# INITIAL PROPOSAL FOR RECOGNITION OF RURAL GENERALIST MEDICINE AS A FIELD OF SPECIALTY PRACTICE WITHIN THE DISCIPLINE OF GENERAL PRACTICE UNDER THE HEALTH PRACTITIONER REGULATION NATIONAL LAW

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

DECEMBER 2019

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

RACGP
Royal Australian College *of* General Practitioners

# Table of Contents

# Identifying information

Applicant Details

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Specialty or field of specialty practice details

Specialty or field of specialty practice:

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

**Verify proposal**

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

……..
Signature

Nick Williamson, RACGP Chief Executive Officer

Name……..

……..
Signature

Marita Cowie, ACRRM Chief Executive Officer

Name……..

# Executive summary

- This is a combined application of the general practice colleges proposing that 'Rural Generalist' (RG) be recognised as a protected title, as a Specialised Field within the Specialty of General Practice.

  The Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) are accredited by the Australian Medical Council (AMC) as the Fellowship education providers in the recognised speciality of general practice. Both colleges recognise the importance of Rural Generalist medicine in delivering best quality care for Australian rural and remote communities.

  This application operationalises a key recommendation of the National Rural Generalist Taskforce Report, which was accepted by Minister Bridget McKenzie in December 2018.

  *"A Rural Generalist is a medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care and required components of other medical specialty care in hospital and community settings as part of a rural healthcare team."*

  This definition was agreed to by the two colleges in collaboration with the National Rural Health Commissioner (the 'Collingrove Agreement') and part of the Taskforce report.

- The key issue this proposal seeks to address is the persisting inequity of access to comprehensive healthcare for people living in rural and remote areas.

  Australians living in rural and remote communities continue to have poorer access to healthcare services and have poorer health outcomes compared with those living in urban and metropolitan areas. Data show that people living in rural and remote areas have higher rates of hospitalisations, mortality, and injury while having poorer access to, and utilisation of, health care services, compared with those living in metropolitan areas.[1]

  Access to equitable and comprehensive healthcare in Australia's rural and remote populations is complex given the challenge of distance and geography. Rural and remote areas have significantly fewer doctors per capita and less access to specialised healthcare resources. While there has been a substantive increase in the number of medical graduates from Australian medical schools, this has not resulted in sufficient doctors being based in rural and remote communities.[2]

- The distinctive RG workforce model with a robust and well-trained RG workforce can make a substantial contribution to solving these issues in rural and remote communities.

  RGs are primary healthcare providers with advanced/additional skills enabling them to work in secondary and tertiary arenas in collaborative networks with other health professionals. They are specifically trained for expert service provision in rural and remote clinical contexts. A workforce trained in this way can enable delivery of high quality and safe care close to home for rural and remote Australians. The workforce model recognises the importance of primary care and generalist scope to quality, cost-effective healthcare delivery and within the limitations of distance, can enable access to patients in a context adaptable way to a broad scope of services that may not otherwise be available to them.

- A highly trained RG workforce of several thousand practitioners is established and providing vital services across rural and remote Australia. This workforce's promotion, growth and sustainability however continues to be impeded by a range of structural barriers.

  Many doctors and medical students considering an RG career option are beset by excessive complexity, inconsistency and inefficiency having to negotiate a complex system across different jurisdictions often involving multiple colleges, curricula and professional standards. Furthermore, the lack of a single recognised title, renders it very difficult to scale-up national policies with respect to promoting, supporting or effectively regulating the workforce.

  Title recognition and by extension recognition of the National Rural Generalist Pathway (NRGP) will alleviate the inconsistency across jurisdictions in support of the pathway for training this workforce and provide a national process for recognising and supporting existing practitioners.

  In particular, title recognition will:
  - provide medical graduates and junior doctors with a nationally-recognised endpoint with status equivalent to other training endpoints, and one that can deliver cross-jurisdictional portability
  - benefit health services in recruiting suitably trained RGs to work in their community
  - create a more structured credentialing and titling framework which can provide clarity regarding best practice quality and safety for RG practice

- This application is preceded by a comprehensive national consultation by the National Rural Health Commissioner on behalf of the National RG Taskforce, (co-led with the two colleges). The consultation included education and training providers (colleges, universities, academics), Commonwealth and jurisdictional governments, Aboriginal and Torres Islander groups, professional bodies, agencies, consumer representatives, clinicians, trainees, medical students and community leaders from across rural and remote Australia. The Taskforce Recommendations including this application, were based on feedback from these, and the advice of the over 200 expert stakeholders of the Taskforce, Working Groups and Expert Reference Groups.

- The consultation confirmed a high level of consensus, goodwill and commitment across government, community and health sectors for implementing and establishing the NRGP. The Commonwealth Government is committed to implementing the NRGP and has supported this application. It has established dedicated RG training and 300 RG positions within its nationally-funded GP training scheme (AGPT) which support the colleges' training programs and the various jurisdiction-funded RG programs.

- A strong RG national workforce can provide a sustainable solution to critical healthcare needs. Recognition of Rural Generalist Medicine as a field of specialty practice is a necessary step toward enabling its growth and retention. It will directly remove specific structural barriers. More broadly it will facilitate health service/training systems, health personnel and the community at large working toward a thriving national network of these practitioners.

# 1. Describe the function of the organisation(s) lodging the preliminary proposal and its/their interest in the proposal.

- Describe the current role of the organisations, with reference to the organisation's statement of purpose, and the functions it performs
- Provide a brief history of the organisations relevant to the application
- Provide brief information on the applicant's governance structures
- Current number of Fellows/Members of applicant bodies
- Provide a current annual report(s)
- Provide a declaration of the organisation(s) interest in the proposal, including agreements and arrangements with funding bodies and MoUs with other entities

The Australian College of Rural and Remote Medicine (ACRRM)

*Mission and Functions:*

The College vision is for - *the right doctors, in the right places, with the right skills, providing rural communities with excellent healthcare.*

Its purpose is: *to improve the quality and safety of care for rural and remote communities by setting professional standards for practice, and delivering lifelong education, support and advocacy.*

Its mission is: *to provide a vibrant professional home for specialist General Practitioners and Rural Generalists that delivers: inspiration, collegiality, value, and social accountability.*

The College membership includes ACRRM Fellows, registrars training to ACRRM Fellowship, junior doctors and medical students interested in careers in RG practice, and Fellowed General Practitioners (GPs) with an interest in the College and its work.

The College provides a Fellowship training program which it delivers both independently and in conjunction with government supported programs. The program has been designed to prepare Fellows for practice as general practitioners in the RG model of care.

The College also delivers its Professional Development Program (PDP) which is designed to enable and assure currency in the skills associated with the Fellowship. The program includes services to manage Fellows' Maintenance of Professional Standards and reporting requirements for clinical credentialing in a range of advanced skill areas associated with the Fellowship.

The College supports members in learning and applying their skill set in their practice.

- It advocates on behalf of its members and their rural and remote communities
- It facilitates and supports peer networking and communities of practice for members
- It provides educational/clinical support resources, courses and events relevant to RGs and rural and remote practice.

Integral to all these activities is the College's continuous program of development, review and advocacy for appropriate professional standards of quality and safety for ACRRM trainees and Fellows and their model of practice.

*History:*

ACRRM has established in 1997 with some 660 foundation members. It was formed to provide professional standards, training and CPD reflecting the model of care practiced by its rural doctor membership. This has come to be known as rural generalist practice. The College now has over 5000 members including, Fellows, registrars, junior doctors and medical students interested in pursuing rural careers.

The College formerly commenced delivery of its national Fellowship training and professional development programs in 2001. It was awarded provisional Australian Medical Council (AMC) accreditation in 2007 and full accreditation in 2011 which it has maintained to the present time.

From the outset, ACRRM's Fellowship program has been delivered both autonomously through its self-funded Independent Pathway and through a supported delivery model which has been auspiced variously through the Commonwealth Government's GPET (from 2001-2015), the Australian General Practice Training (AGPT) and the Remote Vocational Training Scheme (RVTS) programs.

From 2022 ACRRM will assume responsibility for the management functions of the AGPT and RVTS programs as they pertain to supporting registrars in the ACRRM Fellowship program.

*Governance:*

The College is oversighted by ACRRM Board which holds ultimate authority for all corporate governance. There are four peak councils which report to the Board each with their own respective reporting committees and working parties. They are the College Council, the Finance, Audit and Risk Management Council, the Quality and Safety Council and the Education Council. The College has dedicated governance structures to represent its registrar, medical student, junior doctor, and Aboriginal and Torres Strait Islander members. It also has a series of reporting RG Clinical Working Groups which provide expert guidance in key focus areas for RG practice.

*Information on ACRRM Governance and Board and College Council members can be found at the following link:*
*https://www.acrrm.org.au/about-the-college/board-council-and-committees*

*ACRRM Strategic Activities and Logic Map* (2018-21) can be found at the following link:
https://www.acrrm.org.au/about-the-college/history-of-acrrm/college-vision-and-values

The ACRRM Reconciliation Action Plan can be found at the following link:
https://www.acrrm.org.au/the-college-at-work/reconciliation-action-plan

ACRRM Annual Report (2018-19) can be found at the following link:
https://www.acrrm.org.au/about-the-college/annual-reports

*Current number of Fellows/Members:*

As at October 2019[3], the College has some 1760 ACRRM Fellows and 5150 members. This included 701 trainees, 937 medical students, 9 Fellows identifying as Aboriginal and Torres

Strait Islander, 19 trainees identifying as Aboriginal and Torres Strait Islander, 74 members identifying as Aboriginal and Torres Strait Islander.

*For further detail of the ACRRM,*

See: Appendix 1.1 ACRRM functions, history and governance

## The Royal Australian College of General Practitioners (RACGP)

*RACGP function, history and governance*

The Australian College of General Practitioners (ACGP) was formed in 1958 becoming the Royal Australian College of General Practitioners (RACGP) in March 1969. Vocational education and training for general practitioners was formalised in 1973 with the Family Medicine Programme. In 1984-1985, as the first step toward accreditation, a Certificate of Satisfactory Completion of Training was introduced with the award of Fellowship of the College (FRACGP) as the endpoint of the Family Medicine Programme. In the 1990s, the College began a phase of refining its early initiatives including Quality Assurance, Fellowship examinations, a more defined training program, vocational registration, standards of general practice, a greater focus on rural, and Aboriginal and Torres Strait Islander health. By 1996 vocational training and registration became mandatory and were tied to Medicare payments for GPs. In 2017, Federal Health Minister Greg Hunt announced that the RACGP and ACRRM will resume delivery of general practice training in Australia commencing with a transitional period from January 2019 – December 2021. Both the RACGP and ACRRM will deliver training, encompassing the Australian General Practice Training (AGPT) from January 2022.

The RACGP is a not-for-profit company limited by guarantee, governed by the RACGP Council (board of directors), and headquartered in East Melbourne. The RACGPs vision is 'Healthy profession, Healthy Australia'. The mission is to improve the health and wellbeing of all people in Australia and to support General Practitioners (GPs), GP registrars and medical students through:

- Education and training for general practice Fellowships – FRACGP and FARGP, standards, quality, selection, international accreditation, curriculum, assessment, continuing professional development.
- Innovation and policy - for general practice, quality care, technology, practice standards and accreditation, knowledge and evidence, research, RACGP Foundation, policy and practice support.
- Advocacy - a strong voice advocating for general practice and patients in the community and across all levels of Government and stakeholders.
- Collegiality Member engagement, conferences, student to mentor opportunities, digital communities and united professionals.

The evolving nature of general practice has meant that there is a greater emphasis on advocacy, rural and Aboriginal health which have contributed to the broadening focus of the college and its membership. The RACGP established the National Rural Faculty in 1992 in response to the growing need for educational and training support for doctors entering and working in rural practices. In 1996, the Faculty of Rural Medicine, as it was first known, worked closely with the RACGP Training Program to develop a support program for GP registrars interested in rural general practice. This is known as the Rural Training Stream. GP registrars who satisfactorily completed the Rural Training Stream, including its extra, fourth year of vocational training in Advanced Rural Skills, were awarded the Graduate Diploma in Rural General Practice accredited as a formal tertiary award with the equivalent to an Office of Higher Education in each state and territory.

The Fellowship of Advanced Rural General Practice (FARGP) was launched in 2008. The FARGP provides the skills and qualifications for GPs working in rural areas. The College is in the process of developing an integrated RG Fellowship based on the FRACGP and the FARGP. Central to addressing rural disadvantage is the capacity of, and equitable access to, general practice and its role in bringing lasting change in rural communities. RACGP is committed to overcoming long-standing rural disparities and believes that rural health reform must lead to increased support for general practitioners and their communities and work to address current barriers to recruitment and retention. A more responsive and better coordinated health system in the future will need to foster rural innovation, improve access to high quality health care, provide for better coordination and reduce duplication and gaps. RACGP Rural supports and advocates for 19,000 members with over 8,500 registered GPs in rural and remote Australia.

RACGP Rural is committed to addressing rural disadvantage focusing efforts toward strategies which lead to more equitable access to healthcare. The capacity of the health system to respond to current and emerging pressures in rural and remote Australia is a central focus for RACGP Rural.

RACGP's Governance structures can be found at the following link:
https://www.racgp.org.au/the-racgp/council/council-members

The *RACGP Strategic Plan* (2018-2022) can be found at the following link:
https://www.racgp.org.au/the-racgp/about-us/vision-and-strategy/vision-statement-and-strategic-overview

The *RACGP Reconciliation Action Plan* can be found at the following link:
https://www.racgp.org.au/the-racgp/about-us/reconciliation-action-plan

The *RACGP 2018-19 Annual and Statutory Reports* can be found at the following link:
https://www.racgp.org.au/the-racgp/about-us/annual-reports

*RACGP Current number of Fellows/Members:*

| Membership | |
|---|---|
| Fellows: | 22,471 |
| Doctors in training | 4,693 |
| Other | 8,221 |
| Students | 5,493 |
| Total: | 40,878 |

| | |
|---|---|
| Aboriginal and Torres Strait Islander Fellows: | 65 |
| Aboriginal and Torres Strait Islander Registrars: | 55 |
| GP Members working in rural | 8,500. |

## 2. Present a clear statement of the issue or issues that the proposal for the recognition of a new or amended specialty is intended to address

| A. Present a summary of the issues that the proposal is intended to address and state why you consider the existing arrangements cannot address these issues. |
|---|

This application proposes that 'Rural Generalist' (RG) be recognised as a protected title, as a Specialised Field within the Specialty of General Practice.

The key issue this proposal is addressing is the persisting inequity of access to comprehensive healthcare for people living in rural and remote areas. Australians living in rural and remote communities continue to have poorer access to healthcare services, utilise fewer health services, and have poorer health outcomes compared with those living in urban and metropolitan areas. Data show that people living in rural and remote areas have higher rates of hospitalisations, mortality, injury and poorer access to, and use of, primary healthcare services, compared with those living in metropolitan areas[4]. A robust and well-trained Rural Generalist (RG) workforce can make a substantial contribution to solving this inequity by enabling access to high quality care.

Access to equitable and comprehensive healthcare in Australia's rural and remote populations is complex given the challenge of distance and geography. Rural and remote areas have significantly fewer doctors per capita. They also have fewer and less specialised healthcare resources and supporting healthcare professionals. This context necessitates a distinctive workforce model that can optimise the support available to rural and remote Australians. An RG workforce can improve access to preventative care and emergency and hospital care in rural and remote communities leading to better health outcomes.

While there has been a substantive increase in the number of medical graduates from Australian medical schools, this has not resulted in sufficient doctors being based in rural and remote communities to provide the medical services required.[5] The promotion, growth and sustainability of this rural workforce however continues to be impeded by a range of structural barriers and award of protected title would go some considerable way to removing these.

RGs are primary healthcare providers with advanced/additional skills enabling them to work in secondary and tertiary arenas in collaborative networks with other health professionals. The scope of practice of an RG comprises a distinct combination of General Practice, emergency and advanced/additional skills appropriate for rural and remote clinical contexts. Communities can expect enhanced quality and safety through a workforce specifically trained for rural and remote practice with appropriate advanced/additional skills. A sustainable supply of workforce with appropriate skills also contributes to better health outcomes.

This approach recognises the importance of primary care and generalist scope to the future of cost-effective, quality healthcare delivery in Australia. Within the limitations of distance and smallness of scale, it can also enable access to patients to a broad scope of services in a context adaptable way. A medical workforce trained this way will deliver higher quality and safer care closer to home for rural and remote Australians.

There are currently several thousand doctors in rural and remote settings practising across an extended scope of medical care that have attained Fellowship qualifications and training through the general practice colleges reflective of their model of practice.

By necessity, across the country there is a complex of training programs, industrial recognitions and other systems and processes that have evolved to regulate and enable these doctors' practice. Currently these processes are not tied to a nationally registered standard recognising this distinctive practice and its link to the general practice colleges' training, assessment and professional development standards.

Without the clarity and cohesion that this can provide, the RG workforce is beset by excessive complexity, inconsistency and inefficiency. Doctors and medical students considering an RG career option as well as RG qualified doctors seeking to continue their advanced skilled practice, must negotiate a complex system across different jurisdictions often involving multiple colleges, curricula and professional standards. These systems issues are a disincentive to prospective new RGs and are leading many RG trained doctors to either narrow their practice scope or leave rural practice.[6]

Furthermore, the lack of a single recognised title, renders it very difficult to scale-up national policies with respect to promoting, supporting or effectively regulating the workforce. Title recognition and by extension recognition of the National Rural Generalist Pathway (NRGP) will alleviate the considerable inconsistency across jurisdictions in support of the pathway for training this workforce and provide a national process for recognising and supporting existing practitioners.

Under this proposal, recognition of Rural Generalist medicine as a field of specialty practice can facilitate a solution to critical workforce needs. It is a necessary step toward addressing these issues and enabling the growth of this workforce. It will directly remove specific structural barriers. More broadly it will facilitate health service/training systems, health personnel and the community at large working toward a strong and thriving national network of these practitioners.

This proposal outlines how these issues will be addressed through implementing the NRGP with an endpoint of a Fellowship in the nationally recognised specialised field of Rural Generalist medicine. It outlines the Pathway, including the RG training model and the principles on which it is based.

B. Provide a clear definition of the specialty/field of specialty practice as:
i. Understood by the applicant; and
ii. Used by other local and international authoritative sources to demarcate this area of medical practice.

> *"A Rural Generalist is a medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care and required components of other medical specialty care in hospital and community settings as part of a rural healthcare team."*

This definition was agreed to by the two general practice colleges in collaboration with the National Rural Health Commissioner (the 'Collingrove Agreement') and formed an essential element of the National Rural Generalist Taskforce report, which was presented to, and, accepted by Minister Bridget McKenzie in December 2018.

An international consensus statement has been developed and widely endorsed - Cairns Consensus statement on Rural Generalist Medicine (2014) which aligns with the Collingrove Agreement. The Queensland, Northern Territory and Tasmanian state/territory governments have included definitions of a 'Rural Generalist' in their respective legislation.

See: Appendix 2.1 Definitions of Rural Generalist Medicine

C. How will recognition of the proposed new or amended specialty within the National Scheme advance the objectives of the National Scheme, that is:

- To enhance protection of the public, including improvement in the quality of health services
- To facilitate workforce mobility
- To facilitate access to health services in the public interest
- To enable the development of a flexible, responsive and sustainable health workforce and innovation in service delivery

Specialist title recognition will facilitate growth of a robust RG workforce which can enable access to quality care for rural people[7].

**Objective 1: Enhanced protection of the public including through healthcare quality improvements**

*Enabling a scope of practice to address rural medical service gaps*

The RG practitioner has evolved as a direct response to ensuring communities have access to services that meet their healthcare needs that might otherwise be unmet. People living in rural and remote communities face unique challenges due to their geographic isolation and the relatively small pool of doctors, healthcare professionals and healthcare resources in their local area. Their limited access to healthcare services is likely to be a factor in their recording lower health status by all key indicators than their urban counterparts.[8]

People in rural and remote communities typically do not have locally-based medical professionals from the full range of specialties and may have to travel long distances to access non-GP specialists. This can be costly and can cause major disruption to families.[9] It may lead to families deciding to forego care[10] with national surveys finding that most people in remote areas view the lack of a non-GP specialist nearby as a barrier to seeing one.[11] Delays to obtaining appropriate care can exacerbate some conditions and create anxiety for patients. Travelling long distances to access care creates additional patient safety risk[12,13,14] and in emergency scenarios such as accidents and obstetric and psychiatric emergencies it may not be a safe or viable option.[15,16,17]

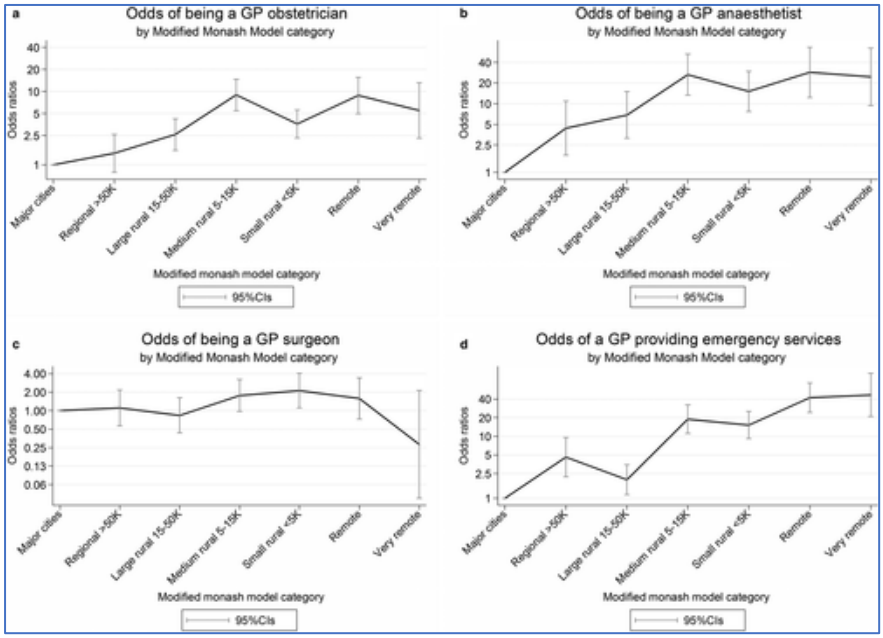
RGs provide an extended scope of practice which addresses the service gaps in rural communities in the skilled areas which in urban centres would typically be considered the purview of other specialties. As well as providing comprehensive general practice and emergency care, rural communities often depend on their doctors having advanced/additional skills for an extended scope of practice to meet their needs. These include skills in the fields of anaesthesia, obstetrics, surgery and more advanced emergency medicine as well as fields such as Aboriginal and Torres Strait Islander health, mental health, aged care, palliative care, addiction medicine, adult internal medicine, paediatrics, and remote medicine. The development and use of these general practice, emergency and advanced/additional skills represent the broad scope of practice of an RG[18].

These service gaps exist because it is not economically nor professionally viable for sustainable teams of all the relevant specialties to be based locally. The RG model enables teams of these

doctors to commit part of the working week to these specific areas of extended scope and to provide the also needed broad scope general practice and emergency services. In this way it is sustainable in both business and professional terms.

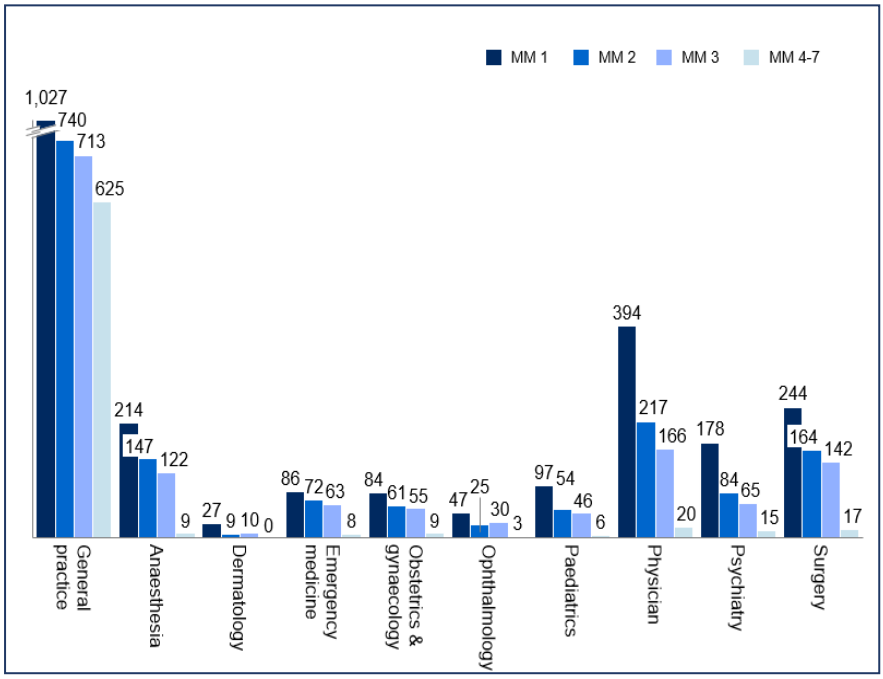
The Australian Institute of Health and Welfare (AIHW) have noted that, *"the higher rate of GPs in Remote/Very remote areas may be due to them having a broader scope of practice, given lower levels of supply for almost all other health professionals"*.[19] MABEL data has shown significantly increased likelihood of rural GPs providing anaesthetics, emergency or obstetrics services as geographical remoteness increased and population size decreased (see Figure 2.1).[20] This corresponds with decreasing numbers of anaesthetists, emergency medicine specialists and obstetricians as remoteness increases (see Figure 2.2).[21]

**Figure 2.1 Odds of being a procedural GP by MM categories**




Source: MABEL dataset, from Russell D et al (2017)[18]

**Figure 2.2 Locations of specialists, by MM classification**




Source: Commonwealth Health Workforce Data Set 2019, from Dept of Health (2019)[19]

*Enabling promotion of medical career with exceptional rural outcomes*

Currently there is no nationally recognised 'RG job title' nor nationally recognised employment positions following what is typically a 10 to 14-year training journey. This makes it difficult to promote rural generalism as a career to early stage doctors. Recognising a protected title will provide formal national recognition of the attainment of additional and extended training and its associated assessment requirements for the RG.

An RG career is a highly attractive value proposition to many aspirant doctors and practicing to the RG scope strongly correlates with rural retention. Removing these barriers to effective promotion of these careers can enable substantial expansion of this workforce and strengthen health services across rural and remote Australia.

There is substantial evidence to demonstrate the attractiveness of the RG model to Australian doctors.[22,23,24,25,26] Further, National AGPT Registrar Surveys of ACRRM (rural) registrars have consistently reported key features of the RG model such as 'practice variety', 'rural location', and 'procedural practice' as the most appealing aspects of training.[27-28] The MABEL survey studies found in particular that procedural practice is a significant predictor of rural retention and that where rural general practice doctors work in hospitals this correlates with an 18% increase in rural retention.[29]

In Queensland where the state government has formally recognised the RG role in legislation, workforce retention outcomes have been exceptional. From commencement of the Queensland Rural Generalist Program (QRGP) in 2007 to 2018, 144 Fellows had completed the program with a 70% retention rate in rural of remote areas (i.e. MM 4+).[30] All Australian jurisdictions should be enabled to attain equivalent positives workforce outcomes for their rural and remote communities.

*Incorporating RG into credentialing and other quality and safety systems*

A nationally recognised title linked to appropriate national qualifications can facilitate consistent, informed decision-making regarding RG doctors' safe, quality practice. Protected title for the RG workforce establishes a link between the field of specialty practice and its accredited qualifications. This will enable creation of consistent industrial and regulatory language to describe the role and its scope and address the considerable variability in the terminology currently used to differentiate the services that RG doctors provide.

Protected title can provide a basis for improved reliability and validity of credentialing decision-making. RGs' qualifications are often not recognised or understood by credentialing committees and RGs are commonly not included on these committees to make assessments. This practice (as well as preventing an opportunity to streamline compliance processes) can lead to erroneous determinations due to credentialing committees failing to understand the RG scope and skill set. Currently, many trained and able rural practitioners are being prevented from providing vital services to rural and remote communities due to such scenarios.[31]

Protected title clarifies the appropriate qualifications of RGs and their scope of practice informing quality and safety standards around their distinctive skill set. It clarifies the appropriate professional home for RG practitioners to ensure their continuing professional development (CPD) needs and other professional standards issues are supported by a fit-for-purpose, peer-led professional framework. This is consistent with the single designated CPD home specification of the new Professional Performance Framework.[32]

The end result of all these developments will be safer care for patients and patients being able to know that when they need RG care, they actually have an RG delivering it.

*Enabling a valuable model of care for Aboriginal and Torres Strait Islander peoples*

The RG model of care is an important part of creating a healthcare workforce which can meet the needs of Aboriginal and Torres Strait Islander peoples living in rural and remote areas. The RG model is designed to provide advanced care services to Aboriginal and Torres Strait Islander peoples *on country* leading to improved health outcomes. It is a preference of many Aboriginal and Torres Strait Islander people particularly those in remote underserved communities to receive advanced care such as renal dialysis, end-of-life-care and birthing services[33,34] *on country*. This arises where they may not have access to social and financial supports in city centres, they may need to stay at home to look after children or family members, or where they may have cultural and spiritual beliefs that make remaining *on country* important.[35]

RGs are well positioned to build effective, continuing relationships of trust with Aboriginal or Torres Strait Islander patients. By working in both hospital and primary care settings (and often other settings such as with retrieval services, aged care services and Aboriginal Community Controlled Health services), the RG can build a stronger doctor-patient relationship with their Aboriginal or Torres Strait Islander patients. RG medicine involves taking a flexible, community-responsive approach to defining each practitioners' role in their collaborative local healthcare team. This lends itself to working effectively with Aboriginal and Torres Strait Islander Health Workers, cultural advisors and other personnel important to providing culturally appropriate healthcare in every local context.

*Better informed patient/community decisions about their safe, quality care*

The national adoption of the RG title will facilitate patient and community awareness of the profession and enable doctors to easily and simply communicate their training and qualifications for providing advanced skilled procedures and services within their appropriate scope of practice.

The designation "Rural Generalist" provides the rural patient with clarity regarding their doctors' credentials and scope. The title also makes explicit that that their extended skills are for provision of necessary/appropriate care in their rural/remote clinical context. Understanding their RG's skill set is especially important for people in rural and remote communities in making decisions about their treatment options. People in the many communities that do not have locally based non-GP specialists, need to know and compare their local doctors' scope of services against the substantial risks and personal costs of travelling to cities for care, which as outlined above, may involve dangerous, physically painful, or financially prohibitive travel or substantial delays in receiving care.

**Objective 2: Facilitating Workforce mobility**

Protected title of the RG designation will facilitate more efficient processes for enabling the safe practice of RG doctors - including in areas of extended skill in which they have been specifically trained and assessed.

A nationally registered protected title will provide a common administrative structure which is tied to a College qualification and will be linked to streamlining the processing of hospital and health service employment and credentialing decisions.

As outlined above, the current administrative complexity and unpredictability of hospital credentialing is a recognised barrier to RGs providing procedural services.[36]

This will also provide a basis for consistency across jurisdictions and address current portability issues for RG doctors wishing to move from one state to another. Presently there is no consistency in terms of whether state or territory governments, or even different hospitals and health services within each jurisdiction formally recognise the skills that an RG has acquired. This currently presents considerable barriers to prospective RGs in accessing necessary training in the diverse skills areas as well as in finding employment.

**Objective 3: Facilitating access to health services in the public interest**

*Enabling provision of safe, quality in-situ services for rural communities*

Specialist title recognition will facilitate growth of a robust RG workforce which can enable access to quality care for rural people[37].
While there are relative shortages of GPs in rural and remote communities, non-GP specialists are virtually absent in many areas.[38] People in rural and remote areas commonly view not having a specialist nearby as a barrier to seeing one (30% of people in outer regional areas, 58% in remote/very remote areas compared with 6% of people in metropolitan areas).[39]

Rural and remote communities can and should have access to local doctors who can meet their primary care needs and as many as safely possible of their emergency, and secondary/tertiary needs either individually or through working effectively with healthcare teams (both local and distal). The RG skill set is designed to meet all these needs. Local access to doctors who can provide advanced care services such as palliative care, mental health, obstetrics and anaesthetics is especially important to the people in rural and remote areas that have the highest needs particularly for people in socio-economically disadvantaged communities and for people who are socially-isolated, from single parent families, older Australians, or chronically ill patients. These are the people most likely to find the social, economic costs and practicalities of travel to cities prohibitive. As outlined above, locally-available advanced care services are also of particular importance for many Aboriginal or Torres Strait Islander peoples living in rural and remote communities.[40]

As outlined at objective (1) above, RG provides a sustainable business and professional model in rural and remote communities where more specialised professional models may not be viable (or may not be viable without the support of local RGs) and is strongly associated with positive rural retention outcomes. An RG workforce can thereby stem the increasing trend toward high reliance on a rural locum workforce with its attendant inadequacies for quality and safety of patient care.

RGs based in the rural community can enrich the quality of care for their patients by enabling continuity of care in receiving their extended care services. Continuity of care is especially valued by people from rural and remote communities[41] and alongside safety, often a key consideration in their decision to stay in their home town for advanced care such as obstetric services.[42,43]

As further detailed below, it is important to note that preservation of rural hospitals can often be a vital aspect of maintaining rural communities and the ongoing safety and well-being of the people in them.[44] RGs together with nurses and midwives are often the only economical way to ensure the continuing viability of rural hospitals and rural emergency response capability.

**Objective 4: Enabling development of flexible, responsive and sustainable health workforce and innovation in service delivery**

The RG model is designed to enable RGs to adapt to the diverse environments presented by rural and remote communities. RG trainees are selected, trained and assessed with consideration of their personal propensity to work in rural and remote settings. The RG scope is comprised of a core skill set which enables practitioners to provide general practice care plus emergency care in a clinical context of relative professional isolation, and in addition, at least one additional area of advanced skills related to the needs of their communities. [45]

As outlined above, RGs can reduce the increasing reliance on locum-led models of care for rural and remote communities with all of the attendant issues of this in terms of both costs and the quality and safety of care that can be received by communities.

Their broad and flexible practice scope allows RGs to practise in the rural locality and continue to maintain a viable business even where the local community demographics and associated demand for medical services may change. RGs can provide advanced specialised care within their scope but are not restricted from offering general practice primary care to flexibly meet the breadth of local patient needs. The RG model builds local capacity to meet the breadth of community needs with available staff and resources by taking a flexible, team-based approach. RGs are trained to work effectively with their local healthcare team which may include nurses, allied healthcare workers, other RGs and non-GP specialists. They are also trained to work effectively with distal specialists, through digital health, collaboration with specialist outreach services and other collaborative models.

D. The extent to which health services are established in the proposed specialist or field of specialty practice and the demonstrated and/or potential ability of this proposal to improve the provision of the service, including:

- Describe the extent to which the area of practice is already established and acknowledges a specialty/field of specialty practice in Australia
- Describe the scope of practice relevant to the discipline and the settings of practice with particular relevance to regional, rural and remote Australia

**Established RG Training programs**

*AMC accredited specialist training and CPD*

The ACRRM has a Fellowship training and CPD program designed to describe the RG scope. These programs have been operating with provisional AMC accreditation since 2007 and with full accreditation since 2011. Over 700 registrars have been trained through to Fellowship though these and some 1800 doctors hold and maintain their Fellowship of ACRRM (FACRRM) compliance.

The RACGP has developed its Fellowship of Advanced Rural General Practice (FARGP) program which has been designed in combination with the FRACGP, to reflect the RG skill set.

*Measures of the extent of Rural Generalist practice*

The Rural Procedural Grants Program is a Commonwealth Government funded program to assist RGs to maintain their extended skills. It is oversighted as a joint-collaboration of the general practice

colleges. Eligible participants must be Vocational Registered (VR) GPs credentialled to provide regular services in their area of procedural practice.[46] As at 30 June 2019, the program had 6023 registrations[47] to undertake CPD training in the areas of emergency medicine, obstetrics, anaesthetics, and surgery. Between August 2018 to June 2019 its registrants undertook 2849 training courses.

*Commonwealth Government sponsored RG training*

The Commonwealth Government made a commitment to developing and implementing a national framework to support RG training and practice in 2016[48] and following the recommendations of the National Rural Health Commissioner and the National RG Taskforce presented in 2018 is progressing the implementation of the NRGP including through provision of funding to support this application.[49] The commitment to the NRGP also forms part of the National Medical Workforce Strategy Scoping Framework.[50] This application is consistent with the recommendations of the National Rural Health Commissioner's Report and it is viewed as an essential element of the package of required actions to implement the NRGP.

In parallel with these developments, the Australian General Practice Training (AGPT) has established dedicated RG training places and the RG policy. The policy comprises a range of variations to the established AGPT requirements that reflect the RG curricula and standards, including a facility for additional training time and more flexibility in location of training.[51] The Commonwealth Government is funding 300 dedicated RG positions in 2019 and 2020 and is looking to increase these numbers in future years. The doctors awarded these places are supported to train to the Fellowship end point of a FRACGP+FARGP or FACRRM.

*Jurisdiction sponsored RG training*

*New South Wales*
The NSW Government launched the NSW Rural Generalist (Medical) Training Program in 2013 through the Health Education and Training Institute (HETI)[52]. Fifteen positions were funded in 2013, expanding to 30 in 2015 and 50 in 2019. The pathway targets PGY2 entry (termed foundation year) and provides support through PGY2, advanced skills training and vocational training. The recognised endpoint is FACRRM or FRACGP plus FARGP.

*Northern Territory*
The Territory Government has recognised RGs and RG Trainees in its Enterprise Agreement (See Appendix 2.1)[53] [54] These 'recognised' positions are available in locations such as Tennant Creek, Katherine and Gove Hospitals. The Territory Government is also supporting a pilot training program targeting remote RGs with FACRRM or FRACGP plus FARGP as training end points.

*Queensland*
The Queensland Rural Generalist Pathway (QRGP) was established in 2007. The recognised endpoint is FACRRM or FRACGP plus FARGP (including specific certification of advanced specialised/rural skills).[55,56]

Queensland formally recognised the discipline of RG Medicine in its State Industrial Award in 2008 (See Appendix 2.1), adopting a state specific definition of Rural Generalist Medicine based on the knowledge and skills of recognised Rural Generalist Medicine contained in the ACRRM curricula statements.[57] An industrial framework is also supported with an appropriate remuneration schedule for doctors employed in the public health system who hold the prescribed Rural Generalist Medicine credentials and are granted scope of clinical practice for these credentials.

The QRGP recruits and selects final year medical students, with training commencing during internship. Additional postgraduate entry points also occur at PGY1-3 and provides a range of supports for them to the end point of Fellowship. The program selects 80 trainees per year and 124 Fellowed doctors have been supported through the program to date with 70% of these continuing to use their additional/advanced skills. [58]

*South Australia*
South Australia has established its Road to Rural GP Program [59] which includes support to enable doctors seeking general practice qualification to gain advanced skills in procedural practice areas. This has been in place since 2012.[60]

The Health Minister has signalled his support for progressing the South Australian RG pathway plan and the state's new Rural Health Workforce Strategy which includes the following strategy:

*"1.2. Prepare for the National Rural Generalist Training Pathway in South Australia:*
*1. Collaborate with the Commonwealth Department of Health to roll out the proposed National Rural Generalist Pathway in South Australia*
*2. Prepare and cost proposals for recommended elements of the National Rural Generalist Pathway within SA, in conjunction with SA rural workforce stakeholders. [61]*

*Tasmania*
The Tasmanian Rural Medical Generalist Pathway (TRMGP) was established in 2014[62]. A small number of rurally-based dedicated TRMGP RMO positions has been made available each year which is accessible to doctors at any year level. The recognised endpoint is FACRRM or FRACGP plus FARGP. Tasmania has adopted the Collingrove Agreement definition of the RG.

*Victoria*
The Victorian Department of Health and Human Services is currently working to strengthen its established RG training. From 2020, all RG related rural medical workforce programs, including the Rural Community Intern Training (RCIT) program, and the Victorian GP-RG Program are to be merged into one program and rebranded as the 'Victorian Rural Generalist Training program'[63].

The Victorian Government's consultation draft, 'Strengthened Rural Generalist Training Plan' includes the key aims of better linking-up of the disparate elements of the existing programs, stronger overarching governance, stronger health services involvement, greater workforce outcomes focus, and greater emphasis on 'Rural Generalist' brand recognition.[64]

The previous Victorian GP-RG Program was operational from 2013 with a minimum annual intake of 11 trainees.

*Western Australia*
The Western Australian Rural Generalist (WARG) Program commenced in 2019 as a joint-initiative of the Commonwealth Government, the Western Australian Government, and a number of partners including Western Australian General Practice Education and Training (WAGPET), WA Country Health Service, Rural Health West, the Rural Clinical School of Western Australia and the Western Australian Primary Health Alliance (WAPHA). The Program supports 30 trainees each year in accordance with the AGPT Rural Generalist policy[65].

The WARG Program is a reshaping of the WA Rural Practice Pathway which has been in operation since 2010. It aims to improve its alignment with the imperatives to train RGs. This is intended to

enable WAGPET to meet its obligations under the new AGPT RG policy and also to form part of the state's wider strategy for rural health.

**Scope of practice and its relevance to regional rural and remote Australia**

RG Medicine provides a broad scope of medical care in the rural context encompassing the following[66]:

- Comprehensive and continuing primary medical care. This includes comprehensive management of acute ambulatory presentations, management of chronic illness, paediatric, adult and aged care, care of common psychiatric illness, and preventative health care. Settings in which this might occur include general practice clinics, hospital and community health service clinics, aged care homes, and/or Aboriginal Medical Services.
- Hospital in-patient and/or related secondary medical care. This may occur in the institutional, home, or ambulatory setting.
- Emergency care – settings which may include general practice clinics, hospitals or retrieval settings.
- Extended and evolving service in one or more areas of focused cognitive and/or procedural practice as required to sustain required health services locally among a network of practitioners. This may occur across the diversity of work settings.
- A population health approach that is relevant to the community which would be applied irrespective of the work setting.
- Working as part of a multi-professional and multi-disciplinary team of colleagues, both local and distant, to provide services within a 'system of care' that is aligned and responsive to community needs. This often involves telehealth and collaborative care arrangements with nurses and specialists, (both local and distal) including FIFO specialists.

RGs commonly work in one or a combination of different work settings and employment arrangements to fulfil the diverse needs of their rural or remote community. Some of the most common areas include:

- Practise in private GP clinics
- Practise in community health services, Aboriginal Medical Services/Aboriginal Community-Controlled Health Services, aged care homes, and hospital-based primary care services
- Practise in hospitals to provide general hospital inpatient care and emergency services as a Visiting Medical Officer (VMO), Medical Superintendent with Right to Private Practice (MSRPP), rostered/salaried Hospital Medical Officer (HMO), RG Senior Medical Officer (SMO) or equivalent. Most RG employment includes on-call rostered work
- Working for aero-retrieval services
- Working for the defence forces
- Working in a broad range of (non-rural) remote clinical contexts such as on ships, in prisons, on islands, refugee camps and for the Australian Antarctic medical services.

The breadth and flexibility of the RG scope of practice uniquely equips RG doctors to maintain a financially and professionally sustainable rurally-based practice adapted to the needs and changing circumstances in their community. It can thus provide the patients in these communities with the safety and well-being benefits of knowing they have locally-based doctors available to provide help when needed across an extensive range of medical services including in emergencies.

# 3. Describe alternative options (both regulatory and non-regulatory) for addressing the issues outlined in point 2

In addition to recognition under the National Law, the proposal must present and compare the advantages and disadvantages of:

- Existing arrangements (no change)
- Other regulation that exists that may be used to address the problem listed in point 2
- Other non-regulatory mechanisms to achieve the desired outcome, for example: self-regulation of practitioners through professional (voluntary) codes of conduct

The options discussed below outline key mechanisms which seek to alleviate the inequity of access to quality medical services that continues to be experienced by people living in rural and remote areas especially in areas outside essential primary care.

***Existing arrangements***

The following options all represent a continuation of the status quo in terms of provision of health services to rural and remote communities. It is the strong contention of this application that current inequities and trends with respect to the quality and safety of services available and accessible to people in rural and remote communities are unacceptable and that substantive, structural change is needed in order that these be addressed.

*Provision of medical services in rural areas by (non-GP) specialists, locum-specialists and patient transport to major centres*

Advantages:

- Patients that are able to access the services they need will continue to be serviced by doctors that have highly specialised knowledge in their respective disciplines.

Disadvantages:

- *Non-general practitioner specialists in situ* - It is unlikely that many rural/remote communities will ever be able to attract or support permanent non-GP specialists. This specialist scope of practice in many cases presents an unsustainable practice and business model for rural and remote communities which have a small and geographically limited patient catchment. Further, this model relies on availability of a complex mix of supporting specialist staff and resources and also on a high patient turnover across a narrow range of medical presentations. Even where specialists may be based in rural locations, they may still rely on the support of local RGs to maintain work rosters. The current system failure is evidenced in the data which show that despite the increase in Australian medical graduates, shortages are worse and gaps are greater.

- *Patients travel to non-general practitioner specialist care* – The tyranny of distance means that patients may need to travel long distances to access emergency and advanced care. Patient transport presents time delays in care which can increase patient risk [67,68,69] and extended travel arrangements represent an impost to rural people in terms of time, stress and financial cost which can act as a prohibitive barrier to their receiving appropriate care. [70,71,72] This is especially so for rural patients that already face significant disadvantage (e.g. poor, aged, chronically ill, socially isolated, etc.).[73-74] The RDAA notes that cost savings to governments of *not* establishing specialist services in rural communities represent a cost

transfer from health budgets to the people living in those communities who are expected to fund their own transport, as well as the costs of living away from home often for extended periods of time (e.g. loss of income, childcare, city accommodation).[75] This can be a particular barrier for Aboriginal and Torres Strait Islander people who may (apart from any social or economic barriers) have cultural reasons for choosing to stay on-country.

- *Provision of locum non-general practitioner specialists* – Many rural and remote communities are now relying on visiting or short-term locums to enable provision of referred, secondary and emergency care services to their local population. This presents a poor health service outcome for rural and remote communities and an expensive model of care for jurisdictions. It has been identified as a key issue in the National Medical Workforce Strategy:

  *"Rural hospitals are overly reliant on locum doctors. The relatively lucrative income from locum work means that some doctors prefer working in the locum system, rather than taking up full-time, longer working hours. Locums are transient so it can be difficult to ensure accountability for their actions and continuity of care for their patients…"* [76]

  This excessive and increasing reliance on a locum workforce for rural patients, is an inevitable consequence of the current systemic barriers to growth and sustainability of the RG workforce that specialist recognition will assist in addressing.

***Other regulation that exists that may be used to address the problem listed in point 2***

*1. Rural Generalists recognised only as General Practitioners with advanced skills*

Advantages:

- Scope of practice and specialised knowledge sets are determined by credentialing committees providing a local solution specific to needs of community.

Disadvantages:

- This would only enable recognition of the individual extended skills held by the RGs that are subject to hospital credentialing processes. It would not recognise extended skilled services that are not provided in hospitals including national priority areas such as mental health, aged care and palliative care. This would forego the opportunity to professionally recognise the distinct and broad, overarching skill set that RGs attain. This disincentivises doctors from attaining the extended skill-set and misses the opportunity for RG doctors' titles to accurately inform employment, resourcing and patient decision-making.

- No uniform or national approach to credentialing. Jurisdictions operate locally rather than referring to a nationally recognised qualification which articulates scope of practice. Local determinations regarding practice are assessed under local credentialing processes rather than under a national approach based on a common understanding of an RGs knowledge, training and skillsets. Ad hoc hospital credentialing on a case-by-case basis would continue under the status quo, however without formal recognition of their professional title, the opportunity is lost to provide a more structured, predictable and facilitated approach. Under current arrangements, the RG profession is frequently not represented on rural and remote hospital credentialing committees and decisions and these can be made in ignorance of the profession and its full scope and training.

- This approach does not formally recognise the RG's as a cohesive scope of practice. This is incompatible with the Medical Board of Australia's requirement for RG practitioners to have a single professional home for the purposes of meeting their ongoing continuing professional development requirements across the range of advanced skilled areas in which they practice under the new Performance Management Framework.[77]

- This approach foregoes the opportunity to develop a clear, well-coordinated and structured training pipeline associated with a defined RG career path. As is currently the case, aspirant doctors will continue to be required to negotiate their way through the training pathways, standards and policies of multiple colleges. Likewise, their training providers may continue to need to negotiate with disparate colleges and education providers to ensure supervision and training posts are made available and meeting disparate standards.

- Under these arrangements there is a significant administrative burden borne by individual practitioners. Rural doctors are already the disproportionately overworked practitioners and the ongoing additional and separate administrative burden presents a substantive disincentive to continue advanced practice.[78]

2. *Rural Generalism is a standalone specialty*

Advantages:

- Provides clarity of professional identity, peer networks and professional home.

- Enables clarity of recognition of the profession by authorities and communities and for them to appropriately know, value and reward the requisite training and practice standards that have been attained

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

Disadvantages:

- There is potential for difficulties in professional mobility, particularly for RGs who may wish to revert to practicing as GPs as their scope of practice may change due to circumstances

- Many doctors view themselves as belonging to both General Practitioner and Rural Generalist professions.

- Disaffection of GPs who practise in rural environments.

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

Advantages:

- Provides transparent and consistent information to public and authorities regarding practitioners' areas of capacity for advanced practice

Disadvantages:

- As at (1) above, this would not provide any recognition of the broad and distinctive core skill set that RGs would have attained. It is imperative to quality, safety and efficacy that patient, employer and health service planning decisions can all be based on an understanding of the full scope of the doctor's training and practice and not just isolated aspects of it.

- As above, as RGs would need to seek separate endorsements for each successive extended skill any recognition that would be attained would involve considerable administrative compliance which may prove a prohibitive barrier to already overworked rural doctors.

- This approach would not incentivise or encourage RGs doctors to maintain their broad, multifaceted scope and take the flexible, adaptive and community-responsive approach to defining their practice scope that is at the core of the RG concept as a workforce solution.

- As above, as this approach does not formally recognise RG it is incompatible with the Medical Board of Australia's requirement for practitioners to have a single professional home for the purposes of meeting their ongoing continuing professional development requirements across the scope of advanced skill areas in which they practice under the new Professional Performance Framework.[79]

- This approach is not consistent with the historic approach by medical disciplines to recognising specialty fields and may therefore create confusion.

4. *Industrial recognition within each jurisdiction*

Advantages:

- Provides clear employment opportunities; appropriate recognition of the RG skill set attained and provides a clear basis for reward in terms of remuneration and appropriate job terms and conditions.

Disadvantages:

- This model, (which is in place in several jurisdictions already including Queensland and Northern Territory) is a positive development but offers only a partial solution to the problems raised in this submission as there are different requirements and differing assessment processes across and within states and territories.

- Recognition is limited to RGs that work in jurisdictional services. It is not transferable to employments contacts with other potential employers such as Aboriginal Medical Services, local government financed health centres, private employers etc. (Noting that RG training and practice is characterised by this movement between different workplaces.)

- Recognition is inconsistent across jurisdictions and does not enable transferability unless it were linked to a common nationally recognised standard. The 10-14-year training journey from medical school to RG Fellowship typically involves considerable movement across jurisdictions and workplaces.

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

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

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

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

# 4. Describe the existing professional standards that are relevant to training speciality practice in the speciality

A. If education programs and continuing professional development programs exist, provide a short outline of them and a link to more detailed information. The short outline could include but is not limited to:

- Name of qualification awarded (if a formal qualification is awarded)
- Length of education and training program
- Program structure, teaching and learning methods and locations (including how the program is organised by year, terms, or phases)
- Number of trainees entering the training program/s for the last five years
- Organisation responsible for training and CPD, if different
- CPD program structure
- Numbers of CPD program participants for the last three years

The Australian Medical Council (AMC) has accredited the RACGP and the ACRRM to deliver general practice Fellowship training.

To be recognised and work independently as a specialist GP, doctors need to qualify as a Fellow of the ACRRM (FACRRM) or as a Fellow of the RACGP (FRACGP). Both Fellowships lead to Vocational Recognition (VR) and registration under the Specialist (General Practice) category with the Medical Board of Australia. These qualifications allow a doctor to work unsupervised as a GP anywhere in Australia and with some exclusions enable MBS eligibility.

General practice training is undertaken in an apprenticeship model where registrars train as a GP under the supervision of an experienced supervisor. This practice-based learning is supplemented and consolidated through discussions with the general practice supervisor, teaching visits from medical educators, workshops with peers, and personal study.

There are different pathways to achieving Fellowship of either of the general practice colleges. All pathways are delivered in conjunction with the respective Colleges' curricula, assessment and standards. Registrars apply and enrol to training through different streams with differing funding, training services delivery and support arrangements.

The available training pathway options include:

| RACGP Fellowship Training | ACRRM Fellowship Training |
|---|---|
| - Practice Eligible Pathway | - Independent Pathway |
| - AGPT (rural or general pathway) | - AGPT (rural pathway only) |
| - RVTS | - RVTS |

Registrars that enroll in either the RACGP or ACRRM Fellowship pathways may be awarded places on the AGPT which is a Commonwealth Department of Health funded program. These registrars are supported in the delivery of their training by the Regional Training Organisations (RTOs). RACGP and ACRRM in conjunction with the Department of Health contracts nine RTOs to deliver a range of their training functions across the 11 training regions according to standards set by the Colleges. Registrar assessment is conducted by the Colleges.

Registrars that enroll in either the RACGP or ACRRM Fellowship training pathways also have the opportunity to be awarded places on the Remote Vocational Training Scheme (RVTS) which similarly to the AGPT is funded by the Commonwealth Government to provide supported training services toward Fellowship with either of the GP colleges with the College conducting their respective Fellowship assessment.

Further information on the AGPT can be found at the following link:
http://www.agpt.com.au/

Further information on the RVTS can be found at the following link:
https://rvts.org.au/about

**Table 4.1 Summary of Fellowship Training Programs**

| | **RACGP** | **ACRRM** |
|---|---|---|
| **Qualification** | Fellowship of The Royal Australian College of General Practitioners (FRACGP)<br>FRACGP + Fellowship of Advanced Rural General Practice (FARGP) | Fellowship of the Australian College of Rural and Remote Medicine (FACRRM) |
| **Duration** | 3 years – FRACGP<br>4 years – FRACGP+FARGP | 4 years*<br>**5 years for Fellowship with AST in surgery* |
| **Program Structure** | 12 months Hospital Training Time<br>24 months in RACGP accredited facilities/training practices:<br>• 3 x 6-month terms in general practice (GPT1-3)<br>• 6 months Extended Skills<br><br>For FARGP:<br>• 12 months in a rural general practice setting (MMM3-7)<br>• Completion of a 6-month 'working in rural general practice' community-focused project.<br>• Completion of the FARGP emergency medicine modules which includes a series of case studies, skills audits and satisfactory completion of two advanced emergency skills course.<br>• Plus a 12 months advanced skills (ARST) | 36 months Core Generalist Training*<br><br>This is based in a combination of the following work locations in MM2-7** areas:<br>• General practice and community-based primary care clinics<br>• Hospitals<br>• Retrieval services<br>• Aboriginal Medical Services<br>Training on AGPT must commence with 12 months hospital training and on all training pathways must include a minimum:<br>• 6 months community /primary care<br>• 6 months hospital and emergency care<br>• 12 months rural/remote experience (MM4-7)<br><br>12 months in Advanced Specialised Training (AST)***<br><br>**Changes associated with revised* |

| | | |
|---|---|---|
| | | *curriculum to take effect from 2020*<br>***Unless MM1-based training needed for specific skill*<br>****24 months for surgery* |
| | ARST can be undertaken at any time after completing the Hospital Training Time. It is recommended that the needs of the community in which candidates intend to practice be taken into consideration when making the choice. | AST can be undertaken after completing at least 12 months of the Core Generalist component with consideration to special requirements of respective AST fields. It is recommended that the needs of the community in which candidates intend to practise be taken into consideration when making the choice. |

**Continuing Professional Development programs**

The RACGP and the ACRRM both have Medical Board of Australia compliant continuing professional development programs which enable AHPRA reporting for Fellows continuing compliance for vocational registration purposes:

- The RACGP Quality Improvement and Continuing Professional Development program, and
- The ACRRM Professional Development Program

For detailed information on the RACGP and ACRRM Fellowship and CPD programs:

See: Appendix 4.1 RACGP Fellowship and CPD
Appendix 4.2 ACRRM Fellowship and CPD

B. Indicate what new standards or requirements are anticipated if the proposal results in recognition of a new or amended specialty of field of specialty practice under the National Law.

There will be no changes to standards or requirements.

# 5. Impact of recognition

| |
|---|
| A. Identify the stakeholder groups likely to be affected by the recognition of the speciality including groups within the regulated profession or segments of the profession, other health professions, health consumers and the community, health service providers, funding bodies education providers and Aboriginal and Torres Strait Islander Peoples. |

*National Rural Health Commissioner Consultations - Stakeholder Groups*

The National Rural Health Commissioner undertook an extensive consultation at a national, jurisdictional and local level as well as representing the contributions of more than 200 expert stakeholders of the Rural Generalism Taskforce, Working Groups and Expert Reference Groups in the development of the RG Pathway. A list of Health profession and National organisations that were consulted is included as **Appendix 5.1.**

| |
|---|
| B. Describe the consultation which has been undertaken to determine the stakeholders affected by the proposal. |

*National Rural Health Commissioner Consultations*

Throughout 2018 (and continued in 2019), the National Rural Health Commissioner undertook an extensive consultation on behalf of the National RG Taskforce which he co-led with the general practice colleges. This application is based on the recommendations of the Taskforce which were informed by the consultation and developed by the Taskforce working parties.

The consultation was conducted at the national, jurisdictional and local level as well as representing the contributions of more than 200 expert stakeholders of the Rural Generalism Taskforce, Working Groups and Expert Reference Groups in the development of the RG Pathway. Briefly, the consultation process obtained feedback from key stakeholders working in rural and remote health workforce, Aboriginal and Torres Islander people, education and training (including students, trainees, colleges, universities, academics), Australian Government, State and Territory Governments, and industrial groups, professional bodies, agencies and consumer representatives. Extensive consultations with National Rural Generalist Taskforce, Working Groups and Expert Reference Groups were conducted with local rural clinicians, trainees, students and rural community leaders across regional, rural and remote Australia has relayed strong support for the National Pathway. Membership and representation of these additional consultations by Taskforce, Working Groups and Expert Reference Groups are included in **Appendix 5.2.** There is a high level of consensus, goodwill and commitment across the rural sector for implementing and establishing the National Rural Generalist Pathway.

The Commissioner held 167 meetings and 33 presentations on the RG pathway with various stakeholder groups. Feedback was collected including the development of a set of principles that underpin the National Pathway. Based on the principles, the Commissioner developed broad advice containing 19 recommendations.

The advice including recommendations can be found at the following link: https://www1.health.gov.au/internet/main/publishing.nsf/Content/National-Rural-Health-Commissioner-publications

*Consultation process*

Jurisdictions and Colleges provided written submissions to the Commissioner. The jurisdictions were essentially supportive of all recommendations. Jurisdictions provided comments in relation to the following areas:

- development of transition plans
- development of funding plans and agreements
- supervision plans
- MBS specialist code access
- process development to recognise existing GP proceduralists
- support for flexible entry and exit points

Medical Colleges were also supportive of the National Rural Generalist Pathway. Colleges offered the following suggestions:

- broader consultation required with further details of the pathway
- supportive of creating the Rural Generalist protected title
- further clarification of how additional skills training will be delivered
- very supportive of an evaluation framework
- details of supervision arrangements to be provided and a need to address supervisor shortage
- details of selection processes
- the funding follows the trainee for the duration of training
- development of infrastructure and jurisdictional arrangements
- support for flipped training models

The AMA supports the development of an NRGP, recognising the pressing health needs of our rural and remote communities and the potential for the NRGP to support improved recruitment and retention in these areas and contribute to improved health outcomes. The AMA notes that there are already many doctors in rural and remote settings practising across an extended scope of medical care, they also agree with the Taskforce view that there is currently no nationally recognised pathway for training this workforce for the future, or any national process for recognising and supporting existing practitioners. The NRGP has the potential to bridge this gap by integrating rural training for general practice, emergency and additional skills, which rural and remote communities need, into a single training program. https://ama.com.au/system/tdf/documents/AMA%20Response%20to%20National%20Rural%20Generalist%20Taskforce%20Advice%20to%20the%20NHRC.pdf?file=1&type=node&id=49718

RACGP invited feedback on the new Rural Generalist Fellowship from the General Practice Regional Training Organisations (RTOs) who undertake GP Fellowship training across Australia in association with AGPT. Feedback was generally positive emphasising the importance of a flexible model of training with the ability of RG registrars to enter and exit at different points which are important factors in the long-term sustainability of the rural health workforce. Any model included in the NRGP should maximise options for rural doctors to gain recognition as a RG at any point in their career.

The National Rural Health Student Network (NRHSN) developed a position paper in parallel with their involvement in the National RG Taskforce. The paper expresses their support for *the current development of a national rural generalist pathway in medicine.* It recognises the

complexities faced by medical students interested in pursuing RG careers and emphasised the need for medical students to be well informed of the pathways to careers in rural generalism. They also stressed that recognition should occur in a manner which ensured that existing RGs training and qualifications were able to be recognised.[80]

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| C. Identify extant medical specialties and/or fields of specialty practice that have significant overlap in scope of practice, required knowledge, skills and competencies with the proposed new or amended specialty or field of specialty practice; and describe what differentiates the proposed new or amended specialty from these existing specialties. |

As well as providing comprehensive General Practice and emergency care, RG's will acquire additional skills for an extended scope of practice to meet rural community needs. It is the nature of general practice that it extends across all specialist fields and this is especially true for many doctors working in rural and remote clinical contexts where patients may have limited access to alternative specialised health and medical personnel. RG training and assessment reflects the need for doctors to have this broad and extended scope as part of their core learning even in areas where they have not chosen to do an advanced skill.

Advanced skills in emergency medicine in particular are viewed as essential skills to ensure the safety and protection of rural people.

The RG curriculum makes a clear extension into fields which would typically be delegated to separate specialties in an urban context. The RG curriculum and training programs offer advanced skills training which have some cross over into the following specialities or fields:

- Anaesthetics
- Obstetrics
- Surgery
- Advanced Emergency Medicine
- Aboriginal and Torres Strait Islander Health
- Mental Health
- Aged Care
- Palliative Care
- Addiction Medicine
- Adult Internal Medicine
- Paediatrics / Child Heath
- Remote Medicine
- Population Health and Health Administration.

The development and use of these General Practice, Emergency and Additional/advanced Skills represent the broad scope of practice of a Rural Generalist.

An outline of each additional/advanced skill for an extended scope and knowledge and skill requirements have been mapped and is included in **Appendix 5.3.**

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

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| A. Identify expected impacts of each option (described in 3) on the various stakeholder groups, including impacts on coordination and continuity of healthcare and the quality and safety of care, workforce impacts, financial impacts, business impacts and competition impacts. |

*1. Recognition of Rural Generalist as a specialist field of general practice*

This option would not involve new models of training or practice, it is expected however to be an enabler to supporting and expanding the number of RG practitioners and extent to which this workforce model is practiced across rural and remote Australia. This RG workforce can make a transformative impact on the pervasive issues of inequitable access to services in rural and remote areas.

There is a well-documented maldistribution of medical practitioners in rural and remote Australia. The doubling of the number of Australian medical graduates has led to an oversupply of doctors in metro and urban areas but has done little to address doctors' shortages for Australians living in rural and remote areas.[81] Australian trained medical graduates today are less likely to work either as GPs or in rural communities compared to graduates of the 1970s–1980s and rural areas continue to remain substantially dependent on International Medical Graduate doctors, that comprise 36-38% of all general practice doctors in small rural centres (>50,000 population).[82]

The maldistribution is especially apparent in the supply of non-GP specialty fields. For a range of reasons, the more vertically specialised a practitioners' scope becomes, the less likely they are to be based in rural and remote communities. The Medical Workforce Reform Advisory Committee (MWRAC) Framework notes that less than 5 per cent of most non-GP specialists are based in rural and remote Australia.[83] From 2005 to 2017 however for every new GP in Australia, there have been almost 10 new doctors in non-GP specialties. And among non-GP specialists, since 2013, new registered practitioners have been three times more likely to be registered as sub-specialist practitioners.[84]

Workforce maldistribution and resulting lack of access is reflected in the substantially lower utilisation of health services by people in rural and remote areas. Rural people's lower per capita health service use (compared to that received by people in cities) is estimated to result in an annual health services funding shortfall of $2.1 billion, including an estimated annual shortfall of $0.811b in MBS spending and $0.85b in PBS and pharmacy spending.[85]

The maldistribution is likely to be contributing to the considerable and persisting disparity between health outcomes for people in rural and remote areas relative to those in major cities:

- Disease burden as measured in Disability Adjusted Life Years (DALYs) worsens with remoteness across most disease groups.
- Both mortality rates and potentially avoidable death rates increase with remoteness. Potentially avoidable death rates for people in very remote areas are 2.5 times higher than for people in major cities.

- Rates of Potentially Preventable Hospital admissions (PPHs) increase with remoteness across nearly all categories with remote and very remote people recording the highest rates across all categories and 1.6 and 2.4 times the overall rates for major cities.
- Hospitalisation rates are much higher in remote and very remote areas, with very remote areas 1.8 times higher than in major cities.[86]

The attainment of title recognition will serve to mitigate against these trends and support the growth of a robust RG workforce, with key expected outcomes, including:

- increased awareness of RG and attractiveness of pursuing RG careers
- improved, nationally-cohesive support across health systems for RG training and skills maintenance
- the RG workforce being visible and explicit in policy, planning and resourcing
- simplified, quality-assured, nationally-consistent credentialing and employment for RGs
- improved understanding by rural communities of their RG doctors and their skill set

As outlined above, the RG training and scope of practice is designed to enable doctors to flexibly and responsively, meet the needs of their diverse rural and remote communities, including Aboriginal and Torres Strait Islander communities. RGs are explicitly trained to become long-term rural doctors. As outlined above, the model of practice can be shown to be both highly attractive to prospective rural doctors and to have exceptional workforce outcomes in terms of rural retention.

The RG scope of practice model can enable continuation of hospitals, emergency care capability and other critical aspects of local health service capacity in rural and remote communities even where non-GP specialists or sufficient numbers of non-GP specialists cannot be recruited or supported. This has important implications for the safety, health and social well-being of people in rural and remote communities. Local hospitals and particularly maternity care facilities have been widely acknowledged as a lynchpin for sustainable communities, medically, socially, and economically.[87]

A study conducted in 2015 found that a trial at the Central West Hospital and Health Service, near Longreach, was able to attract medical students, junior doctors and RG trainees each bringing an advanced skillset to the Health Service, thereby enhancing the local capacity and capability. Furthermore, they were able to contribute to the afterhours / procedural services without on-site supervision. This redesign has seen the local dependence on locums decline drastically, with substantial budgetary savings (e.g. a $7M locum budget is now around $1M). In addition, the authors concluded that changes to teaching and research-intensive health services – in a sense replicating the traditional metropolitan model of a teaching hospital in rural and remote locations – was accompanied by stronger local workforce and clinical capacity, enhanced models of clinical governance with a focus on quality and patient safety, and a self-sustaining approach to developing local workforce.[88] The same study found that of the 48 trainees who enrolled in the Queensland Rural Generalist Medicine program, all completed Fellowship requirements of ACRRM and/or RACGP and that 30 doctors continued to practise in rural and remote Queensland. 5 other doctors worked in rural parts of other States / Territories and one in New Zealand. The study also found that the pathway was also having a positive impact on local communities and health services with the development of similar innovative models of service redesign in other sites as Longreach, Cooktown, Emerald, Mt Isa, and Stanthorpe. In Mt Isa, for example, 9 trainees were recruited compared with none in 2009, with trainees indicating their willingness to continue in local practice beyond the end of training.

Financial analyses of the RG Program are limited. However, an Evaluation and Investigative Study of the Queensland Rural Generalist Program (QRGP) Queensland Health, Office of Rural and Remote Health in Queensland, was conducted in 2013 by Ernst and Young. The evaluation found that the award structure in Queensland Health made provision for the employment of non-specialist senior medical officers – which is the position RGs were previously appointed to. By providing recognition for advanced or additional skills training and deeming the RGs position as a specialist discipline position, the differential in payment (i.e. moving from non-specialist award rate to specialist award rate) on the base salary represented an additional cost injection of $12,150 per capita by the state government. This additional cost represents an annual figure for each RG appointed to a salaried position in a rural hospital. The differential increases to approximately $23,800 when differences between the overall packages are considered. Furthermore, the additional investment associated with the remuneration of the team involving advanced skilled credentialed medical officers totalled $47,660. Savings in travel costs borne by the government (ambulance and helicopter) and accommodation costs covered by the patient assistance transport scheme (PATS) were identified together with an estimated 42.5 bed-day efficiency gain. The total estimated savings was approximately $104,600 which represents a return on investment ratio of 1.2. This implies that for every $1 investment the QRGP returns a saving of $1.20. This estimate does not include expected savings to the system in reduced VMO services or changes to locum arrangements[89].

Models of care where the RG provides additional/advanced skills in proportion to the degree of remoteness are supported by quality and safety outcomes. Australian studies have shown excellent health outcomes for rurally-based RG-led services across a range of locations and advanced skills areas.[90,91,92] Similar outcomes have been seen by RG models in other comparable countries. A Canadian study found similar safety outcomes when comparing caesarean sections provided by rural GPs with specialists[93] while in Nova Scotia, RGs have shown lowest perinatal morbidity and mortality rates in rural hospitals[94]. The implementation of RG services in rural and remote communities offers improved coordination and continuity of healthcare that may not otherwise be available.

Under the RG model, the ongoing role of non-GP specialists in regional settings is not impacted from a workforce, financial, business or competition perspective as the RG model proposes to provide healthcare in areas where none presently exists or is provided on a limited basis. Where patients require specific specialist care offered outside of the scope of practice of an RG, the non-GP specialist is still available to provide specialist care and works in collaboration with the RG. This model is in place in rural locations across Australia and has been shown to work successfully internationally including in Canada.[95] Outside metropolitan contexts, the RG has an important role in supporting and collaborating in provision of care by non-GP specialists. The local availability of RGs qualified to provide services in areas such obstetrics, surgery, emergency care and anaesthetics can ensure that there are enough local doctors to cover work rosters and comprise the full healthcare team in either full-time or part-time roles.

*2. Existing Arrangements*

The following options or combinations thereof signal a continuation of the existing arrangements and can be expected to continue the current trends with respect to workforce and health services provision for rural and remote communities.

- *Reliance on non-GP specialists in situ*

Rural non-GP specialists provide highly valued services to rural communities. As discussed previously, the approach of relying *only* on non-GP specialists to provide care in rural and remote communities is unsustainable and unlikely to ever enable locally-based provision of services in many rural and remote communities.

A narrow-specialised scope of practice in many cases presents an unsustainable practice and business model for rural and remote communities which have a small and geographically limited patient catchment. Furthermore, it is unlikely that communities will be able to attract or support permanent staff in most non-general practice specialties. This is partially because it relies on supporting specialist staff and high patient turnover across a narrow range of medical presentations. The approach has merit in many larger rural centres but even in these locations this would forego the opportunity to include RG workforce which can value-add the quality of services available and assist in maintaining work rosters.

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

The requirement to travel for care has significant and broad ranging negative outcomes for rural and remote communities and their health and safety. Lack of provision of local hospital and advanced care services effectively transfers the burden of patient safety and healthcare costs from health systems to rural and remote patients and their families.

Extensive literature documents the risks associated with patient travel to access distant health care.[96,97,98,99] One study of stroke care for example found that the clinical risks of longer journeys outweighed the benefits of accessing the tertiary service.[100] Another study found that for every mile a seriously injured person had to travel to hospital, the risk of death increased by one per cent.[101] Studies have clearly linked the need for extended travel time to access maternity services to increased rates of mortality and adverse outcomes.[102] Canadian studies have found that women with no local access to maternity services have worse maternal and newborn outcomes than women from similar communities with local access to even limited birthing services.[103]

Travel also involves personal, social and financial costs to patients. As outlined above, these can be especially burdensome and potentially prohibitive to the most vulnerable people, who are already socially and financially disadvantaged.[104] International studies have shown that longer journeys discourage the use of healthcare services.[105] The much lower utilisation of both Pharmaceutical Benefits Scheme and Medicare services recorded by rural people relative to people in major cities would suggest that this is also the case in Australia.[106]

A study by Asthana and Halliday[107] found that rural and remote healthcare service providers have less chance of achieving the economies of scale available to their urban counterparts. They conclude that regardless of where patients reside, they should be provided with an acceptable level of service in terms of quality, effectiveness and accessibility. In addition, as discussed previously, patients and communities still face healthcare inequities with rural and remote workforce shortages because of the inability to sustain an adequate health service. Patients travel large distances and can be displaced from their homes to attend non-specialist appointments in regional areas. Patients may also be subjected to long waiting lists to see a non-GP specialist.

- *Provision of locum non-GP specialists*

  The current over-reliance by jurisdictions on locums rather than a permanent long-term local workforce to provide referred, secondary and emergency care services to rural and remote people is a widely recognised problem. This presents a poor health service outcome for rural communities and a very expensive model of care for jurisdictions. This has been identified as a key issue in the National Medical Workforce Strategy[108]:

  *Rural hospitals are overly reliant on locum doctors. The relatively lucrative income from locum work means that some doctors prefer working in the locum system, rather than taking up full-time, longer working hours. Locums are transient so it can be difficult to ensure accountability for their actions and continuity of care for their patients…*

  There may be a financial and business impact for locum non-GP specialists and incomes of some locums may potentially be reduced.

  For rural and remote communities, these policies have the effect of transferring the economic benefits of government/rural patients' payments to these specialists from the rural or remote community to the city where the specialist resides.

  Gruen et al[109] examined the role of specialist outreach to health care in remote Indigenous populations in Australia. The study identified the barriers faced by people in accessing hospital-based specialist services as follows:

  - Geographical remoteness of patients
  - Cultural inappropriateness of services
  - Poor doctor-patient communication
  - Poverty; and
  - Health service structure.

  With respect to impacts on quality care and safety, other issues of locum non-GP specialists included gaps in service delivery including frequency of service, the consistency of service provision and a complete absence of some disciplines. A lack of notice with respect to visiting service providers, the short length of some visits to communities, consistency of visiting personnel, cultural awareness and language communication were also identified as relevant issues and disadvantages of the locum model[110.]

  The opening statement to a public hearing of the Standing Committee on Regional Australia on the use of 'fly-in, fly-out' workforce practices in rural and remote Australia, the National Rural Health Alliance concluded that additional costs including the high cost of travel, the provision of appropriate accommodation and the need to engage more experienced health professionals all impose additional cost on health and aged care services. The submission argued *"this all adds up to a set of fees and wages that are well above baseline*".[111]

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

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

As described in Section 3, under this approach, there would be no formal recognition of an RG and it foregoes an opportunity to develop a clear, well-coordinated and structured training pipeline for aspiring doctors seeking a career in RG medicine. The impact will continue to be felt by doctors who will have to negotiate different training pathways, standards and policies of multiple colleges. Likewise, they will have to negotiate with different jurisdictions, training providers, and other colleges and education providers to ensure supervision and training posts are made available. Furthermore, under this approach, doctors may need to meet multiple practice standards. This creates an added burden for doctors and acts as a disincentive if a GP is required to deal with multiple components of the system. Many doctors may simply decide to not bother with an overly onerous process while communities will continue to face significant health inequities. The RDAA reports that this is already occurring across rural and remote communities.[112]

Communities will be impacted under this approach if ad hoc hospital credentialing based on a purely case-by-case basis continues under existing arrangements. Without formal recognition of an RG professional title, credentialing committee decisions may well be made in ignorance or misunderstanding of the profession and its scope.

- *Rural Generalism as a standalone specialty*

As discussed in Section 3, the advantages of applying for a standalone specialty of rural generalism include providing clarity of recognition of the profession enabling a simplification of credentialing processes and incentivisation approaches along with a consistency of standards and training. However, RGs are also GPs working in communities providing general practice continuity of care. Many GPs view themselves as belonging to both General Practitioner and RG professions and may feel disenfranchised and de-valued.

- *Endorsements of additional/advanced skills*

As previously discussed, endorsements provide transparent and consistent information to public and authorities regarding practitioners' areas of capacity for advanced practice. However, it would foster a binary and inflexible view of the RG scope. It would provide no recognition of the broad and distinctive core skill set that RGs would have attained. It would not incentivise or encourage RG doctors to take the flexible, adaptive and community-responsive approach to defining their practice scope that is at the core of the Rural Generalist concept. Finally, this approach is inconsistent with the structure and historic approach of other medical disciplines in recognising specialty fields and may therefore create confusion.

- *Industrial recognition within each jurisdiction*

Recognition and credentialing is the domain of hospital sites and is linked to clear employment opportunities. This model (which is in place in several jurisdictions already including Queensland and Northern Territory), is a positive development but offers only a partial solution to the problems raised in this submission. It is limited to RGs that

work in jurisdictional services and is not transferable across states and cannot enable transferability unless it were linked to a common nationally recognised standard. The 10-14-year training journey from medical school to Fellowship typically involves movement across jurisdictions. An RG may be unable to move around their state to practice elsewhere. An RG cannot readily move to an employment contract with other potential employers such as Aboriginal Medical Services, local government financed health centres, private employers etc.

State-based and individual hospital-based determinations regarding practice standards and credentialing differ across states (and within states). Ad hoc hospital credentialing based on a case-by-case basis would continue under the status quo, however without formal recognition of the RG professional title, this process becomes more situational, unpredictable and offers little security for RG doctors. Under these arrangements the administrative burden will be borne by individual practitioners. It adds a costly inefficiency to the system and places a disproportionate burden on overworked doctors and presents a substantive disincentive for their continued provision of extended skills care. [113] There continues to be a significant financial impact on rural health services having to provide locum services rather than rely on local supply of junior doctors and RG trainees who each can contribute from a workforce perspective with advanced skillsets and who can contribute to the afterhours/procedural without supervision.

This approach does not solve the issue of a paucity of rural health workforce shortages and health inequity in rural and remote settings and further foregoes the opportunity to develop a clear, well-coordinated and structured training pipeline associated with a clear career path. Aspirant doctors will be required to negotiate their way through multiple training pathways, standards and policies of multiple colleges. It is ineffective and costly and poses a greater burden on funding bodies including taxpayers.

The training pipeline empathises recruitment and training in rural and remote areas which provides a strong foundation for attracting medical students to rural practice[114]. International studies have also found that rural training pipelines increases access to comprehensive health care services in rural and underserved communities[115]. Likewise, their training providers need to negotiate with different colleges and education providers to ensure supervision and training posts are made available and meeting disparate standards.

# Glossary

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

# Acronyms

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

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