

Australian College of
Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE



COLLEGE SUBMISSION

Senate Community Affairs Reference Committee Inquiry:
The availability and accessibility of diagnostic imaging
equipment around Australia

October 2017



College Details

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About ACRRM

The Australian College of Rural and Remote Medicine (ACRRM) was established in 1997 and is one of two professional Colleges recognised by the Australian Medical Council to provide vocational training towards Fellowship in the specialty of general practice. The College programs are specifically designed to provide Fellows with the extended skills required to provide the highest quality care in rural and remote communities, which often suffer from a dearth of face-to-face specialist and allied health services.

ACRRM's vision is better health for rural and remote people through access to skilled rural doctors. It progresses this through:

- the provision of quality vocational training,
- professional development education programs,
- setting and upholding practice standards and
- support and advocacy services for rural doctors and the communities they serve.

College Fellows and members are characterised by their relative geographical isolation and broad scope of generalist practice, resulting in an increased reliance on teamwork and fit-for-purpose technology. In order to meet the educational and advocacy needs of members, the College continues to be innovative in the development and delivery of distance education and the creation and use of collaborative e-networks and e-technology to bridge the tyranny of distance

The College Submission

ACRRM notes the terms of reference for this inquiry. This submission will be limited to a very general response; however the College recommends that the Committee seeks more detailed input from rural and remote medical practitioners working in a range of service delivery models and circumstances during the course of their investigations.

ACRRM would be please to assist in identifying College Fellows who may be able to provide more detailed information about the availability of diagnostic imaging equipment in rural and remote facilities; the costs of purchasing and maintaining diagnostic imaging equipment in rural and remote private practice; the operation of this equipment; and the supports required to ensure that these services remain available in rural and remote communities.

The Rural and Remote Context

It is important that any assessment of costs and access to diagnostic imaging services is cognisant of the circumstances under which rural and remote health care services are provided. Failure to consider the rural perspective could significantly contribute to poorer access to these services for rural and remote communities.

It has been well documented that rural people already record demonstrably lower health status, use medical services less and receive less government funding toward their healthcare than their urban counterparts. This is due in part to difficulties in accessing a range of primary care, diagnostic and specialist services.

Rural generalist practitioners work under unique circumstances; with a scope of practice and working environment which is very different to urban practice. Rural general practitioners are

often the only readily available doctors and commonly take on roles ordinarily the preserve of specialists in the cities. Likewise rural practices operate under different conditions and challenges. They tend to have higher overhead costs and may have difficulty in recruiting skilled staff.

Rural hospitals are hubs for the whole community, with the benefits of access to a wider range of services, including diagnostic imaging services, benefiting primary care providers as well as the broader community. Treating patients in their community is much more cost effective both for the patients and for the health care system.

Over the past few decades a significant number rural and remote medical facilities have been downgraded or closed. Many of the remaining facilities no longer have the equipment necessary for basic diagnostic imaging, meaning that rural and remote patients must travel to access these services. It also means that rural generalist practitioners are not able to work to their full scope of practice.

In many cases, the reasons given have been for cost or quality and safety considerations.

In spite of the strong track record of the rural generalist model of practice in providing an effective and efficient response to the health care needs of rural and remote communities, there is still a considerable systemic bias against the generalist model of service delivery.

This bias is extending to increasing trends to link quality with volume, and to assume that the volume of services provided or procedures undertaken can be used as an indicator of safety and quality. However there is a growing body of evidence against which rural and remote service models can be benchmarked and which demonstrates that a low-volume service can still provide high quality and appropriate care. The perceived relationship between quality and volume is inconsistent with the generalist model of practice and does not reflect the best interests or needs of rural and remote communities.

There is also an increased tendency for assessments of quality and safety to be undertaken by urban-based practitioners and processes, where there may be limited understanding and experience of the rural and remote context. ACRRM recommends that there be strong rural and remote input, and particularly practitioner input, into the development of any recommendations or policy positions arising from this inquiry.

Policies relating to the age and standard of diagnostic imaging equipment; the qualifications of operators; and lack of access to specialist services should take the rural and remote context into consideration. This includes developing appropriate clinical frameworks and risk management strategies to ensure that quality and safety is maintained while maximising access for people living in rural and remote communities.

Where there are tensions between providing a much-needed medical service to a rural or remote community and the quantity/volume of services undertaken or other factors such as equipment age and operation, community need should be given a high priority. Absence of a service can result in a significantly poorer outcome for rural and remote communities and patients, who may delay or forgo health care if they are forced to travel to access these services.

Rural and Remote Exemptions

The provision of safe, accessible diagnostic imaging and radiological services to rural and remote areas requires a different approach to that in regional or metropolitan centres that are staffed by specialist radiographers and radiologists.

The current Australian Standard Geographic Classification (ASCG) remote area radiology exemption rules have been effective in achieving the goals of accessibility and quality of care for people living in these communities.

The Rural and Remote Radiology Exemption Program allows additional flexibility regarding who is able to perform a diagnostic radiology procedure in a rural or remote area, although procedures in these areas must also be performed by a medical practitioner; or a person, other than a medical practitioner, who: a) is employed by a medical practitioner; or b) provides the service under the supervision of a medical practitioner in accordance with accepted medical practice.

ACRRM operates a program to provide a quality assurance and continuing medical education service for eligible College members and other practitioners who aspire to build and maintain their radiological skills. Participation in this program is recognised as a Quality assurance requirement for remote area exemption. Application for, or continuation of, a remote area exemption will be contingent on practitioners being enrolled in an approved continuing medical education and quality assurance program.

The "Capital Sensitivity" measure encourages service providers to upgrade and replace aged equipment with the aim of improving the delivery of quality of diagnostic imaging services. As an acknowledgement of the circumstances of rural practice, particularly regarding the capital cost of diagnostic imaging equipment, an automatic exemption applies to practices located in Remoteness Area (RA) categories of outer regional, remote and very remote.

The Department of Health may grant exemptions for inner regional locations where the location was previously under the Rural, Remote and Metropolitan Area (RRMA) classification system as, RRMA4 or RRMA5, and

- the diagnostic imaging equipment does not exceed the maximum extended life age by three years or more;
- the equipment is operated on a rare and sporadic basis
- the equipment provides crucial patient access to diagnostic imaging services.

Teleradiology

Teleradiology can be defined as the electronic transmission of diagnostic radiological images in digital form from one location (acquisition site) to another (reporting site) for diagnosis and reporting by a clinical radiologist or any other appropriately credentialed medical specialist using a bi-directional data communication link that keeps all patient data secure.

Local services, supported by with remote supervision enhanced via telehealth, can increase accessibility and equity for rural and regional areas where it is difficult or impractical to recruit and retain radiologists. These local services are critical as they offer a key diagnostic tool to clinicians including the determination of whether to transport the patient to a tertiary centre, which may mean expensive air travel or a lengthy road trip.



Many rural and remote generalists are appropriately credentialed to provide radiological services locally, but value the role of the distant radiologist second opinion to ensure quality imaging and specialist radiologist reporting. ACRRM supports the important role of teleradiology as an adjunct to conventional on-site radiological service provision. The primary purpose of a teleradiology service must always be to improve patient care relative to that available in its absence.

ACRRM emphasises that the provision of teleradiology must not be used to justify removing current exemptions for certain types of services. Most, if not all facilities in more remote areas are low volume in comparison to large metropolitan sites. The removal of exemptions may render operations unviable across the whole imaging facility, therefore removing access to diagnostic imaging altogether from some rural and remote communities and their surrounding catchments.

Recommendations

1. That the Committee seeks more detailed advice from rural and remote medical practitioners working in a range of service delivery models and circumstances during the course of their investigations.
2. That the Committee considers the rural and remote context and its impact on service delivery models and patient access to services in the development of its report and associated recommendations.
3. That the current rural and remote exemption provisions, including the Rural and Remote Radiology Exemption Program which is administered by ACRRM, be continued as effective mechanisms for achieving the goals of accessibility and quality of care for patients in rural and remote communities.
4. That any recommendations and subsequent policies are subject to a 'rural proofing' exercise to ensure that they support quality access to services and do not have any unintended consequences for rural and remote communities. This should be undertaken with significant input from appropriately skilled and experienced rural and remote practitioners.