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THE EXPANDING ROLE OF GENERALISTS IN RURAL & REMOTE HEALTH : A SYSTEMATIC REVIEW

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POLICY CONTEXT

The loss of generalist specialists and decline in the numbers of procedurally skilled generalists in rural Australia has significantly reduced rural populations' access to many essential health services (obstetric, anaesthetic, surgery and emergency medicine). This decline results from policies enacted since the 1950s, the growth of technology and emerging workforce expectations. While the poorer health status and lack of equitable access to medical services for people living in rural and remote Australia has been well documented, there is an imperative to maintain and support a skilled medical generalist workforce and develop appropriate and sustainable primary health care (PHC) service models for communities in rural and remote Australia.

KEY FINDINGS

This review has concentrated on non-specialist generalist medical practice in Australia and particularly in rural and remote Australia.

- Definitions of medical generalism vary across jurisdictions and disciplines especially in the case of 'generalist' specialists whose numbers have declined steadily over the past 50 years and who are particularly scarce in rural and remote practice in Australia
- Differential rebates have accelerated growth in specialisation and sub-specialisation at the expense of generalist practice
- Generalist practitioners will increasingly provide anaesthetic, obstetric and minor surgical services in rural areas which are reliable and effective
- While doctors numbers have increased overall, primary health care practitioner supply decreased and specialist numbers increased nationally
- Medical practice in rural and remote communities is broader and more complex as distance from major secondary and tertiary centres increases

- Rural hospital and maternity services closures have devalued 'generalist' practice and contributed to the loss of a 'critical mass' necessary to provide procedural services in many rural and remote communities
- Rural hospitals are as safe as, and more cost effective than, major secondary and tertiary hospitals
- Strong primary health care services result in good health care outcomes. Greater investment in primary health care and 'generalist' medical services may be more cost effective, efficient and equitable for rural communities compared with specialist and sub-specialist medical service providers
- Specific training and career pathways for 'rural generalists' has been developed in Queensland. It reflects the importance of broad procedural and cognitive skills supported by a training and career pathway with attractive remuneration for salaried medical officers
- Recruiting and retaining health professionals in rural and remote communities will remain difficult for some time. Mid-level practitioners like physician assistants, practice nurses and nurse practitioners can extend the reach of medical generalists and specialist services.

POLICY OPTIONS

Rural and remote communities have low population densities and diseconomies of scale, the majority of these communities rely on medical 'generalists' for their day-to-day health needs. To produce these rural "generalist" practitioners, the health system needs dedicated and targeted support mechanisms. These include:

- Fund the expansion of the clinical teaching capacity of the health system. This should be regionally brokered among stakeholders, within broader State and national policy parameters. Direct investment would replace the system of poorly auditable resource loadings for the clinical teaching capacity of designated public hospitals by State and Territory governments under Australian Health Care Agreements. Clinical teaching and research activity must be a funded and accountable core business of the entire health system, particularly in regional areas
- Health workforce policy implementation should be regional. Establish regionally-based mechanisms for planning and co-ordinating undergraduate education, vocational training pathways for medical graduates and junior doctors. Planning should engage universities, professional colleges, health service providers, communities and policy advisers
- Introduce incentives for junior doctors to undertake generalist training with clear training and career structure as well as preferential access to procedural training posts in hospitals
- Create articulated 'generalist' pathways in training within hospital and community sectors
- Address infrastructure needs in rural and remote areas to support training, including accommodation, consulting space and access to information technology
- Promote the re-establishment of generalist-led community teaching hospitals in both urban and rural areas to enhance education, training and leadership

- Build on the rural/regional medical education infrastructure (in particular rural clinical schools, university departments of rural health, and general practice regional training providers and regional medical schools) to support redesign of regionalised medical vocational education and training
- The imbalance between sub-specialist and generalist medical practice is unaffordable and unsustainable. Whilst super-specialisation has been driven by development of large populations in cities and rational uniting of practice fields, it is also a by-product of perverse financial incentives, perceived status and the history of metro-centric teaching in tertiary hospitals
- Promote recognition of rural and remote medicine under the proposed new national accreditation arrangements
- Fund education and training initiatives required for safe delegated practice arrangements
- Develop and trial accelerated pathways to vocational recognition for rural medicine generalists
- Extend rural generalist training and career structure initiative to other States to facilitate shared accreditation and educational arrangements at prevocational levels
- Institute funds pooling mechanisms at the regional or district level to support flexible and sustainable health care models in rural and remote communities that bridge the primary care and hospital care continuum. This could support more generalist training for rural practice
- The role of generalists in the hospital setting be promoted in policy on hospital role delineation and privileging and credentialing processes
- Fund trials of mid-level practitioners in both autonomous practice roles (nurse practitioners) as well as delegated practice arrangements with doctors (physician assistant model) to enhance the viability and sustainability of rural and remote medical generalist workforce
- Explore the integration of other disciplines into generalist primary health care in rural and remote communities, including nursing, medicine, Indigenous health workers and paramedics
- The model of increased community participation in planning, oversight and delivery of rural and remote health services may provide support for a more applicable suite of services including generalists from a range of disciplines

METHODS

Peer-reviewed relevant literature was systematically searched in a number of health-related databases. The search terms were selected through discussion of the topic areas and through the initial searching process to understand what terms are most meaningful according to the databases. The searches were modified according to the database and the search functionality available in each.

For more details, please go to the [full report](#)

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