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EDITORIAL

Why we need better rural and remote health, now more than ever

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As the world desperately attempts to mount a coordinated and effective response to the recent pandemic outbreak of COVID-19, it is becoming recognised that the greatest impact will likely be felt by the most vulnerable populations. This includes people who live in rural and remote communities with less access to critical health services. For example, although it may be possible to instigate a drive-through testing centre in a city, how do small rural communities manage testing without putting at risk the same clinicians and facilities that are needed for treatment? What happens when local clinicians have become deskilled due to health service role changes and there is suddenly a need for high-level care for more people than can be retrieved to a larger centre? How do we scale up home care, clinic care and hospital care when funding and training has been separately focused on either the clinic or the hospital, yet the same clinicians are required for all? How do we avoid stigmatising and discriminating against rural patients? How do we ensure people living in remote areas do not feel isolated from the national responses? What will be the impact on the large numbers of immune-compromised people with TB and HIV in rural Africa? If the elderly are more at risk, what will be the impact on the large number of elderly clinicians remaining in rural practice because they have been unable to find younger replacements?

These and other questions throw a spotlight on rural health systems and the workforce that sustains them. Just as prevention is better than cure, so is preparation better than crisis response. So what do we know that could prepare our rural health systems to be more resilient, responsive and reassuring to our patients?

To answer this question, we can learn much from those who have been living in many of our remote and rural communities the longest – our first nations peoples. Here we learn of health as

being a bio-psycho-socio-spiritual construct, a holistic approach that is grounded in an appreciation of the places in which we live and where we share both our history and future. I suggest that in contemporary health service policy we would refer to this holism as integration, and in workforce policy we would refer to it as generalism. I contend that if integration and generalism were more widely adopted in rural and remote areas globally, we would be better prepared for not only this present infectious disease threat, but also to deal with ongoing threats posed by, for example, chronic diseases, gender-based and family violence and mental health disorders.

At least four levels of integration are required:

- *Across sectors – primary care, secondary care, other social services*
  Siloed systems of care developed for large metropolitan environments are neither effective nor efficient in smaller rural communities. Thin markets require generalist models to provide the breadth of services required to be delivered locally. The discontinuity that siloed specialist approaches produce for patients is particularly evident when such systems are reduced to being led by outreach or locum models, as important as these may be in supporting local resident generalist models. Building from primary care is critical.

- *Across professions*
  Rural practice is best provided by teams of generalists who have broad and interlinked skills so that they can both work at full scope of practice and provide some cover for each other. This requires no compromise in outcome standards, but flexibility in how those standards are delivered or attained. It enables rapid changes and repurposing in practice patterns without having to recruit entirely new clinicians.

- *Across towns and villages within regions*
  Economies of scale and expanding local service provision, without sacrificing local continuity, can be produced by regionally networked care and funding/business models involving both public and private systems. This regional collaboration is critical to providing attractive and supported jobs, particularly for early-career clinicians, who value being able to have maternity and family leave and time not on-call to enjoy where they are living. Regional collaborative networks become critical, particularly when a natural disaster can close an individual health service down for a period of time.

- *Across care, teaching and research*
  The best health services are constantly analysing their work to produce improvement, upskilling their clinicians and training their successors in end-to-end local degree programs. Too many rural and remote health services outsource these functions to metropolitan institutions, to the detriment of the clinicians and patients. With the democratisation of knowledge and research methods through the internet, there is no longer any justification for this approach. Remote and rural health services must be training the next generation to a standard where they can practice anywhere in the world and where they are inspired and equipped to practice locally. Remote and rural health services can now develop care protocols relevant to their own context and based on their own epidemiology rather than estimating how to adapt protocols developed in urban high-technology contexts.

The outcomes of an integrated generalist approach are:

- *Resilient professionals*
  Sustainable, attractive jobs filled predominantly, by choice, by graduates trained in the local context, and thus distributed equitably according to need, create an environment where clinicians can respond better to inevitable personal and professional crises throughout their career without the default response being to leave or burn out.

- *Responsiveness to population needs*
  Flexible generalist models of care with practitioners trained for and working at a broad scope of practice, regularly analysing epidemiologic, workforce and demographic trends, and supported by point-of-care and telehealth technology, create a system that can adapt and respond to local needs rather than imposing a model from somewhere else on a community.

- *Responsible price*
  By maximising the right care at the first point of entry to the health system, an integrated generalist model reduces duplication, over-investigation and transport and retrieval costs, resulting in cost-effective care both for patients and other system funders. The funding for local health services being spent locally is an important stimulus for local economies, resulting in a virtuous cycle of reputation for both community and practice.

- *Reassurance for patients*
  By leveraging the impacts of stable and predictable continuity and relationships with patients and care delivery closer to home, generalist models enable patients and communities to plan for their futures with greater confidence. Healthy communities become more wealthy communities.

As we come together as a global community to fight the current pandemic, it is more evident than ever that we must think of others, not just ourselves – at social, economic and health system

levels. Those countries that have rural health systems built along the principles above are likely to be able to respond more proactively and safely. For those that do not, heroic individual responses will come, but at great cost.

And yes, there are urgent needs stimulated by this crisis that can improve all systems. The data sharing and cooperative analysis across different levels of government and public and private sectors that this crisis demands could have lasting benefits. The urgent requirement to develop and fund robust telehealth models that accommodate both patient and clinician isolation may change the face of rural practice forever. The realisation that preventative health care is not a cost to society, but an unavoidable investment in its economic security, should reset the balance in health expenditure for the next generation. The demand for systematic and proactive regional collaboration and resource sharing over distance may enable us to move beyond the brittle single-town, single-practitioner models of care that both rural clinicians and communities have endured for too long. And yes, the collective contribution of both generalists and specialists, rural and urban, from all professions, to an overwhelmed system has the potential to finally overcome the fiction of hierarchies in the health professions.

Rural and Remote Health is a vehicle for rural and remote communities and clinicians to share our insights about system improvement. Many of the suggestions above arise from the research published in this journal over the past 20 years. As systems and people are strained to breaking point around the world, we will not be immune. So we stand with you, humbly providing evidence for improving rural health systems, and proudly bringing together and recognising the people who make these systems work for a better world for all.

My thoughts and prayers are with all who are with me at the clinical front line in this crisis, with those authorities making decisions in our best interests with uncertain data, and with all of those we care for. May we live, learn and be loved.

For information on the Australian Government responses to COVID-19:

https://www.health.gov.au [https://www.health.gov.au]

For information from Europe:

https://www.woncaeurope.org/kb/covid-19-resources-for-general-practitioners-family-physicians [https://www.woncaeurope.org/kb/covid-19-resources-for-general-practitioners-family-physicians]

Professor Paul Worley is the Australian National Rural Health Commissioner and Editor in Chief of *Rural and Remote Health*.
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