RURAL DOCTORS ASSOCIATION OF AUSTRALIA

SUBMISSION TO THE MEDICAL BOARD OF AUSTRALIA

Application for the recognition of Rural Generalist Medicine as a new field of specialty practice

Contents

About RDAA

The Rural Doctors Association of Australia (RDAA) is the peak national body representing the interests of doctors working in rural and remote areas and their patients and communities.

RDAA believes that all Australians have the right to excellent medical care regardless of their postcode.

The health needs of people living and working in rural and remote communities, and the provision of healthcare services, varies considerably from community to community. However, access to all health professionals and healthcare services is generally worse than in cities. This is a significant factor contributing to poorer health outcomes and shorter life expectancy in rural and remote areas.

It is essential that healthcare services be provided by doctors and other health professionals who have the necessary training and skills to meet the needs of their own communities to redress rural and remote health inequities.

RDAA uses the term 'rural' to encompass all locations described by Modified Monash Model (MMM) levels 3-7 [1], acknowledging that this includes remote and very remote places where the health needs are often greater and healthcare service delivery challenges most difficult.

Statement of position

RDAA fully supports the application jointly submitted by the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP) to the Medical Board of Australia for 'Rural Generalist' (RG) to be recognised as a protected title, as a Specialised Field within the Specialty of General Practice to formally recognise the role and skills of these clinicians.

Introduction

Consultation with RDA members indicate overwhelming support for the proposal. This includes support from consultant specialty colleges members, who recognise the importance of models of care which allow specialty and subspecialty care not available to people in their local communities to be underpinned by local RGs, thereby reducing the need (and associated financial, social and emotional burden) for patients to travel to access appropriate healthcare, and improving quality of care and patient experience, and outcomes.

[1] The Modified Monash Model (MMM) is a scaled classification system measuring geographical remoteness and population size with MMM 1 being a major city and MMM 7 being very remote.

Members have noted that this recognition will:

- Enhance attraction and retention by raising the reputational profile of the RG career.
- Assist with employment processes, including role descriptions, credentialing and employment.
- Inform decisions both in licensure and access to Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Schedule (PBS).
- Improve workforce planning for rural and remote communities, and enable targeted initiatives and programs to ensure that the medical workforce has the skills to meet community needs.

Background

The inequitable access to health professionals and services in rural Australia are well recognised. This contributes to significantly poorer health outcomes. The data indicates that people living in rural communities: have higher rates of and an increased burden of disease for many chronic diseases; are more likely to engage in behaviours harmful to health (including smoking and alcohol consumption at risky levels) than people in metropolitan areas; and have higher rates of hospitalisations, deaths and injury. They also have poorer access to, and use of, primary health care services, than people living in metropolitan regions.[2,3]

The *Evidence base for additional investment in rural health in Australia* report, prepared for the National Rural Health Alliance by Nous, indicates that there is an annual health expenditure shortfall of over $6.5 billion on non-urban populations compared to urban populations. This equates to almost $850 per person per year.[4]

Inequitable health outcomes for Aboriginal and Torres Strait Islander people are extremely concerning. Aboriginal and Torres Strait Islander people die younger and bear a higher burden of disease for many conditions than non-Indigenous Australians. Access to culturally safe health care – that is mindful that, for First Australians, good health is more than the absence of disease or illness: it includes physical, social, emotional, cultural and spiritual wellbeing, for both the individual and the

[2] Australian Institute of Health and Welfare (last updated 11 Sep 2023). *Web article: Rural and remote health* https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health. Viewed 4 December 2023.
[3] National Rural Health Alliance (2021). *Rural Health in Australia Snapshot 2021.* https://www.ruralhealth.org.au/rural-health-australia-snapshot. Viewed 4 December 2023.
[4] National Rural Health Alliance (2023). *Evidence base for additional investment in rural health in Australia.* https://www.ruralhealth.org.au/sites/default/files/documents/nrha-policy-document/policy-development/evidence-base-additional-investment-rural-health-australia-june-2023.pdf. Viewed 4 December 2023.

community[5] – continues to be woefully inadequate[6], including for the over 60 per cent of Indigenous people that live outside major cities[7].

Why RDAA advocates for rural generalism

The health inequities described above are unacceptable. People who live and work in rural communities make a significant contribution to Australia's wealth and prosperity through major industries including agriculture, fishing, mining and tourism. For example, the Department of Agriculture, Fisheries and Forestry indicates that the Australian food industry *has a reputation internationally as a modern, safe, reliable and sustainable producer of food…We are able to export more than half of our agricultural produce, while more than 90 per cent of fresh fruit and vegetables, meat, milk and eggs sold in supermarkets are domestically produced.*[8]

Rural people have the right to care that supports their health and wellbeing and allows them to participate fully in economic and social activity as close as possible to home.

RDAA has long been an advocate of Rural Generalism as a field of practice that serves to improve access to health services that people in rural communities need, and has been a major driver of efforts to ensure that doctors are trained in the primary care and extended skills needed within their communities, including through the development of a National Rural Generalist Pathway.

The scope, complexity and circumstances of RG practice is very different to general practice in urban environments. The provision and delivery of health care in these areas is impacted by the degree of remoteness and a range of other geographic, climatic, socio-economic, demographic and cultural factors and by emerging health challenges including delivering care in communities beset by flood and bushfires.

Within this context, RGs provide continuity of care for their patients throughout their life journey within the general practice as well as in hospitals, homes, residential aged care facilities and other community settings.

They provide episodic care not only for their own patients, but also for the fly-in-fly-out workers (FIFOs), grey nomads and other tourists that walk through the door of the general practice or rural hospital on any given day, and they are often first responders to emergencies such as road accidents. This continuity of care results in better patient satisfaction and outcomes.

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[5] Australian Institute of Health and Welfare (2022). *Indigenous health and wellbeing.* https://www.aihw.gov.au/reports/australias-health/indigenous-health-and-wellbeing. Viewed 4 December 2023.

[6] "Some aspects of health system performance for Indigenous Australians have improved the last decade. Barriers affecting their access, however, remain, as observed in their disparities in their level of access compared with non-Indigenous Australians."
Australian Institute of Health and Welfare (2022) *Web report: Indigenous Australians and the health system*. https://www.aihw.gov.au/reports/australias-health/indigenous-australians-use-of-health-services. Viewed 27 November 2023.

[7] Australian Institute of Health and Welfare (2023). *Web article: Profile of First Nations people.* https://www.aihw.gov.au/reports/australias-welfare/profile-of-indigenous-australians#population. Viewed 4 December 2023.

[8] Australian Government Department of Agriculture, Fisheries and Forestry (last updated 30 March 2023). *Food*. https://www.agriculture.gov.au/agriculture-land/farm-food-drought/food. Viewed 4 December 2023.

Providing this comprehensive care to patients requires advanced skills training and a clinical scope that covers a wide range of disciplines such as primary care (including in relation to chronic disease management), emergency medicine and critical care. This clinical scope includes advanced procedural and other skills needed by the communities in which RGs live and work such as obstetrics, paediatrics, geriatrics, mental health or Aboriginal and Torres Strait Islander Health.

RGs contribute to the viability of rural communities. Systemic failures that have meant closures of services in rural areas have led to the loss of highly trained clinicians who are no longer able to practice their advanced skill in those areas, increasing the risk of poor health outcomes for rural people and having a negative impact on the community as a whole. An example of this is the continuing closure of rural maternity services[9] and consequent effects on rural communities:

> *Rural maternity services have an exceptional safety record and rural women and their babies are at greater risk where maternity care and birthing services are far distant. While women giving birth on the side of the road is still a relatively rare occurrence in Australia, increased rates of babies born before arrival (BBAs) at hospital are significantly associated with closure of maternity units. When rural maternity services are downgraded or closed, women (and following birth, their newborns) may have to travel significant distances over rough roads for appointments and deliveries at distant centres.*
>
> *Rural women are also often asked to relocate to a town or city with a birthing facility two to four weeks (and sometimes more) prior to their due date depending on distance to travel and assessed level of risk. This places considerable financial and other burdens on expectant mothers, their partners and families. Not all women have the flexibility to leave their family, home or livelihood for extended periods without serious negative impacts. For example, the livelihood of dairy farmers is dependent on milking cows at least twice a day. Any absence from the farm can impact significantly their ability to earn an income and support their families.*
>
> *The downgrading or closure of birthing facilities can also have significant immediate and long-term impacts on access to a broader range of health services and on local communities. Closure of birthing facilities can force rural women and their families to permanently relocate to other towns to start or add to their families, contributing to the social and economic decline of rural communities. In the lead up to or following the downgrading or closure of a rural maternity unit, midwives and Rural Generalists who provided the services often leave the community to go where they can better use their training and skills, not only stripping rural communities of the high-quality medical care that staff with these skill sets provide, but also of opportunities for the employment of supporting health professionals and administrative staff, and the income derived by other local businesses.*[10]

[9] Rural Doctors Association of Australia (2021) *Annual Politicians Function March 2021 – Rural Maternity Services Handout.* https://www.rdaa.com.au/common/Uploaded%20files/_Aus/Policy/RDAA%20Maternity%20Handout.pdf. Viewed 4 December 2023.

[10] Rural Doctors Association of Australia (2018) *Rural Maternity Services in Australia Policy Position* https://www.rdaa.com.au/common/Uploaded%20files/_Aus/Policy/Rural%20maternity%20services%20in%20Australia.pdf. Viewed 4 December 2023.

RGs are an integral part of the local community. If vital health services are maintained locally then this attracts families and other workers to the area thereby ensuring the survival of the community from a social, cultural and economic perspective.

Recognition of RG medicine as a distinct field of practice will enhance the professional standing of these clinicians within the specialty of General Practice and the field of medicine more broadly. Within other specialties doctors have a strong base but seek to advance their skills as generalist specialists or subspecialists. For example, cardiologists are physicians with advanced skills in cardiology that are known and respected. Doctors aspire to be cardiologists.

RG medicine as a distinct field of practice, defined and recognised by the Australian Medical Council, will enable health systems and services to improve their understanding of Rural Generalism, the scope of practice of RGs and the processes and protocols governing their work (e.g. credentialing models). There are senior, experienced Medical Administrators who do not understand the context of rural medicine, what an RG is, or their scope of practice. This can lead to workplace tensions that could be avoided. True understanding of the RG role will improve workplace culture.

Rural Generalism is practiced widely across Australia, has driven significant policy and program innovation in health care, and has improved the provision and delivery of health services in rural areas. Formal recognition through protected title is now needed to demonstrate the value of the expertise and advanced skill/s within their field of general practice that RGs bring to Australia.

Response to options

Option 1 – Recognition of Rural Generalist Medicine as a distinct field of specialty practice within the specialty of General Practice

ACRRM and the RACGP have clearly outlined the benefits of recognition of Rural Generalist Medicine as a distinct field of practice within the specialty of General Practice in their initial proposal and subsequent advice. RDAA supports these statements and underlines the importance of the proposal to address rural health inequities.

Rural generalism has been proven to be successful in providing cost effective access to primary and in hospital care in rural communities as these doctors work across health care settings. RGs provide value to and are valued by rural communities.

Successive Commonwealth and state and territory governments have acknowledged this value through policy and investment, including the establishment the Office of the National Rural Health Commissioner and the development of the National Rural Generalist Pathway.

Rural Generalism:

- Provides access to the care rural people need: safe, flexible models of care that support wrap around, integrated, multi-disciplinary care as close as possible to home.
- Works to provide preventive and early intervention care, thereby reducing the need for patients to be referred elsewhere for more specialised care and reducing the number of avoidable hospital admissions.

- Supports the continued operation of rural hospitals.
- Reduces the significant financial, social and emotional burden on rural patients related to the need to travel to (and often stay in) larger regional or major city locations to receive care.
- Supports visiting consultant specialists to provide care locally to the most acute patients through integrated models across a range of specialties e.g. paediatrics, mental health.
- Reduces demand on metropolitan specialist waitlists by managing complex medical problems locally.
- Enhances accident and emergency capability (including first responder) in rural areas.

An RG workforce allows flexibility for workforce planning and recruitment:

- RGs have the capacity to work across multiple settings (including general practice, aged care and hospitals), improving the viability and sustainability of health services and rural communities more broadly.
- Doctors can move to different areas depending on community needs and the personal and professional needs of the doctor.
- RGs reduce the need for expensive and difficult to source permanent and locum consultant specialist cover.

Rural Generalism does not preclude doctors who want to train in other pathways or specialties, or who are already working in rural areas but are not RGs. Rural GPs and rural consultant specialists are an integral part of the rural health sector.

Rural Generalism supports flexibility, allowing those doctors within the same practice, or network of practices, who wish to focus on primary care to do so while also providing for the broader needs of rural communities, including the staffing of rural hospitals. Rural Generalism also strengthens multi-disciplinary care and consultant specialist outreach models.

Rural Generalism is an international movement: *Supported, coordinated rural generalist medicine programmes are being established or developed in a number of countries as part of an integrated response to rural health and workforce concerns*[11].

Australia is a world leader in this movement, providing expertise and training to many countries that are seeking to find solutions to the rural health challenges they face, including within the South Pacific region and Asia. Recognition would serve to cement this position and could lead to increased opportunities for Australia both as a training destination and as a provider of education and policy expertise.

[11] Schubert, N., Evans, R., Battye, K. *et al.* (2018) *International approaches to rural generalist medicine: a scoping review. Hum Resour Health* **16**, 62 (2018). https://doi.org/10.1186/s12960-018-0332-6. Viewed 8 November 2023.

Option 2 – No change - retain status quo

In RDAA's view, retaining the status quo is not an acceptable option. No change will result in the continued downgrade of services in emergency and procedural services, and failure to increase services in key areas of service need such as mental health or paediatric care.

Retaining the status quo means that there is less incentive for doctors to undertake advanced skills training to provide the needed health care in rural communities. For those doctors seeking to find a balance of professional interests, **not** recognising the additional training and work required to attain the advanced skill/s may tip the scale in favour of training solely in specialties other than General Practice.

General practice as a preferred career dropped to 13.1 per cent from 13.6 per cent in 2021[12] reflecting a continuing decline in interest from 17.8 per cent in 2015[13], with many other specialties attracting significant interest. While this trend appears to have been halted – Department of Health and Aged Care data indicates that a total of 1092 places have been filled for 2024 by both colleges (ACRRM and the RACGP), compared to 989 for 2023 measured at the same time last year[14] – there will still be a lower number of GPs entering the workforce because of the declining intake in the previous five years.

Within the context of increasing health expenditure and budgetary constraints both entry into general practice training and into the primary care workforce have been recognised as significant areas of concern.

Primary care and early intervention provide a better return on investment than the increasingly specialised and sub-specialised treatment and hospital stays at the acute end of the scale that is a feature of the Australian health system.

The shortages and maldistribution of primary care clinicians – in relation to both location and skills – is a significant workforce issue which must be addressed if the systemic imbalance is to be redressed and improved healthcare access and patient outcomes be achieved in rural areas. To this end, government and other stakeholders must ensure proven initiatives to remedy workforce issues are continued and adequately supported. This includes the National Rural Generalist Pathway.

The interest in and value of the National Rural Generalist Pathway has been demonstrated by the increasing number of medical graduates preferencing Rural Generalism. The Medical Deans Australia and New Zealand (Medical Deans) *Medical Schools Outcomes Database National Data Report 2023* notes that *"General Practice" remains second most preferred* [specialty of future practice] *at 13 per cent for all students. However, it becomes the most preferred specialty once the 6 per cent wanting to be a "Rural Generalist" (a practitioner within the formal "General Practice" specialty) are included. "Rural Generalist" is a growing preference for domestic graduates, moving up to rank eighth with 7 percent of domestic students, however not for international students (less than 1 per cent)*[15].

[12] Medical Deans, (2023) *MSOD National Data Report 2023.* p35. https://medicaldeans.org.au/medical-schools-outcomes-database-reports/. Viewed 6 December 2023.
[13] Medical Deans, (2018) *MSOD National Data Report 2013-2017.* p18. https://medicaldeans.org.au/medical-schools-outcomes-database-reports/. Viewed 6 December 2023.
[14] Source: Department of Health and Aged Care 22 November 2023.
[15] Medical Deans, (2023) *MSOD National Data Report 2023,* https://medicaldeans.org.au/md/2023/08/MSOD-National-Data-Report-2023-July.pdf. p34. Viewed 9 November 2024.

Rural Generalism is the most significant driver of interest in general practice careers as is indicated by the following extract from *The Doctors our Communities Need: Building, Sustaining and Supporting the General Practice Workforce in Australia and New Zealand* [16] :

> *Australian medical graduates' preference for a career as a GP has fluctuated a little over the last thirteen years with just under 19% of the 2022 graduating cohort indicating a preference for a future career as a GP or Rural Generalist[17], increasing from the 11% selecting GP in 2010 and 2011 (and noting there was an additional 2-3% selecting Rural & Remote Medicine in these years).*

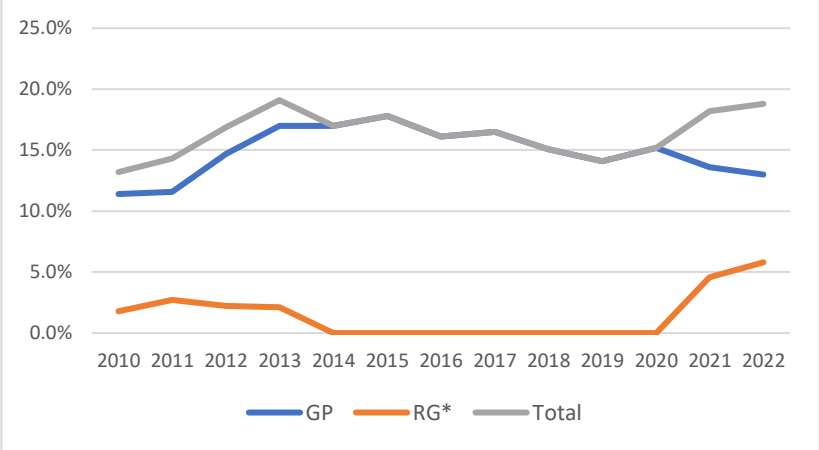

Figure 1. Proportion of medical Australian graduates preferencing General Practice or Rural Generalism*

Note: * Between 2010 and 2013 a response option of 'Rural & Remote Medicine' was available. In 2014 this was removed, and in 2021 the option 'Rural Generalist' added, reflecting the new GP sub-specialty.

Conclusion

Recognition of Rural Generalism as a Specialised Field within the Specialty of General Practice and 'Rural Generalist' (RG) as a protected title is a critical and essential step in formally recognising the role and advanced skills of RGs. It will facilitate improved understanding of the skills and scope of practice of RGs; enhance their standing within the medical profession both within Australia and overseas; contribute to RG practice as an attractive career path which allows doctors to be the kind of doctor they want to be in rural areas; and help to address key challenges facing the Australian health system including health inequities, workforce shortages, the viability and sustainability of health services in rural areas, and any emerging health issues such as those relating to climate change and emergency and disaster response.

[16] Medical Deans Australia and New Zealand (2023) *Position Paper: The Doctors our Communities Need: Building, Sustaining and Supporting the General Practice Workforce in Australia and New Zealand*. Sydney, Australia. Figure 1, p 2. https://medicaldeans.org.au/md/2023/10/The-Doctors-our-comminity-needs-Medical-Deans-Position-Paper-2023-1.pdf. Viewed 9 November 2024.

[17] Medical Deans, (2023) *MSOD National Data Report 2023,* https://medicaldeans.org.au/medical-schools-outcomes-database-reports/.