Royal Australasian
College of Surgeons

Rural Health Equity

Strategic Action Plan
15 December 2020

CONTRIBUTORS

The development of the Rural Health Equity Strategic Action Plan has been primarily led by the RACS Rural Surgery Section committee members, past and present. This plan has built on collaboration across all RACS portfolios including the Fellowship Engagement Portfolio and Education Portfolio. This plan focuses on building partnerships and raising awareness with our stakeholders to ensure there is inclusivity and a shared understanding of health equity for our rural, regional, and remote communities.

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Introduction

ADDRESSING RURAL HEALTH INEQUITY

On average people living in rural, regional and remote locations have worse health outcomes, compared with people living in metropolitan areas.[1] The disparity is exacerbated with increasing remoteness. Geographical maldistribution of specialist services is a significant factor contributing to poorer health outcomes in rural and remote settings.

At present approximately 29% of Australians live in rural and remote locations (classified as Modified Monash Model classification 2-7) and 25% of the population of New Zealand are rural, but according to RACS census findings only 12% of RACS Fellows (FRACS) live and work rurally in Australia and for five of the nine surgical specialties, less than 5% of surgeons were based outside cities. [2,3,4]

To address rural workforce shortages governments have heavily invested in the recruitment of specialist international medical graduates (SIMGs) and the establishment of rural medical schools. The over reliance on the SIMG workforce has unintentionally meant that surgical services especially in remote Central and Northern Australia remain fragile and unsustainable.

RACS COMMITMENT AND VISION

RACS is committed to its social responsibility and mission to address health inequity, through the levers of representation, selection, training, retention, and collaboration for rural surgical services for rural communities. Ensuring RACS maintains an informed focus on rural health is a key goal of RACS Strategic Plan 2019–2021 and Operations Plan 2019. Increased awareness of the rural community needs for surgery and enhancements to the pathways for training in rural areas are key indicators for measuring success as outlined in RACS Strategic Plan 2019–2021 and Business Plan 2020. The strategy provides pragmatic actions to meet the rural surgical goals of the RACS Strategic Plan, policies and position papers and the Surgical Competence and Performance Framework.

RACS GOALS AND IMPLEMENTATION

The strategy requires cultural change within RACS towards a culture that fosters a rural positive ethos. Improving rural health outcomes cannot be achieved without rural voices at the table. Rural representation in all RACS activities is essential, as is managing conflict of interest, where predominantly urban committees make decisions for rural communities. The Rural Health Equity Strategic Action Plan is championed by the Rural Surgery Section and RACS Council. A steering group will be established for managing the principles outlined in the framework and prioritising the actions for implementation which will involve close collaboration with the speciality societies and specialty training boards.

RACS Rural Health Strategy

The RACS Rural Strategy aims to improve health equity for remote, rural and regional/provincial people in Australia and New Zealand. The strategy aims to:

1. increase the rural surgical workforce and reduce workforce maldistribution, through the Select for Rural, Train for Rural and Retain for Rural strategies.
2. build sustainable surgical services in Australia and New Zealand, through the Collaborate for Rural strategy.

The strategy is focused on patient-centred surgical care and sustainable surgical workforces in remote, rural and regional Australia and New Zealand. With persistent health inequity for underserved populations and the impacts of climate change, RACS anticipates the need for a culturally and emotionally intelligent, broad-scope surgical workforce, across all surgical disciplines, with the skills and motivation to work collaboratively and effectively, in areas of need and limited resource environments, including globally. The term rural is used to encompass regional, rural and remote.

Addressing rural health equity is a complex issue. It requires multiple actions at various levels by many stakeholders. Bundled interventions spanning the whole career cycle of a surgeon need to be tailored to context as determined by the location and patient needs. Safe patient outcomes can be delivered by flexible and pragmatic processes.

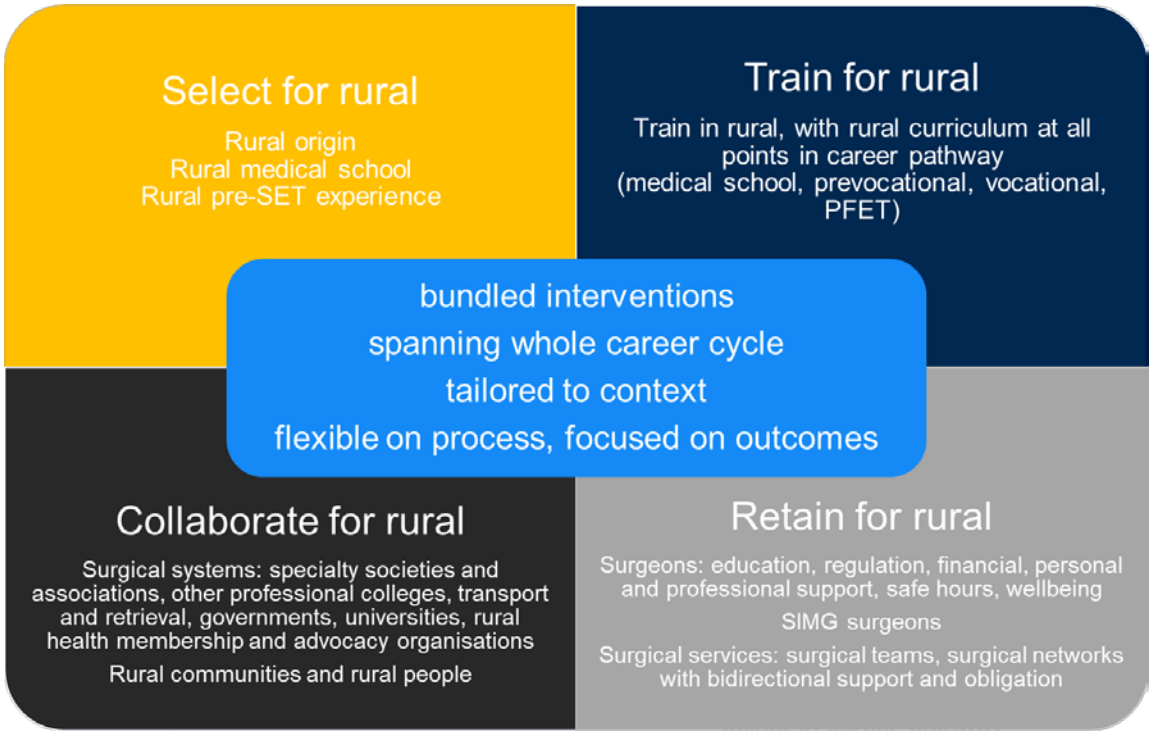

Figure 1. An overview of the RACS Rural Strategy. It addresses multiple points of the surgeon's career cycle with consideration to common intersecting characteristics.

1 Represent for Rural

To attain rural health equity, these actions emphasise the importance of rural representation in the decision making process. It will underpin the four rural strategies which focus on selecting, training, retaining, and collaborating for rural communities.

ACTIONS	DELIVERABLES	STAKEHOLDERS
1. Rurality as a diversity element	1.1. Co-option for diversity, including geographic diversity 1.2. In specialties with rare rural members, a surgeon who is actively involved in rural outreach or rurally interested could be representative	RACS Specialty Training Boards; Specialty Societies and Associations
2. Technology as a tool of inclusion	2.1. Allow remote participation in state and national educational events and research 2.2. Remote access to selection interviews 2.3. One College Digital Transformation enhancements to video-meetings and synchronous streaming of continuing professional development (CPD) events	RACS Specialty Training Boards; Specialty Societies and Associations
3. Manage conflict of interest	3.1. Rural representation on all committees and boards involved in Surgical Education and Training (SET) 3.2. Conflicts of interest are recognised and managed during decision making as prescribed in RACS' policy	RACS Specialty Training Boards; Specialty Societies and Associations
4. Foster a pro-rural culture focused on collectivism and peer co-operation	4.1. Recognition of rural achievements in internal and external media and communication 4.2. Recognition and emphasis of the "dual" training required of a rural surgeon, that is broad scope of clinical practice plus extra skills required of rural practice 4.3. Call out anti-rural cultures/behaviours at RACS and in workplaces (emphasise that rural surgery is not urban-lite or second best/less than surgery in urban settings) 4.4. Positive presentation of rural surgery to Trainees	RACS Specialty Training Boards; Specialty Societies and Associations
5. Establish evaluation framework	5.1. Develop mechanism to gather data, evaluate and improve the rural initiatives	RACS Specialty Training Boards; Specialty Societies and Associations

2 Select for Rural

These actions have the longest timeframe to yield results, are the least complex to address and require the least input of resources to achieve.

ACTIONS	DELIVERABLES	STAKEHOLDERS
1. SET selection requirements and scoring criteria	1.1. Award selection points for 1.1.1. Rural origin 1.1.2. One or more years of rural medical school experience 1.1.3. One or more years of rural pre-SET work exposure. 1.2. Reduce points for items that require predominantly urban work experience 1.2.1. Higher degree qualifications 1.2.2. Referee recommendations and reports that are exclusively attainable from encounters in urban tertiary centres. 1.3. Remove or balance points selection criteria that disadvantage rural applicants.	RACS Specialty Training Boards
2. Interviews	2.1. Virtual selection interviews or interviews in every state and territory. 2.2. Situational interviewing pertaining to equity of access and health outcomes for rural and other underserved communities.	RACS Specialty Training Boards
3. Rural Selection Initiative, analogous to the Aboriginal and Torres Strait Islander Selection Initiative	3.1. Quarantined positions for rural selection applicants. This can be based on either: 3.1.1. 30% of positions for population parity 3.1.2. 14% for RACS parity 3.1.3. one position, for training programs with seven or less positions available. 3.2. For applicants reaching the minimum selection standard plus being of rural origin, 12 months of rural medical school and 12 months of pre-SET rural experience.	RACS Specialty Training Boards

3 Train for Rural

These actions address Australian Medical Council and Medical Council of New Zealand standards of training for excellence and community need. There is flexibility in the local delivery of these actions based on the ratios of surgical specialist-to-population in Australia and New Zealand, and the number of surgeons in each specialty in various geographical settings.

The actions will foster a skilled, broad scope of practice surgical workforce who can provide care to rural and remote areas of Australia and New Zealand and are capable of deployment for regional and global humanitarian work.[5]

ACTIONS	DELIVERABLES	STAKEHOLDERS
1. All trainees have rural work exposure.	1.1. Three levels of rural SET training exposure, related to the surgeon to population ratios in Australia and New Zealand: 1.1.1. Rural/Regional Training Networks (General surgery and Orthopaedic surgery program) 1.1.2. 12-month rural training posts (Otolaryngology Head Neck Surgery, Plastics and Reconstructive, Urology and Vascular Surgery programs) 1.1.3. Rural Focused Urban Specialist (Cardiothoracic, Paediatric and Neurosurgery).	RACS Specialty Training Boards
2. SET training posts are distributed according to community need for surgical care.	2.1. RACS works with Government Health Departments in Australia and New Zealand to identify a system for distributing training posts based on community need. 2.2. Rural representation on all committees and boards involved in SET training. 2.3. Conflict of interests recognised and managed during decision making.	RACS Specialty Training Boards
3. Separate accreditation criteria for rural training posts recognising the unique value of rural training	3.1. Shift criteria that: 3.1.1. Require supervision based on number of FRACS employed to total Full-time Equivalent FRACS 3.1.2. Require certain case numbers to consider other metrics of experience not provided in urban practice (e.g. for first operator experience and direct consultant supervision, broader scope of experience). 3.2. Include holistic criteria for: 3.2.1. Adequate accommodation for Trainee and their family 3.2.2. Adequate internet access	RACS Specialty Training Boards

		3.2.3. Adequate days off at the start and end of rotations for relocation, and relocation support 3.2.4. Access to research facilities and mentors.	
4.	Rural facing curriculum	4.1. All Trainees acquire the generalist skills required for rural practice. 4.2. The generalist curriculum would be the base curriculum with the rural curriculum overlaid, providing knowledge and experience to prepare practitioners with a broader scope of clinical practice that is often required in rural areas, and additional skills in outreach, inreach and health service management.	RACS Specialty Training Boards
5.	Dual fellowship in primary specialty plus Global, Remote/Rural/Regional and Deployable (GRiD) Surgery	5.1. Establish GRiD faculty (see Retain for Rural for more) 5.2. Dual fellowship achieved concurrently with SET training and/or through post-SET fellowship positions.	RACS Specialty Training Boards
6.	Portability/preservation of entitlements across jurisdictions	6.1. Work with the jurisdictions to assist in preventing the loss of employment benefits when trainees transfer between jurisdictions.	RACS Trainee Association (RACSTA); State health jurisdictions
7.	Establish a Rural and remote career coordinator program	7.1. Enrol all rural interested trainees early in SET training with opportunity for later entry into program if rural intention emerges. 7.2. Trainee interview to determine career goals and trainee's motivation, negotiating an individual plan. 7.3. Information and connection hub on rural Fellowships, rural research opportunities, other peer groups and conferences. 7.4. Connecting Trainees with rural and specialty mentors.	RACS Specialty Training Boards; RACSTA
8.	Implement a Rural and Remote Central and Northern Australia Surgical Service Strategy (RCANS)	8.1. Convene a forum with remote surgical stakeholders including directors of surgery from remote surgical services, Australian and New Zealand College of Anaesthetists, Royal Australasian College of Medical Administrators and the Remote and Rural JMO stakeholders to progress the implementation of the Remote Central and Northern Australian Training Network. 8.2. Develop a Remote Central and Northern Australia (RCANS) selection initiative, by selecting junior doctors who are already living, working, and committed to a remote area.	RACS Specialty Training Boards; State health jurisdictions

4 Retain for Rural

These actions involve the retention of individuals (FRACS and SIMGs) and of whole surgical teams and services.

ACTIONS	DELIVERABLES	STAKEHOLDERS
1. Ongoing educational, professional, and personal support for rural surgeons	1.1. Establishment of faculty in Global, Remote/Rural/Regional and Deployable (GRiD) Surgery 1.1.1. Develop GRiD dual fellowship post-Fellowship (PFET) qualification 1.1.2. Surgeons to participate as faculty members, mentors, teachers, supervisors and trainers 1.1.3. Establish a RACS Annual Scientific Congress Section 1.1.4. Curation of GRiD library resource hub 1.1.5. Develop CPD offerings in line with GRiD faculty 1.2. CPD access for rural surgeons to be bolstered with 1.2.1. Remote access to participate in meetings and CPD events. Develop Technology as a Tool for Inclusion policy paper. 1.2.2. Review of current CPD content. 1.3. Revamp RACS Rural Surgery Section Online Information Hub 1.4. Collaborate with regulators to recognise and protect enhanced/broad scopes of practice for rural surgeons (development of GRiD PFET qualification). 1.5. Collaborate with Royal Australasian College of Medical Administrators and jurisdictions to develop a mediator model between rural surgeons and hospital administrators. 1.6. Advocate for safe hours contracts for rural surgeons, with the onus on hospitals to devise protocols for task substitution, transfer or locums and service level responsibility for safe rostering. 1.7. Foster a pro-rural culture within RACS.	RACS; Specialty Societies and Associations
2. Financial sustainability	2.1. Advocate for financially sustainable models of remuneration for rural surgeons (salaried and Visiting Medical Officer models which acknowledge financial risk). 2.2. Portability of entitlements for GRiD fellowship surgeons crossing state borders for dual appointments or explore options for the coordination/pooling of entitlements for surgeons in border towns	RACS; Specialty Societies and Associations; State health jurisdictions

		2.3. Continue funding RACS Provincial Surgeon Fellowships for rural surgeons' CPD travel and accommodation. 2.4. Continue support and promotion of rural specialist programs (e.g. the Support for Rural Specialists CPD grants).	
3.	Support for Specialist International Medical Graduates (SIMG) surgeons	3.1. Optimise application and assessment processes, and exam attainment, with a process for notifying relevant society of SIMG successful application 3.2. Develop an SIMG "welcome pack" for each society 3.3. Improve access to CPD opportunities and formalise professional networks for rural SIMGs with surgical colleagues in urban or larger centres.	RACS; Specialty Societies and Associations; State health jurisdictions
4.	Accountable surgical services	4.1. Advocate for infrastructure and funding for rural surgical services 4.2. Foster a culture of collective responsibility for rural health equity 4.3. Foster a culture of supportive peer relationships across distances, aligned with referral and transfer pathways, with reciprocal responsibility. Accountable larger centres to partner with smaller rural and regional centres by support through telehealth, outreach, inreach, defined referral and transfer protocols, swaps for leave/CPD.	RACS; Specialty Societies and Associations; State health jurisdictions

5 Collaborate for Rural

These actions focus on providing care centred around patient and place, whereby access to safe surgery is delivered as close to home as possible.

ACTIONS	DELIVERABLES	STAKEHOLDERS
1. RACS adopts a framework for National Surgical Systems	1.1. Convene a meeting with the Royal Australian College of General Practitioners Rural, Australian College of Rural and Remote Medicine and nursing stakeholders to develop systems for interdisciplinary training in rural surgical skills including general practitioners with extended scope of practice in surgery. 1.2. Improve links with interdisciplinary teams, including general practitioners with extended scope of practice (anaesthesia and critical care, surgery, emergency medicine) and nurses with extended scope of practice. 1.3. Commence collaboration with other surgical team stakeholders via Council of Presidents of Medical Colleges to encourage development of rural health equity programs in all speciality medical colleges and via the National Rural Health Alliance. 1.4. Commence collaboration with regulators to enable fit for purpose scopes of practice for rural surgeons	RACS; Specialty Societies and Associations; National Rural Health Commissioner; RACGP Rural; ACRRM; Perioperative Surgical Nursing Assistants; transfer and retrieval services; Royal Australasian College of Medical Administrators; Australian Medical Council; Australian Health Practitioner Regulatory Agency and Medical Council of New Zealand
2. Sustainable surgical services for Remote Central and Northern Australia (RCANS) Forum 2021	2.1. Convene a forum in 2021 to develop a strategy for Remote Central and Northern Surgical services. Topics of discussion: selection initiative, training networks, scholarships and return of service obligations. This work could work in conjunction with the ATSI SET pipeline project, led by the RACS Mina advisory group.	RACS; Indigenous Health Committee Mina advisory group; Specialty Societies and Associations; Australian Federal Department of Health; National Rural Health Commissioner; State/territory health jurisdictions; ANZCA; RACMA; Regional Training Hubs
3. New Zealand Provincial and Rural Surgical System Strategy	3.1. Rural Surgery Section committee, with engagement of RACS New Zealand National Board, forms a New Zealand subcommittee (comprising four NZ members, RACS NZ councillors and representatives from NZ National Board). 3.2. Convene a New Zealand Rural Surgical Services Forum in September 2021, developing a strategy bespoke to provincial and rural surgery in New Zealand.	RACS; Specialty Societies and Associations; New Zealand District Health Boards

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