RURAL DOCTORS ASSOCIATION OF AUSTRALIA

The Secretary
House of Representatives Standing Committee on Health
PO Box 6021
Parliament House
Canberra ACT 2600

24 July 2015

Dear Secretary

Thank you for the opportunity to provide a submission to the House of Representatives Standing Committee on Health Inquiry into Chronic Disease Prevention and Management in Primary Health Care. I enclose the submission from the Rural Doctors Association of Australia (RDAA).

Accessible, high quality primary health care is cost-effective, delivering improved health outcomes, improved population health and decreased health costs. With rates of chronic disease rising there must be a focus on supporting, rather than compromising, the delivery of primary health care to those who most need it.

RDAA believes that the best possible health outcomes for rural communities will be achieved through access to a highly skilled and numerically adequate workforce located within the community it serves and supported by a flexible and responsive health system underpinning models of care that:

a) are sensitive to the differential impact they may have in rural and remote Australia
b) are evidence-based, and
c) represent a sound social and economic investment in rural health.

To be sustainable into the future, our health system must better support generalist and team-based community care which is accessible to all Australians, regardless of where they live.

RDAA looks forward to appearing before the Committee to contribute further to this inquiry.

Yours sincerely

Jenny Johnson
CEO

RURAL DOCTORS ASSOCIATION OF AUSTRALIA

Submission to the House of Representatives Standing Committee on Health Inquiry into Chronic Disease Prevention and Management in Primary Health Care

House of Representatives Standing Committee on Health
PO Box 6021
Parliament House
Canberra ACT 2600
Email: health.reps@aph.gov.au

Contact for RDAA:
Jenny Johnson
Chief Executive Officer

24 July 2015

RURAL DOCTORS ASSOCIATION OF AUSTRALIA

The Rural Doctors Association of Australia (RDAA) is a national body representing the interests of all rural medical practitioners and the communities where they live and work. Our vision for rural and remote communities is accessible, high quality health services provided by a medical workforce that is numerically adequate, located within the community it serves, and comprises doctors and other health professionals who have the necessary training and skills to meet the needs of those communities.

INTRODUCTION

Almost one third of Australians live outside major cities. While a rural lifestyle has many rewards, the reality is that the further people live away from major cities, the less healthy they are likely to be. People living in regional and remote areas tend to have shorter lives and higher rates of disease and injury than people in the major urban areas. They are more likely to have adverse social determinants of health[1] and lower health literacy, which places them at greater risk of poorer health outcomes[2]. They also experience higher rates of other risk factors, such as tobacco smoking and alcohol misuse[3] that are associated with the development of chronic diseases.

Rural doctors are leaders in providing and coordinating team-based, comprehensive, continuous and longitudinal care, which is based around the needs of patients, families and communities and is central to best practice approaches to primary health service delivery. They deliver pre-natal to palliative health care and acute and emergency services in a range of settings, including private practices, hospitals, aged care and outreach centres.

Access to these highly-skilled generalist medical practitioners is essential to provide for the complex health needs of people in rural and remote communities, including for the prevention and management of chronic diseases, comorbid and multimorbid conditions.

Attracting and retaining the right doctors and allied health professionals to the diverse communities in rural and remote Australia, and supporting them with appropriate training, infrastructure and support, is vital to enable effective responses to the challenges posed by an ageing population and increasing rates of chronic disease.

[1] AIHW 2014. Australia's health 2014. Australia's health series no. 14. Cat. no. AUS 178. Canberra: AIHW; at 186
[2] AIHW 2012. Australia's health 2012. Australia's health series no.13. Cat. no. AUS 156. Canberra: AIHW; at 182
[3] Op cit; AIHW 2014; at 187

SUMMARY OF RECOMMENDATIONS

Best Practice

1. *Ensure that proposed best practice models have been rigorously trialled, are locally applicable and are evaluated over time.*

2. *Maintain and enhance the rural training pipeline to improve access to and the quality of primary care services and integrated models of care, including by:*

    - *Establishing a national Rural Generalist Training Program and funding model*
    - *Providing adequate numbers of training placements in rural general practices and rural hospitals*
    - *Providing support for rural supervisors and teaching practices.*

3. *Incentivise and support rural generalist practitioners.*

4. *Continue to provide rural recruitment and retention incentives that are directed to rural communities and the skill sets which are needed.*

5. *Provide targeted strategies to address the specific challenges faced by rural and remote communities in utilising telehealth.*

Medicare

6. *Support and incentivise comprehensive continuity of care and disincentivise throughput-based models of practice.*

7. *Recognise and provide adequate remuneration for the complexity of rural practice.*

8. *Ensure Medicare Benefits Schedule (MBS) rules do not act as barriers to holistic, person-centred continuity of care.*

9. *Provide realistic levels of funding and certainty for general practice businesses.*

10. *Abolish the indexation freeze on MBS rebates.*

Primary Health Networks

11. *Develop and implement well-resourced, targeted strategies to improve availability of and access to generalist and community care.*

12. *Facilitate flexible, GP coordinated, team-based care arrangements.*

13. *Facilitate connections with State and Territory governments, Local Hospital Networks and other service delivery practitioners and organisations.*

14. *Provide clear guidelines governing how "market failure" in the provision of health services will be addressed in rural and remote areas.*

State/Territory governments

15. Ensure appropriate communication and accountability mechanisms for Commonwealth and State/Territory governments are in effect.

16. Review and clarify current funding arrangements.

17. Revise care protocols to reflect best practice for rural and remote areas.

BACKGROUND

The health and broader socio-economic impacts that rising rates of chronic diseases—including heart disease, stroke, cancer, chronic respiratory diseases and diabetes—have on individuals, families, communities and national and global systems are well known. They include: premature mortality; long term morbidity; reduced quality of life; higher health care costs to individuals; increased utilisation of health services; increased health expenditure by governments; reduced workforce participation and lost productivity. In short, rising rates of chronic diseases have far reaching consequences that, if unchecked, will be increasingly detrimental to individual and population health outcomes and an ever increasing drain on health and social service resources which will affect longer term economic prosperity.

The World Health Organization (WHO) refers to the burden of chronic diseases as an "invisible epidemic". They are by far the leading cause of mortality in the world, representing 60% of all deaths, yet many are non-communicable and highly preventable.[4] Wilcox cites WHO estimates that 80 per cent or more of all heart disease, stroke and diabetes cases can be prevented as can 40 per cent of all cancers.[5]

In Australia, rising rates of chronic disease are placing increasing demands on the health system – and on other sectors such as employment and housing – across the whole population, with lifestyle issues and caring for an ageing population posing particular challenges.

The high rates of risk for the development of cardiovascular disease, diabetes and chronic kidney disease in the Australian adult population are indicative of these issues. Particularly significant is the percentage of the population having multiple risk factors which increases disease risk. Two-thirds of the adult population have three or more risk factors at the same time, including 10% with five or six risk factors.[6]

Most deaths in this country are now due to chronic diseases or multiple chronic diseases. In 2011 nine out of every ten deaths were attributed to chronic diseases.[7]

[4] World Health Organization. Chronic Diseases and Health Promotion. http://www.who.int/chp/en/ WHO. Accessed 10 June 2015.
[5] Wilcox, S. 2014. Chronic diseases in Australia: the case for changing course. Prepared for the Mitchell Institute. Available at http://www.mitchellinstitute.org.au/chronic-disease/. Accessed 10 June 2015.
[6] AIHW 2015. Cardiovascular disease, diabetes and chronic kidney disease—Australian facts: risk factors. Cardiovascular, diabetes and chronic kidney disease series no. 4. Cat. no. CDK 004. Canberra: AIHW. Available at http://www.aihw.gov.au/publication-detail/?id=60129550538&tab=2. Accessed 10 June 2015.
[7] Op cit. AIHW 2014; at 98

A greater percentage of the burden of chronic disease is now caused by ill-health rather than premature death.[8] Advances in treatment and technologies mean that many people—cancer sufferers for example—have better life expectancy than previously. This has major implications for the management of these diseases including for palliative care. Poorer quality of life and opportunities lost as a result of reduced functioning capacity is a significant issue for many individuals, families, carers and the broader community.

The burden of chronic disease is unevenly distributed.

Higher rates of risk factors are present in outer regional and remote areas[9]. The AIHW cites 2011-12 findings from the Australian Health Survey (AHS) which indicate that people in outer regional and remote areas (excluding Very Remote areas and discrete Aboriginal and Torres Strait Islander Communities) were more likely than urban dwellers to

- be a daily smoker (outer regional and remote 22% compared with 15% in major cities)
- be overweight or obese (70% compared with 60%)
- be insufficiently active (60% compared with 54%)
- drink alcohol at levels that place them at risk of harm over their lifetime (24% compared with 19%)
- have high blood cholesterol (37% compared with 31%).[10]

Findings from the 2014 National Aboriginal and Torres Strait Islander Health Measures Survey showed that, compared with other Australians, Aboriginal and Torres Strait Islander people are: more than three times as likely to have diabetes (rate ratio of 3.3); twice as likely to have signs of chronic kidney disease (rate ratio of 2.1) and more likely to have more than one chronic condition, for example having both diabetes and kidney disease at the same time (53.1% compared with 32.5%).[11]

The degree of isolation and other geographic, climatic, social and economic circumstances of rural and remote communities limit the ability of people living in those communities to access health services. Visits to GPs, specialist medical practitioners, allied health services and hospitals can be problematic, often involving long wait times and requiring considerable time and effort to travel to the necessary service. The emotional, social and economic burden this places on individuals and their families is considerable.

A coordinated policy response is required.

Australia's current policy responses are fragmented, focused on specific diseases or issues and characterised by a continuing emphasis on treatment and a reliance on the hospital system rather than preventive primary care.

This belies the concept of best practice. Evidence suggests that "a strong primary health care system is associated with reduced costs and increased efficiency, lower rates of potentially preventable hospitalisations, reduced health inequities, increased

[8] Ibid; at 92
[9] Ibid; at 186
[10] Ibid; at 187
[11] ABS 2013. Australian Aboriginal and Torres Strait Islander Health Survey: First Results. Australia, 2012-13. http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/39E15DC7E770A144CA257C2F00145A66?opendocument Accessed 21 May 2015

patient satisfaction with care, and better health outcomes, including lower rates of potentially avoidable mortality."[12]. Clearly prioritising primary care prevention would be beneficial in removing impediments to optimal chronic disease management.

Mechanisms to facilitate complementary approaches by State/Territory and Federal governments and robust accountability frameworks are necessary to streamline and integrate governments' responses to chronic disease. Cohesion within the health system would provide a foundation for an integrated approach to delivering prevention services and management of cases at all levels. This would assist in avoiding inefficiencies and duplication and improve individual and population health outcomes.

To effectively respond to the impact of chronic diseases on the Australian population, consideration must be given to health care reform more broadly and to the impact on and implications for the human services sector. There is a critical need to refocus away from short term reactive responses to existing and emerging health issues to longer term, well considered, strategic and proactive plans.

RDAA's position on health care reform

- ***Cost effectiveness cannot be achieved by focusing expenditure reduction measures on only one area of the system:*** A broad-based, non-political, strategic consideration of all aspects of funding for the health care system with the aim of providing efficient, effective, high quality and sustainable health care for all Australians is needed. This discussion should also encompass the current structure of Federal/State health funding arrangements.

- ***Policies should be evidence-based, achievable, equitable and sustainable:*** New proposals should be rigorously analysed and trialled before they are implemented, in order to minimise unintended and adverse outcomes. They must be sensitive to the differential impact they may have in rural and remote Australia.

- ***Investment must focus on supporting, rather than compromising, the delivery of primary health care:*** In Australia's current political and socio-economic climate, the increasing health care costs due to the growing burden of chronic disease and reliance on the hospital system means that an increased focus on primary health care is critical to improving health outcomes and sustaining an effective health system.

RESPONSE TO COMMITTEE TERMS OF REFERENCE

Best practice in chronic disease prevention and management

Identifying "best practice" models for the prevention and management of chronic diseases in rural and remote areas can be challenging, not least because of the geographic, economic, environmental and socio-demographic diversity of rural communities. "One size will not fit all". What is best practice in Strachan may not be

[12] Op cit. AIHW 2014; at 363

in Oodnadatta or in Karratha. Best practice should always be assessed with regard to this diversity.

Stakeholder consultation and appropriate evaluation strategies before, during and after the trialling and introduction of any model will be essential. Localised approaches delivered by those cognizant of local needs and resources will be needed if optimal prevention and management of chronic diseases is to be achieved.

In rural and remote Australia, chronic disease prevention and management models of care must be predicated on an understanding of the unique characteristics and circumstances of these communities and the challenges confronting medical professionals working in them.

Models should be underpinned by a system which:

- ***Recognises general practice and general practitioners as the primary mechanism to deliver high quality primary health care:*** Quality general practice provides holistic, continuous care that will improve health outcomes in individuals and populations in the shorter and longer term and reduce health care costs.

- ***Supports and incentivises quality, longitudinal, comprehensive continuity of care:*** High-volume, episodic, low quality practice will not improve health outcomes or systemic efficiency in the longer term. Specialist rural general practitioners working in full-scope general practices should be rewarded for the quality, longitudinal, comprehensive continuity of care that is provided for a broad spectrum of undifferentiated presentations; preventive care; and management of chronic and complex health conditions.

- ***Incentivises health services that meet community need and build health workforce capacity:*** In addition to active participation in chronic disease prevention and education, this could include after hours and emergency care; visiting medical officer (VMO) services; teaching/training of medical students and registrars; and providing outreach services.

- ***Maintains rural incentive programs and a rural loading for general practice incentives:*** The rural health workforce and general practice incentive programs play a key role in acknowledging and promoting rural workforce recruitment and retention, and quality improvement in general practice. This in turn improves capacity in the rural environment where the complexity of practice, including for chronic disease and comorbid conditions, poses particular challenges.

- ***Provides a realistic funding model and certainty for general practice businesses:*** Many rural practices face mounting professional, economic, systemic and structural pressures that threaten their capacity to provide for the health needs of their communities and, ultimately, their survival. Current funding models are poorly targeted and fail to address this underlying issue. Viable, stable and sustainable rural general practices are the mainstay of healthy rural communities and of the rural medical workforce, and without them a range of other services, including hospital services, would be severely compromised.

Teaching practices should be supported through a range of rurally specific incentive and block funding mechanisms to recognise their role and maintain their viability as providers of quality education and training, particularly for junior doctors and registrars.

- ***Facilitates flexible, team-based care arrangements where the GP is the key coordinator, to maximise workforce efficiency:*** This could include support for the employment of Indigenous Health Workers, Allied Health and Mental Health Workers, Practice Nurses, Nurse Practitioners, Physician Assistants and other mid-level practitioners to enhance the outcomes in primary care models.

  The provision of rurally specific MBS items and/or block funding for these roles would assist in enhancing the capacity of general practitioners to provide team-based care within their practices.

- ***Supports rural generalist services****:* The current systemic bias toward treatment rather than preventive primary care, compounded by a reliance on the hospital system and acute, specialist and sub-specialist services, contributes to a greater risk of fragmented care, duplicative services and patient dissatisfaction. It is expensive at both the systemic and individual levels and is not conducive to improved chronic disease prevention or management, or to better health outcomes.

  While specialist care will always be necessary, generalist practice provides a more efficient model for delivering and coordinating a wide range of services. This is particularly important for effective chronic disease prevention and management in rural areas.

  RDAA supports the establishment of a nationally recognised rural generalist model of practice where general practitioners are credentialed to provide more advanced care where appropriate, with appropriate recognition and reward for practitioners who are delivering a generalist medical service.

- ***Invests in the recruitment, training and retention of rural doctors***: Given the compelling evidence regarding the efficacy of primary care with respect to improved health outcomes and return on investment, providing a numerically adequate, appropriately skilled and supported workforce located within the communities they serve is the best mechanism for addressing chronic disease prevention and management in rural and remote Australia.

  Investment in providing appropriate education, training and support is necessary to attract and retain medical students, junior doctors and more experienced doctors to rural and remote areas.

- ***Supports telehealth****:* The increasing sophistication and availability of information and communication technologies within the health sphere presents opportunities for rural and remote doctors and health services to more effectively provide chronic disease prevention and management with reduced travel time and costs for patients and carers.

There is significant potential to improve the capacity of rural doctors to provide preventive health information; to diagnose, treat, monitor and review patients suffering from chronic diseases, comorbid and multimorbid conditions; and to remotely connect patients with specialists and other health professionals and services. While this potential exists, it must be noted that the therapeutic value of the doctor-patient relationship and the longitudinal, continuous and coordinated care provided by rural doctors cannot be replaced by telehealth consultations.

Barriers to access, and limitations on the uptake and use of, telehealth in rural settings must also be acknowledged and addressed to realise the potential of these opportunities. The degree of isolation and the circumstances of rural and remote communities impact on their capacity to establish and use telehealth services. In particular, there is a lack of enabling human, financial and technological resources.

Other issues include lack of access to adequate training, lack of access to and reliability of technology and equipment, lack of hardware and software technical expertise to repair and service equipment, and extreme weather conditions resulting in more frequent power outages which may result in equipment failure or delays.[13]

Recommendations

1. *Ensure that proposed best practice models have been rigorously trialled and locally applicable before they are implemented more widely, and that they are evaluated over time.*

2. *Maintain and enhance the rural training pipeline to improve access to and the quality of primary care services and integrated models of care in rural communities through a range of strategies, including:*

    - *Establishing a national Rural Generalist Training Program and funding model*
    - *Supporting adequate numbers of training placements in rural general practices and rural hospitals*
    - *Increasing support for rural teaching practices and supervisors.*

3. *Incentivise and support generalist practitioners, whether these be in general practice or other specialties.*

4. *Provide rural recruitment and retention incentives that are directed to the required communities and skill sets, with a focus on chronic disease prevention and management.*

5. *Implement targeted strategies to address the specific challenges faced by rural and remote health practitioners and communities in utilising telehealth.*

[13] RDAA 2015. Telehealth Key Principles. Available at http://www.rdaa.com.au/policies-submissions/policies

Medicare

Medicare was designed to support the health of all Australians through a funding system based on five key principles: universality, access, equity, efficiency and simplicity through the provision of standardised rebates to consumers to ensure they can access primary medical care.

The RDAA strongly supports Medicare as an effective national universal health care scheme and recognises that there are a number of issues that need to be addressed to ensure its efficacy. RDAA supports the Medicare Benefits Schedule Review being undertaken by the Taskforce chaired by Professor Bruce Robinson.

The Medicare Benefits Schedule (MBS) should be responsive to and reflect best practice in cost-effective service delivery of evidence-based care and facilitate equitable and sustainable access to high quality care for all Australians, innovation in service delivery and the capacity to utilise advances in technology.

Recommendations

MBS rebates should:

6. *Support and incentivise comprehensive continuity of care and disincentivise throughput-based models of practice.*

Rewarding sub specialist practice and greater throughput of patients rather than continuity of care impacts heavily in rural areas where isolation, costs, content, context and complexity of practice pose significant challenges.

Quality, longitudinal, comprehensive continuity care that is provided for a broad spectrum of undifferentiated presentations; preventive care; and management of chronic and complex health conditions should be recognised and incentivised through the MBS.

This could be achieved through a variety of mechanisms, including:

- refining MBS item descriptors to ensure that they reflect and reward evidence-based care
- including appropriate rebate items for telehealth in the Schedule
- developing blended funding models that combine payment for voluntary enrolment with a usual provider of primary care, fee-for-service and incentives for high quality care
- recognising and rewarding scope and comprehensiveness to support a shift from high-cost hospital settings to ambulatory care.

7. *Recognise and provide adequate remuneration for the complexity and circumstances of rural practice.*

RDAA believes rural doctors should be professionally recognised and rewarded for the increased training and skills, and the level of advanced practice implicit in rural practice. Higher-level clinical decisions need to be made and greater responsibility taken when working in isolation where there are few professional supports, and limited diagnostic services and other health facilities.

8. Ensure MBS rules do not act as barriers to holistic, person-centred continuity of care.

While improved patient outcomes should always be the fundamental aim of health care, in rural areas multiple morbidities, poorer compliance and less frequent visits to the doctor make this harder to achieve.

One significant barrier to continuity of care, particularly in rural areas, is the current MBS ruling that disallows MBS rebates for both care plans and standard attendance items for the same patient for the same day.

A visit to the doctor for a chronic disease management (CDM) consultation also provides a window of opportunity for other prevention, treatment and management interventions such as screening services for conditions such as cervical, prostate, skin and bowel cancer that can be treated if detected early, or for the delivery of legitimate medical care for a more acute ailment not related to the CDM. A patient may choose to have the latter treated at the expense of his/her ongoing wellbeing or equally may delay or ignore the need for other screening until it is too late to benefit from early intervention.

It is unreasonable to ask a person who has travelled a long distance, or who is living in an area underserviced by GPs, to choose between the CDM consultation and the standard consultation on a particular day and return on another day for the outstanding consultation.

The ability to claim both CDM and standard consultation items for the same patient for the same day is particularly useful if patients have travelled long distances to seek treatment or have had to wait many weeks to be seen close to where they live, and allows the GP to provide holistic, patient-centred care.

9. Provide realistic levels of funding and certainty for general practice businesses.

Rural general practices face mounting economic and other pressures which can jeopardise the viability of practices and compromise the capacity of doctors to provide the comprehensive, continuous, coordinated and longitudinal care necessary for effective chronic disease prevention and management.

A rural general practice is also a small business. Like any small business, private investment requires certainty to mitigate risk. There will be limited future investment in the business of general practice without certainty and realistic funding. This in turn could severely compromise the ongoing provision of care and hospital services in many rural communities.

10. Abolish the indexation freeze on MBS rebates.

The Medicare Benefits Schedule (MBS) has failed to keep up with inflation or accurately reflect practice costs and its structure has driven volume-based practice funding models. The continuing indexation freeze on MBS rebates serves to exacerbate existing pressures on rural general practice viability and increase the likelihood of the negative consequences outlined above. Abolishing the indexation freeze would help to ameliorate this situation.

Primary Health Networks

The introduction of Primary Health Networks (PHNs) provides opportunities for improving coordination and support for practitioners and services in addressing chronic disease. Engaging with rural doctors and implementing targeted strategies to address the specific challenges faced by rural and remote communities will be fundamental to their success. PHNs must recognise the central role that rural GPs and general practices play in rural health care.

PHNs should facilitate strong links with State and Territory governments and Local Hospital Networks (LHNs) to improve patient outcomes through coordination of multiple services providing episodic and longitudinal care.

The role of PHNs in addressing market failure will be critical in rural areas where recruitment and retention of doctors and other health professionals is problematic and practice and other service viability is uncertain. Clear guidelines governing how "market failure" in rural and remote areas will be defined and addressed will be needed. Consideration should be given to providing funding to practices with appropriate governance structures and performance indicators to facilitate recruitment and retention of health professionals to fill identified service gaps.

Recommendations

PHNs should:

11. *Develop and implement coordinated, well-resourced, targeted strategies to improve availability of and access to generalist and community care.*

12. *Facilitate flexible, GP coordinated, team-based care arrangements.*

13. *Provide mechanisms to facilitate engagement with State and Territory governments and connections between Local Hospital Networks and other service delivery practitioners and organisations to improve continuity of care.*

14. *Provide clear guidelines governing how "market failure" in the provision of health services will be addressed in rural and remote areas.*

State and Territory Governments

State and Territory governments currently play a major role in chronic disease prevention and management at the individual, family, community and population levels, through funding of population health initiatives to providing community health, hospital and aged care services.

The existing two-tiered health care funding arrangements, with the Commonwealth primarily funding primary care through Medicare and hospital care provided through the states and territories, creates problems. For example, cost shifting and blurred lines of responsibility impact on chronic disease prevention and management and on health service provision more broadly.

This has a significant impact in rural areas where the roles of state and federal jurisdictions are often inter-twined. Most rural doctors will not only provide general

practice based primary care, but also work under salaried or contractual arrangements for their State or Territory jurisdiction, providing Visiting Medical Officer, after hours and/or emergency services at the local hospital.

There is potential to improve integration and efficiency of service delivery in rural areas and to support quality and continuity of care through better coordination between the Commonwealth and State and Territory jurisdictions. An integrated approach encompassing all levels of health care from prevention to palliation with clearly defined protocols and referral pathways is required to improve patient outcomes.

Strong communication and accountability mechanisms to facilitate complementary approaches by State/Territory and Federal governments are necessary to provide a framework for action to move toward this integrated approach.

Recommendations

15. Improve communication and accountability mechanisms for Commonwealth and State/Territory governments in relation to health service provision.

16. Review and clarify current health funding arrangements.

This must involve ongoing consultation with rural doctors and other stakeholders to minimise the potential negative impacts of cost shifting and support quality and continuity of care.

17. Revise care protocols to reflect best practice for rural and remote areas.

In rural and remote areas, care protocols may involve automatically referring patients to specialists and/or subspecialists in larger regional or urban facilities at considerable financial and emotional cost to patients and their families. In some instances, for example in many aged or palliative care transfers, the interventions cannot be justified economically or in terms of improved health outcomes. Care protocols should be revised to reflect best practice for rural and remote patients.