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

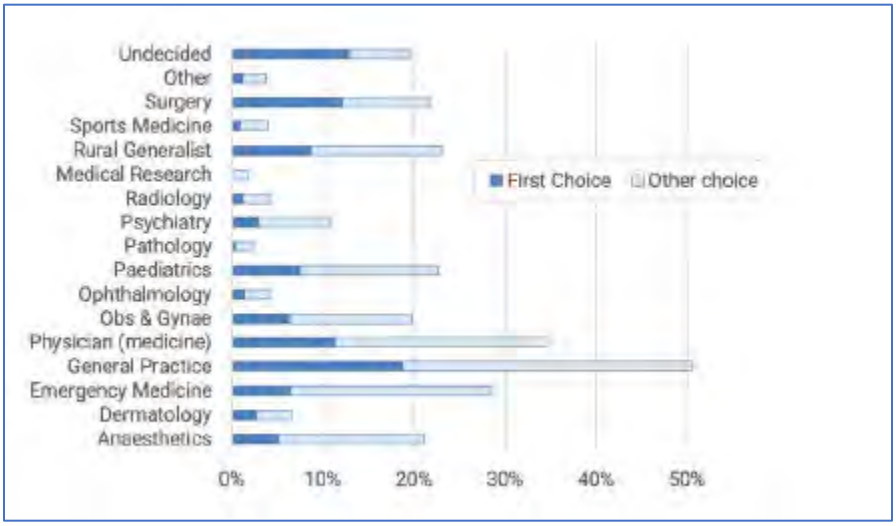
'medical school experience of the speciality' and 'consultant/mentor influence' respectively as their 2nd and 6th top ranked reasons for choosing a specialty.[45]

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

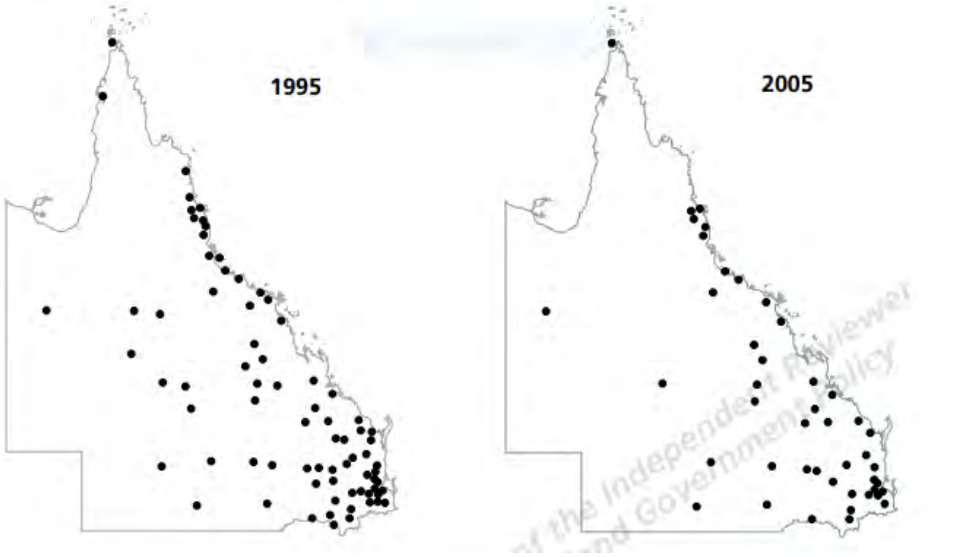
Indicative evidence of the positive workforce outcomes associated with strong support for rural generalist training and some degree of recognition of specialist title for rural generalists are given below.

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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[170] Ibid. Hoang H et al (2014)
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[172] Ibid. Gruen R et al (2002)
[173] Ibid. Queensland Health, Wakerman J (chair) (2019)
[174]Ibid. Regional Medical Specialists Association (2021)
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Attachment 1.1

RACGP

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

Memorandum of Understanding

July 2021

1. PURPOSE

The purpose of this memorandum of understanding (MoU) is to describe the relationship between the Royal Australian College or General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) in progressing their joint application to the Medical Board of Australia for Recognition of Rural Generalist Medicine as a specialist field within the specialty of General Practice (the Application).

The Agreement confirms their intention to work toward the joint application's approval and subsequently in the delivery of training toward Fellowship with recognised title in the specialist field of Rural Generalist Medicine. This work will be done with a view to improving the healthcare and wellbeing of people living in rural and remote communities.

This Agreement confirms the two colleges' intention to work together with mutual respect to foster collaboration and achieve common goals. This Agreement is not intended to represent a legal or binding contract.

2. THE ORGANISATIONS

The RACGP is Australia's largest professional general practice organisation, representing over 40,000 members working in or towards a career in general practice, in urban, regional, rural, and remote communities across Australia. The RACGP is responsible for maintaining standards for quality clinical practice, education and training, and research in Australian general practice.

ACRRM is a medical college accredited by the Australian Medical Council (AMC) to set professional medical standards for training and continuing professional development in the specialty of general practice. ACRRM has a special focus on training and setting professional standards which reflect the needs of practice in remote and rural contexts.

3. DEFINITION

RACGP and ACRRM have endorsed the Collingrove Agreement which specifies:

A Rural Generalist (RG) is a medical practitioner who is trained to meet the specific current and future health care 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 specialist care in hospital and community settings as part of a rural healthcare team.

4. ROLES

ACRRM and RACGP will commit to a respectful, collegiate and supportive approach to this agreement, recognising the range of obligations and responsibilities of each party. They will work cooperatively and collaboratively to identify opportunities and strategies to progress their common goals.

Each organisation will maintain its independence and autonomy under the terms of this agreement, including the right of either organisation to independent action or opinion on any issue.

5. COLLABORATION

Areas for collaboration may include, but are not limited to:

5.1. Rural Generalist Recognition Taskforce:

RACGP and ACRRM will participate in regularly scheduled Taskforce meetings in accordance with the organisations Terms of Reference, to discuss arising issues and to progress the activities associated with the Application.

5.2. Stakeholder Engagement:

RACGP and ACRRM will endeavour to meet together with a range of stakeholders as appropriate to the Medical Board's assessment process.

5.3. Communications:

RACGP and ACRRM may also send joint correspondence, media releases and marketing collateral. These will be issued with the consent of both parties

5.4. Application documentation:

RACGP and ACRRM will contribute to the development of documentation as required by the Medical Board assessment process.

5.5. Monetary support:

Any decisions requiring monetary support would be agreed by both parties and costs split.

5.6. Public announcements:

Any public announcements on Rural Generalist Recognition will be approved by both parties, to ensure that important developments are communicated to stakeholders within a reasonable timeframe.

6. TERM AND REVIEW

Any party may leave the agreement after a consultation meeting with the other party and with three months written notice.

The MoU will remain in place for the duration of the Application process and ongoing. This is viewed as a living document and can be amended at any time by agreement of both Parties to reflect the developing context.

SIGNATORIES

DR SARAH CHALMERS
President
ACRRM

DR KAREN PRICE
President
RACGP

Attachment 1.2 CPMC Presentation

COUNCIL OF PRESIDENTS OF MEDICAL COLLEGES

DIRECTOR'S AGENDA

Wednesday 18th November 2020

6pm AEST Council Directors via zoom link: https://ranzcog.zoom.us/my/ceocpmc ID is: 8514153435

1.	Welcome to 142nd Meeting & Acknowledgement of Country	Dr Kym Jenkins, Chair
2.	Apologies Received	
3.	Declarations of Conflicts of Interest	

6pm COUNCIL DIRECTORS (Presidents) ONLY

4. Governance Session

4.1	Minutes from previous meeting	For approval
4.2	Chair Update	Dr Jenkins
4.3	CEO Report	Angela Magarry
4.4	Change in Directors	For Noting
4.5	SRSA Update	For Noting
4.6	CPMC Education and Medical Workforce Subcommittee	Discuss proposal
4.7	Examinations – begin discussion	Dr Jenkins

5.	**Financial Update**	For Noting
5.1	Audited financial statements- for lodgement with AGM papers	Approval
5.2	Company accounts to end October 2020	

7pm Presidents and CEOs

6. Strategic Session

6.1	Briefing Australian Digital Health Agency at 7pm	15 minutes
6.2	Prof. Ruth Stewart National Rural Health Commissioner at 7:15	20 minutes
6.3	COVID update- continuation of discussion on exams at 7:30	Discuss

7. Other Issues

7.1	Meeting continuity 2020 Possible 17 December; 21 January meetings	Chair

8. 2021 Meeting Schedule **For Calendar**

Thursday 18 February 2021 – RACP Sydney
Thursday 20 May – Sydney – RACP Sydney
Thursday 19 August – RANZCP Melbourne
Tuesday 30 November – RANZCP Melbourne

Briefing Note

Joint-application for recognition of Rural Generalist Medicine as a specialist field with General Practice

November 2020

Purpose:
To update the Council on the purpose and progress of the joint-application to the Medical Board of Australia (Board) for recognition of Rural Generalist Medicine as a specialist field within General Practice.

Application and progress:

- Over 2017-18 the first National Rural Health Commissioner (NRHC), Prof Paul Worley was commissioned by the Commonwealth Government to undertake a national consultation and provide advice to guide the implementation of a National Rural Generalist Pathway. This work was overseen by the National Rural Generalist Taskforce which was jointly led by the NRHC and the general practice colleges. This culminated in the Taskforce Report to the Rural Health Minister which included a recommendation to seek specialist recognition of RG within the discipline of general practice.

- The Rural Generalist Recognition Taskforce was formed to action this recommendation. The Taskforce includes senior members of both general practice colleges and is chaired by the NRHC.

- The Joint-Application of RACGP and ACRRM was submitted to the Medical Board of Australia on 19 December 2019. This was an ''Initial Proposal" for first stage assessment of whether to progress to full assessment.

- The application was forwarded to the AMC Recognition of Medical Specialties Subcommittee for assessment and advice. The Board received and considered initial advice and have written to the Colleges seeking additional information to inform a final determination regarding proceeding to full assessment.

- The Colleges through the Rural Generalist Recognition Taskforce are currently working on this additional information and associated actions.

- Independently of this work the Commonwealth Government is financing the development of Rural Generalist Coordinating Units and associated state and territory-based governance bodies to oversee and support rural generalist training and practice within their respective jurisdictions. It is also establishing a national governance body.

Rural Generalist Medicine
Through the Collingrove Agreement the general practice colleges agreed to the following statement describing the specialist field:

> *A Rural Generalist (RG) is a medical practitioner who is trained to meet the specific current and future health care 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 specialist care in hospital and community settings as part of a rural healthcare team.*

Recognition as a specialist field within general practice
The joint-application seeks to have a designated Rural Generalist Medicine field established and included as an optional registration field with the general practice specialty. For doctors that meet qualification requirements and register as general practitioners, this will provide a specific designation to also recognise their assessed attainment of the distinct and broad scope of competencies associated with quality practice in rural generalist medicine. Protected title would be an outcome of this status.

Why is Rural Generalist Medicine important?
Rural and remote communities cannot sustain the broad scope of specialised resources and clinicians that are readily available to people living in cities. Their population base and hospital systems can often not viably support full-time, locally-based consultant specialists. A more flexible workforce trained in emergency response, hospital-based care and broad scope approach to primary healthcare can give them the best possible care and minimise the need for travel to cities. This is particularly important for disadvantaged groups such as disabled, sick and low socio-economic groups and remote Aboriginal and Torres Strait Islander communities.

Specialist outreach, digital health, and facilitated patient transport to cities are all important to delivering equitable care to people in rural and remote people and the rural generalist skill set includes training in telehealth and other coordinated care models. Rural generalists with advanced skills related to consultant specialists can support them and enable them to sustain work rosters.

What is the impetus for specialist recognition?
Many general practice qualified and registered doctors across Australia are trained, assessed, certified and undertake ongoing skills maintenance in the distinctive scope of rural generalist medicine. This work has no formal national recognition. This lack of national recognition has significant consequences for the viability of this workforce and the services it delivers:

- Without a title, it is difficult to promote rural generalism as a career to aspiring medical students and junior doctors
- The training pathway lacks national coordination particularly with jurisdictional health services
- As an unnamed workforce they are not included in health systems data or planning
- Jurisdictions differ in their industrial recognition and employment awards for these doctors creating barriers to job portability and qualification recognition
- Their unique skillset and training are not recognised in national or jurisdictional systems for purposes of regulations or professional standards
- An agreed standard and registration designation that the public and employers (hospitals, RFDS, AMS and private practices) can rely on will enhance quality and safety of care

Recognition of Rural Generalist Medicine as a specialist field within general practice

Purpose, process and progress

We acknowledge Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the traditional owners of lands across Australia in which we work and live and pay respect to their elders past present and future.

What is a 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 specialist care in hospital and community settings as part of a rural healthcare team."

Collingrove Agreement

Profile of a rural generalist

- Dr Alice Fitzgerald grew up and went to medical school in Adelaide before she decided she needed a change of scenery. She is now based in Kununurra, located at the eastern extremity of the Kimberley Region.
- I work in a town with a population of about 6000. I work 2 days a week in private practice, one day a week as a medical educator for our rural medical students and the remainder of the time working for the local hospital which involves doing a mix of emergency, ward work, outreach clinics to remote communities and my procedural skill is obstetrics.
- One day you are managing a multi-trauma and the next you are congratulating a young couple on their first positive pregnancy test. You get to be around for that couples' pregnancy, delivery and get to know the baby as it starts to grow. I can't think of many other jobs that provide such a range of cases.

Why are rural generalists important?

- Rural/remote communities cannot support highly specialised care models
- Locally-based broad scope care fills local service gaps

- Minimises need for travel for specialist services

- Maximises likelihood needed care is received

- Creates local critical mass for specialised care

- People in rural/remote communities need access to local emergency care
- People in rural/remote communities need access to safe, local birthing services

National Rural Generalist Pathway

- The National Rural Health Commissioner established with brief to implement National Rural Generalist Pathway (2017)
- RG training policy and places established within AGPT (2018)
- RG Coordinating Units grants established Units, governance bodies, and support for training and practice in all states and territories (2020)
- Qld, NSW, Vic have well established RG Programs, other states in various development stages
- NT and Qld have RG industrial award

Training Pathway

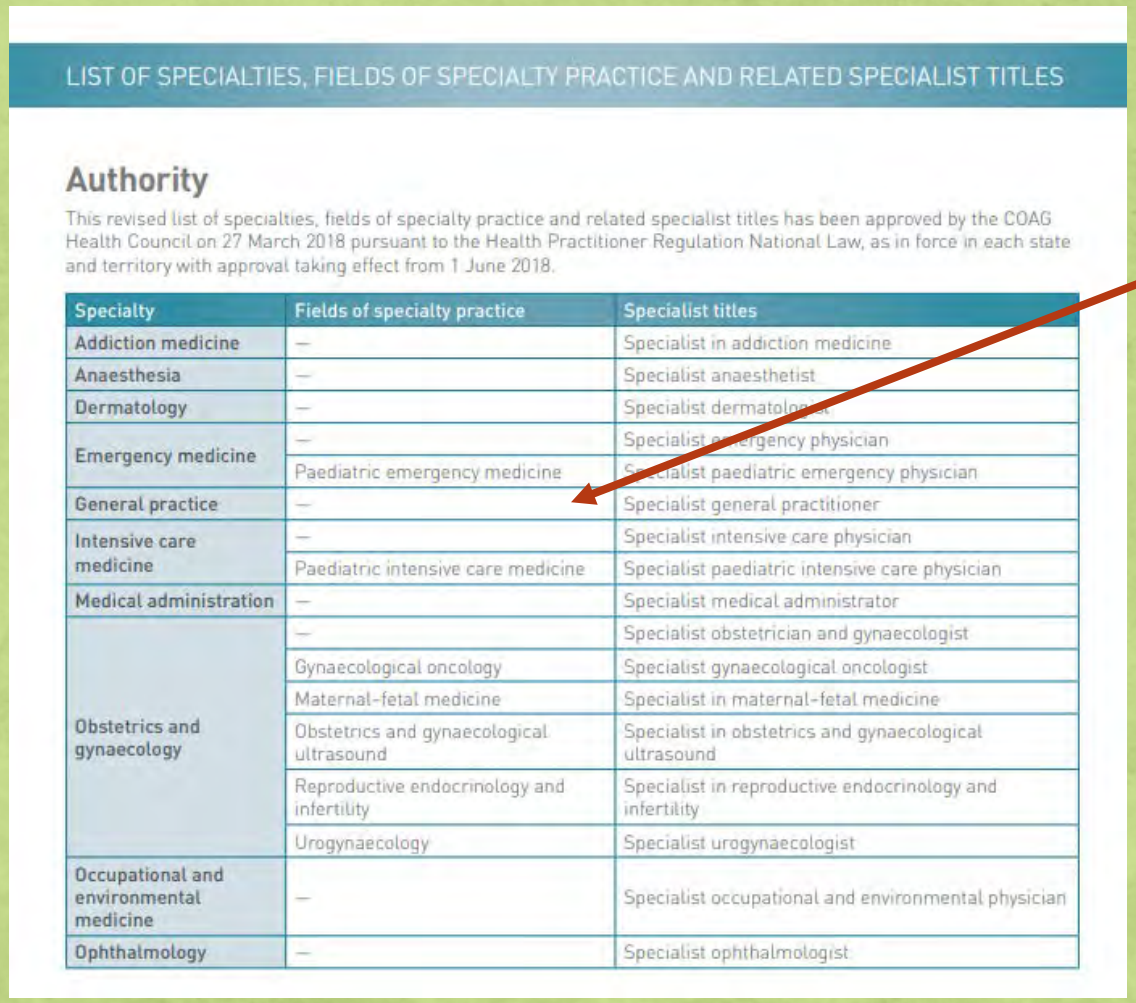
ACRRM Fellowship:

- FACRRM qualification
- Core Generalist Training (3 yrs) incl. hospital and emergency and primary care in flexible settings
- Advanced Specialised Training (1-2 yrs) in 1 of 12 fields of practice (inc. obstetrics, mental health, anaesthetics, paediatrics, remote health, palliative care, Aboriginal and Torres Strait Islander health)
- Program assessment standard - capacity for safe, quality practice in circumstances of relative clinical isolation (incl. considers pop health, Indigenous health, support staff, patient transport etc.)

RACGP Fellowship (RG):

- FRACGP/FARGP qualification
- Hospital term (12 months)
- General Practice community-based training in a rural setting (18 months)
- Advanced Rural Skills Training in a number of fields of practice (12 months)
- Emergency Medicine Core Training 6 months

Recognition as a specialist field



LIST OF SPECIALTIES, FIELDS OF SPECIALTY PRACTICE AND RELATED SPECIALIST TITLES

Authority

This revised list of specialties, fields of specialty practice and related specialist titles has been approved by the COAG Health Council on 27 March 2018 pursuant to the Health Practitioner Regulation National Law, as in force in each state and territory with approval taking effect from 1 June 2018.

Specialty	Fields of specialty practice	Specialist titles
Addiction medicine	—	Specialist in addiction medicine
Anaesthesia	—	Specialist anaesthetist
Dermatology	—	Specialist dermatologist
Emergency medicine	—	Specialist emergency physician
	Paediatric emergency medicine	Specialist paediatric emergency physician
General practice	—	Specialist general practitioner
Intensive care medicine	—	Specialist intensive care physician
	Paediatric intensive care medicine	Specialist paediatric intensive care physician
Medical administration	—	Specialist medical administrator
Obstetrics and gynaecology	—	Specialist obstetrician and gynaecologist
	Gynaecological oncology	Specialist gynaecological oncologist
	Maternal-fetal medicine	Specialist in maternal-fetal medicine
	Obstetrics and gynaecological ultrasound	Specialist in obstetrics and gynaecological ultrasound
	Reproductive endocrinology and infertility	Specialist in reproductive endocrinology and infertility
	Urogynaecology	Specialist urogynaecologist
Occupational and environmental medicine	—	Specialist occupational and environmental physician
Ophthalmology	—	Specialist ophthalmologist

Rural generalist medicine

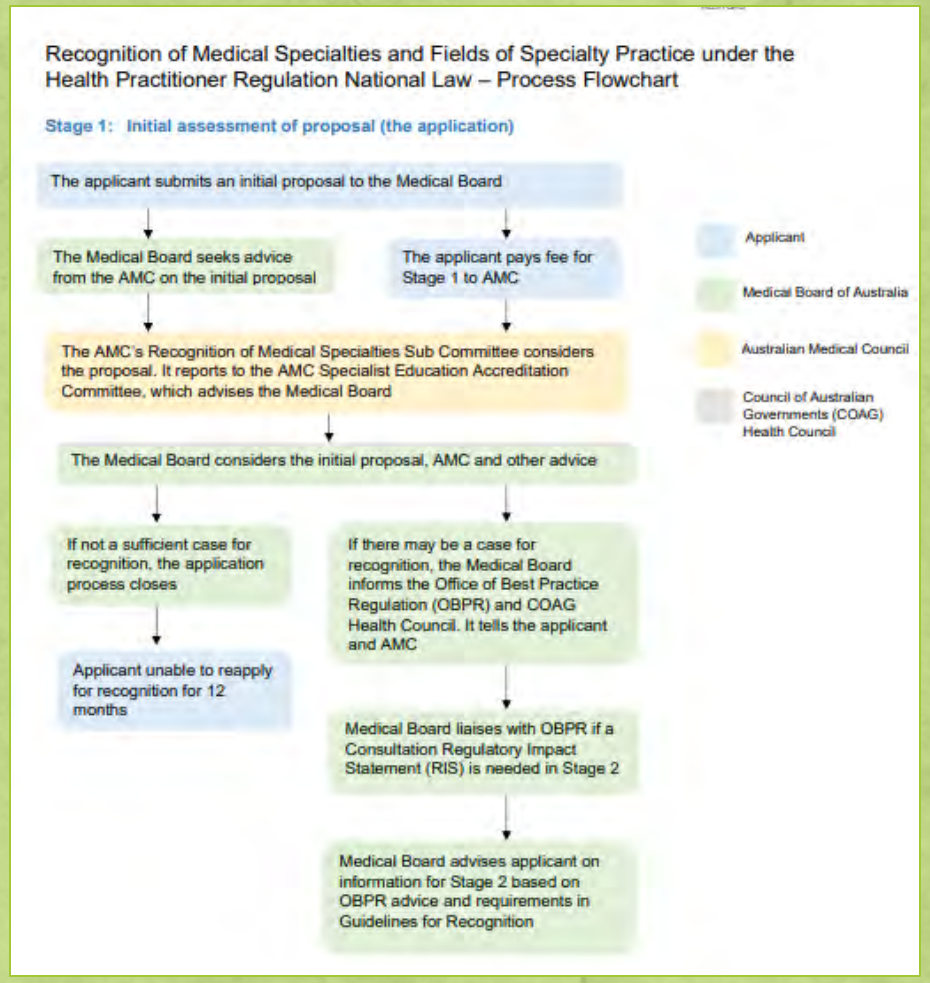
Why is recognition needed?

- Consistency and portability of qualifications
- Coordinated training pathway
- Recognition in workforce, systems, budget and policy planning
- Consistent professional standard for quality and safety purposes
- Simplicity of compliance and administration
- Job title enables career promotion

Application to Medical Board of Australia

Assessment Process

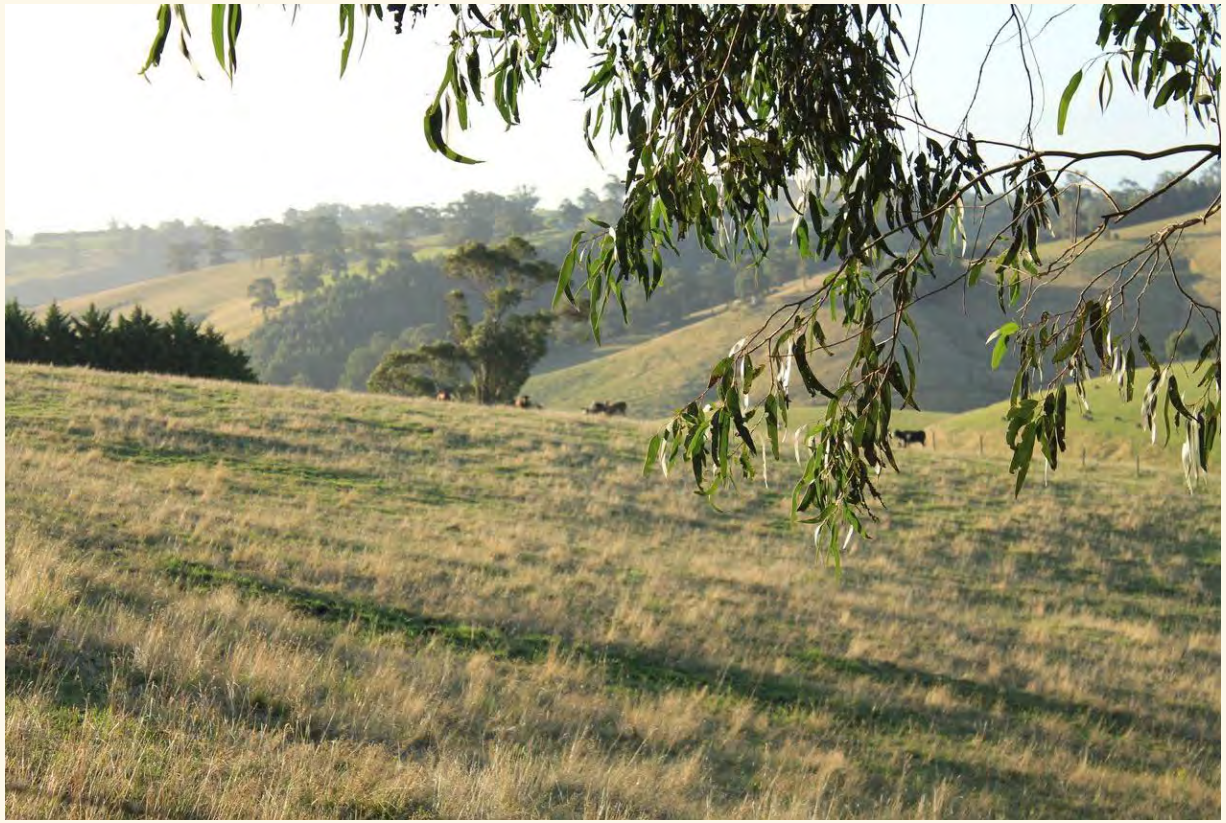
- Dec 2019 submitted stage 1 application to MBA
- AMC assess and advise MBA
- Aug 2020 MBA seek further information
- If approved, progress to full assessment
- May require Office of Best Practice review
- Expected 18-month full assessment and consultation
- Final approval by COAG Health Council



Process going forward

- Feedback invited from Colleges for MBA assessment
- Taskforce can provide further information or discuss individually
- Taskforce aims to supply further information at beginning of 2021
- Expects application and consultation process to continue for at least 18 months

Questions?



Maternity services at Emerald Hc

https://www.health.qld.gov.au/cq/hospitals/emerald/services/maternity

Office of the CEO -... Home google - Google Se... The World Clock M... Connect@ACRRM... Bookmarks

Health alerts: Coronavirus (COVID-19)

Queensland Government
Queensland Health

Contact us | Help Search

Public health & wellbeing | Clinical practice | Health system & governance | Employment | Research & reports | News & events

Attachment 2.1 Sample consumer information

Home > Central Queensland Hospital and Health Service > Hospitals > Emerald Hospital > CQ Health services in Emerald > Maternity services at Emerald Hospital

Welcome to CQ Health

- Home
- [+] Keeping you informed
- [+] About us
- [+] Patients and visitors
- Refer your patient
- [+] Get involved
- [+] Careers
- Services
- [+] Hospitals
- [+] Contact us
- [+] Connect with us

Maternity services at Emerald Hospital

We provide quality women and family-centred care in a safe environment.

Emerald Hospital is the birthing hub for the Central Highlands region which is the size of Tasmania. The region includes :

- Tieri
- Capella
- Springsure
- Blackwater
- Springsure
- Rolleston
- Gem Fields
- Clermont
- Middlemount
- Alpha
- Blackall

The maternity care options available include:

- Midwifery Group practice
- Hospital care provided by the standard team Midwives and Rural Generalist Senior Medical Officers
- Shared Care
- General Practitioners

Emerald Hospital also offers VBACs (Vaginal Births After Caesarean) and delivers patients who have gestational diabetes on insulin.

We care for you throughout your pregnancy journey, before and during birth and beyond.

When to come to hospital

Please come to the maternity unit immediately if:

- your waters have broken
- you have bleeding from the vagina
- you are having regular pains or contractions 5*:0 minutes apart
- you have severe abdominal pain
- there are any changes in your baby's movements. For example, if the movements are less frequent, more than usual or if you have any other concerns around your baby's movements.

Please phone the maternity unit before coming in, if you have time.

Visitors

Check the visiting hours page for the latest information about visiting hours in CQ Health hospitals.

Photographs and video

You are encouraged to bring a camera to capture special memories. If you wish to photograph/video the birth please speak with the midwife or doctor caring for you.

While we aim to make this a positive experience for you, please understand your midwife or doctor may not wish to be included in images of your birth.

Contact us

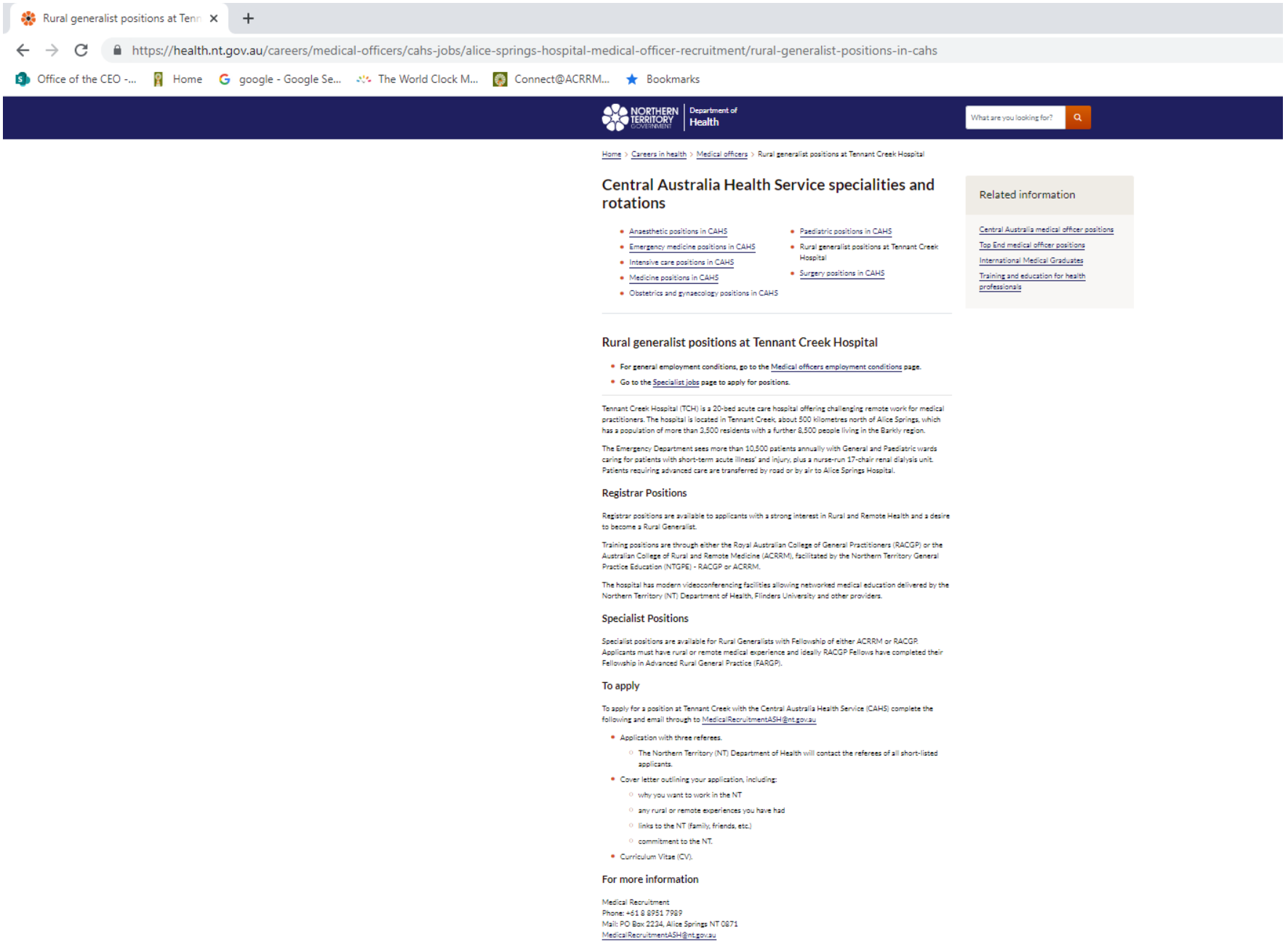
Maternity Unit
Emerald Hospital
Hospital Road

Phone: (07) 4987 9453

Please ring the maternity unit before coming in so we can be prepared for your arrival.

Antenatal classes are now available online.

Attachment 2.2 Sample Rural Generalist Job Advertisements



Rural generalist positions at Tenn

https://health.nt.gov.au/careers/medical-officers/cahs-jobs/alice-springs-hospital-medical-officer-recruitment/rural-generalist-positions-in-cahs

Office of the CEO -... Home google - Google Se... The World Clock M... Connect@ACRRM... Bookmarks

NORTHERN TERRITORY GOVERNMENT | Department of Health

What are you looking for?

Home > Careers in health > Medical officers > Rural generalist positions at Tennant Creek Hospital

Central Australia Health Service specialities and rotations

- Anaesthetic positions in CAHS
- Emergency medicine positions in CAHS
- Intensive care positions in CAHS
- Medicine positions in CAHS
- Obstetrics and gynaecology positions in CAHS
- Paediatric positions in CAHS
- Rural generalist positions at Tennant Creek Hospital
- Surgery positions in CAHS

Related information

- Central Australia medical officer positions
- Top End medical officer positions
- International Medical Graduates
- Training and education for health professionals

Rural generalist positions at Tennant Creek Hospital

- For general employment conditions, go to the Medical officers employment conditions page.
- Go to the Specialist jobs page to apply for positions.

Tennant Creek Hospital (TCH) is a 20-bed acute care hospital offering challenging remote work for medical practitioners. The hospital is located in Tennant Creek, about 500 kilometres north of Alice Springs, which has a population of more than 3,500 residents with a further 8,500 people living in the Barkly region.

The Emergency Department sees more than 10,500 patients annually with General and Paediatric wards caring for patients with short-term acute illness' and injury, plus a nurse-run 17-chair renal dialysis unit. Patients requiring advanced care are transferred by road or by air to Alice Springs Hospital.

Registrar Positions

Registrar positions are available to applicants with a strong interest in Rural and Remote Health and a desire to become a Rural Generalist.

Training positions are through either the Royal Australian College of General Practitioners (RACGP) or the Australian College of Rural and Remote Medicine (ACRRM), facilitated by the Northern Territory General Practice Education (NTGPE) - RACGP or ACRRM.

The hospital has modern videoconferencing facilities allowing networked medical education delivered by the Northern Territory (NT) Department of Health, Flinders University and other providers.

Specialist Positions

Specialist positions are available for Rural Generalists with Fellowship of either ACRRM or RACGP. Applicants must have rural or remote medical experience and ideally RACGP Fellows have completed their Fellowship in Advanced Rural General Practice (FARGP).

To apply

To apply for a position at Tennant Creek with the Central Australia Health Service (CAHS) complete the following and email through to MedicalRecruitmentASH@nt.gov.au

- Application with three referees.
  - The Northern Territory (NT) Department of Health will contact the referees of all short-listed applicants.
- Cover letter outlining your application, including:
  - why you want to work in the NT
  - any rural or remote experiences you have had
  - links to the NT (family, friends, etc.)
  - commitment to the NT.
- Curriculum Vitae (CV).

For more information

Medical Recruitment
Phone: +61 8 8951 7989
Mail: PO Box 2234, Alice Springs NT 0871
MedicalRecruitmentASH@nt.gov.au

SMO (Rural Generalist preferred) - DOOMADGEE Hospital

North West Hospital and Health Service
Western QLD
Government & Defence > Government - State
Full Time

Posted 4d ago

More jobs from this company

Apply for this job | Save job

North West Hospital and Health Service (NWHHS)

- **Unique locations, friendly communities**
- **Regional, rural and remote $$$ incentives**

Covering a region of approx. 300 000 km2 the NWHHS delivers effective, high quality, and accessible public hospital and healthcare services to the residents of the Outback communities within North Western Queensland and the Gulf of Carpentaria.

As an employer we focus on positive health outcomes for the people of our region and embrace innovative ways to achieve this and support our staff to flourish in their careers.

If you are finding the urban healthcare environment a little uninspiring, you will likely find substantial satisfaction in the challenge of a diverse caseload and meaningful community engagement on offer when working at regional, rural or remote facilities.

The Benefits

Our HHS values professionalism, leadership capability, excellence and resilience in our staff. To attract top tier candidates we offer generous remuneration packages and employment benefits that include:

Base salary rates $159,456 - $220,268 per annum (full-time) or $75.60 - $129.50 per hour (part-time) (L13-L25 dependant upon qualifications, skills and experience) with an attraction and retention allowance of 50% of base annual salary, a rural and regional allowance of 15% of base annual salary, an inaccessibility allowance of $18,744 per annum, motor vehicle allowance between $21,300 to $23,500 p.a., professional development allowance of $21,000 p.a. (with 3.6 weeks PD leave p.a.), 5 weeks p.a. recreational leave with 17.5% loading, FREE ACCOMMODATION, and fly-in/fly-out roster options.

The role:

Doomadgee is a community in the northwest of Queensland, located in the Gulf of Carpentaria, approximately 140km from the Northern Territory border and 93km west of Burketown.

The township is not an Outback tourist destination but a successful, largely Indigenous, community, being the traditional homelands of the Gangalidda and Waanyi people, and is governed by the Doomadgee Aboriginal Shire Council.

Many other people from Indigenous nations across Australia have also made Doomadgee their home including the Garawa and Yanyuwa people.

Doomadgee Hospital is a Level Two (2) remote hospital under the Rural and Remote Clinical Services Capability Framework with seven (7) inpatient beds. The facility provides 24 hour acute inpatient and accident and emergency care, as well as a GP clinic. Culturally appropriate services are provided by Aboriginal and Torres Strait Islander Health Workers, nursing, medical, administration and operational staff members working as a multidisciplinary team to achieve optimal patient care and health outcomes.

Your primary role will be as the sole doctor will be providing clinical care for the community. As such you will be seeing patients in three (3) clinical settings: firstly, in a primary care clinic; secondly in the Emergency Department, and thirdly as in-patients on the ward.

Mandatory requirements are a relevant tertiary degree qualification and appropriate registration/licences (please refer to the Role Description for full details). Pre-employment screening, including criminal history checks and Vaccine Preventable Diseases (VPD) risk risk compliance will be conducted for the successful candidate.

Interested?

Potential employees are encouraged to research and familiarise themselves with the location, facilities and position conditions.

Contact: Christoena Pfeffer, Medical Workforce Unit, 07 4744 4882

Apply ONLINE by: Wednesday 14 July 2021

Download the Role Description for future reference and interview preparation.

Be careful
Don't provide your bank or credit card details when applying for jobs.
Learn how to protect yourself here

Attachment 2.3

Department of Health

Queensland rural and remote health service framework

June 2014

Great state. Great opportunity.

Queensland Government

This document has been prepared as a guide to assist Hospital and Health Services (HHSs) in partnership with communities and other service providers to undertake rigorous and transparent needs-based health service planning in rural and remote communities. Each community is unique and therefore planning should be tailored to community requirements.

Assistance is available to undertake the health service planning process for rural and remote communities.

Queensland rural and remote health service framework

Published by the State of Queensland (Queensland Health), June 2014

For more information contact:
System Policy and Performance
Department of Health
GPO Box 48
Brisbane QLD 4001

email statewide_planning@health.qld.gov.au, phone 07 3234 0461.

An electronic version of this document is available at www.health.qld.gov.au

QH251 06/14

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Acknowledgements

The *Queensland rural and remote service framework* was prepared by the Integrated Planning Unit, Policy and Planning Branch with the assistance of:

- members of the Statewide Rural and Remote Clinical Network
- public, private and primary healthcare sector stakeholders from across Queensland who participated in the statewide consultation process
- Department of Health divisions and commercialised business units' staff
- Hospital and Health Services' staff.

Director-General's foreword

The *Queensland rural and remote health service framework* (the framework) has been developed to support Hospital and Health Services in their planning for and delivery of sustainable services to improve the health equity of residents living in rural and remote communities across the state.

Recognising the unique challenges of providing healthcare in rural and remote Queensland, the framework provides an overview of the health service mix, health service capability and workforce profile associated with rural and remote health facilities. Underpinning this new classification is the principle that health services at all levels operate within a health service network, providing timely access to quality and safe care aligned to patient need.

This framework will support achievement of the vision for rural and remote health services as articulated in *Better Health for the Bush: A plan for safe applicable healthcare for rural and remote Queensland*.

Developed by the Statewide Rural and Remote Clinical Network, a group that draws on the collective experience of rural clinicians across Queensland, *Better Health for the Bush* provides a roadmap for the future of rural and remote healthcare that is being backed by an increased investment in frontline service delivery and key enablers such as telehealth and new workforce models.

The framework lays the foundation for a supported approach to effective coordinated care, whilst enabling flexibility to recognise local circumstances.

I encourage those involved in the planning, funding or delivery of health services in rural and remote Queensland to familiarise yourself with both documents.

Ian Maynard
Director-General
Queensland Health

1. Introduction

Queensland is Australia's second largest state, covering 1,722,000 square kilometres. In rural and remote areas of the state the challenge of providing access to health services is magnified by geographical distance. In addition, no two communities are alike. Some rural communities are experiencing rapid growth associated with resource and mining development, while others have an ageing and diminishing population.

Limited and ageing infrastructure and higher costs associated with healthcare delivery are common challenges[1]. In this context it is essential that health services are well planned, with the capability to respond effectively to changes in the level and profile of health need.

As identified in the *Blueprint for better healthcare in Queensland* and *Better Health for the Bush*, improving access to a new generation of safe and sustainable health services for residents of small rural or remote communities is a priority. An example of this commitment is the increased investment in telehealth. Queensland has one of the largest managed telehealth networks in Australia and the benefits to patients and staff include:

- increased access to specialist clinical services through linkages with regional and Brisbane based specialist services, reducing the need for patients to travel and take extended time away from family and work
- increased support for local staff to manage emergency presentations while awaiting transfer to higher level health services
- improved networking and communication across health service networks including providers outside of the public health system
- increased access to professional development opportunities for rural and remote staff.

The telehealth network is continuing to expand and is supporting other innovative service responses in rural and remote areas. While larger rural communities are generally able to support a traditional hospital and specialised service models, increasing remoteness and diminishing population size and density demands innovative service responses. Emergent service models are increasingly based on a generalist workforce and involve strategic partnerships with other healthcare providers. These new models require public hospital services that are seamlessly integrated with the services of other healthcare providers including the Queensland Ambulance Service, private general practitioners, non-government providers, and community and aged care service providers.

Hospital and Health Services (HHSs) are responsible for leading local health improvements in partnership with local communities and other health and community service providers.

The *Queensland rural and remote health service framework* (the framework) supports planning and provision of health services in rural and remote communities across Queensland with the intent to:

- improve the health equity of Queenslanders living in rural and remote Queensland
- support people living in rural and remote Queensland to access a sustainable configuration of health services
- plan and operationalise locally determined health services that better meet the health needs of rural and remote communities.

[1] Australian Government, National Strategic Framework for Rural and Remote Health, 2012

2. Planning for health services in rural and remote Queensland

Factors that determine the local level of access to health services are complex. Planning processes need to support orientation of health services to better meet health needs while considering geographic location, health service networks (across HHS, regional and metropolitan areas), distribution of the population, transport networks, workforce supply, the availability of appropriate infrastructure and equipment, information communication technology requirements, and available funding.

Building on the *Guide to health service planning (v2) 2012*, a new guide, the *Rural and remote health service planning process 2013* has been prepared to support local planning in rural and remote areas. These documents promote a consistent evidence-based approach to determining future rural and remote health service requirements aligned to the following principles:

- **Person focused services**—services are integrated across the health sector (including within and across public, private and non-government systems) to facilitate continuity of care.
- **Health outcome focused services**—improving the health and wellbeing of rural and remote communities.
- **Quality services**—promoting delivery of consistent clinical practice and models of innovative service delivery staffed by a flexible and skilled workforce.
- **Safe services**—providing consistently safe and appropriately supported health services.
- **Sustainable services**—developing, integrating and delivering services in a sustainable way, making efficient and effective use of limited resources.
- **Accessible services**—delivering safe and sustainable services as close as possible to where people live.
- **Culturally appropriate services**—considering cultural diversity and the health needs of specific groups.

The Australian Government has lead responsibility for primary healthcare in Australia. State and territory governments have lead responsibility for planning hospital care. These respective roles need to be considered when planning for the following service areas which are important to rural and remote communities:

- prevention, promotion and protection
- primary healthcare
- ambulatory care
- acute care
- sub-acute care
- maternity and child health
- mental health
- aged care.

The *Rural and remote health service planning process 2013* emphasises:

- community and stakeholder engagement to ensure a shared vision and understanding of health service issues and the changes required to address the issues
- aligning existing health service delivery arrangements with changing patterns of need—identifying and addressing the health needs of service users (or potential users)
- making the most effective use of available and future resources, including partnerships with other providers.

Health services need to be provided by an appropriate, skilled and well supported health workforce[2]. Sustaining a suitable clinical workforce in rural and remote areas has been challenging for many years. The following principles and issues need to be considered.

- **Ease of employment**—simplified engagement and remuneration arrangements that can be clearly articulated to current and potential employees. Arrangements that can sufficiently accommodate the differences in service delivery, balance between public and private work, deliver incentives for rural and remote, and provide sufficient employment security to attract and retain staff.
- **Flexibility**—employment arrangements that can adapt to a range of individual circumstances and service delivery needs.
- **Portability**—employment models and arrangements that facilitate continued mobility between urban and rural opportunities over the span of a career.

[2] Australian Commonwealth Government, National Strategic Framework for Rural and Remote Health, 2012

3. Application of the *Queensland rural and remote health service framework*

The framework:

- provides a consistent approach to the classification of public rural and remote facilities in Queensland as it relates to consistency of terminology
- describes characteristics that should be considered to support sustainable and safe levels of service provision in rural and remote communities
- provides a general overview of service mix, service capability and workforce profile for each classification of rural and remote health facility
- promotes health service networks with formal links between rural and remote health services and higher level services provided from regional and specialist services.

An underpinning assumption is that local care is provided within a broader service network. Health service networks provide essential service links to ensure continuity of care for patients and are necessary for safe and sustainable integrated care. The arrangement of health service networks is a local decision for clinicians and the HHS. The use of networking mediums, such as telehealth can be used at all levels and support different types of health service delivery.

Use of the framework should at all times be considered in conjunction with the *Clinical Services Capability Framework* (CSCF). HHSs must routinely refer to the CSCF regarding minimum service and workforce requirements, and implement mitigating risk strategies for delivery of safe and sustainable health care as required. HHSs must also be mindful of requirements as set out in relevant legislation, standards, guidelines and professional workforce requirements, credentialing and scope of clinical practice.

There will be occasions when health services will be required to respond to and provide short-term care beyond the capability level of a service for patients presenting with complex health issues or emergency presentations. Individual services and facilities need to be enabled to manage emergent situations. This includes training and communication systems and support for staff in the provision and management of imminent birthing—for facilities that do not provide planned birthing care—and adult, child and neonatal emergency resuscitation capability.

On these occasions, a decision should be made about whether the patient can be managed safely at a lower level service for a period of time, and if and when the patient should be transferred to a higher level service. The decision is based on clinical judgement and requires a risk management response. The decision involves assessment of local capability and capacity, and multidisciplinary consultation with a higher level service and other appropriate stakeholders including the patients and their family. At these times, health service networks are essential in supporting local management of clinical care and facilitate (if necessary) the transfer of patients to an appropriate level of service to the patients' care needs.

4. Classification of rural and remote health facilities

To support consistent planning for health services, the framework applies consistent definitions to rural and remote health facilities—as opposed to health services within a facility—as follows:

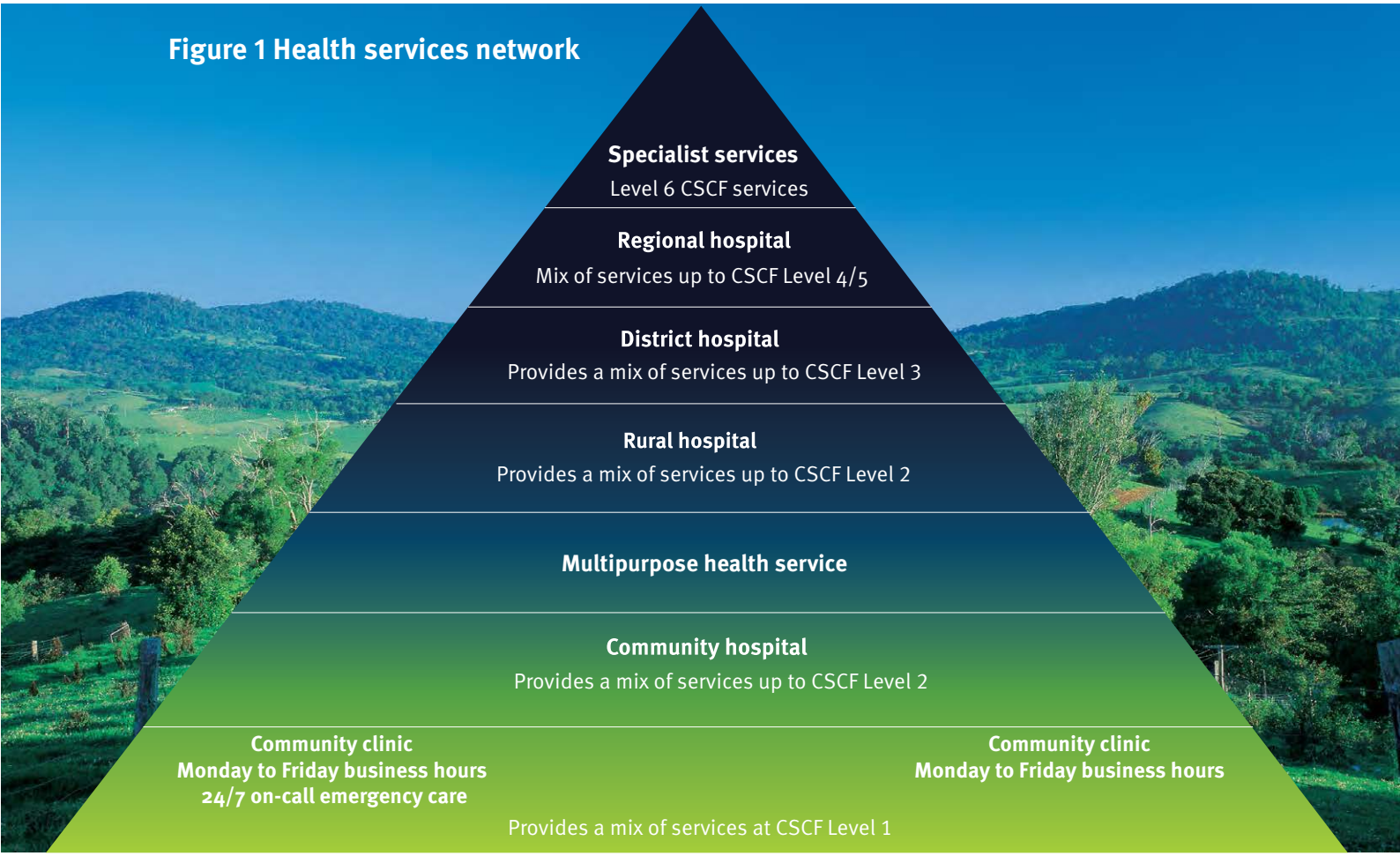
- **District hospitals**—generally serve populations of more than 4000 people and provide a comprehensive mix of CSCF Level 3 acute health services including medical, surgical, emergency and maternity. District hospitals may also provide a range of other primary, ambulatory, aged care and community services.
- **Rural hospitals**—generally serve populations of more than 2000 people and provide a comprehensive mix of CSCF Level 2 acute health services including medical, surgical, emergency and maternity. Rural hospitals may also provide a range of other primary, ambulatory, aged care and community services.
- **Multipurpose health services (MPHS)**—acute health services may be similar in mix and service capability to a rural or community hospital. MPHS also provide dedicated aged care and community care services.
- **Community hospitals**—generally serve populations with less than 2000 people and provide CSCF Level 2 acute services including medical and emergency. Community hospitals may also provide a range of other primary, ambulatory, aged care, surgical, maternity and community services.
- **Community clinics**—generally serve small populations in rural, remote and very remote locations within Queensland. Services provided at a community clinic include treatment and triage for lower acuity medical conditions and minor procedures plus life support and stabilisation prior to transfer to a higher level health service. They may also provide a range of other primary, ambulatory, aged care, prenatal care, postnatal care and community services. Community clinics have two types of operating hours for services:
  - a community clinic with after-hours emergency care is characteristically provided in locations that are a distance of more than 80 kms (or one hour where poor or no road access) from a higher level health service. These clinics provide services Monday to Friday with emergency on call 24 hours, 7 days per week. The ambulance service is provided by a registered nurse or paramedic in association with or from the clinic.
  - a community clinic that is characteristically within 80 kms (or less than one hour by road) from a higher level health service, will provide care between Monday to Friday during business hours only.

Regional and metropolitian health facilities are not in scope of the *Queensland rural and remote health service framework*. All facilities covered by the classifications noted above should operate as part of a larger health service network including regional specialist services and metropolitan specialist services provided at CSCF Levels 4, 5 and 6.

Collaborating across health service networks provides essential service links to ensure continuity of care and integrated levels of care for safe and sustainable services to meet community need. Refer to CSCF summary for generic descriptors of CSCF Level 1 to 6.

A range of agencies from the public, private and not-for-profit sectors are likely to provide services at any one facility. In support of providing care as close to home as is safe and appropriate, levels of services can rise temporarily when local clinicians' provide more complex care, such as renal dialysis or chemotherapy, or visiting or outreach services are provided at the facility, such as mental health or surgical and anaesthetic services. For example, a rural hospital that generally provides CSCF Level 2 services could provide CSCF Level 3 or 4 services, on an ad hoc or planned basis with the support of higher level services and/or with visiting/outreach specialist services.
Figure 1 illustrates the health services network.

Figure 1 Health services network



The following sections more fully describe the characteristics associated with district, rural and community hospitals, multipurpose health services and community clinics.

Workforce profiles included in the charactistics do not provide staffing ratios, absolute skill mix, or clerical or administration workforce requirements. These are best determined locally in line with minimum standards.

5. District hospital

A facility named a district hospital provides a mix of CSCF Level 3 services. A clinical service may rise a CSCF level—temporarily—when local clinicians' provide more complex care or a specialist outreach service is provided.

Health services provided will be informed by:

- local patient and community needs and broader health service networks
- access to other health providers including HHSs
- the range of mediums to support face to face service delivery, including telehealth
- a facility's location—Australian Standard Geographical Classification (ASGC) remoteness area category—and proximity to higher level services
- CSCF service description/requirements, workforce, support service requirements and risk conditions.

Note: HHSs must refer to the CSCF for detail regarding service and workforce requirements in the planning and delivery of safe and sustainable rural and remote healthcare services.

The following table outlines the core, enhanced, clinical and support, aged care services and workforce profile.

District hospital characteristics and services	
Characteristics: • serves rural population catchments of more than 4000 people • National Weighted Activity Unit (NWAUs) are categorised according to the Independent Hospital Pricing Authority and include — Group E hospital (1050-1499.9 NWAUs) — Group F hospital (1500-2649.9 NWAUs) — Group G hospital (2650+ NWAUs).	Core services: • emergency service • medical service • children's medical service • surgical service • children's surgical service • anaesthetics service • children's anaesthetic service • selected outpatient services • palliative care service • cardiac medicine service • mental health services • maternity service • neonatal service • peri-operative service including operating suite service, post-anaesthetic service • medication service • medical imaging service • pathology service.

District hospital characteristics and services
Enhanced services—in line with patient need: • medical oncology service • rehabilitation service • renal service • endoscopy service • cardiac diagnostic service.
Clinical and support services—in line with community health needs: • Aboriginal and Torres Strait Islander support services • alcohol tobacco and other drugs service • allied health service • chronic disease management service • community nursing service • dental/oral health service • general practice service • geriatric evaluation and management service • infection prevention and control program • population health service.
Workforce profile may include: • workforce to provide reliable 24-hour cover • registered medical practitioners who may have additional qualifications as a rural generalist, a general practitioner or advanced skills in areas required by the service • part of workforce may be provided by visiting registered medical practitioners • nursing staff including enrolled nurses and registered nurses who may have additional qualifications and specific expertise such as a nurse practitioner • midwives and/or nurse midwives • radiographer/sonographer, radiographer onsite providing a full scope radiography service and supporting local X-ray operators • pharmacist onsite or via telehealth • laboratory scientist on duty/available • allied health including (but not limited to) physiotherapist, dietitian, occupational therapist, speech therapist, social worker, psychologist, podiatrist (may be provided from community or non-government service) • health care workers/personal carers • Aboriginal and Torres Strait Islander health practitioners—dependant on population need • expanded and new clinical roles such as physician assistants and non-medical proceduralists • clerical and administrative support • operational staff such as gardeners, cleaners, laundry and kitchen staff.
Aged care services may include: • residential aged care • home care packages • home and community care services.

6. Rural hospital

A facility named a rural hospital provides a mix of CSCF Level 2 services. A clinical service may rise a CSCF level—temporarily— when local clinicians' provide more complex care or a specialist outreach service is provided.

Health services provided will be informed by:

- local patient and community needs and broader health service networks
- access to other health providers including HHSs
- the range of mediums to support face-to-face service delivery, including telehealth
- a facility's location—Australian Standard Geographical Classification (ASGC) remoteness area category—and proximity to other higher level services
- CSCF service description/requirements, workforce, support service requirements and risk conditions.

Note: HHSs must refer to the CSCF for detail regarding service and workforce requirements in the planning and delivery of safe and sustainable rural and remote healthcare services.

The following table outlines the core, enhanced, clinical and support, aged care services and workforce profile.

<table>
<tr><th colspan="2">Rural hospital characteristics and services</th></tr>
<tr><td>Characteristics:
serves population catchments more than 2000 people
NWAUs are categorised according to the Independent Hospital Pricing Authority and include:
— Group D hospital (675-1049.9 NWAUs)
— Group E hospital (1050-1499.9 NWAUs)
— Group F hospital (1500-2649.9 NWAUs).</td><td>Core services:
emergency service
medical service
children's medical service
surgical service
children's surgical service
selected outpatient services
palliative care service
mental health services
neonatal service
medication service
medical imaging service—ultrasound service may be provided
pathology service.</td></tr>
<tr><td colspan="2">Enhanced services—in line with patient need:
anaesthetic service
children's anaesthetic service
cardiac medicine service
maternity service
peri-operative service including operating suite service, post-anaesthetics service
medical oncology service
rehabilitation service
renal service.</td></tr>
</table>

Rural hospital characteristics and services
Clinical and support services—in line with community health needs: • Aboriginal and Torres Strait Islander support services • alcohol tobacco and other drugs service • allied health service • chronic disease management service • community nursing service • dental/oral health service • general practice service • infection prevention and control program • population health service.
Workforce profile may include: • workforce to provide reliable 24-hour cover • registered medical practitioner who may have additional qualifications as a rural generalist, a general practitioner or advanced skills in areas required by the service • part of workforce may be provided by visiting registered medical practitioners • nursing staff including enrolled nurses and registered nurses who may have additional qualifications and specific expertise such as a nurse practitioner • midwives and/or nurse midwives • radiographer onsite providing a full scope of radiology services and supporting local X-ray operators • pharmacist provided from the hospital or the community—nurse supplied pharmaceuticals in collaboration with private pharmacy in town or district hospital • allied health including (but not limited to) physiotherapist, dietitian, occupational therapist, speech therapist, social worker, psychologist, podiatrist (may be provided from community or non-government service) • health care workers/personal carers • Aboriginal and Torres Strait Islander health practitioners—dependant on population need/ where Aboriginal population • expanded and new clinical roles such as physician assistants and non-medical proceduralists • clerical and administrative support • operational staff such as gardeners, cleaners, laundry and kitchen staff.
Aged care services may include: • residential aged care • home care packages • home and community care services.

7. Multipurpose health service

The multipurpose service program is supported by state, territory and Australian governments and aims to improve flexibility and integration of health and aged care services for small rural and remote communities. A multipurpose health service (MPHS) is generally established in populations not large enough to support a separate hospital, residential aged care and home/community care services and is characterised by:

- active community participation in planning services for their own care
- provision of quality aged care services within the local community, enabling people to be cared for close to friends and family
- opportunity to focus additional capacity/funding on addressing gaps in service delivery to meet community need
- streamlined assessment and improved communication between healthcare teams/staff
- improved opportunities for staff training, professional development and retention.

Acute services provided by a MPHS may be a similar mix and capability of health services as provided by a rural or community hospital and reference should be made to these tables and the CSCF when considering service and workforce requirements for safe and sustainable services.

8. Community hospital

A facility named a community hospital provides a mix of CSCF Level 2 services. A service may rise a CSCF level—temporarily— when local clinicians' provide more complex care or a specialist outreach service is provided.

Health services provided will be informed by:

- local patient and community needs and broader health service networks
- the range of other health providers including HHSs
- the range of mediums to support face-to-face service delivery, including telehealth
- a facility's location and proximity to higher level services
- CSCF service description/requirements, workforce, support service requirements and risk conditions.

Note: HHSs must refer to the CSCF for detail regarding service and workforce requirements in the planning and delivery of safe and sustainable rural and remote healthcare services.

The following table outlines the core, enhanced, clinical and support, aged care services and workforce profile.

<table>
<tr><th colspan="2">Community hospital characteristics and services</th></tr>
<tr><td>Characteristics:
serves population catchments less than 2000 people
NWAUs are categorised according to the Independent Hospital Pricing Authority and include:
— Group A hospital (0-199.9 NWAUs)
— Group B hospital (200-374.9 NWAUs)
— Group C hospital (375-674.9) NWAUs).</td><td>Core services:
emergency service
retrieval service
medical service
children's medical service
surgical service
children's surgical service
selected outpatient services
palliative care service
mental health services
neonatal service
medication service
medical imaging service
pathology service.</td></tr>
<tr><td colspan="2">Enhanced services—in line with patient need:
anaesthetic service
children's anaesthetic service
cardiac medicine service
maternity service
peri-operative service including operating suite service, post-anaesthetic service
medical oncology service
rehabilitation service
renal service.</td></tr>
</table>

Community hospital characteristics and services
Clinical and support services—in line with community health needs: • Aboriginal and Torres Strait Islander support services • alcohol tobacco and other drugs service • allied health service • chronic disease management service • community nursing service • dental/oral health service • general practice service • infection prevention and control program • population health service.
Workforce profile may include: • workforce to provide reliable 24-hour cover • registered medical practitioner who may have additional qualifications as a rural generalist, a general practitioner or advanced skills in areas required by the service • part of workforce may be provided by visiting registered medical practitioners • nursing staff including enrolled nurses and registered nurses who may have additional qualifications and specific expertise such as a nurse practitioner • midwives and/or nurse midwives • pharmacist provided from the hospital or the community or nurse dispenser—pharmaceuticals in collaboration with private pharmacy in town or district hospital • allied health including (but not limited to) physiotherapist, dietitian, occupational therapist, speech therapist, social worker, psychologist, podiatrist (may be provided from community or non-government service) • health care workers/personal carers • Aboriginal and Torres Strait Islander health practitioners—dependant on population need • X-ray operator • expanded and new clinical roles such as physician assistants, Aboriginal and Torres Strait Islander health practitioners and non-medical proceduralists • clerical and administrative support • operational staff such as gardeners, cleaners, laundry and kitchen staff.
Aged care services may include: • residential aged care • home care packages • home and community care services.

9. Community clinic

A facility named a community clinic provides a mix of CSCF Level 1 services. A service may rise a CSCF level—temporarily—when local clinicians provide more complex care or a specialist outreach service is provided.

Health services provided by a community clinic will be informed by and depend on:

- local patient and community needs and broader health service networks
- the range of other health providers including HHSs
- the range of ways to support face-to-face service delivery, including telehealth
- a facility's location and proximity to higher level services
- CSCF service description/requirements, workforce, support service requirements and risk conditions.

Community clinics have two types of operating hours for services, depending on distance from a higher level service: community clinics with after-hours emergency care, and community clinics that operate between Monday to Friday during business hours only.

Note: HHSs must refer to the CSCF for detail regarding service and workforce requirements in the planning and delivery of safe and sustainable rural and remote healthcare services.

The following table outlines the core, enhanced, clinical and support services and workforce profile of a community clinic with after-hours emergency care.

<table>
<tr><th colspan="2">Community clinic with after-hours emergency care characteristics and services</th></tr>
<tr><td colspan="2">Community clinic with after-hours emergency care—clinic more than 80 km (or one hour where poor or no road access) from a higher level health service.
Clinic service—Monday to Friday business hours services
Emergency service on-call 24 hours, 7 days per week
Ambulance service provided by registered nurse/paramedic in association with or from the clinic.</td></tr>
<tr><td>Characteristics:
do not admit patients, may provide short term observation
are supported by higher level services
onsite or collaborative emergency response service.</td><td>Core services:
emergency service
retrieval service
medical service
children's medical service
selected outpatient services
mental health services
neonatal service
medication service
pathology service.</td></tr>
</table>

Community clinic with after-hours emergency care characteristics and services
Enhanced services—in line with patient need: • medical imaging service • maternity service—pre and post birth care • peri-operative service—pre-operative assessment • medical oncology service • palliative care service • rehabilitation service • renal service.
Optional clinical and support services in line with community health needs: • Aboriginal and Torres Strait Islander support services • alcohol tobacco and other drugs service • allied health service • chronic disease management service • community nursing service • dental/oral health service • general practice service • infection prevention and control program • population health service.
Workforce profile may include: • nursing staff including enrolled nurses and registered nurses who may have additional qualifications and specific expertise such as a nurse practitioner • Aboriginal and Torres Strait Islander health practitioner • physician assistant • onsite paramedic • pharmacist provided from the community or nurse supplied—pharmaceuticals in collaboration with private pharmacy in town or district hospital • X-ray operator(s) • allied health including (but not limited to) physiotherapist, dietitian, occupational therapist, speech therapist, social worker, psychologist, podiatrist (may be provided from community or non-government service) • health care workers/personal carers • clerical and administrative officers • operational staff such as gardeners, cleaners, laundry and kitchen staff.

The following table outlines the core, enhanced, clinical and support services and workforce profile of a community clinic.

<table>
<tr><th colspan="2">Community clinic characteristics and services</th></tr>
<tr><td colspan="2">Community clinic—a clinic is within 80 kilometres (or less than one hour) from higher level health service, and provides care between Monday to Friday during business hours only.</td></tr>
<tr><td>Characteristics:
do not admit patients
are supported by higher level services.</td><td>Core services with Monday to Friday business hours:
medical service
children's medical service
selected outpatient services
mental health services
medication service
pathology service
neonatal service.</td></tr>
<tr><td colspan="2">Enhanced services—in line with patient need:
medical imaging service
maternity service—pre and post birth care
peri-operative service—pre-operative assessment
medical oncology service
palliative care service
rehabilitation service
renal service.</td></tr>
<tr><td colspan="2">Optional clinical and support services in line with community health needs:
Aboriginal and Torres Strait Islander support services
alcohol tobacco and other drugs service
allied health service
chronic disease management service
community nursing service
dental/oral health service
general practice service
infection prevention and control program
population health service.</td></tr>
</table>

Community clinic characteristics and services
Workforce profile may include: • nursing staff including enrolled nurses and registered nurses who may have additional qualifications and specific expertise such as a nurse practitioner • Aboriginal and Torres Strait Islander health practitioner • physician assistant • onsite paramedic • pharmacist provided from the community or nurse supplied—pharmaceuticals in collaboration with private pharmacy in town or district hospital • allied health including (but not limited to) physiotherapist, dietitian, occupational therapist, speech therapist, social worker, psychologist, podiatrist (may be provided from community or non-government service) • X-ray operator(s) • healthcare workers/personal carers • clerical and administrative officers • operational staff such as gardeners, cleaners, laundry and kitchen staff.

10. Further assistance

A range of additional resources are available to further support implementation of this framework and associated health service planning processes including:

- Blueprint for better healthcare in Queensland 2013*
- Better Health for the Bush 2014*
- Clinical Services Capability Framework for Public and Licenced Private Health Facilities*
- Guide to health service planning (v2) 2012*
- Rural and remote health service planning process 2013*
- Operational guidelines for multipurpose health services 2014*
- Consumer and Community Engagement Framework 2012*
- HHSs clinician engagement strategies and consumer and community engagement strategies (available on individual HHSs websites)
- National Strategic Framework for Rural and Remote Health 2012 (www.ruralhealthaustralia.gov.au/internet/rha/publishing.nsf/Content/NSFRRH-homepage).

*To view these documents go to www.health.qld.gov.au

11. Clinical Services Capability Framework summary

The *Clinical Services Capability Framework (CSCF)* describes the services health facilities may provide. The word 'service' refers to a clinical service provided under the auspices of an organisation or facility. 'Facility' refers to the physical structure or organisation that operates a number of services of similar or differing capability level.

Within the CSCF, clinical services are categorised into six capability levels with Level 1 managing the least complex patients and Level 6 managing the highest level of patient complexity (Figure 2).

Figure 2 Clinical services levels by complexity of care

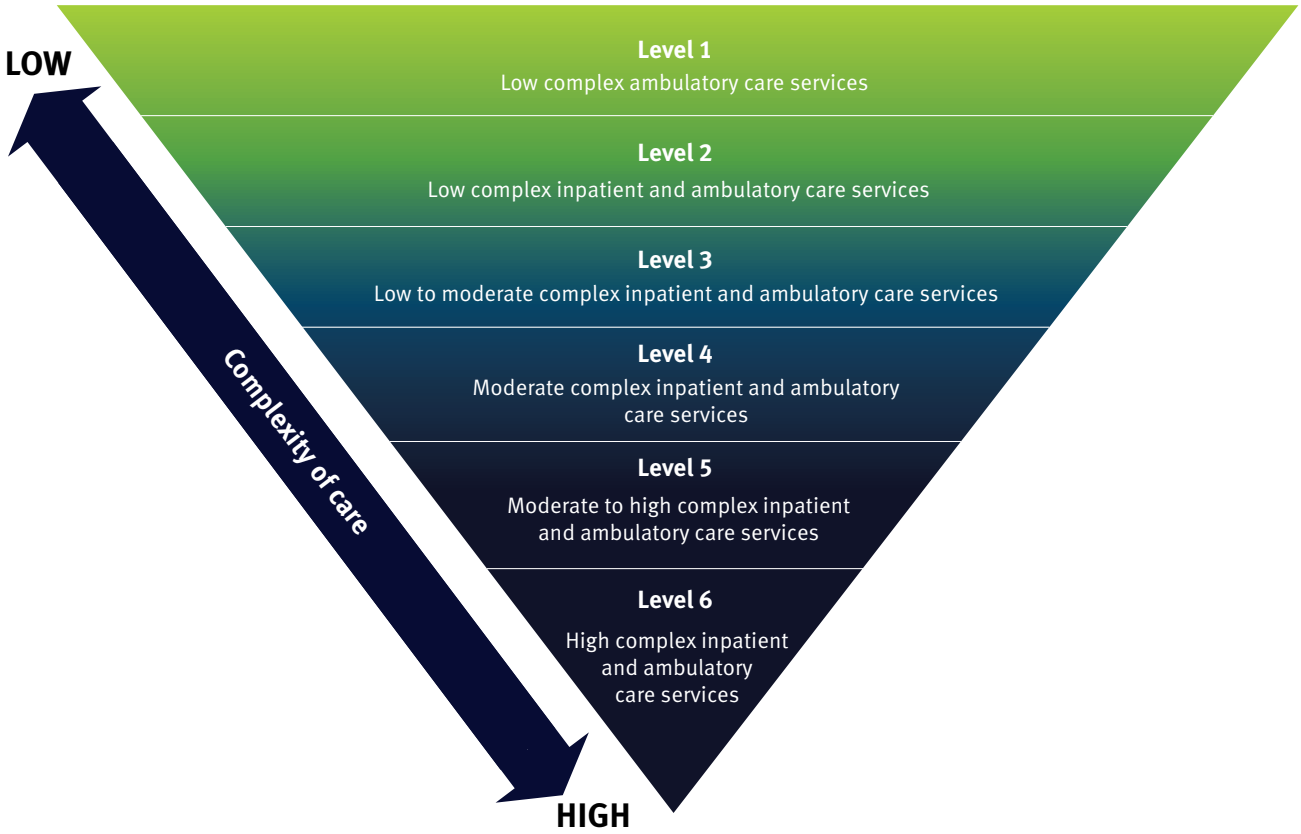


Figure 2 source: *Clinical Services Capability Framework for Public and Licensed Private Health Facilities*

As a general rule, service levels build on previous service level capability. For instance, service Level 6 should have all the capabilities of services up to Level 5, plus additional capabilities resourcing the most highly complex service. Each service level provides the additional capabilities that represent the minimum requirements for that level. A summary of the service levels appears below.

Levels of service

Level 1 service: A Level 1 service will provide a low risk ambulatory care service only, predominantly delivered by health providers (registered nurse and/or health worker) other than a registered medical practitioner. A visiting registered medical practitioner may intermittently provide a medical service and patients requiring a higher level of care can be managed for short periods before transfer to a higher level service.

Level 2 service: A Level 2 service will provide a low risk inpatient and ambulatory care service, delivered mainly by registered nurses and registered medical practitioners with admitting rights to the local hospital. There will be some limited visiting/outreach allied health services provided. A Level 2 service will manage emergency care until transfer to a higher level service. A Level 2 service may have a university affiliation including an education and teaching commitment.

Level 3 service: A Level 3 service will provide a low-risk inpatient and ambulatory care service with access to limited support services. A Level 3 service will predominantly be delivered by registered medical practitioners (available 24 hours, 7 days per week but not necessarily onsite) and registered nurses (including midwives and or nurses with speciality qualifications) with visiting day-only specialist services. Day-only specialist services may include low risk surgery, minor procedures and an education and training role (longer than day-only may be arranged). A Level 3 service will manage emergency care and will transfer to a higher level if required. A Level 3 service will have no access to an intensive care unit or high dependency unit although the service may have access to a monitored area. A Level 3 service may have a university affiliation including an education and teaching commitment.

Level 4 service: A Level 4 service will provide a low and moderate risk inpatient and ambulatory care service delivered by a variety of health professionals (medical, nursing, midwifery and allied health) including resident and visiting specialists. Medical staff will be onsite 24 hours per day, 7 days per week and an intensive care unit (may be combined with a cardiac care unit) with related support services will also be available onsite (size to be determined with review of the intensive care module). If higher level or more complicated care is required, patients may need to be transferred to a Level 5 service. Some specialist diagnostic services will also be available. A Level 4 service will have a university affiliation including an education, teaching and research commitment.

Level 5 service: A Level 5 service will manage all but the most highly complex patients and procedures. It will act as a referral service for all but the most complex service needs. This may therefore mean that highly complex high risk patients will require transfer or referral to a Level 6 service. A Level 5 service will have strong university affiliations and major teaching with some research commitments in both local and multi-centre research.

Level 6 service: A Level 6 service will be the ultimate high level service delivering complex care and acting as a referral service for all lower level services. A Level 6 service can also be a statewide super specialty service accepting referrals from health services across the state and interstate where applicable. This level of service will generally be provided at a large metropolitan hospital. This level of service will have strong university affiliations and major teaching and research commitments in both local and multi-centre research.

Glossary

Australian Standard Geographical Classification (ASGC)/Remoteness Structure/ Remoteness Areas	The Australian Standard Geographical Classification provides a common framework of geography which enables the production of statistics that are comparable and can be spatially integrated. The Remoteness Structure is part of the ASGS ABS Structures and provides a geographical standard for the publication of statistics by relative remoteness. It divides each state and territory into several regions on the basis of their relative access to services. The Remoteness Areas (RAs) divide Australia into broad geographic regions that share common characteristics of remoteness for statistical purposes. The classes of RA in the Remoteness Structure are: RA1—major city; RA2—inner regional; RA3—outer regional; RA4—remote or RA5—very remote.
Consumers	Consumers are people who use or are potential users of health services including their family and carers. Consumers may participate as individuals, groups, organisations of consumers, consumer representatives or communities. Source: *Health Consumers Queensland Consumer and Community Engagement Framework 2012*.
Community engagement	Community refers to groups of people or organisations with a common local or regional interest in health. Communities may connect through a community of place such as a neighbourhood, region, suburb; a community of interest such as patients, industry sector, profession or environment group; or a community that forms around a specific issue such as improvement to public healthcare or through groups sharing cultural backgrounds, religions or languages. Source: *Health Consumers Queensland Consumer and Community Engagement Framework 2012*.
Clinical Services Capability Framework (CSCF)	The CSCF has been designed to guide a coordinated and integrated approach to health service planning and delivery in Queensland. It applies to both public and licensed private health facilities and will enhance the provision of safe, quality services by providing service planners and service providers with a standard set of minimum capability criteria. It is updated by the Department of Health from time to time.
Health service need	Health service need refers to the gap between what services are currently provided to a given population, and what will be required in the future to improve the health status of a community (and avoid a decline). Source: *Department of Health Guide to health service planning v2 2012*.
Health service planning	Health service planning aims to improve health service delivery and/or system performance to better meet the health need of a population. It encompasses the process of aligning existing health service delivery arrangements with changing patterns of need. Source: *Department of Health Guide to health service planning v2 2012*.
Model of care	A model of care outlines best practice patient care delivery through the application of a set of service principles across identified clinical streams and patient flow continuums. An overarching design or description of how care is managed, organised and delivered within the system.

National Weighted Activity Unit (NWAUs)	NWAUs refers to National Weighted Activity Unit determined by Independent Hospital Pricing Authority. Source: www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/nec-determination-2013-14~03-nec-hosptials~3-2-calculation-rural.
Nurse practitioner	A registered nurse with extensive clinical experience and expertise, whose registration has been endorsed by the Nursing and Midwifery Board of Australia as a nurse practitioner under section 95 of the *Health Practitioner Regulation National Law Act 2009*.
Physician assistant	A clinical practitioner, trained in the medical model who works as a member of a multidisciplinary team under the delegation and supervision of a medical practitioner.
Primary healthcare	Primary healthcare is socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems. Comprehensive primary healthcare includes health promotion, illness prevention, treatment and care of the sick, community development, advocacy and rehabilitation. Source: *Australian Primary Health Care Research Institute Primary healthcare position statement 2005*.
Rural and remote community	Rural and remote communities are defined in this paper as those communities with an Australian Standard Geographical Classification (ASGC) Regional Area of RA2 and RA3—regional or Remoteness Area of RA4—remote or RA5—very remote. Source: *Australian Bureau of Statistics Australian standard geographical classification 2011*.
Rural Generalist	Through the Medical Officers' (Queensland Health) Certified Agreement (No. 1) 2005, rural generalist medicine was recognised by Queensland as a generalist discipline in May 2008. A rural generalist is defined as a rural medical practitioner who is credentialed to serve in: • hospital-based and community-based primary medical practice • hospital-based secondary medical practice: — in at least one specialist medical discipline (commonly but not limited to obstetrics, anaesthetics and surgery) — without supervision by a specialist medical practitioner in the relevant disciplines • possibly hospital-based and community-based public health practice-particularly in remote and Aboriginal and Torres Strait Islander communities.
Telehealth	Telehealth is an extension of the way we can communicate with patients, nurses, doctors and other specialists by using in most cases videoconferencing (that is basically a TV screen and a digital video camera). Telehealth allows patients in rural and remote locations to talk to and see a health professional from any hospital in Queensland, without the need to travel too far from home.

Department of Health
Queensland rural and remote health service framework

www.health.qld.gov.au

QH251 06/14

Queensland Government

Attachment 5.1 Sample letter to College President

15 December 2020

Dear A/Prof Sandford

Email: president@racma.org.au

Rural Generalist Medicine joint-application for recognition as a specialist field within general practice

Following from our presentation to the Council of Presidents of Medical Colleges (CPMC) on 18 November, please find some additional general information regarding our application. We hope this serves to address any specific questions you may have and would be pleased to address any further queries.

As discussed at the recent CPMC meeting, the Medical Board of Australia has requested that further consultation be undertaken between the two general practice colleges and all medical colleges, particularly with the specialist medical colleges that have significant commonalities with rural generalist medicine within their practice scope.

We write seeking an indication of your College's support for the application and general perspectives on it through a letter or other appropriate documentation. To assist you in this we would be pleased to arrange a meeting to discuss our position and how the proposal relates to the relationship and operations of our organisations.

To arrange a meeting or for advice on any specific questions you may have regarding the application, please contact us at recogntiontaskforce@acrrm.org.au.

Yours sincerely

Dr Sarah Chalmers
President
ACRRM

Dr Karen Price
President
RACGP

Cc Briefing to CPMC
FAQs

RURAL GENERALIST MEDICINE RECOGNITION AS A SPECIALIST FIELD

FREQUENTLY ASKED QUESTIONS

1.WHAT IS A RURAL GENERALIST?

A rural generalist is 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.

2. WHAT IS THE DIFFERENCE BETWEEN RURAL GENERALIST MEDICINE AND GENERAL PRACTICE?

Rural Generalist Medicine is a specific approach to general practice that is particularly relevant to rural and remote communities. The Rural Generalist Medicine body of skills incorporates the skillset of general practice and is specifically shaped to optimise medical service capacity in rural and remote clinical contexts.

As rural and remote settings are characterized by their restricted access to the range of services, staff and resources available in urban centers, RGs are skilled to perform a broad range of medical services, including some skills, ordinarily the province of other specialties. They are trained to apply these services in an effective way given a relatively low resource base, including working in local healthcare teams and providing local medical leadership in managing patient support from specialists and resources based in urban centers.

Rural generalist practitioners are thus a key component of the multi-professional teams that together can deliver highest quality care in rural and remote communities, which may include other rural GPs, other medical specialists, nurses, Indigenous health workers and allied health practitioners.

3. WHAT WILL CHANGE IF RURAL GENERALIST MEDICINE IS RECOGNISED AS A SPECIALIST FIELD WITHIN GENERAL PRACTICE?

The successful application to have Rural Generalist Medicine recognised as a specialised field within general practice would result in doctors with appropriate rural generalist qualifications, having these indicated in their AHPRA registration within the discipline of general practice.

It is hoped this national formalization of their qualification status will:

- enable health service quality and safety and employment systems to consistently recognise and understand these doctors' capacity and appropriately utilize their skills
- simplify the processes for training, employment and hospital credentialing for rural generalist doctors (which are currently complex and onerous due to lack of coordination)
- enable rural patients to better understand the training and capacity of their doctors
- provide a mechanism for RGs and their skillsets to be counted in rural workforce and resource planning
- Make it easier to promote rural careers as RGs to the next generation

4. HOW CAN RURAL GENERALISTS IMPROVE SERVICE PROVISION FOR RURAL AND REMOTE COMMUNITIES?

Rural generalists (RGs) are trained to deliver the fullest scope of services they safely can in a rural or remote clinical context either independently or as part of a healthcare team. For people who live in places isolated from city-based resources this scope is critical to providing them with safe, high-quality care. Many of these services are especially important to patients without the social, physical or financial capacity to travel to cities for care, such as the socio-economically disadvantaged, the aged or people with disabilities.
RGs are trained to provide continuing, primary care, as well as care in emergencies, hospital-based care and care in other medical specialist areas such as obstetrics, anaesthetics or mental health. They are also trained in telehealth, retrieval and other systems for working effectively with city-based specialists and specialised services.

5. DOES RURAL GENERALIST TRAINING PREPARE DOCTORS FOR REMOTE PRACTICE?

Yes, the term 'rural' is intended to reflect the nature of 'rural generalist' training which requires these practitioners to attain skills reflecting the needs of both rural and remote clinical contexts.

6. WILL RURAL GENERALISTS STILL BE ABLE TO PRACTICE AS GENERAL PRACTITIONERS?

Should the Medical Board of Australia confer recognition on Rural Generalist Medicine as a specialist field within general practice, rural generalist's qualifications would continue to be registered as a General Practice (GP) qualification and as such they would be eligible to practice as Vocationally Registered (VR) General Practitioners and to provide services billable under the MBS.

7. HOW IS TRAINING FOR RURAL GENERALIST MEDICINE DELIVERED?

The general practice colleges have different models for delivering rural generalist training.

- The ACRRM Fellowship qualification (FACRRM) is AMC accredited as a general practice qualification and is designed to reflect attainment of the requisite professional standards for the practice of Rural Generalist Medicine.
- The RACGP currently provides a secondary qualification of Fellowship of Advanced Rural Skills (FARGP) which combined with the AMC accredited RACGP Fellowship (FRACGP) is designed to reflect the scope of practice for quality Rural Generalist Medicine. The College is currently developing a Fellowship (FRACGP-RG) which would be standalone Rural Generalist Medicine qualification.

8. WHICH PROFESSIONAL ORGANISATION WILL HAVE RESPONSIBILITY FOR THE SPECIALIST FIELD OF RURAL GENERALIST MEDICINE?

The two general practice colleges, RACGP and ACRRM, currently provide the training, continuing Professional Development and Fellowship qualifications which the Medical Board of Australia recognises for Vocational Registration purposes for specialist general practitioners. As Rural Generalist Medicine if recognised would be a specialist field within general practice, these existing arrangements would be extended to also apply to the new field.

9. WHAT IS THE NATIONAL RURAL GENERALIST PATHWAY?

This is the name the Commonwealth Department of Health have given to their commitment to constructing a national framework to support doctors to train, qualify and practice as rural generalist practitioners in a way that is structured and consistent and which enables portability across health services and jurisdictions.

10. WHAT DOES THE RECOGNITION PROCESS INVOLVE?

An application for national recognition of Rural generalist Medicine as a specialist field within the specialty of general practice must be submitted to the Australian Medical Council (AMC) and the Medical Board of Australia (MBA) for consideration.

STAGE 1 INITIAL ASSESSMENT OF PROPOSAL

A proposal is submitted to the MBA, describing the objectives of the proposal in broad terms. The Board seeks the AMC's advice and based on this advice will determine whether the application is eligible to proceed to a stage 2 assessment.

STAGE 2 DETAILED ASSESSMENT OF PROPOSAL (APPLICATION)

During this stage, the AMC assesses the detailed case for recognition of a new field of specialty practice on behalf of the MBA. This stage is a rigorous assessment of the case that includes a public consultation process and results in a recommendation being made to the Council of Australian Government (COAG) for final approval which is projected to take around 18 months. This process may also involve an assessment of the proposal by the Commonwealth Government's Office of Best Practice Regulation.

11. HOW IS THE RECOGNITION APPLICATION PROCESS BEING COORDINATED?

The Rural Generalist Recognition Taskforce was established in June 2019 to oversee the application process. It comprises the National Rural Health Commissioner as chair and the chief executives, and senior representatives of both general practice colleges including the President of ACRRM and the RACGP Rural Council Chair.

Further information can be found on these issues at:

Rural Generalist Medicine - RACGP

Rural Generalist Medicine - ACRRM

Briefing Note

Joint-application for recognition of Rural Generalist Medicine as a specialist field with General Practice

November 2020

Purpose:
To update the Council on the purpose and progress of the joint-application to the Medical Board of Australia (Board) for recognition of Rural Generalist Medicine as a specialist field within General Practice.

Application and progress:

- Over 2017-18 the first National Rural Health Commissioner (NRHC), Prof Paul Worley was commissioned by the Commonwealth Government to undertake a national consultation and provide advice to guide the implementation of a National Rural Generalist Pathway. This work was overseen by the National Rural Generalist Taskforce which was jointly led by the NRHC and the general practice colleges. This culminated in the Taskforce Report to the Rural Health Minister which included a recommendation to seek specialist recognition of RG within the discipline of general practice.

- The Rural Generalist Recognition Taskforce was formed to action this recommendation. The Taskforce includes senior members of both general practice colleges and is chaired by the NRHC.

- The Joint-Application of RACGP and ACRRM was submitted to the Medical Board of Australia on 19 December 2019. This was an ''Initial Proposal" for first stage assessment of whether to progress to full assessment.

- The application was forwarded to the AMC Recognition of Medical Specialties Subcommittee for assessment and advice. The Board received and considered initial advice and have written to the Colleges seeking additional information to inform a final determination regarding proceeding to full assessment.

- The Colleges through the Rural Generalist Recognition Taskforce are currently working on this additional information and associated actions.

- Independently of this work the Commonwealth Government is financing the development of Rural Generalist Coordinating Units and associated state and territory-based governance bodies to oversee and support rural generalist training and practice within their respective jurisdictions. It is also establishing a national governance body.

Rural Generalist Medicine
Through the Collingrove Agreement the general practice colleges agreed to the following statement describing the specialist field:

> *A Rural Generalist (RG) is a medical practitioner who is trained to meet the specific current and future health care 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 specialist care in hospital and community settings as part of a rural healthcare team.*

Recognition as a specialist field within general practice
The joint-application seeks to have a designated Rural Generalist Medicine field established and included as an optional registration field with the general practice specialty. For doctors that meet qualification requirements and register as general practitioners, this will provide a specific designation to also recognise their assessed attainment of the distinct and broad scope of competencies associated with quality practice in rural generalist medicine. Protected title would be an outcome of this status.

Why is Rural Generalist Medicine important?
Rural and remote communities cannot sustain the broad scope of specialised resources and clinicians that are readily available to people living in cities. Their population base and hospital systems can often not viably support full-time, locally-based consultant specialists. A more flexible workforce trained in emergency response, hospital-based care and broad scope approach to primary healthcare can give them the best possible care and minimise the need for travel to cities. This is particularly important for disadvantaged groups such as disabled, sick and low socio-economic groups and remote Aboriginal and Torres Strait Islander communities.

Specialist outreach, digital health, and facilitated patient transport to cities are all important to delivering equitable care to people in rural and remote people and the rural generalist skill set includes training in telehealth and other coordinated care models. Rural generalists with advanced skills related to consultant specialists can support them and enable them to sustain work rosters.

What is the impetus for specialist recognition?
Many general practice qualified and registered doctors across Australia are trained, assessed, certified and undertake ongoing skills maintenance in the distinctive scope of rural generalist medicine. This work has no formal national recognition. This lack of national recognition has significant consequences for the viability of this workforce and the services it delivers:

- Without a title, it is difficult to promote rural generalism as a career to aspiring medical students and junior doctors
- The training pathway lacks national coordination particularly with jurisdictional health services
- As an unnamed workforce they are not included in health systems data or planning
- Jurisdictions differ in their industrial recognition and employment awards for these doctors creating barriers to job portability and qualification recognition
- Their unique skillset and training are not recognised in national or jurisdictional systems for purposes of regulations or professional standards
- An agreed standard and registration designation that the public and employers (hospitals, RFDS, AMS and private practices) can rely on will enhance quality and safety of care

Attachment 5.2 Sample letter to stakeholder

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

RACGP

12 April2021

Dr Omar Khorshid, President
Australian Medical Association
PO Box 6090
KINGSTON ACT 2604
Email: ama@ama.com.au

Dear Dr Khorshid,

Rural Generalist Medicine joint-application for recognition as a specialist field within General Practice

As you may be aware, with assistance from the National Rural Health Commissioner, the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP) are undergoing assessment of their application to the Medical Board of Australia (MBA) for recognition of Rural Generalist Medicine as a specialist field within General Practice. We write to provide you with information about our application and the opportunity to discuss these matters with us, and to seek your written support and feedback on our application.

The unacceptable inequity of access to healthcare in rural and remote areas and its consequences in terms of poorer health and safety outcomes is well evidenced and occurs against a backdrop of growing oversupply of specialist doctors in cities. The arguments for systems change cannot be clearer.

A strong, well-trained Rural Generalist workforce represents a critical piece of the infrastructure needed to enable people in these areas to have access to excellent healthcare, and health outcomes comparable with Australians living in metropolitan areas.

While, as you will be aware, there are several thousand doctors trained and working in the rural generalist model of practice across rural and remote Australia, this workforce's sustainability and growth continues to be frustrated by its lack of formal status within national health systems.

We view the attainment of recognition of the specialist field as a necessary step toward a robust national workforce. You will be aware that extensive consultation has already occurred regarding implementation of the National Rural Generalist pathway and that one of the key recommendations of the National Rural Generalist Taskforce advice was to apply for specialist title. To progress our application, the MBA has requested that a further round of engagement be undertaken between the two general practice colleges and key stakeholders in order to inform their decision on whether to proceed to a Stage 2 assessment.

We have appreciated the support of AMA for the National Rural Generalist Pathway to this point. We write seeking an indication of your support for the application and your general perspectives on it through a letter or other documentation.

To assist you in this we would be pleased to arrange a meeting to discuss or provide any additional information. To arrange a meeting or for advice on any specific questions you may have regarding the application, please contact us at recognitiontaskforce@acrrm.org.au.

Yours sincerely

Dr Sarah Chalmers
President
ACRRM

Dr Karen Price
President
RACGP

Cc A/Prof Martin Laverty, Secretary General (mlaverty@ama.com.au)
Marco Giuseppin, Chair, Council of Rural Doctors (m.giuseppin@gmail.com)

Attachments Briefing on Application
FAQs

Briefing Note

Joint-application for recognition of Rural Generalist Medicine as a specialist field with General Practice

April 2021

Purpose:
To overview the purpose and progress of the joint-application to the Medical Board of Australia (MBA) for recognition of Rural Generalist Medicine as a specialist field within General Practice.

Application and progress:

- Over 2017-18 the inaugural National Rural Health Commissioner (NRHC), Prof Paul Worley was commissioned by the Commonwealth Government to undertake a national consultation and advise on implementation of the National Rural Generalist Pathway (NRGP). This was overseen by the National Rural Generalist Taskforce. It culminated in the Taskforce Advice presented to the Rural Health Minister which included a recommendation to seek specialist recognition within the discipline of general practice.

- The Rural Generalist Recognition Taskforce was formed to action this recommendation. The Taskforce includes senior members of both general practice colleges and is chaired by the NRHC. The Commonwealth Government has provided financial support for the application.

- The Joint-Application of RACGP and ACRRM was submitted to the MBA in December 2019. This was an ''Initial Proposal" for first stage assessment of whether to progress to full assessment.

- The application was referred to the Australian Medical Council for assessment and advice. The MBA received and considered initial advice and have written seeking additional information to inform a final determination regarding proceeding to full assessment.

- The Colleges through the Taskforce are currently working on this and the associated actions. A key requirement was to undertake a second round of stakeholder consultation which focussed specifically on the application.

- It is planned that the Additional Advice will be provided in May with a view to progressing to the Second Stage Assessment later in the year.

National Rural Generalist Pathway Implementation
The Commonwealth Government is financing a range of initiatives to progress the NRGP and its implementation. The Rural Generalist Strategic Council has been established, led by the NRHC to oversee all aspects of its national implementation. These include establishing and/or strengthening Rural Generalist Coordinating Units and associated structures in all states and territories and supporting rural generalist places within the national general practice training arrangements.

Rural Generalist Medicine
Through the Collingrove Agreement the general practice colleges agreed to the following statement describing the specialist field:

> *A Rural Generalist (RG) is a medical practitioner who is trained to meet the specific current and future health care 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 specialist care in hospital and community settings as part of a rural healthcare team.

Recognition as a specialist field within general practice
The joint-application seeks to have a designated Rural Generalist Medicine field established and included as an optional registration field within the general practice specialty. For doctors that meet qualification requirements and register as general practitioners, this will provide a specific designation to also recognise their assessed attainment of the distinct and broad scope of competencies associated with quality practice in rural generalist medicine. Protected title would be an outcome of this status.

Why is Rural Generalist Medicine important?
Rural Generalist Medicine model is grounded in the goal of providing the strongest possible medical services locally.

Rural and remote communities cannot sustain the broad scope of specialised resources and clinicians that are readily available to people living in cities. Their population base and hospital systems can often not viably support full-time, locally-based consultant specialists. A more flexible workforce trained in emergency response, hospital-based care and a broad scope approach to primary healthcare can sustain local services and minimise the need for travel to cities. This is particularly important for disadvantaged groups such as the disabled, sick and low socio-economic groups as well as for people living in remote Aboriginal and Torres Strait Islander communities.

The rural generalist skill set includes working effectively in highly skilled local healthcare teams, telehealth and other coordinated care models. Rural generalists with advanced specialised skills can also support consultant specialists and enable them to sustain work rosters in rural areas.

What is the impetus for specialist recognition?
Many general practice qualified doctors across Australia are trained, assessed and certified in the distinctive scope of rural generalist medicine. Their work has no formal national recognition. This undermines the workforces' viability and that of the services they provide:

- Without a title, it is difficult to promote rural generalism as a career
- A national title for the workforce will help to build a coordinated, national training pathway through hospitals, health services and other work settings
- As an unnamed workforce, rural generalists are excluded from health services data and planning
- There is currently no mechanism for health systems to recognise the unique broad skillset and training of rural generalists for purposes of employment, regulations or professional standards*
- Lack of national title to reflect rural generalists' qualifications creates barriers to job portability
- An agreed standard and registration designation that the public and employers (hospitals, RFDS, AMS and private practices) can rely on will enhance patient quality and safety of care

* Except in Queensland and the Northern Territory.

RURAL GENERALIST MEDICINE RECOGNITION AS A SPECIALIST FIELD

FREQUENTLY ASKED QUESTIONS

1.WHAT IS A RURAL GENERALIST?

- A rural generalist is 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.

2. WHAT IS THE DIFFERENCE BETWEEN RURAL GENERALIST MEDICINE AND GENERAL PRACTICE?

Rural Generalist Medicine is a specific approach to general practice that is particularly relevant to rural and remote communities. The Rural Generalist Medicine body of skills incorporates the skillset of general practice and is specifically shaped to optimise medical service capacity in rural and remote clinical contexts.

As rural and remote settings are characterized by their restricted access to the range of services, staff and resources available in urban centers, RGs are skilled to perform a broad range of medical services, including some skills, ordinarily the province of other specialties. They are trained to apply these services in an effective way given a relatively low resource base, including working in local healthcare teams and providing local medical leadership in managing patient support from specialists and resources based in urban centers.

Rural generalist practitioners are thus a key component of the multi-professional teams that together can deliver highest quality care in rural and remote communities, which may include other rural GPs, other medical specialists, nurses, Indigenous health workers and allied health practitioners.

3. WHAT WILL CHANGE IF RURAL GENERALIST MEDICINE IS RECOGNISED AS A SPECIALIST FIELD WITHIN GENERAL PRACTICE?

The successful application to have Rural Generalist Medicine recognised as a specialised field within general practice would result in doctors with appropriate rural generalist qualifications, having these indicated in their Ahpra registration within the discipline of general practice.

It is hoped this national formalization of their qualification status will:

- enable health service quality and safety and employment systems to consistently recognise and understand these doctors' capacity and appropriately utilize their skills
- simplify the processes for training, employment and hospital credentialing for RG doctors (which are currently complex and onerous due to lack of coordination)
- enable rural patients to better understand the training and capacity of their doctors
- provide a mechanism for RGs and their skillsets to be counted in rural workforce and resource planning
- Make it easier to promote rural careers as RGs to the next generation

4. HOW CAN RURAL GENERALISTS IMPROVE SERVICE PROVISION FOR RURAL AND REMOTE COMMUNITIES?

Rural generalists (RGs) are trained to deliver the fullest scope of services they safely can in a rural or remote clinical context either independently or as part of a healthcare team. For people who live in places isolated from city-based resources this scope is critical to providing them with safe, high-quality care. Many of these services are especially important to patients without the social, physical or financial capacity to travel to cities for care, such as the socio-economically disadvantaged, the aged or people with disabilities. RGs are trained to provide continuing, primary care, as well as care in emergencies, hospital-based care and care in other medical specialist areas such as obstetrics, anaesthetics or mental health. They are also trained in telehealth, retrieval and other systems for working effectively with city-based specialists and specialised services.

5. DOES RURAL GENERALIST TRAINING PREPARE DOCTORS FOR REMOTE PRACTICE?

Yes, the term 'rural' is intended to reflect the nature of 'rural generalist' training which requires these practitioners to attain skills reflecting the needs of both rural and remote clinical contexts.

RANZCO The Royal Australian and New Zealand College of Ophthalmologists
THE LEADERS IN COLLABORATIVE EYE CARE

16 December 2020

Dr Sara Chalmers
President
ACCRM

Dr Karen Price
President
RACGP

By email: recognitiontaskforce@accrm.org.au

Dear Drs Chalmers & Price,

I refer to your letter of 15 December seeking support for Rural Generalist recognition. RANZCO is very interested in rural generalist roles and how they may support to patients with eye diseases and ophthalmologists. There are a number of areas within ophthalmology which would benefit for regular interaction with medically trained specialists by people in areas without an ophthalmologist regularly present. We would be happy to discuss this further as required.

Yours sincerely,

Dr David Andrews
CEO

Cc: Prof Nitin Verma – RANZCO President

National Rural Health Alliance

... healthy and sustainable rural, regional and remote communities

14 April 2021

Dr Sarah Chalmers
President
Australian College of Rural & Remote Medicine

Dr Karen Price
President
Royal Australian College of General Practitioners

Dear Dr Chalmers and Dr Price

Thank you for your letter of 12 April 2021 regarding the Colleges' joint application for recognition of Rural Generalist Medicine as a specialist field within General Practice.

The Alliance is pleased to provide our strong support for the application for recognition of Rural Generalist Medicine as a specialist field. The Alliance sees the role of 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 is widely acknowledged that people living in rural and remote Australia generally have poorer health outcomes compared to those living in metropolitan areas, including higher rates of hospitalisation, mortality and injury, and chronic disease. These outcomes are predominantly driven by poorer access, both geographical and financial, to primary health care and specialist services.

There are many professional, financial and personal barriers to attracting and retaining a health workforce to rural and remote Australia. The National Rural Generalist Pathway addresses many of these barriers including providing a clear and less complex training pathway, a valued and recognised qualification and support for the acquisition of a broad set of recognised skills. The benefits of rural generalist practitioners for rural communities are clear, including having access to a professional with primary health care, emergency and other medical specialty care.

We would be happy to provide further information and support if required and wish you the best in progressing this application.

Yours sincerely

Nicole O'Reilly
Chairperson
National Rural Health Alliance

Gabrielle O'Kane
Chief Executive Officer
National Rural Health Alliance

T 02 6285 4660 F 02 6285 4670 E nrha@ruralhealth.org.au W ruralhealth.org.au NRHAlliance
PO Box 280 Deakin West ACT 2600 10 Campion Street Deakin ACT 2600
ABN 68 480 848 412 ACN 620 779 606 ARBN 620 779 606

AUSTRALIAN LOCAL GOVERNMENT ASSOCIATION

22 April 2021

Dr Sarah Chalmers President ACRRM
Dr Karen Price President RACGP
Via email: recognitiontaskforce@acrrm.org.au

Dear Dr Chalmers and Dr Price

Rural Generalist Medicine joint-application for recognition as a specialist filed within General Practice

The Australian Local Government Association (ALGA) is the voice of Local Government in Australia, representing 537 councils across the nation. In structure, ALGA is a federation of State and Territory Local Government Associations.

ALGA and the state and territory local government associations have long advocated for stronger health services including improved access to general practitioners (GPs) in rural and regional areas. Councils recognise the importance of having easy access to a qualified and skilled general practitioner. Many councils have worked tirelessly to attract general practitioners to their area by maximising the support provided including providing housing and a surgery and assisting in other areas including with transport costs and childcare and supporting partners and families through the provision of social, community and employment.

Further, Councils recognise that in rural and remote communities the GP may be the only medical practitioner in the district, unlike metropolitan areas where a GP's scope of work is typically limited, and they can work closely with other medical specialists. Consequently, the rural GP may act not only as the general practitioner but also perform other roles such as emergency care, minor surgery and activities typically undertaken by an obstetrician.

We recognise that a strong, 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 Australian's living in metropolitan areas. ALGA supports your application to the Medical Board of Australia for recognition of Rural Generalist Medicine as a specialist field within General Practice.

Yours sincerely

Adrian Beresford-Wylie
Chief Executive

8 Geils Court Deakin ACT 2600 PHONE 02 6122 9400 FAX 02 6122 9401 EMAIL alga@alga.asn.au WEB www.alga.asn.au ABN: 31 008 613 876

MONASH University

MONASH
MEDICINE
NURSING AND
HEALTH SCIENCES

28 April 2021

Dr Sarah Chalmers
President
ACRRM

Dr Karen Price
President
RACGP

Dear Dr Chalmers and Dr Price,

Thank you for letter seeking an indication of our support for the application for specialist title for the National Rural Generalist Pathway. Monash University is strongly engaged with the development and promotion of this pathway, particularly through our School of Rural Health.

The National Rural Generalist Pathway is an important initiative designed to address the shortage of doctors in regional, rural and remote areas of Australia. The rural generalist pathway emphasises the importance of primary care in providing cost-effective, continuity of care to improve health outcomes for regional, rural and remote communities.

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 other medical specialities, and increases the attractiveness of the pathway as a career. This approach is preferable to establishing a new specialisation that may lead to a divide between GPs and rural generalists, restricting practice in different settings.

Monash University acknowledges the differences 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.

Yours sincerely,

C. A. Mitchell

Professor Christina Mitchell
Dean

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RURAL HEALTH COMMITTEE

Australian Medical Students' Association

AMSA Endorsement of Joint Application for Generalist Recognition

I am writing on behalf of the Australian Medical Students' Association (AMSA) to support the Joint Application between ACRRM and RACGP for Generalist Recognition.

There is no question that a strong, well-trained Rural Generalist workforce can play a key role in assisting rural and remote Australians access equitable healthcare. Indeed, that is the purpose and definition of rural generalism. However, those already working in this field identify strong barriers arising from lack of recognition on their training and lifestyle, in turn reducing the potential of this unique workforce to meet its goals.

From a student perspective, formal recognition increases the appeal of generalist training. Approximately 75% of medical students hope to complete part or all of the training/career rurally; however identify numerous obstacles to this reality - including training pathways and career progression. Further, 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.

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.

For these reasons, AMSA encourages a Second Stage Assessment to be completed by the AMC to expedite the formal recognition of a specialty crucial to supporting the next chapter of rural and regional healthcare.

Yours sincerely,

Jasmine Elliott
Chair, AMSA Rural Health
jasmine.elliott@amsa.org.au

Government of **Western Australia**
WA Country Health Service

Your Ref :
Our Ref : ED-CO-21-146190/ ITS Reference 60841
Enquiries to : Vicki Daily, Senior Project Officer, 08 6553 0940

Dr Sarah Chalmers
President, ACRRM

Dr Karen Price
President, RACGP

By Email: recognitiontaskforce@acrrm.org.au

Dear Dr Chalmers and Dr Price

RURAL GENERALIST MEDICINE JOINT-APPLICATION FOR RECOGNITION AS A SPECIALIST FIELD WITHIN GENERAL PRACTICE

Thank you for your letter dated 12 April 2021.

The WA Country Health Service (WACHS) recognises the critical importance of 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 (WA).

To support this, WACHS has established a Coordination Unit to align rural generalist training in WA and meet the objectives of the overarching National Rural Generalist Pathway. Our Coordination Unit is working closely with local and national stakeholders including the WA Department of Health and the Australian Government Department of Health.

I will ask our Coordination Unit to meet with you to discuss this proposal.

Yours sincerely

Dr Neale Fong
BOARD CHAIR

6 May 2021

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Government of South Australia

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Department for Health and Wellbeing

MHW-H21-2122

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Dr Sarah Chalmers
President ACRRM

Dr Karen Price
President RACGP

Email: recognitiontaskforce@acrrm.org.au

Dear Dr Chalmers and Dr Price

Thank you for your letter dated 12 April 2021, regarding the application for recognition of Rural Generalist Medicine as a specialist field within General Practice.

As you will be aware South Australia has a strong commitment to ensuring excellent healthcare is available to communities in regional and rural areas of the state. We recognise the critical work of the existing rural health professionals and acknowledge that the workforce is impacted by a complex range of issues, many of which are unique to their location.

Stephen Wade, the Minister for Health and Wellbeing recently launched the Rural Generalist Program South Australia as a major outcome of the Marshall Liberal government's Rural Health Workforce Strategy. Further information on the program can be found at https://www.ruralgeneralist.sa.gov.au/.

The recognition of Rural Generalist Medicine as a specialist field will to some extent depend upon the successful development of training pathways and a competency framework ensuring parity with existing specialties. This will provide the confidence and portability of the qualification that will attract trainee medical officers to the specialty.

The benefits to the workforce, health services and most importantly to the public that will be achieved through specialist recognition of Rural Generalist Medicine will be significant.

On behalf of SA Health I support the Australian College of Rural and Remote Medicine and the Royal Australian College of General Practitioners application to the Medical Board of Australia recognise Rural Generalist Medicine as a specialist field within General Practice.

Yours sincerely

DR CHRISTOPHER MCGOWAN
Chief Executive

7 / 5 / 21

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7th May 2021

Recognition Taskforce
recognitiontaskforce@acrrm.org.au

To whom this may concern,

RACGP and ACRRM Rural Generalist Medicine joint-application for recognition as a specialist field within General Practice.

The National Rural Health Student Network (NRHSN) is hereby expressing its support of the application by the National Rural Health Commissioner, the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP) for recognition of Rural Generalist Medicine as a specialist field within General Practice.

Rural generalists are doctors 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 specialist care in hospital and community settings as part of a rural healthcare team.

The unacceptable inequity of access to healthcare in rural and remote areas and its consequences in terms of poorer health and safety outcomes is well evidenced and training pathways for future rural workforce is essential in correcting these.

The NRHSN is the principal student body representing over 11,000 rural health students. As a part of the Rural Health Multidisciplinary Training (RHMT) Program the NRHSN is deeply invested in improving the recruitment and retention of rural health professionals in rural and remote Australia.

The establishment of a specialist field within General Practice would further encourage much needed engagement towards this goal. This would enhance career opportunities for students and junior doctors and outline a coordinated national pathway for students wishing to pursue a career in Rural Generalism.

Our organisation looks forward to the next steps in this development and eagerly awaits any further involvement in this process.

Yours Sincerely,

Jocelyn Ledger

Chair
National Rural Health Student Network

Keep up to date:

The NRHSN is an initiative of the Australian Government Department of Health administered as a consortium by the Rural Workforce Agencies.

Professor Robyn Ward, AM FAHMS
Executive Dean and Pro Vice-Chancellor Medicine and Health
Faculty of Medicine and Health

07 May 2021

President of the Australian College of Rural and Remote Medicine
Dr Sarah Chalmers
President of the Royal Australian College of General Practitioners
Dr Karen Price

c/o recognitiontaskforce@acrrm.org.au

Dear Drs Chalmers and Price,

Thank you for your letter of the 12th April 2021 regarding your joint application to the Medical Board of Australia for Rural Generalist Medicine recognition as a specialist field within General Practice.

As a major education provider of rural medical and other health professional training, The University of Sydney is committed to supporting the needs of rural communities and the Australian rural health workforce in medicine and other disciplines.

We currently have University of Sydney medical students undertaking training at three rural campuses in NSW, including Dubbo/Orange, Northern Rivers and Broken Hill. Over 25% of our medical students undertake extended rural placements during our MD program of one to two years in length, and over 70% undertake rural clinical placements of four or more weeks. We strongly support opportunities for students from rural communities to undertake medical training, with approximately 30% of our students having come from rural origins in our 2021 cohort. From 2022 we will also be commencing our end to end training for 25 medical students per year at our Dubbo/Orange campus.

The Faculty of Medicine and Health has a distinguished history relating to the training of doctors that meet the healthcare needs of Australian rural and remote communities. We recognise the importance of creating a medical workforce for the future in a sustainable and cost-effective way. Our MD program aims to ensure our graduates are trained to a high standard in comprehensive general practice and emergency care, and other medical specialist care in hospital and community settings that form essential parts of a rural healthcare team.

We offer our strong support for the proposal to formally recognise Rural Generalist Medicine as a specialist field within General Practice. We believe this will provide benefits to medical students, medical graduates and the rural communities they serve.

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 healthcare more broadly, as this recognition may lead to more medical graduates located in rural regions who could engage with our education and research programs. 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.

We congratulate you on this work. We hope the proposal for Rural Generalist Medicine recognition is supported by the Medical Board of Australia and believe it will provide new opportunities for our medical graduates to undertake careers in rural medicine.

Yours sincerely

Robyn Ward AM FAHMS
Executive Dean and Pro Vice-Chancellor Medicine and Health

Department of Health

GPO Box 125, HOBART TAS 7001, Australia
Web: www.health.tas.gov.au

Tasmanian Government

Contact: Dr Allison Turnock
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WITS: 121145

Dr Sarah Chalmers
President
Australian College of Rural and Remote Medicine

Dr Karen Price
President
Royal Australian College of General Practitioners

Email: recognitiontaskforce@acrrm.org.au

Dear Drs Chalmers and Price

Subject: Recognition of Specialist Field - Rural Generalist Medicine – Joint-application

Thank you for your letter of 12 April 2021 seeking support from the Tasmanian Department of Health for the Rural Generalist Medicine joint-application to be recognised as a specialist field within General Practice.

Tasmania has a long history of training rural generalists through the work of the Australian Antarctic Division. This expertise has lead to the Centre of Antarctic, Remote and Maritime Medicine (CARMM) committee now acting as the steering group for the Tasmanian Rural Generalist Pathway – Coordination Unit (TRGP-CU).

The Tasmanian Department of Health recently released, *Health Workforce 2040,* for consultation. This document highlights medical workforce need in the north-west of Tasmania and notes the importance of a generalist workforce.

The Tasmanian Rural Generalist Pathway is one initiative underway in Tasmania to increase the medical workforce in our currently underserved rural and remote areas. This program is currently expanding under the Commonwealth Government's *Coordination Units for the development of the National Rural Generalist Pathway* program. In Tasmania, the TRGP-CU has been focussing on matching rural generalist training with the skills needed in the community.

Noting the above, the Department of Health in Tasmania supports in principle the Stage One application for the Rural Generalist Medicine joint-application for recognition as a specialist field within General Practice. We look forward to your ongoing engagement with us through subsequent stages of the process to ensure that we are working together to build a stronger rural health workforce.

Yours sincerely

Kathrine Morgan-Wicks
Secretary

10 May 2021

11 May 2021

Dr Sarah Chalmer
President
Australian College of Rural & Remote Medicine

Dr Karen Price
President
Royal Australian College of General Practitioners

By email to: recognitiontaskforce@acrrm.org.au

Dear Drs Chalmers and Price

Re: Support for joint application for recognition of Rural Generalist Medicine as a specialist field within General Practice

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is pleased to provide this letter in support of the joint application of ACRRM and RACGP for recognition of Rural Generalist Medicine as a specialist field within General Practice.

The RANZCP acknowledges the major shortages in the mental health workforce, particularly in rural and remote areas of Australia and is supportive of workforce initiatives such as rural generalist training that will improve access to mental healthcare for people living in rural and remote Australia. The RANZCP looks forward to continuing discussions with both colleges about how to increase rural training places.

As mentioned, the RANZCP plans to pursue the development of a Diploma in Psychiatry which could be used within the Rural Generalist Medicine qualification but would also be available for any medical practitioners who want to increase their skills in mental health.

RANZCP members are keen to be involved in the training and assessment of rural generalists with advanced skills in mental health and we look forward to receiving copies of the mental health program curricula of both colleges.

If you would like to discuss anything further, please don't hesitate to contact me at president@ranzcp.org.

Yours sincerely

Associate Professor John Allan
President

Ref: 2265

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13 May 2021

Dr Sarah Chalmers
President
Australian College of Rural and Remote Medicine
c/o recogntiontaskforce@acrrm.org.au

Dear Dr Chalmers

Re: Letter of support – joint-application for recognition as a specialist field within General Practice

On behalf of Indigenous Allied Health Australia (IAHA), I write to confirm IAHA's support for the joint application of the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP), for recognition of Rural Generalist Medicine as a specialist field within General Practice.

Access to health services in rural and remote Australia remains a challenge, with workforce maldistribution a key factor. 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 health care teams. Recognition of Rural Generalists as a specialist field may support increased uptake of the pathway and help ensure the sustainability of the profession.

We endorse the application made to the Medical Board of Australia and wish ACRRM and RACGP well with the ongoing development of the Rural Generalist workforce.

Should you wish to contact IAHA regarding this letter of support, please contact IAHA Director of Policy and Research, Mr Paul Gibson, on (02) 6285 1010 or via email to paul@iaha.com.au.

Yours Sincerely

Donna Murray
Chief Executive Officer
Indigenous Allied Health Australia

THE UNIVERSITY of ADELAIDE

2021/204

Dr Sarah Chalmers
President, ACRRM
Level 2, 410 Queen Street
BRISBANE QLD 4000

Dr Karen Price
President, RACGP

Email: recognitiontaskforce@acrrm.org.au

27 April 2021

Dear Dr Chalmers and Dr Price

The University of Adelaide's Faculty of Health and Medical Sciences is a world leader in health education and research, seeking to improve health care across Australia and internationally. The integration of our research and teaching ensures our graduates are equipped to deliver the best health care and to be tomorrow's health leaders.

Within the faculty, Adelaide Rural Clinical School is responsible for providing at least 25% of medical students with a full academic year of rural clinical placement with a view to attracting students to a career in rural generalism. We are proud that currently over 20% of the alumni from ARCS are working in remote and rural Australia. There is capacity to increase this proportion of alumni with additional recognition of the role of rural doctors and with the recent development of a rural generalist training pathway in South Australia.

In South Australia, the 62 small rural hospitals (the majority of which have no resident specialist service providers) are obviously dependent on rural generalists to care for their local communities. The rural generalists 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.

We write to demonstrate our strong support for the joint Australian College of Rural and Remote Medicine and the Royal Australian College of General Practioners proposal to formally recognise rural generalism as a specialist field within General Practice.

We look forward to hearing the outcomes of the next round of engagement with key stakeholders.

Yours sincerely

Professor Benjamin Kile
BSc (Hons), LLB, PhD, FAHMS
Executive Dean, Faculty of Health and Medical Sciences

cc. Professor Lucie Walters, Adelaide Rural Clinical School

Professor Benjamin Kile
Executive Dean, Faculty of Health and Medical Sciences
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D2021/75857

07 May 2021

Dr Sarah Chalmers & Dr Karen Price
Presidents ACRRM and RACGP
recogntiontaskforce@acrrm.org.au

Dear Dr Chalmers and Dr Price

Thank you for your correspondence dated 12 April 2021 regarding the joint application for recognition of rural generalist medicine as a specialist field within general practice by the Australian Medical Council (AMC).

The Rural Doctors Association of Australia (RDAA) welcomes the opportunity to support the application and believes that recognition of rural generalist medicine is a critical element to addressing the inequity of access to health care services for Australians living in rural and remote communities.

In sites where rural generalists will predominantly train and work are Modified Monash Model (MMM) 3-7 communities. In MMM 4 there are over 220 less Full Time Equivalent medical practitioners per 100,000 population than what is in capital cities. The maldistribution is significant and this is further exaserbated when looking at non-GP specialist workforce distribution.

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 we 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 posses are essential to the health and well being 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 credentialling, 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.

Please contact Ms Peta Rutherford on 02 6239 7730 or ceo@rdaa.com.au if you have any further questions relating the matters outlined in this correspondence.

Yours sincerely

Dr John Hall
President

Dr Sarah Chalmers
President
Australian College of Rural and Remote Medicine

Dr Karen Price
President
Royal Australian College of General Practitioners
Email: c/o – J.Schneider@acrrm.org.au

Our ref S21/141

Dear Dr Chalmers and Dr Price

Thank you for writing about your colleges' application to the Medical Board of Australia for recognition of Rural Generalist medicine as a specialty field within General Practice.

I note the Medical Board of Australia has requested you undertake a further round of consultation, in addition to that of the National Rural Health Commissioner, in order to inform its decision on whether to proceed to a stage two assessment.

General practitioners providing both comprehensive general practice and emergency care and other medical specialty care in hospital and community settings are a key workforce in NSW rural communities. Recruitment and retention of the rural medical workforce is an ongoing challenge for NSW rural district hospitals. NSW is supportive of strategies and initiatives that support recruitment and retention of the rural medical workforce.

On behalf of NSW Health, I support your application proceeding to a stage two assessment on the basis that the assessment considers both the benefits and risks related to the impact of the Rural Generalist specialist field.

One of the issues in recruiting doctors to work in small rural communities is the challenge of professional isolation, maintenance of skills and balancing workforce requirements to support delivery of in-hours and after-hours services. As part of the next phase of the application process, NSW would like more information on how recognition of Rural Generalist as a speciality field within general practice will assist in addressing these issues that have a significant impact on recruitment and retention.

The definition of a Rural Generalist includes that the medical practitioner works in both the hospital and community setting. As part of the stage two assessment process, NSW would like to further understand how eligibility will be determined at the time the medical practitioner applies for recognition of Rural Generalist as a speciality field within general practice. In addition, NSW would also like to understand what would happen if the Rural Generalist subsequently ceases working in a hospital setting and/or moves to a non-rural setting.

It is noted that if Rural Generalist becomes a speciality field within general practice it will provide data on the number of Rural Generalists and this will support better workforce and service planning. However, that benefit may be minimised if the Rural Generalist does not continue to work to their full scope.

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Rural Generalists and rural general practitioners are a vital workforce in our rural communities. As part of the further assessment of the application, NSW would like more analysis on how this recognition may impact the wider rural general practitioner workforce and if this could affect recruitment and retention of rural general practitioners who are not Rural Generalists. NSW would not like to see changes that may reduce medical workforce flexibility and make management of the rural workforce more complex.

Consideration of the range of both benefits and risks during the stage two assessment will better prepare for implementation should health ministers agree to proceed with recognition of Rural Generalist medicine as a recognised specialty field.

Thank you again for writing. For more information, please contact Dr Linda MacPherson, Medical Advisor, Workforce Planning and Talent Development, NSW Ministry of Health, at linda.macpherson@health.nsw.gov.au or on 9391 9107.

Yours sincerely

Elizabeth Koff
Secretary, NSW Health

6/6/21

7 June 2021

Dr Sarah Chalmers, President
Australian College of Rural and Remote Medicine
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Dr Karen Price, President
Royal Australian College of General Practitioners
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AMA

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Dear Dr Chalmers and Dr Price,

I write in response to your letter dated 12 April 2021 regarding AMA support for recognition of rural generalist medicine as a specialist field within general practice. The AMA is supportive of this and we welcome the opportunity to work collaboratively to support the application.

The AMA supported this proposal as part of the National Rural Generalist Taskforce Advice to the National Rural Health Commissioner in 2018 and we still see this as a key part of the National Rural Generalist Pathway (NRGP).

Recognising rural generalist medicine as a protected title and specialised field within general practice will support the development of the NRGP and enhance the attractiveness of rural generalism to trainees. This will contribute to developing a workforce that can provide extended services for the healthcare needs of rural and remote communities.

Recognition of rural generalism is consistent with other medical specialties. For example, cardiology is one of several specialised fields for Specialist Physicians. All cardiologists are physicians but not all physicians choose to acquire the skills required to be recognised as cardiologists.

The AMA believes that the rural generalist title will also 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 generalists will meet the specific needs of the communities and regions where they work, building on the skills of the current rural health workforce.

The AMA understands that existing general practitioners will be able to apply for Recognition of Prior Learning for training they have completed or work they are already doing in rural communities to the scope of a Rural Generalist. We would like to ensure that this is part of the process moving forward.

The AMA is committed to solving the rural medical workforce crisis and believe that this will be an important step. You have my full support and the full support of the AMA. I look forward to collaborating on further efforts to progress the NRGP.

Yours sincerely

Dr Omar Khorshid
Federal President

RACP
Specialists. Together
EDUCATE ADVOCATE INNOVATE

From the President

7 June 2021

Dr Sarah Chalmers
President ACRRM

Dr Karen Price
President RACGP

Via email: recognitiontaskforce@acrrm.org.au

Dear Dr Chalmers and Dr Price

Rural Generalist Medicine joint application for recognition as a specialist field within general practice

Thank you for your letter 15 December 2020, and the opportunity to provide consultation feedback to the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australasian College of General Practitioners (RACGP) on the proposed joint application for recognition of Rural Generalist Medicine as a specialist field within general practice.

Rural generalists make significant contributions to rural and remote medicine while recognising the scope of practice for Rural Generalists vary between regions and states/ territories. Rural generalists support the provision of services in rural clinics and hospitals to some of our most underserved areas where attraction and retention of a health workforce is most challenging. We welcome initiatives that address community need and promote equitable access to high quality healthcare for rural and remote populations and commend ACCRM and RACGP's partnership and leadership in rural and remote health workforce development.

In formation of the RACP's feedback about the joint application, we have consulted with membership of RACP committees involved in local workforce matters, medical education, health policy and advocacy, Indigenous health, general and acute care medicine and general paediatrics. We have also consulted with our Consumer Advisory Group. Members considered the implications that recognition of Rural Generalist Medicine as a specialist field within general practice would have on consumers, rural and remote communities, the RACP and the wider healthcare sector. Overall, while there was general support and acknowledgement that the proposal would improve rural and remote medicine career pathways and workforce development, the RACP would like further consideration and detail about some of the broader impacts before determining unreserved support for the proposal.

Outlined below are some matters for consideration we identified through our consultation. We would be happy to discuss these matters further with the Recognition Taskforce.

1. **Further definition of the proposed rural generalist competencies, scope of practice and intersections with other medical professions**
   The two definitions provided in the consultation papers for a rural generalist leave some room for interpretation:

   "A Rural Generalist (RG) is a medical practitioner who is trained to meet the specific current and future health care 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 specialist care in hospital and community settings as part of a rural healthcare team." (page 2, underline added)

   "Rural generalists (RGs) are trained to deliver the fullest scope of services they safely can in a rural or remote clinical context either independently or as part of a healthcare team." (page 4, underline added)

   We understand the need for the individual practitioner's scope of practice to flex in response to local contexts however, in terms of assessing broader health workforce implications, it is important to have more specificity in terms of the expected competencies and likely scopes of work. In particular, we would like further information about how rural generalists' scope of work relates to those of general physicians and general paediatricians.

2. **Detail about how rural generalists will work with other healthcare professionals**
   Leading on from item two above, we would value more discussion about how increasing the recognition (and purportedly number) of rural generalists will impact existing models of care, affect the composition of healthcare teams and the implications for the existing rural health workforce. For example, how will rural generalists work with a patient's usual GP and rurally located general physicians and paediatricians? Considering the potentially substantial overlap of skills within healthcare teams that may include a rural generalist and a physician/paediatrician/emergency physician, how will an appropriate degree of skill redundancy be maintained to ensure care is provided effectively?

   In some rural locales, general physicians provide on-call hospital cover as well as public and private specialist general medical care in inpatient and outpatient settings. Reducing the service opportunities for general physicians may decrease the viability and attractiveness of rural practice and unintentionally reduce the availability of consultant physician level care in rural areas. Better outlining the models of care between general physicians/paediatricians and rural generalists will aid attraction, development and retention of each of these specialty workforces in rural areas.

3. **Resourcing for training and education**
   Rural physicians play a key role in the work-based training and supervision of rural generalists. Increasing the number of rural generalist trainees will require concomitant increased capacity for supervision and education.

Rural generalist trainees are likely to have clinical training experience requirements in common with basic physician trainees and general medicine/paediatrics advanced trainees. An increase in demand for these clinical experiences from rural generalist trainees may reduce opportunities for basic physician trainees and general medicine/paediatrics advanced trainees to undertake rural training experiences.

We would like to see further consideration and discussion of these educational impacts and plans to address them.

4. **Potential increase in the cost of healthcare for rural patients**
Our Consumer Advisory Group was concerned that promotion of enhanced skills and increased recognition may contribute to a rise in healthcare costs for rural patients. For example, if a general practitioner is qualified as a rural generalist, it is reasonable to speculate that they may charge a higher 'gap' payment fee than a general practitioner. We would like further information about measures to ensure this change will not contribute to an adverse financial effect on consumers.

5. **Clarity of specialist titles and fields of specialty practice**
Healthcare consumers can find the plethora of medical specialties and specialist titles confusing, especially in the context of navigating a complex health system. The proposed new field of specialty practice and specialist title are notably similar to those currently in use for general medicine:

Field of specialty practice	Specialist title
General Medicine	Specialist general physician
Rural Generalist Medicine	Specialist rural generalist

Noting that the National Law is a regulatory instrument to protect the public through the "protection of title"[1], we would suggest that the title should be sufficiently descriptive of the specialty and distinguishable from other specialist titles to support healthcare consumers to make informed choices. The title 'specialist rural generalist' may not be readily understood by consumers. While we recognise that the term rural generalist has a history, we encourage caution in the selection of this nomenclature and invite further consideration as to how the terminology will be received by and benefit consumers.

Additionally, we invite further comment regarding how general practitioners with advanced skills who are currently referred to as rural generalists will be affected by the protection of the 'specialist rural generalist' title and what recognition pathways will be developed to recognise these competencies.

6. **Rural health needs fundamental reform**
Both health workforce and health system reform are needed to improve health outcomes for rural Australians. Defining and recognising rural generalist career pathways can contribute to workforce development but there is more that needs to be done to address workforce maldistribution and to achieve fundamental health system change. We

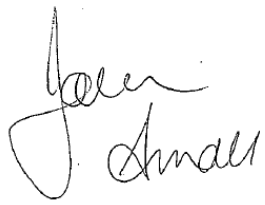
[1] Guidelines for the Recognition of Medical Specialties and Fields of Specialty Practice under the Health Practitioner Regulation National Law, p2

encourage the Recognition Taskforce to provide more detail about associated recruitment, retention and workforce distribution plans for Rural Generalists and commentary on how achieving recognition will contribute to rural health reform and improved health outcomes for rural communities.

Thank you again for the opportunity to provide comment on this application. We look forward to continued discussion and contributing to our shared goal of improving rural health outcomes through workforce development.

Should you wish to discuss this further, please do not hesitate to contact me via email: President@racp.edu.au.

Yours sincerely



Dr Jacqueline Small
President-Elect and Acting President

10th June 2021

The Project Manager
Medical Board of Australia (MBA)

Rural Generalist Medicine joint-application for recognition as a specialist field within General Practice

This letter confirms support from CRANAplus for the RACGP-ACRRM joint-application for recognition of Rural Generalist Medicine as a specialist field within General Practice.

CRANAplus, the peak professional body for remote and isolated health professionals in Australia, has enjoyed a long and successful association with both RACGP and ACRRM and their members; working together to achieve our shared strategic priorities.

I have personally met with ACRRM and RACGP to discuss the aims and objectives of the joint-application.

If successful, the RACGP-ACRRM joint-application proposal will make a significant impact in addressing the unacceptable inequity of access to healthcare in rural and remote communities and receives our strongest support.

CRANAplus has a keen interest in the development of a National Rural Generalist Pathway and endorses the adoption of a formal status within national health systems.

We note that that the National Rural Health Commissioner undertook an extensive consultation regarding a National Rural Generalist Pathway and one of the key recommendations from this was to apply for specialist title.

I am available for further comment if required via the email contact listed below.

Yours sincerely

Katherine Isbister RN/RM
Chief Executive Officer - CRANAplus
ceo@crana.org.au