a video link and/or assistant and/or patient liaison/care coordinator role.
- Health promotion campaigns and health literacy campaigns should include oral health.
- Health promotion measures to reduce smoking rates in rural areas.
- Encourage governments to make the import and the growing of betel nut illegal.
- Reduce the influence of the social determinants for poor health by improving the uptake of education programs (which requires access to high quality education). This must include longitudinal interventions evaluating attitude change, education change and changes in oral health outcomes.

General practice

- Develop a system where scripts for ongoing, unchanging medication can be provided without a GP appointment being required.
- Subsidize the employment of practice nurses in rural, regional and remote general practices.

Key recommendations

This report provides a framework to help address the gaps in rural, regional and remote health service access in Australia.

This was an event organised for and by consumers in the spirit of the National Safety and Quality Health Service (NSQHS) Partnering with Consumers Standard, which recognises that “systems are designed and used to support patients, carers, families and consumers to be partners in healthcare planning, design, measurement and evaluation” and “communication and structured listening, through to shared decision making, self-management support and care planning”.

This report proposes a number of actions that could support the goal of improving health service access to rural, regional and remote areas, fulfilling the health rights of all Australians, not just those in metropolitan areas.

Communication was identified as a key element of concern but extends across all sectors of the health service industry and needs to be addressed in education and practice beyond the limitations of rural, regional and remote communities. As such, it has not been included as one of our top 10 recommendations.

As a first step, we propose the following actions should be progressed as a priority due to their ability to inform and underpin the remaining action. This is not to discount other elements of concern that need to be addressed in ongoing policy deliberations.

Top 10 recommendations

Short to
medium term

1. **Medicare updates:** Urge Medicare to allow for rebates in payment of more than one medical, health visit or procedure per day and to pay double rebates for those from rural, regional and remote places to see specialists in private practice. Also, urge Medicare to increase the rebate for access to mental health care, and update the MBS items list for obstetricians.

2. **Prescriptions for chronic care:** For those with life-long chronic conditions needing recurring medications, develop a system where scripts for ongoing, unchanging medication can be provided without a GP appointment being required.

Medium term

3. **Primary health education:** Urge all health professional educational and training institutions to include greater awareness of the benefits and opportunities in rural, regional and remote areas.

4. **Digital health literacy:** Provide funding for local community groups to support their communities in improving digital health literacy. This would benefit all those in rural, regional and remote areas in receiving video and/or other online triage and check-ups with external specialists.

Medium to long term

5. **Health care coordinator role:** Develop a VET training course, from existing units, to create a career path as a health care coordinator. This role would focus entirely on patient navigation of the health care system. The role would be an asset in ongoing mental health care, specialist referrals, obstetric needs, digital health literacy and/or include specialisations such as dental health (for triaging over video link) or other allied health specialities. It is a stand-alone role with distinct competencies and qualifications. Recognition could be given to nurses and allied health professionals to provide this level of support and guidance to consumers to navigate the system.

Long-term

6. **RACCHOs:** Advocate for the development of the RACCHO model to improve multi-disciplinary health service provision in rural, regional and remote areas.

7. **Dental health services:** Call for an increase in funding to the Royal Flying Doctor Service Dental Programs; call for fluoridation of water supplies for all rural communities and towns with a reticulated water supply for populations of 1000 people or more; urge government to include a rebate for dental health services for all members of rural and remote communities.

8. **Hospitals:** Urge metropolitan hospitals to take on the responsibility of facilitating specialists' services to hospitals and clinics in rural, regional and remote areas.

9. **Allied health workforce:** Support and actively promote the growth of the rural allied health workforce inclusive of allied health professionals and allied health assistant roles to improve access to allied health services in rural, regional and remote communities.

10. **Emergency QR codes:** QR codes for immediate access for emergency information and patient history and GPS location.

We recognise there is a broad and diverse community of stakeholders who bring expertise and a desire to address these issues at all levels and in all sectors of the community. We look forward to working collaboratively to continue raising the profile of rural, regional and remote health service access on the national stage.

Thank you

CHF and the NRHA are grateful for the participation of the following representatives in the roundtable discussion, and for their subsequent consultation and feedback that formed the basis of the recommendations provided in this report. The views and recommendations in this report represent the outcomes of the roundtable discussion. The report does not necessarily reflect the specific views of CHF, NRHA, individual roundtable participants or the organisations they represented (some of whom may have official positions that differ from that represented in the report).

Professor Ruth Stewart

National Rural Health Commissioner

Dr Judith Gardiner

Diplomate Board Director, Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Professor Leonard Crocombe

Associate Professor Oral Health, University of Tasmania

Dr Nicole Jeffery-Dawes

Australian Psychological Society

Dr Bridget Clancy

Royal Australasian College of Surgeons

Ed Johnson

Co-founder and Clinical Innovation Advisor, Umbo

Cath Maloney

CEO at Services for Australian Rural and Remote Allied Health

Leanne Wells

CEO Consumers Health Forum of Australia

Dr Gabrielle O’Kane

CEO National Rural Health Alliance

Linda Beaver

Co-facilitator, Rural and Remote Special Interest Group, Consumers Health Forum of Australia

References

- ⁱThe right to health is framed by Australia being a signatory of the International Covenant on Economic Social and Cultural Rights (ICESCR); article 5(iv) of the Convention on the Elimination of All Forms of Racial Discrimination (CERD), articles 10(h), 11(1)(f) , 12, 14(2)(b) and 16(1)(e) of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), articles 24 and 25 of the Convention on the Rights of the Child (CRC) and articles 23(1)(c) and 25 of the Convention on the Rights of Persons with Disabilities (CRPD).
- ⁱⁱ Australian Government, Australian Institute of Health and Welfare, Rural and Remote Health, 2021 [accessed 16 December 2021]
- ⁱⁱⁱ Public Health Information Development Unit. Social Health Atlas of Australia: Remoteness Areas – Time series [data]. Torrens University Australia; 2021 May [accessed 11 December 2021]. www.phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-remoteness-areas
- ^{iv} National Rural Health Alliance, 2021, *Rural Health in Australia Snapshot 2021*, [accessed 12 December 2021] [Rural_health_in_Australia_snapshot_111121-ref - Rural_health_in_Australia_snapshot.pdf](http://Rural_health_in_Australia_snapshot_111121-ref-Rural_health_in_Australia_snapshot.pdf) (ruralhealth.org.au)
- ^v Australian Rural Health Alliance, 2021, *Rural Health in Australia Snapshot 2021*, [accessed 12 December 2021]
- ^{vi} Calculations by the National Rural Health Alliance based on the National Health Workforce Dataset and population figures provided by the Australian Government Department of Health.
- ^{vii} Australian Rural Health Alliance, 2021, *Rural Health in Australia Snapshot 2021*
- ^{viii} Australian Government, Department of Health, 2021, The National Preventive Health Strategy 2021-2030 [accessed 16 December 2021]
- ^{ix} The Hon Greg Hunt MP, Minister for Health and Aged Care, 2021, media release 13 December 2021, *Australia launches National Preventive Health Strateg* [accessed 16 December 2021]
- ^x The Hon Greg Hunt MP, Minister for Health and Aged Care, 2021
- ^{xi} Australian Institute of Health and Welfare 2019, Rural & remote health. Cat. no. PHE 255. Canberra: AIHW. Viewed 08 January 2021, <https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health>
- ^{xii} Cosgrave, C., Maple, M. and Hussain, R., 2018, An explanation of turnover intention among early-career nursing and allied health professionals working in rural and remote Australia-findings from a grounded theory study. *Rural & Remote Health*, 18(3).
- ^{xiii} Russell DJ, Zhao Y, Guthridge S, Ramjan M, Jones MP, Humphreys JS, Wakerman J. Patterns of resident health workforce turnover and retention in remote communities of the Northern Territory of Australia, 2013-2015. *Hum Resour Health*. 2017 Aug 15;15(1):52. doi: 10.1186/s12960-017-0229-9. PMID: 28810919; PMCID: PMC5558760.
- ^{xiv} Australian Institute of Health and Welfare 2019, Rural & remote health. Cat. no. PHE 255. Canberra: AIHW. Viewed 08 January 2021, <https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health>
- ^{xv} National Rural Health Alliance, 2021, *The Case for Better Health Care*
- ^{xvi} Australian Commission on Safety and Quality in Health Care, 2021, Health literacy <https://bit.ly/3q3mPEW> [accessed 11 December 2021]
- ^{xvii} OECD (Organisation for Economic Co-operation and Development) (2016) *Survey of Adult Skills (PIAAC)*, OECD website, accessed
- ^{xviii} Casamassimo, P.S., 2000, Relationships between oral and systemic health. *Pediatric Clinics of North America*, 47(5), pp.1149-1157.
- ^{xix} Australian Medical Council Limited, 2009, Australian Health Practitioner, *Good medical practice: a code of conduct for doctors in Australia*.
- ^{xx} National Rural Health Alliance, 2021, *Rural Health in Australia Snapshot 2021*
- ^{xxi} National Rural Health Alliance, 2021, Developing RACCHOs model of health care: the case for better health care [Friday, 29 October 2021]
- ^{xxii} Pegon-Machat, E., Tubert-Jeannin, S., Loignon, C., Landry, A. and Bedos, C., 2009. Dentists' experience with low-income patients benefiting from a public insurance program. *European journal of oral sciences*, 117(4), pp.398-406.