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College Submission

June 2024

Unleashing the Potential of our Health Workforce: Scope of Practice Review Issues Paper 2

Introductory Comments

The Australian College of Rural and Remote Medicine (ACRRM) acknowledges the opportunity to provide this submission. We are pleased to have had the opportunity to have previously provided a formal submission and taken part in a series of workshops associated with this consultation. We look forward to continuing to work with the review team toward reforms that can offer the best possible outcome for people in rural and remote areas and First Nations communities.

The Phase 2 Issues Paper does not appear to have reflected the key issues and recommendations that the College has raised in our previous submission and associated discussions. We are concerned that the paper gives little consideration to remote and rural perspectives, nor to solutions which involve provision of care by well-supported doctors, and no consideration to any potential risks to healthcare that may arise from the proposed reforms implemented at scale. We would reiterate our recommendation that the review adopt a more rigorous and holistic risk assessment of the reforms under consideration especially as these apply in remote and rural contexts.

In providing this Submission, the College would like to highlight some overarching areas of concern in addition to providing commentary around the proposed Options for Reform.

Focus on remote and rural context

Systems to support services in rural and remote areas warrant significant and detailed consideration. These support the people that have least access to care, provided by the narrowest range of healthcare professions, and these inequities are commonly exacerbated by workforce shortages.

We note that the only substantive reference to rural contexts in the paper is on page 30. The section proposes that these contexts be treated as distinctive from the predominant urban models and in these contexts, localised solutions should be identified. While the College welcomes the recognition of the need for localised solutions, we would emphasise that without identification of broad typologies of models of care and consideration of the implications for implementing these models at scale, these will not be effectively supported by national training, credentialling and funding structures.

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Potential perverse outcomes for rural doctor workforce

ACRRM strongly supports reforms which will enable the fullest and best possible use of all members of the healthcare team to meet service needs in remote and rural areas. This requires that reforms are achieved in a way that does not have the unintended consequence of worsening the already fragile rural, remote and First Nations medical workforce.

In the view of the College, Issues Paper 2 fails to fully consider, nor attempt to mitigate any possibilities that reforms may worsen access to doctors in remote and rural areas. This may occur firstly where reforms undermine the viability of service models for private Rural Generalists (RGs) and specialist General Practitioners (GPs) and secondly, where reforms incentivise opportunistic budget cutbacks to government provision of services by medical practitioners in remote and rural areas including remote First Nations communities.

Notably absent from the Issues Paper is any acknowledgement that access for all Australians to care provided by a doctor, is or should be an aspirational standard for national governments. In the absence of any such explicit recognition of this as a goal, the likely outcome over time of the approach engendered in the issues paper is that most Australians living in remote, rural and First Nations communities will not.

As previously noted, the review appears to be progressing, informed only by evidence of positive outcomes of expanded health practitioner scope interventions, and without consideration of any wider or downstream perverse consequences.

A 2023 review of 240 studies including from Australia, New Zealand, Europe, and North America, into the emergence of medical deserts and scope of practice policy interventions, identified a key gap as being *"the scarcity of longitudinal studies to investigate the impact of factors contributing to medical deserts and interventional studies to evaluate the effectiveness of approaches to mitigate workforce issues."*[1]

Studies from the United Kingdom, where major changes to enable expanded scope practice for health practitioners working in primary care, has also noted that those developments had been based on limited evidence, focussed on particular types of practitioners, and a narrow range of outcomes, and that there had been limited focus on the wider impacts.[2]

There is substantive international evidence that general practice relative to other medical specialties faces a diminishing value proposition and that this is leading to GPs representing a shrinking proportion of the medical workforce. More concerningly for our college, this trend away from primary care/family medicine has invariably coincided with burgeoning medical deserts in rural areas in these countries.

This pattern is apparent in all the key countries cited in the literature review as providing evidence of successful interventions to expand health practitioner scope, including New Zealand[3], the United States

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[1] Flinterman LE, González-González AI, Seils L, Bes J, Ballester M, Bañeres J, Dan S, Domagala A, Dubas-Jakóbczyk K, Likic R, Kroezen M, Batenburg R. (2023). Characteristics of Medical Deserts and Approaches to Mitigate Their Health Workforce Issues: A Scoping Review of Empirical Studies in Western Countries. *International journal of health policy and management*, *12*, 7454. https://doi.org/10.34172/ijhpm.2023.7454

[2] Gibson J, Francetic I, Spooner S, Checkland K, Sutton M (2022) Primary care workforce composition and population, professional, and system outcomes: a retrospective cross-sectional analysis British Journal of General Practice 2022; 72 (718): e307-e315. DOI: https://doi.org/10.3399/BJGP.2021.0593

[3] Allan and Clarke (2021) GP Future Workforce Requirements Report October 2021. https://www.rnzcgp.org.nz/gpdocs/new-website/publications/2021-GP-future-workforce-report-FINAL.pdf

(US)[4], Spain[5], France[6],Canada[7] and the United Kingdom (UK). In the UK, national surveys have reported 42% of GPs indicate that they are planning to quit the profession in the next five years.[8] In Ontario, Canada, a 15 year low in the number of doctors choosing Family Practice was recorded[9], and in the predominantly rural province of Alberta, a survey of over 1300 practices, conducted following the introduction of Nurse Practitioner clinics found 60% of family physicians did not expect their practices to be viable within the ensuing 6 months and 91% reported they were somewhat or very concerned about the viability of their practice.[10]

Another UK study found that patients, particularly those in high needs areas are accepting of care by other professionals but would prefer their GP particularly for more complex needs, a positive and continuous relationship with the GP was especially emphasised by people from the most deprived areas with the most complex needs.[11]

The Issues Paper includes an extensive range of proposed or exemplar models of care and in the 13 instances where these reference the role of the GP, all indicate the intention of reducing the role of the GP and all bar one excludes or presents the opportunity to exclude the GP entirely from the provision of care.

Rural Generalist approaches and rural healthcare teams

Our College supports doctors to become specialist GPs trained to work in the rural generalist model of practice. As such they are purpose-trained through the ACRRM Fellowship (FACRRM) to provide comprehensive primary care, secondary care, population and public health services and emergency care within the distinctive clinical context of rural and remote locations.

RGs and other GPs are commonly one of few providers of medical services in rural and remote areas and are often the first point of contact for patients. Rural and remote GPs work under unique circumstances and with a scope of practice and working environment which can be very different to urban practice. As one of few readily available health care practitioners, they are trained to be able to take on a range of roles which would ordinarily fall to specialists, allied health professionals, or specialised health care teams in larger areas.

These doctors work across a range of settings including in GP clinics, Aboriginal Community Controlled Health Services (ACCHSs) and hospitals, and in emergency situations. They must be adequately funded and supported to continue to deliver these services. Likewise, if they are to work to a broad scope of practice

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[4] National Centre for Health Workforce Analysis (2023) HRSA Health Workforce, State of the Primary Care Workforce 2023 – November 2023. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/state-of-primary-care-workforce-2023.pdf

[5] Dubas-Jakóbczyk K, Gonzalez AI, Domagała A, et al. Medical deserts in Spain—Insights from an international project. *Int J Health Plann Mgmt*. 2024; 39(3): 708-721. https://doi.org/10.1002/hpm.3782

[6] Casassus B (2023) French doctors' morale is at its lowest point as industrial actions mount *BMJ* 383:p2307

[7] Li K, Frumkin A, Bi WG, Magrill J, Newton C. (2023). Biopsy of Canada's family physician shortage. *Family medicine and community health*, *11*(2), e002236. https://doi.org/10.1136/fmch-2023-002236

[8] Royal College of General Practitioners (2022) *Brief GP Shortages in England* https://www.rcgp.org.uk/getmedia/3613990d-2da8-458a-b812-ed2cf6d600a6/RCGP-Brief_GP-Shortages-in-England.pdf

[9] Ontario College of Family Physician, (2023) New data shows decline in family practice, deepening the crisis. https://ontariofamilyphysicians.ca/news/ontario-college-of-family-physicians-calls-for-immediate-support-for-family-doctors/

[10] ThinkHQ AMA Alberta (2024) Family Practice Viability Study. https://www.albertadoctors.org/Media%20PLs%202023/ama-fm-viability-january-2024.pdf

[11] Donaghy E, Sweeney K, Henderson D, Angus C, Cullen M, Hemphill M, Wang HX H, Guthrie B, Mercer S (2024) Primary care transformation in Scotland: a qualitative evaluation of the views of patients *BJGP*.2023.0437. **DOI:** https://doi.org/10.3399/BJGP.2023.0437

and meet as many community needs as possible, they must be supported by adequate facilities, infrastructure, and equipment.

They are critical to the provision of primary care services in rural and remote areas, providing continuity of care for patients at all stages of their treatment and having the necessary skills and training to provide early intervention to those in need.

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

RGs have always worked within healthcare teams and are accustomed to working in ways which are flexible and responsive to the needs of local communities where they provide healthcare services. Necessary care and healthcare services are provided utilising the workforce and resources available.

This approach is reflected in the Ngayubah Gadan Consensus Statement – Rural and Remote Multidisciplinary Health Teams , and the College is disappointed that the Consensus Statement and it's approach has not been mentioned or acknowledged in Issues Paper 2. The Department of Health and Aged Care website defines the Consensus Statement as:

> ***"A key reference document for governments, policy makers and fund holders, workforce planners, training, service and peak organisations, health professionals and workers, and communities"***

The College supports the expanded/full scope approach across all healthcare professions in rural and remote settings, where it is appropriately applied.

- The concept of Rural Generalism has always relied on a team-based approach to care, with all health professionals cooperating, not competing.
- This requires not just RGs working to their full scope, but also rural nurses and rural allied health professionals working to their full scope in management of chronic illness, palliative care, mental health care, maternity and other services which would be performed by specialists in larger centres.
- These positions are clearly articulated in the Consensus Statement.

Response to Emerging Directions and Options for Reform

1. Workforce design, development, and planning

Problem	Poor Recognition of primary care health professional skills and capabilities impedes interprofessional trust, multidisciplinary team-based care, and effective health workforce planning
Reform Option 1	National skills and capability framework and matrix
Problem	Limited focus on primary care in the entry-level curriculum and poor support for health professionals impedes their ability to develop skills specifically required for primary care

Reform Option 2	Develop primary health care capability to equip health professionals to practise effectively to full scope of practice
Problem	Poor support for early career health professionals and inconsistencies in post-entry education and training impede health professionals' ability to develop primary care skills post-professional entry
Reform Option 3	Early career and ongoing professional development, includes multi-professional learning and practice to maintain primary care skills and support the team to work together effectively

The College notes that the reform options all appear to relate to primary care health professionals other than doctors and recognises and respects that these professions respectively are the experts in understanding their own training and competencies.

Noting that neither the reform problems nor solutions address or consider the role of doctors or their practices, we do not consider that these will take full account of their implementation issues and impacts for the provision of primary care as detailed in our comments above.

With respect to Reform 1, on the understanding that the proposed Skills and Capability Framework would relate to other primary care health professions and not ACRRM Fellows or other specialist GPs, we would make the following comments.

- Firstly, that it would be imperative that the Framework that is designed does not have the unintended consequence of creating further layers of compliance and complexity. There remains uncertainty as to how the implemented framework will ultimately articulate to the various layers of compliance, credentialling and employment. There is risk however that the administrative burden itself could potentially create a prohibitive barrier to service provision.

- Secondly, we would stress the need that the Framework classifications avoid reflecting urban practice patterns and/or not reflecting practice as it occurs in remote and rural areas, and do not inadvertently create additional barriers to services provision in these contexts, where breadth of practice is most likely to be needed.

With respect to Reforms 2 and 3:

- The College strongly supports development of capacity within training programs for health professionals that would enable a broad and generalist scope. We consider this an important foundation for building an appropriately skilled remote and rural workforce. We note the rural generalist nursing and health professional programs at James Cook University (JCU) provide an exemplar of programs providing strong generalist capabilities to underpin broad scope rural practice.

- ACRRM is similarly supportive of strengthened opportunities for broad scope, cross-disciplinary upskilling, and professional development and would assert that this is most needed and least resourced in rural and remote settings. We note that the allied health rural generalist pathway proposal has set a best practice rubric for how this approach can improve access to quality care for people in rural and remote parts of Australia.

The College notes that the review proposes that success will be characterised by:

- Improved consumer awareness of health professional skills leading to informed health care decisions and choice of health professional.
- A responsive, flexible, and innovative primary care team that recognises its skills base and utilises it effectively to support optimal primary care in response to community need.
- Improved health outcomes, including consumer experience, resulting from more accessible and efficient primary care services provided closer to home.
- Primary care team members having an improved understanding of the role of colleagues**,** recognise shared capabilities and skills and trust other team members to contribute their skill to team outcomes.
- Workforce planning being informed by the skills and capabilities of the primary care team and able to meet community need.
- Improved professional satisfaction and workforce retention resulting from more comprehensive recognition and utilisation of professional skills and capabilities.

These goals are all being achieved by RGs working in rural and remote areas to provide a range of healthcare services which fall to specialists in urban settings and across a range of settings including GP Clinics, ACHHSs, rural hospitals and emergency response. It is imperative that the Scope of Practice Review acknowledges the role of rural generalist medicine and rural generalist approaches more broadly in the delivery of healthcare services in multidisciplinary teams across rural and remote Australia.

2. Legislation and regulation

Problem	Highly restrictive regulation indirectly limits scope of practice
Reform Option 4	Risk based approach to regulating scope of practice to complement protection of title approach to enable health professionals to more consistently work to full scope of practice
Problem	Legislation and regulation are not adequately responsive to emerging evidence or innovation in scope of practice
Reform Option 5	Independent evidence-based assessment of innovation and change in health workforce models to inform legislation and regulation and enable contemporary best practice
Problem	Inconsistency between state and territory Drugs and Poisons legislation impacts consistency of scope of practice between jurisdictions
Reform Option 6	Harmonised drug and poisons regulation to support a dynamic health system by providing clarity between states and territories

Reform Option 4

The analysis and rationale given in the review associated with this option appears to be viewed entirely through the lens of identifying where legislation and regulatory frameworks are restricting opportunities for non-medical health professionals to operate in areas of overlap with medical practitioners or non-traditional scope.

ACRRM supports all initiatives to broaden scope where this will improve access to high quality, safe services. There is an associated risk however, that this approach may see broadening of health practitioner scope being viewed as an end in and of itself, an approach which is likely to lead to frameworks being developed which are not reflective of the best interests of communities.

We note that this reform embodies substantial and fundamental change to institutional frameworks. In this vein we would highlight that in all the various proposed change options, it is of vital importance to ensure strong guardrails to ensure all decisions:

- Reflect the best outcomes for communities, mindful of the immediate and second order consequences across the entire spectrum of care
- Prioritise patient safety as paramount (noting that access to care is a critical element of safety for people in rural and remote contexts),
- Do not encourage perverse consequences such as incentivising business models that encourage over-servicing, or destructive market competition which ultimately leads to diminished local servicing (for example, by practitioners leaving town, or closure of clinics particularly in under-serviced rural and remote areas)

The College is pleased to see that this option maintains protection of title. While the College is well versed in the problems that can arise from titling, we consider it important that patients can have a clear understanding of the role of their healthcare professional. Irrespective of alternative frameworks, the professional title is likely to be patients' main guide to understanding the role and training of their health professional, and the medical colleges and professional organisations are well positioned and incentivised to ensure the continuing integrity attached to their respective titles.

Reform Option 5

The College is supportive of this approach in principle but notes that there continues to be a lack of clarity throughout the review documentation regarding whether references to health workforce are intended to include medical practitioners. We would consider the involvement of GPs including RGs as essential, whether this be as representative members, or as providers of expert advice. It would also be essential that the decision making of any independent organisation was informed by appropriate expertise in rural, remote and First Nations community perspectives and service contexts.

Reform Option 6

The College supports this reform in principle and sees value in the proposal to harmonise legislation with respect to drugs and poisons legislations and address inconsistency across States and Territories. We note however, that as above, the analysis seems to assume, that expanding health practitioner access under the acts, is an end in and of itself. We would reiterate the importance that decisions are made in the best interests of communities and reflect a holistic assessment of the consequences and impacts.

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3. Funding and payment policy

Problem	Primary health care funding and payment models do not support health professionals to work at full scope in multidisciplinary teams
Reform Option 7	Funding and payment models that incentivise multidisciplinary care teams working to full scope of practice to support the primary health care team
Problem	MBS payment rules and inadequate digital infrastructure restrictive of health professionals need to make direct referrals within their scope
Reform Option 8	Direct referral pathways supported by technology that enable health practitioners to make referrals within their scope and to improve access to care for consumers

Reform Option 7

The College supports the concept of blended payment models that incentivise multidisciplinary teams. These should in all circumstances include a GP to ensure that the team-based care incorporates access to ongoing medical consideration and advice. The College would support some degree of flexibility where teams are based in highly remote areas and may receive these medical services through a continuous program of visits and/or via digital technologies.

Blended funding models by providing supplementary funding sources to the Medicare system are particularly relevant for management of complex and chronic disease which is more prevalent in rural and remote areas, and which is currently underpaid and clearly undervalued compared with the income which can be generated by a high-volume throughput of patients.

Reform Option 8

ACRRM firmly contends that all Australians irrespective of where they live deserve access to continuity of care from a GP as a minimum healthcare service standard. It is recognised that many people in rural and remote, including remote First Nations communities may not have access to a locally based doctor but may have an ongoing relationship with a doctor who visits episodically, has a relationship with their locally-based professionals, and, is available more regularly via digital technologies.

Referral patterns need to include local doctors who can provide ongoing medical advice and management to the patient and medical follow-up as required. The College would not support a framework whereby patients engaged with consultant specialists and health professionals but cut their GP out of the loop. This is a critical break in the communication chain which is typically the key strength of good primary care.

The College would stress that the patient's care pathway should include a regular medical practitioner in the flow of communication. Further to this, any change in referral and requesting arrangements needs to be supported with the establishment of information technology systems throughout rural and remote areas, that have the capacity to provide real time medical information to practitioners as required. We have been advised of incidents where rural patients have been prescribed inappropriate medication based on an assumption of a minor ailment and failure to diagnose a more serious medical program. It was only through their rural GP having the opportunity to review the patient, and the GP's capacity to

review the patients' electronic record and learn what they had been prescribed that they were able to be aware of, and rectify this problem.

Response to cross-cutting themes

Rural and remote considerations

Every Australian should have access to a doctor, and this standard should be upheld wherever they live. A key element of any clinical framework should be recognition of the need for a RG/GP to take a key coordination role in their patients' continuous medical care.

The College has repeatedly highlighted the risk under expanded scope models that under budgetary pressures, governments will increasingly come to consider it acceptable to deem people living outside cities as no longer deserving of access to in-person medical care.

The promotion of non- medical models of care and the substitution of medical services for other services may be perceived to represent cost saving to governments. There is a clear risk that cost-cutting exercises will exacerbate the disparities in funding and services to rural and remote people relative to people living in urban centres.

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

Another risk is that urban centric models encouraging a broadening scope of practice of health practitioners do not recognise the perverse consequence of rendering doctors or other key healthcare service providers financially unviable within a given rural community. In these situations, unlike in cities, people in that community will not be able to catch public transport to a similar service in a neighbouring suburb and at a practical level may lose access to that service. This is particularly true for people who have high needs such as those with very low incomes, those who are aged, or those with debilitating medical conditions.

In developing all reform options it will be critical to consider the distinctive impacts that these will have on people living in rural and remote including remote First Nations communities. Consideration needs to be given at the macro level to the downstream impacts of broad scale reforms.

It is equally important that consideration be given at the more tactical level to the detailed implementation of reforms to ensure they do not inadvertently reflect urban priorities and contexts and have unintended perverse consequences when implemented in rural and remote contexts.

For these reasons the College considers it imperative that a rural-proofing lens be applied to any proposed system reforms which considers the potential perverse consequences across the diversity or rural and remote communities including remote Aboriginal and Torres Strait Islander communities.

About the Australian College of Rural and Remote Medicine (ACRRM)

ACRRM's vision is **the right doctors, in the right places, with the right skills, providing rural and remote people with excellent health care**. It provides a quality Fellowship program including training,

professional development, and clinical practice standards; and support and advocacy services for rural doctors and the communities they serve.

ACRRM is accredited by the Australian Medical Council to set standards for the specialty of general practice. The College's programs are specifically designed to provide Fellows with the extended skills required to deliver the highest quality rural generalist model of care in rural and remote communities, which often experience a shortage of local specialist and allied health services.

ACRRM has some 6000 rural doctor members including 1000 registrars, who live and work in rural, remote, and Aboriginal and Torres Strait Islander communities across Australia. Our members provide expert front line medical care in a diverse range of settings including general practices, hospitals, emergency departments, Aboriginal Medical Services, and other remote settings such as RFDS and Australian Antarctic Division.

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ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander peoples as the custodians of the lands and waters where our members and staff work and live across Australia. We pay respect to their elders, lores, customs and Dreaming. We recognise these lands and waters have always been a place of teaching, learning, and healing.