Parliamentary Inquiry

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India’s rural health system – 1.2 bn, 72% rural, low percapita income. Very significant fluctuations in population density, very low per capital expenditure on health. Bhore 1946 Committee is the foundation of the Indian system – three tiers: health care centres, sub district hospitals, district hospitals – similar population thresholds to the UK, communitisation approach - local health animateurs at the village level – financing now according to need rather than performance, decentralised planning, incentives for safe childbirth. Equity and access has been improved by this process. Remote rural areas suffer because there are standardised population norms which don’t recognise distance from services. Growth in young women taking up nursing as a profession in rural areas. AMRIT clinics nurse led not for profit services, housed in community settings partner with other NGOs – Tribal nurses are likely to stay on and perform better than non-tribals. 60% of care provided by nurses. Example of TB as a socially determined illness, micro credit company providing soft loans to support health treatment and completing the treatment, promoting of vegetables and back yard poultry to improve diet, establishment of new child care approached to support children under 3 to allow mothers to work also a bridge to provision of health care. Impact of Covid distributed clinical care model has offered some resilience. Also the base for community network of volunteers, also a basis for surveillance: key themes – allocation based on need, time to travel important, community health worker, social care makes services responsive to need, integration of public health care.

Anne Marie – How do you encourage communitisation in terms of people engaging with the process and the training of people as health care professionals

Pavitra – people are trained remotely and then return to their communities, particularly tribal nurses.

Jon – specialist doctors versus GPs and then new national insurance scheme for health

Pavrtia – need to do more work to promote generalist rather than specialist approaches, communitisation complements the

Rogers Strasser – University of Waikato

Rural is a matter of perception – a mindset rather than a distance, Geographic size of England is small but in the minds of the population the distances are small. Resources concentrated in cities, communication and transport difficult, access is the real issue rural health workforce shortage, rural practitioners are extended generalists – wider range of services, high level of clinical responsibility, live where they work and can therefore influence community health more, urban models don’t transfer, local services preferred, people will not travel, specialist support role important, role f specialists is local support. Interprofessional team work – happens better in rural due to shortages of skilled staff. Recruitment and education and training. 3 factors most strongly associated with rural practice entry are rural upbringing, then rural experience, third targeted rural practice. Northern Ontario School of Medicine case study – distributed, community engaged learning is the key model. 90 sites across northern Ontario, online teaching approach. Community engagement is the centrepiece of the operation – GP training is varied and based in a range of widely dispersed clinical settings. Longitudinal integrated clerkship. 2000 applications for 64 places, most recruits from remote and rural communities and the majority from Northern Ontario – achievement of very high academic standing. Excellent student experience – “you don’t know it until you live it”. 62% go into general practice, double the national average, 69% stay in N Ontario. More generalist doctors, more reflective of local people, remote rural workforce stability framework – artic programme – Sweden, Norway, Scotland , Iceland and Canada – frameworks because of: taking the long view, planning – the core, aligning with needs, profiling recruits recruitment – information sharing, community engagement, supporting spouses, retain – team cohesion – retention, cpd, training in remote rural settings – including funded travel. Success includes: recognition of remote and rural issues, inclusion of engagement, targeted investment annual cycle of activities, monitoring and evaluation – success as an ongoing work in progress. Annual cycle of activities. Social accountability – good practice and very important as a functioning concept – partnership pentagram – community should always be on part of this pentagram. Conclusion – commonalities – everywhere has similar issues, recruitment and education and training important, stability framework is important. Paradox distinctive places, when you’ve seen one rural place you’ve seen one rural place! But there are some commonalities. One size does not fit all – people living in rural communities need high quality care close to home.

Anne Marie – new care pathways not well done in the UK – accident and emergency a key piece – is there scope for a global training programme – perhaps based on the Ontario model, how did you get the investment for the activity. World Bank discussion paper – reimagining primary health care workforce in rural settings due to be published – central theme importance of starting local – modification is more challenging than starting from scratch due to vested interests. Global training – NO School of Medicine training for health equity network founding member -examples of success in places like the Philippines – scope for UK schools to participate. Case study is available on the NO approach. Community pressure made the justification for the medical school. Social Accountability is at the heart of the approach.

Jon – communitisation, social agenda, longitudinal places important, recruit and retain is important. Roger – what could we do in England to address this challenge. Rural and Covid is also important it has shown the inequities and disconnect between the cities and rural areas. Has stimulated resourcefulness and self-reliance. Covid has accelerated change significantly. Dundee Longitudinal Clerkship. Scotgem LIC approach – this model is embraced by GPs in rural Scoland. Wales, Bangor and Aberystwyth, Northern Ireland University of Ulster – Graduate Entry Medical School. England – developing programme at Keele – Lincoln NCRHC – really important to start local and build from there.

Manabu Saito

Director Rural Generalist Programme Japan (island and isolated communities link). Founder of this P Graduate rural training programme. Remote island interest and focus – no rural training programme to support him in this ambition. This led to the launching of the programme – run by a company (he is CEO) supported by university. Also doing a PHD. Japan – similar large urban context – mountainous and remote features over 400 islands. Rural depopulation is a key challenge. Challenges – ageing population, recruitment and retention, lack of pathways to rural health. Isolated and challenging. Hospital based medical care, access to mainland and solo to group practice – in litigious society doctors who do everything considered dangerous. Only way to mainland is to charter an ambulance helicopter. Population is only 2000 but some individuals in remote settings – also GPs visit these individuals. Team delivery model is in development. Social care in Japan is also very important – reflecting the older population – social care is delivered differently covers 7 levels based on the level of needs of individuals. Innovations – rural generalist model – no concept of General Practice in Japan, partnerships with Australia, distant education – can only be done by applied practice. Remote supervision model imported from Australia – 50 graduates next year. Trainees on rural programmes tend to be older. Programme one year in duration so barriers are low. 6 teaching hospitals in rural areas. Not all GPs are ideally suited, short term workforce challenges- collaboration important. Linking social and medical care is important. Scope for UK and Japan collaboration.

Anne Marie – Insurance programme – focus on social care agenda – how can we get the idea of insurance accepted in the UK. How do we change the belief that being a generalist is important?

Manabu – branding is important – Island GP works better than a generalist term like “rural” Government has introduced this from the age 40 onwards as part of a national recognition of the issues around social care – everything available at 90% of cost from 65 onwards. Problem with low esteem in Japan for GP as well as in UK. New branding gives strength to the esteem.

Jon Wynn – turned a television icon into reality! The loss of the generalist GP is a clear trend of challenge. Wider rural offer is attractive but the sense of enhanced responsibility is a big challenge. Could a generalist programme be developed to fit this model.

Manabu - Important to set up a new infrstructure.

Jon – South West could be an ideal geography for this. Perhaps rebranding is the key.

Roger – skills set of rural generalists – requires a specific range of knowledges and skills – CLINICAL COURAGE is really important in terms of the generalist agenda. The best place for rural practitioners to learn is in rural settings. Medical establishment are resistant to this concept as it is disruptive in terms of traditional models.

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Mayara Floss - Brazil

Alan Morgan - USA

Vidal Alaball Josep - Spain

Professor Ian Couper – South Africa

Anne Marie and Jon Wynn Jones set the scene for the event – Anne Marie was very positive about the previous session and indicated that she had noticed a lot of resonances particularly the similarities around the island agenda between the UK experience and Japan. Jon referred to communitisation as the key theme, social accountability agenda with Roger Strasser, Manabu – in Japan concentrated on the notion of the rural specialist generalist.

Alan Morgan – covid experiences are a key part of the experience in the USA. Alan CEO National Rural Health Assocation – membership of 90% of rural providers. Gives significant influence with the Federal Government. 500 rural health clinics across the USA. 500 rural community (Govt sponsored) health centres supporting under served populations funded in part through Medicaid in the USA. Just short of 2000 rural hospitals across the USA. Critical support facilities at the rural level have a modest number of acute beds. US never set up to cope with significant numbers of ICU patients. 20% of the nation’s rural are elderly (Meidcare), 16% poor on Medicaid programme – 36% supported – not unusual for rural hospitals to see the vast majority of people on health programmes supported on 25-30% have private health care insurance. 83% of rural counties have seen a mortality from covid to date over 1 million cases in rural counties. Mortality at a higher rate of increase in rural than urban. In May this story shifted and over the summer it impacted more on rural communities. Rural health inequalities driven by this agenda/experience. In rural America very few people are following social distancing and other key rural.

Workforce shortages are the key issues in the USA. Tele-health freed up to respond to these challenges. 43% rural hospitals operating at a loss – in a rural context payment based on episodic care has led to a number of facilities closing. Federal Government major intervention has helped but due to increasing surge hospitals are still closing. In USA method has been to take the best students and they come from an urban bias.

Rural residency training programmes focused on rural youngsters working on their own ground has made a huge difference. Covid has “crashed” the workforce, no room for flexibility in a rural context. Key lessons – collaboration is really important increasing organisational capacity. Delivery of care and payment mechanisms have become important factors. Reimaging on how we deliver US healthcare has come out of this with an enhanced focus on primary care and prevention.

Anne Marie asked about social care?

Alan – determinants of rural health are important – hospitals closure is driven by the impact of the economic downturn on closures. This has been a huge issue in dealing with the underlying public health issues. No good solutions to this agenda around social care.

Anne Marie – no spare capacity – how could you plan to manage surges in the future.

Alan – a demand led model has not served the population well – a focus on efficiency has been the mantra and it works better in an urban setting. Access is a real challenge in rural settings which militates against efficiency. Rural healthcare ultimately challenged on a workforce basis – telehealth can help but its not the whole story. It does however “crush” local providers.

Anne Marie – how do you move from an efficiency model to a need focused model.

Alan – this case has been made using data which shows that the efficiency model doesn’t work. Covid has proved that the rural low density model doesn’t work. It has driven a focus on prevention and public health.

Mayara Floss

Brazilian Health System – A very large country – over 200 million population – 47% of South America. It is deeply rural in many areas. Brailian Unified Health system SUS is the focus of the rural agenda. Big move to the private sector in Brazil has led to limitations in the development of the health trajectory in Brazil.

Showed the evolution of the health timeline underlying the policy agenda. Pandemic has led to chaos in Brazil but SUS has kept things going with key principles – these are very similar to the examples from India and other settings.

Community health workers operate on a very similar basis to the Indian example local people embedded as the eyes and ears of doctors. Local health councils have also been developed as part of a community response to the management and communication of local health needs

Telehealth in Brazil is increasing and provides some support and also opportunities for the triaging of information.

Mayara rural seeds is an international campaign that has been established from Brazil. Important to support LMIC rural health support around the world.

Significant COVID impact in Brazil.

Anne Marie – fabulous and gives a very clear perspective on the challenges faced by LMIC. How are the community groups established. In India the same approach has been followed. In England local politicians predominate how have you managed to engage people from the community? What would supporting LMIC look like?

Community health workers are hired by the health system – they are then trained to work on health promotion. It is key that they don’t have a political agenda at all in this context. System pays according to need rather than demand.

Help can come in not attractive local health capacity away from the places that most significantly need it.

Jon – working in teams is a key theme which arises from this discussion, mentoring and engaging with younger doctors are both important.

Josep Vidal Alaball

Josep has some experience of the UK works in Catalonia. Move is from the benefits to the dangers of telemedicine. In the last 10 years in Catalonia this has been a significant experience. 2010 economic crisis led to the development of the telehealth agenda. Waiting lists have been reduced through programme. Telemedicine most potent in rural areas.

Covid 19 has been a major disrupter – it has been particularly acute in rural settings where low critical mass has led to the closure of small facilities. Face to face visits are now a very small aspect of the overall agenda – level of intensity has really climbed. E consultations have been really useful as part of the care agenda going forward. The use of these consultations has increased significantly. Video consultations have been less popular and effective than more basic levels of engagement. No links to medical records and doesn’t work well with slow broadband. The future more remote monitoring would be useful. Chatbots would also be useful. Consultations can be increased by e-enabled opportunities sometimes for “banal” reasons. Inequalities over access esp in terms of the digital capacity of older people for example. Telemedicine should not be used as an excuse for inferior care and support. Patients need to accept this as an approach. Use accelerated in the short term by Covid – but consent is important as a core of the longer term agenda.

Anne Marie – great insights in terms of the knowledge and application of tele-medicine – further on in terms of the agenda than we are in the UK. What sort of telemedicine approach would work best going forward?

Josep – Telemedicine provides opportunities and choices but should be driven by patient capacity and need. It needs to be based on a patient centred approach. Over time successful application of telemedicine will build acceptance and effective patient use and response to the choices it provides for them.

Anne Marie – how easy is it to empower patients to get things to work as effectively as possible in the context of telemedicine.

Jon Wynn Jones – Primary Care system in Spain is a world leader. Is there an extent to which telemedicine has put more pressure through additional channels into the systems. The evaluation followed in Spain points out the importance of evaluation – the only example highlighted amongst the speakers so far.

Ian Couper – Stellenbosch University

Physician Assistants a key aspect of the presentation. 1948 prior to change of Government SA planning a national health service. Nationalist Government choked that development off. 1994 there was a plan but it is still to be implemented. 20% covered by private health care which soaks up 80% of the resources. Government moving towards national health insurance. This is not the same as universal health coverage. Move to health insurance has led to a focus on primary health care – this has been nurse led at the clinical level. This process is continuing. Brazil has influenced this process as has pre 1948 history. Support for primary health care teams not well developed. In rural areas district hospitals staffed by generalists. Acute settings are under staffed in terms of doctors. Getting the numbers required is a major issue as is the cost of training. Overseas (Cuban) doctors have helped, commitment to increase training has begun to take up some of the slack but there are not enough medical schools. Very difficult to drive trainees back to rural areas. White elite replaced by black elite and not enough focus on rural needs. Community services bringing teams together has made a significant difference but there is no proper pre and post community training and professional support process to sustain these arrangements. Best doctors travel to work overseas. Bursaries and training and support for rural doctors important for MLIC. Leadership and management is very important.

Physician associates are an important part of the agenda. People who can do the procedures without needing the full doctor training to make things work. 3 year training programme – the term associates makes it clear that these individuals have some self determination. Their training focuses on relationships with patients from day one. From 2011 these individuals have become well established. Has not been effectively as hoped due to fluctuations in the enthusiasm for this approach. A number are now getting drawn into the private health sector which is unfortunate.

Anne Marie – how do you effectively recruit into these professions

Ian Couper – too high a standard for the medical profession – more generally? Getting these individuals embedded makes a significant difference

Anne Marie – Community services a revolving door

Ian Couper – no there are lots of opportunities to make this work on an ongoing basis it is often sustained by multi-disciplinary working

Jim Rourke – Canada – Vocational training focus for rural development in Canada. Seeking now to focus on the patient. Rural health care not accessed as frequently as urban users do. Focusing on a health care approach which is patient focused. Perhaps too much focus on rural doctors important but other team aspects and focus are important. Nurse practitioner are very important access to care improved by telemedicine when it works well. Where the health care is delivered is very important and Govt negotiations with health care providers and applying a rural lens in the development is important.