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From the President

11 December 2023

Dr Joanne Katsoris
Executive Officer
Medical
Ahpra
GPO Box 9958
Melbourne Victoria 3001

Via Email: medboardconsultation@ahpra.gov.au

Dear Dr Katsoris

Consultation on the recognition of Rural Generalist Medicine

Thank you for the opportunity to provide feedback on the application by the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP) to have Rural Generalist Medicine (RGM) recognised as a new field of specialty practice within the specialty of General Practice, under the Health Practitioner Regulation National Law (National Law). The Royal Australasian College of Physicians (RACP) is genuinely committed to addressing health equity, including inequities experienced by people who live in rural and remote parts of Australia. The following comments should be viewed as arising from that position and commitment.

The RACP trains, educates and advocates on behalf of over 21,000 physicians and 9,000 trainee physicians, across Australia and New Zealand. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients and communities.

The RACP is very aware of the ongoing inequity of access to comprehensive healthcare for people living in regional, rural and remote (RRR) areas. In turn, it agrees that training, attracting and retaining skilled medical workforce in RRR areas is critical in delivering high quality healthcare services to the underserved RRR populations. Currently 11.5% of RACP Australian members live and work outside major cities. As such the RRR physician workforce is a key focus of the RACP. The RACP has recently endorsed its Regional, Rural and Remote Physician Strategy (the Strategy). The Strategy provides recommendations that will be used in seeking to expand access to specialist services to better support these

underserved populations, and to examine the role the RACP can play in such endeavours. The RACP is currently in the process of planning the strategy's implementation.

It is acknowledged that rural generalists (RGs) make a significant contribution to rural and remote medicine through the skills and expertise they offer, while recognising the scopes of practice for RGs vary between locales. The RACP welcomes initiatives that address community need and promote equitable access to high quality healthcare for RRR populations. The RACP commend ACCRM and RACGP's partnership and leadership in rural and remote health workforce development.

The RACP's feedback on this application has been drafted following thorough consultation with its two Divisions (Adult Medicine and Paediatrics and Child Health), its Faculties and Chapters, peak advisory body on strategic and cross-College issues, College Council, its education committees, and its state and territory committees, as well as relevant specialty societies.

Overall, there was general support and acknowledgement that the proposal will likely improve rural and remote medicine career pathways and workforce development.

However, the RACP would like further discussions, consideration and clarification regarding some of the perceived impacts and implications on consumer and community safety and quality of care that would need to be addressed before determining unreserved support for the proposal. The main themes of issues or concerns raised during the College's consultation were:

- Impact on regional, rural and remote models of care
- RGs scope of practice
- RGs duration of training
- RGs training and supervision, in particular the additional Rural Skills Training (ARST)/Advanced Specialised Training (AST) relevant to other specialist medical colleges. For the RACP it is palliative care, paediatric and adult and acute care medicine.
- RGs continuing professional development and maintaining currency of skills, particularly their ARST/AST.
- How RGs will interface with palliative care, paediatric and adult and acute care medicine
- Unintended consequence on RRR primary care
- Health provider and consumer perceptions of and interpretation of this new title.

Details of these themes emerging from member consultation are set out below. Detailed feedback in response to the consultation questions based on our member feedback is also attached.

Impact on RRR models of care

The RACP would like further exploration of the impact on current RRR models of care. For example, further examination of how RGs fit into the RRR health system and healthcare provision as a whole and the model of care provided to the consumer by GPs, non-GP specialists - in particular RACP member specialist groups - and allied health, and how this would impact the consumer accessing healthcare.

Our members noted that there is a risk that the expanded scope of practice of RGs compared with primary health care specialists currently trained by the RACGP may also create perverse drivers, namely of medical practitioners away from primary care to hospitalist/hospital-based practice as well as consumers preferring to access hospital-based care in RRR. Thus, this initiative may exacerbate challenges around RRR access to primary

care rather than enhancing it. This will be particularly the case if RGM recognition translates to employment award recognition, specific MBS item number allocation and, in turn, greater remuneration and employment security compared with community-based general practice.

RG's Scope of Practice

As stated in our response to the earlier consultation, the RACP understands the need for the individual practitioner's scope of practice to be flexible in response to local contexts. However, the RACP would like more clarification in terms of ARST/AST.

Of the 12 AST/ARSTs, three are specific to the RACP craft groups of palliative care, paediatrics and adult internal medicine. There is a marked and significant difference between the duration and depth of training between RACP trainees undertaking palliative care, paediatrics and adult internal medicine training (six years) to a RG's requirement of 12 months. The RG's scope of practice, continuing professional development (CPD) and maintenance of currency of skills will need to be addressed.

Additionally, this requires managing health provider employers and consumer perceptions and interpretation of this and how they differ from GPs and non-GP specialists. How will the employers and the public easily distinguish between existing non-GP specialists and this new category of GP specialist, as well as understand what the individual RG's scope of practice is compared to a GP or non-GP specialist?

We also urge consideration of how the individual RG's AST or ARST be regulated and clearly communicated to the consumer and general public in order to provide visibility and protect public safety and quality of care.

RG's Training, Continuing Education and Supervision

Of the 12 ASTs/ARSTs, three of these are provided and accredited through other specialist Colleges (Anaesthesia, Emergency Medicine, Obstetrics).

In order to ensure and maintain standards of the other AST/ARSTs relevant to other specialist medical colleges would it be a requirement for ACCRM and RACGP to work with the other specialist medical colleges to ensure quality of training, education and CPD where it is not currently being done?

For example, the RACP's Clinical Diploma (known as Clinical Foundations from 2024) in Palliative Medicine is a well-established pathway developed over many years which might be a basis for such collaboration and would provide for better training for RGs in the specialty.

Unintended consequence on RRR primary care

The RACP believes that RGs are not the only answer in providing healthcare in RRR settings. A significant unintended consequence of recognising RGM as a new field of specialty practice may be attracting current and future GPs away from the primary care model to a more RG hospital-based MBS and health service award funded model.

The RGM model is clearly defined in the consultation document as one of primary care provision associated with skills in emergency medicine and another advanced skill area. It will be key that the scope of practice of RGM as a specialty field incorporates not only accredited training in these areas but also continuing practice in all three areas, including community-based primary care. Without such a requirement, this recognition is likely to exacerbate rather than facilitate a solution to health and healthcare access in RRR areas.

As members of teams that incorporate a model of shared care with general practice, our members are concerned that this outcome would not be in the interest of our RRR communities. We are concerned this proposal may create a pathway for reducing primary care access and as a result, diversion to and inappropriate usage of already stretched RRR hospital-based services. An increase in presentations to RRR hospitals for ambulatory care-

sensitive (ACS) conditions risks the creation of a vicious cycle of more RGs moving to hospital-based practice and a further reduction in local community-based general practice.

We urge further broad consideration on potential solutions to bolstering, recognising and empowering RRR generalist practice to identify mechanisms that do not have significant negative unintended consequences and maintain the strengths of primary and interdisciplinary care.

System-wide approach to embedding generalism

We acknowledge that RGs and their recognition by Ahpra represent a potential solution when looking at one part of the RRR community health puzzle. However, to sustainably impact RRR health outcomes there needs to be a holistic solution that is built on strengthening generalism in all specialties, ensuring there are rural training opportunities and requirements across all stages of undergraduate, prevocational and vocational training, and a team-based model of care that spans the evolving and integrated roles of non-GP specialists, nurses, GPs and allied health working in RRR settings. A broader approach such as this would encourage and facilitate the performance of all health practitioners in RRR areas to operate at the upper end of their scope of practice in alignment with existing regional clinical governance frameworks and support systems.

These perspectives, which have been provided by our Divisions, Faculty, Chapter, College bodies and specialty society leadership, are further discussed under the review question headings.

Thank you again for the opportunity to provide comment on this application. We will await further clarification regarding the perceived impacts and implications outlined above and how they will be addressed before determining unreserved support for the proposal.

We look forward to continued discussion and contributing to our shared goal of improving RRR health outcomes through workforce development.

Please contact [redacted] RACP College Dean on [redacted] or [redacted] should you require further information.

Yours sincerely

[redacted]

Dr Jacqueline Small

Attachments:

1. RACP member feedback on MBA Consultation questions regarding the recognition of Rural Generalist Medicine

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Royal Australasian College of Physician Member response to Consultation on the Recognition of Rural Generalist Medicine

December 2023

Contents

1. Has the claim that regulatory action is necessary to recognise Rural Generalist Medicine as a field of specialty practice been substantiated?

- Unclear rationale for need for recognition of new field of specialty practice - It is noted that the proposal is one of the aims of the National Rural Generalist Pathway (the Pathway), an initiative of the Commonwealth Government. The National Rural Health Commissioner has been tasked by the Commonwealth Government with establishing the Pathway. It is unclear in the determination of the need of a separate specialty (i.e. 'What will be achieved, that cannot already be achieved by the existing FRACGP/FACCRM specialist entities?"). The statement that "employers and the public will continue to be unable to easily distinguish the skill set of RGs from other GPs and non-GP specialists" was felt by some RACP members to be questionable, as current employment contracts with jurisdictional health services have provision to employ GP specialists as senior medical officers in hospitals.
- RGM separate specialty rather than field of specialty practice for GP - Despite the statements from RACGP and ACCRM, some RACP members questioned if RGM were successful in becoming a new field of specialty practice, whether it should be a field of specialty practice within general practice. The scope could be better recognised as a specialty in its own right due to the greater expertise of the rural generalist in emergency care, intensive care, obstetrics and surgery, each of which is outside of general practice.
- Demonstration of competency and currency in AST/ARST - Recognition of all AST/ARST should, beyond time-based clinical experience, require a foundational assessment of competency and attainment of a formal qualification from the relevant non-GP specialist medical College. This already occurs for anaesthetics, emergency medicine and obstetrics AST/ARST. Currency of practice includes meeting the requirements of the relevant College's CPD program, or if delivered by another accredited CPD Home, meeting those requirements under the individual's scope of practice. A qualification and CPD compliance would clearly articulate which AST or ARST had been completed. This would provide clearer information and reassurance to consumers and health service employers when considering the quality, currency and scope of RG's practice.

2. Have the positive consequences of recognition of Rural Generalist Medicine as a field of specialty practice under the National Law been stated? Are there additional positive consequences that should be considered?

- Workforce benefits may be overstated - Members were concerned that benefits in terms of recruiting RGs to rural practice through creation of RGM as a new field of specialty practice under the specialty of General Practice may be overstated. A similar procedural focus in emergency medicine has not led to easy recruitment of emergency physicians to rural regions, rather virtual emergency services have emerged with retrieval medicine emerging as a specialty.
- Academic foundation and impact on quality of care and innovation – The future of a new specialty is highly dependent on having local capacity to support ongoing innovation and quality improvement in training and service delivery. Some members felt that the academic and research foundation of RGM outlined in the application may, compared with general practice as a broad specialty and other non-GP specialties, be both limited and overstated. The future of a new specialty is highly dependent on having the capacity to support innovation. What evidence is cited

refers predominantly to general practice rather than RGM specifically. Of the 17 listed 'key rural generalist appointment in universities' only one third (6/17) appear to be employed by Australian universities.

- Team-based care - Having both RGs and RRR non-GP specialists could support new models of integrated interdisciplinary team care, especially with virtual care models and training networks. It is agreed that it may encourage people to train in an area that has specialist recognition and esteem in addition to promoting value and respect of RRR work as unique and highly skilled.
- Improved access – Certain procedures, consultations and investigations could be undertaken by RGs (in their relevant AST or ARST) which may reduce the waiting times for the consumer and potentially travel time to visit a non-GP specialist if one were not available in their location.
- Adhering to the spirit and intent of the Collingrove Agreement – Given the potential impact on local primary care and diversion of GPs to exclusive hospital-based practice at renewal of registration RGs should demonstrate continued and significant alignment with the definition of rural generalists as outlined in the Collingrove Agreement. Particularly it is suggested this should include, within the last 12 months, at least one month each of demonstrated activity relating to community-based general practice, emergency medicine and the additional area of advanced skill in which the rural generalist was trained.

3. Have the potentially negative consequences of recognition of Rural Generalist Medicine as a field of specialty practice under the National Law been stated? Are there additional negative consequences that should be considered?

The RACP would like to highlight potential negative and unintended consequences that should be considered and further explored before proceeding with this application. These include:

- Exacerbating existing primary care/GP workforce shortages – A new field of specialty practice under GP could reduce the number of medical trainees applying to the GP training pathway. This would further exacerbate the widely reported GP/primary care shortage crisis and falling intention to training in GP demonstrated by current final year medical students and prevocational doctors.
- Reducing capacity to train other specialties and attendant impact on local non-GP specialty workforce – An increased focus of RGs on exclusively rural hospital-based employment is likely to impact other specialist medical College initiatives to develop rurally-based training pathways in relevant specialist areas. These include the RACP's adult general and acute care medicine, general paediatrics and palliative care medicine training pathways. In turn this may impact non-metropolitan, non-GP specialist workforce and training capacity and the quality of training for future non-GP rural generalist specialists.
- Lack of flexibility and impact on diversity in the RG workforce – The level of on-going commitment to maintaining skills and expertise may be unachievable, particularly for doctors working part time. The demand for full-time RGs may lead to a workforce bias towards people with reduced carer responsibilities, which often tend to be men.
- Quality of care – The level of training required for a RG's ARST or AST is significantly less than that required via other relevant specialist medical College training pathways. While such skills, if used to provide services to currently underserved rural population, may improve access this is likely to be achieved by a workforce with a reduced depth and breadth of training and restricted scope of practice. In turn it may have an attendant impact on scope and quality of care for RRR communities. This is likely to be exacerbated by consumer confusion regarding scope of practice and specialty. For example, from a consumer perspective, there is

likely to be difficulty in differentiating between a rural generalist in obstetrics (who had undertaken one year of training in the area) and a specialist obstetrician (six or more years of training).
To mitigate these issues appropriate models of team-based care should be considered including the need for RGs practicing within an advanced skill area to undertake such practice in conjunction with a non-GP specialist. Such non-GP specialists (e.g. physician, paediatrician, psychiatrist, obstetrician and gynaecologist, anaesthetist, surgeon) have received more extensive training and maintain broader scope and frequency of practice within their area of practice. Such a requirement and arrangement would provide appropriate clinical oversight, risk management, quality assurance, mutual support, continuing education and collegiality.

- Impact on already tenuous status of general practice as a career – A new hierarchy of RRR GP specialists could be created, namely those with formal RGM recognition and those without. This could further exacerbate the perception of RRR deficits with RRR communities feeling less supported because they don't have a RG, even if they have a GP and non-specialist healthcare services.
- Workforce inflexibility – Formally recognised RGs may find it hard to return to metropolitan clinical practice including general practice. Thus, this may be viewed as an inflexible qualification and career pathway. This is also likely to discourage those practitioners who may need to move to larger centres for child carer and educational needs, particularly women.
- Anticipated higher health care costs for MBS and jurisdictional health care – Following formal recognition, it is assumed that RGs will then request to change their funding model and will apply to access new or non-GP specialist MBS items which could lead to higher costs to the consumer and the healthcare service.
- Fragmentation and reduced quality of care – Recognition may drive further fragmentation of care pathways. Where a GP would refer to a non-GP specialist, the RG may not consider referring on. This may lessen the quality of care for the consumer and the community as it would make non-GP specialist care unviable and further increase non-GP specialist medical workforce shortages in RRR areas.
- Exacerbating rural GP workforce shortage – This is likely to create a substantial driver for RGs to leave primary care roles to take up exclusively hospital-based roles. It is envisaged this will further exacerbate the existing shortage of primary care GPs in rural communities. The drivers for taking up hospital-based roles would include the ability to access a different and more highly paid employment-based award model, seniority rather than activity-based remuneration, and entitlements including leave and continuing medical education allowances.
- Consumer confusion – There is concern that the community and consumers would be confused regarding the difference between RGs and non-GP specialists are creating further insufficient consumer health knowledge and understanding. For example, an RG with an AST/ARSTs in paediatrics may call themselves a 'rural generalist paediatrician' which may be perceived by the consumer being the same as a 'specialist general paediatrician" also a rural specialist and palliative care could easily be confused with a specialist palliative care physician.

4. Are there specific issues or claims in the application that should be the focus of the AMC assessment of the application?

The RACP would like the following additional items to also be the focus of the AMC assessment of the application:

- Training delivery, quality and accreditation – Additional details on the RGM training pathway, such as selection into training, curriculum development, AMC accreditation, supervision, evaluation, CPD and accreditation, maintaining workforce diversity, and

how the AST/ARSTs related to other non-GP specialist Colleges are managed. These details are critical for all other medical specialty bodies to provide feedback to issues such as duplication, benchmarking, guidance on referral pathways, cross-accreditation/recognition of prior learning, approval of and sharing of training resources, and capacity of supervision by other specialist medical colleges for both their own and RGM trainees.

- Impact on non-GP specialist training and medical workforce – RGM trainees are likely to have clinical training experience requirements in common with RACP basic physician trainees and advanced trainees in general and acute care medicine, paediatrics and palliative care medicine. An increase in demand for these clinical experiences from RGM trainees may reduce opportunities for basic physician trainees and general medicine/paediatrics advanced trainees to undertake rural training experiences.
  Recognition of RG and flow on affects to MBS recognition and consumer confusion may create disincentives for existing RRR non-GP specialists to train and remain in RRR practice. This is particularly the case for those RRR non-GP specialists who access MBS funding through private community-based practice. If this proposal is implemented there must also be greater efforts and funding directed to incentivising and retaining non-GP specialists who currently or in the future may wish to live and work in regional areas. Existing Commonwealth-funded incentives and MBS enhanced remuneration already available to GPs should be extended to non-GP specialists.
  The RACP would like to see further detailed consideration and discussion of these potential training/educational/supervision/workforce impacts and plans to mitigate them.
- Advanced skills certification rather than specialty field – In recognition of the potential negative impacts of this proposal (see Question 3.) a more appropriate initiative would be the development and recognition of advanced skills certification that would be available for a range of health practitioners to access and enhance skills development as adjuncts to their existing specialty recognition. This could accommodate and maintain the benefits of this proposal while at the time extending the benefits of generalism and advanced skills to a broader range of existing and future RRR practitioners. Thus advanced skills could be recognised for
  - GP with advanced skills certification
  - Non-GP specialists (e.g. physicians, paediatricians, anaesthetists) with advanced skills certification in areas such as emergency medicine working outside their primary specialist expertise but relevant to the multi-skilling appropriate for RRR practice
  - Non-medical health care providers with advanced skills certification (e.g. nurse practitioners, Aboriginal and Torres Strait Islander health practitioners)
- Capacity to train – RRR-based RACP Fellows play a key role in the work-based training and supervision of RGs. Increasing the number of RGM trainees will require commitment to support increased capacity for supervision and education, which is vital to avoid reducing the pipeline for training non-GP specialists in RRR areas.
- Currency, CPD and quality of care – It is not only important to be trained in and be deemed competent in working within a scope of practice at the end of training. Practitioners are also required to maintain skills and to ensure their practice is kept current as healthcare practices evolve. It will be an ongoing challenge to maintain a diverse set of skills. It may be appropriate to formally require demonstration of wide-ranging new knowledge because of the speed of change. There is increasing availability of brief training courses such as Advanced Life Support in Obstetrics (ALSO), Advanced Paediatric Life Support (APLS) and Early Management of Severe Trauma (EMST).

- Collaboration and partnership with non-GP specialist medical colleges – It should be ensured that there is collaboration with non-GP specialist colleges to develop AST/ARST training and both CPD resources and compliance mechanisms to ensure quality specialty-relevant resources are available and utilised for meeting the requirements of on-going training, credentialling and scope of practice within defined AST/ARST.
- International Medical Graduates (IMG) – Given the importance of the IMG workforce contribution in RRR settings, it is unclear how they will be employed into and retained in these positions. Further consideration and clarification on how they would be assessed to be comparable is required.

5. In the application for the recognition of Rural Generalist Medicine as a new field of specialty practice are there any impacts for patients and consumers, particularly vulnerable members of the community, that have not been considered or need more detailed consideration?

- Potential impact on existing workforce - The impact on community should be positive unless it results in a contraction of the RRR medical workforce. There is a possibility that locum GP and non-RG specialists would potentially be no longer able to work in these communities due to restrictions of the job description/credentialing requirements to be formally recognised as a RG.
- More effective, efficient and evidence-based pathways for developing regional medical workforce – The evidence that is provided to support the premise that this application will lead to an increase in junior doctors developing careers in rural practice is limited. Existing strategies to increase rural doctors have a strong evidence base and include recruiting medical students from rural areas, strong rural placements, and rural internships and prevocational training. The anticipated burden of on-going skills maintenance and high expectations on RGs may also be a disincentive to RGM training. Were this application, as is argued, to further impact GP and non-GP specialty training in rural Australia there is the risk that it may have the potential effect of worsening medical workforce retention in all specialties. We urge further consideration of this risk and mitigating approaches.
- Health determinates not healthcare - The acknowledgement that rural health disadvantage is so pervasive, including smoking levels and screening rates, shows that lack of specialised doctors may not contribute meaningfully to rural health disadvantage but rather a focus on investment to improve the determinants of health and primary health care delivery is required.
- Inequality, consumer out of pocket expenses and health care system and funding impacts - More detail regarding the referral structure to existing non-GP specialists and the likely reimbursement models (vs current GP to specialist referral model) is required. Enhanced skills and increased recognition may contribute to a rise in healthcare costs for rural patients. This may have flow on effects not only to the Commonwealth and jurisdictions, but also to consumer out of pocket and health insurance fund expenditure. For example, if a GP is qualified as a RG, it is reasonable to speculate that they will charge a higher ‘gap’ payment fee compared with a non-RG GP. Further detail is thus required regarding financial modelling and measures that will be put in place to ensure support of this application does not contribute to an adverse financial impact on the health system overall and particularly consumers, either directly or through their health insurance premiums. Were consumer-directed costs to increase this may, even if it improves access to some services, exacerbate regional health care inequality by directing such services to those who can afford to pay.

6. In the application for the recognition of Rural Generalist Medicine as a new field of specialty practice, are there any impacts for Aboriginal and/or Torres Strait Islander People that have not been considered or need more detailed consideration?

- Workforce – In line with the anticipated impact on regional general practice recognition and incentivisation of RGs to work in higher remunerated hospital and procedural based areas this is likely to create an even great income disparity for those doctors working with or planning to train and work with Aboriginal Australian and/or Torres Strait Islander peoples. This may have a particular impact on the Aboriginal Community-Controlled Health sector where lower salaried positions, less access to MBS billing and a lack of gap payment income is the norm. Add to this the potential for both increased overall access and inequity (see 5. above) and this may have an adverse impact on community-based healthcare for First Nations peoples.
- Preventable ambulatory sensitive conditions and hospital presentations - The likely diversion of community GP workforce to hospital-based practice is likely to drive the presentation of potentially preventable conditions to local hospitals and emergency departments. In turn such demand runs the risk of supporting a vicious cycle of further increasing hospital-based activity, demand and advocacy for hospital-based RGs, and in turn diversion of the community-based GP to RG and the medical workforce of hospitals. Even if RGs were required to maintain demonstrated currency and practice in community-based GP (see 2. Above Adhering to the spirit and intent of the Collingrove Agreement) increased time in the local emergency department is still likely to reduce local primary health care delivery capacity.
- Aboriginal and Torres Strait Islander doctors – Aboriginal Australian and Torres Strait Islander health professionals experience significant pressures that other health professionals do not. It would be important that the recognition of a new field of speciality does not lead to inappropriate or intolerable pressure on Aboriginal and Torres Strait Islander doctors to work towards this specialisation. For non-Indigenous doctors it is important that new areas of specialisation do not weaken or take time away from developing culturally safe practice, and expertise and experience in providing care for First Nations individuals and communities.

7. Are there specific stakeholder groups that should be consulted further as the application is assessed and what would they add to understanding of the application? (please see Attachment B for the stakeholder groups for this consultation)

- Royal Flying Doctors Service
- Australian College of Nurse Practitioners

8. What are the interactions now between Rural Generalists and other medical and health practitioners including other General Practitioners? How are these likely to change if Rural Generalist Medicine is recognised as a field of specialty practice?

- Lack of detail and clarity required - The RACP considers this to be a very important question, that was not clearly outlined in the submission, and this should have been evaluated in the first instance. It is unclear if it is outlined in the submissions by the National Rural Health Commissioner. Our response depends on the details of the

additional AST/ARST that are envisioned to be the core capabilities of this new speciality. Without this information it is difficult to qualify a response to this question.

- Impact of quality of care – Further to the response provided above (see 3.) given the information provided, the RACP has concerns regarding ensuring the scope of practice of RGs is clearly articulated and that they do not provide healthcare services to consumers which is beyond their scope. There is a risk that RGs operating without a clearly defined and communicated scope of practice could delay or not refer their patients on to non-GP specialists. Non-GP specialists are trained and maintain currently in an advanced set of skills and competencies that exceed those of RG working within their advanced skill area. There is a risk that consumers and communities will not receive the standard of care they expect from a clinician operating within a defined specialty field with an attendant impact on quality of care including misdiagnosis and treatment delay and overall poorer health outcomes. The sometimes utilised narrative in responding to RRR medical workforce need of 'any doctor is better than no doctor' has not served our rural communities well. Extending this to a narrative to 'any specialist is better than no specialist' is likely to have a similar outcome if not managed with extreme care and detail.
- Existing interactions with other specialists – While it is difficult for the RACP to provide a detailed narrative, recognition of RG is likely to support the development of a two-tier specialist health care system characterised by differing strata of specialist expertise. In turn this is likely to create confusion with GPs regarding who to refer to and clinical variation in healthcare processes and outcomes.

9. Your views on how the recognition of Rural Generalist Medicine will impact on the following:

• disincentives/incentives for General Practitioners to undertake rural practice resulting from additional training requirements

• unnecessary deskilling or restrictions in the scope of practice of other practitioners who practise in rural environments.

- Impact on scope of other practitioners - Further research needs to be undertaken to understand the consequences of increasing the number of RGs and how this will impact the existing non-RG rural health workforce. For example, how will RGs work with a consumer'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 high quality care is provided effectively?
- Reducing capacity to train other specialties and attendant impact on local non-GP specialty workforce – As previously stated, an increased focus of RGs on exclusively rural hospital-based employment is likely to impact other specialist medical College's initiatives to develop rurally-based training pathways in relevant specialist areas. These include the RACP's adult general and acute care medicine, general paediatrics and palliative care medicine training pathways. In turn this may impact non-metropolitan, non-GP specialist workforce and training capacity and the quality of training for future rural generalists.
- Lack of flexibility and impact on diversity in the RG workforce – As previously stated, the level of on-going commitment to maintaining skills and expertise may be unachievable, particularly for doctors working part time. The demand for full-time RGs is likely to lead to a workforce bias towards people with reduced carer responsibilities, which in general are males. Thus, recognition of RG and the drive to the hospital-based practice is likely to create a disincentive to female participation in the field.

- Non-GP specialist service opportunities - 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. Such specialists provide health care across an advanced set of skills and competencies that exceed those of RG working. Thus, the process of potentially supplanting and replacing existing and future specialists and their capacity to train and provide health care my result in increased healthcare access, but lower quality care. 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.

10. Have all economic impacts for governments, businesses and consumers been identified? Should further economic analysis be undertaken during the AMC assessment to assess the claims of minimal costs impact of recognition, and if yes, what should be the focus of the analysis?

- Further detail and economic analysis and modeling required – The economic impact of this model is contingent on the flow on effects to models of care, jurisdictional award recognition and MBS funding models. In addition, the impact on local primary care access, consumer out of pocket and health insurance costs and service inequality have not been outlined.
- Increased consumer costs – Were RGs to continue community-based practice (an area which is not assured or required as part of this submission) it would be anticipated that there may be an expectation, at least on the behalf of the practitioner, that specialised level of expertise would be expected to translate to a higher level of renumeration which would in turn be passed onto the consumer as a gap payment and increased out of pocket expenditure.
- Impacts beyond primary care and Government employing health services/ hospitals RGM recognition may have additional impacts on other practitioners and services beyond those outlined by the RACP. Consideration of these and consultation with appropriate stakeholder should also be undertaken including with Nurse Practitioners and their models of care, telehealth and outreach services, career medical officers (senior practitioners without a vocational qualification currently working in rural health services and hospitals) and international medical graduates (IMGs).