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Professor Paul Worley
National Rural Health Commissioner

By email: Paul.Worley@health.gov.au; nrhc@health.gov.au

Dear Professor Worley,

Re: NRG Taskforce Advice to the Commissioner – National Rural Generalist Pathway

Thank you for giving the AMA the opportunity to comment on the National Rural Generalist Taskforce Advice to the National Rural Health Commissioner (the Commissioner) which identifies a set of principles for a National Rural Generalist Pathway (NRGP), and which has been developed as a guide to discussions with Governments and professional bodies when considering implications for the implementation of a NRGP.

The AMA acknowledges the Commissioner's role in leading and coordinating development of the document and applauds the Commissioner's effort in undertaking an extensive consultation process that has enabled key stakeholders including students, trainees, colleges, universities, academics, industrial groups, professional bodies, agencies and consumer groups to provide input into the development of the Advice. It is important that a high level of consensus on the NRGP is reached, not just within the broader profession but also within general practice itself.

General comment

Australians living in rural and remote areas have poorer access to local health services and higher rates of morbidity and mortality than Australians living in metropolitan areas. At the heart of this disadvantage is a lack of health professionals with the training, skills and qualifications to locally meet the continuing, comprehensive health needs of rural and remote communities.

Poor access to sub-specialist services in rural and remote areas has meant that generalist primary care medical practitioners are increasingly relied upon by rural and remote communities to provide a significant amount of surgical, anaesthetic, obstetric care and other additional skills.

However, over the last decade the medical workforce has become increasingly specialised, driven by changes in knowledge, technology, health service delivery and health care financing. Subsequently, the number of medical graduates choosing a generalist career path has decreased. The desire for specialisation and sub-specialisation combined with busy practices, lack of support and poor remuneration for doctors has also contributed to the decline in the provision of generalist care in all settings.

The AMA has strongly supported 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.

While we note that there are already many doctors in rural and remote settings practising across an extended scope of medical care, we 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.

As you are aware, in September this year I wrote to you highlighting the AMA National Rural Generalist Pathway Working Group's (NRGPWG) response to the initial discussion papers. The letter emphasized that:

- There is a need to find a model that is unifying and shows respect for the broader general practice community;
- There is still significant confusion, even within the medical community, about the concept of rural generalism – what constitutes a rural generalist, as opposed a GP working in a rural community;
- There is concern that existing GPs who are providing comprehensive services to their community may be disadvantaged through the absence of any specific detail about how they might be recognised within the pathway;
- While the NRGPWG is keen to see competitive salaries and conditions for NRGP trainees, more information/details were needed on the "single employer" proposal;
- The NRGPWG did not support the proposal to either recognise rural generalists as sub-specialty of general practice or to explicitly recognise rural medicine as a distinct specialty;
- The NRGP should not be used as a platform to reform GP Rural Incentive Program (GPRIP); and
- The NRGPWG did not support the proposal for rural generalists to have access to non-GP specialist MBS rebates.

While the AMA is pleased to note that many of the concerns highlighted in the letter have been addressed by the Taskforce Advice to the Commissioner, we still have some concerns with regard to Recommendation 11 (GP Rural Incentive Program reform) and Recommendations 16 (access to non-GP specialist rebates). Please see AMA response to the specific recommendation below for further discussion on both issues.

Importantly, we believe access to training posts will be a critical element of any successful NRGP model. This may include extending the NRGP beyond general practice training posts to include general specialists as part of efforts to help ensure that Australia can build a sustainable generalist workforce that meets the needs of rural communities. Therefore, it is paramount that the Commonwealth and state/territory Governments fund sufficient additional training posts required to meet the needs of the NRGP and that these should be quarantined for the NRGP. Further, the pathway must be effective in smaller, more isolated locations providing medical services for people who are most in need, and that the skills developed must be appropriate for delivering optimal services and for Aboriginal and Torres Strait Islander people. In this context the AMA agrees with the Taskforce Advice that Recommendations will require a staged implementation plan that includes thorough and ongoing consultation.

AMA response to specific recommendations

1. <u>The Pathway</u>

Recommendation 1: The Taskforce recommends that the proposed structure for the National Rural Generalist Pathway be adopted by Federal, State and Territory Governments, and advises that the following system enablers exists, providing a solid foundation for the implementation of the Pathway:

a. Each of the three required elements – medical school program, junior doctor, and registrar training (including additional skills/emergency/general practice) has been demonstrated to be capable of being delivered to high standards in rural settings.

b. Each general practice College has an education program that currently meets the requirements for high quality educational outcomes in post graduate training and has existing or emerging relationships with other Colleges relevant to the broad scope of required training.

The AMA supports the proposed structure and system enablers for the NRGP. Our initial concern that the NRGP should also be able to cater to those doctors who wish to opt into this program at a later stage in their career and to have flexible points of entry and exit, have been addressed by the proposed structure (Figure 1) in the Taskforce Advice.

The issue of the organisation(s) who will coordinate the delivery of NRGP, however, has not been dealt with in the Taskforce Advice. This represents a critical detail and, while we acknowledge that GP training is currently undergoing significant reform and it is difficult to nominate a suitable organisation(s), it is important for the Advice to outline key principles detailing what an appropriate organisation(s) might look like. These would include:

- Appropriate expertise;
- Appropriate scale so that it is not disadvantaged in negotiations with other organisations in areas such as the provision of training places;
- Ability to provide effective case management for RG trainees;
- Appropriate accreditation arrangements are in place; and
- The organisation(s) does not seek to duplicate existing structures.

Recommendation 2: The following principles apply to the National Rural Generalist Pathway, framed by learnings from Aboriginal and Torres Strait Islander concepts of health and community and the importance of community control and decision-making:

a. A holistic and integrated understanding of health - Educational Outcomes will be based on the *Collingrove Agreement*. Integration of General Practice, Emergency and Additional Skills are required to meet rural community needs.
b. The importance of 'country' - The Pathway will be rurally based and have multiple entry and exit points, beginning with school career advice and selection into rurally based medical programs; continuing through rurally based junior doctor and registrar training; and maintained with a comprehensive continuing professional development program. This will ensure that regional Australia is the reference point for the social, family and career decisions made by Rural Generalists and their partners.
c. Respect for the wisdom of Elders and local Aboriginal decision-making - The Pathway can be built on current evidence, successful local innovations and the experience of leaders in the sector.
d. Community control - The Pathway requires clear engagement with and leadership from rural and remote communities to ensure it remains responsive to community needs.
e. Cultural safety - The Pathway must provide support and mentor trainees to ensure a cohort of doctors is graduated who meet the needs of Aboriginal and Torres Strait Islander peoples and prioritise Aboriginal and Torres Strait Islander control and decision-making; they and their supervisors must have an appropriate understanding of the culture of rural communities and the patients they will serve; and they must be able to reflect on their own cultural influences.

The AMA supports Recommendation 2 as the principles (a-e) have been framed by learnings from Aboriginal and Torres Strait Islander concepts of health and community and the importance of community control and decision-making.

Recommendation 3: That the following elements are part of the design and delivery of the National Rural Generalist Pathway:

a. Securing continuity of training positions, with salaries following the trainee through a 'duration of training' contract, thus providing more secure employment and leave entitlements for the entire postgraduate component of the Pathway.
b. Incorporation of flexible approaches to gaining competence for practice, including increased training in Rural Generalist practice.
c. Better matching Additional Skills acquisition with community needs (where the trainee plans to work).
d. Supporting personalised learning through developing Programmatic Assessment for Learning and Entrustable Professional Activities.
e. Providing Recognition of Prior Learning and Credit Transfer arrangements for both prospective trainees entering the pathway at different stages and also for grand-parenting or upskilling existing rural practitioners seeking to be recognised as Rural Generalists.
f. Engagement and professional support for Rural Generalist supervisors and mentors.
g. Opportunities for collaboration between regions to support trainees.

The AMA supports Recommendation 3. We have argued for continuity of training positions (and competitive salary and conditions), incorporation of flexible approaches, employment arrangements that support access to a variety of clinical experiences and continuity of entitlements that will enable trainees to move between regions and better match skills acquisition with community needs. We also raised concerns that existing rural GPs who are providing comprehensive services to their community may be disadvantaged through the absence of any specific detail about how they might be recognised within the new pathway. Recommendation 3 addresses both of these issues.

Recommendation 4: That the following Educational Outcomes are adopted for the National Rural Generalist Pathway. Rural Generalists are trained:

a. As core skills, to provide high quality culturally safe community and population-based General Practice.
b. As core skills, to provide emergency/trauma services at the local rural hospital or health-care facility/practice.
c. As core skills, to provide in-patient care for a wide range of patients, and to organise retrieval/referral as appropriate.
d. As core skills, to provide after-hours services for their communities.
e. As core skills, to work in teams, including through telehealth, provide healthcare and health service leadership, quality improvement, and advocacy for their rural communities.
f. To be adaptive and practice where there is no or limited access to other local specialists.
g. To provide a range of Additional Skills that reflects the needs of diverse rural communities.
h. To ensure patient safety, practice standards, and individual skills and knowledge are maintained and enhanced through a robust continuing education program

The AMA supports Recommendation 4. Primary care forms the basis of health improvement for communities. Being able to provide comprehensive general practice care is central to this. The NRGP requires building on these essential skills to create a larger skill set in emergency medicine and an extended skill to meet the healthcare needs of communities.

The AMA also supports the range of extended skills proposed that included Anaesthesia, Obstetrics, Surgery and Emergency Medicine, as well as the increasingly diverse needs of rural communities, including Indigenous

Health, Psychiatry, Aged care, Palliative Care, Addiction Medicine, Adult Internal Medicine, Paediatrics and Public Health.

The AMA notes that these educational outcomes are also consistent with international framework such as the CanMEDS roles (Frank JR, Snell L, Sherbino J, editors. CanMEDS 2015 Physician Competency Framework. Ottawa: Royal College of Physicians and Surgeons of Canada: 2015)

2. A Planning and Evaluation Framework

Recommendation 5: That a funded prospective Evaluation program monitors impact and outcomes of the Pathway and Training Program on trainees and supervisors, the rural medical workforce, rural health services, and rural communities

The AMA supports Recommendation 5 noting that the Taskforce Advice has provided more details regarding mission and activities related to implementing a National Pathway including inputs, outputs, impact and short and long-term outcomes expected from the National Pathway, Training Program and practice incentives.

3. Rural Generalism Recognition

Recommendation 6: Consistent with the definition of a Rural Generalist in the *Collingrove Agreement*, the Rural Generalist has a:

- Protected title; and
- Specialised field within the Specialty of General Practice

The AMA's initial concern at the proposals to either recognise rural generalists as sub-specialty of general practice or to explicitly recognise rural medicine as a distinct specialty (both were seen as potentially divisive and that the concept of rural medicine as a distinct medical specialty had been previously tested and rejected by the Australian Medical Council), has been allayed by the NHRC clarification that:

- The recommendation is consistent with current training and recognition systems in medicine. A useful example can be found in the speciality of Specialist Physicians, where Cardiology is one of several specialised fields. All Cardiologists are Physicians but not all Physicians choose to acquire the skills required to be recognised as Cardiologists;
- The intention of recognising Rural Generalists as a protected title and specialised field within general practice is to support the development, and enhance the attractiveness to trainees of a specific training pathway for this career, thereby developing a workforce that can provide extended services for the healthcare needs of rural and remote communities;
- Additional skills developed and practised by Rural Generalists will be relative to the specific needs of the communities and regions where they work in order to add value to the current rural health system;
- The recommendation for a Rural Generalist to be recognised as a protected title within general practice will make it easier for rural communities, jurisdictions and employers to identify and understand the scope of practice for Rural Generalists;
- The suggested recognition also means there is no need to create an entirely new curriculum to train Rural Generalists. The existing RACGP and ACRRM curricula can be utilised, as recommended in the ModMed Report;
- Existing general practitioners will be able to apply for Recognition of Prior Learning for training they have completed or work they are already doing in rural communities to the scope of a Rural Generalist;
- In the event of a Rural Generalist ceasing to work at full scope, it is proposed that they would not lose

their protected title – they would simply be a Rural Generalist not working to full scope; and
- It is proposed that the Specialty title is relevant Australia-wide, whereas the Specialised Field is relevant only to Modified Monash Model Regions 2-7.

Recommendation 7: Consider developing endorsements within the Australian Health Practitioner Regulation Agency (AHPRA) Framework to provide a public register of the current Additional Skills of each Rural Generalist.

The AMA acknowledges that AHPRA endorsement has the potential to assist with the public transparency and support credentialing processes for the work of Rural Generalist, but we also note that using endorsements may put in place a requirement for more qualifications. We agree with the Taskforce Advice that this concern will need to be considered alongside the potential public benefits of such an approach, and ask that further work to identify how this will work in practice is done.

4. Rural Generalist Pathway Support, Incentives and Remuneration

Recommendation 8: Case Management Faculties (tailoring training, support and guidance) are included in the transition and ongoing business case for the Pathway.

The AMA supports the inclusion of Case Management Faculties in the transition and ongoing business case for the Pathway, but we are of the view that the Case Management Faculties must be properly funded.

Recommendation 9: The 'duration of training contract' by a single employer model is included in the business case for the Pathway.

The AMA is keen to see competitive salaries and conditions for NRGP trainees and to overcome the lack of portability of entitlements, which is a major issue that has arisen in relation to the current GP training pathway. Security of employment will also act as an incentive for trainees to choose a career as a rural generalist.

We support the Taskforce view that the benefits of one employer and continuity of employment also support the rural community locus of training, and educational coordination across teaching hospital/health service/practice networks being maintained. This is likely to achieve continuity of mentorship, leadership and supervision – all key elements of the Pathway.

Recommendation 10: Appropriate clinical governance (quality improvement activities) and genuine peer review as part of this, is costed and implemented in a nationally consistent way through appropriate consultation processes.

The AMA agrees with Recommendation 10. Appropriate clinical governance (quality improvement activities) and genuine peer review are a necessary part of the program and must be costed and implemented in a nationally consistent way through appropriate consultation processes.

Recommendation 11: A tiered reform of the General Practice Rural Incentive Program (GPRIP) should be considered by the Department of Health, using the overarching principle of medical workforce incentives that recognise and reward working in more rural locations, using a wider scope of practice and commitment to community.

The AMA is open to open to reform and better structure of the GPRIP and supports Recommendation 11 on the condition that it is not budget neutral. It is the position of the AMA that rural doctors currently receiving GPRIP should not be disadvantaged by any attempts to restructure the GPRIP payment and that any considerations for a tier payment to reward additional skills should be funded from new money.

The AMA cannot support proposed changes to the GPRIP that have the potential to leave some GPs and practices financially worse off under new arrangements.

It is important to note that the GPRIP impacts many rural GPs who may not become rural generalists and they must not be negatively impacted by the introduction of the Pathway. An appropriate reform requires broad consultation involving various stakeholders. The AMA encourages broad consultation with various stakeholders to progress appropriate reform in this area.

Recommendation 12: The Department of Health also amend the GPRIP to allow for front loading of GPRIP after two years of rural work, to support a capital purchase in the rural community where the medical practitioner works.

The AMA supports Recommendation 12 with the same conditions as applied to the response to Recommendation 11 above. Any reform to the GPRIP must not prejudice rural doctors currently receiving GPRIP. Any considerations for a tier payment to reward additional skills must be funded from new money. The AMA supports the proposal to allow for front loading after two years of rural work, to support a capital purchase in the rural community where the medical practitioner works

Recommendation 13: The Department of Health response to the Review of the Procedural Grants Program is broadened to include a Rural Generalist Additional Skills Program, which incorporates other Additional Skills beyond Surgery, Obstetrics, Emergency and Anaesthetics.

The AMA has already advocated for this, subject to additional funding being made available.

Recommendation 14: The Department of Health retains the existing indemnity insurance support program – the Premium Support Scheme.

This reflects an existing AMA position that the Department of Health retains the existing indemnity insurance support program – the Premium Support Scheme.

Recommendation 15: Locum access, professional development support, and other incentives are available to Rural Generalists in a nationally consistent way.

Access to locum, professional development and other non-financial incentives will also be critical elements of any successful NRGP model. The AMA, therefore, supports Recommendation 15 to enable locum access, professional development support, and other non-financial incentives being available to Rural Generalists in a nationally consistent way. Additional funding and consideration of innovative models will be required to achieve this aim which will be best achieved through further consultation.

Recommendation 16: Rural Generalists are given access to Medical Benefits Scheme specialist item numbers when providing clinical care in areas of accredited Additional skills, including access to telehealth item numbers.

The AMA supports increased remuneration for doctors practicing rurally and the principle of equal pay for equal work. As such, we support Recommendation 16 in principle, but with very specific conditions and caveats regarding scope of practice and credentialing arrangements for additional skills. First, access to Medical Benefits Scheme specialist item numbers must be available to all general practitioners when providing clinical care in areas of accredited Additional skills, not just rural generalists. Many doctors in rural and remote settings already practice across an extended scope of medical care and that the notion of equal pay for equal work as a basic premise should apply.

The AMA is concerned that this is a potentially divisive proposal within general practice and the medical community more broadly. While we provide in principle support, we would like the discussion of access to non-GP specialist MBS rebates to be part of a much broader discussion about MBS rebates for primary care, not something that is restricted to the NRGP.

The AMA also notes that the issue of defining scope of practice and credentialing will require broad ranging discussions including the RACGP and ACRRM, specialist medical colleges, State/Territory Health Departments, Primary Health Networks, Local Hospital Networks and other relevant stakeholders.

There must also be measures in place to ensure that access to non-GP specialist rebates does not create perverse incentives by driving rural generalists away from comprehensive general practice in favour of better remunerated areas of the MBS. This will be critical to ensuring that rural generalists help solve issues of workforce maldistribution and do not create new problems.

Recommendation 17: The Department of Health provides a rural loading for all clinical services, including but not limited to those provided by Rural Generalists, which is a percentage of the relevant Medicare rebate for that service, and is increased based on Modified Monash Model category from MMM2 to MMM7.

The AMA supports Recommendation 17. This is similar to the AMA/RDAA Rural Rescue Package (a package of measures developed by the AMA and the Rural Doctors Association of Australia that recognises both the isolation of rural and remote practice and the need for the right skill mix in these areas).

With regard to the use of the MMM, the AMA strongly supports the MMM as the most appropriate measure of rurality, and we have incorporated the MMM in the Rural Rescue Package.

Recommendation 18: Rural hospital teaching and research is recognised in the Hospital Funding Agreements and funding is quarantined to support and facilitate these arrangements in a nationally consistent way.

As highlighted above, access to training posts will be a critical element of any successful NRGP model. It is paramount that the Commonwealth and state/territory Governments fund sufficient additional training posts required to meet the needs of the NRGP and that this funding should be quarantined and supported nationally in a consistent way.

Recommendation 19: The National Rural Health Commissioner works with jurisdictions and recognised industrial bodies to progress recognition of a Rural Generalist within the State Medical Certified Agreements and Awards and Visiting Medical Officer (VMO) contracts.

The AMA supports Recommendation 19 as this would be a necessary step to operationalise the relevant remuneration arrangements that apply.

The AMA looks forward to continuing to work with you in the development of the NRGP and please contact Ms Sally Cross at scross@ama.com.au should you require any further information.

Yours sincerely

Dr Tony Bartone
President