College Submission

March 2024

Scope of Practice Review: Issues Paper 1

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 (RG) model of care in rural and remote communities, which often experience a shortage of local specialist and allied health services.

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

Initial Comments

The College welcomes the Scope of Practice Review and sees this as an opportunity for system reforms that can greatly improve health services for rural, remote, and Aboriginal and Torres Strait Islander communities particularly where a rural generalist approach is applied to models of care. That said we also recognise, as with all reforms, that if not appropriately designed, these changes could worsen rather than improve the already yawning inequities in provision of healthcare to people in these communities.

We are disappointed that the initial analysis and evidence review appears to have concluded that broadening of scope of practice would have virtually universal positive outcomes without any reference to potential risks or unintended costs. In particular while referencing rural success stories it has not identified any need for caution, or a nuanced approach to considering implications in contexts characterised by geographic isolation, minimal resourcing, limited patient pools, and pervasive workforce shortages.

Even where there are benefits to expanded scope models, the potential perverse consequence of a medical practice becoming financially unviable must be considered. In isolated communities (unlike in citites) this can lead to people in that community at a practical level no longer being able to access

medical care. Furthermore, as models which favour less expensive health professional options present opportunities for cost savings to health services, there is significant risk that the broadening scope can provide justification for budget structures which entrench a national health system which no longer seeks to provide doctors in rural and remote areas.

Expanded and full scope practice has particular value in conditions of relative professional and geographical isolation and limited clinical resources such as occurs in rural and remote areas including Aboriginal and Torres Strait Islander communities. Rural Generalist Medicine (RGM) is rooted in the concept of context-appropriate service that maximises the care that can be accessed locally. In these contexts, the economies of a highly specialised staff and resource system of care that can occur in major centres do not apply. Despite the absence of scale economies there is strong evidence that the RG model provides an excellent return on investment and an economically effective service delivery model, in addition to providing significant benefits through a fit for context skilled workforce and the benefits of strongly integrated care.

At the core of any rural and remote health policy must lie the commitment that people in rural and remote areas warrant the best possible care and as a minimum, at a standard comparable to that provided to their urban counterparts. ACRRM believes this care can and should be to the highest clinical standards but may not take the same form as best practice care in cities. To maximise the care that rural and remote communities can access, the training and professional development provided to healthcare professionals should support the rural generalist/full scope approach to practice.

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

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

General Comments

ACRRM supports doctors to become specialist General Practitioners (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 clinical context of rural and remote locations.

RGs and other GPs are often the only provider of medical services in rural and remote areas, and in areas where health services do exist, are often the first point of contact for patients. These doctors work under unique circumstances and with a scope of practice and working environment which can be very different to urban practice. They may be one of few available health care practitioners and as such, they may need to take on a range of roles which would ordinarily fall to specialists, allied health professionals, or health care teams in larger areas.

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These practitioners are critical to the provision of primary care services in rural and remote areas, as they provide continuity of care for patients at all stages of their treatment and have the necessary skills and training to provide prevention, early intervention and then secondary or follow-up care as appropriate.

Response to Key Themes

1. Legislation and Regulation

The College is pleased to note that the issues paper acknowledges the inconsistencies and barriers within the current legislative and regulatory systems governing the primary health care system, and in particular those which prevent health professionals from working at their full scope of practice. While a health professional may be competent and qualified to perform a particular activity, they are impeded if the relevant legislation or regulation does not explicitly authorise that profession to perform that activity.

For example, a number of ACRRM members have recently been impacted by the consequences of legislation which recognises a named profession in the updates to the Health Practitioner Regulation National Law relating to surgeon titling.

What do you believe are the key legislative and regulatory reforms which have the potential to most significantly impact health professionals' ability to work to full scope of practice?

RG Employment Awards

The joint application for recognition of Rural Generalist Medicine (RGM) as a specialist field within General Practice is now well advanced and a final determination by the Health Ministers' Committee is likely to be made in 2024.

Should the application be successful this would provide a consistent and clear basis for industrial awards which recognise the distinct training, assessment and professional development associated with the RG scope. For the ACRRM Fellowship, additional to the generic General Practice education standards, this includes mandatory training and assessment related to obstetrics, emergency medicine, hospital inpatient care, and population health, and an additional one to two years of assessed advanced specialised training in a selected field. All RG assessment measures the capacity of the candidate to apply skills within the clinical context of rural and remote settings.

A protected RG title would provide an opportunity for all jurisdictions to take a consistent approach to remunerating nationally registered specialist RG doctors in their services. This could significantly add to the attractiveness of this rural career and would simplify employment and credentialing arrangements for systems managers. It would also provide a clear terminology to inform patients, communities, and health services about their care and services options (and the associated training and skillsets) in engaging these doctors.

As its profile has grown, rural generalism has rapidly increased in popularity. Our ACRRM RG Fellowship training program has seen a 20% increase in annual enrolments since 2018 when the National Rural Generalist Pathway report was tabled in parliament and has a national cohort of over a thousand registrars. The MDANZ medical graduate surveys have indicated that with the introduction of an RG option not only did 6.5% of graduates indicate their interest in RG (a dedicated rural career) as their

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preferred specialty, but also, the total percentage of graduates indicating their preferred career as in general practice (i.e., GP or RG) increased from 16.5 to nearly 20%. [1]

Single Employer Models

Single Employer Models (SEMs) are a positive development toward building a strong RG workforce. ACRRM is committed to progressing initiatives to implement appropriately designed SEMs and to contribute to their development and delivery at all stages, noting that they are not the only or whole solution to addressing workforce issues.

RG registrars face challenges in attaining Fellowship which require bespoke solutions, given that RGs provide broad scope services to meet the needs of people without easy access to the specialised services available in cities. To attain this scope involves training in multiple workplaces and a longer and more complex training journey than that requisite for general practice Fellowship. Additionally, rural workforce shortages, limited training capacity, and geographic distances all add further complications to navigating the training journey.

The SEM approach provides a mechanism for addressing the inability to accumulate job entitlements for the duration of training and has broader potential benefits such as streamlining training and contributing to better integrated patient care.

Under SEMs, registrars maintain one employer for the duration of Fellowship training, usually a jurisdictional health service. The Single Employer provides the participating registrars' salary and work entitlements, and secondment arrangements are established with the additional workplaces in which the registrar may train. In the ideal under these arrangements, training toward a Fellowship qualification as a specialist GP and RG would provide a seamless movement between hospitals, general practices and other work settings such as Aboriginal and Torres Strait Islander Medical Services or Retrieval Services.

The College supports SEMs as an opt in model, part of a range of employment options available to RG registrars as befits the diversity of contexts in which RG training occurs and the varied training journeys that RGs pursue.

To be effective, employment models for the training workforce must then be transferred to complementary frameworks in which careers in rural practice beyond Fellowship can also be appropriately remunerated and incentivised. There may be opportunity particularly in rural and remote communities that have not been able to sustain private practice clinics, for establishing government funded SEMs for Fellowed doctors to enable medical service provision.

To what extent do you think a risk-based approach is useful to regulate scope of practice (i.e., one which names core competencies, skills or knowledge capabilities required to authorise a health professional to perform a particular activity, rather than named professions or protected titles)?

The College considers that both risk-based and protected title approaches can potentially be effective where these are appropriately designed and implemented. We see potential benefits and risks to both approaches. We do not see these approaches as mutually exclusive and would not support dismantling of

[1] MDANZ (2020-22) Medical Deans – Medical Schools Outcomes Database - National Data Reports 2020, 2021, 2022. Retrieved from: https://medicaldeans.org.au/data/medical-schools-outcomes-database-reports/

the essential structures of professions and their registration and accreditation authorities to implement risk-based models.

Professional title and their associated professional structures are the basis for patients understanding of their health service options. There is strong public understanding of the broad professional classifications and their associated skillsets and trust that these are backed by sufficient training and quality assurance structures. Both these attainments are the product of generations of efforts that should not be undervalued. However, the more recent trend of ever-increasing subspecialisation in both medical and allied health fields we view as a largely negative development in the interests of stronger national healthcare, and one that is particularly unhelpful in the context of rural and remote health services.

We would see potential for negative outcomes in maintaining a risk-based approach in terms of the burden this would place on the system in not necessarily supporting or guaranteeing fully informed consent in regard to services provided to patients. This will have greater adverse effects within the rural and remote and Aboriginal and Torres Strait Islander community contexts due to the already limited workforce capability and limitations of access to skills maintenance, let alone access to services already accredited under existing professional structures supported by the college.

In all cases, appropriate solutions must balance the conflicting objectives of safeguarding patients and upholding quality care standards including quality access to care; minimising administrative complexity, compliance, and rigidities; and ensuring local relevance and responsiveness.

Protected titles – Surgeons Titling

As previously noted, the College is currently seeking protected title for RGs with the potential positive workforce outcomes as detailed. The proposal is specifically designed to expand and not impede professional flexibility and service provision. RGM would not be a sub-speciality; RGs are expected to attain the full general practice scope. The title would sit within general practice rather than apart from it. It would be introduced with simple, facilitated pathways for specialist GPs to attain protected title, and the status quo would be unchanged for non-RG specialist GPs in terms of their entitlements and practices to provide a range of advanced specialised services in hospitals.

The protected title for surgeons in contrast, excludes any mechanism by which a rural GP/RG can provide critical surgical services including even minor services such as skin flap surgery and communicate to their patients in a simple way, their extensive skills/training qualifications. This is particularly problematic for people in rural and remote areas, where the alternatives to receiving local GP/RG provided care are likely to be limited and to typically involve considerable personal cost and time away from home.

ACRRM has been extensively involved in consultations relating to protected titles over many years, in particular the recent amendments to the Health Practitioner National Law regarding surgeon titling. The College submitted a response to the Consultation RIS on this topic in March 2022, indicating that it did not support moves to legislate to protect the title “surgeon” and viewed any possible public confusion over cosmetic surgeons titling as an isolated and particular problem that should be addressed in isolation, on its own merits.

The College reiterated the same concerns in several later consultations, and ACRRM President Dr Dan Halliday presented evidence at the Health and Environment Committee Public Hearing, outlining the perverse consequences of the proposed legislation. Despite these concerns, and their impact on rural and remote communities, the Health Practitioner Regulation National Law was amended to restrict the surgeon

title to those holding specialist registration in three medical specialties. The decision undermines the validity of the National Rural Generalist Pathway (NRGP), which Commonwealth and state governments have invested significantly in, to specifically support training for rural general practice doctors to provide advanced procedural skills.

The perverse outcome of the protected title is that RGs who have completed advanced skills training in surgery and/or obstetrics as approved by the ACRRM curriculum are no longer permitted to call themselves surgeons.

In the case of RGs holding ASTs in Surgery or in Obstetrics and Gynaecology they have the necessary surgical training and qualifications yet cannot describe themselves surgeons, refer to procedural skills as surgery, nor will they be able to advertise or clearly communicate their services to the rural and remote communities they serve. To provide an example, a FACRRM holding an AST in Obstetrics is no longer able to introduce him or herself to a woman at the commencement of a caesarian section as “I am Dr x and I will be your surgeon today/performing your surgery today”.

Title restrictions have led to competent and qualified practitioners in rural and remote areas being discouraged from providing critical surgical services. Consequently, people in these locations who already face significant barriers to accessing this care, will have had their access restricted even further.

It is noted that the rationale behind the amendment was to protect the public from doctors undertaking cosmetic procedures holding themselves out as “cosmetic surgeons”. However the legislation as enacted does not prevent those practitioners of concern from actually continuing to perform the procedures of concern, due to the fact that the Health Practitioner National Law protects titles and not types of practice. The National Law – with a very few exceptions – is designed to regulate what practitioners may call themselves, rather than specifying in the law what they can and cannot do.[2]

Risk-Based Approach

Noting that the protected title model can bring both positive and negative consequences, we consider the Risk-Based Approach to be similarly capable of delivering positive and negative outcomes.

We would not support this approach replacing the current system, if it were to be adopted, we would see it sitting alongside a structure of named, titled professions. This might involve defining aspects of expanded scope or areas of common overlap and in this way minimizing the need for sub-specialisation and making service provision more flexible by enabling overlapping areas of scope across professions.

We would see some key potential risks in this approach without the benefit of the structure and rigour that is provided by the medical colleges and other accredited health professional bodies and their mature accreditation structures. This might include a loss of understanding by patients about the skillset of their health professionals. It may lead to a lack of clarity of subject matter expertise and lack of rigor attached to decision making, and it may also lead to excessive complexity, uncertainty or arbitrariness in job classification and certification.

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[2] Health Council Consultation RIS Use of the title “surgeon” bey medical practitioners in the Health Practitioner Regulation National Law, December 2021, page 26

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What do you see as the key barriers to consistent and equitable referral authorities between health professions?

Rural and remote healthcare is best served through team-based models with appropriate collaborative arrangements in place. Wherever possible, the GP should be the first point of contact for patients and regarded as the key person in the continuum of care. ACRRM considers there is strong merit in appropriately skilled healthcare professionals being able to request investigations and significantly contribute to chronic disease management plans in rural areas where there is no other option and where without this option, patients may be forced to pay for private allied health services with no rebate. The College recommends an approach which ensures that these initiatives do not result in a fragmentation of care, and that collaboration and written communication with the primary care practitioner is required so that the patient journey is not disjointed. A key strategy would be making the most of outreach and telehealth options to engage the broad training and skillset of the RG and rural GP to support local delivery of care and facilitation of chronic disease and allied health services where substantive local services are challenged. It is important to recognise the value of efforts to support the continuing viability of an RG or a rural GP service- of any kind – as where these are lost, it is likely to be very difficult to reestablish them in the future.

The College supports models of care that involve a collaborative and team-based approach where possible. In rural and remote areas, this includes adopting a distinctive, flexible, and broad scope of practice within each practitioners' safe scope to deliver the fullest and best possible care locally. As previously advised the Ngayubah Gadan Consensus Statement, compiled by the Office of the National Rural Health Commissioner, is widely endorsed by national peak bodies including our College, and sets out these best practice principles and approaches.

Whatever model is adopted, it is important that high quality, continuity of care is maintained, and most importantly, collaboration with the relevant RG/GP. It is noted that while expanded scope of practice has the opportunity to improve access to care it also has the potential to fragment care and disrupt the patient journey. It is important that every patient has the opportunity to have a single point of coordination of their medical care irrespective of what other care arrangements are in place.

Primary care provision is provided in GP clinics, in hospitals, and, through nursing and allied health services. It involves referral and follow up from other consultant specialists. This can lead to communication breakdowns and fragmentation.

In rural areas the local health care team can often provide a much better integrated care experience due in part to the closer working relationships of all team members. This is also the case because GPs, particularly those with the RG scope, often provide services in private practices and Aboriginal Medical Services as well as in hospitals allowing a stronger continuity and coordination of patient care.

A qualitative study by Sutarsa and associates identified that locally-based, general practice doctors providing hospital services were strongly associated with quality care by rural and remote patients. They found these patients understood quality of care primarily through the lens of ongoing and respectful relationships with their doctors across primary and secondary care. These relationships, were considered crucial for improving the perceived quality of care: ensuring continuity of care; promoting integrated rural health care systems; cultivating trust from communities; and enhancing patient satisfaction. In their study of patients in hospitals in rural New South Wales they found:

"Employing GP-VMOs in rural hospitals enables the knowledge and sensitivity gained from their ongoing interactions with patients in primary care to be effectively utilised in the delivery of hospital care, thereby, allowing continuous, patient-centred care to be provided to rural and remote patients."[3]

Contrastively, a key weakness in the integrated care of people in rural and remote areas occurs when they are required to travel to major centres to receive care. Fragmentation also occurs where services are provided by Fly-In-Fly-Out (FIFO) medical or allied health specialists or via telehealth by urban based professionals to people in rural and remote communities. These individuals often do not share information with their patients' regular practitioners who will provide the in situ follow up and emergency care. Tellingly, the likelihood of GPs not being informed of their patients' treatments received by consultant specialists increases with remoteness.[4] There is need for these services and the individuals providing them, to have clear responsibility and protocols for reporting back to the rural doctor providing the patients' continuous care.

2. Employer practices and settings

What changes at the employer level would you like to see to enable health professionals to work to full scope of practice? (For example, changes to credentialling, practice standards, clinical governance mechanisms or industrial agreements)

RGs' capacity to provide broad scope services relies on credentialing and employment frameworks that recognise RG training; set achievable and appropriate metrics for training/maintenance of skills; and minimise prohibitive administration and compliance hurdles.

Credentialing quality and safety measures are often defined by, and for, professionals with a highly specialised scope for practice in urban centres. They generally do not consider the RG context, training, or scope. This often leads to problematic standards such as prohibitive minimum volumes of practice, or requirements for training/experience in tertiary facilities that preclude RG qualifications. These often are of little relevance to RG practice.

Importantly, clinical standards are commonly developed without consideration of the impacts of 'access' to patient safety and quality.

Additionally, compliance for clinical privileging is administratively onerous. This is difficult for all specialists, but for broad scope doctors the administrative impost is duplicated across multiple specialties. The extent to which this is impacting rural doctors and their capacity and preparedness to provide expanded scope care has been raised by both ACRRM and the Rural Doctors Association of Australia (RDAA)[5] and is evidenced by a 2019 survey of the Australian Medical Association (AMA) survey of rural

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[3] Sutarsa N, Kasim R, Slimings C, Bain-Donahue S, Barnard A (2021) Effects of employing primary care doctors in hospital to improve the quality of care and health outcomes of rural patients: A systematic scoping review. Aust J Rural Health 29(4):492- 501 https://doi.org/10.1111/ajr.12779

[4] AIHW (2018) Survey of Health Care: selected findings for rural and remote Australians. Cat. no. PHE 220. Canberra: AIHW

[5] RDAA (2019) RDAA Policy Position: Credentialing and Defining the Rural Generalist Scope of Practice https://www.rdaa.com.au/common/Uploaded%20files/_Aus/Policy/RDAA%20Policy%20Credentialing.pdf

doctors finding in the top ten priorities *“ensure GPs with recognised procedural skills can access appropriate hospital credentialing and facilities”*.[6]

These issues are further detailed:

- RDAA Policy Position[7]
- ACRRM Policy Statement [8]

RG representation in clinical credentialing frameworks and decision-making

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

Which particular activities or tasks within health professionals’ scope of practice would you particularly like to see increased employer support for?

Rural Generalist advanced specialised fields

The College would like to see remuneration for a range of advanced skilled services provided by RGs associated with their additional training and higher assessment standards. They often have structured CPD that they are required to meet particularly in areas of advanced specialised training where they have completed one to two years of additional training and dedicated assessments. These areas include mental health, palliative care, population health, paediatrics, emergency medicine and Aboriginal and Torres Strait Islander Health.

Develop rural-centric multidisciplinary team-care models with associated minimum care standards

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

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[6] AMA (2019) Rural Health Issues Survey: Improving Care for Rural Australia.
https://www.ama.com.au/sites/default/files/documents/AMA_2019_Rural_Health_Issues_Survey_Report.pdf

[7] RDAA (2019) RDAA Policy Position: Credentialing and Defining the Rural Generalist Scope of Practice
https://www.rdaa.com.au/common/Uploaded%20files/_Aus/Policy/RDAA%20Policy%20Credentialing.pdf

[8] ACRRM (2022) Position Statement Defining safe and quality procedural and advanced care in rural and remote locations: May 2022.
https://www.acrrm.org.au/docs/default-source/all-files/college-position-statement-defining-safe-and-quality-procedural-and-advanced-care.pdf?sfvrsn=53ba09ac_20

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3. Education and training

What are the key barriers health professionals experience in accessing ongoing education and training or additional skills, authorities or endorsements needed to practice at full scope?

The Rural Generalist Model of Care

The RG model is designed to train doctors with a broad and responsive skill set to provide the services that best fit the needs of their rural community. Collaborative healthcare team models are a cornerstone of this approach.

RG training and practice can be constrained due to a lack of recognition by employers and healthcare systems of these doctors' training and credentials. Through the Rural Generalist Recognition Taskforce a joint application for recogntion of RGM as a specialised field within general practice has been made by ACRRM and RACGP in association with the National Rural Health Commissioner. The application completed an initial assessment, and was recently subject to a national consultation as part of the second and final stage (detailed) assessment.

The Federal government is also committed to establishing a supported career pathway for a range of rural generalist allied health practitioners able to take a rural generalist approach within their respective professional scopes. This will support important complementary workforce development to strengthen the efficacy of health care services built around rural generalist models of care.

Given these developments, the importance of the rural generalist approach and strategic work to support this must be recognised as an enabler to innovative workforce models and workforce capacity building. There needs to be recognition of RG's advanced and specialised training in the hospital system by states and territories. Currently, despite the clearly structured and accredited training and assessment of ACRRM Fellowship, individual jurisdictions and Hospital and Health Services apply a bespoke and often unpredictable process to determine each RG's capacity and credentialing. The resulting uncertainty can obstruct provision of safe, quality-assured skilled services for these communities, and discourages prospective rural doctors from attaining this valuable extended skill set.

Training

RGM reflects a scope of practice which is essential to meeting the needs of rural communities and this requires to be recognised and funded through the training framework.

It is also important that RG and rural general practice, are promoted at the high school, medical student and prevocational level.

ACRRM members welcome programs such as the John Flynn Prevocational Doctor Program which provide exposure to rural general practice, however these programs require increased funding for expansion and the security of long-term funding.

The College recommends additional measures to support careers in rural healthcare:

- Universities should be accountable for demonstrating long term rural outcomes, and not measured simply by the number of rural placements or rural internships they offer.
- Rural placements should be rural. In many cases, "rural" placements are in regional areas.
- Increased support for supervision capacity in primary care.

- Frameworks that appropriately support the more costly and arduous path that rural training presents for many healthcare professionals. For example, the cost of supporting two rents during a rural placement can often be a barrier for many trainees.
- Increased investment, and stronger system levers to connect these programs to the ACRRM RG Fellowship program, to smooth the pathway to the Fellowship end point and to entry into the RG professional community.

Skills maintenance

It is critical that RGs and rural GPs, particularly in under-served communities, can access the necessary training to maintain and upgrade the skills they need to be able to continue to deliver high-quality care.

Rural doctors have significant needs in terms of training and upskilling and many struggle to meet these needs. The Strategy needs to address how doctors wishing to upskill or undertake training can access appropriate incentives, funding, and support to do so.

There is a need for structured programs to facilitate participation in training programs in larger centres, including funding and accommodation attached to these programs to allow rural doctors to access them. Alternatively, increased delivery of onsite training should be considered e.g., bringing Advanced Life Support and other courses to smaller towns, and allowing Visiting Medical Officers (VMOs) to participate.

In rural communities, quality healthcare is best achieved through a teamwork approach where all professionals are flexible and responsive in their scope to meet local needs. There is a particular merit in hospital and health services' education and upskilling initiatives explicitly recognising and supporting the valuable role of RGs and other local GPs and health professionals who may not be staff members (including those providing services as VMOs). These health professionals should be viewed as integral to the health services' commitment to providing quality healthcare for their catchment communities and thus part of their educational programs and efforts.

Increased funding to recognise the training and clinical consultancy roles of Rural Generalist and rural General Practitioner supervisors

All strategies to increase the interest in, and uptake of, careers in rural generalism and general practice are dependent on the availability of accredited and appropriately skilled and experienced supervisors for registrars who are undertaking the general practice placement component of their training.

This is also the case for other healthcare professionals such as Nurse Practitioners and Pharmacists, who could benefit from accredited RG supervision and consultation arrangements as part of a multidisciplinary, team-based approach to the provision of care.

College members acknowledge the benefits provided by accredited supervision, not only of registrars, but also medical students and other healthcare practitioners. These include the overall enjoyment and rewards of teaching; the stimulation of new information and ideas that can be provided by registrars; and potentially securing a future workforce for their practices or for rural communities more broadly.

There are a number of challenges associated with the recruitment of supervisors. The rural workforce is ageing and while there is a strong cohort of emerging Fellows, there may be shortfalls associated with the retirement of existing supervisors before the new influx is ready to replace them.

The role of RG and general practice supervisors goes beyond merely supporting learning and ensuring patient safety. It extends to taking on a clinical consultant advisory role, where the supervisor may be

called on to draw on their advanced clinical knowledge and experience to advise, and on appropriate request, take over the management of a patient in the same way that a consultant in a hospital might advise an intern or junior doctor. A similar situation could occur where an ACRRM-accredited RG is called on by a Nurse Practitioner or other healthcare professional, to provide management or advice in a clinical consultant capacity.

These clinical consultancy services are critical to the provision of safe, high-quality care in rural and remote areas in addition to enhancing registrar knowledge, but the current MBS delineations are in need of review to ensure they fully acknowledge the time and skills of the supervisor or appropriately accredited RG in this important area. The College acknowledges the existing support provided to general practice supervisors and practices; however given the workforce and financial imperatives, additional recognition for supervisors is warranted. The potential for accredited RGs to provide specialised clinical consultancy advice and management in specific situations should also be investigated. This additional individual support would provide recognition for the clinical consultancy skills provided by supervisors, with the intention of retaining existing, and encouraging new, supervisors.

Funding policy

If the workforce maldistribution and rural workforce shortages are to be addressed, rural doctors and other allied health professionals need to be adequately remunerated for their services and incentivised to work in areas which may not have the services and opportunities of cities and for which remoteness may lead to increased costs of living.

Primary care should provide essential healthcare services to all Australians, however, in reality, the general practice sector, and particularly the rural general practice sector, is grossly underfunded. A 2023 report found an estimated annual national health underspend on rural and remote Australians of around $6.5 billion, translating to $850 less per capita per annum less spent on health services for people in these areas compared to their counterparts in major cities.[4] In these areas GPs including RGs represent the vast bulk of the medical workforce.[9]

This in turn impacts negatively on access to primary care for people living in rural communities, including Aboriginal and Torres Strait Islander people. Consequently, their health outcomes are poorer, with lack of primary care also resulting in higher treatment costs as conditions escalate to require secondary or tertiary care.

How could funding and payment be provided differently to enhance health professionals' ability to work to full scope of practice, and how could the funding model work?

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

[9] Australian Institute of Health and Welfare. (2023). *Rural and remote health.* Retrieved from https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health

to achieve best practice for people in rural land remote areas, the more nuanced, flexible, and holistic approach utilising the RG scope and skillset may be needed.

The 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 the top of their scope, but also rural nurses and rural allied health professionals working to the top of their scope in management of chronic illness, palliative care, mental health care, maternity and other services which would be performed by specialists in larger centres. These positions are articulated in the Ngayubah Gadan Consensus Statement of which the College is a signatory.

Any review of scope of practice needs to consider the potential consequences of shifting clinical responsibility from doctors to other health professions. An increase in scope could result in increased indemnity costs for these professions which in turn would impact the net cost of service provision to tax payers.

Which alternative funding and payment types do you believe have the most potential to strengthen multidisciplinary care in the primary health care system?

Diversified and Flexible Funding Sources

Flexible funding should be available to specifically support rural and remote, locally based services. This funding must be fit-for-purpose and proportionately recognise and reward the effort and skill of medical/health care providers in meeting their patients' needs. To lend resilience, there needs to be a range of potential funding sources and policy levers. These would enable practices to adopt viable models of care appropriate to community needs and circumstances. The College supports further consideration of innovative funding pools which also support the delivery of infrastructure and training; foster partnerships between a range of local and regional entities including local government; and maximise the potential of existing community skills, infrastructure, and resources.

Blended Funding Models

ACRRM supports the principle of blended funding models which provide supplementary funding sources to the Medicare system. This is 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. The $6.5 m annual national funding gap between total per capita funding for health services received by people in rural and remote areas relative to people in cities,[4] demonstrates the extent of this undervaluing.

Innovative funding solutions

System-wide structures need to be in place to ensure innovative solutions to get services to rural areas can be supported and are not overlooked. In particular, consideration should be given to providing public funding for private clinics in small towns when the private clinic is providing what would be a public funded service in a regional centre.

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Future funding models

Best practice medical service delivery in the rural and remote community paradigm involves distinctive models of care. Too often, systems of care have been designed to fit the funding models rather than communities' needs. The separation of hospitals and private sector/primary care in Australia does not reflect the integrated way that care is provided in rural and remote locations and has enabled blame shifting and ultimately neglect of many rural and remote communities' health service needs.

Alongside revision of pricing metrics to ensure sufficiency of funding, funding models should be constructed to enable and incentivise approaches to rural health resourcing which will deliver robust rural health services sustainable over the long term.

These structures should:

- **Incentivise future-focused expenditures** to build a strong future workforce and signal a strong long-term commitment to maintaining rural capacity and resources. They should encourage investment in rurally-based training, valuing practice for its full worth and the professions such as RGs and specialist GPs already providing crucial services and incentivise the building of sustainable local services.

  Investments in appropriately trained staff that stay in rural areas and become part of the fabric of those communities and present a much greater return on investment than reliance on locums and other expensive stop gap solutions. Most critically, funding structures should strongly signal to rural communities that their health services are permanent, and that they can build their lives there, in the knowledge that they will continue to have access to care when needed.
- **Direct 'rural' funding to staff and resources that are based in rural areas -** rural funding to urban-based FIFO specialists, telehealth providers, and administrators incrementally drains resourcing away from the rural point of care where it can be most effective. It also serves to undermine the fragile critical mass in each community necessary to sustain local services.

Incentivise investment in models of care and resourcing that can maximise quality services within each rural context. These approaches would include training staff with an appropriate scope of practice for the rural context such as RG doctors, and nurses and other professionals with a broad RG scope. It would also involve resourcing hospitals in a manner complementary to the rural model of care.

The Section 19.2 exemptions merit consideration as a mechanism for improving access to primary care whereby these are expanded in association with new funding models and service redesign. For example, consideration could be given to incorporating areas in lower MMM classifications under frameworks supporting hub and spoke models taking advantage of in-reach, outreach and telehealth supported services. Such frameworks should have funding applied locally, where the need is greatest, and be supported by RG and GP models of collaborative care. These could also support greater application of SEM models.

What risks do you foresee in introducing alternative funding and payment types to support health professionals to work to full scope of practice, how do these risks compare to the risks of remaining at status quo, and how might these risks be managed?

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

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

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

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 may 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 longing 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.

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.

The College also has some concerns that the longer-term system costs of expanded scope practice have not been fully assessed or acknowledged. The differential costs of medical care relative to other health professions reflects the higher costs of practitioners' longer and more extensive training and professional development, registration, and medical indemnity. The transfer of the comparable levels of clinical responsibility from doctors to other healthcare professionals will ultimately require that comparable costs to employers and health systems will also apply to those professions. It is likely that there will be some lag time in these system costs being reflected in indemnity insurance and other systems for the professionals who assume expanded scopes, and it is important that these changes are incorporated into cost-benefit analyses and longer-term planning.

4. Technology

How do you think technology could be used better or differently in primary health care settings to enable health professionals to work to full scope?

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ACRRM acknowledges that telehealth and other forms of digital healthcare are an important component of RG practice noting that these are not an acceptable 'replacement' for face-to-face services and instead should be viewed as a tool to support and strengthen in-person care.

Digital healthcare can improve health outcomes by facilitating timely access to essential specialist services and advice. It can further extend the scope of practice of RGs to provide comprehensive care for patients in the local community in consultation with other specialists if required. There is particular value for both patients and practitioners in shared care arrangements which facilitate quality models of care involving the patient-end clinicians (RGs) and remote-end specialists/consultants.

What risks do you foresee in technology-based strategies to strengthen primary health care providers' ability to work to full scope, and how could these be mitigated?

In the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023–24*, IHACPA outlined its intention to investigate innovative models of care and services related to virtual care, with an initial focus on virtual care delivered by emergency departments.[10]

The College strongly supports the use of telehealth as a tool to support and strengthen in-person care, however there is a clear risk that telehealth consultations will become standard practice, particularly for access to specialist services.

Our members are increasingly concerned about the trend towards replacing vital in-person emergency services with virtual FACEM consultations, and the recent IHACPA comments have served to exacerbate these concerns. This is a solution which fails to put local RGs and GPs at the centre of provision of care. Most small rural hospitals do not have specialist emergency physicians on staff and rely on the services of local GPs and particularly RGs which have advanced training in emergency medicine.

As outlined above, local GPs/RGs are responsible for the continuity of care of the patients in their community and these doctors will be called upon to respond to these patients' medical emergencies. In these situations, the locally based providers of continuous care must assume responsibility to exercise their clinical judgements with potentially critical gaps in their knowledge of the patients' health care history and context. There is a strong risk with telehealth models that care will become fragmented. As above, this underscores the need for clear obligations on the part of health providers providing specialised aspects of a patients' healthcare through telehealth to inform the doctor with overall responsibility for their continuous care.

Shared tripartite telehealth consultations for patients in rural and remote areas, involving the patient, the local GP/RG and the medical or allied health specialist are one key strategy for which the College has been advocating for many years. Such consultations should attract appropriate funding which values the contribution of all healthcare providers.

The role/responsibility of the digital healthcare providers to upskill the locally-based providers of care in rural and remote areas, who by virtue of the patients' geographic isolation from the specialised health services, will have elevated responsibilities in that patients' ongoing care, should be viewed as a natural

[10] IHACPA Consultation Paper, page 27

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extension to their telehealth service provision. Funded programs to support this approach warrant consideration.

Another important model of care that warrants greater support, are telehealth models in which a rural or regionally based doctor works in tripartite arrangements with the patient and their nurse practitioner, Aboriginal Health Worker or other health professional based in a more remote location in that region, so that the continuous care can be effectively shared in an arrangement which incorporates continuity of medical services and advice. Ideally, this arrangement would be supplemented with occasional face-to-face care by the doctor where possible.

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