NATIONAL RURAL HEALTH ALLIANCE INC.

# Models of Specialist Outreach Services

# for rural, regional and remote Australia

**Paper by the National Rural Health Alliance**
**for the Rural Sub-Committee of AHMAC**

**February 2004**

# TABLE OF CONTENTS

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## Summary

There is substantial market failure in the market for medical specialist services in Australia, one consequence of which is relatively poor access to specialised medical services in rural and remote areas.

Overcoming this market failure requires a significant improvement in the attractiveness of the market to those providing specialist medical services in these areas.

Poor access to specialist medical services in rural and remote areas is but one indicator of a relatively disadvantaged segment of the Australian population in relation to health status and access to appropriate services.

The Alliance advocates the development of a national plan to improve the health of people living in rural and remote areas. A national plan, derived from *Healthy Horizons*, would provide a cohesive framework within which locally-relevant models of medical specialist outreach services could be developed, in conjunction with other steps necessary to improve the health of people living in rural and remote areas. These other steps would include identifying and dealing with emerging workforce problems such as the ageing of the rural medical specialists and the paucity of female medical specialists in these areas.

Governments should develop and endorse 'service access standards' to provide benchmarks to assist regions and others in planning health services and to define for Australians the publicly-funded health services to which they can reasonably expect access.

The recommendations to Health Ministers from the 'Improving Rural Health' Reference Group for the Australian Health Care Agreements provide further guidance on the broader framework relevant to the role and nature of medical specialist outreach services.

'Top down' approaches to implementing models of health services are inappropriate: local communities should be assisted to devise local solutions for their health care needs.

Providing specialist medical services in very remote communities presents special challenges, but overcoming the barriers should be a priority as there would be flow-on effects to primary health care and the health of the communities.

The Alliance considers that the following matters are vital for the successful implementation of medical specialist outreach services.

- While short-term targeted funding continues to be used, funds must be administered by suitable organisations.
- Funding should be provided separately for evaluation which should cover short-term impacts and longer term outcome evaluation, measuring changes to health status of the communities.
- Services should be developed in collaboration with the State and regional health authorities and the respective medical colleges, but they must be managed locally.
- Special funding should not be provided to support metropolitan specialists providing outreach services in regional areas unless the service is an agreed part of a health service plan for the region.
- Planning for specialist medical services of a region should be based on the priority health needs of the population, be within a multidisciplinary framework, only cover specialist services agreed to by their own professional group as *bona fide*, and allow for specialist outreach nursing and allied health services where appropriate.
- Planning of specialist outreach services must be realistic, recognising that for some conditions referral to a larger centre or tertiary hospital will always be necessary, although outreach assessment services can play a useful role for these conditions.
- Plans must recognise that regionally-based specialists are likely to be generalist specialists.
- Medical specialists can play a key role to play in supporting and enhancing primary health care and this should be built into specialist outreach services.
- Specialist medical services should be provided locally wherever possible with a key objective of regional self-sufficiency in secondary medical care.
- Where a region has not yet attained self-sufficiency in secondary medical care, the main focus of the imported specialists' roles should be supporting the locally based heath workforce, including medical specialists in regional centres, to strengthen their capacity to provide safe and effective services within their regions.
- Planning, developing, and implementing specialist outreach services should address critical success factors as identified in the literature and through local experience. The factors considered by the Alliance to be the critical ones are listed below on page 8.

The Alliance has identified seven specific actions which it believes are important to provide an effective framework for specialist outreach medical services, and to make them more effective and sustainable.

## Introduction

This paper has been prepared by the NRHA at the request of the Australian Department of Health and Ageing. Its purpose is to inform discussions at the AHMAC Rural Sub-committee about issues related to the development of specialist outreach services in rural, regional and remote Australia and critical success factors for such services.

The paper identifies some key issues that must be addressed in policies and programs designed to increase access to specialist medical services by residents of rural and remote areas. It identifies some actions which, if implemented, would assist in the further development of effective specialist outreach services.

This paper focuses on specialist medical care, but the Alliance wishes to emphasise the importance of strengthening primary health care in rural and remote areas through the development of multi-disciplinary teams of which specialists are an essential part. In the longer term, the improved health derived from such a focus and the associated reduction in incidence of serious chronic disease will reduce the need for specialist medical care in rural and remote areas[1]. Medical specialists have a key role to play in increasing the emphasis on primary health care and the development of roles and professional interaction within the multi-disciplinary teams.

The paper is informed by the views of members of the NRHA's Council based on their experiences with health services in regional rural and remote areas. It also draws on relevant findings and conclusions of consultancies about specialist medical services in this area previously commissioned by the Australian Department of Health and Ageing (eg the James Cook Flinders and Monash Universities' *Evaluation of Strategies to Support the Rural Specialist Workforce* and covered in the literature review component of the draft final report of the Strategic Capital Alliance's Review of Specialist Services). Attachment 1 contains some examples of issues raised by the Alliance's Council for inclusion in this paper.

The bottom-line for the Alliance is that appropriate, affordable and accessible specialist services are a right for all Australians – including for Indigenous people and those in rural and remote areas who are often in the greatest need of their services.

[1] Although one of the Alliance's correspondents has cautioned as follows: "whilst increased access to primary care by indigenous communities would be positive for those communities, unless there are other changes such as increased access to paid employment, education opportunities etc then it is hard to see a significant and sustained reduction in renal disease etc."

**The market for specialist medical services**

The market for specialist medical services in Australia is characterised by:

- a shortage relative to demand - both overall and markedly so for some specialties, being driven at least in part by:
  - the economic circumstances of General Practice which encourages high referral rates to specialists;
  - the de-skilling of some General Practitioners;
  - the use of medical specialists for some types of service which in other countries are provided to a greater degree by other health care professionals (eg midwives); and
  - the impact of rapidly rising medical indemnity premiums;
- a degree of neglect of primary health care, leading to an over-reliance on specialised medical care to deal with readily preventable chronic diseases;
- high and increasing out of pocket costs for out of hospital medical specialist services;
- medical specialists being heavily concentrated in major metropolitan and urban centres;
- medical specialists having a wide range of choices about their location and type of practice;
- the preference of many medical specialists for work in private practice, supported by a range of health policies; for example:
  - the heavy underpinning of the charges for using medical specialists through Medicare Benefits;
  - heavily subsidised private health insurance premiums for in-patient treatment as a private patient; and
  - privatisation of many services previously provided as public hospital services eg out-patient clinics at public hospitals.

Given these market characteristics it is to be expected that access to specialist medical services is very restricted in areas with many downsides from a medical specialist's viewpoint. The downsides of practising in rural, regional and remote areas of Australia have been well documented.

Australia's health policies have equity and access to necessary health services on the basis of health need as key platforms. In general terms the health of people living away from urban areas is poor relative to their urban counterparts. Thus a major challenge to governments, health policy makers, health service planners health funders and health service providers is to improve access to medical specialist services in rural, regional and remote areas by finding effective measure to overcome market failure. Such measures must be identified and implemented to increase the market's attractiveness in these areas to medical specialists.

For success, any program to increase access to medical specialists in rural and remote areas will have to address the reasons behind this market failure.

**Overarching comments**

***Local provision of specialist medical services***

The Alliance supports local provision of specialist medical services wherever possible. Travel to major metropolitan centres, unless essential because of a need to be assessed or treated at highly specialised services and facilities only available in such centres, should be minimised. Such travel is disruptive to family life, often unhelpful to the illness or disease that makes it necessary, and costly to both the individual and the local economy. Access by some means to specialists is essential: the work of anaesthetists, surgeons, obstetricians and paediatricians saves lives.

The delivery of the majority of medical services within the region through a networked system or similar alternative is preferable to the delivery of services from distant metropolitan centres. Among other things, this approach facilitates ongoing communication between the specialist and other health professionals involved in a patient's care, providing continuity of care and building local capacity for delivering an appropriate level of care locally.

***Health service access standards***

The Alliance considers that it is inappropriate to consider issues and models for specialist outreach services in isolation from broader considerations of access to health services for people living in rural and remote Australia. Currently there are no health service access standards. Such standards would be a very useful tool to guide future health service planning and to educate Australians about the publicly-funded health services to which they can reasonably expect access. Further, they would be useful to guide the re-balancing of health funding to more closely link funding to health needs.

***Highly specific short-term funding programs***

The Alliance is uneasy about the practice of the Australian Government of providing small amounts of funding for highly specific, short-term programs to address substantial, ongoing healthcare and health workforce issues. Certainty of ongoing funding is a key issue for the sustainability of specialist outreach programs. While pilots are a useful way to test innovative approaches this would be of longer term benefit if funding to support improved access to specialist medical services to a specific region was long-term. Successful pilots could then be sustained or alternative approaches adopted if a particular pilot was unsuccessful.

The evaluation processes for lapsing programs have been poor and the evaluation of health outcomes almost non-existent. There should be interim reports of successful models identified throughout the life of the various programs, in order to inform decision-making at both government and local levels.

Further, there are at least three specific programs targeting rural medical specialist issues, but there appears to be no overall strategic approach to defining the role of medical specialists in regional, rural and remote areas and to improving access to their services.

These programs co-exist with special programs for general practitioners, nurses, pharmacists and allied health practitioners.

Thus there is a suite of apparently unco-ordinated, parallel health workforce initiatives, each with its own distinct administrative processes. These are being implemented in the absence of any clearly articulated and agreed national plan to improve health outcomes in rural and remote areas, despite *Healthy Horizons* providing a strategic framework from which such a plan could be developed.

Further, the administrative arrangements for these targeted programs are sometimes inappropriate. While such programs continue, they should be administered by relevant organisations with close involvement of the relevant health workforce. Successful administration of MSOAP, for example, requires representation from medical specialists and substantial in-house knowledge and expertise related to regional specialists. Currently MSOAP is more a support program for GPs than for existing rural specialists.

Experience has shown that local knowledge and understanding of issues at a local operational level allow for early identification of problem areas with a service and appropriate, timely recommendation for amendments to service Agreements. The flexible administration and successes achieved under the Bush Nursing and Rural Hospitals Program is seen in contrast to the rigidity and in many cases the lack of local involvement seen in the administration of MSOAP.

> *"On MSOAP, the issue surrounding sustainability cannot be overestimated. If a service cannot be sustained over an extended period, then why set it up in the first place. Organisations that take this path take the wrath of their local communities as a result. I have some concern over the 'Information Management' component, or proof that the service is needed. Many rural communities do not have access to this data or it is not yet collected. We need to keep this component broad where possible.*
>
> *The area we're in at the moment has two visiting psychiatrists one day/fortnight for a population of 65,000. That's pretty good compared to many but without MSOAP we would have nothing whatsoever. The longer we maintain the service the better the relationship is becoming with local GPs and the other health service providers eg taking the phone calls (from their base), providing education, providing referral. In short, they are developing the relationship, connection and are taking some responsibility. I can't help but think that if we nurture and support these relationships then the opportunity for permanent recruitment may arise. We all know that 50% of the battle is getting these guys on the 'plane and destroying the myths of rural lifestyle."*

Services should be developed in collaboration with the State and regional health authorities and the respective medical colleges, but they must be managed locally, by a local group with representatives of the local health service, representatives of the medical staff council and consumers.

Flexibility for communities in the development of health plans is essential. It will enable local communities to integrate programs to suit their unique health requirements and fully

utilise their limited resources. At any time there may be funding sources across a range of services from local, state and commonwealth programs, as well as private providers. Additionally the workforce and health status circumstance within the community may change during the life of a program.

***A national plan to improve health in rural and remote area residents***

The Alliance supports a more focussed and co-ordinated approach to addressing health workforce and healthcare access problems in rural and remote areas. A national plan to complement *Healthy Horizons* would provide an implementation framework within which locally-relevant models of medical specialists outreach could be developed. Local communities should be assisted to devise local solutions for their health care needs, informed by evidence about their own health needs, available resources and health priorities, the experience of other communities and the findings of research and evaluation of alternative approaches.

To assist in this process it would be useful for the Australian Department of Health and Ageing to publish and regularly update a compendium of good practice models which have been successful in increasing access to specialist medical care in sustainable ways in regional rural and remote areas with previously poor access.

***Evaluation***

Effective evaluation of existing and innovative approaches to the provision of specialist medical services in rural ad remote areas is vital if future funding is to be well directed. Targeted programs should provide separate funding for evaluation which should cover both short-term impacts and longer term outcome evaluation, measuring changes to health status of the communities.

Evaluation enables us to learn from history. It is useful to identify the reasons why some pre-existing specialist practices may have ceased in a particular area. It could have been a result of wider systemic issues or more specific local issues. If there is a specific reason why specialists have ceased to practise in an area, then that issue needs to be addressed - in addition to the wider issues - if a specialist service is to be resumed, even on an outreach basis.

**Report to Health Ministers from the 'Improving Rural Health' Reference Group for the Australian Health Care Agreements**

The Alliance reiterates its support for action in the six specific areas identified in this report, namely:

- workforce;
- specialist services;
- aged care services;
- Aboriginal health;
- transport; and
- funding models.

The strategies on specialist services recommended to Ministers in this report are at Attachment 2. They focus on:

- developing local service centres;
- improving the operation of existing programs that support rurally-based and outreach specialist programs (eg MSOAP);
- improving allied health services so that follow up and support is available for specialist services; and
- remodelling the workforce infrastructure.

Each of the other five action areas has relevance for specialist services. Hence any action to improve access to specialist medical services should be in the wider context of addressing the other five key action areas listed above.

**Comprehensive planning based on community needs.**
Currently there is some 'adhockery' in the provision of outreach specialist medical services, driven by a range of factors such as the personal interests and motivation of individual specialists providing outreach services, the views of general practitioners and poorly informed community views.

Planning for specialist medical care services of a region should be based on the health service needs of the population, taking into account actual and projected population demographics, plus epidemiological evidence of disease patterns, risk factors and the health of the communities in the catchment areas. Early, meaningful and creditable consultation with local communities and local service providers is an essential step in effective planning for specialist outreach services

Planning should be across all health and aged care services and associated workforces using a multi-disciplinary framework and not consider individual specialties or specialist medical care in isolation. The addition of a new specialist to a region, say in paediatrics, is likely to affect the nature and pattern of the overall services required in the community. For example diagnosis and treatment by a paediatrician could lead to the need for specialised nursing, speech therapy or the monitoring of unfamiliar medication. The special skills and equipment required to support the work of the paediatrician or other medical specialists are not necessarily available in the community. In this example, funding should therefore be available to support outreach nursing and/or allied health services as appropriate.

Too often an outreach services fails because the complementary care required is not available and the specialists concerned have unrealistic expectations of local facilities and health professionals.

> *"..visiting medical specialists might do major operations in a rural area and expect hourly monitoring by nurses and physiotherapy – but the nurses are part-time, there are no physiotherapists and the only monitoring machine was sent away last week for service"*

An alternative approach likely to be more effective is to consider the population's needs in broad areas of care, for example birthing services or child health (not obstetricians or paediatricians) and how best to provide these services to the local communities in the region's catchment area. This will entail a determination of sustainable service models and their associated workforce requirements. Such a level of comprehensive health service planning would be beneficial across the board.

**Critical success factors for specialist outreach services**

Attachment 3 summarises factors identified by a consultancy[2] commissioned by the Australian Department of Health and Ageing as being critical to the success of medical specialist outreach models.

The Alliance considers that most of these factors appear relevant. The list below is of those critical success factors that the Alliance believes to be the most important.

- services are designed to meet a priority, essential population need for the service and cannot be reasonably provided by primary care providers;.
- there are sufficient and secure levels of funding for the service;
- the provision of outreach specialist medical service is defined as core business for the host service provider, not an optional add on;
- the service builds upon local services and contributes to local capacity building and infrastructure;
- effective administrative and clinical support structures and processes are in place, including that local services are adequately resources and staffed and that outreach visits are appropriately planned and coordinated;
- there are sufficient numbers of specialists to ensure regular services, to protect against specialist burnout and to provide sufficient peer support and review;
- provision for the professional and personal needs of the specialists and their families;
- adequate income levels for specialists; and
- specialists involved have appropriate motivations and personal characteristics (eg living in the region, collegial, educational, contributing, willing to be accessible between outreach visits to others caring for the same patients).

**Issues related to medical specialist outreach services provided by core specialist services from regional centres**

***Regional self-sufficiency***

Each region should have a core of specialist services able to meet the regular, specialist medical care needs of its catchment communities. Therefore the priority for each region for specialist medical services should be to build a critical mass of each specialty appropriate for local provision. This will provide continuity of care, effective succession planning, opportunities for peer support and a range of other benefits identified as critical to the success of both regionally-based specialist services and outreach programs.

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[2] James Cook Flinders and Monash Universities' *Evaluation of Strategies to Support the Rural Specialist Workforce*

***Specialist outreach as core business***

Outreach services should not be optional add-ons, but key services which are the responsibility of the area health authority/regional hospital. Hence specialist medical services in regional centres should be planned so that part of their essential business is to provide outreach services where they are needed and can be justified.

Currently it appears that provision for outreach is not routinely built into service plans and resource allocations. Outreach is generally seen as an optional extra, adding to the difficulties in establishing and sustaining such services and placing extra pressures on services in regional centres.

If services are curtailed for any reason (eg budget problems or workforce shortages) it is the outreach services which are most vulnerable, though the health needs in the areas serviced by the outreach specialists might be enormous and the problems faced by the residents in travelling to regional centres unsurmountable for many people.

***Generalist specialists***

Sub-specialisation within broader medical specialties is increasing (eg there are 14 subspecialties within the specialty of Physician and many surgical sub-specialties). It is not feasible to have individual practitioners in regional, rural and remote areas from each sub-speciality.

Physicians and surgeons (and others) practising in these areas must have a broad training in general medicine and surgery respectively. A broad knowledge and skill base in their speciality should also apply to other specialists eg psychiatrists. The increasing trend for sub-specialisation is a key driver of specialist training programs so that it appears to be increasingly difficult for specialist registrars to obtain the broad expertise appropriate for rural practice. There may be a role here for the Colleges in encouraging and supporting more generalist training and encouraging and supporting regional specialists. The Australian Government could demand more positive approaches on their behalf to rural training.

Without intervention nationally, to ensure the ready availability of broad programs of specialist training and to deal with barriers discouraging female medical specialists from working away from metropolitan areas, the rural specialist workforce will continue to age and remain predominantly male. This demographic has implications for the appropriateness and sustainability of outreach specialist arrangements.

***Maintain realism***

There will always be highly specialised services which are not appropriately provided locally. Thus referral to tertiary centres will remain necessary for complex conditions requiring highly specialised treatment and care. It may be appropriate to provide specialist outreach services in these specialities where local assessment is viable, with treatment then being provided more centrally at a tertiary referral centre.

Similarly, where population numbers are insufficient in a region to support a sustainable number of doctors in a particular specialty, referral to larger centres will remain a necessity. In some cases where this situation applies, outreach to the regional centre can

be appropriate, though this will depend on viability, for example the need for little-used specialised equipment or unusual skills in local health care professionals.

As for any other professional, the market works for specialists and they are understandably reluctant to leave the metropolitan areas if it will lead to reduced income. Where populations are borderline in respect of maintaining a viable practice the fee structure should be further reviewed to compensate for the lower volume and income in rural areas. In some instances the public hospitals cannot afford a full-time specialist; the conditions for joint public/private appointments could be made much more attractive than they currently are. This raises many of the recruitment and retention issues (family, locums, CPD, management support) that apply to all professionals.

**Issues related to medical specialist outreach from metropolitan/urban centres to regional areas**

***Promoting self sufficiency***

For those specialties identified as appropriate for local provision, outreach services from major metropolitan centres to the region should not generally be providing routine specialist services to outlying areas. Rather they should focus on supporting the locally based heath workforce, including medical specialists in regional centres, to strengthen their capacity to provide safe and effective services within their regions. Outreach services from the cities must not 'cherry pick' work from existing regional specialists.

***Defining roles and protocols***

In the short-term, whilst a critical mass is being established in an area, outreach services from metropolitan centres could be funded to provide specialist medical services to outlying areas of the region. This role should always include a substantial element of transfer of skills and expertise to the local health workforce and be in line with an agreed service development plan for the region.

As with outreach service provided from local centres there must be agreed protocols about roles and responsibilities eg who is responsible for follow-up care (routine or in an emergency), what must be provided by the specialist outreach team and what locally (eg personnel, equipment, supplies, complementary services), and who is responsible for organising and funding the program and its detailed implementation.

Special funding should not be provided to support metropolitan specialists providing outreach services in regional areas unless the service is an agreed part of a health service plan for the region. In such cases there must be co-ordination with other health services and clear and agreed protocols defining the roles and responsibilities of the outreach specialist and of locally-based health professionals

**Special issues relevant to specialist outreach services for remote communities**

Providing specialist medical services in very remote communities presents special challenges. Particular barriers include:

- accessibility due to poor transport infrastructure which is often unreliable in adverse weather conditions;

- lack of housing and suitable treatment buildings from which services can be delivered;
- unreliable communication networks (telephone, video link up, internet access); and
- lack of support for administration, x-ray, pathology, nursing, medical back up.

Addressing these problems would also have considerable positive spin-offs for primary care services and should be a priority.

**Guidelines for programs to support medical specialist outreach initiatives**

While short-term highly targeted funding and support programs continue, it is important to obtain best value. The Alliance suggests the following guidelines as a starting point for discussion and seeks ongoing involvement in their refinement.

To qualify for funding a specialist outreach proposal must:

- be an integral part of an overall needs-based health service plan for the region;
- demonstrate that the proposal is targeted to a community with a high need for the proposed service and which currently has low access;
- have been developed in meaningful consultation with those affected by the proposal including the community to which the service will be provided, medical specialists currently practising in the area, other health care professionals and health care service providers;
- incorporate into its design, research findings and other evidence about the critical success factors for medical specialist outreach programs. To assist applicants the Australian Department of Health and Ageing should make a summary of relevant evidence and update it regularly;
- include extensive cultural awareness education programs for all those involved, undertaken before the commencement of the services and repeated as necessary throughout the life of the service when the proposed service is to Indigenous communities;
- be able to demonstrate how the proposed service will be sustained beyond the period of funding applied for for, or why the funding should be sustained;
- provide for appropriate professional support and ongoing professional development opportunities, both face-to-face and by video/teleconferencing; and
- take advantage of information technology such as telehealth.

**Summary of key action areas**

This paper has highlighted several actions required to improve the effectiveness and spread of medical specialist outreach services. These are summarised in the table below.

| Recommended action | Purpose | Responsibility |
|---|---|---|
| Develop a national plan to improve the health of residents in rural and remote areas of Australia | To provide a national implementation framework for *Healthy Horizons* to guide local actions | Australian/State/Territory Health Departments and Ministers |
| Develop 'service access standards' | To provide benchmarks to assist regions and others in planning health services<br><br>To define for Australians the publicly-funded health services to which they can reasonably expect access. | Australian/State/Territory Health Departments and Ministers |
| Adopt an Index of Access to Health Care | To ensure that all rural and remote areas are equitably treated as far as resources and aces are concerned. | RWAV is in the process of completing a scoping proposal for such an Index. |
| Formal agreements between governments and between funders and service providers identifying responsibilities, access targets and funding arrangements for specialist medical services in rural and remote Australia, including specialist outreach programs. | To clarify responsibilities. | Australian/State/Territory Health Departments and Ministers and health service providers. |
| As a priority fix infrastructure problems which are a major barrier to specialist outreach programs in remote areas. | To remove major barriers which affect not only specialist outreach programs but virtually every other aspect of health care, economic development and quality of life in remote areas. | Governments at all levels. |
| Publish and regularly update a compendium of good practice models of specialist outreach services to rural and remote areas | To inform community debate and decisions about devising local solutions for their health care needs | Australian Department of Health and Ageing |
| Publish and regularly update an authoritative statement identifying critical success factors for specialist outreach services | To assist in the planning and implementation of specialist outreach services | Australian Department of Health and Ageing |
| Revise and update guidelines for the MSOAP | To achieve greater effectiveness of the program and support for it | Australian Department of Health and Ageing |

**Attachment 1**

# Case studies from NRHA Council members illustrating issues related to the provision of specialist medical services in rural and remote areas

**Rural NSW**

The New England Area Health Service (NEAHS) has a strong preference for specialist staff prepared to live and work locally. Multiple factors militate against this. Perhaps the strongest is the inadequate supply of medical graduates in Australia over a prolonged period, leading to an under-supply and the opportunity for specialists to select their geographical area of work without market forces to direct them rurally.

"Fly-in " specialists have become increasingly common in rural areas in NSW as a means of providing a limited cover for limited or non-existent rural specialists (or less commonly, to provide a service in a specialty where the workload is insufficient to maintain a full-time service). Probably the commonest discipline covered this way in NSW is psychiatry - I understand there are 3 resident psychiatrists west of the Great Divide. With an approximate population of one million, the Department of Health (DoH) recommends 100 for this area. Most areas fly-in enough psychiatrists to provide the most basic service (and certainly not a service able to meet the need, let alone expectations of communities).

Locally we fly-in oncology, gastroenterology, HIV, Hepatitis C, rheumatology etc. Most of these services are developed using individual contacts and are not part of a well arranged system. The specialists who provide these services have an element of altruism but also see an opportunity to raise their income level. Because the demand is high and the supply short, the payment tends to be more generous than would be received in a metropolitan area. As well, there is a dislocation allowance to cover the inconvenience of travel.

Taking all of these factors into consideration, I would like to propose a model with significant rural benefits. Currently medical appointments are to one site. The fly-in specialists take on a second position independently. The proposal is to create joint city-country positions.

Co-operation would be required. The critical element is that each city post filled or created would be part-time and linked to a rural need. This would increase the number of city posts available, but guarantee a rural supply. As an example, Tamworth needs a gastroenterologist. When a selected city hospital is next recruiting for 2 of these positions, they would appoint 3 people, each with the requirement that they spend 1/3 of their time in Tamworth (some other ratio may also be selected).

If it was an employment expectation, there may be no need to offer an increased rate of pay and travel expenses would be the only additional expense. The city-country relationship would be strengthened and the city hospital would increase its referral base (currently a desirable objective). There is a significant benefit in the cross-fertilization of ideas between institutions. It would basically become a full-time job-share across multiple sites. Eventually, some specialists may choose to move rurally.

The strongest commitment needed is probably from the city area to enforce the rural expectation. Government commitment to fund travel/accommodation costs would be appreciated, as would central organization of the process and a clear statement that all position must be city-rural job-shares if there was a rural need.

**Western Australia**

In WA, very few specialists live in the regional areas except for the coastal fringe and Kalgoorlie, leaving a very large area of thinly populated areas with lots of small towns and health services known as the wheatbelt.

There are no specialists in any health discipline between Perth and Geraldton - no surgery or birthing facilities and no visiting specialists.

WA almost needs to be considered in a different way to the east because of the many small health services and the sparse regional centres that are about as large as many of the smaller rural towns in eastern areas.

But most of all any service needs to be reliable, not here today gone tomorrow and any new services should not be introduced at the expense of existing services, unless it has been constantly demonstrated that the service is no longer meeting the need of the community.

What governments use as a the yard stick for delivery of services is the number of and the frequency of usage of services, but in many instance this is a 'chicken & the egg' situation: services not available so there are no statistics available so its assumed the is not the need.

**Specific example of inappropriate use of resources to fund specialist outreach services**

Too often the program is used by those building a practice, not currently accessible in the rural area, but of low priority or possibly a fairly useless bit of boutique practice (dermatologist to coastal areas for freckles or plastic surgeon to retiring coastal areas for eyelid droop!).

**Attachment 2**

# Relevant Recommendations in the Report to Health Ministers from the 'Improving Rural Health' Reference Group for the Australian Health Care Agreements

## Specialist Services

Rural Australian communities do not have reasonable access to high quality specialist services delivered in sustainable service centres.

- 29% of the Victorian population live in rural areas and are serviced by only 5.3% of Consultant Physicians
- Rural specialists identified six top unmet needs when interviewed in 2002 by the DHA:
  - The existence of a critical mass of rural specialists;
  - Opportunities for professional development, CME, and up skilling in tertiary teaching hospitals;
  - Adequate relief, locum support, and peer support;
  - Sufficient funding for trainee and rural specialist positions;
  - Family and spouse support/employment; and
  - Financial support

## Recommended Strategies

### *Develop local service centres*

1. Provide funding to improve regional services and associated networks (that link city and country) based on community need.
2. Implement the AMWAC specialist/population ratios to assist in the development of a critical mass of specialists.
3. Ensure funding formulae account for capital and equipment replacement.
4. Develop and implement quality and safety standards appropriate to service provision in rural Australia.

### *Improve the operation of Medical Services Outreach Assistance Program and similar programs*

5. Encourage use of state funded facilities.
6. Establish mechanisms that use the services of regional specialists to facilitate development of regional expertise.
7. Develop teaching and support roles in specialist areas such as anaesthetics.
8. Link to workforce issues involving recruitment and retention strategies.
9. Develop workforce benchmarks for a core set of specialists including general physicians, paediatricians, general surgeons, obstetricians and gynaecologists, psychiatrists, ophthalmologists, ear, nose and throat specialists, anaesthetists and emergency care specialists.

***Improve Allied Health Services***

10. Allocate funds to More Allied Health Service to cover all costs, such as land travel and accommodation, rather than salary and air travel alone.
11. Encourage allied health services to complement and work with state funded services.

***Remodel the workforce infrastructure***

12. Establish mechanisms which allow for up-skilling of rural specialists in tertiary teaching hospitals.
13. Increase the number of rural training posts and work with the Australian Medical Council to include minimum rural training/practice benchmarks in the accreditation of specialist Medical Colleges.
14. Investigate and implement a national specialist locum service.
15. Develop systems for IT support and training, especially to support telehealth.
16. Fund the creation of hospital training posts that allow rural GP trainees to conduct all or most of their training in the country rather than having to return to the city.

**Attachment 3**

# Critical Success Factors for Specialist Outreach Services

Critical success factors for specialist outreach models can be summarised as:

- appropriate levels of funding for the service;
- adequate income levels for specialists;
- sufficient numbers of specialists, to ensure regular services for consumers and protect against specialist "burn out";
- suitable administrative support structures and processes, including remote clinics that are adequately resources and staffed, and appropriate planning and coordination of outreach visits;
- consumer demand for the service, and a positive consumer response; and
- a service that builds upon local services and contributes to local capacity building and infrastructure.

An expanded version of these factors is set out below.

**Economic**

- Adequacy of funding of service, including ongoing access to resources.
- Appropriate incentives for doctors and staff to provide the service and which contribute to its success include appropriate funding, goodwill, camaraderie, academic links and networking opportunities.
- Profitability (read professional income for specialists).

**Administrative**

- Coordination and prior planning of visits.
- Service regularity with continuity of specialist staff.
- Back-up support so that the work of the specialists in their 'regular jobs' was continued while they were away performing outreach duties.
- Organisational structure.
- Administrative skills in specialists.
- High level support.
- Ability to address medico-legal challenges.
- High quality infrastructure, facilities and technology in outreach areas.
- Evaluation.

**Service delivery**

- Consumer need and acceptance.
- Availability of specialists.
- Succession planning and training.

**Professional**

- Quality of service.
- Sustainable motivating factors fro specialists.
- Effective Relationship with other health professionals, particularly local GPs.
- Training and CPD both for specialists themselves and other local health professionals.

**Social**

- Meeting personal and family needs

**Attachment 4**

# Critical success factors in a specialist outreach program

## Australian Rural Health Education Network (ARHEN) comments

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ARHEN offers the following comments as input to this paper to the Rural Sub-Committee of AHMAC:

- The issues pertaining to remote areas, and those pertaining to rural towns, need to be considered as distinct issues, as there are some key differences.

- The paper currently focuses too heavily on supporting the specialists, which is important, but not the primary consideration.

- The primary consideration needs to be equitable (not equal) access to specialist services by residents of both rural and remote areas. The secondary consideration is supporting existing primary health care teams.

- It is important to ensure that specialist outreach programs do not ultimately increase the dependence of rural and remote communities on fly in, fly out service – they should work to increase the capacity of rural/remote health care providers to deal with the health care needs of their communities.

- While it may not be achievable to have an adequate number and range of specialists residing and working in all rural and remote areas at all times, to the extent which it can be achieved, having specialists living and working in rural and remote areas is preferable to fly-in, fly-out, specialist services. Care needs to be taken that specialist outreach programs do not create perverse incentives which make it more attractive for specialists to concentrate in metropolitan areas and only do outreach to rural and remote areas, thus creating greater long term barriers to sustainable rural/remote specialist practice.

- Where possible, specialist care should be provided close to the patient's rural/remote area of residence. There is a danger that specialist outreach services may concentrate on assessment only in rural and remote locations, and that patients may routinely be referred to cities or large regional centres for ongoing care.

- In some situations, remote primary health care services may be under-funded, whereas specialist outreach services may be relatively well funded. In this situation, the provision of specialist outreach may in fact burden rather than support primary health care teams.

- Rural hospitals often lack the equipment as well as skilled staff to support specialists; and effort is needed to upgrading skills and equipment in these settings, to ensure ongoing benefit to communities.

- In supporting primary health care teams, the specialist should have a strong education focus. To maximise the impact of visits, staff development activities should be included in all visits, targeting community-based staff and/or town based staff in regional centres, depending on the setting. Safeguards are also needed to ensure that GPs are not deskilled by having specialists taking over aspects of care that they are currently handling.

- The team visit approach rather than the single specialist approach is strongly supported. Teams can include a range of personnel including nursing and allied health staff. The specialists within the team should include not only junior specialist doctors/health providers, but a mix of experienced and junior personnel, to develop a culture where future health providers and nurtured in a rural and remote context, and develop an understanding of rural and remote health issues.

- Specialist colleges should ensure that training programs require trainees to undertake rural and remote experience.

- There needs to be a strong emphasis on consistency, with the same specialists visiting regularly, for more than one day at a time, and building relationships with local primary health care staff and communities. Continuity of care, and development of relationships (trust and knowledge) between patients and the team is critical.

- A strong emphasis on sustainability is also needed. Funding should be for a reasonable period (eg a minimum of five years), with commitment from all governments to allow time for the program to become established and gain acceptance. The program should be working towards building the infrastructure necessary to have regionally based specialist staff with training programs, eg registrars rotating through over reasonable periods of time (no less than 6 months).

- Outreach visits need to be well advertised within communities, with an effective and consistent booking and co-ordination systems in place.

- In the initial stages of a program, there needs to be a process of community consultation, to ensure communities are aware of the process, understand the services being considered, and have an opportunity to give their views on whether and how it should be delivered. This is particularly important in the case of Aboriginal communities which may not previously have had access to these kinds of services.

- Ongoing consultation is also needed, especially in situations where the outreach clinics are not well attended, so that problems can be identified and addressed.

- Monitoring and evaluation should be built into and funded through the program. As the program is relatively expensive, cost-benefit analysis is important.