RACGP

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

Additional Advice to Medical Board of Australia for the application for recognition of Rural Generalist Medicine as a specialist field within General Practice

Jointly submitted by the Australian College of Rural and Remote Medicine and the Royal Australian College of General Practitioners

July 2021

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Identifying information

Applicant Details

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Specialty or field of specialty practice details

Specialty or field of specialty practice:

Rural Generalist Medicine as a field of specialty practice within the discipline of General Practice.

Verify proposal

The information presented is complete, and it represents an accurate response to the Guidelines for the Recognition of Medical Specialties and Fields of Speciality Practice under the Health Practitioner Regulation National Law.

……………………………………………………………………………………….
Signature

Marita Cowie, ACRRM Chief Executive Officer

Name……………………………………………………………………………

1. Overview of organisations lodging the preliminary proposal

1.2 AMC Advice *A MoU, or any other arrangements between the two applicants has not been provided. In order to meet the requirements for this section, evidence of a MoU between the ACRRM and RACGP should be provided.* *In addition, if this proposal proceeds to the State 2 process, evidence is required of MoUs or consultation with the colleges whose disciplines overlap with the additional skills of rural generalists.*

1.1 Agreement between the general practice colleges

The Colleges have signed a Memorandum of Understanding reflecting their commitment to work together in accordance with the goals of this proposal.

Please see attached:

- *Attachment 1.1 RACGP-ACRRM Memorandum of Understanding*

1.2 Agreements and Discussions with other medical colleges

As outlined in the Application, the National Rural Health Commissioner's consultation involved extensive discussions with medical colleges and correspondence which addressed the issue of specialty recognition including the Commissioners address to the CPMC meeting in 2018.

The Taskforce (represented by the National Rural Health Commissioner, RACGP and ACRRM Presidents) presented to the Council of Presidents of Medical Colleges (CPMC) on the application on 18 Nov 2020. The Taskforce sent a follow up letter to all College Presidents which included additional details of the application and inviting further discussions. This has led to further and ongoing consultation with several colleges detailed at *Section 5*.

Please see attached:

- *Attachment 1.2 CPMC Presentation – Agenda, briefing and presentation*

2. Statement of issues

AMC Advice

More information is needed to meet the requirements of this section. The proposal has not clearly and consistently articulated the issues that it intended to address or supported these by evidence that the proposed deliverables will be achieved. The applicants should revisit the response to this section, particularly focussing on providing this evidence of how the issues will be addressed with specialist recognition.

Note on arguments and evidence:

The following explanations and evidence in accordance with the Medical Board's request are given as *additional information*. While there is some overlap with what has previously been presented, it is assumed that the information in our previous submission has been read and does not need to be repeated. No additional issues are raised however they have been repositioned for further clarity and consistency. Further and more detailed evidence has been provided wherever possible.

Rural Generalist Medicine has not been established as a national specialist title in Australia or elsewhere. Any evidence to support the impacts of its establishment is thereby partial and indirect.

As requested, this additional information, provides evidence of the positive outcomes from the partial measures toward specialist title, that have been put in place in Australia through the state and territory based rural generalist programs. It is important to recognise that these gains are confounded by the considerable legacy issues and the persisting institutional attitudes and other barriers associated with a lack of national recognition that the proposal identifies and seeks to address.

As outlined by the National Rural Generalist Taskforce Advice Report – the attainment of specialist title, was recommended as one of a package of interdependent recommendations, which together are described as the National Rural Generalist Pathway (NRGP). The NRGP is an identified component of the draft National Medical Workforce Strategy. A national interjurisdictional governance body, the Rural Generalist Strategic Council is oversighting the NRGP implementation. As such the potential outcomes of the attainment of specialist title, should appropriately be viewed with the expectation of implementation of a range of other supporting developments.

This proposal is world leading. The specialist field has not been formally recognised in any other country, however the issues this problem seeks to address are prevalent across the world and there is considerable interest in, and support for this process by governments and professional groups in other countries.[1,2,3]

2.1 Issues that the proposal seeks to address and supporting evidence

Value Proposition:

Rural Generalist Medicine enables people in rural and remote places to have the best possible access to high-quality medical care, by providing an economic workforce solution of locally-based general practice doctors trained to provide a broad scope of services to a defined and assessed professional standard including to work in GP clinics, hospitals and emergency depts, and to enable collaborative team-care solutions.

As outlined in the application the interrelated headline issues the proposal will help to address are:

- The much lower health status recorded by people in rural and remote areas relative to people in cities[4]
- The inequitable and unacceptably poor access to quality healthcare services for both acute and continuing care of people in rural and remote areas relative to people in cities[5]
- The persisting issues of attracting and retaining sufficient doctors to meet the breadth of services required in rural and remote areas[6]

Key issues to be addressed:

Key factors contributing to these headline issues that will be directly addressed through this proposal, include:

Issue 1: The need to maintain a minimum range of permanent, locally-available, specialist services in rural and remote areas to sustain essential emergency care

Issue 2: The need to maintain a minimum range of permanent, locally-available, advanced specialised services germane to primary care in rural and remote areas

Issue 3: The unfeasibility of providing the full range of specialist services, staff, and resources of major cities - in rural and remote areas

Issue 4: The unviability of specialist/subspecialist practice models to support permanent staff in rural and remote contexts with limited patient catchments

Issue 5: Systems barriers to recruitment, training, employment, service provision and quality assurance for the rural doctors with the training, scope, and model of care to meet many of these wider service needs (in the absence of their formal recognition)

Supporting evidence of issues:

Issue 1: The need to maintain a minimum range of permanent, locally-available, specialist services in rural and remote areas to sustain essential emergency care

In emergency scenarios such as accidents and obstetric and psychiatric emergencies provision of care locally can often be vital to patient safety.[7,8,9]

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.[10] 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.[11]

Extensive literature documents the risks associated with patient travel to access distant health care.[12,13,14] One study of stroke care for example found that the clinical risks of longer journeys outweighed the benefits of accessing the tertiary service.[15] 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.[16]

The testimonies of rural communities on these issues given to the New South Wales inquiry into rural health services evidence the need for essential permanent emergency (and other advanced skilled services) capacity in the local area:

"I gave birth to my third baby on the side of a highway in the middle of the night in 2011. Going into labour two weeks before her due date, I feared I wasn't going to make it to the birthing hospital in the ACT. I went directly to our local hospital (Yass). I was packed into an ambulance and sent down the Barton Highway in the dark, in the middle of the night, going at speed. I still think about that night and I still think about the stress of worrying what was going to happen to my baby. Was my baby going to be okay? Was I going to be okay? What if we hit a kangaroo? Lucky I was ok and so was my baby, now 9 years old. But if we don't resume births at Yass Hospital, there will come a time when a Barton Highway birth is fatal for mother or baby or both".[17]

"Just some examples of poor outcomes resulting from limited access to health services in Wee Waa include:

1. *A woman who died at home alone because she didn't want to go to hospital as she knew there was no doctor there. She had specifically stated in a care plan that she wanted to die in hospital.*
2. *A terminally ill resident who, after being treated in Tamworth hospital, was unable to return to Wee Waa due to the absence of a VMO, despite his wishes. He died in Tamworth & his family were burdened with the additional expense of bringing his body back to Wee Waa.*
3. *A teenager with a severe laceration having to drive himself from Wee Waa to Narrabri as he was unable to be treated at Wee Waa hospital.*[18]

Issue 2: The need to maintain a minimum range of permanent, locally-available, advanced specialised services germane to primary care in rural and remote areas

There are a range of key advanced specialised services which in rural and remote contexts should appropriately be viewed as essential to primary healthcare.[19] For example, birthing and neonatal care, cancer treatments, renal care, end of life care, addiction care, and preventive screening.

Lack of local access to these is inequitable. It is likely to lead to some patients delaying or foregoing needed care as well as to fragmentation of their care.

National patient surveys have found that 58% of people in remote areas view the lack of a non-GP specialist nearby as a barrier to seeing one (compared to 6% in major cities). They found that the likelihood of forgoing seeing a specialist because there was

none nearby increased with remoteness and that people in remote areas were 10% more likely to report this than people in major cities. These studies also found that the likelihood of care fragmentation due to lack of communication from specialists to patients' regular general practitioner increased with remoteness with people in remote areas being 10% more likely than people in major cities to report that their usual general practitioner had not been informed about specialist care they had received.[20]

International studies have shown that longer journeys discourage the use of healthcare services.[21] The much lower use of both Pharmaceutical Benefits Scheme and Medicare services recorded by rural people relative to people in major cities would suggest that this is also the case in Australia.[22]

There are considerable barriers to many people in rural and remote areas being able to travel extended distances to receive care including high needs groups such as the aged, people with disabilities and Aboriginal and Torres Strait Islander people.[23,24] The lack of public transport or other access to transport services is a key issue for many of these peoples. It is also widely noted that patient travel assistance schemes are administratively onerous and inflexible, and typically only partially cover costs. Kelly et al found that travelling to the city hospital is a significant barrier to remote and remote Indigenous patients and that arranging and supporting travel is time-consuming work that is not recognised by the healthcare system.[25] A survey of rural people in New South Wales, found 42% of respondents viewed the costs to travel away from home for health treatment to be a deterrent and/or prohibitive.[26]

There is evidence that this lack of access inhibits patients receiving critical preventive care. For example, people living in *Remote and very remote* areas also have lower rates of bowel, breast and cervical cancer screening[27,28]

Extended travel to access healthcare also creates an intrinsic risk to patient safety. Land transport accidents are a leading cause of death in *Remote* and *Very remote* areas. 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.[29] A study by Greenup et al into patients travelling to access hospital care identified a direct relationship between increasing remoteness and travel risk. The review identified 45 people who had died in road accidents in the process of obtaining medical treatment in Queensland between 2002 and 2015, an average of 3.21 deaths per year. They concluded that individuals living in regional and remote Queensland are exposed to a larger risk than those living in the major cities of Queensland when required to travel to hospital for referred care.[30]

A survey of over 800 people from across regional, rural and remote New South Wales in recording respondents feedback to whether they felt they had reasonable access to a range of key services highlighted service gaps in fundamental care provision such as maternity care, palliative care and mental health.[31]

General Practice	96%
Ambulance	95%
Access to hospital or hospital service	90%
Emergency department (hospital)	87%
Pathology	89%
Aged care	86%

Dental	77%
Other allied health	67%
Early childhood services (including mother and baby)	55%
Palliative care	53%
Maternity services	51%
Psychology and mental health services	47%
Disability services and child development services	44%
Domestic/family violence, sexual assault services	42%
Oncology treatment	40%
Alcohol and other drugs treatment and services	39%

Similarly, the Rural Workforce Agency of Victoria survey of rurally-based general practice doctors found respondents felt they would meet their communities' needs better if they had further advanced skills training in a range of areas including: dermatology and skin cancer care (39%), mental health (23), obstetrics and gynaecology (including ultrasound and women's health) (18%), and emergency medicine (13%).[32]

The extent to which these access issues are impacting rural communities is demonstrated by their extensive coverage in community submissions to the 2021 New South Wales Inquiry into rural health services access and outcomes. Some examples are given below:

"Many residents, particularly the elderly, have lost faith in the provision of local healthcare & live their lives in fear of not being able to receive the necessary healthcare in their time of need. We are sure there are many instances of people who have either delayed or decided not to bother seeking medical treatment due to the difficulties in accessing it locally. This is obviously going to result in poorer health outcomes. ..To not properly treat patients locally in the regions means one of two things occurs; (a) they must travel/be transported to another location, meaning added cost & stress, & a transfer of the cost of treatment to another cost centre within the Department, &/or (b) they are not treated adequately or at all, resulting in poor health outcomes including death. It simply does not make any moral or economic sense to under-resource healthcare in regional communities."[33]

"Staff who are suitably qualified, experienced and committed to working and living in the Far West is a crucial component of providing high quality and consistent care that people in our region deserve, as much as anywhere else in the State. The waiting lists for visiting specialists can be long, with some patients waiting more than 12 months for an appointment. Given that many of the population sit in a low socio-economic band and cannot afford to travel for medical treatment, the trend of lower health outcomes will continue to be an issue for the region if not addressed."[34]

"The patient experience, wait-times and quality of care are ongoing issues. Wait times are increasing to access GPs, as well as wait times to access specialists in regional centres such as Wagga Wagga or Canberra. The cost to access specialists and specialised educators is far more than in metropolitan areas. Further, the additional costs of travelling to regional centres to access these services are an additional burden to those living in rural areas. Outpatient clinics are unavailable to those located in rural areas, when these services are provided at no cost to those living in metropolitan areas. Some patients are unable to afford the costs associated with seeking treatment by a

specialist. The isolated travel fund allowance is cumbersome to access due to the excessive amount of paperwork required and the outcome of funding is very limited."[35]

"Council has been advocating for improved medical services for several years. For example, there are limited maternity services in Yass and residents have to travel to Queanbeyan, Goulburn or Canberra. Similarly, residents needing dialysis and oncology services must travel into the ACT. Many residents in Yass Valley rely on Community Transport to travel for these services. This has been particularly challenging during the COVID-19 restrictions as many of the community transport drivers are volunteers many of whom are vulnerable to the virus"[36]

"The local maternity ward is a much loved component of the Gunnedah Hospital and has received welcome attention from local fundraising groups to ensure that it is at a standard suitable for our residents. However, the operation of the maternity ward is dependent upon the availability of two local doctors and if they are unavailable, the ward, simply shuts with patients transferred to the Tamworth Hospital. It is unthinkable that metropolitan based mothers would have to deal with the possibility that the maternity ward at their local hospital may or may not be open on the day or hour they arrive to have their baby. It remains a great fear for the Gunnedah community that when we inevitably lose one of the local GP's required to operate the maternity ward, the service will go the way of so many other local health services and simply be closed forever and centralised to the regional city of Tamworth."[37]

"The reality is however that throughout rural NSW hospital operating theatres stand unused, no babies are being delivered and regularly there is no doctor available to attend emergency wards. Perhaps the Inquiry could access the occupancy rates for the various hospitals. It should be remembered that there is very limited public transport available as a result patients are either driving themselves, utilising community transport or waiting and then travelling in ambulances…It is no longer possible for expectant mothers to give birth in the smaller rural hospitals because you need a team of specialists to deliver and care for a new born and we simply don't have enough babies to justify having such a team on standby. This is even more challenging now that we have specialist maternity nurses."[38]

"Maternity, oncology and renal care are most needed and called for locally. Despite a population of more than 17,000 people, Yass Valley mothers cannot deliver their babies at Yass Hospital and must travel to Queanbeyan, Goulburn or Canberra for labour and delivery. This causes additional anxiety and stress, over and above the normal fear women can have of labour and delivery. Yass Valley women have a high risk of an unplanned and unsupported highway birth, and are forced to be away from their other children and support networks to access maternity care. …Yass Hospital must resume full time maternity and delivery care with the midwifery continuity of care model for our growing population. The well-known and expanding 'continuity of care' model with local midwives and GPs working together would deliver more than 185 babies each year in Yass."[39]

Issue 3: The unfeasibility of providing the full range of specialist services, staff and resources of major cities - in rural and remote areas

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 health care services that exists in metropolitan areas in regional, 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.

Issue 4: The unviability of specialist/subspecialist practice models to support permanent staff in rural and remote contexts with limited patient catchments

Financial viability and sustainability of clinical practice is an important consideration. It is not possible to sustain some specialty/subspecialty practices in rural or remote areas and it is not realistic to expect specialist doctors to live and work in rural areas, if there is not a consistent and ongoing need for their clinical services.[40]

Specialist and subspecialist practice models rely on substantial population catchment numbers and caseload which are often not possible in rural contexts. These specialists' clinical practice models are often based on metropolitan tertiary hospital settings with immediate access to extensive specialist staff and resources which do not reflect rural clinical contexts.

Issue 5: Systems barriers to recruitment, training, employment, service provision and quality assurance for the rural doctors with the training, scope, and model of care to meet many of these wider service needs

National statistics of the rural generalist workforce are not collected and difficult to measure given the lack of specialist title.

There is considerable evidence of the declining number of doctors providing advanced care services in rural areas which is occurring despite the considerable investment by the federal government in training this workforce.

New South Wales Rural Workforce Agency (NSW RDN) in its annual needs analysis has identified the decline in the *"interest or preparedness of GPs to work as VMOs in hospitals"* and the declining rural procedural general practitioner workforce as a key issue, identifying that:

"RDN workforce predictions show by 2025 rural NSW will have less than 156 GP VMO Proceduralists.

- *30% of the current proceduralist workforce is over 60.*
- *It can take seven years to attract, recruit and embed a GP Proceduralist….*

(This workforce shortage) Often leads to gaps in GP services available, including inpatient, ED and procedural services...

Rural towns depend on GP Proceduralists to ensure ongoing access and sustainability of primary health care for rural communities. Declining numbers leads to a reduction in locally available services. Birthing services are unavailable in many remote locations. More pressure on existing GP Proceduralist workforce creates fatigue and burnout. LHD locum costs continue to escalate, while ongoing closure of financially unviable solo and smaller practices continue to exacerbate this."[41]

The decline is further evidenced by community testimonies to the New South Wales Inquiry into health services.

…Instead we have observed an increasing tendency for our local GPs to disengage with the LHD and drift away from Visiting Medical Officer (VMO) work, which is what underpins our rural hospitals….It has now become common practice for Coolah, Dunedoo and Baradine not to have in person medical cover, especially on weekends and after hours. This places more pressure on Coonabarabran Hospital. Whilst Coonabarabran Hospital is meant to have 24hr in person medical cover on an on-call basis, it has had times when it has had to rely on telemedicine due to the LHO not being willing or able to supply in person cover.[42]

"As an example of the downgrade to Narromine Hospital, during the tenure of the previous long term doctors in the town, two of them conducted over 7000 procedures during their time serving the community. This, all at Narromine Hospital.

The delivery of babies, setting broken limbs, appendix removed and other minor operations. Now there is basically nothing done there. Why is it a baby can be delivered in St George Hospital in western QLD but it can't happen in Nyngan, Bourke, Cobar or Narromine? All these mothers and families are forced to travel 3-400 kms in many cases. The distance to travel to seek good health services is also leading to significantly worse health outcomes because of the tyranny of distance. Many elderly people particularly will put off seeking advice on that lump or pain because it's too far to seek the advice. They suffer in pain and silence and their condition worsens. The cost to both them and government blows out. The cost cutting is counterproductive."[43]

This workforce decline is the consequence of a complex interplay of factors. While lack of specialist title is neither the sole problem nor will it provide a unilateral solution, it presents a critical roadblock to a thriving, effective workforce. Some key aspects of the problems it creates are canvassed:

- *The concept of rural generalism as a career cannot be formally marketed nor effectively promoted in medical schools and training hospitals*

  There is a self-evident challenge to promoting a career option that has not been conferred a professional title. The lack of national title not only creates language barriers to describing a future career path but underscores to the emergent workforce the lack of value and status placed by the national health sector in the role. Pertinently, irrespective of training and experience, it is not officially possible (with the notable exception of Queensland) to point to potential mentors and role models in this career path as they are not deemed as meriting a professional title.

  The Australian Medical Students Association Rural Health Committee have also highlighted that *student feel that rural generalism isn't as ''clear cut'' or defined as other specialties,* and that, *recognition as separate from mainstream general practice will reduce confusion the student population has regarding generalism;* and hence assisting AMSA to promote Rural Generalism as a career.[44]

  This is particularly of concern given that the Medical Deans of Australian and New Zealand (MDANZ) annual data report, found final year medical students ranked

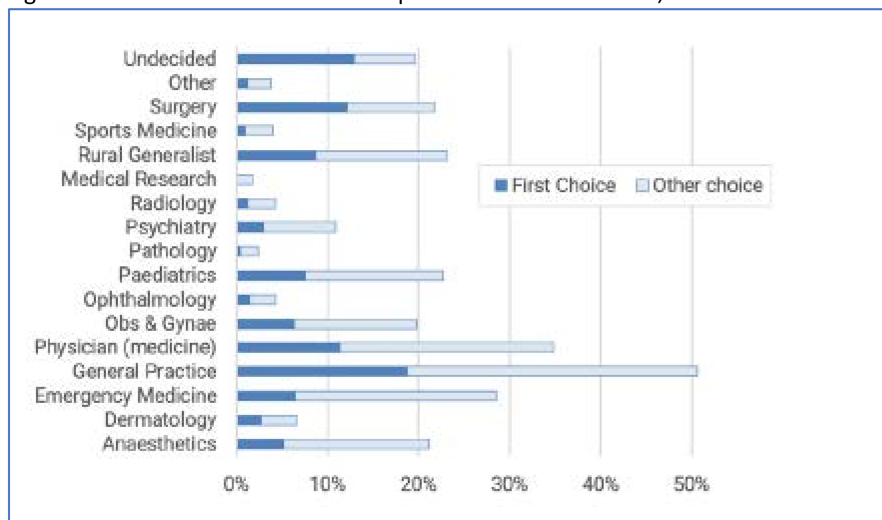
'medical school experience of the speciality' and 'consultant/mentor influence' respectively as their 2nd and 6th top ranked reasons for choosing a specialty.[45]

Thus, from the outset of doctors' careers the value proposition of the considerable additional effort involved in pursuing rural generalist training is substantively undermined.

This is particularly so, when in choosing a rural generalist training pathway, these future doctors are asked to opt for the challenges that are associated with rurally-based training; an additional one to two years of training compared to a standard general practice Fellowship; and, a far more complex training pathway across different work settings, with the extended responsibility, work and time commitments of hospital and emergency work, in addition to the commitments and challenges of the general practice clinic.

There is nonetheless considerable interest from medical students in rural generalist practice as a specialist field career path and its lack of formal recognition is out of step with their career planning and expectations. A recent national survey of 1,129 medical students by the General Practice Student Network identified "Rural Generalist" as one of the potential career paths and found that over 23% of respondents ranked this in their top three preferred careers. This popularity did not appear to negatively impact interest in General Practice which was ranked in the top three preferences by 51% of respondents.[46]

Figure 1.1 Medical students current preferred career choice, 2019



Source: GPRA Medical Student Survey Report 2019 (page 12)

- *Fellowship training is complicated and obstructed by the lack of specialist title and by extension recognition of the appropriate skill set associated with its training and supervision particularly within the hospital systems*

  Historically, rural generalist trainees have been required to negotiate their own path through hospital, general practice, and other work settings in order to gain the requisite Fellowship training and experience, and have faced system complexity and obstruction.

Rural Generalist training programs in all states and territories are being supported by the federal government to actively address these issues. In seeking to facilitate training within their own hospital systems, the lack of a reference point of professional title (with the exception of Queensland and Northern Territory[*]), is creating systems barriers for the program administrators.

The absence of an agreed title linked to formal training qualification creates problems for example, in enabling trainees to access hospital training posts and appropriately experienced supervisors and in appropriately recognising registrars' training and experience to enable their clinical practice. Furthermore, without professional title, determinations regarding rural generalist training technically cannot stipulate a rural generalist's input. The lack of professional title also makes it difficult to formalise hospital linkages with the private general practice sector as there is no clear, official terminology by which the trainees or their profession can be described.

Without professional title, it is possible that many states and territories will see the need to follow the example of Queensland and legislate individually for professional title creating further potential for inconsistencies and involving duplicative effort from all legislatures.

- *Employment is compromised by the lack of a named job and there is no basis for job portability*

  There is no capacity to employ people (except in Queensland and Northern Territory) to the job of Rural Generalist. In the jurisdictions where this is possible, the job is accepted on the understanding that it will have no status in other jurisdictions, should the doctor decide to relocate.

  As outlined above, the absence of title is a statement to doctors seeking to pursue careers in this field of the lack of esteem the national profession holds for it. At a practical level, it also means that they cannot anticipate that their credentials will have explicit recognition by potential employers as a coherent body of skills and experience that they would bring to the workplace. These all present disincentives to attaining high quality skills, experience, and accredited training in this area of critical workforce need.

  This also inhibits healthcare employers seeking to employ people with this skillset in rural and remote areas. They cannot advertise for, nor actively recruit rural generalist doctors, forcing them to use inefficient and ineffective processes.

- *The absence of professional title and the associated lack of esteem and awareness for these practitioners and their skill set, inhibits healthcare systems from incorporating them into credentialing systems and processes and facilitating their practice.*

[*] In Queensland, Rural Generalists are doctors with a credentialed clinical scope of Rural Generalist Medicine certified by award of relevant Fellowships conferring eligibility for a designated industrial award. In the Northern Territory, Rural Generalists are identified only by their Industrial award identified in their Enterprise Agreement which specifies award of the relevant Fellowships or participation in training toward them.

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. In these contexts, homogeneity within specialities is common, and highly structured training and professional development frameworks for their associated clinical credentialing are appropriate.

These protocols are a poor fit for rural generalists that have a diverse scope of practice, less depth of specialisation, a low resource clinical setting and a necessarily different set of metrics for defining the safest and optimal clinical point for referral or patient transfer to major centres for care.[47]

The consequence is that rural generalists to provide these services must manage and continuously meet an excessive range of credentialing measures and processes. Furthermore, it commonly occurs that compliance expectations are prohibitive to practice in rural areas even where these may be practiced safely. While many standards may reflect best practice safety in urban contexts, a more nuanced, flexible, and holistic approach may be needed to achieve best practice safe care for rural people utilising the rural generalist scope and skillset.

A recent study found that procedural sedation is practiced extensively by non-specialist doctors across rural hospitals in New Zealand with positive outcomes for patients including avoidance of patient transfers and with acceptable levels of quality and safety. The study identified points of conflict with nationally set minimum clinical standards, preventing what was safe and practicable in rural hospitals. It saw need and value for a national quality and safety framework which safely and realistically, reflected this model of care in rural areas and defined appropriate standards for the distinctive rural professionals involved with its delivery in the resource context of rural hospitals.[48]

The current administrative complexity and unpredictability of hospital credentialing is a recognised barrier to RGs providing procedural services. Both the Rural Doctors Association of Australia (RDAA) and the Australian Medical Association (AMA) have identified this as a priority issue. The RDAA have developed a position statement on the issue.[49] The AMA conducted a survey of rural doctors in 2019 which ranked *"Ensure general practitioners with recognised procedural skills can access appropriate hospital credentialing and facilities"* as one of their top ten priorities.[50] The Rural Workforce Agency of New South Wales in its submission to the NSW Inquiry into rural health services identified decades of increasingly prohibitive compliance regulations as a major contributing factor to the decline in the rural procedural workforce in that state.[51]

Similar patterns of hospital credentialing systems reflecting urban specialist standards, and preventing safe healthcare provision by general practice doctors in rural areas has also been evidenced in the United States and Canada.[52,53] An American Academy of Family Physicians paper identified the common practice of family doctors providing emergency services in rural areas and noted that the establishment of the emergency medicine specialty has led to *"experienced family physicians sometimes denied credentialing, regardless of their emergency department work experience, with some being replaced in their practice environment by less experienced emergency medicine residency trained providers."*[54]

The rural generalist model can positively address all these issues. Despite the many systems barriers, there is considerable evidence to suggest that where the training and practice of this workforce is given strong support (including title recognition), considerable improvements can be made to the quality of care rural communities can receive. These outcomes are outlined at *Section 2.3*. The specific mechanisms by which specialist title can support the rural generalist model and evidence of their efficacy are given at *Section 2.2*.

2.2 Proposed deliverables to address these issues and evidence that deliverables can be achieved

As outlined in the previous application speciality recognition would contribute to addressing the issues outlined above by contributing to the growth of a highly skilled rural generalist workforce and facilitating its efficient and effective safety and quality regulation.

The key interdependent mechanisms by which this proposal will contribute to addressing the five key issues are listed below:

Deliverable 1: Conferring national recognition and status will incentivise doctors to undertake the extra training, commitment and effort entailed in rural generalist medicine

Deliverable 2: Conferring a 'name' to the career path will enable rural generalist careers to be marketed in schools, medical schools and hospitals

Deliverable 3: Specialist title will allow rural generalist practice to be moderated by safety and quality systems with a consistent, nationally understood reference point linked to a common qualification standard

Deliverable 4: Specialist title will lend a common job title to enable job portability, more effective, simplified workforce recruitment, and enhance job appeal

Deliverable 5: Specialist title will enable rural doctors with the rural generalist skill set to be incorporated into workforce and health service resource planning

Deliverable 6: Strengthening the rural generalist workforce will bring more long-term doctors to regional, rural, and remote areas

Deliverable 7: Strengthening the rural generalist workforce will Improve health service capacity in regional, rural, and remote communities by rural generalist doctors providing skilled services otherwise not locally available

Supporting evidence for deliverables:

Deliverable 1: Conferring national recognition and status will incentivise doctors to undertake the extra training, commitment and effort entailed in rural generalist medicine

While it is not possible to demonstrate the impacts of national title without this having been attained, it can be noted that Queensland which is the only state that has conferred recognition to its Rural Generalists working in its state health system can be shown to have achieved significant improvements within its jurisdiction in terms of providing a rural generalist workforce, and that its achievements in this area are stronger than anywhere else in Australia.

While Queensland (5.2m pop, 20%), is the third largest jurisdiction in Australia behind, New South Wales (8.2 m pop, 32%) and Victoria (6.7m pop, 26%) it appears to have the highest number of practicing rural procedural general practitioners including among all other states and territories.

The Rural Procedural Grants Program (RPGP) is the seminal national scheme to support rural generalist practice. It supports vocationally registered general practitioners to maintain their clinical credentials in key rural generalist areas. As such, it is generally understood that most active procedural rural generalists take part in the scheme. These areas include procedural obstetrics, anaesthetics, surgery, emergency, and emergency mental health services. Queensland has consistently recorded the highest number of doctors of any state or territory subscribing to any part of the national RPGP.

Table 2.1 Enrolments in procedural skills support program in largest states, by state and year

	2018		**2019**		**2020**		
	Obs, Surg, Anaest	**EM**	**Obs, Surg, Anaest**	**EM**	**Obs, Surg, Anaest**	**EM**	**Mental Health EM***
ACT/NSW	335 (18%)	884 (21%)	308 (17%)	864 (21%)	309 (17%)	878 (21%)	22 (11%)
VIC	328 (18%)	680 (16%)	322 (18%)	681 (16%)	329 (18%)	695 (16%)	24 (12%)
QLD	482 (26%)	912 (22%)	484 (27%)	898 (22%)	506 (28%)	937 (22%)	109 (54%)
National Total	**1836**	**4159**	**1803**	**4136**	**1835**	**4237**	**202**

*Support for Mental Health Emergencies training introduced in 2020

Queensland appears to contribute the most rural generalist trainees to the AGPT training program.

Table 2.2: Rural Generalist enrolments in AGPT by state as at April 2021

State/Territory	**Number of RG registrars[55]**
NSW & ACT	108
NT	39
QLD	270
SA	44
TAS	16
VIC	64
WA	87

Queensland records a disproportionately strong rural workforce at the internship level. It is likely that these numbers reflect the implementation and consolidation of the

Queensland Rural Generalist Program (QRGP) which enlists participants from Postgraduate Year 1 (PGY1). This suggests both that there are sufficient rurally based senior medical practitioners to support these internships and that there are sufficient junior doctors motivated to undertake them. This positions the state strongly toward building its future rural generalist workforce.

Table 2.3: Number of rural internship positions and interns by state in 2018[56]

	Rural intern positions* for PGY1 doctors (2018)	**PGY1 doctors undertaking rural internship (2018)**
New South Wales	111	109
Victoria	232	232
Queensland	253 (33%)	253 (33%)
South Australia	5	5
Western Australia	10	10
Tasmania	94	94
Northern Territory	48	48
ACT	8	8
National	**761**	**759**

*Internships where all or majority is undertaken in MM2-7

Deliverable 2: Conferring a 'name' to the career path will enable rural generalist careers to be marketed in schools, medical schools and hospitals and build workforce

There is a strong inter-relationship between the establishment and success of the QRGP and its associated RG specialist title and the James Cook University (JCU) medical school. JCU graduates represent almost half of all QRGP trainees (42% of all trainees and fellows).[57]

Table 2.4: Queensland medical schools' annual intake and total participants in QRGP

Medical School	**Student intake 2018[58]**	**Total trainees and fellows in/completed the QRGP as at 2019[59]**
Bond University	128	21
Griffith University	207	65
JCU	200	205
Queensland University	385	240

While recruitment in all Queensland medical schools is likely to be positively affected by the establishment of specialist title within the state, JCU can and does strongly market Rural Generalist Medicine as a career pathway to its students. Qualitative analysis of graduate's explanations for their choices of specialty pathways shows that JCU graduates typically know of and name, *rural generalist* career options when discussing their preferred careers.[60]

The chair of the Australian Medical Students Association Rural Health Committee, has indicated, that they are aware that *students feel that rural generalism isn't as "clear cut"* or defined as other specialties. Though there will always be diversity in generalism, its recognition as separate from mainstream general practice reduces the confusion the student population has regarding generalism; hence assisting us in promoting it as a career.[61]

It is noted that while the concept can be marketed in Queensland, it is marketed in the context of a national system that does not recognise the title. These developments are thus viewed as suggestive but not equal to the status and broad awareness that could be achieved with national title.

Deliverable 3: Specialist title will allow rural generalist practice to be moderated by safety and quality systems with a consistent, nationally understood reference point linked to a common qualification standards

National recognition has not been achieved and its impacts cannot be measured. Positive outcomes can be observed in Queensland where jurisdictional title is established, however the lack of national recognition means their effectiveness and broad adoption are limited.

In Queensland, rural people's healthcare benefits from their services' employment and planning being informed of the credentials, skillset, trainee numbers, scale, and distribution of its rural generalist workforce.

Employment of Rural Generalists within the hospital system can be advertised with title. The subsequent appointment of a RG confirms attainment of the Fellowship of ACRRM, or the Fellowship of RACGP + FARGP (including specific certification of advanced specialised/rural skills) or equivalence as the associated clinical standard.,[62]

The clinical standard is consistent across the state, and clear and broadly understood throughout its health services. The RG title confers that the employee has successfully completed training in at least one advanced specialised skill, has attained advanced emergency medicine skills, has an expanded general practice skills for practice in rural clinical settings and training, experience and capacity as a community-based general practitioner. The Fellowship curriculum, assessment and continuing professional development standards are published and freely available.

The title also helps patients to make informed choices about the care they receive. For example, hospital service patient guides to maternity care options can point to the availability of rural generalists.

Attachment 2.1: Sample Consumer Information [Queensland Health: Patient Maternity Options]

Deliverable 4: Specialist title will lend a common job title to enable job portability, more effective, simplified workforce recruitment, and enhance job status and appeal

In Queensland, the Government can advertise for Rural Generalists. These employment opportunities are highly visible to all doctors in the state especially junior doctors that are considering their career options. They also showcase career opportunities for doctors on the Rural Generalist training program. As outlined above, all Rural Generalist positions have automatic recognition of Fellowship credentials irrespective of the area within Queensland Health in which they may be employed simplifying transfers and providing some assurance that their training and skillset will be recognised. It can be expected that this has contributed to the successful building of the Rural Generalist workforce in Queensland.

In the Northern Territory, although specialist title has not been established as a clinical standard, industrial recognition has been established and the position of Rural Generalist is incorporated in the Territory Enterprise Agreement. [63,64] Rural generalist positions are able to be advertised and appointed in the Territory health services. While the development of an associated rural generalist support program is in its infancy, industrial recognition has helped establish positions and rural generalist training hubs at Tenant Creek, Katherine and Gove Hospitals and the training to Fellowship of over twenty rural generalists in recent years in an area of significant workforce shortage.

It should be noted that for doctors in these two jurisdictions, this recognition does not extend beyond their borders and cannot support them, should they wish to relocate.

Attachment 2.2: Sample job advertisements for Rural Generalists, Queensland, *and the* Northern Territory

Deliverable 5: Specialist title will enable rural doctors with the rural generalist skill set to be incorporated into workforce and health service resource planning

Logically, resource allocation for the benefit of improving health services is based on the available data on what skilled clinicians are or could be made available. The evidence arising from the New South Wales inquiry into rural health services strongly suggests that health service planning has not intrinsically considered the rural generalist workforce and their resource support requirements in rural hospitals and points to the long-term decline in resourcing rural health services that has resulted. [65]

As outlined above, the New South Wales Rural Workforce Agency (NSW RDN) in its annual needs analysis identified the decline in the rural procedural general practitioner workforce as a key challenge and recommended the following actions to address this:

"…

- *Ensure the new rural generalist pathway is supported and integrated with LHD and GP workforce planning.*
- *A better understanding of the future demand for proceduralist services is required to aid workforce planning initiatives.*
- *A better understanding of the capability required to succeed in rural medicine will allow tailoring of training and ongoing CPD support.*
- *Integrated acute and primary health care service planning in rural communities, involving public, private and not-for-profit sectors.*
- *Adopt a holistic approach to attracting, training, supporting and retaining the incoming proceduralist workforce.*
- *Recognise and value the unique and highly skilled contribution of GP Proceduralists as the cornerstone of rural primary health care. Families and partner support is essential to ongoing retention and requires the engagement of the community."* [66]

All these goals rest on a capacity to bring better recognition, valuing and coordination to the development of an RG workforce and the need for a common language to monitor, measure and drive progress for this key area of professional practice.

Kerr et al in their international study of rural emergency departments, identified the diversity of employment arrangements including the extensive use of general practitioners skilled in emergency medicine. They concluded that there was a need for consistency of language to describe these to allow a base for effective communication between governments, training providers and policy makers who are seeking to improve health systems and health outcomes.[67] Similarly, the American Academy of Family Physicians, in noting the significant contribution of rural family physicians to emergency medicine workforce saw a need for changes to workforce modelling to include the role of these family physicians particularly in rural areas.[68]

The National Medical Workforce Reform process is likely to progress the establishment of a new workforce planning framework and commissioned reviews are underway into the development of this Framework. Currently there is no role designation which can denote this workforce and their contribution. Specialist title can provide a mechanism and terminology to incorporate the rural generalist workforce in this fundamental planning framework. This is particularly pertinent as despite the lack of specialist title, the National Medical Workforce Strategy (as per its scoping document) is expected to identify the NRGP as a key element of national workforce development.[69]

In Queensland where specialist title is established within the health services, the Rural Generalist role is defined and incorporated in the state's *Rural and Remote Health Services Framework*.[70] As outlined above, Queensland has been exceptional in its capacity to sustain the provision of advanced care services by rural generalists and the QRGP reports that 83% of doctors that have undertaken the program continue to provide the advanced care services they attained.[71]

Attachment 2.3 Queensland Rural and Remote Health Services Framework 2014

Deliverable 6: Strengthening the rural generalist workforce will bring more long-term doctors to regional, rural, and remote areas

As outlined in the application, there is substantial evidence to demonstrate the attractiveness of the RG model to many Australian doctors.[72,73,74,75,76] National AGPT Registrar Surveys of ACRRM (rural) registrars have consistently reported key features of the RG model such as 'practice variety', 'rural location', and 'procedural practice' as the most appealing aspects of training.[77-78]

Evidence also clearly shows the strong association between rural retention and rural generalist practice. The MABEL survey studies found in particular that procedural practice is a significant predictor of rural retention and that where rural general practice doctors work in hospitals this correlates with an 18% increase in rural retention.[79] This is further demonstrated by 67% long-term rural retention outcomes of programs such as the QRGP as outlined below.

A singular focus on a particular non-GP specialty area or on GP clinic-based practice is attractive to many medical students and early career doctors. Such doctors have access to clear training and career pathways including rural pathways and these are promoted to them in a manner likely to be appealing.

Evidence points to a substantial section of the emergent medical workforce for whom the diversity of rural generalist practice together with the adventure and community-

orientation of rural and remote practice is highly appealing. As the Queensland experience suggests, specialist title, can enable Rural Generalist practice to be effectively promoted as a distinctive career with a distinctive training pathway. This will enable a much more effective and widespread mobilisation of this group of doctors to an area of critical workforce need.

Deliverable 7: Strengthening the rural generalist workforce will improve health service capacity in regional, rural, and remote communities by rural generalist doctors providing skilled services otherwise not locally available

Rural generalists are providing extended specialist services predominantly in rural and remote areas where there are no subspecialists to provide these. The Australian Institute of Health and Welfare (AIHW) have noted that, *"the higher rate of GPs in Remote/Very remote areas may be due to them having a broader scope of practice, given lower levels of supply for almost all other health professionals"*.[80] MABEL data has shown significantly increased likelihood of rural GPs providing anaesthetics, emergency or obstetrics services as geographical remoteness increased and population size decreased.[81] This corresponds with decreasing numbers of anaesthetists, emergency medicine specialists and obstetricians as remoteness increases.[82]

Rural, regional, and remote hospitals across Australia rely heavily on their employment of rural generalist doctors to maintain their services. The Rural Procedural Grants Program provides a picture of the extent to which rural generalists are providing needed advanced care services across rural and remote Australia. The program is only eligible to rurally based Vocationally Registered General Practitioners (VR GPs) credentialed in an area of advance specialised services. In 2020 it enrolled a total of *6476* doctors for support toward their emergency medicine, mental health emergencies care, and procedural obstetrics, surgery, and anaesthetics credentials maintenance.

While the rural generalist title is not formally recognised in the United States and Canada, the value of the rural generalist model whereby the general practitioner with advanced skills provides essential emergency and other advanced care services in rural and remote communities is widely recognised and extensively practiced.[83,84,85,86]

The national value proposition of the RG workforce, as reflected in the Collingrove Agreement is to have the scope of practice to be able to pivot to fill the service gaps and changing circumstances and needs of rural communities. Community based practice may be the area of need is some situations, in others (as was the case at the point of establishment of the QRGP), the most vital area of service gap is in hospitals, others may need a combination of both. As was seen in the Covid-19 outbreak, the training rural generalists receive in public health, telehealth, and advanced airways management[87] all become important skills that they can call upon.

2.3 Evidence of outcomes from recognising rural generalist model

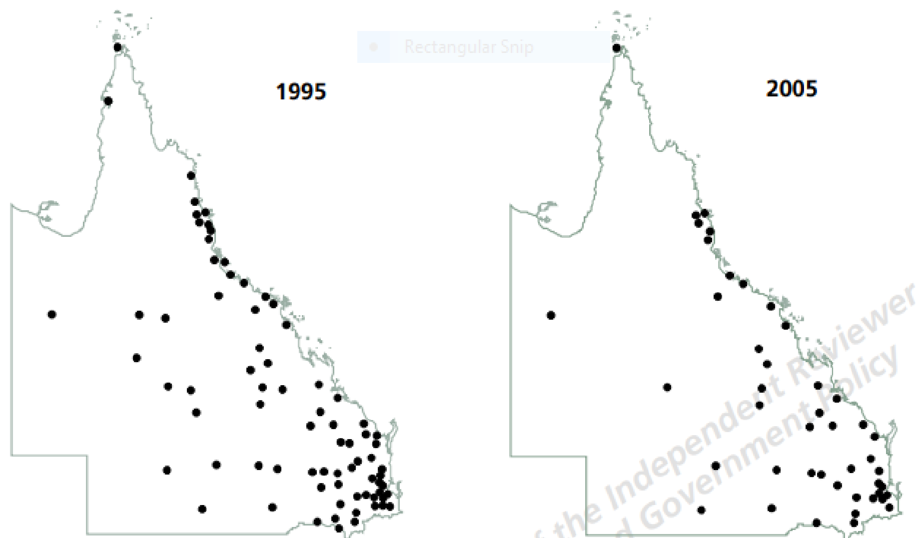
Indicative evidence of the positive workforce outcomes associated with strong support for rural generalist training and some degree of recognition of specialist title for rural generalists are given below.

Outcomes from Queensland Rural Generalist Program

The 2005 Public Hospitals Inquiry following a series of high-profile adverse events, found rural hospitals had heavily relied on International Medical Graduates to staff their hospitals with insufficiently robust qualifications assessment. The Inquiry also identified that Queensland was experiencing the worst medical shortages of anywhere in the country, and that there was endemic, under-resourcing, understaffing and unsafe working hours occurring particularly in the state's rural and regional hospitals.[88] Thirty-nine birthing units closures occurred over 1996 to 2005, this coincided with doubling of the rate of babies born before arrival (BBA) the highest rates occurring in regional and rural areas.[89] A 2005 Queensland Government report found that 62% of women living in rural areas of the state had to travel away from home to give birth. Of the 75% of these women that received public healthcare, 46% were deemed as low risk births and of these (1,600) women, 83% travelled for care because they did not have a choice as there was no local birthing service.[90]

A multi-pronged approach to restoring the rural generalist workforce was taken. In 2008, the FACRRM or FRACGP+FARGP qualifications were credentialed for clinical scope of practice in Rural Generalist Medicine which was recognised as a discipline specified by the respective Fellowship curricula. An industrial award associated with this credential was established for doctors employed in state hospitals.[91] The QRGP supported training designed for rural generalist practice toward the credential Fellowships including prevocational training.

Figure 2.1: Public sector birthing places in Queensland, 1995 and 2005



Source: Rebirthing – Report of the Review of Maternity Services in Queensland (2005)

- In 2008, rural retention rates associated with general practice training in Queensland were exceptionally low. It was found that **27%** of general practice registrars in Queensland that had undertaken training on the designated "rural" training pathway had continued to be 'rurally' based.[92]

- In 2020, of QRGP alumna, five or more years out from Fellowship, **67%** have spent five or more of these years based rurally.[93] These QRGP outcomes can be benchmarked by contemporary standards, against the most recent rural retention figures available from the AGPT which found that of all its former designated "rural" pathway registrars, **42%** had remained working rurally 5 years out from Fellowship.[94]

- An Ernst and Young review in 2013 found the QRGP met communities' needs by reducing critical medical workforce shortages and enabling of health services to expand service delivery making services more accessible and affordable to local residents. The review identified due recognition of the profession by Queensland as one of the critical success factors for the program. [95]

- Since the commencement of the QRGP, four rural generalist led rural maternity units have been reopened.[96] Queensland has 32 (of its total of 40) state facilities that provide birthing, antenatal and postnatal care - in regional, remote and very remote areas. Twenty of these are in predominantly rural generalist-led facilities in outer-regional, remote and very remote areas.[97] Studies have confirmed the rural generalist 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.[98]

- Queensland has the highest ratio of general practitioners in regional, rural and remote areas per 100,000 population of all states and territories, with 115.6 doctors in these areas per 100,000 people, compared to a national average of 108.1.[99]

- Further evidence suggesting the relative success of the QRGP in providing a permanent rurally-based workforce for its rural communities is that despite being the most decentralised state in the country Queensland has recorded the lowest or second lowest usage of locum staff of any state or territory. Looking at the FTE rate of employed doctors from major cities who worked at a second location in a rural area for general practitioners, the national rate was 1.2 and Tasmania and Queensland had the lowest rates at 0.4 and 0.8 respectively. For specialists, the national rate was 5.5 and Queensland and Tasmania had the lowest rates (2.6 and 2.9 respectively).[100]

Evidence of QRGP outcomes for primary care provision:

The comments below are made in reference to the AMC team's advice:
"No evidence is provided of how the rural generalist programs which are well established in some jurisdictions have improved access to primary care services." (Page 5)

The value proposition of the RGM model is to create an agile, community responsive workforce. The QRGP commenced with a specific goal of addressing the critical shortfall in rural hospital services and has over time evolved to meet changing community needs. Its workforce outcomes reflect these shifts. It commenced providing advanced training in emergency medicine, obstetrics and surgery and anaesthetics. It now provides training in over 10 advanced specialised training areas including mental health, palliative care, and addition medicine.

The program is clearly contributing to all essential and underserviced areas of rural healthcare (hospital and clinic-based care). Program records also show that as the workforce crisis levels in hospitals have been addressed, the program and its doctors has been able to pivot, providing more services in the clinic-based areas of rural generalist care.

Table 2.5: QRGP alumna practice types, 2015 and 2020

2015	2020
72% undertake hospital-based practice only	51% undertake hospital-based practice only
13% undertake GP clinic practice only	13% undertake GP clinic practice only
15% undertake blended practice [101]	36% undertake blended practice [102]

Evidence from the New Zealand Rural Hospital Medicine training program

The New Zealand Rural Hospital Medicine (RHM) program was recognised by the Medical Council of New Zealand as a vocational scope of practice in 2008. The RHM program culminates in the Fellowship of the Division of the Rural Hospital Medicine New Zealand (FDRHMNZ) and is offered with the option of a combined RHM-GP training pathway. The combined RHM-GP training program has been identified by its practitioners as *"similar to Australian rural generalist pathways."* [103] While there are important points of difference with this model, it provides some further indication of the impacts of dedicated, nationally recognised rural generalist training.

As in Queensland, the recognition of the scope of RHM in New Zealand came in response to serious rural hospital workforce shortages and lack of any recognised training pathway. [104] Similarly to Queensland, the program has produced exceptional rural retention outcomes and while addressing the need for rural hospital practitioners, it has also contributed to skills acquisition and practice in rural community based care.

The assessment of the graduate outcomes for the 29 Fellows that had completed the program over its first 10 years found:

- 83% were working in rural areas
- 59% had completed dual training and gained GP and FDRHMNZ Fellowship

Of the graduates practising rurally:

- 91% were working in rural hospital practice
- 36% were working in hospital and community general practice
- 18% were working in hospital and emergency medicine practice [105]

Evidence from Canada

While Rural Generalist Medicine has no formal status in Canada, increasingly the terminology and approach are used by rurally-focussed medical schools and rural doctors organisations including in the National Rural Roadmap of the peak rural doctor's professional associations. The latest *Roadmap Report 2021* has specified action priorities to progress accreditation of rural generalist medicine and rural generalist models of care. [106, 107]

Memorial University medical school in Newfoundland provides what it has described as training pathways to rural generalist practice. It describes *rural generalist medical practitioners as "rural GPs or rural family doctors, … who provide primary medical and community-oriented primary care and often hospital-based secondary care such as emergency medicine, in-patient hospitalist care, intra-partum obstetrics and, sometimes, basic anesthesia and surgery*".

An analysis of national data found that **26.9%** of Memorial Family Medicine postgraduates were practicing in a rural location two years after completing their postgraduate training compared with the national average of **13.3%** (2004–2013) [108].

3. Alternative options (both regulatory and non-regulatory) for addressing the issues

AMC Advice

The proposal addresses some of the information requirements of this section.

However, the applicants did not explore alternative options thoroughly, which impedes the capacity to assess if approval of the new field of specialty practice would provide the greatest public benefit, compared with alternative options.

The following advice revisits the options outlined in the application and provides an expanded analysis on each of these.

3.1 Existing arrangements (No new regulations)

It is well evidenced that current arrangements are failing to provide people in rural and remote locations with sufficient or equitable access to the broad range of specialist health services available to people in cities (see *Section 2.1*).

The key mechanisms by which services beyond the usual scope of general practitioners in cities are currently accessed by people in rural and remote areas include:

- General practitioners credentialed for advanced/additional skills (without specialist recognition)
- Non-GP specialists based locally
- Patients travelling to major centres for non-GP specialist services
- Locum or visiting non-GP specialists, or
- Non-GP specialist assistance via telehealth

For clarity, each is considered individually although in practice they may occur in combination. In all current models of non-GP specialist led provision of care outlined, effectiveness pivots on their supplementation with locally based services by skilled doctors with a broad scope of practice.

1. *General practitioners credentialled for advanced/additional skills (without rural generalist recognition)*

   Advantages:

   - This process currently is the basis by which general practitioners can provide advanced skilled services in hospitals and is enabling rural generalist procedural practice extensively across rural and remote Australia.

   - Through hospital credentialing, general practitioners with the appropriate skills and training can provide advanced specialised care for their local community whereby their skill set has been rigorously assessed to ensure quality and safety of care.

   - The skills assessment can incorporate a measure of skills attainment, skills currency, and the appropriate requirements within the local context which is

especially important in rural and remote settings with distinctive resource and service exigencies.

Disadvantages:

- These processes only recognise and enable practice of advanced care services that occur in public hospital settings. They provide no recognition of advanced skilled care provision in services provided within the general practice clinic or other community settings (e.g. mental health, aged care, palliative care).

- These processes leave considerable discretion in the hands of the staff of regional facilities and as such can be ad hoc and unpredictable. Determinations can be subject to the perspectives of individuals or conflicting interests of healthcare services and are limited by the level of knowledge of decision makers of rural generalist training and qualifications. Given the lack of specialist title, there is no imperative to consider the rural generalist professional perspective or to seek professional representation in determinations. There is also no common national standard to provide an accepted reference point, and thus a degree of continuity and predictability to these processes. (These issues detailed in Section 2).

- Hospital credentialing process are administratively onerous. They usually involve assessing each advanced skill individually. For rural generalist doctors that may provide a range of advanced care services, this can be administratively intensive and inefficient. Additionally, many rural generalists provide services across a range of rural hospitals and the credentialing processes generally need to be replicated in each community. The absence of specialist title for rural generalist practice means that there is no recognised national standard against which these can be benchmarked to facilitate process simplification.

- Hospital credentials recognise individual skills but do not confer any formal status to the comprehensive scope of practice the practitioner has attained. They do not provide a basis for identifying and classifying the overall skillsets that these practitioners may bring to their job, and they do not provide a job title by which a doctor can accurately describe themselves to their patients, community and peers. Hospital credentialing does not allow workforce planning to recognise that the rural generalist doctors in hospitals not only have their credentialed skill, but also bring workforce capacity in primary care, emergency care and potentially other areas. This has important implications for making informed determinations to ensure rural and remote communities have the resources they need within budget constraints. Hospital credentialing also does little to support or facilitate a smooth, well-coordinated and structured training pipeline for rural generalist practitioners associated with a defined rural generalist career path.

(2) Requisite specialist services provided by local non-GP specialists

Advantages:

- Patients can access the specialist services they need and can be serviced by doctors that have highly specialised knowledge and skills in their respective disciplines.

- As these doctors are locally based the coordination and continuity of care is likely to be strong. Non-GP specialist doctors based locally, will have a strong connection to their community and the community will have access to the doctor as required.

Disadvantages:

- This model relies on the assumption that specialists can be made available. There are fundamental barriers making it unlikely that many rural or remote communities will ever be able to attract or support permanent non-GP specialists. This specialist scope of practice in many cases presents an unsustainable practice and business model for rural and remote communities which have a small and geographically limited patient catchment. Further, this model relies on availability of a complex mix of supporting specialist staff, technology, and resources and on a high patient caseload across a narrow range of medical presentations.

- The non-GP specialist model is focused on a deep and intensive scope of knowledge and skills. This minimises the flexibility of practitioners to provide community-responsive practice to meet the breadth of needs and service opportunities in rural communities. It also makes it difficult for these practitioners to adjust to shifts in patient patterns and needs that frequently occur in isolated small communities (for example seasonal or major event based influxes of visitors, or the sudden loss or gain of population due to industries or local business failing or starting up).

- The specialist model does not generally represent an economic approach for rurally based services. In geographically isolated communities where a limited number of locally-based medical practitioners are realistically possible, maximal efficiency will be gained from an approach of employing local doctors that are flexible, broadly skilled and can meet as many as possible of the most urgent and essential care needs. The optimum combination of general practitioners, rural generalists and specialists will vary across communities. Even where non-GP specialists are viably able to be permanently based in rural locations, the community may still be best served by their being supported to maintain work rosters by local rural generalists able to supplement their income providing other needed services. In the ideal construct, rural specialists also work with rural generalists and assist in their training and upskilling and vice-versa. Rurally-based specialists often welcome these mixed models of service, in their testimonies to the New South Wales Inquiry into rural health services, specialists welcome the rural generalist pilot training program in their area, and emphasise the value of rural specialists working with rural generalists to support their skills development. [109]

- The sparsity of the rural non-GP specialist workforce appears to create additional professional challenges for its practitioners. A Commonwealth Health Department workforce audit noted that medical specialists in rural Australia struggle with professional isolation, lack of support and lack of infrastructure. [110] Locally based rural generalists can provide not only roster support, but also lessen these doctors' sense of professional isolation.

- Despite more intensive training in their speciality area, non-GP specialists based in rural areas are likely to be faced with many of the same obstacles to provision of practice as rural generalists. They will work within the same resource and geographical constraints, and despite additional training may not be able to provide many of the

most specialised services due to the absence of specialist support services and resources. They may also face similar impediments to their practice due to credentialing standards which set minimum requirements reflecting tertiary hospital level staff and resources or tertiary hospital volumes of practice or access to city-based professional development. Rural non-GP specialists testimonies to the New South Wales Inquiry into rural health services reflect many of these issues.[111]

(3) Patients travel to non-GP specialists in major centres to receive care

Advantages:

- Patients will receive in-person care by non-GP specialists with highly specialised knowledge and skills in their respective disciplines. The specialist will have ready access to the full range of support resources, technologies, and staff commensurate with urban practice. The patient may be able to use the opportunity to see a range of other specialist healthcare professionals as required.

- There may be situations where the intensive specialised facilities that are only available in major cities are the only acceptable model of care for a patients' condition.

Disadvantages

- These doctors are not available to address urgent issues that may arise for their patients and do not obviate the need for provision of emergency or follow up care in the local context.

- Patients may need to travel long distances to access emergency and advanced care. This travel can present a considerable impost to many patients and their families. The cost and disruption that it engenders commonly prevents or delays needed care being received particularly among high needs groups.[112] Additionally, the travel [113,114, 115, 116] and social dislocation[117, 118] themselves can diminish patients' safety, health and well-being. (These issues detailed at *Section 2.1*)

- Any cost savings to governments of not establishing non-GP specialist services in rural communities are effectively a cost transfer from health budgets to the people living in rural and remote communities.[119] They create the impost to arrange and fund their transport, as well as the costs of living away from home often for extended periods of time (e.g. loss of income, childcare, city accommodation).[120] The Patient Transport Assistance Scheme (PTAS) is intended to cover travel expenses but only partially covers these and does not recompense time or effort. Additionally, it involves considerable administration and inflexibility which have often proved prohibitive.[121,122]

- The separation of non-GP specialists from the rural community, breaks down the continuity of care that rural people can receive. The patients are unlikely to build an effective doctor-patient relationship with their specialist. Furthermore, the specialist foregoes the opportunity to build effective relationships with other members of the healthcare team. The opportunity is lost to upskill and share knowledge with their local doctors. Should the patient experience a serious deterioration in their medical condition, local doctors will need to address the

problem. The lack of communication between specialists and local doctors may become a significant problem at this point. People in remote areas are significantly more likely than people in cities, to report that their usual local doctor has not been contacted regarding care they have received from a specialist.[123]

(4) *Provision of Locum, Fly In-Fly Out (FIFO) and Drive In-Drive Out (DIDO) specialists*

Advantages:

- Patients will receive in-person care by non-GP specialists with highly specialised knowledge and skills in their respective disciplines in the convenience of their local setting. These models can take many forms but at their best patients will be able to have a continuing albeit episodic relationship with their specialist.

- The main advantages of FIFO and DIDO healthcare services are that they can provide needed care to people who may otherwise need to travel large distances at considerable personal and financial cost. Provided that there are adequate and well-resourced primary care services in place, visiting specialists can add significantly to the quality of care being offered and are often greatly appreciated by locals.[19]

- It is likely that in some instances these services offer health care that could otherwise not be provided in small rural or remote communities, with the resultant benefits to both patients and to resident clinicians. At their best, these models provide, specialists with a long-term relationship with the community, with consistent points of availability, building strong linkages to the local doctors and health care teams, and contributing to the upskilling and skills maintenance of the local workforce.

Disadvantages:

- Locums are ultimately transient so it can be difficult to ensure accountability for their actions and continuity of care for their patients and constructive working relationships with local healthcare teams.

- Government investment in these pro-rata services may come at the cost of longer-term investments in ensuring permanent, locally based resources and staff. These services fill immediate service gaps however, by so doing, there is a risk that they discourage, funding and forward planning to ensure that permanent, essential locally based services remain strong and future workforces are developed.[124]

- Dependence on locums rather than provision of locally based staff can be excessively expensive. For example, implementing a rural generalist led hospital and community primary care services model in Longreach saw the locum services budget of $7m reduced to around $1m.[125]

- These services may directly compete with local services and undermine the business case for locally based practice, ultimately diminishing quality care. Local practitioners provide continuity of care and are permanently available to patients. They are however financially reliant on the patient load within their area and as such are vulnerable to competition from visiting practitioners. This risk is likely to

increase with the growing oversupply of city-based specialists. This raises the importance of conferring national recognition on the local rural generalist doctors and signalling national respect for their services and skillset.

- Visiting specialist services are complicated to administer, particularly in remote communities where the provision of culturally appropriate services is so critical. Personnel tend to change frequently and availability of services from the communities point of view can be inconsistent and unpredictable. [126]

- There is potential for burnout among FIFO and DIDO doctors who travel constantly, cover long distances and work long hours, often without adequate peer support or supervision, to deliver these services. [127,128]

(5) *Specialist assistance via Telehealth*

Advantages:

- Patients may be able to receive specialist care without unreasonable delays and without unreasonable personal impost. Ideally, these interactions would be delivered in a tripartite arrangement involving local doctors to maximise the coordination of care.

Disadvantages:

- There is a range of medical services that cannot be effectively delivered virtually such as physical examinations. To some degree these issues can be overcome where specialists work closely with local doctors.

- It is unlikely that patients will form strong relationships with practitioners through telehealth interactions and this again underscores the importance of supporting local doctors that can deliver continuous and holistic care.

- There is a risk that telehealth services provided by specialists will follow the same patterns as specialists in cities and be characterised by poor communication between the urban-based specialist and the local doctors who will be required to treat the patient for regular general practice care and in emergencies.

- As above, there is a risk that telehealth services may come to be viewed as an acceptable replacement to local services in rural areas and become a justification by planners for not replacing or maintaining strong local in-person services and resources. Evidence of these developments is extensively discussed in the testimonies to the New South Wales health services Inquiry. [129]

- Telehealth services may compete for business with local doctors and with much lower operational costs may well lead to rural patients losing their local doctors.

3.2 Other existing regulation that may be used to address the issues

1. Rural Generalism is a standalone specialty

Under this model, Rural Generalism would be recognised by the Medical Board as an entirely separate specialty rather than within the discipline of General Practice. It would establish its own professional college, and Fellowship training and professional development programs which would need to receive accreditation through the AMC. Practitioners would be registered with the Medical Board and they would (ideally) be eligible to provide services under the Medical Benefits Scheme where appropriate.

Advantages

- This would provide clarity of professional identity, peer networks and a professional home for doctors with the rural generalist skill set

- This would enable clarity of recognition of the profession by authorities and communities and allow them to appropriately know, value and reward the requisite training and practice standards that have been attained.

- This would enable simplification of credentialing and incentivisation approaches due to the consistency of standards and training that could be achieved

- This model could still allow for general practitioners that do not have the full rural generalist scope but have attained advanced skills in a particular area to attain hospital credentials or other forms of recognition of qualification for advanced skilled practice. As is currently the case, they could continue to be recognised as VR GPs and their skill could be discretely recognised.

- This would provide the rural generalist specialty and the general practice specialty the capacity to build independent professional identities and cultures and shape these in a manner which may be most attractive and maximise job satisfaction to their different memberships. They can also direct their energies into the resources and initiatives most useful to their respective professions.

Disadvantages:

- There is potential for difficulties in professional mobility for rural generalists should they wish to revert to practicing as general practitioners. Their scope of practice may change due to circumstances including a decision to cease rural practice. Some consideration would need to be given to appropriate mechanisms to enable this.

- This could potentially create structural barriers to general practitioners undertaking bridging activities to gain recognition as rural generalists should they so choose. As above, it would be important under this model to ensure that there were clear and facilitated pathways for this to occur.

- This may create a conflict for the many doctors that view themselves as belonging to both general practitioner and rural generalist specialties. There would be a need to explore models such as joint-Fellowship or joint-recognition or other approaches to address this.

- This may discourage rural generalists and general practitioners from working together effectively particularly on issues related to primary care. Should this model proceed there would be value in establishing forums for collaboration and constructive

dialogue. The experience of the two general practice colleges collaborating on the delivery of the Australian General Practice Training and initiatives such as General Practice Mental Health Standards Collaboration and the Rural Procedural Grants Collaboration provide useful models for this.

- This may lead to disaffection of the general practitioners who practise in rural environments. They may feel that the recognition and valuing of the rural generalist training and scope of practice where this is not acknowledged as being articulated to the general practice model, diminishes the status of the general practice profession and their own particular skill set and scope. There would be a need to ensure that this model was supported by efforts to clarify and promote the national value placed on rural general practice.

- This would involve considerable overlap of training, curricula, and standards between the two professions. This may create duplication or unnecessary complexity. There are already two general practice colleges with established and distinctive curricula, training programs and standards and the colleges have been able to deliver the requisite consistency to independently meet general practice accreditation standards so this step would be unlikely to present a major barrier.

2. *Endorsements of additional advanced skills within general practice without protected title*

Under this model, practitioners would be nationally registered with the Medical Board in the discipline of general practice and their registration would include reference to any endorsed advanced specialised skills which had been nationally recognised. This would likely occur through recognition of the advanced specialised skills programs they complete as part of their Fellowship training as rural generalists.

Advantages:

- This model would provide transparent, consistent information to the public and to regulatory authorities regarding practitioners' area/s of capacity for advanced practice. Patients and the wider public could gain a clear understanding about an advanced skill that has been attained which may be of interest to them.

- The endorsements (unlike hospital credentials) would be nationally registered and therefore consistent across the country and address some of the portability issues. They would not obviate the need for local credentialing assessment but should facilitate simplified mechanisms for credentialing doctors in their areas of advanced skills.

- This approach would be an improvement upon the current credentialing arrangements in that the advanced skills recognised could extend beyond those that occur in hospital settings and requiring credentialing processes. It could cover the full scope of rural generalist practice including for example, aged care, mental health, and palliative care.

Disadvantages:

- As with hospital credentialing, this would not recognise the broad and distinctive core skill set that rural generalists would have attained. Quality, safety, and efficacy is best served where patient, employer and health service planning decisions can all be based

on an understanding of the full scope of the doctor's training and practice and not just isolated aspects of it.

- As with hospital credentialing, this approach does not incentivise flexible, broad scope practice only provision of a discrete advanced skill. It offers no incentive to emergent doctors to attain the broad, multifaceted scope and take the flexible, adaptive, and community-responsive approach to defining their practice scope that is at the core of the rural generalist concept as a workforce solution. Nor would it provide any motivation to doctors to maintain this broad scope of practice.

- This approach is not consistent with the historic approach by medical disciplines to recognising specialty fields. As such, taking this approach is likely to create confusion and would stand apart as a system decision to *not* value this professional skillset as highly as other specialist fields. It would thereby, reinforce many of the structural bollards to recruitment, training, and credentialing.

- Under the model, this national network of doctors would not be identifiable as a workforce for the purposes of service and workforce planning. Its practitioners would be denied the opportunity to be visible as a profession in health services and to speak with a common professional voice on regulatory/service determinations about their work and regarding the areas of practice for which they are the bearers of the substantive knowledge and experience.

- Under this model, with no common professional title or identity to describe their practice, these doctors may come to view themselves as a disparate group of subspecialists rather than a coherent rural profession of broad and flexible scope generalists. As an extension of this, they may transfer their key professional ties to the diverse subspecialties, whose practice, as outlined above is typically designed and oriented toward urban practice with concentrated tertiary resources, intensive scope, and high patient caseload. This highly specialised approach is not a good fit for small rural communities.

- This model which does not acknowledge the coherent rural generalist scope, is likely to also facilitate a framework by which rural generalist doctors are required to duplicate the professional memberships and associated quality assurance processes for every area in which they provide advanced skills with the attendant financial and administrative burdens that this would engender. The extent to which these issues impact rural doctor's practice is outlined above (see Section 2.1).

3. *Industrial recognition within each jurisdiction*

Advantages:

- This model provides clear employment opportunities; establishes appropriate recognition of the rural generalist skill set attained and provides a clear basis for reward in terms of remuneration and appropriate job terms and conditions.

  The positive workforce outcomes of this model (which is in place in Queensland and the Northern Territory) have been widely evidenced in Queensland where rural generalist practice has been linked to the credentialed scope of the Fellowship qualifications.

Notable outcomes have also been achieved in targeted remote centres in the Northern Territory (*See* Section 2.3).

Disadvantages:

- This model only offers a partial solution to the problems raised in this submission as it cannot establish a national standard, nor does the standard have any standing beyond, jurisdictional hospital services.

- Under this model, recognition is limited to rural generalists that work in jurisdictional health services. It is not transferable to employments contacts with other potential employers such as Aboriginal Medical Services, local government financed health centres, private employers etc. Rural generalist training and practice is characterised by this movement between different workplaces and this is an essential element of its value proposition for rural communities. Doctors that are not employed within the state hospital system forgo the opportunity to be so titled even where they may have attained the same rural generalist skill set and may practice to a similarly broad and advanced scope.

- A risk of this model is that it confers recognition of the special training and broad skill set of doctors working in the public system that cannot be conferred upon doctors with the same qualifications and skillset working in private practice and other employment arrangements. This can contribute to a misconception that the latter doctors have not attained the rural generalist skill set and training.

- Recognition would continue to be inconsistent across jurisdictions and unless it were linked to a common nationally recognised standard, it would prevent employment transferability. The existing barriers to progression and professional inflexibility throughout rural generalists' career would continue as would the complexities of negotiating the 10-14-year training journey from medical school to RG Fellowship which typically involves considerable movement across jurisdictions and workplaces.

- The process of establishing industrial recognition with all states and territories has already commenced with Queensland and Northern Territory unilaterally establishing their own title. Completing this process would involve an onerous series of duplicated but not consistent legislative processes in the remaining states and territories. These considerable efforts could be avoided through establishment of national title.

3.3 Other non-regulatory mechanisms to achieve the desired outcome, for example: self-regulation of practitioners through professional (voluntary) codes of conduct

There are no alternative non-regulatory mechanisms which would effectively address the issues outlined in this application.

The general practice colleges have already prescribed a wide range of self-regulatory mechanisms, curricula, and standards relevant to their members' training and practice in addition to those imposed by the Medical Board of Australia's Codes, Guidelines and policies. The key issues this proposal seeks to address however relate to the external systems and processes that are impacting RGs training and practice and these processes' inability to recognise the Colleges' standards.

External regulatory change is needed to remove current barriers to developing a medical workforce and service delivery model for rural and remote communities and to assist in improving the disparity of access to medical care experienced by rural and remote communities where medical services are limited or absent. Regulatory change is also necessary to provide for a dedicated nationally recognised RG training pathway.

4. Existing professional standards

4.2 AMC Advice

More information is needed to meet the requirements of this section. Clarity is required regarding whether the existing Fellowships, FACRRM and FRACGP, and FRACGP FARGP are proposed as the pathways for specialty recognition in the field of specialty practice of rural generalist medicine, and accreditation of them would be sought for that purpose.

The Fellowship of the Australian College of Rural and Remote Medicine is proposed as a pathway for speciality recognition in the field of specialty practice of rural generalist medicine, and accreditation will be sought for that purpose.

The Fellowship in Advanced Rural General Practice (FARGP), awarded in combination with the vocational Fellowship of the RACGP (FRACGP), is proposed as a pathway for speciality recognition in the field of specialty practice of rural generalist medicine, and accreditation will be sought for that purpose.

Following specialty recognition of rural generalist medicine, the RACGP intend to develop a four-year, standalone fellowship called the FRACGP-RG. This would then replace the FRACGP/FARGP pathway, and accreditation would be sought for that purpose.

5. Impact of recognition

5.2 AMC Advice

The proposal provides evidence of stakeholder consultation and engagement, however, there are gaps in information required for this section. The proposal does not show evidence of sufficient stakeholder engagement and consultation specific to the recognition of Rural Generalist Medicine as a field of specialty practice (rather than in the context of the National Rural Generalist Pathway) and is a considerable gap.

Consideration should also be given to asking jurisdictions about the role of Rural Generalist in their health system and their views on how specialty recognition would improve the current situation.

To address requirements of this section the following information is requested and would be necessary before a stage 2 application:

Applicants to show evidence that there was consultation around the issue of recognition of rural generalist medicine as a new field of specialty practice and what the result was.

Stakeholder groups should include, but are not limited to:

- *Specialist medical colleges that have overlap in scope of practice, required knowledge, skills and competencies with rural generalist medicine*
- *Heath consumers and community*
- *Aboriginal and Torres Strait Islander organisations*
- *Jurisdictions*

Letters of advice of consultation:

Medical Colleges*	
Australian College of Sports and Exercise Medicine (ACSEM) President	Letter sent 15 December 2020
Australian College of Emergency Medicine (ACEM) President	Letter sent 15 December 2020
Australian College of Dermatologists (ACD) President	Letter sent 15 December 2020
Australian and New Zealand College of Anaesthetists (ANZCA) President	Letter sent 15 December 2020
College on Intensive Care Medicine (CICM) President	Letter sent 15 December 2020
Royal Australian College of Dental Surgeons (RACDS) President	Letter sent 15 December 2020
Royal Australian College of Medical Administrators (RACMA) President	Letter sent 15 December 2020
Royal Australian College of Physicians (RACP) President	Letter sent 15 December 2020
Royal Australian College of Surgeons (RACS) President	Letter sent 15 December 2020
Royal Australian and New Zealand College of Ophthalmologists (RANZCO) President	Letter sent 15 December 2020

Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) President	Letter sent 15 December 2020
Royal Australian and New Zealand College of Psychiatrists (RANZCP) President	Letter sent 15 December 2020
Royal Australian and New Zealand College of Radiologists (RANZCR) President	Letter sent 15 December 2020
Royal College of Pathologists of Australian (RCPA) President	Letter sent 15 December 2020
Consumer Groups	
National Aboriginal and Community Controlled Health Organisation (NACCHO)	Letter sent 12 April 2021
Australian Local Govt Association	Letter sent 12 April 2021
Australian Consumers Health Forum	Letter sent 12 April 2021
Rural Health Workforce Australia	Letter sent 12 April 2021
National Rural Health Alliance (NRHA)	Letter sent 12 April 2021
Health Professional Groups	
Australian Council of Midwifery (ACM)	Letter sent 12 April 2021
Australian College of Nursing (ACN)	Letter sent 12 April 2021
CRANAplus (College of remote area nurses and allied health)	Letter sent 12 April 2021
Council of Aboriginal and Torres Strait Nursing and Midwifery (CATSINaM)	Letter sent 12 April 2021
Indigenous Allied Health Association (IAHA)	Letter sent 12 April 2021
National Association of Aboriginal and Torres Strait Islander Health Workers and Professionals (NAATSIHWP)	Letter sent 12 April 2021
Society Australian Rural and Remote Allied Health (SARRAH)	Letter sent 12 April 2021
Doctors Associations	
Rural Doctors Association of Australia (RDAA)	Letter sent 12 April 2021
Australian Medical Association (AMA)	Letter sent 12 April 2021
Australian Indigenous Doctors Association (AIDA)	Letter sent 12 April 2021
Jurisdictional Health Departments – Secretaries/Heads	
Australian Capital Territory	Letter sent 12 April 2021
Northern Territory (Health Minister)	Letter sent 12 April 2021
New South Wales	Letter sent 12 April 2021
Queensland	Letter sent 12 April 2021
South Australia	Letter sent 12 April 2021
Tasmania	Letter sent 12 April 2021
Victoria	Letter sent 12 April 2021
Western Australia	Letter sent 12 April 2021
Medical School Deans with copy to respective Rural Clinical School Heads	
Western Sydney University	Letter sent 12 April 2021
Newcastle University	Letter sent 12 April 2021
University of Adelaide	Letter sent 12 April 2021
University of Western Australia	Letter sent 12 April 2021
Monash University	Letter sent 12 April 2021
Griffith University	Letter sent 12 April 2021
University of Queensland	Letter sent 12 April 2021
Deakin University	Letter sent 12 April 2021
Flinders University	Letter sent 12 April 2021
University of Melbourne	Letter sent 12 April 2021
University of Tasmania	Letter sent 12 April 2021
Charles Sturt University	Letter sent 12 April 2021

Australian National University	Letter sent 12 April 2021
James Cook University	Letter sent 12 April 2021
Sydney University	Letter sent 12 April 2021
Curtin University	Letter sent 12 April 2021
University of Wollongong	Letter sent 12 April 2021
University of New South Wales	Letter sent 12 April 2021
Junior Doctors	
Australian Medical Students Association (AMSA)	Letter sent 12 April 2021
National Rural Health Students Network (NRHSN)	Letter sent 12 April 2021

Presentations:

- Council of Presidents of Medical Colleges (18 Nov 2020)

Meetings held:

- Commonwealth Department of Health (9 Oct 2020)
- Royal Australian and New Zealand College of Psychiatrists (29 March 2021)
- Dean, Prof Cheryl Jones and Meredith Makeham, University of Sydney (5 May 2021)
- RANZCA, RANZCOG, RACS (29 April 2021)
- CEO, Katherine Isbister, Council of Rural and Remote Area Nurses and remote Allied health workers (CRANAplus) (18 May 2021)
- NACCHO Chair, Deputy Chair, and CEO (25 May 2021)
- Western Australia County Health Services (16 June 2021)
- Minister Natasha Fyles, Minister for Health, Northern Territory (21 June 2021)

Feedback received:

- CEO, RANZCO (16 December 2020)
- Exec Dean, Medicine and Health, University of Sydney (12 April 2021)
- Chair, National Rural Health Alliance (14 Apr 2021)
- Dean, Medicine, Nursing and Health Sciences, Monash University (14 April 2021)
- Chief Executive, Australian Local Government Association (23 April 2021)
- Chair, Australian Medical Students Association (4 May 2021)
- Exec Dean, University of Adelaide, Faculty of Health and Medical Sciences (4 May 2021)
- Chief Executive, South Australian Department of Health and Wellbeing (7 May 2021)
- Chair, Western Australian Country Health Service (7 May 2021)
- Chair, National Rural Health Students Network (10 May 2021)
- Secretary, Tasmanian Dept of Health (10 May 2021)
- President, RANZP (11 May 2021)
- CEO, Indigenous Allied Health Association (13 May 2021)
- CEO, RDAA (17 May 2021)
- Exec Dean, Faculty of Medicine, University of Queensland (17 May 2021)
- Chair, RDAA Rural Specialists Group (1 June 2021)
- Secretary, NSW Health (7 June 2021)
- President, RACP (7 June 2021)
- President AMA (7 June 2021)
- CEO, CRANAplus (9 June 2021)

Attachment 5.1 Sample letter to Medical College Presidents and attachments
Attachment 5.2 Sample letter to Stakeholders and attachments
Attachment 5.3 Consultation meetings outcomes (RANZCP, RACS, RANZCA, and RANZCOG, and NACCHO)
Attachment 5.4 Consultation feedback letters received

6. Impact of options for addressing issue or issues covered by the proposal for the recognition of a new or amended specialty

B6.1 AMC Advice
Although a case for recognition of rural generalist medicine has been well evidenced in some areas, due to gaps in engagement with stakeholders, the expected impacts of each option on the various stakeholder groups has not been adequately addressed. This includes GPs who are currently providing services in rural areas who do not currently hold formal rural generalist qualifications as detailed above. *Following consultation with stakeholder groups listed under Section 5.2, the applicants should revisit the response to this section*

Option 1: Recognition of Rural Generalist as a specialist field of general practice (the proposal)

This is expected to be an enabler for expansion of the rural generalist workforce and practice of the rural generalist model across rural and remote Australia. This workforce can positively address pervasive issues of inequitable access to services in rural and remote areas.

Rural generalists are trained to provide both comprehensive general practice and emergency care and required components of other medical specialty care in hospital and community settings as part of a rural health team. The rural generalist training and scope of practice is designed to provide quality care in isolated, low resource, low patient caseload contexts. They enable doctors to flexibly and responsively, meet the needs of their diverse communities. The model of practice can be shown to be both highly attractive to prospective rural doctors and to have exceptional workforce outcomes in terms of rural retention (See *Sections 2.2-2.3*.).

The attainment of title recognition will support the growth of a robust workforce, with key expected outcomes, including:

- increased awareness and incentive to pursue rural generalist careers
- improved, nationally cohesive, systems support for training and skills maintenance
- simplified, nationally consistent, quality-assurance, credentialing and employment
- greater visibility and integration of the workforce in policy, planning and resourcing
- improved understanding by rural communities of their doctors' skillset

Evidence of the positive outcomes that have occurred in association with the limited rural generalist title that exists are given at *Section 2*.

Stakeholder group[1]	Impacts of recognition of Rural Generalist Medicine as a specialist field within General Practice
Junior Doctors, medical students, and medical Schools	The Rural Generalist model is an attractive rural career pathway for a significant number of aspiring doctors. These doctors who can provide a future workforce for rural and remote communities, welcome the opportunity to progress this career path with full recognition by their health systems and employers and a clear, structured and support training pathway. The Australian Medical Students Association Rural Health Committee have supported this application *to expedite the formal recognition of a speciality critical to supporting the next chapter of rural and regional healthcare.* These students are aware that *doctors already working in this field identify strong barriers arising from lack of recognition on this training and lifestyle in turn reducing the potential of this unique workforce to meet its goals.* They advise that *from a student perspective, formal recognition increases the appeal of generalist training. Approximately 75% of medical students hope to complete part or all of training/career rurally however identify numerous obstacles to this reality – including training pathways and career progression. Further, students feel that rural generalist training isn't as 'clear cut' or defined as other specialties. There will always be diversity in generalism, its recognition as separate from mainstream generalist practice reduces the confusion the student population has regarding generalism; hence assisting us in promoting it as a career.* They suggest the *'hidden curriculum' of suitable employment systems, hospital credentialing and streamlined training which result from this recognition further add to the accessibility of the program to interested students.* The National Rural Health Student Network has supported the application. They consider that *the establishment of a specialist field within general practice would further encourage much needed engagement towards improving recruitment and retention of rural health professionals in rural and remote Australia. It would enhance career opportunities for students and junior doctors and outline a coordinated national pathway for student wishing to pursue a career in Rural Generalism.* The University of Adelaide Faculty of Health and Medical Sciences, Executive Dean has expressed their strong support for the proposal. Prof Kile advised that *in South Australia, the 62 small rural hospitals (the majority of which have no resident specialist service providers) are*

[1] Italicised references are cited from correspondence received as part of the consultation, provided at Attachment 5.3

	obviously dependent on rural generalists to care for their local communities. The rural generalists to provide primary care, emergency medicine and hospital inpatient services. It is within this context that the University of Adelaide acknowledges the importance of rural generalists in recognition of their assessed attainment of the distinct and broad scope of competencies associated with quality practice. Monash University Medical Dean, Prof Christina Mitchell has supported the application, indicating that *the recognition of rural generalists as a specialisation allows medical graduates and trainees to enter this pathway at multiple stages with due credit given to previously developed relevant skills and clinical experience. It is consistent and equitable with processes in the medical specialities and increases the attractiveness of the pathway as a career.* It further indicates, *Monash University acknowledges the difference in roles between general practice and rural generalist practice and strongly supports appropriate national recognition of the extended scope of rural generalist practice as a specialisation within general practice.* The Executive Dean of the University of Sydney, Faculty of Medicine and Health, Prof Robyn Ward following from College representatives meeting with her Medical Dean, Prof Jones and key staff, has written to offer their *strong support for the proposal*, which they believe *will provide benefits to medical students, medical graduates and the rural communities they serve.* Prof Ward recognised that this acknowledgement *would allow our Faculty to more easily promote rural generalist training as a clear career path for our students. It may also increase opportunities for academic research and education in rural health more broadly, as this recognition may lead to more medical graduates located in rural regions who could engage with our education and research program. It would also provide greater transparency for healthcare consumers who would more easily be able to recognise the level of training undertaken by doctors with this qualification, contributing to improved quality and safety for people seeking healthcare in rural regions.* The University of Queensland Medical Dean, Prof Stuart Carney has supported the application noting the significant benefits of Rural Generalist recognition in Queensland. Prof Carney also commented, *the final arbiter of these reforms must be patient safety - providing assurance to the patient that their doctor has the requisite skills to provide comprehensive generalist practice in both routine and emergent situations.*
Health services	The rural generalist model can enable health services to continue to meet their obligations to maintain hospitals, emergency care capability and other critical aspects of local health service capacity in rural and remote communities even where non-GP specialists or sufficient numbers of non-GP specialists cannot be recruited or supported.

	A study in 2015 found that a trial at the Central West Hospital and Health Service, near Longreach, was able to attract medical students, junior doctors, and RG trainees with advanced skillsets to the Health Service, thereby enhancing local capacity and capability. The redesign reduced the local dependence on locums drastically, with substantial budgetary savings (i.e. a $7m locum budget was reduced to around $1m). The authors concluded that the changes created a rural teaching hospital type model and were accompanied by stronger local capacity, enhanced models of clinical governance with a focus on quality and patient safety, and a self-sustaining approach to developing local workforce. Of the 48 trainees who enrolled in the program, all completed their Fellowship requirements, 30 continued to practise in rural and remote Queensland and the remaining doctors continued to work rurally in other locations. The study found the pathway had facilitated development of similar innovative models in Cooktown, Emerald, Mt Isa, and Stanthorpe. In Mt Isa, for example, 9 trainees were recruited compared with none in 2009, with trainees indicating their willingness to continue in local practice beyond the end of training. [130] The model can deliver considerable cost savings. An Ernst and Young evaluation of the QRGP and its establishment of titled, industrially recognised and remunerated Rural Generalist positions in Queensland hospitals, projected a return on investment ratio of 1.2 (i.e. every $1 invested in the workforce would return a saving of $1.20). The evaluation calculated the additional costs of appointing rural generalists to provide in-situ care to rural communities against the savings in travel costs borne by the government (ambulance and helicopter) and accommodation costs covered by the patient assistance transport scheme (PATS) and an estimated 42.5 bed-day efficiency gain. This estimate did not include expected savings in reduced VMO services or changes to locum arrangements[131]. It also didn't consider the broader financial savings to rural patients and their families that were able to receive care locally. Consultations feedback: The South Australian Department of Health and Wellbeing has indicated its support for the application. It has identified that the benefits to the workforce, health services and the public that will be achieved through specialist recognition of Rural Generalist Medicine will be significant. The Tasmanian Department of Health has lent it support to the application and indicated that the Tasmanian Rural Generalist Pathway is an initiative in Tasmania to increase the medical workforce in their currently underserved rural and remote areas. The Western Australian Country Health Service has indicated its recognition of the critical importance rural generalism and the role it will play in developing a sustainable health care model to meet the

	requirements of rural communities across Western Australia. In meeting with College representatives, it was noted that there was opportunity to further discuss mechanisms for employment and payment structures which can effectively support and sustain both essential rural hospital services and primary care services. New South Wales Health has indicated its support for the proposal to advance to the second stage assessment and would like to further explore a range of the details of its implementation as part of the is assessment. Minister Natasha Fyles, the Northern Territory Minister for Health has met with College representatives and indicated her support for the proposal and sees considerable merit for it, and rural generalist workforce development in the Territory. The Minister indicated she would be discussing the proposal with her Department.
People in rural and remote communities	The rural generalist model's capacity to ensure provision of the broad scope of medical services locally has implications for the safety, health, and social well-being of people in rural and remote communities. The locally based, broad scope care that rural generalist models provide, can be delivered safely and to high quality. It minimises the need for patients to travel to cities for with the attendant negative risks and outcomes for their safety, health and well-being. (see *Section 3.1*) Models of care where the rural generalist provides additional/advanced skills in proportion to the degree of remoteness are supported by quality and safety outcomes. Australian studies have shown excellent health outcomes for rurally based rural generalist-led services across a range of locations and advanced skills areas.[132,133,134] Similar outcomes have been seen by RG models in other comparable countries. A Canadian study found similar safety outcomes when comparing caesarean sections provided by rural general practitioners with specialists.[135] An exemplar of this is in Queensland where specialist title and a comprehensive program of support for the rural generalist model stemmed the systematic withdrawal of rural maternity services in that state and led to reopening of four rural maternity wards (See *Section 2.3*). Tennent et al reviewed the birth outcomes of Queensland's hospitals and found no quality difference between the outcomes of the rural generalist led maternity wards and those of major city hospitals including for more complex deliveries.[136] The rural generalist model and a rural generalist workforce sustain strong local healthcare services. Local hospitals and other critical care services particularly maternity care facilities have been widely

	acknowledged as a lynchpin for sustainable communities, medically, socially, and economically.[137] Consultations feedback: Th Australian Local Government Association have indicated their support for the proposal and noted that *a well-trained rural generalist workforce represents a critical piece of the social infrastructure essential to enable people in rural and remote areas to have access to excellent healthcare and health outcomes that are comparable with Australians living in metropolitan areas*. *Councils recognise that in rural communities the rural GP may act only as the general practitioners but also perform other roles such as emergency care, minor surgery and activities typically undertaken by an obstetrician.* The NRHA which represents a cross section of rural health interests including rural health consumers supports this application. It considers *the role of the rural generalist as a key element in the quest to address the longstanding and continuing challenge of attracting and retaining a health workforce to rural and remote Australia*. It sees *clear benefits of rural generalists for rural communities, including having access to a professional with primary health care, emergency, and other medical specialist care.*
Rural and remote Aboriginal and Torres Strait Islander communities	The rural generalist model of care is an important part of creating a healthcare workforce which can meet the needs of Aboriginal and Torres Strait Islander peoples living in rural and remote areas. The model emphasises providing advanced care services to Aboriginal and Torres Strait Islander peoples in situ. This is consistent with the preference of many Aboriginal and Torres Strait Islander people particularly those in remote underserved communities to receive services locally such as renal dialysis, end-of-life-care, and birthing services[138,139]. This reflects the fact that they may not have access to social and financial supports in distant city centres, they may need to stay at home to look after children or family members, or where they may have cultural and spiritual beliefs that make remaining *on country* important.[140] Rural generalists are well positioned to build effective, continuing relationships of trust with Aboriginal and Torres Strait Islander patients. By working in both hospital and private clinics (and often other settings such as with retrieval services, aged care services and Aboriginal Community Controlled Health Services), the rural generalist can build a strong doctor-patient relationship with their Aboriginal or Torres Strait Islander patients. Consultations Feedback: In meeting with the colleges, the CEO, Chair and Deputy Chair of NACCHO indicated the organisation's in-principle support for the

	application. They indicated that workforce recruitment and retention particularly for their rural and remote workforce was of critical importance to their members. They emphasised the importance that all Rural Generalist registrars are adequately trained and prepared for culturally safe practice and for provision of primary care. The GP Colleges and NACCHO agreed to continue to meet to progress rural workforce issues collaboratively. It was recommended going forward that consultation with NACCHO members could be undertaken through NACCHO as their peak body that could disseminate information. The Indigenous Allied Health Association (IAHA) has confirmed its support for the application. The Association has noted that access to health services in rural and remote Australia remains a challenge and has indicated that *utilisation of the Rural Generalist workforce is one strategy to support improved access to care which meets the needs of rural and remote communities, as a component within multidisciplinary healthcare teams. Recognition of Rural Generalists as a specialist field may support increased update of the pathway and help ensure the sustainability of the profession.*
General practitioners	The use of the title 'Rural Generalist' would lead to differentiation in the perception of rural GPs versus that of Rural Generalist GPs. This differentiation is unlikely to diminish the public perception of either group. Both play important roles in rural healthcare that are highly valued by rural communities. It is unlikely that the well-established esteem rural communities have for 'their local GP' would change. They may, however, gain a better understanding of the specific skillset of their Rural Generalist and how that differs from the practice of other specialist doctors whose scope overlaps that of the Rural Generalist. Rural GPs may be impacted by the proposal if increased remuneration or other benefits are attached to the Rural Generalist specialised field of practice and not to Rural General Practice. It is difficult to speculate on the impact of undefined future changes of policy. Just as there are ways to reward an expanded scope of practice there are ways to reward quality general practice. Different communities have different needs – some communities will have a greater need for one type of professional skills over another. It's important that both rural GPs and Rural Generalist GPs are supported and valued; and that there are workforce strategies implemented for both groups to ensure retention of existing rural GP's as the pool of rural GP's and rural generalists is expanded. There have been some concerns raised that recognition of the Rural Generalist may deter non-Rural Generalist GPs from applying for rural positions for fear of not being skilled enough. This is a risk that needs to be managed by the colleges, by workforce agencies, the recruiters

	and the employers to ensure that all GPs are adequately skilled, enabled and supported to work rurally. The opportunity for a simplified process for recognition of advanced skills will be welcomed by many general practice doctors with advanced skills. General practitioners that have attained advanced skills in procedural and non-procedural areas would welcome the opportunity for national recognition of this attainment. Experienced rural doctors with advanced skills that do not have the attendant college qualifications may be motivated to seek formal recognition of these which should be facilitated which the colleges can support. Recognition of the RG title will provide benefits for those GPs working to that scope of practice. Support for and valuing of rural GPs as a significant part of the primary health care workforce will require the implementation of different strategies and the GP colleges commit to working with the Commonwealth and State Governments on that goal. Consultations feedback: The Rural Doctors Association of Australia (RDAA) (which represents rural GP and rural non-GP specialists) has supported the proposal. It has indicated its views as follows: *"RDAA strongly believes a Rural General workforce is the key to ensuring people in rural and remote communities have access to medical care close to home with doctors who have advanced skills in a range of clinical areas such as mental health, paediatrics, obstetrics, anaesthetics, surgery, palliative care etc. With integrated workforce models that include General Practitioners, Rural Generalists and either visiting specialists or resident specialists (who are in short supply), rural and remote Australians will be able to have their health care needs met.* *We are often challenged that rural generalists are not better than GPs, and completely agree, however, they are different. The scope of practice is different. The place of work will likely be different. The skills maintenance requirements are different. The training is different.* *RDAA believes that greater understanding and acceptance of these differences, by the Health system and clinicians, will be achieved through a formal recognition of rural generalist medicine by the AMC.* *In many rural communities, medical services will not be sustainable across the primary and secondary services unless we have integrated workforce models and for doctors in particular that requires Rural Generalists. If there are only doctors working in community based general practice, who do not work at the hospital, it puts the rural hospital services at risk. Alternatively, if small rural hospitals, staff their hospitals with full time consultant specialists they will de-skill and have a significant amount of unproductive time, or if they staff the hospital*

	with full time salaried staff, hospital management will likely move into offering more outpatient type services to ensure the team is productive, which would have a significant negative impact on the viability of community based general practice. Even in small rural and remote communities with no hospital, the clinical skills Rural Generalists poses are essential to the health and wellbeing of the people living there. *Recognition of rural generalist medicine by the AMC will assist in the credentialing processes which hospital doctors are subject too. Currently, RDAA is aware of situations where one doctor being allowed to perform to the top of their scope of practice in their area of advanced clinical skill, yet in another District due to the limited understanding of Rural Generalism and rural context, the same doctor will have limitations placed on their clinical practice. Each Health District of which there are more than 120 across Australia (thanks mainly to the 80 odd in Victoria) and each has an independent approach to credentialing, and Rural Generalists are often subject to a greater level of systematic scrutiny due to the lack of formal AMC recognition of the training and qualification. Rural Generalist medicine is the key to enabling people living in rural and remote Australia to access quality and safe medical services close to home as much as possible and where clinically appropriate. RDAA commends the work of ACRRM and RACGP on this joint application and on behalf of all our members (many who are rural generalists) we hope the AMC grants its approval."* The AMA (which represents GPs and non-GP specialists) has expressed its full support for the proposal. It views the specialist field approach as consistent with other specialties (e.g. as cardiologists are physicians) and recognises that specialist title will "*make it easier for rural communities, jurisdictions and employers to identify and understand the scope of practice for rural generalists. Additional skills developed and practised by rural generalist will meet the specific needs of the communities and regions where they work, building on the skills of the current rural heath workforce."* The Association provides this support on the understanding that Recognition of Prior Learning will be available to GPs with the relevant training and experience.
Non-GP specialists and other health professionals	Under the rural generalist model the ongoing role of non-GP specialists in regional settings is not impacted from a workforce, financial, business or competition perspective as the model proposes to provide healthcare in areas where none presently exists or is provided on an insufficient/limited basis. Where patients require specialist care offered outside of the scope of practice of a rural generalist, the non-GP specialist is still required to provide this and ideally works in collaboration with the rural generalist. This model is in place in rural locations across Australia and has been shown to work successfully internationally including in Canada.[141]

	Outside metropolitan contexts, the rural generalist has an important role in supporting and collaborating in provision of care by non-GP specialists. The local availability of RGs qualified to provide services in areas such obstetrics, surgery, emergency care and anaesthetics can ensure that there are enough local doctors to cover work rosters and comprise the full healthcare team in either full-time or part-time roles. The role of rural generalists in assisting non-GP specialists in rural areas is identified in testimonies to the NSW Rural Health Services Inquiry: *"Rural and regional communities have strong ties to their local health services including their local General Practices. Highly committed and well trained procedural General Practitioners have always provided the foundation of health care in rural and regional areas. Their services support Accident & Emergency, General Medical, Anaesthetic and Obstetric departments often in collaboration with local specialists.* *This mutual arrangement has made specialist services sustainable as well as providing professional satisfaction with a compatible quality of life for both parties."*[142] Consultations feedback: The RANZCP have indicated their support for this application. They acknowledge the major shortages in mental health workforce in rural and remote areas and are supportive of rural generalist training as an initiative which will improve access to people living in rural and remote Australia. They are interested to be involved in training and assessment of rural generalist with advanced skills in mental health and to explore the possibility of a diploma. The RANZCOG have indicated in meetings that they are pleased with the current arrangements with respect to rural generalist training as it pertains to advanced training in obstetrics and gynaecology. The RACS and the RANZCA also indicated in our meeting that they were generally positive towards the proposal with recognition of the need to further discuss the details. They indicated a range of issues that they did not initially understand about the proposal that were able to be clarified in meetings and subsequent correspondence. Both Colleges currently engage in various degrees of joint-standards collaboration related to rural generalist medical practice. They both indicated their interest in further discussing and progressing these arrangements. The Rural Doctors Association of Australia – Rural Specialists Group have supported the application making the following points: *"Our members work in an environment where integrated models between rural GPs, rural generalists and consultant specialists are able to provide an outstanding level of care, enable each medical*

	practitioner to work to top of scope in their clinical practice as well as provide a supportive environment that facilitates continued learning and development. *As specialists, we recognise our numbers are extremely limited in rural and remote Australia. Rural generalists provide a critical link between the role of the GP and the Consultant specialist in these services. Rural Generalists have undertaken additional training, and participate in extra continued professional development, under the supervision and tutelage of rural specialists such as our group represents.* *Our members either currently or in the past have been involved in the training of rural generalists, and value their role in providing quality care as part of an integrated medical team.* *We do not see any role as better than another, but the RDAA Rural Specialists Group does recognise there is differences between each role of the GP, the Rural Generalist, and the Consultant Specialist. This is the same as AMC recognition of different roles in various medical specialty streams such as a General Physician, and a Cardiologist.* *We support the formal recognition of the different roles, skills and training of a General Practitioner and a Rural Generalist. There are elements which are consistent in both training programs as there are with General Physician and Cardiologist, but there are also significant points of difference in training and ongoing clinical practice.* *Formal recognition would enable a clear articulation of the training and the role of the Rural Generalist, which many of our city based colleagues struggle to understand as they are not exposed to the rural context and environment and do not have the opportunity to appreciate the differences and skills a Rural Generalist has to offer."* RACP has indicated general support for the proposal but is seeking further detail on a range of issues. *"These include:* • *working with other professionals* • *resourcing training and education* • *potential increase in healthcare cost* • *clarity of specialist titles* • *broader rural generalist reform"* The Taskforce is continuing to discuss and clarify these issues with the RACP. The CRANAplus, representing remote area nurses and health professionals, along with NRHA which represents the breadth of rural health professions and rural health consumers, and the Indigenous Allied Health Association have all indicated their support for the proposal. They have all recognised the importance or respectful, collaborative team care to delivery of health services in rural and

	remote areas and view the application as one of a range of important steps toward strong, sustainable rural healthcare teams.

2. Existing Arrangements

Option 2 Existing Arrangements

The following options or combinations thereof reflect the current situation and can be expected to continue the current trends with respect to insufficient workforce and health services provision for rural and remote communities.

- *RGs advanced skills recognised but not their RG title*

  Under this approach, there is no formal recognition of a rural generalist and the opportunity is foregone to support a structured training pipeline toward a named career. Ad hoc hospital credentialing is undertaken on a case-by-case basis. Without formal recognition of title this process becomes highly situational, unpredictable, administratively onerous and offers little security for rural generalist doctors' practice.

  Under current arrangements, the rural generalist profession is not recognised and thereby, commonly not represented on hospital credentialing committees or other key decision-making bodies. Determinations about credentialing and quality frameworks are often made without knowledge of the profession and its full scope and training. Further, in the absence of the esteem attendant of specialist title, there is a default tendency for doctors representing groups with established specialist title to predominate decision processes.

  This complexity and uncertainty add costly inefficiency to the system and places a disproportionate and considerable administrative burden on overworked rural generalist doctors. This presents a substantive disincentive for their continued provision of extended skills care and has led to many rural doctors discontinuing their advanced skilled practice. [143,144]

- *Reliance on non-GP specialists in situ*

  Rural non-GP specialists provide highly valued services to their communities. It is both unrealistic and unsustainable to build rural health systems based on an expectation that there would be sufficient doctors to meet the breadth of subspecialist care needs of rural and remote communities.

  Specialist practice involves high patient caseload over a narrow scope of medical presentations which is ill-fit to serving small isolated populations. Furthermore, many specialty practice models rely on the ready availability of the gamut of specialised resources and staff that are only available in cities. The approach has merit in larger regional centres but even in these locations there would still be strong merit in providing a rural generalist workforce to value-add the quality of services available and assist in maintaining work rosters.

  In most non-GP specialties, very few practitioners are permanently based outside of the major regional centres and this is unlikely to change significantly. There is a

dearth of training facilities, accredited training practices, and qualified supervisors in rural and remote (i.e. MMM4-7) areas and many training programs require the scope of the specialised support resources and staff of tertiary hospitals in order for credentialed specialist practice to occur.

- *Patients travel to receive non-GP specialists care*

  The requirement to travel for care has significant and broad ranging negative outcomes for rural and remote communities and their health and safety.

  Lack of provision of local hospital and advanced care services effectively transfers the burden of patient safety and healthcare costs[145] from health systems to rural and remote patients and their families. These barriers can be shown to diminish rural and remote people's utilisation of healthcare services.[146,147] and are especially harmful to the most disadvantaged patients[148]

  - Many patients are not able to access or to afford transport, public transport is commonly not available, and patients may not have the health or the capacity to transport themselves.

  - Patients may not be able to leave their family or their business for an extended period or the absence may come at considerable personal and financial cost. [149,150,151-152]

  - The experience of receiving care particularly over an extended period in a distant centre separated from social networks can also impact on patients' health and well-being. This can be a barrier for Aboriginal and Torres Strait Islander people who in addition to social and economic barriers may have cultural reasons for choosing to stay on-country.[153]

  - It is noted that the Patient Transport Assistance Scheme is available to support this travel. This only partially covers travel costs and does cover any of the costs of childcare or loss of business or work time, it is administratively onerous and many high needs patients including the very ill lack the capacity to cope with the administration of these.

  - Extensive literature documents the risks associated with patient travel to access distant health care.[154,155,156,157] One study of stroke care for example found that the clinical risks of longer journeys outweighed the benefits of accessing the tertiary service.[158] 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.[159] Studies have clearly linked the need for extended travel time to access maternity services to increased rates of mortality and adverse outcomes.[160] Canadian studies have found that women with no local access to maternity services have worse maternal and newborn outcomes than women from similar communities with local access to even limited birthing services.[161] Travelling for care diminishes patient safety. Patient transport presents time delays in care which can increase patient risk [162] and the travel itself presents a quantifiable patient risk, identifying 45 deaths occurring in Queensland from 2002-2015 while patients were traveling to access hospital care. [163] Two Harvard studies

found that closure of rural hospitals resulted in a 3% rise in 30-day mortality for patients overall and a 5% rise in 1-year mortality for time-sensitive conditions; there was no evidence of any cost savings from closures.[164]

- *Provision of Locum, FIFO and DIDO specialists*

  These specialist services are an essential part of rural healthcare. In the ideal these not only enable access to care but supplement, relieve, support, upskill and build local services. There are however considerable shortcomings to this form of care and most significantly it risks becoming viewed not as a complement or a stop gap, but rather as a substitute for maintaining local services and permanent continuous and coordinated care.

  The current over-reliance by jurisdictions on locums rather than a permanent long-term local workforce to provide referred, secondary and emergency care services to rural and remote people is a widely recognised problem. This presents a poor health service outcome for rural communities and a very expensive model of care for jurisdictions. This has been identified as a key issue in the National Medical Workforce Strategy.[165]

  Gruen et al noted the value of specialist outreach services but that this would always come at the opportunity cost of providing the same services within the local hospital setting and other hospital-based specialists having to absorb more work as a result.[166] This is supported by Perkins who notes that outreach services deduct from the *'development of a robust local workforce with impacts for the sustainability, productivity and quality of services*'.[167] Wakerman et al question whether or not FIFO health services are part of the problem or a panacea and are concerned they may add to the deficit view of working in rural and remote health care[168], and Hanley expresses concern that such services do not contribute to social capital or social cohesion.[169]

  These considerations are especially important given the work of Huang et al which emphasises that preservation of rural hospitals can be a vital aspect of maintaining rural communities and the ongoing safety and well-being of the people in them.[170]

  A report by the House of Representatives inquiry conducted by the Standing Committee on Regional Australia urged the Australian government to see FIFO and DIDO workforces expressed concerns that the practice 'could lead to a hollowing out of established regional towns, particularly those inland'. They emphasised the need for the transient workforce to be viewed as supporting rather than replacing the local workforce. The report identified the need for planning models in determining cost effective solutions to incorporate all the costs of this form of service provision including the need to maintain local staff with capacity, local infrastructure costs including FIFO doctors' accommodation and the administrative burdens placed on local staff by FIFO doctors.[171]

  Studies by Battye et al, and Gruen et al[172] both examined the role of specialist outreach to health care in remote Indigenous populations in Australia. The studies identified cultural inappropriateness of services and poor doctor-patient communication, infrequency of visits, high visiting specialist turnover, shortness of

visits all as key issues. These underscore the value of continuity of relationships for patients and services by local doctors.

- *Provision of specialist services through Telehealth*

  Telehealth is a valuable tool which provides communities with another way to access GP services. In rural and remote communities where access to their GP may require travelling long distances, and where public transport options are fewer, telehealth can allow patients to access the care they need.

  However, telehealth should only be used when appropriate. Telehealth cannot substitute many essential aspects of medical care that are only possible through in-person interactions. It is especially important therefore that these can be supplemented and supported through collaboration with local practitioners.

  The potential lack of continuity of care/relationships with patients and the local healthcare team is likely to be heightened by the lack of physical contact and the relative ease of establishing corporate phone services in a remote community.

  There is heightened risk in the instance of corporate telehealth services that they compete with local doctors and undermine the business model for local services or be viewed by government health services as an acceptable alternative to funding local doctors.

Stakeholder group	Impacts of existing arrangements
Health services	Under current arrangements health services are failing to provide adequate and acceptable access to people in rural and remote communities to essential health care services including community based primary care and those that would be provided by non-GP specialists in cities. The maldistribution of the health workforce and its well documented impacts for rural people's healthcare are recognised national priority issues. It has been recognised by all state health departments – through their commitment to their respective rural generalist programs and the Commonwealth health department through its commitment to implementing the National Rural Generalist Pathway that this is an important step towards addressing these problems.
Rural and remote communities	It should be noted that the system of care most desirable to rural and remote communities will vary considerably due to their diversity of circumstances. In general, rural and remote communities welcome the services of locums, telehealth services and outreach specialist services. They do not however view these as an acceptable replacement for health department's meeting their obligations to maintain strong locally based services. Rural communities feel especially strongly about local birthing services and emergency services. [173]

	For rural and remote communities, policies to finance locum services rather than community-based ones, have the effect of transferring the economic benefits of government/rural patients' payments to these specialists from the rural or remote community to the city where the specialist resides.
Rural and remote Aboriginal and Torres Strait Islander communities	Continuity of care, culturally safe care and strong relationships with the local community are all major priorities. These can be strongly supported by permanent locally based practitioners including practitioners able to provide emergency, obstetric, mental health and other advanced care services. Another key issues for Aboriginal and Torres Strait Islander communities is the capacity to receive care on country and within their community particularly for birthing, oncology and other advanced care services.
General practitioners	The problems of rural credentialing are a major issue for rural doctors across Australia that provide advanced care services in rural hospitals. - Rural credentialing an issue for AMA (annual survey) - Rural credentialing an issue for RDAA (paper) Registrars continue to face considerable obstacles to accessing training posts, having their training recognised to allow their training in advanced posts, and having their credentials recognised should they transfer to alternative hospitals or jurisdictions. The problems more generally of rural general practitioners that provide advanced care services having no voice in health service determinations at the jurisdictional and federal levels related to their services, their quality-assurance regulation and service funding.
Non-GP specialists	Non-GP specialists are interested to ensure standards of care within their respective specialty fields are maintained in rural areas. Currently a range of joint-consultative forums involving both general practice colleges and the relevant non-GP specialty are in operation to achieve broad agreement on standards. Rurally based non-GP specialists have stressed there are major flaws in current frameworks which tend to minimise support for locally-based practitioners. These practitioners see a role for collaboration with rural generalists to maximise the care that can be provided. [174] Rurally-based specialists has emphasised the need for support and recognition for the role that they do. They are welcoming of mixed models of service, in their testimonies to the New South Wales Inquiry into rural health services, specialists have welcomed the rural generalist pilot training program in their area, and have emphasised the value of rural specialists working collaboratively with rural generalists to support their skills development. [175]

3. Other existing regulation that could be used to address the problem

Option 3.1 Rural Generalism as a standalone specialty

This model would create specialist title and thereby should deliver similar benefits as outlined by this proposal. The model however signals a clearer differentiation between the general practice and rural generalist professions which would have a range of outcomes.

Relative to the proposal, this option would further enhance the clarity of the role for all users and systems and strengthen the sense of professional identity among its practitioners. Conversely, it would sharpen the boundaries between general practice and rural generalist practice.

The degree to which this could be managed in a positive way would depend on the establishment of appropriate mechanisms to manage primary care workforce mobility and ensure effective inter-professional collaboration.

Stakeholder group	Impacts of Rural Generalist Medicine as a standalone specialty
Health services	From the perspective of health services this would bring a degree of clarify to training systems, marketing to junior doctors and students over and above what might be achieved through the proposal. There are potential risks to service provision arising from a lack of professional mobility can from a potential loss of professional cohesion and satisfaction with rural doctors.
Rural and remote communities	This could be expected to bring similar outcomes to rural and remote communities as those outlined in this proposal. The relative merits of this proposal for communities would be affected by the degree to which this option could be implemented such as to ensure continuing local medical workforce cohesion and portability.
Rural and remote Aboriginal and Torres Strait Islander communities	The perspective for Indigenous communities would be similar to other members of rural and remote communities as above.
General practitioners	The issues raised in *Option (1)* above related to a sense of professional separateness would be more formalised under this model. These doctors may view this title as undermining the value of their own specialist title and there may be need for efforts to address any such disaffection particularly through active promotion of the value of general practice. There is a risk that experienced general practitioners with advanced skills to attain recognition as a rural generalist may have difficulties in having these skills recognised. There are currently facilitated

	pathways to Fellowship recognition in place within the RACGP and ACRRM, which may need to be further refined.
Non-GP specialists	The implications for these specialists are consistent with the implications under the proposal.

Option 3.2 Endorsements of additional/advanced skills

Under this model, endorsements would be part of a practitioners' registration and would provide a national framework providing transparent and consistent information to public and authorities regarding practitioners' areas of capacity for advanced practice.

This could be expected to improve the consistency and simplicity of the credentialing process and address many of the issues of employment portability. This model would also enable recognition of advanced skills that are practiced outside the hospital and health service system.

This model would not lend the status associated with a job title to rural generalist doctors nor recognise the broad and distinctive skillset they would have attained. It would not incentivise rural generalists to attain or maintain this scope, nor to take the flexible, responsive approach to defining their practice that characterises rural generalism.

As these doctors would be distinguished only by their advanced skill, there is considerable risk this approach will nurture a rural procedural and advanced care workforce that view themselves as subspecialists, and mirror the highly subspecialised workforces in cities that are ill-fit to meeting rural needs.

Stakeholder group	Impacts of establishing additional/advanced skills endorsements for General Practitioners
Health services	Rural generalists commonly provide emergency, inpatient as well as other areas of medical care within hospitals. This model presumably involves separate endorsements for each of these areas. It would inhibit doctors' capacity to provide services across a range of areas in the rural hospital as it would be likely to generate excessive compliance requirements.
Rural and remote communities	This model may go some way to increasing the number of advanced skilled doctors available to rural communities by reducing systems barriers. Its effectiveness would be tempered by its foregone opportunity to recognise or value these doctors' practice with specialist title. The absence of an actual job title would also make it less clear and more complex for rural patients to understand the nature of their doctors' skill set.
Rural and remote Aboriginal and Torres Strait	This model would enable national endorsement of doctors' attainment of advanced skills in areas such as Aboriginal and Torres Strait Islander Health and population health.

Islander communities	The Indigenous communities' perspectives would otherwise be similar to the broader rural and remote communities' perspectives as above.
General practitioners	As above this would simplify and bring national consistency to the process of attaining credentials to practice advanced skills and recognise advanced skill practice outside the hospital. This model would provide equal recognition to all general practitioners that gain an advanced skill irrespective of whether they have attained the broad and distinctive skill set of rural generalist medicine and particularly would not acknowledge or incentivise rurally-oriented training. This may reduce barriers to practice but would fail to acknowledge differences in skillsets and training. This model would continue to prevent doctors with the rural generalist skill set from recognised title and thereby from developing a strong professional identify and voice in health systems and encouragement to attain and maintain their skill set.
Non-GP specialists	The impact of this model for non-GP specialists would be minimal and not significantly different from the proposal.

Option 3.3 Industrial recognition within each jurisdiction

Under this model, recognition and credentialing is the domain of hospital sites and is linked to clear employment opportunities. This model (which is in place in several jurisdictions already including Queensland and Northern Territory), offers a solution to some but not all of the problems raised in this submission.

Under this model, recognition is limited to rural generalists that work in jurisdictional services and is not transferable across states and cannot enable transferability unless it were linked to a common nationally recognised standard. The 10-14-year training journey from medical school to Fellowship typically involves movement across jurisdictions. The recognition has no status in negotiating employment contracts with other potential employers such as Aboriginal Medical Services, local government financed health centres, private employers etc. undermining the workplace flexibility that is fundamental to the value of the rural generalist model.

Stakeholder group	Impacts or Rural Generalist's industrial recognition within each jurisdiction
Health services	Jurisdictional health services would benefit from some form of recognition to assist them to address the many systems barriers involved in managing their respective rural generalist program. This would also enable them to advertise rural generalist positions and increase the visibility and popularity of rural generalist jobs. This option may be problematic for jurisdictions in processing cross-jurisdictional employment transfers if recognition is not consistent across states.

	The process of establishing title unilaterally within each jurisdiction is arduous and less efficient than that achievable through a single national title.
Rural and remote communities	Industrial recognition (with other important initiatives) has helped to improve workforce availability in Queensland (see Section 2 above) and could conceivably have a similarly positive outcome in other jurisdictions.
Rural and remote Aboriginal and Torres Strait Islander communities	These communities' perspectives would be similar to the broader rural and remote communities' perspectives as above.
General practitioners	The issues with this recognition are similar to the issues associated with specialist title recognition as outlined at Option 1 above.
Non-GP specialists	This is likely to have minimal impact on Non-GP specialists.

Glossary and Acronyms

Glossary

Advanced/additional skills	These refer to range of skills incorporated in the Rural Generalist skill set that are extended beyond those typically viewed as the essential skills for general practice/family practice. These may reflect intensive or extensive expertise in a broad range of areas of medical practice which may be primarily procedural or non-procedural in nature. Some advanced/additional skills are part of the core Rural Generalist skill set while others are optional and ideally reflective of the service requirements of the practitioners' community.
General Practitioner	A medical practitioner who is vocationally recognised in the discipline of general practice.
Modified Monash Model	The Modified Monash Model (MMM) is a system adopted by the Commonwealth Department of Health to define whether a location is a city, rural, remote or very remote. The model measures remoteness and population size on a scale of Modified Monash (MM) category MM 1 to MM 7. MM 1 is a major city and MM 7 is very remote. MMM classifications are based on the Australian Statistical Geography Standard - Remoteness Areas (ASGS-RA) framework.
Non-General Practitioner Specialist	A doctor with Australian specialist registration in any specialist field other than general practice. This terminology has been used to assist in readability. It is acknowledged that the specification encompasses a diverse range of practitioners.
Rural Generalist	A medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care and required components of other medical specialty care in hospital and community settings as part of a rural healthcare team.
Vocationally Registered General Practitioner (VR GP)	A doctor with specialist registration with the Australian Health Practitioner Regulation Agency (AHPRA) in the specialty of general practice.

Acronyms

ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community-Controlled Health Service
ACRRM	Australian College of Rural and Remote Medicine
AGPT	Australian General Practice Training
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
AMC	Australian Medical Council
AHPRA	Australian Health Practitioner Regulation Agency
ARST	Advanced Rural Specialised Training
AST	Advanced Specialised Training
CPD	Continuing Professional Development
DALY	Disability Adjusted Life years
FACRRM	Fellowship of the Australian College of Rural and Remote Medicine
FRACGP	Fellowship of the Royal Australian College of General Practice
FARGP	Fellowship in Advanced Rural General Practice
GP	General Practitioner
HETI	Health Education Training Institute
HMO	Hospital Medical Officer
MABEL	Medicine in Australia – Balancing Employment and Life (data set)
MBA	Medical Board of Australia
MBS	Medical Benefits Schedule
MMM	Modified Monash Model
MSRPP	Medical Superintendent with Right to Private Practice
MWRAC	Medical Workforce Reform Advisory Committee
NRGP	National Rural Generalist Pathway
NRHA	National Rural Health Alliance
NRHSN	National Rural Health Students Network
PATS	Patient Assistance Transport Scheme
PBS	Pharmaceutical Benefits Scheme
PDP	Professional Development Program
PGY	Post Graduate Year (e.g. PGY1, PGY2 etc.)
PPH	Potentially Preventable Hospital (admissions)
QI CPD	Quality Improvement and Continuing Professional Development
QRGP	Queensland Rural Generalist Program
RACGP	Royal Australian College of General Practice
RCIT	Rural Community Intern Program
RDAA	Rural Doctors' Association of Australia
RG	Rural Generalist
RMO	Registered Medical Officer
RTO	Regional Training Organisation
RVTS	Remote Vocational Training Scheme
SMO	Senior Medical Officer
TRMGP	Tasmanian Rural Medical Generalist Program
VMO	Visiting Medical Officer
VRGP	Vocationally Registered General Practitioner
WAPHA	Western Australian Primary Health Association
WARG	Western Australian Rural Generalist (Program)
WAGPET	Western Australian General Practice Training

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