History of the Prevocational General Practice Placement Program in WA

HEALTHfix consulting

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Executive Summary

This report has been commissioned by Western Australian General Practice Education and Training (WAGPET) to document the Prevocational General Practice Placement Program (PGPPP) in WA.

A key take home message from this analysis of the PGPPP is that the program in Western Australia has become much more than simply a Commonwealth funded GP education and training program.

This is the message that has come from managers, trainees, supervisors across Western Australia and especially those championing the need for a clear pathway into rural general practice.

Over time the program has become fully integrated with WA's wider medical education and training programs and more importantly it has fully focused on the requirements of the Western Australian environment, workforce needs and communities, so much so that it bears little resemblance to the national PGPPP that the Commonwealth has ceased funding.

In fact it more resembles the Community Residency Program that the State government funded between 2007 and 2009.

The program in WA differs fundamentally in its design features from the national scheme on many levels:

1. Composite placements mean that the prevocational training mirrors the actual service model used by most rural doctors in WA and ensures more "hands on" experience for trainees. This is unlike other states where the majority of placements under PGPPP are exclusively General Practice.

2. A single accreditation process has been achieved for all supervisory practices in Western Australia, all other states require separate accreditation between the RACGP, ACRRM and the Postgraduate Medical Council.

3. Careful design of the WA program has seen up to 81% of doctors undertaking the PGPPP go on to GP training (WAGPET Annual Report 2014) compared to 30% nationally (interview with Chief Executive, GPET).

4. Western Australia has achieved a fully integrated and single education and training provider and now enjoys economies of scale. 16 providers are responsible for the program across the rest of Australia.

5. The maturity of the program means that administrative issues, relationships and partnerships with government and not for profit sector and most importantly General Practices across WA are in place and working effectively.

The program has managed to be at the forefront of efforts in WA to improve the training pathways to General Practice and most importantly to rural General Practice.

Through its integration with the state funded Community Residency Program it has provided a cost effective alternative to hospital based medical education and training. Indeed the financial analysis shows that the cost for a community placement is basically equivalent to the State government's Junior Doctor Business Case, estimated cost for a hospital placement.

With the potential demise of the program, the costs previously borne by the Commonwealth will now fall to the State government by requiring additional hospital based posts as the 30 PGPPP trainees will now have no alternative but to train in the public hospitals.

In any future program, all of these critical success factors will need to be considered as essential to the success of any medical education and training program.

The feedback from a wide range of stakeholders including past trainees, supervisors and partner organisations was overwhelmingly positive about the outcomes from the program and their own experience in it.

The stakeholders were all clearly in support of three key benefits from the program:

- The first of these is has been the ability to have an uninterrupted integrated rural training pathway. The pathway begins with a requirement that at least 25% of medical students come from a rural background, the next step in the pathway was the establishment of the Rural Clinical Schools where students can train in the country during their medical school. Once they graduate junior doctors must spend time in a hospital to get their general registration and cannot work unsupervised in the community, the prevocational training programs addressed this issue and allowed junior doctors to train in rural communities with appropriate supervision. The final link in the rural training pathway is the support for the two rural General Practice pathways (ACRRM and RACGP) which both require training in rural areas.
- The second main benefit of the program has been the ability of this program to influence junior doctors' career decisions.
- Third, the unique experience offered by a composite placement across hospitals and General Practice represents the only program of its type which provides doctors with a clear insight into the potential integration and benefit of working across primary and secondary care, alongside their patients.

Conclusion

This assessment of the history of the PGPPP in Western Australia has uncovered a uniquely Western Australian program that has evolved over time and adapted to universal support from all of those coming into contact with the program. Over time it has responded to:

- The changes in medical workforce needs and medical service models operating in WA.
- The working environment of General Practitioners working across community and hospital settings and in so doing has broken down barriers and silos between primary and secondary care.

- The need for direct medical workforce support to rural communities and Aboriginal Community Control sector to meet the unmet needs in these areas. This was specifically acknowledged by rural stakeholders and not for profit sectors.
- Meet the needs of both supervisors and trainees through clear and transparent processes. The success of the program in meeting the clinical training needs of junior doctors has been well received and the program highly regarded by them.
- The need for a cost effective model that is a sensible alternative to hospital placements.

The loss of this program as a fundamental building block in the support of doctors considering a career in areas of greatest workforce shortage and need will be hard felt in Western Australia. It will also mean the direct loss of the medical workforce in these critical areas and the cost of the training of these doctors will again fall to the State's public hospitals and further strengthen the hospital side of the medical workforce, at a time when WA needs GPs.

"The junior doctors really want to keep these placements, try before you buy"

Junior Doctor

"Invaluable for career decision making"

Supervisor

"It builds the confidence of junior doctors"

Junior Doctor

The Report

Background

This report has been commissioned by Western Australian General Practice Education and Training (WAGPET) to document the Prevocational General Practice Placement Program in WA.

It is done at a point in time when the Commonwealth Department of Health has ceased its financial involvement with Prevocational General Practice Placement Program as part of a response to the commission of audit into Federal government funded programs and a wider overhaul of General Practice Education and Training.

WAGPET has taken the view that the program appears to have had a lasting and impressive track record in improving GP training in Western Australia, and its achievements and failures need to be recorded for the benefit of future education and training programs.

The report will explore on a national basis:

- The purpose of the program
- The history of the program, how it evolved and who instigated the program
- How the program changed over time.

The report will also explore from a Western Australian perspective:

- How the program worked operationally in Western Australia
- How the program in Western Australia differs to that in other States
- How the program contributes to the General Practice profession
- What successes the program has for the different stakeholders, including the Commonwealth, State, communities, practices, Aboriginal Medical Services and remote, rural and regional areas.

What is the Prevocational General Practice Placement Program (PGPPP)?

At its heart the PGPPP is designed to provide junior doctors with exposure and hands on experience and education in community based General Practice. It encourages them to consider entering a General Practice training program. All other junior doctor prevocational training and experience is with large acute hospitals and is focused on acute and specialised medical practice and training.

This is the only junior doctor program currently offering community based education and training with General Practice.

The program objectives and aims of the PGPPP, as described by General Practice Education and Training (GPET), were to enhance junior doctors' understanding of General Practice and the role GPs play in the delivery of health services at the primary and secondary health care levels.

The program provides a ten to thirteen week rotation in General Practices for junior doctors to increase their exposure to the provision of primary medical care and consider General Practice and/or rural and remote medicine as a career option.

The program aimed to provide junior doctors with a positive and well-supported experience in the primary care setting that improved a junior doctor's knowledge, practice and understanding of:

- The role of the doctor in delivering primary health care services
- General Practice as a community based business entity

- Continuity of care in the primary health care setting, and
- Best practice around effective referrals between primary and secondary care.

The purpose and history of the Program

The PGPPP was formally established as a training program in all states under Section 3GA of the Health Insurance Act 1973 in 2005 as an initiative by the Commonwealth Government. It was in direct response to the significant national shortage of GPs.

Its aim was to encourage junior doctors to undertake supervised placements in GP and other primary care settings to experience GP and make an informed decision about enrolling in a specialty such as GP. It was funded by the Department of Health and Ageing, and managed co-jointly by the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP) under a governing body of stakeholders with an independent chair know as the National Advisory Committee (NAC).

The program has had a variety of titles and iterations over the years, but it first emerged in 1998 as a pilot program to help deal with consequences arising from the introduction of provider number legislation in Federal Parliament.

Prior to 1996 junior doctors wanting to experience General Practice could work in any practice at any time and access a provider number with no supervision or educational requirements.

The provider number legislation was introduced in 1996 in response to a perceived oversupply of General Practitioners in Australia (erroneously as it turned out). The legislation effectively introduced a requirement for GPs to undertake a training program before they were able to claim the full Medicare entitlement for their service. It also introduced a moratorium on allocation of provider numbers. The legislation effectively slowed the supply of GPs nationally.

Once the provider number legislation was passed only trained vocationally registered doctors were able to access provider numbers and overseas trained doctors were restricted from accessing provider numbers (with some exceptions).

These legislative changes to restrict the entry into General Practice had two immediate impacts.

First, The restrictions quickly exacerbated shortages in rural and remote areas and led to a crisis in supporting rural and regional communities with General Practitioners.

Second, the introduction of the requirement for a GP training scheme meant a scheme had to be quickly introduced with appropriate curriculum, accreditation, establishment of supervisors and accredited practices.

Initially this role fell to the Royal Australian College of General Practitioners to establish and run.

The crisis in recruitment of GPs to rural and regional areas gathered momentum with advocacy coming from rural doctor groups and rural communities. This eventually led to a major focus from the Federal government to introduce incentives to attract GPs to work in rural areas and also a specific focus on creating pathways for Australian trained doctors into rural practice.

Amongst these various incentives was the Rural and Remote Area Placement Program. This program was established to give junior doctors exposure to rural and remote general practice in an educationally sound and supportive environment.

The initiative to provide rural based prevocational GP training was seen as a major success in focusing junior doctors towards a career in rural practice.

The outer metropolitan areas quickly sought inclusion into the program and eventually the prevocational program was applied across both metropolitan and rural areas by 2005, with a requirement that at least 50% of the placements needed to be in rural areas which is still applicable to the present day.

National governance and management of the PGPPP changes over time

The governance and management changed progressively over time as follows:

- In 1998/99 two pilot programs involving prevocational training placements in South Australia and Western Australia were run by the Rural Doctors Association with funding provided by the Commonwealth Department of Health and Ageing.
- In 2000 the success of the rural prevocational training pilots was acknowledged with funding by the Commonwealth for a new program known as the Rural and Remote Area Placement Program (RRAPP) run by the Australian College of Rural and Remote Medicine (ACRRM). Under this program ACRRM sub contracted a variety of training providers including Universities and accredited Regional Training Providers and General Practices.
- In 2005 the RRAPP was changed to include the Outer Metropolitan areas and became known as the Prevocational General Practice Placement Program (PGPPP). A National Advisory Committee was formed to oversee the Commonwealth funded program. The program was jointly managed and run by the Royal Australian College of General Practitioners for the Outer Metropolitan areas and large regional centres and by ACRRM for the rural areas.
- In 2009, the Government announced the transfer of the management of PGPPP to General Practice Education and Training Limited (GPET), effective 1 January 2010. GPET was a wholly owned Commonwealth company, limited by guarantee, and subject to the Commonwealth Authorities and Companies Act 1997.
- GPET was provided with all of the associated GP education and training funds including the PGPPP and it in turn funded and contracted 17 regional training providers across Australia to provide all of the GP education and training with Colleges and the Post Graduate Medical Councils required to accredit the placements.
- GPET required, that in Western Australia WAGPET would be the sole provider of the PGPPP in that State and was the predominant GP education and training provider in Western Australia. The Rural Clinical Schools had been previously and successfully running a number of rural placements under the program through ACRRM, these were transferred to WAGPET at the beginning of 2013 after a twelve-month transition period.

Overall the program in various forms had survived a series of reviews and evaluations, all of which pointed to a highly valued program delivering good prevocational training outcomes (see references). The essence of the changes in governance and

management over this period were largely around reducing the large number of funded bodies and training providers into a single agency responsible for GP education and training.

All of the relevant evaluations of the program over this period identified that the nature of the program;

- gave junior doctors the opportunity to experience general practice and community-based medicine before committing to vocational training,
- recognised that General Practice cannot be experienced in a hospital setting, unlike most other medical specialties. It is absolutely essential for junior doctors to be exposed to community-practice/primary healthcare in their early years of training, given they will need to engage with community-based services in their future career regardless of specialty.

All evaluations and reviews of the various community programs highlight the unique benefits that these programs provide junior doctors, in addition to the establishment of a training pipeline into community practice. These benefits have been well documented and include:

- an effective teaching and learning environment
- good clinical exposure and experience
- greater understanding of the health system as a whole
- good support for the junior doctors and a more satisfactory working environment.

The Mason report on health workforce highlighted the cost of the PGPPP to the Commonwealth, what it did was compare the cost to the Commonwealth of training doctors at different stages from medical students through to registrars.

Currently the costs of the junior doctors are born by the hospitals and hence State governments. With two levels of government responsible for the funding of the Internship (State) and Undergraduate and vocational training the real cost of education and training becomes lost.

For example, with the demise of the PGPPP the junior doctors who would otherwise be receiving prevocational education in community and GP settings, at cost to the Commonwealth, will now be receiving that education only in hospitals at higher and additional cost to the State.

The delivery of PGPPP in Western Australia

In 2001 the Australian Government established GPET to develop, oversee and fund regionally based vocational and education and training. GPET achieves this through the management of the Australian GP Training (AGPT) program, which provides vocational education and training for medical graduates, and (more recently) the Prevocational General Practice Placement Program (PGPPP) providing prevocational GP placement opportunities for junior doctors.

GPET now sub contracts 17 regional training providers nationally and WAGPET in WA.

A separate analysis of the WA experience with the PGPPP is required as WA took a different approach to many other States and Territories in delivering the

program and the State government was also much more involved as an active partner in delivering an integrated program through the state funded Community Residency Program.

During the course of this assessment particular attention was directed towards the views and experiences of WA trainees and supervisors within the program itself and involved numerous interviews both in person and by telephone. All participants generously offered their time and were overwhelmingly supportive of the program and their respective experiences in it.

The report focuses on the period 2005-2014 as this is the time that WAGPET has been actively involved in managing, innovating and designing prevocational training.

The WA Program – How it differs with other States

The WA program enabled junior doctors who are employed by a major hospital to work in the community. The normal rotations are for 10-11 weeks but in rural areas most junior doctors undertake a double rotation. This has been advocated as it takes time for a junior doctor to settle into general practice and the hospital placement. If on top of this they are trying to settle into a community, it may well be 6 weeks before they feel competent to work across the different sectors.

In WA the program has only allowed PGY2 and above trainees, this differs to the National program where around 50% of all PGPPPs are at the PGY1 level. By doing this WA has achieved a conversion rate of up to 81% of PGPPP doctors going on to a career in General practice, nationally this is more like 30%.

In 2007 WAGPET supported three junior doctors to undertake five rotations in the community, this has grown rapidly so that in 2014 WAGPET supported 30 PGPPP placements (116 rotations) undertaken by 74 different junior doctors across the state, including 10 different employing hospitals and 30 different employing sites.

Only three of these sites were purely in General Practice, the vast majority were composite sites with the junior doctor working in both the community and hospital during the same placement. Nationally most placements were purely in General Practice.

As stated before these composite placements were an initiative of WA, they have been highly successful and embraced by junior doctors. The key reason for ensuring a combined hospital GP rotation, especially in rural areas, is that it directly reflects the way in which the rural service model operates with rural doctors being the centre of both medical care in either community or hospital settings.

While State and Commonwealth funding might be separate, care provided by doctors in these settings is not and actually achieves the long held aim of continuity of care for patients.

One of the important aspects of the composite posts was that it allowed places like the north west of WA to train junior doctors. In the north west of WA it is very difficult to establish a normal busy General Practice, as the usual economic drivers are very different. Costs are high, the population is small and isolated and the normal small business difficult to sustain. The composite posts allowed the PGPPP to flourish in this environment and become an important part of the training pathway for rural practice.

Year	Number of Rotations	Number of Junior Doctors
2008	31	13
2009	27	18
2010	35	25
2011	61	43
2012	80	54
2013*	115	80
2014	116	74

*In 2013 WAGPET became the sole provider of the PGPPP, previous to this the Rural Clinical School had a number of placements across rural WA, mainly based in general practice.

WA must also be acknowledged as being the only state that had achieved a single accreditation process for its PGPPP placements. WAGPET were able to broker a joint accreditation process between the Postgraduate Medical Council, RACGP and ACRRM for recognition of the education and training within the PGPPP model.

Other important success factors for the WA program include:

- Clear guidelines and understanding between organisations on how junior doctors are recruited into the program.
- Clear guidelines on addressing issues that may arise for junior doctors.
- Seamless employment of the junior doctors despite working between the hospital and the community.
- Good orientation for the junior doctors into community practice.
- Clear guidelines on the funding arrangements for the program and how this works for the practice, hospitals and junior doctors.
- Funding that supports community placements and for rural accommodation and travel are essential additional supports needed to maintain the program.
- General Practice capacity with a training focus that supports excellent teaching, supervision and support for the junior doctors.
- Regular and routine feedback and review on the practice and junior doctor.

Community Residency Program – a partnership with the State government

Developing such a strong focus in the PGPPP involving both hospital and General Practice placements in the WA model was only made possible by the close partnership developed between WAGPET and the Department of Health in WA.

Both parties could see the ultimate benefit to the community and the junior doctors by ensuring their early experiences of the interaction between hospitals and General Practice could and should be positive.

The Community Residency Program (CRP) was a unique program delivered in WA in response to a number of issues. WAGPET's research had shown that what attracted many doctors to GP was the variety and ability to "add skills in a particular area, including emergency management, paediatrics, minor surgery and obstetrics

In the early years of training there was no opportunity for junior doctors to experience this

kind of work and so the idea of a 50/50 GP/hospital position was born. It reflected the way many rural doctors actually worked and enabled junior doctors to work in areas such as the north west alongside salaried medical practitioners who were undertaking both hospital and General Practice work in a seamless service.

Placements in these remote areas would not otherwise have been possible as there are very few private General Practices.

There were some key drivers that led to the development of the CRP.

The report "Maintaining an Effective Procedural Workforce in Rural Western Australia" identified concerns about the gap in, and projected decline of, Western Australia's rural procedural medical workforce and the pressing need to increase the training and education programs available to facilitate the development of procedural and surgical skills with Australian trained medical graduates and prevocational doctors.

At the same time increasing numbers of medical students were being graduated from WA universities and increased opportunities for good clinical exposure were needed. It was acknowledged that the community settings offered a great opportunity to train additional junior doctors.

The Department of Health represented by Dr Simon Towler, Chief Medical Officer and Dr Janice Bell, Chief Executive Officer of WAGPET, founded the Community Residency Program. It was overseen by the Community Residency Steering Committee which was supported by the Workforce Branch of the Department. The CRP officially ran as a separate program under the auspice of WAGPET from 2007-2009.

The objectives of the Community Residency Program were to:

- Provide most of the requirements of prevocational training in a community setting that met the standards of the Postgraduate Medical Council in terms of curriculum, supervision, assessment and support.
- Blend community with hospital training and develop communication channels and workflow arrangements between hospitals, especially regional and peripheral generalist hospitals, and the primary care setting in rural and outer metropolitan area.
- Offer rotations that facilitated the ease of movement between Community Residency and tertiary hospital rotations.
- Offer placements that met the needs of various specialists colleges including Royal Australian College of General Practitioners and the Australian College of Rural ad Remote Medicine for this level of training.

The decision to support this unique WA program has been acknowledged and strongly supported by medical students in both the 2008 and 2009 GP surveys conducted jointly by WAGPET and the AMA.

The 2008 Survey Report indicated that "the flexibility and variety perceived to be available in GP was attractive" and that 94.8% indicated a desire to mix their medical training.

Similarly, the 2009 Report recommended a need for variety in career paths and training in GP, with

82.9% expressing an interest in mixing GP with other medical training.

WAGPET managed both prevocational programs from 2007-2009. In 2010 when GPET took over the funding for the PGPP Program; CRP and the PGPP Program were integrated into one prevocational program at WAGPET.

In late 2011, GPET made the decision to offer WAGPET the contract to be the sole provider of the PGPP Program in WA from 2013. GPET gave WAGPET 12 months to ensure there was a smooth transition in WA from in the move from two providers for the PGPPP to a single provider.

For the first time in Western Australia, one organisation was responsible for community placements for GP education and training.

The delivery of PGPPP through WAGPET as the sole provider would generate efficiencies and as WAGPET also delivered the AGPT program it presented opportunities to leverage existing AGPT program placement and medical education resources for the delivery of the PGPP Program as well as offering improved opportunities to manage training capacity.

It would also simplify the marketing and advertising of position with one organisation approaching junior doctors and the hospitals.

Funding Model

WAGPET pays the employing hospital for each individual doctor at their salary level a rate of 120% to cover leave, administration and other variables.

They fund 10 different employing hospitals and 30 different placement sites.

Under this model the doctor is paid by their employing hospital each of whom may have a slightly different interpretation of the award and conditions for payment for overtime etc. There are instances of two doctors working at the same site being paid differently for working after-hours.

WAGPET fund the placement site for:

- office accommodation of the doctor in the practice
- supervision and education
- travel and accommodation.

Other costs include:

- orientation for each doctor at the commencement of their placement
- selection of the doctor
- External Clinical Teaching visits
- marketing of posts
- development of new posts and General Practice support.

Relative costs

The relative costs of the PGPPP was assessed against the equivalent hospital medical education and training costs for junior doctors to determine the relative cost effectiveness of the program.

To assess the relative costs of employing a junior doctor in the community compared to working in a teaching hospital the Junior Doctor Business Case (JDBC) analysis that was accepted by

government to fund the training and employment of the increased number of medical students coming through our universities was compared with the GPET allowances for community placements reported in the 2013 Annual Report.

In the JDBC 1 FTE RMO costs $185,000 (2014/15) to supervise and train, each RMO works 44 weeks per annum (2 weeks Professional Development, 2 weeks public holiday leave, 4 weeks annual leave). This cost does not include any rural allowances.

GPET fund each PGPPP per week of placement $4331 (2012 actual from GPET 2013 Annual Report) consequently placement of 1 RMO cost WAGPET $190,000 to work for 44 weeks. This cost includes allowances for all on costs including additional rural cost.

As at least 50% of all PGPPP must be undertaken in rural areas this represents a significant cost. Taking into account the rural allowance the cost for a community placement is roughly equivalent to the JDBC cost for a hospital placement.

Stakeholder Feedback

Interviews were undertaken with 15 different individuals covering the Colleges, WAGPET, Supervisors, Silver Chain, Junior Doctors, Australian Medical Association, Aboriginal Medical Services, Rural Health West, Rural Clinical School, the Medical Workforce Branch of the Department of Health, WA Country Health Services and GPET.

All interviewees were asked a series of open-ended questions around the impact of the program and some specific to the particular interviewee. The broad questions posed were:

"The Program was a positive one for General Practice and the whole of health by giving medical practitioners an understanding of what GPs actually do"

College member

"It is an essential part of the training pathway to rural practice"

Rural Clinical School

"It is a fantastic program that really makes a difference"

Silver Chain

- How long were you involved in the program?
- How did the program change over time?
- How well did the program work for you operationally?
- What successes did you see from the program?
- Where there any particular challenges?
- Do you have any take-home messages?

All of the stakeholders regardless of whether they were participants, organisations, or supervisors saw the benefit of this program. Many of the stakeholders had been involved from the early pilot programs commencing in the late 1990s to the fully integrated program of 2014. They commented on the changes in the administration to how it became a streamlined and easy to follow program, with good processes and clear guidelines. They also reported on many of the positive aspects of the program such as its flexibility that made it attractive to the newer graduates.

All stakeholders agreed that the program had achieved its initial primary objective of attracting young doctors into a career in General Practice and community medicine and many commented on the positive unintended outcomes of the program as discussed below.

Impact on the Profession

There is universal agreement that this program in WA has definitely helped recruit doctors into General Practice. Supervisors have seen many PGPPPs come back to their practices and work as GP registrars.

The conversion rate in WA is up to 81% PGPPP doctors going on to GP training.

Other benefits identified by the majority of stakeholders include the extra pair of hands in the practice, helping the practice to see more patients and helping with workforce shortages.

Many doctors saw an early reluctance of GPs to take on the supervision and training of PGPPP as they can be very time consuming and initially slow down the GP, over time this reluctance ceased as GPs realised the benefits of having young doctors in their practice, many are now disappointed when they do not get a PGPPP.

> "It has laid the foundations for getting more doctors here, it is much easier now to get an extra pair of hands"
>
> Supervisor

> "Junior doctors in hospitals often struggle to have direct patient contact, it is much easier in the community"
>
> Supervisor

The benefits cited by supervisors included keeping up to date with what is happening in specialty medicine, and the closer relationships with the hospitals. Silver Chain commented on the opportunity this program gave to have additional workforce in the community enabling doctors to undertake a different range of services such as home visits and attend aged care centers.

Communities

Crucially for rural communities the PGPPP has been acknowledged as a clear attempt by government to ensure a pathway is available at every aspect of a doctor's education and training in order that they consider rural practice as a professionally rewarding career.

Junior doctors, supervisors and several rural based organisations stated that this program gave junior doctors the opportunity to gain a more "hands on experience" and develop longer-term relationships with their patients.

As many of the placements in WA are composite posts between the hospital and General Practice, there has been a definite benefit in the junior doctor being able to understand what the GPs are able to do in the community and what the hospital will do with particular conditions. They have then been able to make sure other practitioners in both settings understand how each other work. This helps to integrate care and stops patients being sent needlessly from one setting to another. In essence it is an educational tool to help break down the barriers between primary and secondary care.

The rural communities in Western Australia have always taken a keen interest in the availability of Australian trained doctors entering rural practice.

In fact the Western Australian Medical School was originally supported through fund raising efforts by communities and rural Shires. This continued with the Country Medical Foundation. A body unique to Western Australia whose purpose was to use funds raised by local government to support rural students entering medicine.

It is then no surprise that both the Rural Clinical Schools and the junior doctor placements under PGPPP have been promoted and supported by rural communities.

This includes welcoming them to the community and wide coverage in local rural media.

Aboriginal Medical Services

There are six PGPPP composite positions based in Aboriginal Medical Services and hospitals and one in population health. Six of these positions are based in the Kimberley; this has allowed vertical integration of training with the Rural Clinical School, junior doctors and GP training.

These positions have been integrated into the Rural Practice Pathway and are highly competitive amongst the junior doctors. The Kimberly AMSs have seen a complete change in the attraction of GPs wanting to work with them, and the link has been identified as being stronger with the PGPPPs than with the medical students. The doctors working with the AMSs enjoy the teaching part of their jobs and this helps to retain and attract new doctors. As commented on earlier there was initial reluctance amongst the doctors to take on the junior doctors as they were concerned about the workload, however over time this has changed to them being very positive about the PGPPPs.

Governments

As the number of medical graduates has more than doubled over the last ten years there has been increasing number of junior doctors to train. Hospital supervisors and teachers have come under more and more pressure to teach additional medical students in addition to the junior doctors.

The change to the way medicine is practiced with shorter lengths of stays in hospitals and much of the elective surgery being undertaken by the private sector has resulted in most teaching hospitals seeing the high end of acutely ill patients with less exposure to the undiagnosed unwell patient. These patients tend to stay in the community and it is this environment that now offers an excellent opportunity for clinical exposure to trainees.

As the health care needs are changing with the growths of co-morbidities, chronic disease and the ageing population more clinicians are needed to work in the community.

There has been much discussion in the Eastern States about the fact that Australia now has enough doctors, they are just not distributed where they are needed. It is the generalist doctors and rural doctors that are mainly in short supply, this program has the potential to expose junior doctors to these careers at the time when they are making career choices and potentially addressing this issue.

As highlighted by Silver Chain and junior doctors this program is a pipeline not just to General Practice but also to other community specialties such as palliative care. The junior doctors have also commented on how important this program has been to those that want to specialize as they now understand what is possible to do in a community setting.

> **"Made a big difference in attracting junior doctors into General Practice"**
>
> Supervisor and a Junior Doctor

> **"Makes a difference and has become a vital part of the rural workforce"**
>
> Rural Organisation

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Timeline of the Prevocational Community Programs in WA

Year	Program	Governance	Funder
1996	Provider Number Legislation	Commonwealth Department of Health	
1997	Pilot Programs (WA one of first programs)	Rural Doctors Association	Commonwealth Department of Health
2000	Rural and Remote Area Placement Program	Australian College of Rural and Remote Medicine	Commonwealth Department of Health
2005	Prevocational General Practice Placement Program	National Advisory Committee supporting delivery by RACGP and ACRRM who contract out to WAGPET and Rural Clinical School	Commonwealth Department of Health
2007	Community Residency Program	Community Residency Steering Committee supporting delivery by WAGPET	State Health Department
2010	PGPPP CRP is integrated into PGPPP	GPET contracts WAGPET and Rural Clinical School	Commonwealth Department of Health
2013	PGPPP	GPET contracts WAGPET as the sole provider in WA	

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