Integration of General Practitioners into rural hospitals position statement

2021

1. Introduction

1.1. Rural general practitioners (GPs) and rural generalists (RGs) need to work collaboratively between rural hospitals and private general practices to best service community need and to improve health outcomes.[1] The implementation of the Commonwealth Government's initiative National Rural Generalist Pathway (NRGP) provides an ideal opportunity to facilitate the necessary industrial and cultural change.

1.2. Rural GPs provide a broad range of care and services to the communities they care for. This encompasses primary care, emergency care and secondary care. In addition, rural GPs have or often need to acquire a broad range of additional skills to meet the needs of their respective communities due to lack of local or outreach non-GP specialist services. Whilst many rural GPs provide essential services at the local hospital or health service(s) as visiting medical officers (VMOs), or through other employment arrangements such as fractionated appointments, other Rural GPs have no connection or involvement whatsoever with their local hospitals. Often, this is due to stringent bureaucratic processes introduced by local hospitals or health services.

1.3. Industrial arrangements and remuneration across the jurisdictions differ for the employment of rural GPs. This is often the barrier for GPs to work at the local hospitals as well as out of their private practices. A properly functioning arrangement would have Rural GPs remunerated by the MBS for services provided in their private practice and by the State for services provided in their hospitals. Health services must not rely on locum medical officers to provide services at a greater financial burden than a local Rural GP. Locum medical officers are not always guaranteed which may lead to servicing shortfalls.

1.4. Across the jurisdictions, there are various models for integrating GPs into rural hospitals. This position statement outlines fundamental principles for how these arrangements should be made.

1.5. Ensuring Australia's rural GPs, whether employed by the State or working in private general practice, are working together in rural towns in integrated and mutually satisfying arrangements will lead to increased job satisfaction and contribute positively to retention of this workforce. These models will be also be attractive to GP Registrars and increase the likelihood of them returning to these towns at the completion of their Fellowship in General Practice, thereby strengthening the rural medical workforce in these communities.

2. Current Challenges of engagement models

2.1. When rural GPs are not granted rights to provide services at the local health service(s), care to the community is undermined in three key ways:

(a) Health services must rely on engaging locum medical officers to provide services at a greater financial cost than if there was an integrated workforce in the town. Locum medical officers are not always available when needed, which may lead to servicing shortfalls and poorer community health outcomes.

[1] Rural GPs often have additional skills and qualifications in clinical procedures to service the needs of their communities. Rural generalist by definition have these additional skills as per the Collingrove agreement. For the purpose of this document, reference to GP includes RGs.

(b) Workforce engagement models at rural hospitals are incentivised by industrially accepted awards in some jurisdictions. In addition, the Commonwealth Government provides additional incentives that are not easily available to private rural GPs. These financial incentives cannot be matched by private rural general practices, where they exist, resulting in an inability to recruit doctors to join their already understaffed practices.

(c) Relationships between local general practices and health services, essential to a functional and integrated rural medical service, are often compromised.

2.2. The AMA supports models of employment, conditions and standards for rural GPs and RGs providing clinical services at rural health services which are transparent, fair and consistent. Doctors in training, and doctors relocating to these communities, should be supported and treated equitably. Where suitable, state-wide employment models should be considered. Models that facilitate easy entry and exit strategies for rural doctors should be encouraged.[2]

3. Local governance and support frameworks

3.1. The AMA recommends that any health service in rural or remote location should recognise that a large proportion of their service provision is primary care; and therefore it is imperative to work collaboratively with their local general practice community. Health service administrators should recognise and embrace the complex relationship between the local health service that they are responsible for, with all other health providers and leaders within their community. There needs to be a recognition that whilst many doctors wish to work rurally, buying or running general practices is becoming less and less attractive, especially because of a generational shift in the rural workforce.

3.2. Evidence shows strong primary care focus results in improved health outcomes for the community.[3] Therefore, organisation of rural health services must be based on health needs of the community, which are largely primary care services.

3.3. As such, health service administrators should actively seek collaborative models of governance, remove unnecessary boundaries, and look at innovative funding models to ensure that the small workforce is integrated and results in in the best service model for the community.

3.4. Where appropriate, GPs working in private practice should be encouraged, upskilled as needed, and supported to provide additional clinical services at the public health service by exploring engagement models that are fit for purpose for that community.

3.5. Telehealth and virtual services must not be considered a direct replacement for face-to-face service in a rural town. The introduction of virtual services should involve a collaborative consultation process between health service, local rural GPs and RGs, and community members to determine the best suite of services that suit rural patients and health care providers, considering economic, workforce, and practical considerations.

3.6. The AMA supports collaborative and coordinated succession planning between the public and private sectors and the creation of integrated service models that are attractive for recruitment and retention of the next generation of rural doctors.

4. Credentialing and scope of rural clinical practice

[2] See: AMA Position Statement: Easy Entry, Gracious Exit Model for Provision of Medical Services in Small Rural and Remote Towns – 2019.

[3] Starfield B, Shi L, Macinko J. Contribution of Primary Care to Health Systems and Health. Milbank Q. 2005 Sep; 83(3): 457–502; Hartman TC, Bazemore A, Etz R, et al. Developing measures to capture the true value of primary care. BJGP Open. 2021; 5(2): BJGPO.2020.0152.

4.1. The AMA supports a credentialing framework for rural GPs and RGs that is consistent, fair, not laborious or burdensome and equitable to ensure patient safety. Credentialling should not be unfairly restrictive to a rural GP or RG's scope of practice, but a process that assures competency and safe practice in a rural setting consistent with the capability of the facility.[4]

4.2. Credentialing committees should be cognisant of the differing holistic skills and capability of rural doctors and how safe service delivery differs in a rural context from metropolitan and urban areas.

4.3. The AMA supports the implementation and endorsement of the NRGP, to provide skilled Rural Generalists for Australian communities. The NRGP endorsement should not, however, be used as a minimum standard for credentialling of scope of practice in rural areas. Existing and experienced rural GPs and RGs with extended and advanced clinical and procedural skills, who may not meet the definition of a Rural Generalist as described under the NRGP but are deemed competent and safe to continue to provide safe practice, should be supported to continue to provide clinical services.

5. Reskilling and Upskilling

5.1. The AMA acknowledges that maintenance of clinical skills in multiple domains of practice is a challenge for many rural doctors. As such, the AMA encourages and supports the use of innovative methods and flexible training models to ensure maintenance of clinical skills for credentialed GPs and Rural Generalists. This may comprise (but is not limited to) the use of "in reach" upskilling, as well as innovative technologies and educational modalities to maintain additional skills appropriate to the practitioner's rural or remote context. This should be proactively supported by local hospital or health services.

5.2. Where rural GPs have lost access to hospital clinical privileges (e.g. due to a lack of recency of experience) and wish to regain these skills, they should be supported by their local hospital or health service to do so. The AMA supports fostering of relationships between rural, regional and metropolitan hospitals in order to help facilitate upskilling or re-skilling, to enable the valued rural workforce to deliver services locally.

5.3. The AMA supports ongoing access to procedural grants and other incentive programs as a means of providing financial support for doctors undertaking focussed upskilling for the purposes of maintaining procedural and other specialised skills.

See also:

AMA Position Statement: Fostering Generalism in the Medical Workforce - 2019
AMA Position Statement: Medical workforce and training - 2019
AMA Position Statement: General Practice in Primary Health Care - 2016
AMA Position Statement: Rural Workforce Initiatives 2017

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[4] The AMA supports the position outlined in the Rural Doctors Association of Australia 'Credentialing and defining the scope of practice of Rural Generalists' position statement.