College Submission
October 2023

Scope of Practice Review - Unleashing the potential of our Health Workforce

Thank you for the opportunity to provide feedback to the Scope of Practice consultation.

Our College was formed to provide the training and professional standards needed to enable doctors to provide the broad scope required to maximise access to care safely in rural and remote areas. As such ACRRM has been at the vanguard of innovation and advocacy for this approach nationally and internationally for over a quarter of a century.

ACRRM believes that in many circumstances and especially in the case of RG Medicine operating to an expanded scope of their trained competencies, has the potential to greatly improve care in our country. We note however that our healthcare system is complex and that effective system change involving scope of practice will involve diverse, nuanced and context-appropriate solutions.

This is a critical discussion for our College, and we have opted to provide our response to the survey questions in this submission format to better reflect the views of members and fully cover associated issues.

About the Australian College of Rural and Remote Medicine

ACRRM's vision is ***the right doctors, in the right places, with the right skills, providing rural and remote people with excellent health care.*** It provides a quality Fellowship program including training, professional development, clinical practice standards; and support and advocacy services for rural doctors and the communities they serve.

The College is accredited by the Australian Medical Council to set standards for the specialty of general practice. The College's programs are specifically designed to provide Fellows with the extended skills required to deliver the highest quality RG model of care in rural and remote communities, which have limited access to consultant specialist and allied health services.

Fellowship of the College (FACRRM) entitles doctors to national recognition as specialist General Practitioners (GPs) and the associated patient access to the Medicare Benefits Schedule (MBS). The FACRRM also reflects doctors' skills in the RG model of practice. A RG medical practitioner is a General Practitioner who has specific expertise in providing medical care for rural and remote or isolated communities and who can understand and respond to their diverse range of health care needs. This

includes applying a population approach, providing safe primary, secondary and emergency care, culturally engaged Aboriginal and Torres Strait Islander peoples' health care as required, and providing specialised medical care in at least one additional discipline.

ACRRM has more than 5000 rural doctor members including 1000 registrars, who live and work in rural, remote, and Aboriginal and Torres Strait Islander communities across Australia. Our members provide expert front line medical care in a diverse range of settings including general practices, hospitals, emergency departments, Aboriginal Medical Services, and other remote settings such as RFDS and Australian Antarctic Division.

1. Benefits of Expanded Scope Practice

1.1 Who can benefit from health professionals working to their full scope of practice:

- **Consumers**
- **Funders**
- **Health practitioners**
- **Employers**
- **Governments**
- **Other Groups**

1.2 How can these groups benefit? Please provide references and links to any literature or other evidence

As a procedural matter, we note that the framing of these two survey questions will have implications for the validity of the survey outcomes. The survey questions presume that there is no potential that a respondent holds the position that a health professional working to their full scope of practice is 'not' beneficial and do not provide a response option to this effect.

Who can benefit?

Our College supports the advancement of generalist, broad scope practice models as having the potential to greatly improve access to, and the delivery of, healthcare especially in rural and remote areas. We would stress however the need for nuance and would see considerable risk in taking a blunt universalist application of this approach across the diversity and complexity of our healthcare sector.

ACRRM contends that all groups listed (consumers, health practitioners, employers, and governments) may potentially benefit from models of care whereby health professionals work to their full or expanded scope of practice. We believe that in rural and remote contexts, full and expanded scope of practice is especially valuable.

It does not logically follow however that this approach would benefit all these groups or be to the net community benefit in all circumstances. We note that there are circumstances in which health practitioners focussing on a narrow area of practice can optimise care. Conversely, for some parts of the workforce particularly in urban centres, the time and resource invested in attaining the necessary skills for full scope practice may be more beneficially invested in maintaining skills for their specialised scope.

It should also be noted that this position is predicated on an understanding that all scopes of practice are supported by appropriate training, assessment, ongoing skills maintenance, and other appropriate quality assurance and indemnity mechanisms. These mechanisms have implications in terms of time and costs for individual practitioners, health services, patients, and taxpayers.

How can these groups benefit?

Rural and Remote contexts

Expanded and full scope practice has particular value in conditions of relative professional and geographical isolation and limited clinical resources such as occurs in rural and remote areas including Aboriginal and Torres Strait Islander communities. In these contexts, the economies of a highly specialised staff and resource system of care that can occur in major centres do not apply. The absence of scale economies can be offset however through a fit for context skilled workforce and the benefits of strongly integrated care.

Due to relatively small patient catchments, it is unlikely that private practitioners and services, nor governments, will ever establish the breadth and depth of medical, nursing, and allied healthcare services that exists in metropolitan areas in rural or remote areas. Geographic distances will continue to create a substantial barrier to these people accessing many of these services. This being the case alternative (non-urban) models of practice and service delivery are required to optimise the services that can be accessed locally.

The healthcare services that people in rural and remote communities are physically able to access remain critical to their health and well-being. Thus, models of care appropriate for rural and remote contexts, need to put the community and its needs at centre, and the role and scope of all members of the local healthcare team including their relationships with outreach and telehealth providers need to be defined responsively to these needs.

Rural and Remote multi-professional team models

ACRRM supports the expanded/full scope approach across all healthcare professions in rural and remote settings, where it is appropriately applied. The concept of Rural Generalism has always relied on a team-based approach to care, with all health professionals cooperating, not competing. This requires not just RGs working to the top of their scope, but also rural nurses and rural allied health professionals working to the top of their scope in management of chronic illness, palliative care, mental health care, maternity and other services which would be performed by specialist in larger centres. Rural healthcare is the ideal environment for collaborative team-based care rather than the competitive and fragmented model of care that is becoming increasingly the norm in our cities.

The Ngayubah Gadan Consensus Statement of which the College is a signatory articulates these positions:

> *"Rural and remote multidisciplinary health teams (RRMHTs) comprise health professionals, practitioners, rural generalists, workers and students, including but not limited to health disciplines such as nursing, medicine, allied health, Aboriginal and Torres Strait Islander Health Workers and Practitioners, dental, psychology, pharmacy, midwifery, nurse practitioners, paramedicine and assistant workers such as dental assistants, allied health assistants and physician assistants. Importantly, RRMHTs include non-clinical members such as administrative workers, information technology (IT) workers, community leaders and volunteers.*

The core RRMHT is locally based and the composition is determined according to the best possible place based care to meet the health needs of the specific community.

RRMHT members may be employed in different public, private and not for profit health services (forming clinical networks) and are supported by their organisations to work together to provide the best possible primary health care.

RRMHTs and tertiary care services regularly work together as a result of the need for emergency care, planned hospital care, or to support patients following discharge from a hospital admission. Strong connections between key staff in the tertiary system and RRMHTs, whether through membership of the RRMHT, or through service level agreements supports better patient outcomes.

The RRMHT may call on outside expertise from visiting or virtually accessible health professionals, including non-General Practice specialists when required.

The RRMHT is closely connected to the communities they serve, working collaboratively to design, improve and deliver appropriate, affordable and accessible models of care that meet the health and wellbeing needs of the community.

With clearly defined roles, professional autonomy, and communication processes the RRMHT works together to provide high quality, holistic person-centred care to their patients and their community."[1]

Rural Generalist Medicine

ACRRM was formed to provide the training and professional standards needed to enable doctors to provide the RG scope of practice. In this model of care, general practice doctors with specific competencies to work in rural and remote contexts, work to their fullest scope including to deliver emergency and other advanced specialised services such as obstetrics, anaesthetics, and paediatrics. ACRRM has been delivering services, innovating, and advocating for recognition of this model for over a quarter of a century.

RGs provide care that may not otherwise be accessible to people in rural and remote locations. They are specifically trained to provide this as effectively as possible within their safe scope and within the clinical conditions in which they practice (i.e. characterised by limited staff and resources). They have a diverse scope of practice, skills for working in low resource clinical settings including working in team care locally, and with distal specialists, and a distinct set of metrics for defining the safest and optimal clinical point for referral or patient transfer to major centres for care.[2]

Many practice models that predominate in urban centres are highly specialised with strongly defined protocols around the assignment of clinical roles and the associated training and skills maintenance. They are typically based on an assumption of easy access to the full gamut of specialised equipment and personnel. These models are a poor fit for doctors serving rural and remote communities and it commonly occurs that compliance expectations associated with these models are prohibitive to delivery in rural and remote contexts. Not providing these services locally, presents a material risk to patient safety and wellbeing. While these models may reflect best practice quality and safety in urban contexts, to achieve best practice for people in rural land remote areas, the more nuanced, flexible, and holistic approach utilising the RG scope and skillset may be needed.

The Rural Generalist Medicine (RGM) model is beneficial to rural and remote communities in the following important ways:

Economic approach

RGM is an economical approach. It minimises the costs to both patients and health care systems of patient transport to cities. It avoids the excessive costs of locums. RGM can be tailored to available resources and local healthcare priorities of communities. Its generalist approach also foregoes the higher costs and staffing challenges due to more subspecialists being required to cover the full range of service needs.[3]

Health systems

From a health systems perspective, RGM has doctors applying a broad and evolving skillset, thereby increasing professional satisfaction, productivity, and rural retention. Stable models of locally-based, team-care are promoted and there is a reduced reliance on locums. This in turn supports establishment of a strong, quality rural learning environment for students, registrars, and others to create a self-sustaining workforce. Medico-legal costs and associated risks are thus reduced. [4]

Minimising patient travel

Where there are local services provided by RGs, there is greatly improved access to care. Travel has financial, time and social cost to rural patients which is most likely to prevent access to care to those with the most disadvantage and healthcare need.

Failure to provide local access to many specialised services is clearly leading to many patients foregoing needed care. Over 2019-2021, rurally-based patients, and remotely-based patients received 9% and 36% fewer GP services respectively and 25% and 59% fewer (non-GP) specialist services that people in major cities.[5] Remoteness is also associated with poor coordination of care between rural GPs and city-based specialists.[6]

RGs may provide immediate care in situ, or as is often the case with non-procedural care, they provide the services they can for their patients between appointments with the city-based consultant specialists. They thereby improve the quality-of-service provision, reduce the frequency of review, and reduce the burden of travel.

Extensive literature documents the risks associated with patient travel to access distant health care.[7,8,9] One study of stroke care for example found that the clinical risks of longer journeys outweighed the benefits of accessing the tertiary service.[10] Another study found that for every mile a seriously injured person had to travel to hospital, the risk of death increased by one per cent.[11]

Accessing care itself can present a significant threat to rural people's safety. A Queensland study identified a direct relationship between increasing remoteness and travel risk for people seeking medical treatment in cities, with a recorded average of 3.2 road fatalities per year of rural people who were traveling for the purpose of obtaining medical treatment.[12]

Providing Integrated Care

RGM enables rural communities to be assured of access to comprehensive primary care that is integrated with secondary and tertiary healthcare services. The model emphasises the integration across the spectrum of healthcare delivery and cradle to grave. RGs are trained to work across the care spectrum in a manner which is responsive to community need. They are trained to provide these services in the high-community accountability, low-resource, small health-team environments of rural and remote contexts.

There are a range of key advanced specialised services which in rural and remote contexts should appropriately be viewed as essential to primary healthcare. For example, birthing and neonatal care, cancer treatments, renal care, end of life care, addiction care, and preventive screening.[13] Hays and associates have highlighted that access to local advanced and hospital services is the preferred model of care for many rural and remote people and thus providing this is germane to providing 'quality care''.[14] Sutarsa and associates have conducted qualitative studies finding that locally-based, general practice doctors providing hospital services were strongly associated with quality care by rural and remote patients. They found these patients *understood quality of care primarily through the lens of ongoing and respectful relationships with their doctors across primary and secondary care.* These relationships, *were considered crucial for improving the perceived quality of care: ensuring continuity of care; promoting integrated rural health care systems; cultivating trust from communities; and enhancing patient satisfaction.*[15]

Providing Emergency Care

Providing strong emergency care closer to the point of injury through expanded provision of rural and remotely based RGs can contribute to outcomes improvements for patients. In emergency scenarios such as accidents and obstetric and psychiatric emergencies provision of care locally can often be vital to patient safety.[16,17,18] RGs are trained in emergency care as a core skill and specifically trained to provide this in rural and remote clinical contexts with low staff and resources and complexity related to patient transport and collaborating with distal specialists.

Incidences of hospitalisation and death related to accident and injury in Australia rise with remoteness across all metrics.[19] Regional and remote road crashes accounting for 65% of Australia's fatal crashes from 2010-2018. The road crash fatality rate per population increases dramatically with levels of remoteness with the death rate being nearly three times as high for *Remote* areas and nearly four times as high for *Very remote* areas, compared with Australia overall.[20, 21,22]

Studies demonstrate that safe RG-led care can and is provided in rural and remote Australia. For example, a study of anaesthetic care provision in rural South Australia[23] and of provision of urgent myocardial infarction management in rural Victorian hospitals.[24] Pinidiyapathirage and associates identified the prevalence of serious agriculture-related injuries presenting to rural hospitals in southwest Queensland and noted that delays in presenting to hospital were commonly a factor in clinical outcomes. Their study found that RG-led hospitals provided a positive model of care in these situations which, with appropriate design, adequate resourcing, and links to city-based specialist services, can manage most reviewed presentations locally.[25]

Providing maternity care and birthing services

Local maternity services are essential to deal with obstetric emergencies and studies have clearly linked the need for extended travel time to access maternity services to increased rates of mortality and adverse outcomes.[26] Canadian studies have found that women with no local access to maternity services have significantly greater incidence of adverse perinatal outcomes than women from similar communities with local access to rural birthing services with caesarean section capability.[27] In Australia, Born Before Arrival (BBA) rates which are associated with higher risks of negative maternal and neonatal outcomes have been linked to geographic distance from maternity services.[28]

RG services in Australia can be shown to provide high quality, safe care. Studies have confirmed the RG led birthing units have been providing patients in rural Queensland with birthing care to a quality and safety standard equivalent to that in cities including for more complex deliveries.[29] Similar findings have come from RG-led maternity units in Western Australia[30,31] and New South Wales.[32] Studies in rural Queensland have also identified safe provision of neonatal care involving RGs.[33]

Access to maternity care is also a significant quality of care issue for people living in rural and remote settings. There is a strong preference in Aboriginal and Torres Strait Islander communities for birthing on country.[34] This is also a strong preference for many people in rural and remote communities.[35] Local birthing services are likely to be most important to the people with the least financial and/or social support to enable them to spend extended periods of time in distant major centres.

Providing Mental Healthcare

People in rural and remote areas have higher rates of mental health disorders and risk of suicide than other Australians.[36] These communities have relatively few if any locally-based health professionals across the gamut of mental health services, with remote communities' access to support services estimated to be less than a third of that available in cities.[37]

RGs have training in community clinic based mental health care as well as both management of psychiatric emergencies, and hospital care. Mental health skills learned to the broad scope relevant to rural and remote contexts are part of core ACRRM Fellowship training and some Fellows opt to complete additional advanced specialised training.

2. Risks and Challenges

2.1 What are the risks and other impacts of health practitioners working to their full scope or expanded scope of practice? Please give examples of your own experience

2.2 Please give any evidence (literature references and links) you are aware of that support your views.

Our College strongly supports RG approaches to care which involve not just ACRRM (RG) Fellows but all rural health professionals working to a flexible and broad scope of practice with an emphasis on

team care with the goal of local delivery of the broad possible scope of services safely to people in rural and remote areas.

There is strong merit in this approach in contexts in which there is a relatively small local healthcare team and a relatively low resource environment and geographic isolation from the full scope of resources of major cities.

The successful implementation of this approach requires careful management of the following key issues:

- **Access to Medical Care**

  Policy with respect to team care models should be based on a foundation principle that rural and remote communities warrant and deserve access to the same high standards of healthcare as any other Australian. While their models of care may take different forms to those in major cities, they should be designed and funded to provide an acceptable level of access to continuous, local primary medical care along with appropriate access to emergency, secondary and tertiary care.

  There is a risk going forward under expanded scope models that under budgetary pressures, governments will increasingly come to consider it acceptable to deem people living outside cities as no longer deserving of access to in-person medical care.

  People in rural and remote areas already receive far less funding per capita toward their healthcare than their counterparts in cities (i.e. approx. $855 per capita per year) and this happens despite their having on average, higher rates of morbidity and mortality and lower socioeconomic status.[38] The shortfall in funding toward rural people's healthcare, reflects their much lower use of government funded services which is clearly linked to poorer access.

  Noting that models of care that substitute medical services for other services represent cost saving to the government these present a clear temptation for service funders to save themselves money by promoting non-medical models that further exacerbate the disparities in funding and services to rural and remote people relative to people living in major cities.

  ACRRM submits that every Australian should have access to a doctor who can take a role in coordinating this continuous medical care and this should be upheld irrespective of where they may live. Thus a key element of any clinical framework should be recognition of the need for a RG or specialist GP to take a key coordination role in their patients' continuous medical care.

  Our College believes that models of care that see nurses, midwives, pharmacists, and allied health professionals providing services that would traditionally be the province of doctors can and should be supported where they can improve access to safe, quality care that would otherwise not be available especially for people in rural and remote areas. These should never be seen as justification for no longing accepting responsibility for provision of access to the services of a doctor for these people.

- **Integration of Care**

  The role of the RG/GP is to provide a central point of continuity and coordination of medical care.

Many people living in remote locations do not have easy access to doctors but may have relatively easy access to locally based nurses and/or other health professionals. In these situations quality care may be improved through the locally based professionals assuming significant and expanded roles in these people's ongoing care. The College considers in these situations that the best quality care will arise where these patients also have a RG/GP with whom they can have an ongoing care relationship either though regular outreach visits, telehealth, and/or patient transport arrangements. In all such arrangements it is essential that the RG/GP works in an effective partnership with strong two-way communication to enable continuous, coordinated care.
It is important in all circumstances that clinical roles, responsibility, and relationships are clearly defined. Changing the scope of practice may change the onus of responsibilities for communication and cooperation across the care continuum. Where roles and responsibilities have changed, or where local arrangements differ from the wider system frameworks, clinical governance and communications channels need to be adjusted to appropriately reflect them. The obligations to collaborate and communicate should apply in both directions of the primary, secondary, and tertiary care continuum.

- **Training, Medico-legal risk, and Medical indemnity**

  National assessments of the net costs and benefit of delivery of health services through expanded and full scope practice need to be inclusive of the adjusted time, resource and financial costs of training, ongoing compliance activities and medical indemnity cover that these may engender.
  Different professions have differing levels of training, and standards with respect to professional currency and continuing skills maintenance. Expanded scope may require review and expansions to these frameworks to ensure they reflect the necessary quality standards.
  Medico-legal risk and medical indemnity frameworks have similarly all evolved to reflect training frameworks and assignments of responsibilities. It is important these are adjusted as necessary to reflect practitioners' scope. It is particularly important that health professionals who are working to an extended scope of practice particularly in rural and remote locations, are not deterred from taking on these roles due to additional insurance costs or other indemnity-related concerns or are practicing without sufficient cover.

- **Division of prescribing and dispensing roles**

  In order to prevent conflicts of interest in patient treatment, it is a fundamental principle of our health system to separate the roles of prescribing and dispensing medications. There has appropriately been consistent opposition to doctors establishing a dispensing role for this reason and this logic should equally apply to pharmacists performing prescribing roles.

3. Real Life Examples

3.1 Can you identify best practice examples of health practitioners working to their full or expanded scope of practice in multidisciplinary team in primary care.

3.2 Please give any evidence (literature references and links) you have to support your example.

3.3 Please provide references and links to any literature or other evidence.

Our College trains doctors to work in precisely these contexts and most of our Fellows work in roles which to varying degrees reflect this model. While the College has around 5000 doctors working in a diverse range of care models, some case examples are given below.

RG working in digitally-enabled team-based care, Laynhapuy Homelands, NT

Dr John Kelly (FACRRM) is the full-time, senior RG for Laynhapuy Aboriginal Community Controlled Health Service (LHS). The service supports 30 extended traditional kinship groups known as 'homelands'. These communities are about 750 km east of Darwin and 200 km southwest of Nhulunbuy. Each community has a population of about 100. Travel to these sites is via non-sealed road and can take 3–4 hours from Nhulunbuy depending on the conditions. The roads are often closed in the wet season and charter flights take 20–30 minutes. The clinics are staffed by one to three Aboriginal health workers who typically hold a Certificate II in Aboriginal and/or Torres Strait Islander Primary Health Care. Nursing teams travel in pairs to provide weekly visits to the homelands clinics and a general practice registrar attends periodically. Most weeks they travel up to 220km, usually by 4WD. Most staff stay one to two nights because there are so many places to cover.

Dr Kelly provides clinical oversight and patient consultations predominantly by telehealth. The doctor had been previously based on site and despite relocating has remained with the LHS and developed a long-term relationship with staff and patients. It is believed that this established relationship is a key factor in the successful implementation of the model.

As with many remote Aboriginal health services there is a lack of doctors and greater reliance on the expertise of Aboriginal health workers, nurses, and trainee doctors to deliver effective health care. This includes the challenges of providing adequate supervision of trainee doctors. The RG uses telehealth and videoconferencing to provide remote clinical oversight and advice to Aboriginal health practitioners, nursing staff, or trainee doctors. This includes weekly staff debriefs, mentoring, and structured training sessions with the registrars. In this way all staff are upskilled, medically guided, and personally supported while patients receive coordinated, culturally safe, continuous care.

For literature on this model of care see St Clair et al[39]

RG with Mental Health AST, Deloraine, Tasmania

Dr Aaron Hawkins (FACRRM) is a RG working in Deloraine, which has a general practice and a small district hospital. The clinical week is split between ward rounds and being on call for the hospital and day to day work at the general practice. Dr Hawkins also works as a medical educator with ACRRM. Dr Hawkins uses his advanced specialised skills training in mental health, working a day a week in a mental health clinic. His patients are self-referred or have been referred for review and advice by his fellow GPs.

RG working in Aeromedical services, Geraldton, WA

Dr Anthony Rengel (FACRRM) works for the RFDS based in Geraldton, Western Australia. His work is diverse from managing a general practice clinic at a remote nursing post, to working in the emergency department at Geraldton, to providing outreach medical clinics for families on a mining site at Shark Bay to addressing obstetric emergencies and retrievals. He has even on occasion had to attend to a stonefish poisoning by a scuba diver on Shark Bay.

RG with Obstetrics AST, Kununurra, WA

Dr Alice Fitzgerald (FACRRM) works as a RG in Kununurra, a town with a population of around 6000, located at the eastern extremity of the WA Kimberley Region. She works two days a week in a private

practice, one day a week as a rural medical educator and the remainder of the time working for the local hospital which involves doing a mix of emergency, ward work, outreach clinics to remote communities and obstetrics.

RG registrar, Dunich, North Stradbroke Island, Qld

Dr Stewart Hazleton works for seven days out of every fortnight as the lone doctor on North Stradbroke Island. Between 9am and 5pm on those days Dr Hazleton manages the Marie Rose Centre in Dunwich, an outpost of the Redland Hospital Emergency Department, where he is supported by a Queensland Health nurse and an administration officer. After hours he is on-call for any and every medical emergency that happens on the island, often working in partnership with Queensland Ambulance Service Officers. Over six months, Dr Hazleton has managed car accidents, downed planes, and serious drug overdoses and delivered two babies. He likens the job to one of a rural doctor stationed out bush, with limited resources and the need to manage transport issues according to the time of day and weather conditions. Caring for the island's occupants encompasses a broad spectrum of health needs; from paediatrics to Aboriginal health and geriatric care.

RG with Obstetrics AST, Geraldton, WA

Dr Nathan Combs (FACRRM) works between his GP clinic and the hospital, doing obstetrics in Geraldton. In the clinic he sees general practice patients and antenatal patients for antenatal clinic. If patients are sent to hospital, if, for example, the baby's not moving or they are in labour, he attends to them in the hospital and rearranges his GP patients to suit. If labour continues into the night, he follows his patients through. He also provides on call services for obstetrics and gynaecology to the hospital after hours. Due to the lack of public specialist clinics in Geraldton, as a GP, he is often called upon to do more technically difficult consults for his patients who wouldn't otherwise be able to access them.

RG Registrar, LifeFlight Cairns, Qld

Dr Sandi Dawson is a LifeFlight Retrieval Registrar, which involves working full time with the Cairns QGAir EMQ Rescue Helicopter. She works in a healthcare team, alongside the helicopter pilot, air crew officer, rescue crew officer and intensive care flight paramedic. The team operates in shifts over a 24hr period, 7 days a week to provide emergency aeromedical retrievals. This includes facilitating the transfer of critically unwell patients from rural hospitals and health care facilities to regional and tertiary facilities. It also involves being tasked as part of the primary response to scenes such as farm accidents, motor vehicle accidents or mass casualty events where we land on scene, provide medical care and fly to definitive care. Dr Dawson also frequently staffs the rural primary care facilities that she visits. She also staffs, the rural hospital services (emergency, wards, birth suite, operating theatre etc). An example, of the scope of work she provides, was at Christmas when she flew via helicopter to Australia's northernmost island to retrieve a woman with life threatening complications of pregnancy. After stabilising the patient, the team flew back to Thursday Island where she gave an anaesthetic to facilitate her caesarean section, then intubated and stabilised the critically unwell baby and arranged retrieval onwards to Intensive Care. Six days later, the mother and baby arrived back to Thursday Island ready for discharge home and she provided basic primary care including post-natal checks and contraception advice.

For literature on:

- RG obstetric models in WA see Wazir et al[40]
- RG anaesthetist models see: Orser and Wilson [41]
- RG single employer service model see: Rimmer et al[42]

Assistants in Medicine

In addition to the Rural Generalist models of care listed above, the College believes the *Assistants in Medicine* program provides another positive clinical model characterised by the expanded scope approach.

The *Assistants in Medicine* program employs final year medical students to assist with tasks in the hospital setting. The program has been effective in New South Wales. It has been rolled out in several other states and is under consideration for wider adoption. It presents an opportunity to decrease workload on junior doctors, increase exposure for students, enable students to have a paid job, and relieve the pressure on other members of a multidisciplinary team.

4. Facilitating Best Practice

4.1 What barriers can government, employers and regulators address to enable health practitioners to work to their full scope of practice?

4.2 Please provide references and links to any literature or other evidence.

Some key barriers include:

- **Clinical frameworks reflect urban/specialised models of care and preclude RG practice**
  RGs' capacity to provide broad scope services relies on credentialing and employment frameworks that recognise RG training, that set achievable and appropriate metrics for training/maintenance of skills, and that avoid prohibitive administration and compliance hurdles.
  Credentialing quality and safety measures are often defined by and for professionals with a highly specialised scope for practice in urban centres. They generally do not consider the RG context, training or scope. This often leads to problematic standards such as prohibitive minimum volumes of practice, requirements for training/experience in tertiary facilities that preclude RG qualifications and are of little relevance to the RG practice environment. Importantly, clinical standards are commonly developed without calculation of the impacts of 'access' to patient safety and quality.
  Additionally, compliance for clinical privileging is administratively onerous. This is difficult for all specialists, but for broad scope doctors the administrative impost is duplicated across multiple specialties. The extent to which this is impacting rural doctors and their capacity and preparedness to provide expanded scope care has been advocated by our College and the Rural Doctors Association of Australia (RDAA) [43] and is evidenced by a 2019 survey of the Australian Medical Association (AMA) survey of rural doctors finding in the top ten priorities *"ensure GPs with recognised procedural skills can access appropriate hospital credentialing and facilities"*.[44]
  These issues are further detailed:
  - RDAA Policy Position [45]
  - ACRRM Policy Statement [46]

- **Uncertainty of resourcing of broad scope services in rural and remote areas**
  Services in rural and remote towns that might be described as extended primary care, that is services for which easy access is especially important, (e.g. obstetrics, emergency care,

palliative care, paediatrics), are under constant threat of downsizing or closure. For example, over the twenty years between 2001 and 2021 in Australia, 120 rural birthing wards were closed and diverted to regional centres.[47] This constant uncertainty undermines thriving communities and discourages potential doctors from permanently locating in rural and remote areas.

- **Inequitable remuneration**
  While funding varies across jurisdictions, there is a discrepancy between the services that RGs provide in hospitals and provision of those same services by other specialties under hospital remuneration frameworks. Similarly advanced specialised services in non-procedural fields such as mental health, paediatrics and palliative care which are supported through the MBS are paid at lower rates for RGs than for other specialist practitioners. Further it is commonly reported that rural locums and FIFO doctors are being paid significantly more than their colleague doctors who are locally-based. All these discrepancies, are not only inequitable but signal lower national esteem for the work of RGs, discouraging doctors to these rural careers.

4.3 What enablers can government, employers and regulators address to enable health practitioners to work to their full scope of practice? Please provide references and links to an y literature or other evidence.

4.4 Please provide references and links to any literature or other evidence.

- **RG Recognition**
  The joint-application to the Medical Board of Australia is undergoing its final stage assessment which will including a national consultation. Broad stakeholder support for this application will contribute to a successful outcome. RG Recognition will assist to address many of the institutional barriers to the development of a thriving RG workforce and ensure that these doctors and their practice is identified and represented in decision-making, planning and funding.

- **RG representation in clinical credentialing frameworks and decision-making**
  A key enabler to decision-making congruent with the safest and highest quality care is to ensure RGs are represented in decisions related to their safe practice. As RGs practice commonly extends into areas of medicine dominated by other specialties their unique practice scope, expertise and clinical context are often not given due consideration in decisions around what services they are able to provide and the appropriate experience, training and CPD to support their safe practice.

- **Develop rural-centric multidisciplinary team-care models with associated minimal care standards**
  Team-based care models that are principally focused on strengthening locally-based resources and supporting local sustainability should be developed. These might involve digital health, outreach, and other services from cities that would support the locally-based practitioners. For example, outreach specialists should support and upskill locally based staff and focus on strong communication to maximise follow up care by local staff.

The RG has a key role to play in these models providing locally-based coordination of medical care and essential to these approaches is an established set of minimum national standards which identify the need for all rural and remotely based people to have a continuing relationship with a doctor including opportunity for in-person consults in their local area.

- **Pivoting funding from locum and outreach models to sustainable locally-based services** Rural and remote communities cannot thrive where they face uncertain futures in terms of access to the most essential medical care. Governments need to make clear headline commitment to sustainable locally-based services and ensure funding models at all levels incentivise and reward locally-based service providers. These approaches can offer more cost-effective care than locum-based models and offer vastly better outcomes in terms of accessibility, quality and safety and general contribution to local community well-being.

- **Better remuneration models for locally-based doctors and locally-based private practices** Currently in Australia, doctors' income levels increase with increasing proximity to urban centres where the workforce is most concentrated. If the workforce maldistribution and rural workforce shortages are to be addressed, rural doctors and other allied health professionals need to be adequately remunerated for their services and incentivised to work in areas which may not have the services and opportunities of cities and for which remoteness may lead to increased costs of living.

5. Additional Views

5.1 The broadest range of views will give the review a thorough foundation on which to consider new policy and regulation.

5.2 Please share with the review any additional comments or suggestions in relation to scope of practice.

Nil comments.

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ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the Traditional Owners of lands across Australia in which our members and staff work and live and pay respect to their Elders past present and future.

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