Options for West Australian GP Education and Training

Supporting doctors to practice where they are needed most

Prepared by
Dr Felicity Jefferies
Healthfix Consulting
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Executive Summary

This report assesses the current prevocational community training, education and delivery models in Western Australia. It recommends four levels of intervention into prevocational GP education and training.

The report recommends a first level of intervention whereby WAGPET can reduce costs to ensure financial stability and viability of the existing program. This can be immediately undertaken by WAGPET.

The report progresses to recommend how the Community Prevocational Training can be more fundamentally embedded into the current hospital based prevocational training. It is this process that is needed to move the current small, boutique and optional program into a fundamentally integrated part of the wider medical education and training effort. This work needs to involve hospitals and the Postgraduate Medical Council (PMC).

WAGPET has the credibility within the sector to take a leadership and advocacy role for the completion of a comprehensive medical education and training plan and also to lead a renewed focus on preparing our doctors for a career in general practice.

On this basis a third level of intervention looks at how WAGPET can act as a catalyst for remodeling and redesigning the overall GP training pathway so that it embeds prevocational community training with relevant hospital based terms as a high quality, fast track pathway for GP training. This will need to be undertaken in collaboration with RACGP, ACCRM and PMC.

Finally, the report urges WAGPET to make a direct approach to the Director General and the Minister for Health seeking involvement and support towards the preparation of the medical education and training plan for the State. And to offer its direct involvement in the development, design and implementation of the single entry and allocation of prevocational and vocational training in WA.

Introduction

In light of recent medical workforce studies in Western Australia, most notably the report entitled "WA - A sorry State of Medical Education and Training", it is increasingly clear that Western Australia's medical workforce challenges demand changes to the existing infrastructure and medical education and training programs in this State.

The report found a significant shortage in total doctors in Western Australia estimated at 950 and a significant part of this shortage being in General Practice. The maldistribution of doctors in this state has long been a feature of our medical workforce and is most acutely felt in rural, regional and outer metropolitan areas. This is an issue we have in common with most other States and Territories. However the report demonstrated that Western Australia suffers a more acute medical workforce problem than other states in several key areas:

1. WA is more reliant on overseas trained doctors than any other State (1,150 extra doctors compared to the national average)
2. WA has the lowest per capita level of General Practitioners compared to every other State
3. WA produces the lowest per capita level of medical graduates of any State

So within a State that has too few doctors, too few GP's and a maldistribution of the few GP's we do have, any change must be driven by clear and supported pathways of education and training into those areas where the State needs doctors the most. That means pathways to General Practice and rural, regional and outer metropolitan areas.

The medical workforce challenge is further compounded by a trend in health demand towards an increasingly ageing population and an attendant growth in chronic disease.

All of these circumstances require a strong and vibrant General Practice and primary health care response to meet the future health needs of Western Australians. Failure to do so will see hospital growth and costs increase exponentially.

As the primary vehicle for GP education and training in Western Australia, WAGPET has a unique opportunity to position itself to provide a strengthened and integrated range of education and training fundamentally integrated with the states wider medical workforce education and training. This report also explores ways in which these objectives can be achieved.

WAGPET has the credibility within the sector to take a leadership and advocacy role for the completion of this comprehensive medical education and training plan and also to lead a renewed focus on preparing our doctors for a career in general practice.

To assist in this effort, WAGPET has engaged Dr Felicity Jefferies, Director, Healthfix Consulting to consider its prevocational community training, education and delivery and explore ways in which WAGPET's programs can be more fully imbedded with other medical education and training effort.

Purpose and Methodology

The purpose of this report is to assess current prevocational community training, education and delivery models for effectiveness and value for money. It will evaluate and propose alternative business and service models to ensure future general practitioner training and education and growth is sustainable and fully integrated with other prevocational training programs both Commonwealth and State funded.

Key deliverables included

- Presentation of an assessment on the success of the PGPPP program within Western Australia including recommendations for improvement
- Determine from existing prevocational community training models where there may be synergistic opportunities for streamlining and cross subsidisation
- Report on the funding accountabilities of the relevant program funders and identify any cross subsidisation
- Determine how the existing work done with Silver Chain and Brightwater might be factored into the recommendations
- Include an evaluation report with recommendations that propose 2-3 costed, alternative sustainable business and service models of prevocational general practitioner and community training

In conducting this assessment the key methodology involved:

- Identification and liaison with key stakeholders to gather the necessary data and feedback to inform the assessment (See appendix 1)
- Gathering the necessary evidence and data to inform the assessment of prevocational community training, education and delivery models
- Determining the critical success factors for prevocational community training models within the context of different regional, operational, legislative, industrial commercial and political environments.

While the assessment was on a statewide basis the liaison was conducted remotely.

History

Prevocational community training and education was first initiated in the late 1990's as a response to the 1996 provider number legislation which prevented junior doctors from working in General Practice. This became known as the Rural and Remote Area Placement Program (RRAPP) with WA being one of the first states to successfully pilot the program.

The RRAPP first began in WA in the late 1990s as a dedicated rural program to encourage prevocational doctors to experience rural general practice. This was in response to concerns about shortages in the rural GP workforce and the future of rural medicine at that time, which was heavily reliant on recruitment of overseas trained doctors.

The approach at that time was predicated on the notion that early exposure to rural general practice in education and training programs would see more Australian trained doctors exposed and encouraged to consider rural general practice as a rewarding and professionally stimulating career option.

The program itself was a precursor to the later establishment of rural clinical schools, which expanded the principle of early exposure to rural practice to include undergraduates.

The success of the RRAPP saw it converted into a national program PGPPP from 2005. It was initially jointly managed by both the RACGP and ACCRM, with a National Advisory Committee overseeing the program. In 2010 the Commonwealth decided that the program would be run by a single entity, General Practice Education and Training (GPET).

With responsibility assigned to GPET to run the program a number of key changes occurred over subsequent years:

- The program was streamlined and run locally by a network of Regional Training Providers (RTP) contracted by GPET. There were 17 RTP's nationally and GPET contracted all of them to provide the PGPPP
- The rural/urban distribution of these placements now follows the same pattern as general practice registrars and is no longer an exclusively rural program
- The program has grown considerably in size over the last 5 years and currently offers around 970 placements of 10-13 weeks each per year throughout Australia

The aim of the program is to enhance junior doctors understanding of general practice, gain a better understanding of the component parts of the Australian health care system and encourage them to take up a career in general practice.

All junior doctors who have not entered into specialty training (with the exception of GP Registrars and there are some restrictions on provisionally registered doctors) are eligible to apply for the program.

In the current environment, there is growing importance of general practice and primary health care services as a cost effective means of responding to an ageing population with commensurate growth in chronic disease.

As a consequence PGPPP has grown in importance to the wider system from its early origins as a vehicle to address shortages of GP's in rural areas to a statewide vehicle that could strengthen future General Practice.

History (cont.)

There are many who believe that in addition to this objective all doctors should undertake community placements in order to better understand the practical application of the notion of continuity of care in Australia's health system.

As the community ages and with growth in chronic diseases and co-morbidities many people with complex disease will need to be cared for mainly in the community and specialists will need to interface with this group much more frequently. As result it is equally important that hospital based specialists understand the capabilities of the community health services as a means of maintaining good health.

It would seem that while the general principle of community based pre vocational training is well established, the PGPPP has not yet emerged from a relatively small boutique program, with substantial differences in application across States and Territories into a mainstream and integrated part of the wider medical education and training system.

The program is at something of a cross road and the challenge is to ensure that the program is given the opportunity to emerge as a fundamental and mandated part of the wider medical education and training program, left undeveloped it runs a risk of being isolated as an additional cost to a stretched hospital based medical education and training program.

Before considering what type of program should emerge it is worth considering the common features of the program across States and also the variations.

Current National Program – Common Features

While the PGPPP is not a completely standardised program it does have common features in each jurisdiction. These common features include:

- All doctors are rotated from their employing hospital for a period into the community, this ensures they retain their employment terms and conditions and indemnity cover whilst in the community (though most RTPs recommend the prevocational doctors have their own indemnity)
- All community placements are aligned to a specific RTP but not necessarily to a specific employing hospital
- All prevocational doctors undertaking this program are also given an orientation into community medicine, though this may take place in the general practice or by the RTP (this includes things like understanding electronic health records, the PBS, medicare billing, etc)
- Standards of supervision and education in the community setting are also universal fundamentals of the program
- Additional costs of rural placements are covered by the RTP which includes travel and accommodation
- The costs of the placement in the community are supernummery to the hospital costs

The program is run in all states and is managed by the seventeen RTPs. GPET fund each RTP by a set amount per week for each FTE placement. This allows for flexibility with the nature of the placements and each RTP has adopted some different features in their programs.

Current National Program

Current National Program – Variations Between Jurisdictions

The historical basis for the PGPPP and the flexibility available under the funding arrangements has allowed some variations in the program between the jurisdictions.

Victoria and NSW have set the PGPPP rotation to specific employing hospitals/networks. In Western Australia this occurs in Broome, Bunbury and is proposed for Fiona Stanley Hospital.

These variations include the selection process, level of entry, relationship with employing hospitals and nature of the community rotations.

Selection Process

There are a number of variations between jurisdictions in both application and selection processes with some States having the applications made by Junior doctors through the Hospitals and some through the RTP. In most cases selection processes do not involve interviews.

Level of Entry

Some RTP's are accepting Interns as part of the PGPPP, with additional resourcing towards supervision and salary support. However most focus on PGY 2 and 3 as entry level for the program.

Relationship with Employing Hospitals

Some PGPPP placements are allocated to specific hospitals and are part of that hospitals rotations. When this happens the junior doctor knows which hospital they must work at in order to apply for a specific PGPPP and the hospital knows exactly how many positions they have available to offer junior doctors in hospital and community setting.

Nature of the Community Rotations

Most placements are only in general practice. WA placements are different in this aspect as the majority are composite posts consisting of both hospital and general practice work in the same day, consistent with the medical service model in WA.

WA Model

WA has 30 PGPPP placements across the state, including 10 different employing hospitals and 30 different employment sites. Only 3 of these placements are purely in General Practice, the vast majority are composite placements with the junior doctor working in the local hospital and community during the same placement. Most other RTPs have purely general practice placements.

The composite placements were an initiative of WA, they have been highly successful and embraced by junior doctors. The rotations are on average between ten and eleven weeks with each site usually having 5 rotations a year.

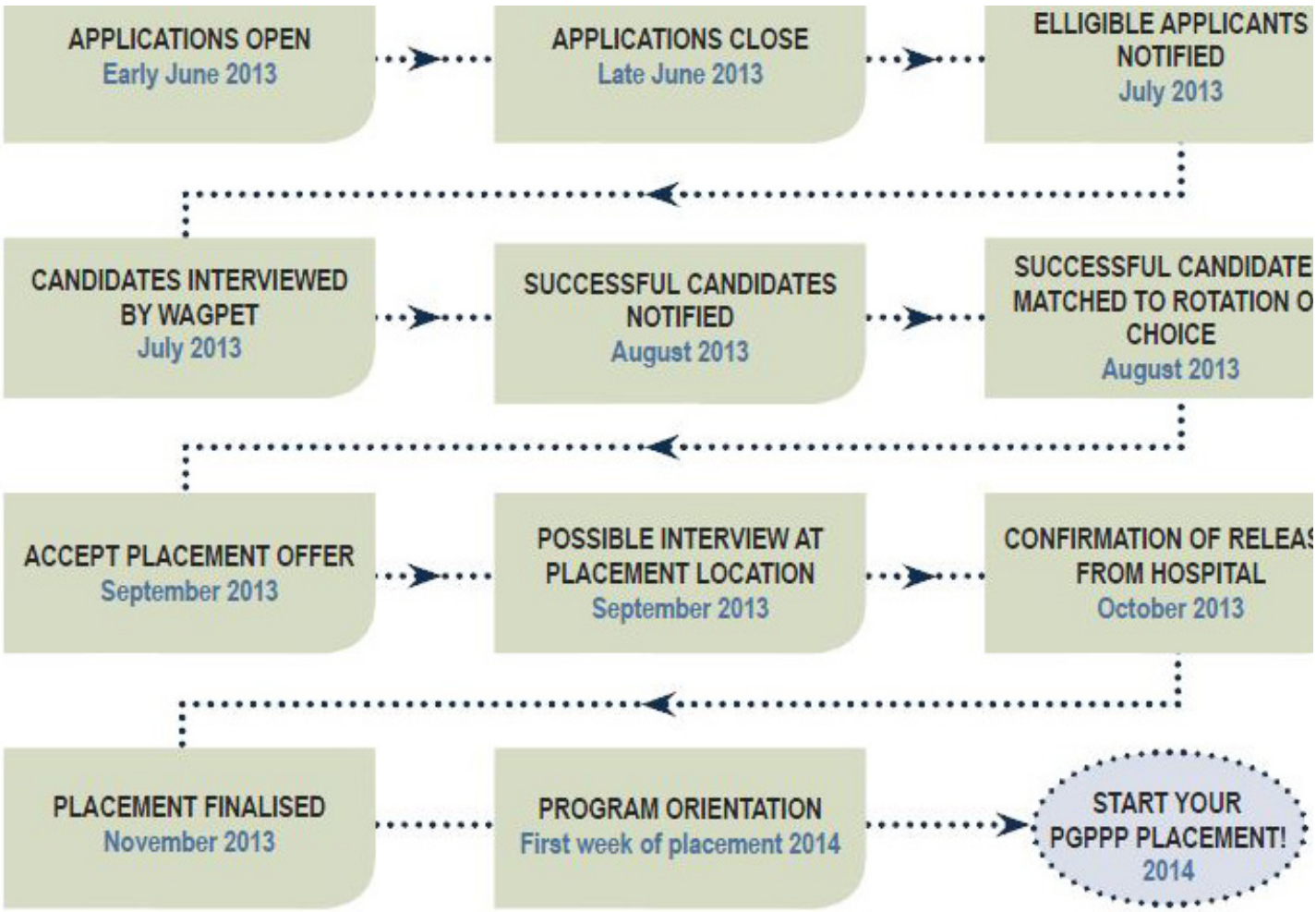
Selection and Placement

In WA prevocational doctors interested in the PGPPP apply to WAGPET and in a separated application to their employing hospital. They must be selected by the employing hospital (and if that is WACHS they are interviewed prior to final selection) and also by WAGPET who interview all the applicants for PGPPP.

The process is complex and in the case of WACHS candidates selected for certain PGPPP sites they must also be selected by that employing hospital (Broome and Bunbury). This process currently relies on the goodwill of the interviewers. It seems to be overly complex and burdensome especially as at the current time many of the applicants withdraw from the placement.

Once the applicant has been selected by the employing hospital and by WAGPET for their PGPPP, WAGPET liaise with the hospital to ensure the prevocational doctor is rotated into the community placement at the doctors selected time.

This process again relies on the goodwill of the employing hospital to prioritise the community placement at the applicants preferred time, in some cases the employing hospital can have anywhere between three and seven prevocational doctor in the community in any given term. This can make it difficult for the employing hospital to know exactly how many doctors they need to recruit at the beginning of the year as the recruitment occurs prior to final WAGPET notification of how many PGPPP placements they need to make in each term.


APPLICATIONS OPEN
Early June 2013
APPLICATIONS CLOSE
Late June 2013
ELLIGIBLE APPLICANTS NOTIFIED
July 2013
CANDIDATES INTERVIEWED BY WAGPET
July 2013
SUCCESSFUL CANDIDATES NOTIFIED
August 2013
SUCCESSFUL CANDIDATE MATCHED TO ROTATION O CHOICE
August 2013
ACCEPT PLACEMENT OFFER
September 2013
POSSIBLE INTERVIEW AT PLACEMENT LOCATION
September 2013
CONFIRMATION OF RELEAS FROM HOSPITAL
October 2013
PLACEMENT FINALISED
November 2013
PROGRAM ORIENTATION
First week of placement 2014
START YOUR PGPPP PLACEMENT!
2014

Funding Model

WAGPET pay 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:

- 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 recieved by WAGPET for 2014.

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 WAGPET for each PGPPP per week of placement $3879 (WAGPET actuals 2014) consequently placement of 1 RMO cost WAGPET $170,676 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 it seems that it is roughly equivalent to train a junior doctor in the community as it is to train them in the hospital.

Critical Success Factors

Critical success factors of the WA Model include:

- Clear guidelines and understanding between organisations on how junior doctors are recruited into the program
- Clear guidelines as to who to contact in which environment when issues arise with the junior doctor and how this is shared between organisations
- Seamless employment of the junior doctor from the hospital to 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
- Streamlined accreditation for the community placement
- Funding that supports community placements and for rural accommodation and travel are essential additional funding supports needed to maintain this 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 practice and junior doctor

The Western Australian PGPPP satisfies all of these critical success factors and has been a very innovative and highly regarded program amongst junior doctors and accredited practices.

The program has been able to quickly adapt to changing circumstances and respond. An example of this was the capacity of WAGPET to broker a joint accreditation process between PMC, RACGP and ACRRM for recognition of the education and training within the PGPPP model.

Options for reform to community prevocational training models.

As described in this assessment the main vehicle for providing community based medical education and training in Western Australia is through the PGPPP.

With the continual growth in demand for medical education and training the hospitals are facing increased pressure on their capacity to provide the traditional medical education and training. Access to sufficient and appropriate clinical placements is becoming increasingly difficult.

The State government is exploring ways in which the education and training capacity can be expanded including private hospitals and community settings. The PGPPP is well placed to provide this capacity and are a cost effective training alternative, given that the costs of placements are equivalent to those in the hospitals.

Interventions Proposed

More importantly, in Western Australia the critical shortage of General Practitioners and the importance of General Practice in meeting future health care demand reinforces the need for an investment into education and training pathways that encourages a higher proportion of newly graduated doctors into GP training.

The current PGPPP is not geared to meet this potential future. It is still a relatively small, boutique program which is an optional pathway for doctors wishing to enter General Practice. On a national basis approximately 30% of doctors entering General Practice incorporate a PGPPP placement. However in WA up to 73% of all junior doctors undertaking a PGPPP go on to take up General Practice training. (it often takes up to 4 years after the PGPPP for the junior doctor to take up a training position in General Practice)

The PGPPP and community prevocational training models are at a cross road.

There is no doubt they have a part to play in any future growth in medical education and training. However the absence of a clearly articulated medical education and training plan designed to address current and future workforce challenges means there is no clear role for community education and training models.

This leaves two choices for the WAGPET.

Advocacy for a WA medical education and training plan

Advocacy for the completion of a medical education and training plan for Western Australia would ultimately allow all education and training providers to harness their combined efforts in a coordinated and planned response to the current and emerging medical workforce crisis. Development of a clear plan for the future would allow WAGPET to design a community based education and training response integrated and imbedded with the wider medical education and training effort.

This would require a preparedness on the part of WAGPET to increase its advocacy in respect to the design of community based medical education and training.

Redesign the training pathway to General Practice

In the absence of a clear medical education and training plan for WA it is open for WAGPET to design a future community prevocational training program for General Practice that will be a product available to the State and Commonwealth governments when the inevitable bottlenecks in hospital based medical education and training occurs.

This would position WAGPET to take responsibility in WA for all community medical education and training, designing all elements (hospital and community) associated with preparing doctors for a career in General Practice.

While this assessment proposes a more fundamental focus by WAGPET on community based prevocational training models there remain some more immediate and pragmatic changes to the existing program that require early attention.

These options for the existing PGPPP include relatively simple adjustments to the existing program to ensure it remains financially stable and more appropriately aligns the governance and funding arrangements. The current program is underfunded by approximately $280,000 per annum and on that basis alone cannot be sustained at the current level. This is the first year that the program has been underfunded and has been brought about because of an increase in junior doctors salaries, increased numbers of rural placements (with additional costs of relocation, accommodation and travel) and a 2.6% efficiency dividend imposed by GPET. The first option therefore focuses on relatively minor changes to ensure financial stability in the program.

The subsequent options consider more fundamental change to the program imbedding it more comprehensively within the broader hospital based medical education and training program. The latter approach will require support and agreement with other funding bodies and most importantly the State government.

Intervention Options

Option 1 - Streamline administration and costs of existing PGPPP

The changes proposed under option 1 reflect those measures that can be undertaken unilaterally by WAGPET and are all within WAGPET's authority. They are designed to maintain the existing PGPPP as a separate boutique program, but streamlining the administration of the program and ensuring the costs are within the current budget parameters. If nothing is changed the program in its current form is not financially viable.

Remove duplication of supervision and teaching costs

Unlike other States, the WA model involves combined rotations between hospital and community based settings. Understandably the PGPPP funding provides for supervision and teaching at the community level, however for the larger hospitals resources have already been allocated for supervision and teaching, so providing additional funding for this purpose for these combined rotations represents duplication.

With some advance notice it would be fairly simple to cease paying the larger placement hospitals teaching, education and placement costs. These hospitals include Joondalup, Kwinana, Swan Districts, Armadale, Bunbury, Geraldton, Kalgoorlie and Broome. All of these hospitals have a fairly large number of junior doctors for whom they receive funding to supervise and teach.

It should be remembered that these hospitals are already benefiting from a "free resource" in the form of a WAGPET funded rotation in their hospitals. As a result it would be highly unlikely for these hospitals to cease the program as there remains a significant net financial benefit to them.

A draft letter initiating this decision is attached at Appendix 2.

It would be important to continue the teaching and supervision payments for the smaller sites where the majority of junior doctors are undertaking PGPPP placements and other sources of supervision and teaching payments are unavailable. These sites include Derby, Kununurra, Kimberley Public Health Unit, NIckol Bay and Carnarvon.

The current WAGPET budget of funding teaching, training, supervision and accommodation for the hospitals for this year is around $867,803 for 21 placements. Six of these are at the smaller sites, 15 at the larger sites so ceasing this duplicate payment would save approximately $550,000, based on current year budgets.

Interview Process

This seems to be overly complex and in reality most junior doctors wishing to undertake a PGPPP are able to access a placement. The current arrangements mean that many junior doctors simply apply for all available programs (including PGPPP) and withdraw as offers are made.

It would seem sensible to enable all junior doctors wishing to undertake one of these places to be supported to do so with only the practice having the ability to veto any placements.

This alone would free up a significant amount of administrative time and effort that is spent on interviewing approximately 100 applicants a year (approximately 1 week). The 2014 budget of $5000 for interviews would also be saved.

Option 2 - Streamline administration, costs and governance

Apply the changes proposed under Option 1 and simplify the WA model to reflect the arrangements already applying in Broome and already in place in Victoria and NSW.

This involves aligning each PGPPP with a specific employing hospital. This would then enable each employing hospital to recruit a specific number of FTE at the beginning of the year, knowing that they have a certain number of PGPPP to fill for the year.

If possible each employing hospital will have set yearly rotations that each junior doctor can choose, if PGPPP is part of these rotations then it would be important to make the other terms more in line with a future career in community medicine. This approach is currently being considered for both Fiona Stanley and Broome hospitals and should be expanded to all participating hospitals.

Payment systems can also be streamlined so that the employing sites are given a PGPPP budget equivalent to the salary (PGY 2 Level) at an average annual rate, this will eliminate the practice where WAGPET chase hospitals for invoices as placements occur and avoid the situation where payments are at rates above the allocation of funds from GPET.

This will also ensure the employing hospital understands what they are being funded to deliver for the relevant budget year. This would ease some of the current administration burden on WAGPET and the employing hospitals.

Applying this option moves the PGPPP more towards an imbedded part of the existing hospital based medical education and training program and would make application to a combined hospital and community placement far easy for applicants and administration.

Option 3 – Integrating a community prevocational training model

This option envisages expanding and integrating the current PGPPP from a small, boutique and optional component of GP training, run independently of hospitals into a fully integrated and essential part of medical education and training for those doctors wishing to pursue a career in General Practice.

A fast tracked GP education and training pathway

Essentially this means offering a high quality, fast tracked and more relevant education and training pathway to General Practice, following general registration.

While all graduates will continue to undertake an intern year at hospitals, they will then be eligible to enter a general practice pathway, involving community placements and hospital placements in areas that are relevant to the skills and experience required in General Practice. The design of the pathway would need to be a combined effort led by WAGPET, GPET and involve RACGP, ACRRM in the design phase and then discussed and negotiated with Hospitals and the Post Graduate Medical Council.

Intervention Options (cont.)

Candidates for the program would apply for the fast tracked GP training with the hospitals offering the combined hospital and community pathway in one application process.

This approach would ensure that every doctor wishing to pursue a General Practice career would be supported to do so immediately after general registration, this would represent a clear, unambiguous and accredited pathway. This fast track process would be an attractive option against other more arduous processes to enter other specialties. It would also represent an alternative investment strategy for the State and Commonwealth government.

Expanded community placements for improved clinical experiences

The current prevailing view is that in the very near future education and training capacity will need to grow beyond the traditional public hospitals into private, not for profit and community settings. There exists a largely untapped resource of clinical experience in the community setting.

While the priority for WAGPET should be directed towards a fast tracked pathway to General Practice it may be possible to extend the community clinical experience to other doctors in training as part of a capacity building for medical education and training. The current community placements are being delivered for the approximately the same cost as hospital based education and training.

As a result having a high quality community based rotation available to doctors more generally would be welcomed.

The expansion would need to coincide with a State government effort to expand clinical placements for the growing numbers of Doctors in Training. Any additional funding required would need to be sourced from the funds available for existing medical education and training, in other words the community clinical placement would substitute for components of the traditional hospital clinical placements.

This program would be expanded with an aim that it is no longer just about giving junior doctors a taste of community medicine to see if they wish to undertake general practice training but instead ensure that the large majority of doctors in WA are exposed to community based medicine and to provide clinical cases no longer easily accessible in the hospitals.

WAGPET are already working with Silver Chain and Brightwater to explore options for placements within these organisations. This work is at an early stage of development but holds important potential for inclusion in the provision of expanded community based placements.

Contextual Issues

State Government

The wider context and environment seems ready for more fundamental reform to the medical education and training system in this State. For example, the Minister for Health has already made clearly known that he wishes to see:

- Preparation of a medical education and training plan for the State, designed to address the current and emerging medical workforce issues
- Streamlining and introduction of a single point for entry and allocation process into internships and prevocational and vocational training to be prepared

The Chief Medical Officer, Dr Gary Geelhoed is overseeing the preparation of the medical education and training plan as required by the Minister and Professor Con Michael has been designing the process for a single entry and allocation of intern, prevocational and vocational training placements.

These endeavours represent fertile ground for WAGPET to adopt a clear supportive position for both of these developments and to offer its own direct support in the design and ultimate delivery of the community based education and training component.

Commonwealth government

It is likely that with the Commonwealth budget due to be brought down on May 13, 2014, some changes may be expected in the medical education and training field. The delivery of the PGPPP and the role of GPET may receive at least some degree of scrutiny. While not entirely clear for this budget, some level of contingency planning is needed in the event that the PGPPP is not continued as a discrete program.

If not addressed in this budget the existing PGPPP would appear vulnerable, given it is a boutique and optional program in the preparation for General Practice and requires additional funding to operate separately from the remainder of the medical education and training effort. The reality is that PGPPP needs to be understood that it is the same as any other rotation, it is a job that is not supernummery and offers additional skills and should not be seen as a program that sits outside traditionally accepted prevocational standard rotations. The difficulty is that some people may see the program as redundant now that we have applications for GP training far in excess of supply.

It is possible that the government may implement the recommendations from the Mason review, which suggests redirecting the PGPPP funding into a rural and remote training pathway.

On this basis it would seem important for WAGPET to seek to evolve the PGPPP program into a more integrated component of medical education and training in this State.

Recommendations

Recommendation 1

Option 1 and 2 should be implemented as soon as possible. This will save WAGPET approximately $550,000 pa.

Recommendation 2

Option 3 should be pursued by WAGPET with the design to fast track GP education and training pathway priority, in conjunction with RACGP and ACCRM.

Recommendation 3

WAGPET to approach the Minister for Health and the Director General seeking direct involvement in the preparation of the medical education and training plan and single entry and allocation of prevocational and vocational training.

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Appendix 1

Draft letter explaining the WAGPET decision to cease funding to supervision / training support, where such support is already provided through the State government

Armadale, Rockingham Kwinana, Swan Districts, Joondalup, Geraldton, Bunbury, Kalgoorlie, Broome

Dear _____,

WAGPET has recently undertaken a review of the Prevocational General Practice Placement Program (PGPPP). This has been a highly valued program whereby junior doctors are given an opportunity to work jointly in your hospital and the community during the same term.

Reviews have highlighted the success of this program across WA and positive feedback from junior doctors has been ongoing. There is significant pressure to continue to grow these placements, especially in the environment of increasing numbers of junior doctors needing good clinical training exposure. Currently WAGPET fund 30 additional junior doctors to undertake placements across the state.

This program has funded X additional junior doctors to work in your hospital this year, as the doctors work half time in the community this is equivalent to X FTE. These junior doctors are funded at 120% of their salary to cover the on-costs associated with their employment and are also funded for their accommodation and travel. In addition WAGPET is also funding a teaching/supervision payment and a practice support payment.

After discussion with a number of stakeholders it was highlighted that the funding for the supervision/training and practice support is in fact also being paid for by the Junior Doctor Business Case (JDBC) as well as Royalties for Regions in the case of rural hospitals.

It was decided that in the cases where the costs are covered by other state government funding sources that WAGPET should no longer fund additional supervision/training and practice support for the fully funded PGPPP placements.

WAGPET currently fund X Hospital FTE at 120% of their salary and in the case of rural doctors, X accommodation subsidies of $X per week and return air fares to Perth for the junior doctors orientation to PGPPP. All of these components will continue to be funded.

If you wish to discuss this with me please contact me on [0000 000 000].

Yours sincerely,

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Prepared by
Dr Felicity Jefferies
Healthfix Consulting
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