



Australian Government

National Rural Health Commissioner

National Rural Generalist Taskforce
Advice to the National Rural Health
Commissioner on the Development of the
National Rural Generalist Pathway
December 2018



Disclaimer

This document is the consensus view of the individual members of the Taskforce. It does not bind individuals to the recommendations nor does it represent the views of their organisations or affiliations. Publication of this document by the Commissioner does not necessarily reflect the views of the Department of Health or indicate a commitment to a particular course of action.

Acknowledgement

The National Rural Generalist Taskforce acknowledges the traditional owners of country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to Elders both past and present.

A Message from the National Rural Health Commissioner

In my many visits across Australia I have been conscious of the incredibly valuable service that our current rural medical workforce, including overseas trained doctors, provides to rural and remote communities. I have heard the urgency of their calls for the National Rural Generalist Pathway (the Pathway) to support their current practice and provide a sustainable future workforce. At the same time, students, junior doctors and registrars have told me that they require a structured, supported Pathway to gain the skills they need for rural and remote practice.

The Advice and recommendations are the culmination of extensive consultation at a national, jurisdictional and local level and represent the contributions of more than 200 expert stakeholders across the country.

I would like to take this opportunity to thank members of the Taskforce, Working Groups and Expert Reference Groups for their contribution to the development of the Pathway and their detailed feedback to draft versions of the Advice.

Table of Contents

Executive summary	3
Definition of a Rural Generalist	5
The National Rural Generalist Taskforce	6
Overview of the Pathway structure.....	7
Recommendations	9
Chapter One: Introduction.....	15
Chapter Two: The Pathway	20
Chapter Three: A Planning and Evaluation Framework.....	28
Chapter Four: Rural Generalist Recognition	33
Chapter Five: Support, Incentives and Remuneration.....	38
Chapter Six: Taskforce, Working Group and Expert Reference Group Membership and Consultations	49
Contacts	65

Executive summary

Aim

This document has been written as Advice to the National Rural Health Commissioner by the National Rural Generalist Taskforce. It is anticipated that this Advice will provide a guide to discussions with Governments, professional bodies and health services when considering the implementation of a National Rural Generalist Pathway.

Introduction

Rural doctors have a long and proud history of serving communities in diverse settings across Australia. They follow a tradition of caring for the wellbeing of communities practised by Traditional Healers over millennia.

Healthcare for Australia's rural and remote populations is complex and given the challenge of distance and geography, depends on doctors who can integrate skills that are traditionally delegated to separate specialties in urban practice. As well as providing comprehensive General Practice and emergency care, rural communities often depend on their doctors having Additional Skills for an extended scope of practice to meet their needs. These Additional Skills include the fields of Anesthesia, 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, Pediatrics, Remote Medicine, Medical Education, Public Health and Health Administration. The development and use of these General Practice, Emergency and Additional Skills represent the broad scope of practice of a Rural Generalist.

There are many doctors in rural and remote settings already practising across an extended scope of medical care, who were and continue to be supported by jurisdictional training pathways and existing College curricula. However, there is currently no nationally recognised pathway for training this workforce for the future, or any national process for recognising and supporting existing practitioners.

There is an increasing number of medical graduates from Australian medical schools, but this alone has not resulted in sufficient access to the medical services required for rural and remote communities. In fact there is a persistent and pernicious workforce maldistribution. There is a well-established correlation between poorer access to health services and poorer health outcomes. Poorer health outcomes in turn lead to poorer social and cultural opportunities, and poorer economic participation, economic development and productivity.

These challenges must be addressed for the future of all who live in regional, rural and remote Australia. All Australians have the right to access high quality healthcare no matter where they live.

The purpose of this Advice, developed for the National Rural Health Commissioner, is to meet these challenges head on.

This Advice identifies a set of principles and a framework for a National Rural Generalist Pathway (the Pathway). The Pathway will build the workforce "in place" to address rural community needs. It will establish integrated, collaborative regional health

training networks spanning rural Australia (MMM2-7), with the locus of training and practice in communities that need Rural Generalist doctors.

The good news is that there is much evidence to draw on. Two decades of research and development in rural medical education and rural health workforce can be applied to the Pathway as a training and workforce framework. *The Stronger Rural Health Strategy* has put some of the building blocks in place. In addition, there are regional and jurisdictional models that address components of the Pathway already operating in different parts of the country at varying stages of implementation. The aim is to draw upon these successes and the related research evidence to inform the Pathway principles and components. The national Pathway is important for scaling up appropriate capacity of rural workforce Australia-wide, while the principles outlined allow for jurisdictional and regional variation in training delivery by providing flexibility to enhance existing pathways and programs and incorporate new developments.

The recommendations in this Advice explicitly base Rural Generalists as primary healthcare providers with Additional Skills for working in secondary and tertiary arenas in collaborative networks of other health professionals, including other specialists. This approach recognises the importance of primary care and generalist scope to the future of cost-effective healthcare delivery in Australia. A medical workforce trained this way will deliver higher quality and safer care closer to home for rural and remote Australians.

This Advice is intended to support and recognise the value of all doctors who practise in rural and remote communities. Different communities and their doctors need different models of accessible high quality sustainable care. Some rural and remote communities rely on doctors working in General Practice. Some communities are of sufficient critical mass to support other specialists working in different fields. But there are a multitude of communities that need Rural Generalists who span both worlds of General Practice and additional specialist services. One rural doctor is not better than the other, but their skills and practice models are likely to be different depending on where they work. All are needed in their appropriate contexts, as matched to community need, and working in highly complementary regionally-networked teams.

The “job” of a Rural Generalist is unique and with high quality, networked training, career structure and recognition, remuneration and professional supports, it will be attractive to the next generation. This Advice supports the principle that equal work deserves equal remuneration whether provided by a General Practitioner or another specialist type. There is an equity principle of rural doctors being remunerated on par with other specialists when providing a particular service. This precedent has been well established, for example, in the Medicare Benefits Schedule fees for delivering a baby and facilitated in State awards by the advocacy of groups such as the Australian Medical Association (AMA) and the Rural Doctors Association of Australia (RDAA). This parity is critical to attracting and retaining the best trainees and clinicians to train on the Pathway.

At the same time, the Advice recommends that additional incentives should be tailored to support trainees and rural doctors who deliver the extended scope of services required to meet the needs of rural and remote communities. This is because this scope, often wider in more remote communities or communities where there are few non-General Practice specialists, requires the doctor to be appropriately trained, to undertake regular professional development, and to commit to after-hours work.

Work-life balance is important for Australian rural doctors, as is part-time work during any person's career. The remuneration and incentives framework should enable Rural Generalists working across broad scope, to be rewarded for this and to balance their work and non-professional interests.

In the same way the Recommendations are explicit in underlining the effectiveness of training in place and its link to workforce retention. Rural students and students interested in rural practice should have opportunities to join the Pathway at multiple points in their career, to choose, if they wish, to complete their training in the regions where they live or want to work and they should have the opportunity to participate in co-ordinated community placements throughout their undergraduate and postgraduate training.

The Pathway is designed to respond to the problem of poorer access to healthcare services the further away a community is from the major cities, including communities of smaller size. Based on decades of evidence, the locus of the Pathway is therefore in rural and remote communities, providing a "grow your own" solution where it is most needed.

This Advice is concerned with Rural Generalist training pathways in General Practice; however the training and workforce framework outlined in this document can be applied to a range of other medical specialities and health disciplines, if appropriately tailored. The overarching goal is to increase the health and wellbeing of rural and remote communities by improving the supply and distribution of a sustainable and appropriately trained workforce.

Any health reform must have at its heart the ultimate public benefit to the community. This has been the compass setting that has guided the Taskforce deliberations and the recommendations that follow.

Definition of a Rural Generalist

The Office of the National Rural Health Commissioner [the Commissioner] was established by an Act of Parliament in June 2017 and the first Commissioner was appointed in November 2017. (1)

The first legislated priorities for the Commissioner were to define what it means to be a Rural Generalist and to provide advice to Government on the development of a National Rural Generalist Pathway to redress the maldistribution.

In January 2018, the two General Practice Colleges, the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP), came together at the invitation of the Commissioner to agree on what it means to be a Rural Generalist. Known as the *Collingrove Agreement*, it articulates that:

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 specialist care in hospital and community settings as part of a rural healthcare team.(2)

The National Rural Generalist Taskforce

After further consultation with professional training organisations, clinicians, trainees, health service leaders and community representatives across rural and remote Australia, a National Rural Generalist Taskforce (the Taskforce) was established by the Commissioner in May 2018 to guide the development of the Pathway and to harness the broad-based expertise of the rural health sector.

The Taskforce has used specially constituted Working Groups and Expert Reference Groups to draw on the contributions of a large number of stakeholders from across the country.

The Taskforce vision

1. A regional, rural and remote health “grow your own” training system that embraces Aboriginal and Torres Strait Islander understandings of health, healthcare and decision-making; is continuous and integrated; and overcomes the disadvantage rural and remote communities face in accessing healthcare.
2. Regional Teaching and Training Networks spanning MMM 2-7, with the focus of supporting Rural Generalist practice based in communities which need Rural Generalists. The networks will integrate high quality clinical care, research and teaching to drive a culture of excellence underpinned by a sustainable and skilled workforce, for working in hospitals and community practice.
3. Improved access to a wider range of local medical services, leading to improved health; improved health leading to greater wellbeing and social and economic development for rural and remote communities, particularly Aboriginal and Torres Strait Islander peoples, and our nation as a whole.

The Taskforce Plan

To develop a National Rural Generalist Pathway that:

- a. Attracts, develops and retains more students and trainees to rural medical training pathways and Rural Generalist practice;
- b. Is regionally-driven (community locus) and adaptable to different jurisdictions, regions and their existing models; and
- c. Provides opportunities to gain the range of skills and work at a scope of practice for supporting the needs of regions and towns where separate teams of General Practitioners and other Specialists are not sustainable.

The Advice

The Advice on the development of the National Rural Generalist Pathway is divided into six chapters.

Chapter One outlines the background to the establishment of the National Rural Generalist Taskforce.

Chapter Two outlines the Pathway, including the Rural Generalist training model and the principles on which it is based. The model for the Pathway, and the thinking that has shaped it, have emerged as a result of the extensive consultation, coupled with a

clear, broad and deep understanding of the literature and global experience in this field.

Chapter Three outlines the program logic that underpins the Pathway and the Planning and Evaluation Framework for measuring its impact.

Chapter Four outlines the issues of professional recognition that must be addressed for the Pathway to maximise the benefits for rural communities and rural health services.

Chapter Five describes a range of support, incentives and remuneration options that could maximise the attractiveness of the Pathway to prospective trainees and retain them in practice after graduation.

Chapter Six provides details of the National Rural Generalist Taskforce membership, a list of members of each Working Group and Expert Reference Group and details of other groups and individuals consulted by the Commissioner during the process of developing this Advice.

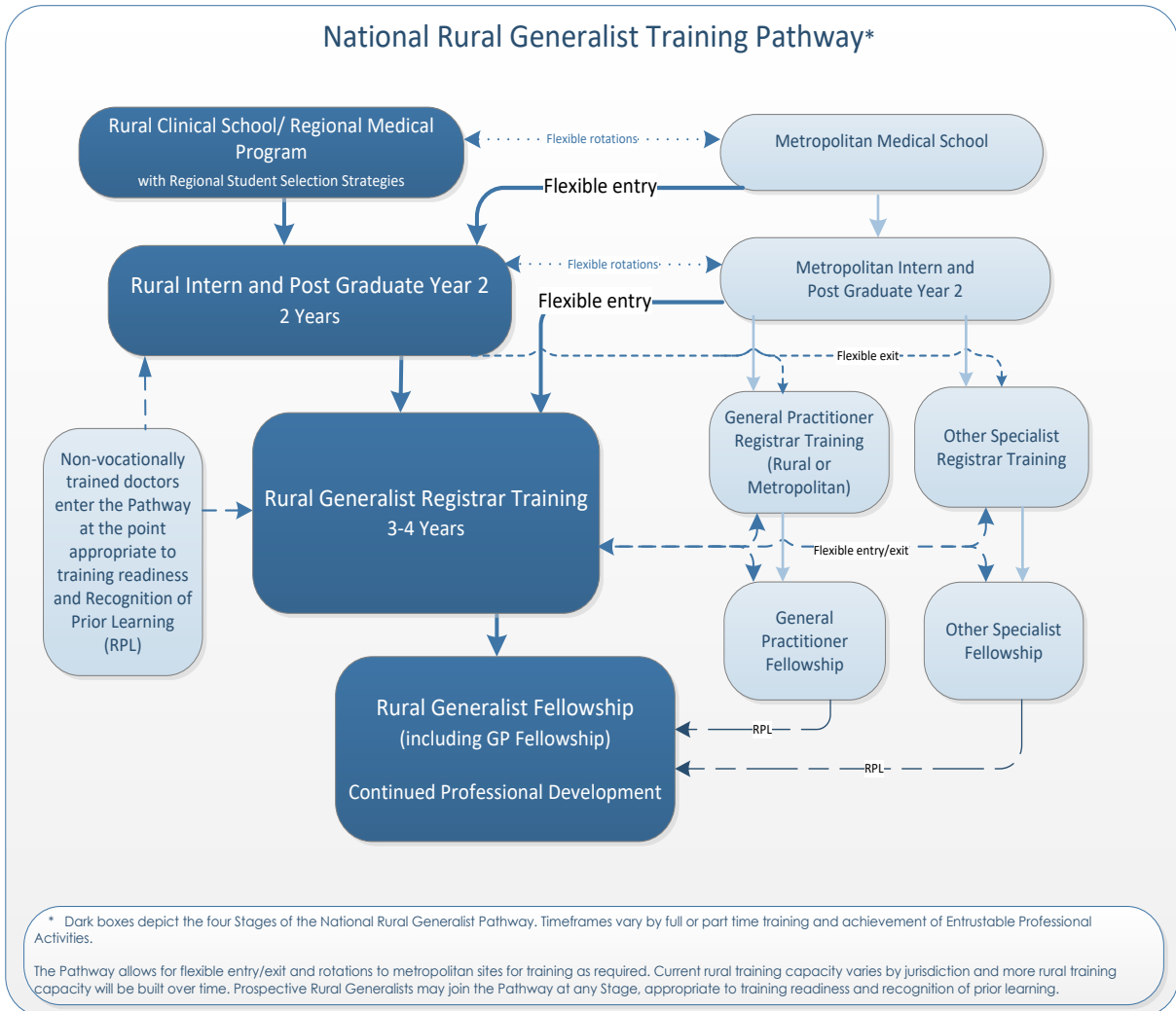
Overview of the Pathway structure

The Pathway must be attractive to prospective trainees. Based on the premise that candidates who aspire to rural medicine should have the opportunity to study and train regionally, joining at any stage, the Pathway training elements comprise the rural clinical school/regional medical program and a postgraduate component: junior doctor training and registrar training linked together with multiple community placements. The postgraduate elements should be supported by an employment and mentorship structure for the trainee, for example a “duration of training” contract, that supports both quality of training and preservation of employment benefits (Fig 1). Once Fellowship is achieved, the Pathway continues through to career development and skills maintenance, with relevant, targeted practice incentives.

Tailored selection processes that involve the community and are based on training-readiness are fundamentally important. Students and trainees, either urban or rural origin, need to be selected, at relevant times, based on a connection to and/or an understanding of rural communities so that they are likely to thrive in a rural education and workplace environment. Further, selecting for parity of Aboriginal and Torres Strait Islander Rural Generalists is also important for better addressing the needs and culturally safe care of Aboriginal and Torres Strait Islander people.

The proposed structure for the postgraduate training component of the Pathway is a five to six-year training program delivered through the creation of teaching and training hospital/health service/practice networks across regional, rural and remote Australia (Figure 1). Please see Chapter 2 for a detailed explanation of the proposed training in each of the years of the Pathway. The Pathway delivery networks should align with existing health service networks and can leverage existing clusters of education and training, such as Regional Training Organisations, existing Rural Generalist Programs in some jurisdictions, Regional Training Hubs, Regional Medical Programs and Rural Clinical Schools.

Figure 1 – National Rural Generalist Pathway



Recommendations

In forming these recommendations, the Taskforce is very aware that the Pathway must be effective in a wide range of locations, including smaller, more isolated locations where people with the greatest needs for healthcare live. In particular, the skills Rural Generalists develop must be appropriate for delivering optimal services, closer to home, for Aboriginal and Torres Strait Islander peoples, from whom there is also much to learn. In addition, the Taskforce recognises the crucial role of communities in the selection of students and support of trainees in the Pathway.

Consistent with its vision and plan, the Taskforce has made recommendations to the Commissioner. The Taskforce recognises that the recommendations will require a staged implementation plan that includes thorough and ongoing consultation and financial support.

National Rural Generalist Pathway Design and Delivery (Chapter 2)

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

- a. Each of the three required elements – Medical School, 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 postgraduate training, and has existing or emerging relationships with other Colleges relevant to the broad scope of required training.

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* which integrates General Practice, Emergency and Additional Skills, as required to support enhanced quality, safety and continuity of care in health services that meet rural community needs in a cost-effective, sustainable way.
- b. The importance of “country” - The Pathway will be based in teaching and training hospital/health service/practice networks across regional, rural and remote Australia, and centred on communities where generalists are needed. There will be multiple entry and exit points and opportunities to choose to participate in high quality rural training “in country” via rural medical programs, rurally based junior doctor and vocational training. Connection to country and family will be maintained with a comprehensive continuing professional development (CPD) program and professional networks. Although allowing for short intensives as required in major cities, this principle will ensure that rural and

remote communities of Australia are the reference point for the social, family and career decisions made by Rural Generalists and their partners.

- c. Respect for and consideration 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 including Aboriginal and Torres Strait Islander communities and community-controlled health services, to ensure it remains responsive to community needs.
- e. Cultural safety - The Pathway must include structured mentorship and tailoring of training for trainees, including Aboriginal and Torres Strait Islander Peoples, to ensure a cohort of doctors is graduated that is culturally aware, meets the needs of communities including Aboriginal and Torres Strait Islander peoples and prioritises Aboriginal and Torres Strait Islander control and decision-making; they and their supervisors must also have an appropriate understanding of the culture of rural communities and the patients they will serve; and they must be willing and able to critically-reflect on their own cultural influences and the impacts the latter might have on the provision of care to their patients.

Recommendation 3: That the following elements of postgraduate training are identified for potential development by the two General Practice Colleges as part of the design and delivery of the National Rural Generalist Pathway:

- a. Incorporation of flexible approaches to gaining and demonstrating competence for practice, including increased training in Rural Generalist practice.
- b. Better matching Additional Skills training with community needs and where the trainee plans to work.
- c. Supporting personalised learning through developing Programmatic Assessment for Learning and Entrustable Professional Activities.
- d. Providing Recognition of Prior Learning (RPL), Credit Transfer and up-skilling arrangements for both prospective trainees entering the pathway at different stages or practitioners seeking to be recognised as Rural Generalists.
- e. Engagement, professional support and up-skilling for Rural Generalist supervisors and mentors.
- f. Opportunities for collaboration between regions to support trainees and Fellowed Rural Generalists.

Educational Outcomes for the National Rural Generalist Pathway (Chapter 2)

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

Rural Generalists are trained:

- a. To ensure patient safety, cultural safety, and practice standards are at optimal levels in their practice context; and to maintain and enhance individual skills and knowledge through a robust continuing education program.
- b. as core skills, to provide high quality culturally safe community and population-

- based General Practice.
- c. as core skills, to provide emergency/trauma services at the local rural hospital and/or health-care facility/practice.
 - d. as core skills, to provide in-patient care for a wide range of patients, and to organise retrieval/referral as appropriate.
 - e. as core skills, to work in teams, including through telehealth and multi-town network models, to provide healthcare and health service leadership, quality improvement, and advocacy for their rural communities.
 - f. to provide after-hours services for their communities.
 - g. to be adaptive and practise where there is no or limited access to local specialists.
 - h. to provide a range of Additional Skills that reflects the needs of diverse rural communities.

Rural Generalist Pathway Evaluation (Chapter 3)

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

Rural Generalist Recognition (Chapter 4)

Recommendation 6: That the two General Practice Colleges support the national recognition, as a protected title, of a Rural Generalist as a Specialised Field within the Specialty of General Practice.

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

Rural Generalist Pathway Support and Remuneration (Chapter 5)

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

Recommendation 9: A mechanism for ensuring preservation of employment benefits and continuity of mentorship, for example, a “duration of training contract” by a single employer, is included in the business case for the Pathway.

Rural Generalist Practice Support and Incentives (Chapter 5)

Recommendation 10: Appropriate clinical governance (quality improvement activities) and genuine peer review, as part of this Pathway, is 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 remote locations, using a wider scope of practice, and commitment to community, including after-hours work.

Recommendation 12: The Department of Health also amends 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.

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.

Recommendation 14: 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.

Rural Generalist Remuneration (Chapter 5)

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.

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.

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

Collectively the Taskforce and the broader consultation process has enabled feedback from key stakeholders in regional rural and remote health workforce, education and training including students, trainees, colleges, universities, academics, industrial groups, professional bodies, agencies and consumer representatives, ensuring rich and dynamic input into the shape of these recommendations. Beyond the Taskforce consultation, meetings by the Commissioner with local rural clinicians, trainees, students and rural community leaders across regional, rural and remote Australia has relayed strong support for the national Pathway and the nature of the recommendations. There is a high level of consensus, goodwill and commitment across the rural sector for implementing these Recommendations and establishing the Pathway.

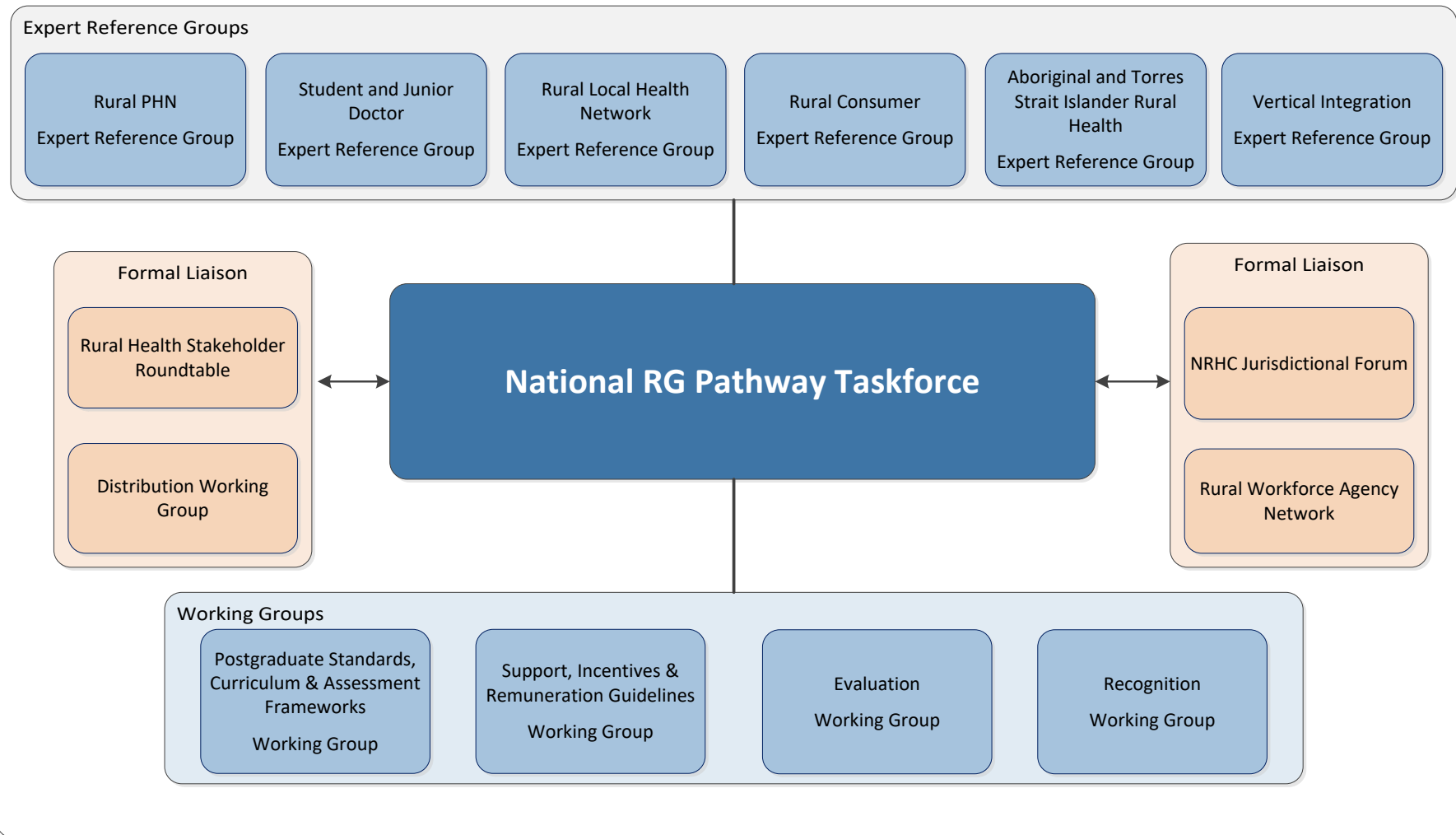
Next steps

This Advice to the Commissioner will inform the next phase of policy development with Commonwealth, State and Territory governments and other stakeholder leaders. This includes developing the economic basis for the Pathway.

This Advice is also intended to promote wider awareness of the work of the Office of the Commissioner, given the generous contribution to this document by the breadth of communities, government leaders, and the broader rural sector. Consistent with the transparent and collaborative process used to develop this Advice, further comment and perspectives are always welcome. Please address any comments to: NRHC@health.gov.au

Ultimately, the passion to see healthy rural communities, supported by sustainable medical services, is driving this work. A future rural medical workforce that is designed for the future health, economic development and success of rural Australia is imminent. This is a paradigm shift towards a sustainable, locally trained workforce. You are invited to join us.

Figure 2: National Rural Generalist Pathway Taskforce
Governance Structure for Taskforce



Chapter One: Introduction

The Setting – a system of unequal parts

It is well demonstrated that while Australia enjoys one of the highest standards of healthcare in the world, those living outside metropolitan centres do not have the same levels of health and life expectancy.(3) This is the lived reality for ten million Australians, and for many Aboriginal and Torres Strait Islander Australians the gap in health outcomes is even greater.

Rural and remote communities face two major obstacles in accessing comprehensive healthcare – distance and population size. The smaller scale of rural and remote towns and some regional centres means that permanent teams of specialist healthcare providers offering a full range of the required specialities are neither viable nor sustainable; only 15% of non-General Practice specialists live in rural areas.(4) Geographical disbursement means that residents of these towns are frequently required to travel long distances to larger regional centres to access the healthcare they require, often facing long patient waiting lists, lost productivity and incurring travel and accommodation costs with limited local follow-up.(5, 6) This causes upheaval and disruption not only to individuals and their families, but also to their employers and communities. Larger regional centres in turn often lack sufficient numbers of appropriate resident health workers to adequately service catchment populations and are reliant on locums and short-term rotating doctors from metropolitan hospitals to fill workforce gaps. On the other hand, it is recognised that General Practitioners with Additional Skills are more likely to work in smaller more isolated towns, and to stay.(7, 8)

There is ample evidence to show a correlation between lack of access to appropriate health services and poor health outcomes for rural and remote communities. (9, 10)

Recognition of this correlation has seen governments, at Commonwealth, State and Territory levels, develop and implement a range of programs aimed at addressing both the supply and the maldistribution of the health workforce. In addition to the Australian General Practice Training program, these initiatives have included the establishment of a network of Rural Clinical Schools and University Departments of Rural Health that have led to a marked increase in the vertical and horizontal integration of rural education and training for medical, nursing and allied health students.

Jurisdictions have also increased opportunities for medical graduates to undertake prevocational training in regional hospitals and rural community internships. Some jurisdictions including Queensland, New South Wales, Victoria and Tasmania have introduced Rural Generalist programs in addition to the existing multiple pathways to train for General Practice.(11-14)

More recently the Commonwealth has invested in the *Integrated Rural Training Pipeline* that includes the establishment of twenty-six Regional Training Hubs, aimed at increasing opportunities for postgraduate training in rural areas. The 2018/19 Federal Budget also contained measures to improve access to health services through the *Stronger Rural Health Strategy*(15, 16). The establishment of the Office of the Rural Health Commissioner, and its legislated functions, is also part of this increased focus on rural health reform.

The Office of National Rural Health Commissioner

On June 21, 2017 the Senate passed legislation to enable the appointment of a National Rural Health Commissioner. The Commissioner's appointment commenced in November 2017.

The role of the National Rural Health Commissioner, as set out in the legislation, is concerned with three main tasks, starting with medicine(1):

- a. defining what it means to be a Rural Generalist;
- b. developing a National Rural Generalist Pathway; and
- c. providing advice to the Minister on the development and distribution of the rural workforce and on matters relating to rural health reform.

This Advice concerns the legislated role's first two elements.

The definition

The first task of the Rural Health Commissioner, as described above, was to define the role of a Rural Generalist. This has been achieved through the development of the *Collingrove Agreement*, which provides the following definition:

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 specialist care in hospital and community settings as part of a rural healthcare team.(2)

The definition was developed in collaboration with the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practice (RACGP) and was formally announced by Senator the Hon Bridget McKenzie, Minister for Regional Services, Minister for Sport, Minister for Local Government and Decentralisation, on February 9, 2018. More detail on the *Collingrove Agreement* can be found in the National Rural Health Commissioner's first *Communiqué* available at:

<http://www.health.gov.au/internet/main/publishing.nsf/Content/National-Rural-Health-Commissioner-publications>

We now have an agreed language that enables the description of the variety of health services and models of practice that are needed in different rural and remote settings. Rural and remote communities need great rural General Practitioners, and other great rural specialists. They also need great Rural Generalists. One is not better than the others, but each is required in different settings to support optimal rural community healthcare that is sustainable and cost-effective.

The training gap

Since being appointed, the Commissioner has consulted with a broad range of stakeholders and communities in rural, regional and remote Australia. These consultations have confirmed that, despite the best efforts of so many committed champions, the rural training system consists of disparate parts managed by multiple stakeholders. Students and postgraduate trainees who are interested in rural practice are faced with a series of barriers and a disjointed pathway throughout their training. The current rural training options tend to be administered in a year on year placement

system for limited places in regional, rural and remote regions. The approach is more often opportunistic than structured and does not create ongoing connections to a region. The far easier and often only option for aspiring rural doctors is to undertake different stages of their junior doctor and fellowship training in metropolitan centres. Many do not return to rural Australia. At each step along the current pathway, there is a loss of the potential rural and remote workforce with the worst effects on small communities. This is the gap – a gap that needs to be filled by a training system which provides opportunities for more continuous training in regional teaching and training networks, with the locus in small communities, producing well-trained Rural Generalists to meet community need.

The National Rural Generalist Pathway (the Pathway) will bridge this gap by integrating rural training for General Practice, Emergency and Additional Skills into a single training program. The training will result in, at both a town and regional level, sufficient numbers of doctors with a breadth of skills to provide relevant high quality local care. Importantly, by increasing the number of Rural Generalists working in all Australian regions, the on-call rosters in rural and remote communities will become more sustainable, reducing burnout and workforce turnover. Thus rural doctors and their families can enjoy living, not just working, in rural and remote Australia.

By strengthening regional teaching and training networks and by providing opportunities for cohesive structured and continuous rural medical training spanning rural under and post-graduate training, the Pathway will provide a stable local workforce supply and stem the flow of trainees moving to metropolitan centres for junior medical stages and their vocational training.

The required rural pathways for other medical specialties and health professionals critical to the rural healthcare team must also be built around this pivotal initiative. The national Pathway will also recognise and accommodate the considerable variations in rural and remote population characteristics, health services and geography across the country and the unique policy settings that accompany these differences.

The numbers – quantifying need

After analysing the scale of current Rural Generalist training initiatives underway, the current capacity for rural training, and existing rural workforce turnover, the Pathway needs to graduate approximately 350 Rural Generalist doctors per year. This represents approximately 10% of the annual graduation from Australian Medical Schools and just under a quarter of the annual 1,500 Australian General Practice Training [AGPT] intake. This number is based on current conditions. It may expand or stabilise subject to the Pathway achieving a sustainable rural workforce. In addition, consideration has been given to the capacity and readiness of different jurisdictions to host training in different regions.

Methodology

This estimate of 350 doctors represents consensus of a number of approaches to defining the need. The following outline for determining Pathway numbers is based on available workforce planning data and known evidence about rural and remote General Practice.

There are 750 doctors enrolled each year to undertake training as a General Practice (GP) registrar in the rural training pathway of the AGPT (50% of all GP registrars) (17).

Registrars on the rural pathway are required to do their vocational training in ASGC-RA 2-5 (spanning all regional, rural and remote locations). However, around half of the Australian rural population (46.7%) lives in MMM4-7 (town sizes <15,000 population). To train sufficient Rural Generalist doctors who can serve the populations in MMM4-7 (with the wide range of skills that these communities need), 46.7% of the 750 places on the AGPT rural pathway should be Rural Generalist places, equating to approximately 350 places.

Another approach to considering the number of Rural Generalists needed is basing this on the number and MMM distribution of places on the most mature Rural Generalist program in Australia, the Queensland Rural Generalist Program (n=80 places)(18). The percentage of Rural Generalist registrars per MMM in Queensland can be applied to the MMM population size in other states and territories which sums to a national figure of n=373 Rural Generalist places if based on MMM4-7 and 311 if based on MMM2-7. This re-affirms that 350 is a reasoned number of places for training Rural Generalists Australia-wide considering both need (MMM4-7) and training capacity (MMM2-7).

Finally, the rates of rural General Practice workforce turnover in MMM 4-7 communities can be used to project the number of Rural Generalists needed to replace the doctors leaving these communities. Rural Workforce Agency data (2018) shows there are around 3,365 self-reported procedural General Practitioners nationally. Of available research, McGrail and Humphreys showed that rural General Practitioners (excluding registrars with highest turnover) based in MMM4-7 have a turnover rate of 11-18% per year (highest in more remote locations). Thus 350 Rural Generalists is a conservative estimate, at only 10.4%, to account for current MMM4-7 turnover. Another study which did not exclude registrars nor delineate by MMM also identified a turnover of around 10% for rural GPs/GP registrars. (19, 20)

Using these three methods, whilst acknowledging that each has its limitations, there appears to be some convergence about the number of Rural Generalist positions needed in a national pathway with respect to current training and workforce dynamics.

Initial consultations with various stakeholders have identified that this number would be a feasible target to train in regional networks of different states and territories, with the potential for flexible roll-out and for some expansion, as required. These discussions will continue.

The proposed approach, once in steady state, represents a total of over 2,000 doctors in Rural Generalist training at any one time, with 350 Fellowed graduates emerging annually. This represents a key ongoing contributor to the rural and remote regional-level workforce pool. It provides a locally grown counter-balance to the current reliance, particularly in smaller towns, on approximately 2,000 overseas-trained doctors. Additionally, it provides a sustainable rurally-based alternative to the city-based doctors that are currently regularly sought to provide crisis and long-term locum support for rural health services.

A gradual adjustment from locum-led health services to locally-led, continuous regional training networks, producing doctors with a range of skills to work effectively across the needs of rural and remote communities, will help to transition smoothly to a

more cost-effective and sustainable workforce supply and retention model for rural Australia.

Conclusion

The Pathway is based on sound evidence, bridges the gaps in the current system, and will be attractive to students and junior doctors. It provides the numbers needed to ensure a sustainable Rural Generalist workforce, particularly for the smaller communities where need is greatest. It provides choice for those interested in rural practice to enter at multiple points in their career. It connects Rural Clinical Schools and regional medical school programs with opportunities to continue high quality rural training as a junior doctor and then continue as a Rural Generalist registrar to Fellowship. All of these elements of training are based on providing opportunities for high quality learning and professional support in regional, rural and remote Australia. The Pathway will also be a foundation for building the capacity of other rural disciplines to be developed.

Chapter Two: The Pathway

Introduction

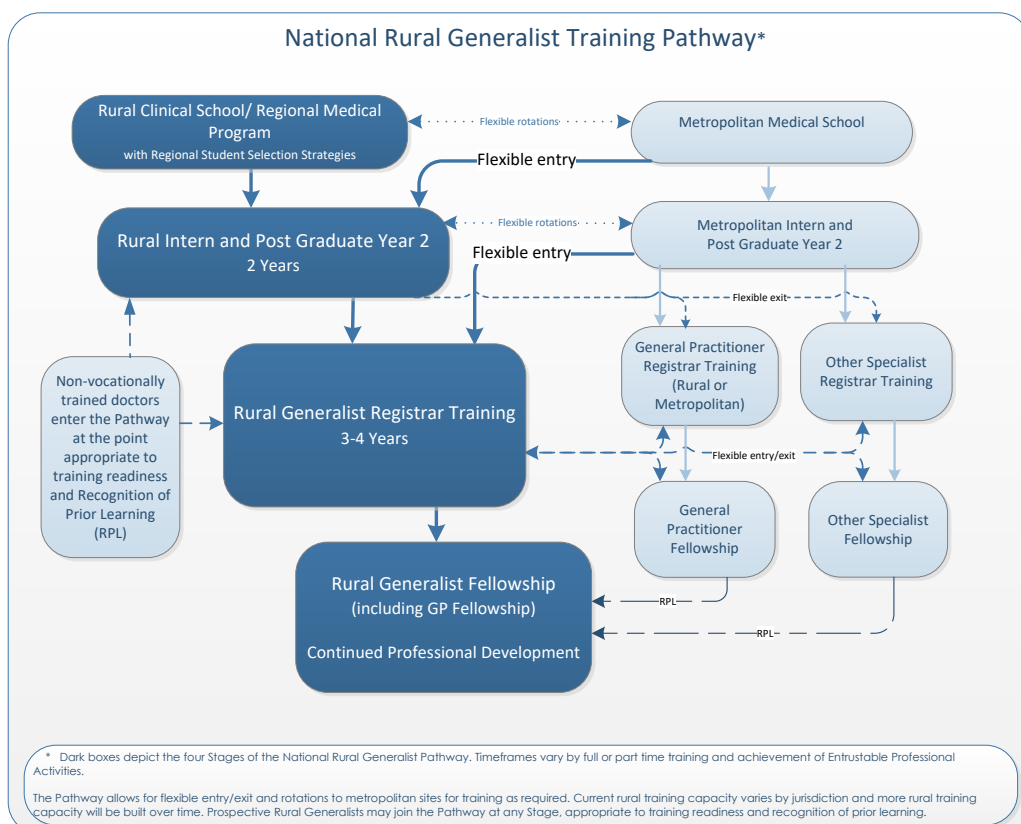
The second task of the Commissioner was to develop a national Pathway for Rural Generalists. There has been consultation with a very broad range of stakeholders on this important task and the work of the Taskforce has greatly benefited from the expertise and good will of many.

The Taskforce was also aided by a thorough background briefing provided by the Department of Health.

Overview of the structure

The proposed structure for the postgraduate Pathway is a 5-6-year training and workforce framework delivered through the creation of teaching and training hospital/health service/practice networks across regional, rural and remote Australia. The Pathway delivery networks can align with existing health service networks and clusters of education and training. It is recommended that the Pathway connects with rural clinical school/regional medical programs and gives doctors interested in rural practice the opportunity to continue working and training in high quality rural junior doctor and Rural Generalist registrar positions. Once Fellowship is achieved, the Pathway continues through to career development and skills maintenance, with relevant, targeted practice incentives (Figure 1).

Figure 1 – The National Rural Generalist Pathway



The postgraduate elements of the Pathway include continuity of training following medical school graduation, including an indicative two years each of junior doctor,

General Practice and Additional Skills components. Historically, most Additional Skills training has occurred in a one-year placement. However, feedback from trainees and supervisors has indicated that many trainees require more than this single year to be confident for independent practice in their skill area. In addition, many trainees are electing to undertake training in more than one Additional Skill to meet the needs of their prospective rural region. Thus, the Pathway allows for flexibility of one to two years of Additional Skills training.

Funding should follow the trainee/registrar so that educational quality, employment benefits, and mentorship span hospital and community settings, and equal consideration is given to the clinical service requirements of both settings in allocating training places. Such an approach, possibly with a more sustained "duration of training" contract for the doctor, will also enable flexibility for trainees, providing for meaningful parenting, personal and carer's leave.

Outcomes

The benefits of a funded and cohesive Pathway will include secure employment opportunities, long-term workforce planning, doctors with skills to address community need, and the vertical and horizontal integration of Rural Generalist practice in rural primary healthcare, all of which will lead to the future economic development of rural and remote communities.

The Pathway feasibility

Recommendation 1: The Taskforce recommends that the proposed structure (Figure 1) for the National Rural Generalist Pathway be adopted by Federal, State and Territory Governments, and advises that the following system enablers exist, 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.

Rural Clinical Schools have two decades of evidence of high quality educational outcomes. Regional medical programs have been piloted successfully in Northern Queensland, the Northern Territory, Eastern Victoria, and Northern NSW and have been expanded with the announcement of the Murray Darling Medical School Network in the most recent Federal Budget(15). The principles of a national Pathway can inform and support the development of further regional medical programs.

The educational quality of PGY1 and 2 learning in rural communities has long been demonstrated in regional hospitals and via the former Prevocational General Practice Placements Program (PGPPP) and is being expanded, as signalled through the current Rural Junior Doctor Training Innovation Fund (RJDTIF).

Successful jurisdictional-based and college-supported Rural Generalist programs already exist and can be built upon in the establishment of the national Pathway.

Specialist level training in regional communities has been supported by multiple Specialist Colleges and successfully expanded through the Specialist Training Program [STP] initiative. This provides existing education infrastructure with the potential to support regionally-based Rural Generalist Additional Skills training.

General Practice training in rural communities through the AGPT (delivered by Regional Training Organisations), the Remote Vocational Training Scheme (RVTS), the ACRRM Independent Pathway, and the RACGP Fellowship of Advanced Rural Practice, has been shown to be an appropriate preparation for success in Fellowship-level exams.

b. Each General Practice College has an Education Program that currently meets the requirements for high quality educational outcomes in postgraduate training, and has existing or emerging relationships with other Colleges relevant to the broad scope of required training.

The educational design principles used by ACRRM and RACGP are of high quality and enable/encourage contextualisation at the local/regional level whilst delivering consistent and appropriate outcomes. ACRRM and RACGP training and curricula have been used successfully by individual jurisdictions for Rural Generalist training.

The curriculum resources provided to Registrars by ACRRM and RACGP with involvement of other registrar/training agencies involved in training, can support Rural Generalist practice. Development by RACGP and ACRRM of further training options for different Additional Skills is an important consideration for collaboration with other Specialist Colleges.

The current FACRRM and FRACGP & FARGP qualifications provide appropriate signposts for Rural Generalist practice. The current assessment approaches used by ACRRM and RACGP are also valid, reliable, of high quality and are relevant to Rural Generalist practice. The RACGP and ACRRM have committed to the establishment of an agreed national Rural Generalist outcome standards framework to guide the further development of these qualifications. The endorsement by the two Colleges of a comprehensive national Rural Generalist training outcomes statement is the next essential step.

Pathway elements

The pre-existing elements in the Pathway are intended to be deliberately recognisable. The Pathway model builds on what is already in place and is functioning well. The objective is to enhance existing regionally driven training models in order to sustain and enrich rural and remote communities.

The Pathway is not linear and entry or exit is possible at multiple transition points (Fig 2). Medical students and junior doctors who identify and engage with the Pathway early in their careers should be supported by appropriate training arrangements and opportunities to achieve Rural Generalist qualifications. In addition, it is important that students/doctors are not confined or restricted to Rural Generalist vocational training, and exit points from the Pathway are supported in the event of a change in career direction.

In addition, the Pathway recognises the critical importance of early, prolonged and repeated rural General Practice experience for medical students, prevocational trainees and registrars. Preferably, this begins with longitudinal integrated rural General Practice experience at the undergraduate level, followed by rural General

Practitioner exposure in prevocational training and then early rural General Practice placements as part of the postgraduate training program.

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* which integrates General Practice, Emergency and Additional Skills, as required to support enhanced quality, safety and continuity of care in health services that meet rural community needs in a cost-effective, sustainable way.

The Pathway will have nationally consistent end points as agreed between the two General Practice Colleges, with the aim that the Rural Generalist title is formally recognised by AHPRA. The Pathway will bring national consistency to, and integrate, Rural Generalist governance, standards, recognition, remuneration and design of models of rural workforce.

- b. The importance of country - The Pathway will be based in teaching hospital/health service/practice networks across regional, rural and remote Australia, and centred on communities where generalists are needed.

There will be multiple entry and exit points and opportunities to choose to participate in high quality rural training "in country" via rural medical programs, rurally based junior doctor and vocational training. Connection to country and family will be maintained with a comprehensive continuing professional development (CPD) program and professional networks. Although allowing for short intensives as required in major cities, this principle will ensure that rural and remote communities of Australia are the reference point for the social, family and career decisions made by Rural Generalists and their partners.

- c. Respect for and consideration of 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.

It is important that the Pathway builds on existing successful rural medical education initiatives. Equally, the Rural Generalist Training Pathway can integrate with the changes to General Practice training in Australia, particularly with the transition to College-led training over the next three years. The Pathway also takes account of the current Rural Generalist jurisdictional models and teaching and training infrastructure.

- d. Community control - The Pathway requires clear engagement with and leadership from rural and remote communities, including Aboriginal and Torres Strait Islander communities and community-controlled health services, to ensure it remains responsive to community needs.

The commitment to a Pathway that is responsive to community need requires careful consideration about how community need is defined. The starting point

for this process is engagement with rural communities to understand the health services that most matter to them, and to enable their participation in the recruitment and retention of students, trainees, and the practising Rural Generalist workforce.

A number of stakeholders in the rural sector play a role in assessing need, as outlined in the Planning and Evaluation Framework (Chapter 3). It is recognised that community need is not uniform and alters over time. Rural Generalist practitioners will need to constantly review and maintain/adjust their skill-base according to changing need. It is also likely that national and jurisdictional recognition of the "Rural Generalist" and a growing cohort of doctors with the Rural Generalist skill-set will influence new models of rural medical care to meet community needs.

- e. Cultural safety - The Pathway must include structured mentorship and tailoring of training for trainees, including Aboriginal and Torres Strait Islander peoples to ensure a cohort of doctors is graduated that is culturally aware, meets the needs of communities including Aboriginal and Torres Strait Islander peoples and prioritises 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 willing and able to critically reflect on their own cultural influences and the impacts the latter might have on the provision of care to their patients.

There may often be a distinction between the breadth of training required to achieve the Rural Generalist qualification and the eventual scope of practice of the individual Rural Generalist. Context, infrastructure availability, and local models of healthcare influence scope of practice. It is important for there to be appropriate and streamlined continuing professional development (CPD) for maintaining the skills needed for practice, and up-skilling in new areas, to allow Rural Generalists to effectively address community needs. The professional development process needs to be appropriately networked and as accessible as possible. It should not be cumbersome on individual doctors wishing to maintain wide skills sets.

The retaining of Rural Generalist status (once achieved) will be dependent upon ongoing compliance with prescribed CPD requirements as determined by the two GP Colleges. It is important to clarify that the Taskforce recommendation is that Rural Generalist remuneration (see Chapter 5) should be based on skills obtained and used, the level of service provided, and the practice context, not merely on the Rural Generalist's professional identification.

Design improvements

An initial review of the current curricula and assessments for the FACRRM and FRACGP & FARGP has identified potential improvements to better meet the needs of trainees, supervisors and rural health services. Critical to these improvements is the need for support and mentoring of both supervisors and trainees. Potential areas are listed below.

Recommendation 3: That the following elements of postgraduate training are identified for potential development by the two General Practice Colleges as part of the design and delivery of the National Rural Generalist Pathway:

- a. Incorporation of flexible approaches to gaining and demonstrating competence for practice, including undertaking increased training in Rural Generalist practice

The Pathway must incorporate flexible ways of gaining competence in teaching and training hospital/health service/practice networks across regional, rural and remote Australia. This includes having options to achieve competency through working in smaller rural hospitals and community practices. Demonstration of competency in Core and Additional Skills training needs to be largely based on practice in the settings where Rural Generalists are most likely to be employed.

Intensive rotations or periods of work in larger regional or metropolitan hospital and community settings are also important when needed to foster supportive clinical networks and to enable skills volume to be attained in reasonable time. Mechanisms for collaboration between ACRRM/RACGP and other Specialist Colleges in the development and implementation of Additional Skills training, up-skilling, and professional support, could be strengthened and supported. Opportunity exists to work with a wider group of Colleges in order to provide the breadth of the currently named "Advanced Skills" posts now required by rural communities.

- b. Better matching Additional Skills training with community needs and where the trainee plans to work.

Trainees will better understand the range of Additional Skills required in places they might like to work if they are familiar these communities prior to deciding on their Additional Skills training. Continued development and addition to the skill set held by the practitioner should be encouraged as driven by meeting community needs and relative to the skills interests of the Generalist.

- c. Supporting personalised learning through developing Programmatic Assessment for Learning and Entrustable Professional Activities (EPAs).

An increased emphasis on In-Training Assessments, Programmatic Assessment for Learning, and EPAs would facilitate a wider range of learning setting, assist in increasing the confidence and competence of the trainees, and provide recognition for independent practice in certain domains even whilst still training under supervision in other domains.

- d. Providing Recognition of Prior Learning (RPL), Credit Transfer and up-skilling arrangements for both prospective trainees entering the pathway at different stages or practitioners seeking to be recognised as Rural Generalists.

Including a Programmatic Assessment for Learning approach during the application process may also assist in implementing RPL/Credit Transfer for lateral entrants, as learners and supervisors would be required to establish an understanding of what the learner already knows and what further learning is

required to meet the Pathway outcomes i.e. an individualised approach for all trainees.

- e. Engagement, professional support and up-skilling for Rural Generalist supervisors and mentors.

Supervisors are key to the quality of training in the Pathway. Increased emphasis on, and training for [through staff development] the supervisors and mentors of Rural Generalists, will benefit trainees throughout all stages of the Pathway.

- f. Opportunities for collaboration between regions to support trainees and Fellowed Rural Generalists.

A national approach to training would be enhanced by employers and educational providers cooperating to facilitate the seamless movement of registrars across teaching hospital/health service/practice networks across regional, rural and remote Australia for high quality education.

Educational Outcomes for the Pathway

Both ACRRM and RACGP support the articulation of an agreed set of clear national outcomes for the Pathway. They will then use these outcomes to ensure flexible learning approaches for trainees and other learners are developed that meet community and workforce needs and leverage teaching hospital/health service/practice networks across regional, rural and remote Australia for learning and professional support.

The definition of Rural Generalist training contained in the *Collingrove Agreement* provides the baseline for an agreed Scope of Practice for Rural Generalists and the determination of an Educational Outcome Framework for a National Rural Generalist Pathway.

The following national educational outcomes are based on a synthesis of curriculum documents from both the RACGP and ACRRM.

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

Rural Generalists are trained:

- a. To ensure patient safety and practice standards are at optimal levels in their practice context; and to maintain and enhance individual skills and knowledge through a robust continuing education program.
- b. as core skills, to provide high quality, culturally safe, community and population-based General Practice.

This may occur in accredited General Practices, Aboriginal Medical Services or equivalent accredited health services in rural communities, and include the use of telemedicine, critical enquiry and research, and the training of registrars and students.

- c. as core skills, to provide emergency/trauma services at the local rural hospital and/or health-care facility/practice.

Note that further identification of the level of Emergency skills as a core component of the Rural Generalist Program will be delineated jointly by RACGP/ACRRM, including how this translates to recognition of emergency care provided by Rural Generalists in a rural/remote setting without hospital infrastructure, such as a remote Aboriginal Medical Service or small rural town.

- d. as core skills, to provide in-patient care for a wide range of patients, and to organise retrieval/referral as appropriate.
- e. as core skills, to work in teams, including through telehealth and multi-town network models, to provide healthcare and health service leadership, quality improvement, and advocacy for their rural communities.
- f. to provide after-hours services for their communities.
- g. to be adaptive and practise where there is no or limited access to local specialists.

This includes the development of advanced leadership, coordination and decision-making skills particularly in relation to health systems and emergency patient management.

- h. to provide a range of Additional Skills that reflects the needs of diverse rural communities.

This will include the important fields of Anaesthesia, Obstetrics, Surgery, and advanced Emergency Medicine to meet the birthing and critical care needs of rural communities, and also include the increasingly important fields of Aboriginal and Torres Strait Islander Health, Psychiatry, Aged Care, Palliative Care, Addiction Medicine, Adult Internal Medicine, Paediatrics, Remote Medicine, Public Health, Medical Education and Health Administration.

It is noted that these educational outcomes are consistent with international frameworks such as the CanMEDS roles.(21) It is also clear from these outcomes that a Rural Generalist is not a General Practitioner with Special Interests, but rather a doctor whose scope of practice is aligned to the needs of rural communities.

Conclusion

This Chapter has provided an overview of the principles, structure and intended outcomes of Rural Generalist training within a continuous rural Pathway. The recommendations aim to assist with guiding appropriate ongoing educational program design and implementation in consultation with relevant stakeholders.

Chapter Three: A Planning and Evaluation Framework

Introduction

Planning and evaluation are inherent to the development of the Pathway, the post-graduate training program component and any accompanying Rural Generalist practice incentives.

Planning

Health workforce planning aims to achieve a proper balance between the supply and demand for different categories of health workers, in both the short and longer-term. Given the time and cost involved in health workforce training, it is important that training positions are well planned and linked with community needs and viable employment models.

The Planning Framework for the Pathway recognises that multiple groups are already engaged in planning the rural workforce. Workforce planning is the core business of governments, jurisdictions, rural health organisations and rural communities. However, for planning a fit-for-purpose rural workforce, and within that, where Rural Generalist training and employment positions are most applicable, it is important for Rural Generalist doctors to be specifically counted and applied in rural workforce planning systems.

Evaluation

Evaluation is defined as gathering information to test the value of and inform decisions about an intervention. It is a critical investment at the beginning of interventions like the Pathway to effectively allow program design assumptions to be tested, to ensure proactive strategic data collection takes place, and to facilitate timely Pathway improvement. This ongoing focus on quality baseline and follow-up data helps to avoid costly and low quality reporting about program effects.

Queensland and New South Wales have already begun to evaluate their Rural Generalist training programs, but more work needs to be done to build strong comprehensive evaluation systems nationally, in order to understand the value of Rural Generalists and the Pathway to rural communities. The Evaluation Framework, similar to the Planning Framework, depends on data that accurately measures Rural Generalists and their scope of practice, alongside other rural workforce, and links this with other data from rural health services and rural communities.

The Evaluation Framework is based on a clear understanding of the mission of a National Rural Generalist Training Pathway:

Mission

The National Rural Generalist Pathway aims to develop and implement a continuous and integrated Rural Training Pathway, adaptable to different jurisdictions and regionally driven, which attracts, develops and retains more students and trainees to rural medical training pathways who have a range of skills and scope which address the needs of Australia's regions and towns. More Rural Generalists, coupled with the right practice incentives and an enabling practice context, are expected to improve access to a wider range of medical

services, as needed by rural communities, and in the long-term improve rural community health, social and economic outcomes.

The Evaluation Framework is based on a logic model (and related Schema) built around this Pathway mission and based on evidence from Australian and International rural health services and rural medical education research. This encompasses the inputs, outputs, impact and short and long-term outcomes expected from the national Pathway, Training Program and practice incentives.

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

Table 1 - Draft Logic National Rural Generalist Pathway

The National Rural Generalist Pathway aims to develop and implement a continuous and integrated Rural Training Pathway, adaptable to different jurisdictions and regionally driven, which attracts, develops and retains more students and trainees to rural medical training pathways who have a range of skills and scope which address the needs of Australia's regions and towns. More Rural Generalists, coupled with the right practice incentives and an enabling practice context, are expected to improve access to a wider range of medical services, as needed by rural communities, and in the long-term improve rural community health, social and economic outcomes.				
INPUTS & ACTIVITIES - Resources and activities to deliver the outputs	OUTPUTS - What will happen to achieve short term impact	SHORT-TERM IMPACT - What will happen to deliver the outcomes?	SHORT-TERM OUTCOMES - What will be achieved?	MEDIUM-to-LONG TERM OUTCOMES - What will be achieved?
<p>Legislation passed in Parliament July 2017</p> <p>RHC appointed Nov 2017</p> <p>RHC team, processes & documentation instituted Jan –Jun 2018</p> <p>Taskforce, Working and Reference Groups set up May 2018</p> <p>Policy consultation – policy development, budgeting, national consensus building, discussion and options papers</p> <p>Other strategic meetings, sector engagement, agendas, minutes</p> <p><i>Stronger Rural Health</i> policy alignment</p> <p>State policy alignment (workforce plans, credentialing)</p> <p>Conferences, workshops and community consultation.</p> <p>NRHC office strategic and communication plan</p> <p>Communication and recruitment plan</p> <p>Planning and Evaluation framework, data collection</p>	<p>GP College-agreed definition of a Rural Generalist (RG) doctor for driving a training program</p> <p>College-endorsed RG curriculum and assessment standards (applying latest educational theory, existing curriculum – core and additional skills for adaptable practice, considerate of different volume/complexity skills, multiple skills, RPL)</p> <p>RG professional recognition (protected title with endorsement)</p> <p>RG supervised training posts developed based on the scope of services rural communities need and future jobs</p> <p>Principles for (community) selection of RG registrars (direct and lateral entry, links to rural medical training/ high school, interests)</p> <p>Coordinated and supported RG training in teaching hospital/health service/practice networks across regional, rural and remote Australia</p> <p>Duration of training contract PGY1-6; based in rural communities where RGs needed, with in-reach to regions/cities (flexible entry/exit, part / full time training)</p> <p>Relevant RG remuneration and practice incentives for viable practice models and sustainable work</p> <p>Quality improvement systems which optimise safe RG scope</p> <p>Evidence for planning and baseline evaluation data</p>	<p>An effective rural community-centred national RG training pathway, developing doctors with the scope of practice rural communities need within viable practice models (training and practice adaptable to other jurisdictions/ regions)</p> <p>More domestic and International graduates selected/enrolled in RG training/ RPL/Fellowship</p> <p>Effective remuneration and incentives for RG extended scope of practice, working across clinical settings and working more remotely</p>	<p>More RGs and RG supervisors in rural workforce</p> <p>Better rural workforce distribution and retention</p> <p>More rural doctors working at extended scope in areas needed by communities, so extended services more accessible</p> <p>Less use of short-term locums in extended care areas</p> <p>More appropriate and fewer retrievals/transfers of rural patients to city hospitals</p> <p>Regional Health Teaching Networks bringing benefits of local research, teaching and clinical care to rural patients.</p>	<p>Improved indicators of optimal healthcare in areas needed by communities (e.g. key services community needs are available, early intervention and continuity of care, culturally-appropriate care, coordinated team-based care, affordable for consumers)</p> <p>Improved indicators of health outcomes in areas needed by communities (e.g. primary care, emergency, obstetrics, paediatrics and child health, aged care, mental health, addictions medicine, palliative care, internal medicine, surgery, anaesthetics Aboriginal and Torres Strait Islander health, remote health, public health + other)</p> <p>Reduced health service costs</p> <p>Rural community self-determination and confidence in health service, delivery of quality services, teaching, research.</p> <p>Improved rural community economic participation and development</p>

1. Better Evaluation. *Better evaluation. Sharing information to improve evaluation.* 2018. <http://www.betterevaluation.org/> (accessed 19 March 2018).
2. Centre for Epidemiology and Evidence. *Evidence and evaluation guidance series population and public health division. Developing and using program logic: a guide.* Sydney: NSW Ministry of Health 2017. www.health.nsw.gov.au (accessed 19 March 2018).
3. World Health Organization. *Towards Universal Health Coverage: A global toolkit for evaluating health workforce education* (unpublished). 2014.

To measure the impact and outcomes relative to the logic, three focused streams of evaluation activity will need to occur, as outlined here:

1. *Training and Professional Outcomes*

Identify the outcomes (location and scope of practice) of Rural Generalist postgraduate training. The Commonwealth Department of Health already has a Registrar Information Database Exchange (RIDE) dataset and this data can be linked with new data, for example which could be collected by the GP Colleges, about the location and scope of work of rural doctors nationally. These data can then be linked to rural outcome evaluation work underway at the medical school and rural clinical school level if linkage keys can be determined. A final protocol needs to be developed, agreed, ethically endorsed, resourced and implemented.

2. *Workforce and Scope of Practice*

Explore the number and distribution of the Rural Generalists before and after the Pathway is implemented. Potential data sources include the Rural Procedural Grants Program and Premium Support Scheme dataset held by Commonwealth Department of Human Services accessible via the Commonwealth Department of Health, the Minimum Dataset maintained by Rural Workforce Agencies, Jurisdictional workforce data, Medical Student Outcomes Database (MSOD) and the MABEL survey. The MABEL survey dataset includes new questions about Rural Generalists which provide valuable information due to the large number of covariates with which to explore workforce predictors. Additionally, new data may be able to be collected for exploring the location and scope of work of Rural Generalists within the Australian Health Practitioner Regulation Authority (AHPRA) Annual Medical Workforce Survey and by the two GP General Practice Colleges, who have an interest in where their fellows are working and at what scope. Once collected and validated, the data about Rural Generalists, their distribution and scope of work can be integrated with other data about other rural workforce, health services and health outcomes for appropriate pre and post evaluation testing. A final protocol needs to be developed, agreed, ethically endorsed, resourced and implemented.

3. *Community Outcomes*

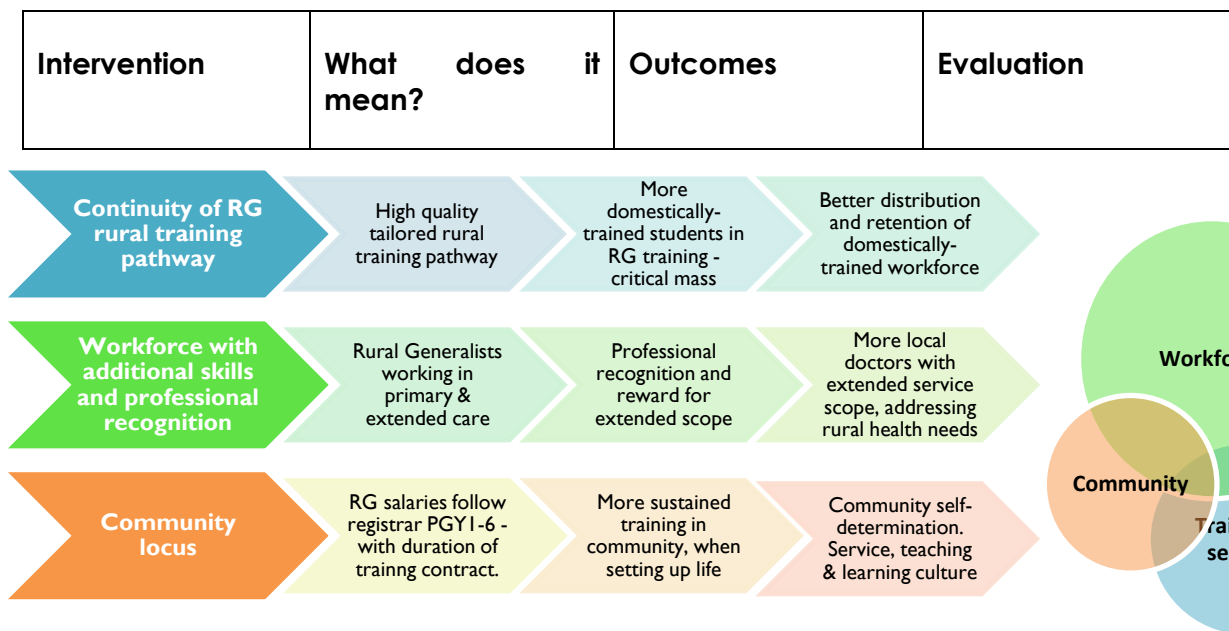
Describe Rural Generalist practice in context and explore community outcomes. This work involves undertaking rich descriptions about Rural Generalist doctors in their practice context and the impact of generalist services on communities including on consumers and carers in communities. The impact on community will be guided by the logic model and will include the impact on the local doctors, the health service and the people who are using the services of Rural Generalists. An agreed protocol will be guide the selection of case communities, who are using Rural Generalist services, in different jurisdictions with or without Rural Generalist training already in place.

This should include Aboriginal and Torres Strait Islander communities. A suite of standardised methods and tools, including stakeholder interview questions, key health service and outcome indicators and direct service costing methods will be applied to collect data and the data will be compared at a national level to understand the similarities and differences in community context impacting Rural Generalists and the outcomes of their services for rural and remote communities. The final protocol needs to be developed, agreed, ethically endorsed, resourced and implemented.

Resourcing and capacity building

The scope and complexity of the Planning and Evaluation Framework requires sustained funding, coordination and research-evaluation leadership. Existing competitive grant funding opportunities are limited for evaluation purposes. Crowd funding is equally challenging to coordinate and implement. Longer-term investment would assist to engage a team of national leaders in a coordinated way to manage this program of evaluation activity and to build capacity by engaging doctoral and academic staff in rural health systems research around this topic.

Schema of National Rural Generalist Pathway Intervention and Outcomes



Conclusion

The Planning and Evaluation Framework presented in this Chapter, provides a detailed perspective of the mission and activities related to implementing a National Pathway, relative to impacts and outcomes that can be expected. In describing these elements, the proposed causes and effects of the Pathway can be appraised and specific data infrastructure can be established early in the process of implementing a Pathway. This data infrastructure is critical for informing the design of the Training Program and other incentives for producing a workforce in the right place with the right skills to support healthier rural communities. As such, it is critical that nationally, a structured Planning and Evaluation Framework is implemented for the national Pathway.

Chapter Four: Rural Generalist Recognition

Introduction

This chapter discusses a range of options for the recognition of Rural Generalists. Recognition of the skills and scope of work provided by Rural Generalists supports safety and quality of health services by allowing employers and the public to freely access information about the training that doctors have completed relative to the services they provide. By identifying Rural Generalists in a nationally consistent way, it is also easier to undertake workforce planning, recruitment and credentialing processes. Recognition of a Rural Generalist practitioner is also critical for attracting students and junior doctors to this career path, as the Queensland Rural Generalist Program has demonstrated.

The option recommended in this chapter, and supported by both the RACGP and ACRMM – that Rural Generalists are recognised as a specialised field within the speciality of General Practice – recognises the collegiality of General Practitioners across the variety of contexts in which they work. This chapter also outlines how the Pathway is structured in a way that is inclusive of all learners entering at multiple stages of their career and is explicit in facilitating recognition for rural doctors already practising to this scope of practice.

Current situation

The Australian Health Practitioner Regulation Agency (AHPRA) administers the National Registration and Accreditation Scheme (NRAS). According to the Medical Board of Australia document, "List of specialties, fields of specialty practice and related specialist titles", [1 June 2018], the speciality of General Practice has the title "Specialist General Practitioner", with no currently listed "fields of specialty practice". The COAG Health Council approved this list of specialties on 27 March 2018 pursuant to the Health Practitioner Regulation National Law. (22)

RACGP and ACRRM are the two Specialist Medical Colleges accredited by the Australian Medical Council (AMC) to provide specialist training for General Practice in Australia and are responsible for setting and arbitrating the standards for General Practice in Australia. Both Colleges have specialist medical training standards that meet the standards as determined by the AMC.

Most doctors currently working at a generalist scope in rural and remote locations in Australia are trained via standards and curricula set by either the RACGP or ACRRM, and are recognised by the Medical Board of Australia as Specialist General Practitioners.

Proposal for future recognition

The Commissioner brought the two Colleges together in early 2018 to determine an appropriate definition of a Rural Generalist for the Australian context. The resultant *Collingrove Agreement* states that "A Rural Generalist is a medical practitioner who is trained to meet the specific current and future health care 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 specialist care in hospital and community settings as part of a rural healthcare team."

Recommendation 6: That the two General Practice Colleges support the national recognition, as a protected title, of a Rural Generalist as a Specialised Field within the Specialty of General Practice.

This is consistent with current training and recognition systems in medicine. A useful example can be found in the specialty of Specialist Physicians, where Cardiology is one of a number of specialised fields. All Cardiologists are Physicians but not all Physicians choose to acquire the skills required to be recognised as Cardiologists. The proposed recognition of the Rural Generalist as a specialised field within the specialty of General Practice would mean that all Rural Generalists are General Practitioners, however not all General Practitioners will choose to acquire the skills required to be recognised as a Rural Generalist.

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.

Implications of this Proposal

At this point, it must be noted that Rural Generalists are not the only type of doctor required by rural Australia. In some larger regional centres, teams of General Practitioners and other Specialists may be more applicable. But in communities further away and of smaller scale, full time individual specialists are not viable. Rural Generalists are usually the most sustainable workforce to deliver the high-quality care that the communities need and their ability to work across communities makes them a very cost-effective option in low volume settings.

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. Under the principles of community control, local health services and rural and remote communities will play a vital role in determining the range of services they most need for helping their local population. As outlined in Chapter Two, the ability to deliver emergency services does not depend on having a hospital in the town. A Rural Generalist has the flexibility to be able to provide emergency care in a range of community and hospital settings.

By recognising the Rural Generalist as a Specialised Field within the Specialty of General Practice, it is envisaged that the similarities between General Practice and Rural Generalists will be able to be recognised and celebrated, along with the differences. In addition, given that General Practice is already a well-understood field, the current recommendation for a Rural Generalist to be recognised as a protected title within this specialised field will make it easier for rural communities, jurisdictions and employers to identify and understand the scope of Rural Generalists.

The suggested recognition of Rural Generalists within General Practice also means there is no need to create an entirely new curriculum to train Rural Generalists. The existing RACGP and ACRRM curricula can be effectively utilised for Rural Generalist training. Current educational end-points for the Rural Generalist Pathway would be FRACGP & FARGP or FACRRM.

According to the Rural Health Commissioner's first *Communiqué*:

The National Rural Generalist Pathway aims to train doctors to provide the broad range of General Practice, Emergency and other specialist services required by their communities, and will include ways for existing rural doctors to either be recognised as Rural Generalists if they are already practising as such, or, if they wish, to broaden the range of their skills to meet the same needs.

In this way, existing General Practitioners will be able to apply for Recognition of Prior Learning for training they have completed or work that 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. All Rural Generalists would also be able to use the title General Practitioner at any stage. 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.

It is important that communities, jurisdictions, and other employers, are informed and consulted about issues related to recognition of their doctors. Such consultation is inherent to the formal assessment process that the AMC undertakes on behalf of the Medical Board of Australia once an application for recognition has been received. In addition to this, the AMC consults with all relevant professional bodies relevant to introducing a new title.

Endorsements as further recognition

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.

AHPRA endorsements are an additional mechanism, further than Recommendation 6, for recognising and documenting the Additional Skills Rural Generalists acquire for an enhanced scope of practice. To be considered for endorsement, these skills require specific formal training, certification, and ongoing CPD. (23)

The AHPRA requirements for endorsement are:

- 1) A National Board established for a health profession may, in accordance with an approval given by the Ministerial Council under section 15, endorse the registration of a registered health practitioner registered by the Board as being qualified to practise in an approved area of practice for the health profession if the practitioner:

- a. holds either of the following qualifications relevant to the endorsement—
 - a. an approved qualification;
 - b. another qualification that, in the Board's opinion,
 - i. is substantially equivalent to, or based on similar competencies to, an approved qualification; and
 - ii. complies with an approved registration standard relevant to the endorsement.

2) An endorsement under subsection (1) must state—

- a. the approved area of practice to which the endorsement relates; and
- b. any conditions applicable to the practice by the registered health practitioner in the approved area of practice.

If this approach were pursued, there would not necessarily be any requirement for Rural Generalists to obtain an endorsement in order to practise. Doing so, however, would place this additional training/skill on the public record and make it clearer to health services and to the general public which area/s of Additional Skills a Rural Generalist has obtained, and has kept current. If for example, a female patient wished to find out which doctor had the appropriate obstetric skills to deliver her baby in the rural area where she lived, that information would be available and accessible through AHPRA. Endorsements, in addition to a protected title, are also another way to recognise the additional training and skills of a Rural Generalist and could be seen as another incentive for doctors to become a Rural Generalist.

Similar to a protected title, an endorsement has the potential to assist with public transparency and support credentialing processes for the work of the Rural Generalist. Multiple Additional skills can be listed and updated over time as Rural Generalists may change how they work based on different community needs or personal interests. Concerns have been raised that using endorsements may put in place a requirement for multiple qualifications. This concern is valid and must be considered alongside the potential public benefits of such an approach.

Other options considered for recognition

Recognising Rural Generalist practice as a stand-alone specialty field of medicine was another option considered. This would require a change in the way that certain General Practitioners are recognised, and the addition of an entirely new specialty to the AHPRA list of specialties, fields of specialty practice and related specialist titles. The main concerns were that this could create a divide between primary care groups, by focusing more on differences between General Practice and Rural Generalist practice, rather than similarities. Another risk of this approach was related to potential restrictions of practice; for example, a Rural Generalist may not be permitted to work outside of a rural location.

Other alternatives considered included seeking to have “Rural Generalist” as an endorsement within the specialty of General Practice, or not seeking a protected title for “Rural Generalist” and rather seeking endorsements for the Additional Skills within the Specialty of General Practice. The former is not consistent with the way that medical disciplines have recognised specialised fields within their specialty and would be confusing if further endorsements of Additional Skills were also sought. The latter

provides no formal differential outcome or status (and therefore limited incentive) for doctors to undertake a National Rural Generalist training program and is not encompassing of the emergency care element of a Rural Generalist within the *Collingrove Agreement*.

These other options have therefore not been considered further.

Conclusion

Recognition is an important component of the Pathway and integral to creating and sustaining an appropriate workforce for rural and remote communities.

The two General Practice Colleges have agreed to support the proposal to have *Rural Generalist* recognised as a Protected Title and as a Specialised Field within the Specialty of General Practice.

A protected title status for a Rural Generalist as a specialised field within the specialty of General Practice reinforces that the responsibility for governing Rural Generalist practice rests with the General Practice Colleges and strengthens the role of comprehensive primary care in supporting health needs in rural and remote communities. For clinicians, it provides clear and public recognition as to their scope of practice. For the next generation, it will be an important factor in encouraging them to become a Rural Generalist. For rural communities, it provides transparent and rigorous public accountability for the skills of their providers relative to different scopes of practice.

Chapter Five: Support, Incentives and Remuneration

Introduction

The aim of this chapter is to present a set of principles and a range of initiatives, intended to support Rural Generalist practice being an attractive training and career option. The initiatives also aim to support the existing Rural Generalist workforce and encourage a wide scope of services relative to rural and remote community needs and reward the doctors working in more remote communities and regions. This package of initiatives therefore has the potential to improve Australia's rural workforce distribution.

The recommendations outlined in this chapter are a suite of options that draw on the collective wisdom of practising rural doctors, trainees and students, and lessons learned from existing training programs. They are presented for consideration by Commonwealth, State and Territory governments to assist them to deliver the right doctor, with the right skills in the right place at the right time – particularly in the context of Australia's rural and remote communities (see Figure 4). The right package is one that can be tailored to the needs of individual Generalists and their practice context, which is feasible to implement and effective for its purpose. Whilst promoting national consistency is desirable, it is recognised that different jurisdictions may choose to utilise different approaches to maximise the impact of local resources and opportunities.

The *Collingrove Agreement* provides the framework for these initiatives. They aim to support registrars to achieve the required skills outlined in the Agreement, as well as recognise current Rural Generalists across Australia.

The recommendations recognise the following overarching principles:

Rural medical workforce incentives should recognise and reward **all** doctors working in smaller, more remote locations, providing a wider scope of the services and demonstrating a commitment to community (staying and investing in the community).

The Pathway should include a well-supported, coordinated and facilitated training and workforce framework that provides continued assistance during and beyond the training years to support rural clinicians.

Rural Generalist Registrars/Trainees and Fellows should be remunerated to recognise their provision of services using both their Core and Additional skills.

A broad range of components relate to Rural Generalist remuneration which require consideration as a whole package (see Figure 4):

- Salary from patient billings, salaried positions, visiting medical officer arrangements.
- Non-salary incentives such as accommodation, motor vehicle, specialist support, education roles, research support.
- Other Commonwealth Government incentives, for which rural doctors may already be eligible e.g. GPRIP, procedural grants to support professional development, etc.

- State government entitlements in addition to salary for professional development and working remotely.
- Opportunities for support from NGOs - Regional Training Hubs, Regional Training Providers, Rural Workforce Agencies, Primary Health Networks, and Universities.

Case Management

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

A case management faculty (tailoring training, support and guidance) is required to encompass each of the teaching hospital/health service/practice networks across regional, rural and remote Australia. It will develop and accredit posts in areas of community need of suitable volume and complexity to meet training elements. The faculty will tailor these posts around trainee interests, support the selection of trainees likely to thrive in different networks, support trainees and facilitate a smooth transition through the various stages of their five to six-year postgraduate training and all the posts entailed and underpin professional development activities for Rural Generalists in the network. This recommendation has received the strongest level of support and endorsement from stakeholders and it already occurs effectively in some states with structured Rural Generalist training and existing infrastructure.

The responsibilities of the case management faculty would include:

- Marketing of the program (with some economies achieved through collaboration via an overarching national coordination point).
- Selecting trainees and managing other RPL and lateral entry points.
- Negotiation of posts of suitable volume and complexity that address the needs of communities and provide the required training elements.
- Supporting high quality training experience by regular structured check-ins with trainee and supervisors. These would assist with early trouble-shooting of issues during the training period.
- Career guidance about the individual's clinical interests and suitable communities where their skills would be used.
- Negotiation and facilitation of Additional Skills positions relative to community need and viable practice models for the community.
- Supporting professional and non-professional needs and interests which relate to a trainee's enjoyment of training and living in the community. This includes supporting trainees with additional socio-economic or cultural needs to full participate in training and professional life as a Rural Generalist.
- Supporting learning across teaching and training hospital/health service/practice networks – including building relationships with general practices and hospitals in the region and their links with other health services.
- Manage multi-organisational stakeholders involved in medical training
- Post-Fellowship support, guidance, including linkages with Rural Generalist supervision and ongoing professional development opportunities.
- Attend workforce training and health service planning meetings.

There are multiple employment transitions/processes for Rural Generalists to undertake in order to complete a postgraduate training pathway. The case management faculty is a key education and training unit able to tailor and coordinate seamless

training experiences suited to the skills, professional interests and non-professional needs and interests of Rural Generalist Trainees.

Currently in most jurisdictions, there are separate units or individuals that undertake these roles for Junior Doctor training (Hospital Medical Education Units), General Practice training (Regional Training Organisations) and Additional Skills training (sometimes State-wide coordination, sometimes individual specialists in supportive hospitals). But key learning from existing successful Generalist Training Pathways suggest that it is imperative that a single continuous approach is created to support the integrated and flexible training required by Rural Generalists. The location and line management of this faculty requires negotiation between the two Colleges and each jurisdiction to ensure maximisation of outcomes in each context.

Attractive Employment Arrangements

Recommendation 9: A mechanism for ensuring preservation of employment benefits and continuity of mentorship, for example, a “duration of training contract” by a single employer, is included in the business case for the Pathway.

Overwhelming feedback from students and junior doctors indicates that the current employment arrangements for postgraduate training are a disincentive to participating in training programs. Currently General Practice training programs are unable to accrue entitlements such as parental or long service leave.

One mechanism that could be considered to overcome this barrier is a one-employer or “duration of training” contract for the Pathway, which aligns with the Rural Generalist Pathway’s quality of training principles (more seamless transitions and security of posts). It also aligns with the employment benefits available to trainees in most other specialty training. With “duration of training” contracts, it is proposed that there is continuity of employment over the period when trainees are establishing their lives in rural communities. This model allows for leave accruals and recognition of long service leave, and eligibility for paid parental leave. These entitlements are currently lost when becoming a General Practice registrar.

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

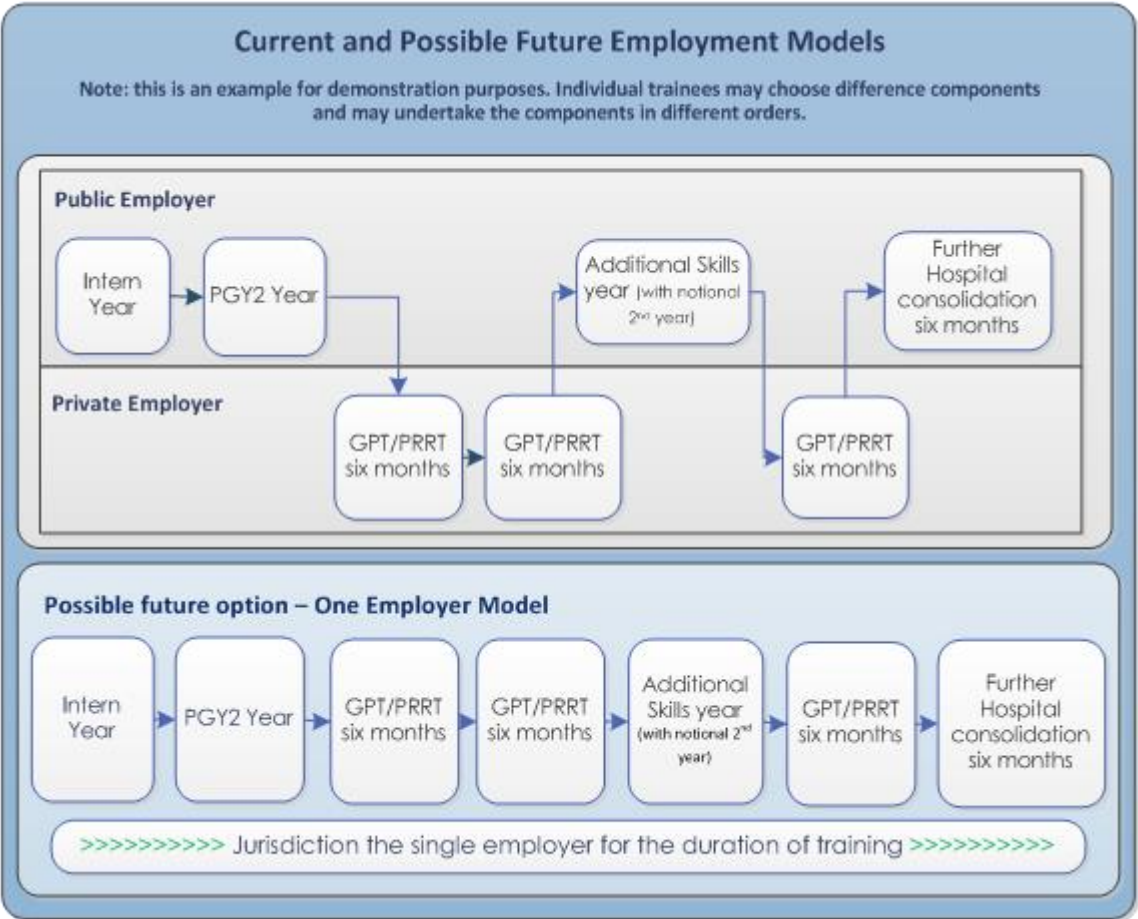
The employer is ideally in the community where Generalists work so that the focus on high quality training for that context is maintained. The employer, for example, could be a small regional health service, with specific contractual agreements for trainees to work/train in General Practice in the teaching and training hospital/health service/practice network. Alternatively a state-wide organisation could hold the employment contract and entitlements and sub contract to health services and practices.

Whilst allowing for selection into the Pathway at multiple stages, consideration in the employment model could be given to Colleges and communities being involved in the selection of Rural Generalists as interns, similar to the Canadian model of

training.(24) This includes selecting for parity of Aboriginal and Torres Strait Islander doctors, many of whom are strongly connected to “country”. This would allow communities to identify the doctors most likely to have a connection to their community, and to stay.

While trainees may be required to relocate to different hospitals and practices within teaching and training hospital/health service/practice networks during their training, it is possible that they could have a single employer and under a state-wide award with continuity of leave and other accruals for the duration of their training. The current alternative in most jurisdictions is for General Practice training to involve employment in private practice for up to 18 months and six months in another practice or hospital, thus resulting in discontinuity for the trainee and diminished attractiveness compared to arrangements for many other specialty training programs which are under a continuous state public service award.

Figure 3 - Current and Possible Employment Models



The one employer “duration of training” arrangement may benefit from a blended funding model that allows for Medicare billing to contribute to the trainee salary. A 19(2) exemption may be one option to enable the Rural Generalist trainee to access MBS items; however, this needs to work within Commonwealth-State Healthcare Agreements. Additionally, Service Level Agreements (SLAs) between community settings and hospitals and health services may be important for articulating both the trainee’s and supervisor’s roles and responsibilities for General Practice and Additional

Skills training, and the expectations of the different organisations. The Rural Generalist case management faculty has the potential to support negotiations for such SLAs.

Clinical governance

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

Patient safety and quality improvement in rural and remote health care outcomes are key success indicators for a national Pathway. In developing the Pathway, there is an opportunity for jurisdictions, hospitals and private practices to collaboratively review clinical governance tools, resources and activities and ensure there is strong commitment to genuine peer review within clinical service delivery involving Rural Generalists. Achieving some nationally consistent standards for this could assist in developing appropriate skills maintenance activities for practising Rural Generalists.

Rural health services should include Rural Generalists on governance teams that ideally would be established across the teaching and training hospital/health service/practice networks rather than town by town. This would create a network of peers in both hospital and community health services at a regional level. Such governance teams could consider the context and scope of each Additional service in a collaborative regional approach in various areas of care. This will assist the creation and monitoring of high quality regional service models in primary and hospital-based services, which include telehealth and outreach services provided by the Rural Generalist and other Specialist workforce.

Incentives

According to MABEL research, if a practitioner is opposed to working rurally, financial incentive is a weak motivator. (25) For others who may be undecided, and not yet committed to rural, an attractive package is very important. This must compare well with what their earning capacity may be in other locations and other specialties.

The Department of Health announced it would reform the GPRIP arrangements in the 2018/19 Federal Budget. (26) The new program is due to commence on 1 July 2019. The work that the Taskforce has undertaken has been aimed at recommending amendments to the existing program.

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 remote locations, using a wider scope of practice, and commitment to community, including after-hours work.

Using the overarching principle of Medical workforce incentives [that recognise and reward rurality, scope of the services provided and commitment to community], a new model is proposed.

The basic equation is:

- Foundation payment equivalent of 60% of your current entitlement
- If you are a FRACGP/FACRRM/Registrar add 40% of your current entitlement.
- If you have Emergency skills and provide the service add further 30% of current entitlement
- And if you have an Additional Skill and provide the service add further 30% of current entitlement.

This would provide a fairer distribution of funds for the extended scope of services by Rural Generalists. It also continues to support **all** General Practitioners working in rural and remote communities. Critically, it also provides an incentive for Rural Generalist Registrars to remain in the Pathway and to choose rural options within it.

Recommendation 12: The Department of Health also amends 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.

Eligible GPRIP practitioners could ideally be able to front load their payments after two years to support a capital purchase in the community where they plan to work, such as the general practice or a house. This aligns with supporting community development and economic growth.

This arrangement may also support existing rural doctors who will be looking to sell their practice in the next few years, as large upfront costs have been identified in surveys as a key reason why young doctors are deterred from going rural.

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 provision of procedural grants managed by ACRRM, RACGP and RANZCOG has been in place since 2004 and are accessed by Rural Generalists and General Practitioners who provide the services. Currently for Obstetrics, Anaesthetics and Surgery, General Practitioners with these Additional Skills are eligible to apply for grants of \$2,000 per day up to 10 days per year in each discipline. For Emergency Medicine, the grant is \$2,000 per day up to three days per year.

It is proposed that this program is expanded to include support for all the Additional Skills required by Rural Generalists. The current lack of such support is a disincentive for trainees to choose these critical areas of practice for supporting rural population health. For those who have trained in these new fields, their inclusion in this program will bolster their continuation of using these skills. For rural and remote patients, expanding this program will support high quality care, particularly for the large proportion that needs enhanced levels of care for mental health and chronic diseases.

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

The Premium Support Scheme (PSS) is an important program for private services by Rural Generalists and ideally should remain unchanged.

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

For some hospitals and/or private practices there is no alternative other than to engage locum services to support the permanent workforce time away from work for personal leave as well as professional development. Rural Workforce Agencies have supported placement of suitably qualified doctors in such positions. Existing programs are important and should be continued at this stage.

In a number of rural communities, some employers have established sufficient medical workforce numbers to enable self-sufficiency. Through training adequate numbers of rural generalists and implementing the regional network approach that underpins the Pathway, all regions should progress to less reliance on locum support.

Access to professional development is a key incentive when recruiting new Rural Generalists, as well as the long-term retention. This incentive could be through a financial payment, e.g. Queensland state award provides \$20,000 per annum for Senior Medical Officers, including Rural Generalists along with three to six weeks leave for professional development.

For locations where recruitment of Rural Generalists is challenging due to low volume and/ or low complexity, there may be opportunities to market positions where professional development time is included in their normal annual work plan through organised and rostered clinical placements/exchanges as well as time for formal courses.

Such professional development opportunities are available in all jurisdictions for senior practitioners in urban public hospitals. There must be equitable support for Rural Generalists who work in public hospitals/health services in rural communities.

Remuneration

There are multiple components of a Rural Generalist's remuneration package; some are directly in control of the Commonwealth Government, while other elements are found in the jurisdiction or private practice area of responsibility. Prior to joining the Pathway, trainees will want to know that the eventual job will be paid fairly, from all sources, in comparison to earning opportunities in other specialties and in urban locations.

Medicare billings are a key source of income for non-hospital extended services by Rural Generalists. In some states such as South Australia and Victoria, it also is the payment mechanism for medical practitioners providing outpatient emergency services and impacts the payment levels for inpatients services at small rural hospitals.

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.

A key component of the fairness of the package is to recognise equal pay for equal services. In relation to the MBS, this means that Rural Generalists should have access to General Practice item numbers when providing General Practice services and access to relevant specialist item numbers when using their Additional Skills.

There are precedents for this approach. Recently the MBS Review Clinical Committee for Obstetrics recommended that if a General Practitioner or a non-General Practice specialist performs the same procedure, the rebate should be paid at the non-General Practice specialist rate, and the differential payment arrangement is removed, e.g. item 35677.

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.

As part of a package to provide a competitive remuneration package that attracts doctors to rural and remote regions, it is proposed that all rural doctors have access to a rural loading, based on an additional percentage payment of MBS rebates and which increases with remoteness (by MMM2-7). There are two precedents for this. The first is the rural loading on the bulk-billing incentive. The second is that the MBS Review Clinical Committee for Obstetrics has recommended that the Government consider financial incentives to recognise the additional workload Specialists and GP Obstetricians have in rural obstetric practice.

In addition to MBS incentives for increasing remoteness and length of service, jurisdictional initiatives can provide complementary benefits. For example Queensland Health offers its salaried medical workforce an Inaccessibility Allowance ranging from \$6,900 to \$48,300 per annum. Western Australia, through WA Country Health, offers a significant professional development package including overseas professional development after five years of service, and a significantly higher salary for rural positions e.g. intern positions.

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

Rural Doctors, including Rural Generalists, train in both public and private settings. To bring the benefits of teaching and training hospital/health service/practice networks to rural patients, consideration must be given to how research and training is better funded in these settings. The benchmark is the urban tertiary teaching hospital, where the contractual arrangements for salaried specialists includes funded time for patient care, research, teaching, quality improvement and professional development.

Regional, rural and remote jurisdictional health services must be funded for, and provide, equitable access to these activities for rural medical staff, including both salaried and VMO staff. One example where this is in place is the Country Health WA

Medical Award, where there is a specific 20% non-clinical time allocated for rural medical practitioners.

In private practice, General Practitioners can access specific support for teaching either through the PIP for undergraduates, or through specific program funds for junior doctor and registrar teaching. This should be accessible by all rural doctors. However, recognition of research and quality improvement time does not exist in the current funding through the MBS. Rural Clinical Schools and University Departments of Rural Health can provide supportive infrastructure, but funding for all rural doctors to be active participants must be enabled.

Jurisdictional recognition

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.

With the proposal in Chapter Four to nationally recognise the Rural Generalist as a protected title and a Specialised Field within the Speciality of General Practice, it is important that this national recognition is also reflected in the policies at jurisdictional levels. As an example, recognition of this title in Queensland Health policies has been very important in the workforce success of their Rural Generalist Program. Where policies are led at the Local Health Network level, e.g. in Victoria, they must reflect the contribution that Rural Generalists can make to their workforce and service delivery.

Other incentives

As part of a rural medical practitioner's remuneration package, incentives other than wages may need to be included. The items should form part of the total remuneration package.

- Accommodation – this is offered by many employers, e.g. private practice and jurisdictions. A range of options includes:
 - House owned by practice/jurisdiction (always check with other government services what accommodation is available in their portfolio/local council) – could be offered.
 - Rental assistance paid to the medical practitioner – this has advantages as the lease arrangements can be in their name, and if there is any damage, the employer will not be accountable. Also, if for some reason the medical practitioner leaves the position, employers are not retaining housing stock that is not being used. Finally, one of the biggest advantages is that the medical practitioner can lease a house, which is suitable for their family and lifestyle needs.
- Relocation Assistance – many of the jurisdictions provide some support to relocate medical practitioners to rural areas. Through AGPT there is a payment to support registrars however it is insufficient to cover the relocation costs of a household.

- Motor Vehicle – provision of a motor vehicle or motor vehicle allowance is an incentive which has been included in a number of state awards for some medical practitioners. Often the payment is an allowance, allowing the medical practitioner to select their own vehicle and if employment ceases they remain responsible for ongoing payments. Fringe Benefit Tax (FBT) implications and logbook requirements are notable.
- Family support - One of the key influencers regarding recruitment will be the employment opportunity for the medical practitioner's spouse or partner. Employers need to identify early in the recruitment process the need for support in this area, and liaise with local council and businesses in an effort to facilitate this if required.

Children's education also is a key influencer on a medical practitioner relocating to a rural community. Enrolments to school open early the year before the student is due to commence. If an employer knows that they are likely to be recruiting later in the year, discussions with the school principals in the area to ensure a smooth enrolment process are facilitated, if required.

Importantly, the emphasis of the National Rural Generalist Pathway in regional Australia articulating with community selection processes and existing regional medical school cohorts is aimed at specifically decreasing the stress of family relocation from urban locations, as it is anticipated that more rural doctors will have rurally based families with spouse or partner employment already accounted for.

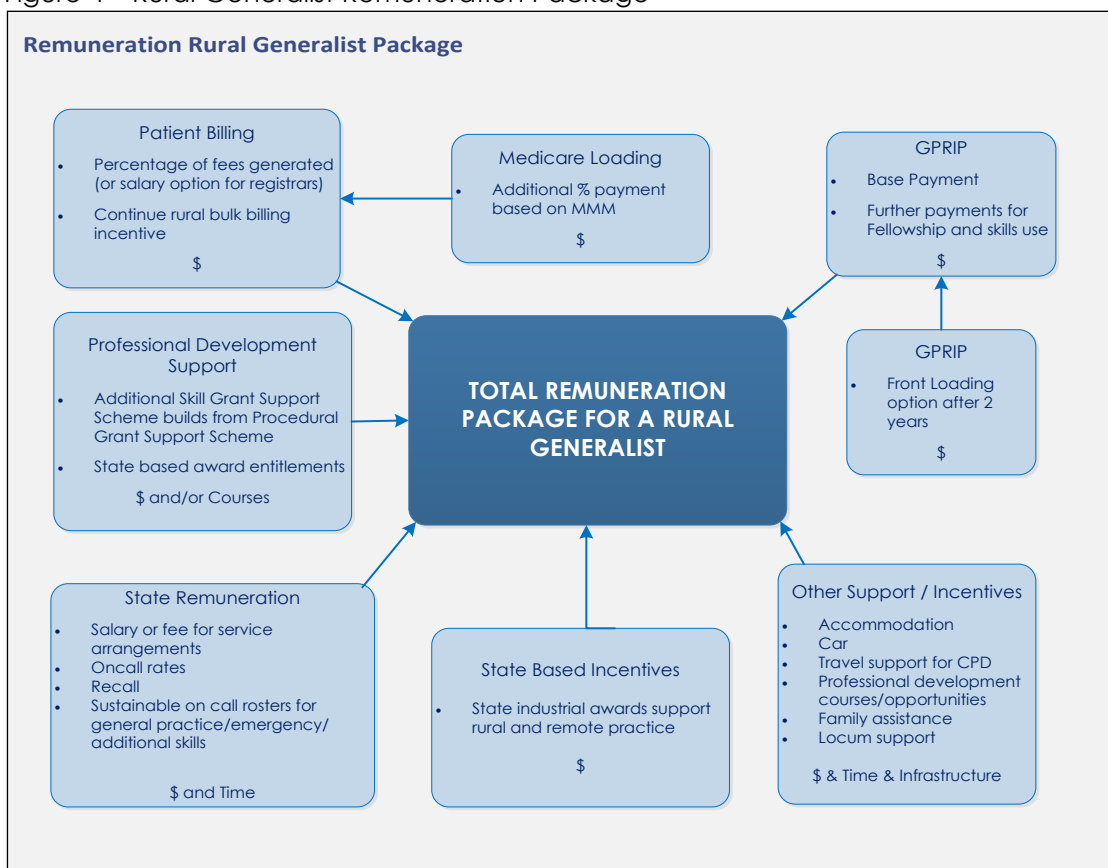
- For short-term employment, e.g. six months or less, the provision of accommodation with added extras of electricity, Internet, and phone certainly make relocation much simpler for the medical practitioner. These incentives do not have to be restricted to short term employment, and will depend on location and recruitment market.
- Introductions - One of the least expensive initiatives that an employer can offer is introductions to their work team and community members. However, this can be very valuable in the retention of the medical practitioner. This is particularly relevant for Aboriginal and Torres Strait Islander communities, where an introduction to the Elders of the community facilitates a smooth transition to the area and encourages connection to community. This should also extend to social activities and sporting groups.

For all private practice employers, it is strongly recommended that the recruitment support provided by Rural Workforce Agencies in each jurisdiction be accessed when commencing the recruitment process. Rural Workforce Agencies will be able to assist in developing the remuneration package. The cost of these non-wage incentives may not necessarily be the sole responsibility of the private practice/practice owner/practice manager. Other stakeholders such as local council may also be able to provide some assistance to create a remuneration package that is competitive and maximises recruitment potential for the community.

Conclusion

Providing support for both Rural Generalist trainees and practitioners is critical to the success of the Pathway. Both the training and the job should be attractive to the next generation of doctors, should be fairly remunerated in comparison to alternative specialties, and should reflect additional incentives for increasing remoteness. Recognising the integrated nature of rural generalism, this package will include funding from multiple sources. The advent of the Pathway should facilitate support for all rural doctors who are part of the teams required to meet the needs of their communities. As further development is undertaken, similar incentives and support will need to be considered for the other health professionals who are part of the rural health team.

Figure 4 – Rural Generalist Remuneration Package



Chapter Six: Taskforce, Working Group and Expert Reference Group Membership and Consultations

National Rural Generalist Taskforce Members

Emeritus Prof. Paul Worley - Chair

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Dr Adam Coltzau

Ms Marita Cowie

Mr Jeff Moffet

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A/ Professor Ruth Stewart

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Professor David Atkinson

Professor Amanda Barnard

Dr Mike Beckoff

Mr George Beltchev

A/ Professor David Campbell

Dr Hwee Sin Chong

Dr Dawn Casey

Dr Melanie Considine

Ms Candice Day

Mr Mark Diamond

Dr Rose Ellis

Mr David Hallinan

Dr Kali Hayward

Dr Sandra Hirowatari

Dr Tessa Kennedy

Dr Martin Laverty

Dr Belinda O'Sullivan

Ms Carolyn Reimann

Dr Mark Rowe

Dr Kari Sims

Professor Ian Symonds

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Dr Mark Rowe – Co-Chair

Dr Claire Arundell

Ms Gaby Bolton

Dr John Douyere

Dr Teena Downton

Dr Catherine Engelke

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Dr Steven Lambert

Dr Olivia O'Donoghue

Ms Carolyn Reimann

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Dr Allison Turnock

Mr Peter Barns

Dr Dawn Casey

Dr Hwee Sin Chong

Dr Emma Cunningham

Ms Ashley Brown

Ms Candice Day

Dr Phil Gribble

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Ms Megan Cahill

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Mr Nick Crowle

Professor Richard Hays

Professor Jennifer May, AM

Ms Maureen McCarty

Dr Matthew McGrail

Dr Deborah Russell

Professor Roger Strasser

Ms Michelle Taitz

Professor John Wakerman

Professor Lucie Walters

Emeritus Professor Paul Worley

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Emeritus Professor Paul Worley - Chair

Dr Frank Evans

Ms Lisa Davies Jones

Mr Steve Rodwell

Mr Scott McLachlan

Mr Shane Boyer

Mr Andrew Freeman

Ms Chris Giles

Mr Stewart Dowrick

Ms Jill Ludford

Dr Nicki Murdock

Dr Danielle Allan

Ms Linda Patat

Dr John Elcock

Mr Wayne Jones

Dr Chun Yee Tan

Mr Michael Di Rienzo

Dr Dale Seierup

Dr Shannon Nott

Dr Ka Chun Tse

Dr David Rimmer

Ms Jo Whitehead

Dr Hendrika Meyer

Ms Maree Geraghty

Rural PHN Expert Reference Group Members:

Emeritus Professor Paul Worley - Chair

Dr Tamsin Cockayne

Ms Pattie Hudson

Ms Melissa Neal

Dr Leanne Beagley

Mr John Gregg

Ms Suzanne Mann

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Student and Junior Doctor Expert Reference Group Members:

Dr Kari Sims – Chair

Ms Carolyn Reiman – Deputy Chair

Dr Claire Arundell

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Dr Tessa Kennedy

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Ms Davina Oates

Dr Carolyn Siddel

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Mr David Trench

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Professor. Janice Bell

Mr Shane Boyer

Ms Christine Cook

Dr Steve Flecknoe-Brown

Professor Jennene Greenhill

Dr Steve Holmes
Dr Bek Ledingham
Professor Jenny May
Dr Laurie McArthur
Professor Richard Murray
Dr Sue Page
Mr Steven Pincus
Dr Simon Quilty
Dr Richard Tarala
Dr Phillip Truskett
Professor Deb Wilson

Aboriginal and Torres Strait Islander Rural Health Expert Reference Group Members:

Emeritus Professor Paul Worley – Chair
Mr Karl Briscoe
Dr Tammy Kimpton
Ms Janine Mohammed
Ms Donna Murray

Rural Consumer Expert Reference Group Members:

Mr Mark Diamond - Chair
Dr Martin Laverty – Deputy Chair
Mr George Beltchev
Ms Katherine Burchfield
Dr Dawn Casey
Ms Dorothy Coombe
Dr Chris Moorhouse
Ms Lynne Strathie
Ms Sally Sullivan
Ms Leanne Wells

Jurisdictional Forum Members:

Emeritus Professor Paul Worley - Chair

A/Professor Kathleen Atkinson

Dr Hwee Sin Chong

Dr Dilip Dhupelia

Dr John Douyere

Dr Rose Ellis

Ms Maree Geraghty

Dr Hugh Heggie

Dr Claire Langdon

Dr Linda MacPherson

Dr Hendrika Meyer

Mr Jeff Moffet

Dr David Oldham

Ms Tarah Tsakonas

Dr Allison Turnock

Ms Lorraine Wright

National Rural Health Commissioner Consultations

National Organisations

Rural Workforce Agency Network – CEOs Meeting

Regional Training Organisations Network – CEO Meeting

Australian Society of Anaesthetists – Prof David Scott

Australia and New Zealand College of Anaesthetists – Dr Rod Mitchell, President

AMA Council of Rural Doctors – Council Meeting

AMA Council of Doctors in Training - Council Meeting

Pharmaceutical Society of Australia - Mr Shane Jackson, National President

Rural Doctors Association of Australia - Council Meeting

CRANaplus, Mr Christopher Cliffe, Chief Executive Officer,

Australian College of Rural and Remote Medicine – Council Meeting

AMA, Presidents Michael Gannon and Dr Tony Bartone and Dr Warwick Hough, Director - General Practice & Workplace Policy

Indigenous Allied Health Australia - Ms Donna Murray, CEO

Australian Indigenous Doctors Association - Dr Kali Haywood, President. Mr Craig Dukes, Chief Executive Officer

Australian Rural Health Education Network - Dr Lesley Fitzpatrick, CEO

Services for Australian Rural and Remote Allied Health - Mr Jeff House, Chief Executive Officer,

AHPARR – Ms Nicole O'Reilly, Convenor

Allied Health Professions Australia –Ms Lin Oke EO,

Australian Medical Students Association - Ms Alex Farrell, President

National Rural Health Alliance - Mr Mark Diamond, Chief Executive Officer, Ms Tanya Lehmann, Chair

Medical Board of Australia, Dr Joanna Flynn, Chair

Medical Deans ANZ - Helen Craig, CEO; Professor Richard Murray, President

Royal Flying Doctors Service - Board of Directors Meeting

AMSA Rural Health - Ms Nicole Batten Co-Chair; Co-Chair Ms Gaby Bolton; Vice Chair Ms Candice Day

Australian Dental Association - Ms Eithne Irving, Deputy Chief Executive Officer

Remote Vocational Training Scheme - Dr Pat Giddings and Dr Tom Doolan

Federation of Rural Australian Medical Educators – National Executive Meeting

Rural Doctors Association of Australia Specialists Group - Meeting

College of Surgeons - Council Meeting

Council of Presidents of Medical Colleges – Council Meeting

Rural Health Stakeholder Roundtable – Meetings

The Royal Australian College of General Practitioners – Council Meeting

Australian Council of Deans of Health Sciences – Council Meeting

Royal Australasian College of Surgeons – Mr John Batten and Council Meeting

Royal Australia and New Zealand College of Obstetricians and Gynaecologists - Rural Council Forum

RDAA Junior Doctors Forum – Forum Meeting

Australian Medical Council – Council Meeting

Health Professions Accreditation Council’s Forum – Forum Meeting

Australian Hearing Services – Ms Sarah Vaughan, Board Director

Australian College of Emergency Medicine - Dr Simon Judkins, President and CEO Dr Peter White

Primary Health Care Institute – Mr Mark Priddle and Dr Shirley Fung

Stroke Foundation – Ms Sharon McGown, Chief Executive Officer

GP Supervisors Association – Dr Steve Holmes, President

GP Registrars Association – Dr Andrew Gosbell, CEO

AMA Federal Council – Council Meeting

Royal Australia and New Zealand College of Ophthalmology – Dr Cathy Green, Dean of Education, and Policy team

Australian Government

Senator the Hon Bridget McKenzie, Minister for Regional Services, Minister for Sport, Minister for Local Government and Decentralisation

The Hon Greg Hunt MP, Minister for Health

The Hon Dr David Gillespie, former Assistant Minister for Health

Federal Parliament

Standing Committee on Community Affairs – *Inquiry into the accessibility and quality of mental health services in rural and remote Australia*

Commonwealth Department of Health

Senator the Hon Bridget McKenzie, Minister for Rural Health

The Hon Greg Hunt MP, Minister for Health

Dr David Gillespie, previous Assistant Minister for Rural Health

Ms Glenys Beauchamp PSM, Secretary Professor Brendan Murphy, Chief Medical Officer

Mr David Hallinan, First Assistant Secretary, Health Workforce Division

Ms Chris Jeacle, Assistant Secretary, Rural Access Branch

Ms Fay Holden, Assistant Secretary, Health Training Branch

Ms Maria Jolly, First Assistant Secretary, Indigenous Health Division

Mr Chris Bedford, Assistant Secretary, Primary Health Networks Branch

Mr Mark Cormack, Previous CEO, Health Workforce Australia

A/Professor Andrew Singer, Principal Medical Advisor, Health Workforce Division

A/Professor Susan Wearne, Senior Medical Advisor, Health Workforce Division

National Mental Health Commission - Ms Maureen Lewis, Deputy Chief Executive Officer, and Ms Lucinda Brogden, Commissioner

Dr Lucas De Toca, Principal Medical Advisor, Office of Health Protection

Dr Chris Carslile, Assistant Secretary, Office of Health Protection

Australian Capital Territory

The Hon Meegan Fitzharris, ACT Minister for Health and Wellbeing, Higher Education, Medical and Health Research, Transport and Vocational Education and Skills

Aspen Medical - Mr Andrew Parnell, Government and Strategic Relationship Director,

National Health Co-op - Mr Blake Wilson General Manager; Adrian Watts CEO

Northern Territory

The Hon Natasha Fyles, Attorney-General and Minister for Justice; Minister for Health

Mr Stephen Pincus Chief Executive Officer Northern Territory General Practice Education (NTGPE)

Northern Territory Medical Program – Prof John Wakerman, Associate Dean

FCD Health – Ms Robyn Cahill, CEO

Western Australia

Office of the Minister for Health, Neil Fergus, Chief of Staff and Julie Armstrong, Senior Policy Advisor

WA Department of Health - Dr DJ Russell-Weisz – Director General, Dr David Oldham, Director of Postgraduate Medical Education

WA Country Health Service - Mr Jeff Moffet, CEO, Dr Tony Robins, EDMS

WA Primary Health Alliance – Ms Linda Richardson, General Manager

WAGPET - Prof Janice Bell. CEO

Rural Clinical School WA - Prof David Atkinson, Director

Rural Health West - Ms Kelli Porter, General Manager Workforce

Healthfix Consulting - Mr Kim Snowball, Director

Curtin Medical School - Professor William Hart, Dean of Medicine

WA Country Health Services - Dr David Gaskell, DMS Kimberley Region

Broome Health Campus - Dr Sue Phillips, Senior Medical Officer

Kimberley Aboriginal Medical Service Executive – CEO

Nindilingarri Cultural Health Service – Ms Maureen Carter, CEO and staff, Fitzroy Crossing

Fitzroy Crossing Hospital and Renal Dialysis Unit - staff

Broome Aboriginal Medical Service – Dr David Atkinson and staff

Broome Regional Hospital Junior Doctors - Meeting

Rural Clinical School Western Australia – Broome Staff and Students, Meeting

Queensland

Department of Health - Ms Kathleen Forrester, Deputy Director General Strategy, Policy and Planning Division

Darling Downs HHS, Queensland Country Practice – Dr Hwee Sin Chong, Executive Director, Dr Dilip Duphelia, Director Medical and Clinical Services

Dr Denis Lennox, Previous Director, Rural & Remote Medical Support

Longreach Family Medical Practice – Dr John Douyere and staff

Longreach Hospital, Dr Clare Walker and staff – Meeting and Multi-Disciplinary Ward Round

Central West Health Service Dr David Rimmer, DMS and other Executive members

Central West PHN, Ms Sandy Gillies, Manager and other staff

Centre for Rural and Remote Health, James Cook University – RG trainees, Longreach

St George Hospital – Dr Adam Coltzou, DMS, GP staff, junior doctors and students

Darling Downs HHS – Dr Peter Gillies, CEO

Stanthorpe Hospital – Dr Dan Manahan, DMS, Dr Dan Halliday, ACRRM Board Member, Vickie Batterham, A/DON and staff

Stanthorpe Medical Practitioners – GPs, Junior Doctors and Hospital Staff - Meeting

Warwick Hospital - Dr Blair Koppen, Medical Superintendent, Anita Bolton DON and RG trainees

Condamine Medical Centre – Dr Lynton Hudson and Dr Brendon Evans

Goondiwindi Hospital – Dr Sue Masel DMS Lorraine McMurtrie DON and staff

Goondiwindi Medical Centre – Dr Matt Masel, staff, Registrars and Students, Doctors Meeting

Dr Col Owen, Past President RDAA and RACGP, Inglewood

University of Queensland Regional Training Hub, Dr Ewen McPhee, Director, Rockhampton

Centre for Rural and Remote Health, James Cook University – Professor Sabina Knight, Director, Mt Isa

Institute of Health Biomedical Innovation - Professor Julie Hepworth

New South Wales

The Hon Brad Hazzard, Minister for Health

Dr Nigel Lyons, Deputy Secretary, Strategy and Resources, NSW Health

Dr Linda McPherson, Medical Advisor Workforce and Planning, NSW Health

University of Sydney - Professor Arthur D Conigrave, Dean, Faculty of Medicine,

The Hon Dr David Gillespie MP

NSW Rural Doctors Network Executive – Meeting

Western NSW Local Health District – Mr Scott McLaughlin and Executive

Senator for NSW, The Hon John Williams

National Party Room Meeting, NSW Government, Sydney

Kevin Anderson, MP, Member for Tamworth, Tamworth

Glenrock Country Practice, Wagga Wagga, Dr Ayman Shenouda, and Ms Tania Cotterill

Royal Far West, Ms Lindsay Cane, Chief Executive Officer

UNSW Rural Clinical School, Wagga Wagga – student, junior doctor and consultant meeting

UND Rural Clinical School, Wagga Wagga – Professor Joe McGirr, Director and staff

Dr Cheryl McIntyre, Inverell Medical Centre

Inverell Town Rural Doctors - Meeting

Professor Rod McClure, Dean, Faculty of Medicine, University of New England

Molong Health Service and District Hospital

University of Sydney Rural Clinical School, Dubbo – Student Meeting

University of Western Sydney Rural Program leaders, Orange

Parkes District Hospital – Staff and junior doctors meeting

University of Newcastle Rural Clinical School, Tamworth – Prof Jenny May, Director

GP Synergy – Dr John Oldfield, CEO

NSW Ministerial Advisory Committee for Rural Health, Queanbeyan

South Australia

The Hon Mr Stephen Wade MP, Minister for Health and Wellbeing

Department of Health and Wellbeing - Christopher McGowan, Chief Executive

Country Health SA – Ms Maree Geraghty, CEO and Dr Hendrika Meyer, Executive Director Medical Services

Rural Doctors Workforce Agency - Ms Lyn Poole, Chief Executive Officer,

Flinders Rural Health SA - Professor Jennene Greenhill, Director

University of Adelaide - Professor Ian Symonds, Dean of Medicine,

Flinders University - Professor Lambert Schuwirth, Strategic Professor in Medical Education,

Flinders University - Professor Jonathan Craig, Vice President and Executive Dean

Mr Rowan Ramsey MP, Federal Member for Grey

Mr Tony Zappia MP, Federal Member for Makin

Dr Peter Clements, Rural Generalist Educator, Adelaide

Dr Ben Abbot, Rural Generalist Surgeon, Jamestown

GPEX, Ms Chris Cook, CEO

Victoria

Professor Euan Wallace, CEO Safer Care Victoria, Melbourne

Mr Dean Raven, Director, and Ms Tarah Tsakonas, Senior Policy Advisor, Victorian Government Department of Health and Human Services Workforce, Melbourne

Monash Health - Ms Rachel Yates, Principle Advisor, Innovation and Improvement

Professor Donald Campbell, RACP

Monash University Rural Clinical School – Professor Robyn Langham and staff, Bendigo

Bendigo Hospital – junior doctor and student meeting, Bendigo
Bendigo Health – Mr Peter Faulkner CEO, Bendigo
Rural Workforce Agency Victoria, Ms Megan Cahill, CEO, Melbourne
Western Victoria Health Accord – Meeting in Portland
Glenelg Shire Workforce Group, Meeting in Portland
Rural and Regional CEO Forum, Melbourne
Prof John Humphreys, Monash University, Bendigo
Murray to Mountains Intern Program – Mr Shane Boyer, Shepparton
Rural Health Forum, La Trobe University and Murray PHN, Mildura
RFDS Rural Health Sustainability Project, Mildura
Attend Anywhere Video Consulting Programs – Mr Chris Ryan, Director, Melbourne

Tasmania

The Hon. Michael Ferguson MP, Minister for Health, Launceston
Department of Health - Dr Allison Turnock, Medical Director GP and Primary Care, Hobart
HR+ Rural Workforce Agency – Mr Peter Barns CEO, Launceston
Dr Bastian Seidel, Rural GP, President RACGP
North West Health Service, Executive Director of Medical Services, Dr Rob Pegram
Professor Richard Hays, Rural Medical Generalist, Hobart
Dr Brian Bowring and Dr Tim Mooney, Rural Generalists, Georgetown

Invited Presentations on the National Rural Generalist Pathway

NSW Rural Doctors Network Annual Conference 2017, Sydney, NSW
Rural Medicine Australia 2017, Melbourne, Vic
RACGP Annual Convention 2017, Sydney, NSW
Rural Doctors Workforce Agency Annual Conference, Adelaide, SA
WHO Global Health Workforce Summit, Plenary Presentation, Dublin, Ireland
WONCA World Rural Health Conference, Plenary Presentation, New Delhi, India
6th Rural and Remote Health Scientific Symposium, Canberra, ACT
Tasmania Rural Health Conference, Launceston, Tas
Victorian Rural and Regional Public Health Service CEO Forum, Melbourne, Vic

Hunter New England Professional Development Program for Doctors, Pt Stevens, NSW

Murray to Mountains Rural Intern Training Program Annual Dinner, Shepparton, Vic

"Are You Remotely Interested?" Conference; Realising Remote Possibilities, Centre for Rural and Remote Health, Mount Isa, Qld

National Regional Training Hubs Forum, Canberra, ACT

Australian Primary Health Care Research Conference, Melbourne, Vic

Medical Oncology Group of Australia Annual Scientific Meeting, Adelaide, SA

Griffith Rural Medicine Retreat, Griffith, NSW

Rural Doctors' Association of South Australia Annual Conference, Adelaide, SA

Western NSW Primary Health Workforce Planning Forum, Dubbo, NSW

National Rural Health Student Network Council Meeting, Adelaide, SA

Victorian Health Accord Clinical Council Conference, Melbourne, Vic

Flinders University Regional Training Hub Launch, Mt Gambier, SA

10th Anniversary of the Joint Medical Program, Armidale, NSW

National Rural Training Hubs Conference, Sydney, NSW

Seventh Rural Health and Research Conference, Tamworth, NSW

Central Queensland HHS Clinical Senate, Rockhampton, Qld

Medical Deans ANZ Annual Mid-Year Meeting, Canberra, ACT

GP Training Advisory Council, Melbourne, Vic

RACGP Annual Convention 2018, Gold Coast, Qld

Rural Medicine Australia 2018, Darwin, NT

NSW Local Health Districts and Regional Training Hubs Meeting, Sydney, NSW

Australian Medical Council AGM 2018, Launceston, Tas

Royal Australasian College of Physicians (SA), Annual Scientific Meeting 2018, Adelaide, SA

Prevocational Medical Education Forum 2018, Melbourne, Vic

Contacts

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Further information about the National Rural Health Commissioner can be found on the Commissioner's website at www.health.gov.au/national-rural-health-commissioner

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2. Historic agreement landed for rural practice [press release]. Canberra: Commonwealth Department of Health 2018.
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