WAGPET

RURAL GENERALIST PROGRAM

Business Case for Rural Generalists in Western Australia

Executive summary

This paper provides the underpinning foundations for the business case for Rural Generalist (RG)Training in Western Australia. It describes the conceptual framework for RG that has informed the development and implementation of the Western Australia RG Program (WARG) and the professional framework of how RG aligns with and integrates with general practice and non-GP specialist practice. What this paper cannot do is to tell whether RG is financially viable -the work on financial modelling, especially from a community perspective is yet to be available.

What is needed from CMWIC to progress this work is a snapshot of health care activity and workforce distribution and trends. This data would need to be streamed by region and each major centre.

In terms of workforce analysis:

- Clinical presentation by procedural discipline
- Activity levels of presentations conducted by RGs
- Activity levels of presentations conducted by non-GP specialists
- Gross and net increase and decrease in clinical activity over past 5 years
- Workforce increase or decrease trends- by discipline and specialty (can overlay presentation numbers)
- Locum shifts filled in last 12 months for service provision- benchmarked against each other region per weighted activity unit
- Current workforce labour resourcing and distribution for public services

In terms of workforce RG innovation:

- Current RGs working on MSA in region
- Current RGs employed in community practice and billing for primary services
- Activity being billed through MBS for specialist services in town
- Presentations that account for activity in community practice
- Any unmet service needs- PATS data on common referrals and disciplines
- Any emergent service needs unmet- retrieval and semi-elective inter-hospital transfer data by discipline
- Costing by discipline of referrals out of region
- Calculated savings/ expenditure by referral per annum by discipline

In terms of community disease burden:

- Possible preventable hospitalisation by DRG code
- Current community MBS presentations

In terms of consumer engagement:

- Satisfaction ratings with medical services
- Unmet demand for services

In terms of market analysis:

- Major risks or threats noted from medical workforce (qualitative and/or quantitative)
- Attrition, attraction and retention trends
- Training posts-advanced skills posts available and training posts delivered

The concept of a doctor being ascribed the title of Rural Generalist, without specific credentialing, remuneration or recognition was a solution to a much more complex, chronic problem than could be addressing by so doing. As a result, various organisations have laid

claim to the awarding of the title and to the training of doctors choosing to undertake a variety of clinical jobs all with the nominal title of Rural Generalist. We have seen the effects of multiple organisations all working in the same space but with competing organisational needs and priorities. Much of the work to date in WA has been to ensure effective communication channels so that agencies can work together towards a common goal, of building a vibrant sustainable rural GP and RG workforce. This means having a shared set of values and common purpose, challenging work when there are disparate funding sources and competing organisational agendas.

The conceptual foundations for WA Rural Generalist training

RG exists to serve the needs of rural and remote communities across WA. The foundations below form the solid basis for the RG conceptual framework[1].

Foundation	Description
Safe quality care through safe quality training	RG training aligned with health care delivery that is relevant and responsive to patient need
Workforce distribution by location and vocation	Scope of practice matched to community healthcare plan informed by patients' health needs
Community and Training facility partnerships with reciprocal respect	Governance recognises the central role that patients and communities play in RG training
Value based resource allocation	Targeted resourcing made available based on community need, patient health outcomes and scope of practice
Data driven timely interventions	Communities actively involved in delivery of RG training and workforce planning at a local and national level

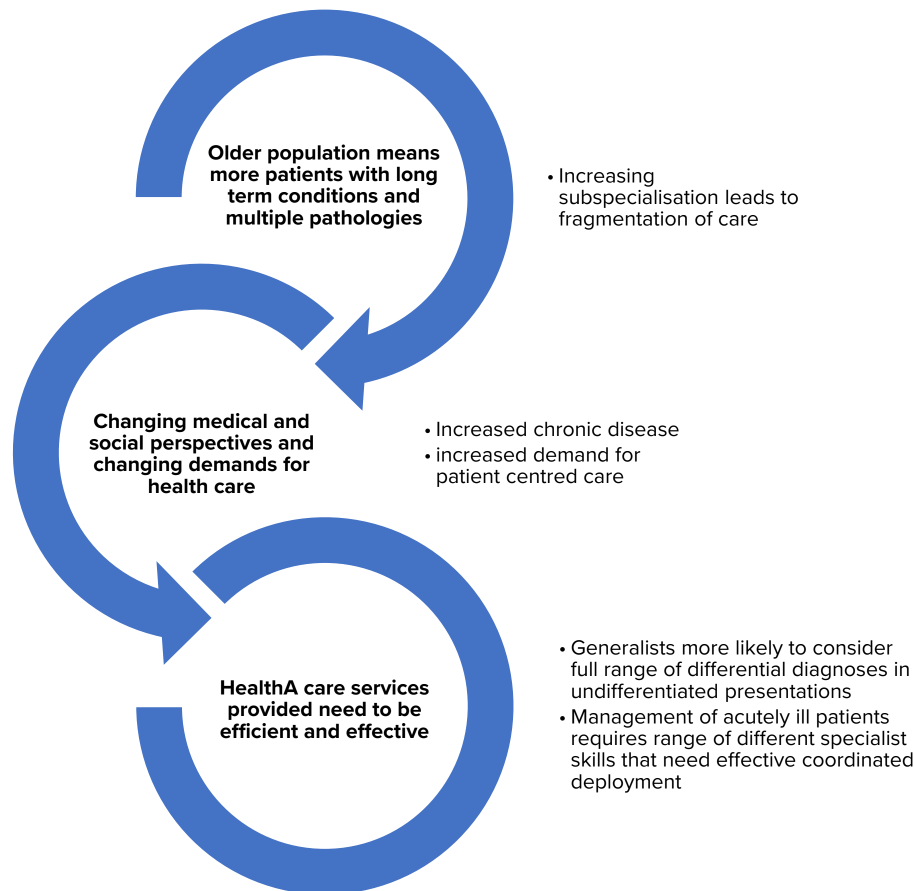
The case for Rural Generalism in Western Australia

Well-functioning health systems are dependent on a foundation of high performing primary care[2]. The growth of non-GP specialists (4.5% per year) continues to outpace the growth of GPs (3.5% per year) despite worldwide evidence that health care systems with a strong primary health care system function optimally[3]. It has been suggested that a system in which at least half of its specialists are primary care doctors provides better health outcomes at lower cost[4].

Subspecialisation leads to fragmentation of care and this will lead to greater problems in the health system, particularly as our population ages. An older population means more patients with long term conditions and multiple pathologies. Any new condition in an older person is likely to be associated with an already existent one. Chronic illness means continuity of care is essential.

[1] From WAGPET Business Strategy. Available at: http://www.wagpet.com.au
[2] Key Components of a well-functioning health system. WHO. Accessed at https://www.who.int/healthsystems/EN_HSSkeycomponents.pdf?ua=1
[3] ANZ-Melbourne Institute Health Sector Report. Accessed at: https://melbourneinstitute.unimelb.edu.au/__data/assets/pdf_file/0011/3809963/ANZ-Health-Sector-Report-2021.pdf
[4] WONCA Rural Medical Education Guidebook, Chapter 1.2.6 Health Outcomes and the balance of primary care physicians vs specialists

Generalists are more likely to consider the full range of differential diagnoses. Our health system needs general practitioners capable of managing the breadth of illnesses that present in the community and competently deploying the specialist skills and resources needing to manage the acutely ill patients requiring secondary care.

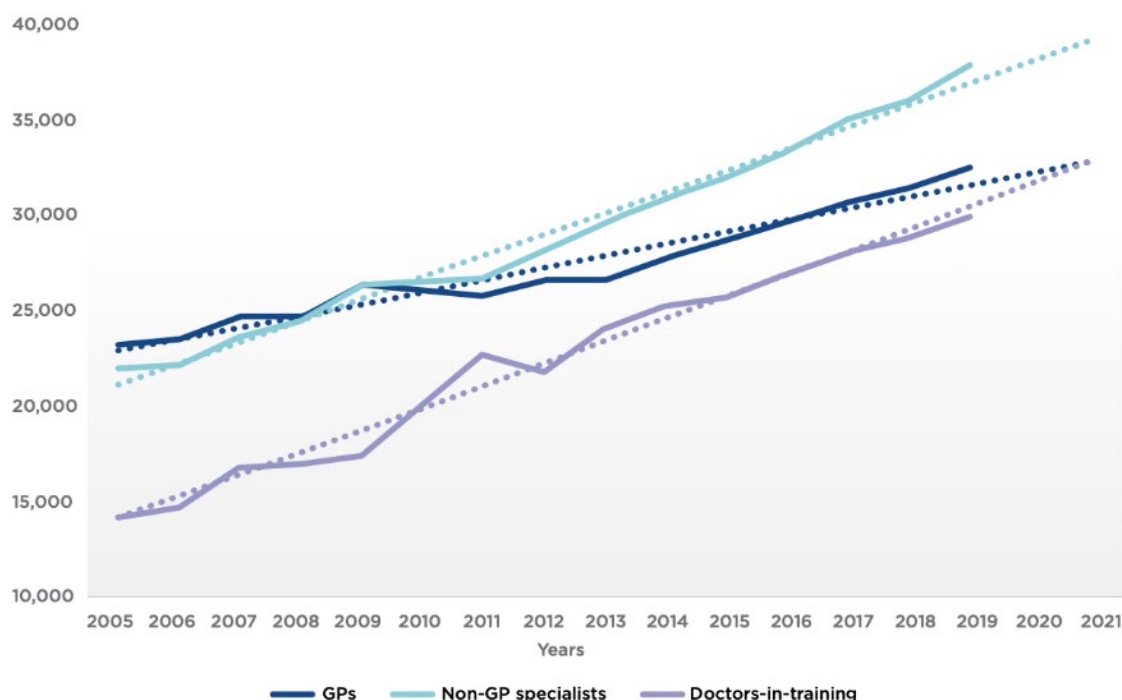


In order for general practice to work optimally it requires effective integration between primary and secondary care. Without such interconnection, the system will work less efficiently and effectively. Tension within the system creates a new equilibrium but with unintended and unforeseen consequences. The new equilibrium may look unchanged on the surface but over time balance is eroded and the tensions become entrenched and an unhealthy and less stable balance results.

Over several decades, blunt government policy drivers designed in part to manage the health care budget by reducing GP over-servicing in some urban centres unintentionally led to rural and remote health care needs being significantly and chronically underserved. We now have maps drawn up linking the student or doctor, training activities and organisations involved and multiple rural programs. On the ground many of these programs appear to be delivered synergistically but the multiplicity and expectation violations threaten most, diminishing their overall effectiveness.

The case for change in Western Australia

Figure 1. Number of doctors 2005 to 2019 (linear projections to 2021).



Source: Health Workforce Planning Tool, Department of Health.

WA has the lowest regional and remote GPFTE per 100,000 population of 91.1 compared to the national number of 101.1[5].

WA

	2019	2018	2017	2016	2015	2014	Growth/change (last 2 periods)	Growth (CAGR)/ change all periods
Number of GPs (primary state)	**3,881**	**3,840**	**3,741**	**3,604**	**3,392**	**3,256**	**1.1%**	**3.6%**
VR	*3,110*	*2,995*	*2,846*	*2,700*	*2,531*	*2,433*	*3.8%*	*5.0%*
Non VR	*366*	*467*	*571*	*606*	*555*	*548*	*-21.6%*	*-7.8%*
GP Trainee	*405*	*378*	*324*	*298*	*306*	*275*	*7.1%*	*8.0%*
Number of GPs (multi state)	4,170	4,090	3,996	3,826	3,626	3,483	2.0%	3.7%
Number of GPs (primary state) per 100,000 population	148.0	147.9	145.0	141.0	133.5	129.3	0.1	18.7
Number of GPs (multi state) per 100,000 population	159.1	157.6	154.9	149.7	142.7	138.3	1.5	20.7
GP Full Time Equivalent (GPFTE)	**2,839.1**	**2,698.1**	**2,578.2**	**2,457.5**	**2,276.7**	**2,155.9**	**5.2%**	**5.7%**
VR	*2,394.0*	*2,224.6*	*2,105.5*	*1,986.3*	*1,838.4*	*1,767.3*	*7.6%*	*6.3%*
Non VR	*236.6*	*290.0*	*314.7*	*331.5*	*302.8*	*273.5*	*-18.4%*	*-2.9%*
GP Trainee	*208.5*	*183.5*	*158.0*	*139.7*	*135.5*	*115.1*	*13.6%*	*12.6%*
GPFTE per 100,000 population	108.3	103.9	99.9	96.2	89.6	85.6	4.4	22.7
Regional & remote GPFTE	514.5	505.0	491.0	468.0	447.0	429.0	1.9%	3.7%
Regional & remote GPFTE per 100,000 population	91.1	89.5	86.8	82.9	78.6	75.3	1.6	15.9
Female GPs (% primary state)	46.8%	45.6%	44.8%	43.8%	43.7%	43.0%	1.2%	3.8%
Female GPFTE (%)	38.5%	37.9%	36.8%	35.8%	35.0%	33.7%	0.6%	4.9%
Number of Services by GPs	16,005,372	15,462,832	14,689,136	14,057,667	13,174,674	12,491,045	3.5%	5.1%
Number of Services by GPs per population	6.1	6.0	5.7	5.5	5.2	5.0	0.1	1.1
Number of Services by GPs to patients aged 65 years+	4,455,617	4,257,632	3,998,444	3,776,221	3,513,022	3,327,493	4.7%	6.0%
Number of Services by GPs per population aged 65 years+	11.5	11.4	11.1	10.9	10.5	10.3	0.1	1.2
Population ('000)	2,621.5	2,595.9	2,580.4	2,556.0	2,540.7	2,517.6	1.0%	0.8%
Population aged 65 years+ ('000)	388.7	374.3	359.9	346.5	334.4	323.0	3.9%	3.8%
Population in regional & remote ('000)	564.5	564.2	565.5	564.4	568.7	570.0	0.1%	-0.2%

WAGPET GP registrars have had a positive impact on the rural GP workforce in WA, with 26 GPs (22.6% of arrivals) joined the permanent rural general practice workforce from the WAGPET GP training program, in 2019[6].

[5] General Practice (GP) Workforce providing Primary Care services, Australia, State and Territory - Statistics by calendar year. Accessed at: https://hwd.health.gov.au/resources/data/gp-primarycare.html

[6] There were 20 registrars staying on in rural WA when Fellowed or 10.4% of arrivals in 2017, 26 or 20.0% in 2018 and 26 or 22.6% in 2019. Rural Health West Annual Workforce Update, November 2019. Accessed at: https://ruralhealthwest01.blob.core.windows.net/www-production/docs/default-source/marketing/publications/annual-workforce-update-november-30-2019-final_21072020_complete_lr.pdf?sfvrsn=2

Table 1 Rural GP numbers by primary model of service provision 2018 v 2019

Primary model of service provision	2018	2019	Difference	
Resident GP	486	486	0	*0.0%*
Fly-in/fly-out and drive-in/drive-out*	133	135	2	*1.5%*
Member of a primary health care team**	46	46	0	*0.0%*
Hospital-based GP (DMO/SMO)	59	62	3	*5.1%*
GP registrar	112	115	3	*2.7%*
Other	2	3	1	*50.0%*
Total	**838**	**847**	**9**	***1.1%***

* Includes fly-in/fly-out and drive-in/drive-out GPs working for RFDS Western Operations, WACHS (DMOs and SMOs), ACCHSs and private GPs
** Primarily ACCHSs

Excluding WAGPET GP registrars, the turnover in the permanent rural general practice between 2018 and 2019 was 14.8%, a 1% growth from 2018 (7 GPs) and 108 rural GPs departed the rural general practice workforce (8 more than 2018).

Policy changes have unintended as well as intended consequences. In 2018, towns in the Peel region were re-classified, including outer-metropolitan locations of Alkimos, Bullsbrook, Gidgegannup, Pinjarra, Serpentine and Yanchep (previously classified as MM2 locations and then re-classified as MM1 in 2019).

Table 7 Changes in the permanent rural general practice workforce by region 2018 v 2019

		Movements OUT of rural WA				Movements INTO rural WA				
Region	**N per region Nov 2018**	**Left rural WA**	**Moved to another rural region**	**Total out**	**% departed from region**	**Arrived from outside rural WA**	**Arrived from another rural region**	**Total in**	**N per region Nov 2019**	**% arrived into region**
Goldfields	69	12	1	13	***18.8***	9	0	9	65	***13.8***
Great Southern	86	7	0	7	***8.1***	11	1	12	91	***13.2***
Kimberley	87	21	4	25	***28.7***	16	4	20	82	***24.4***
Midwest	84	20	2	22	***26.2***	10	1	11	73	***15.1***
Outer Metropolitan	35	7	1	8	***22.9***	19	1	20	47	***42.6***
Pilbara	62	12	2	14	***22.6***	9	1	10	58	***17.2***
South West	220	19	0	19	***8.6***	33	2	35	236	***14.8***
Wheatbelt	71	9	2	11	***15.5***	7	3	10	70	***14.3***
Other*	18	1	1	2	***11.1***	1	0	1	17	***5.9***
Overall	**732**	**108**	**13**	**121**		**115**	**13**	**128**	**739**	

* RFDS Western Operations in Jandakot and Indian Ocean Territories

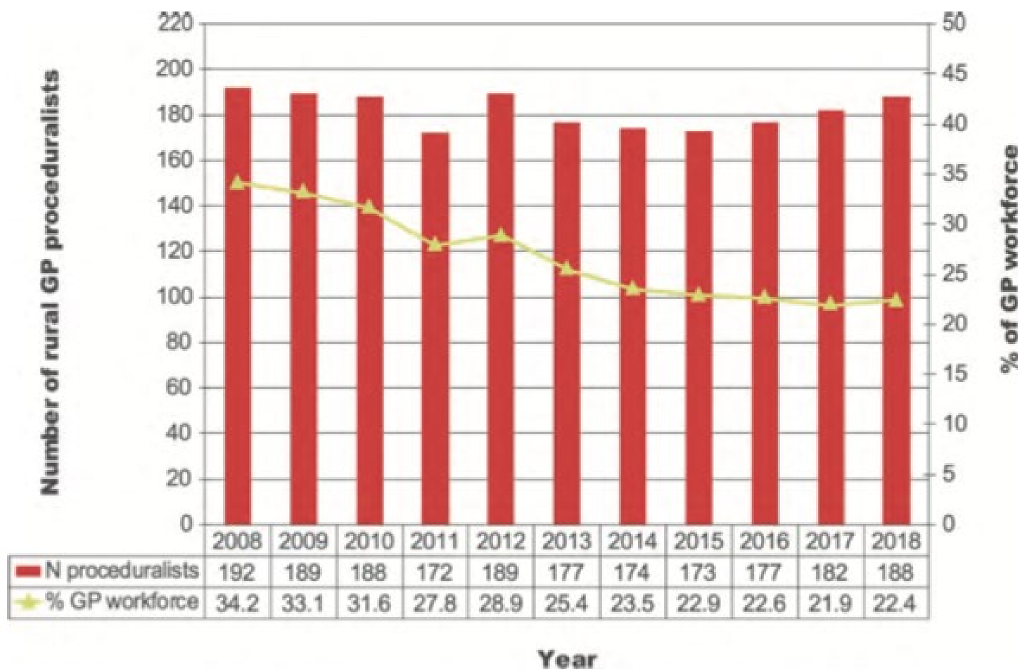
The most common destination for GPs leaving rural WA remained Perth, consistent with previous years. Between November 2018 and November 2019, 108 GPs (14.8%) left rural WA and 13 GPs (1.8%) moved from one rural region to another, totalling 121 GP (16.5%) departures from regions.

The majority of GP movement inwards was to the South West region, which gained 35 GPs (14.8%). The highest proportional inwards movement was into the Outer Metropolitan region, receiving 20 GPs, with 42.6% of their workforce in 2019 being new arrivals.

There were 193 rural GP proceduralists as at 30 November 2019, 5 more than in 2018.

Encouragingly the GP proceduralist proportion of the overall workforce rose by 0.5% in 2018 to 22.4%.

Figure 13 Number and proportion of rural GP proceduralists 2008 to 2018



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
N proceduralists	192	189	188	172	189	177	174	173	177	182	188
% GP workforce	34.2	33.1	31.6	27.8	28.9	25.4	23.5	22.9	22.6	21.9	22.4

Western Australia has among the lowest specialist to population ratios in Australia, with inequitable distribution between metropolitan and rural areas. Medical workforce shortages and lack of access to specialist care tend to increase with geographical remoteness, impacting on the health and wellbeing of people in rural and remote areas[7].

Imbalance across medical specialties can have a direct cost to the health system with supplier induced demand. The costs of health care are increased for rural and remote communities, particularly in consideration of the costs of ambulance travel and loss of income due to length of stay in hospital.

[7] Medical Workforce Report WA 2015-16.

Services delivered and related indicators	2018–19 Target	2018–19 Actual	Variation (actual minus target)
Aged and continuing care services			
1. Average cost of a transition care day provided by contracted non-government organisations / service providers	$348	$312	-$36
2. Average cost per home-based			
a. hospital day of care	$319	$291	-$28
b. occasion of service	$119	$129	$10
3. Average cost per day of care for non-acute admitted continuing care	$710	$714	$4
4. Average cost to support patients who suffer specific chronic illness and other clients who require continuing care	$27	$22	-$5
Palliative and cancer care services			
5. Average cost per client receiving contracted palliative care services	$7,323	$5,898	-$1,425
Public Health Services			
6. Cost per person of providing preventative interventions, health promotion and health protection activities that reduce the incidence of disease or injury	$38	$45	$7
Patient transport services			
7. Cost per trip for road-based ambulance services, based on the total accrued costs of these services for the total number of trips	$433	$455	$22
Policy and corporate services			
8. Average cost of Public Health Regulatory Services per head of population	$4	$6	$2
9. Average cost per full time equivalent worker to undertake the System Manager role of providing strategic leadership, planning and support services to Health Service Providers	$5,069	$5,090	$21

WA has had the fastest population growth in Australia between 2001-2011 with an estimated 24% growth in population and the population continues to grow. High population growth implies a higher demand for medical services, particularly in areas such as outer metropolitan and in Mandurah. In 2011 WA also had the second highest proportion (after the Northern Territory) of its resident population residing in remote and very remote locations. Aboriginal and Torres Strait Islander peoples make up 3.4% of the total WA population and have the greatest health needs of any group[8].

Potentially preventable hospitalisations (PPHs) are those hospitalisations considered as potentially able to be prevented through timely and accessible, quality primary and community based care (Falster and Jorm 2017). In Australia, the relationship between Primary Health Care (PHC) and PPHs is influenced by socioeconomic factors, geographical location, lifestyle factors and factors such as the coordination of care between primary, secondary and tertiary services. (Erny-Albrecht, Oliver-Baxter & Bywood, 2016; Falster et al 2015; Roos et al 2005).

In 2019 a study was published looking at the geopgrahical variation[9] in primary healthcare service utilisation and potentially preventable hospitalisations.

Lower PHC service utilisation and higher PPHs/ hospitalisations:	**Higher PHC service utilisation and higher PPHs/ hospitalisations:**
• Located mostly country areas • Lower GP ratio • Further from hospital ED • More socio-economically disadvantaged • Larger proportion of Aboriginal residents	• Further from hospital ED • More socio-economically disadvantaged • Slightly higher proportion of Aboriginal residents

[8] Medical Workforce Report 2015-16.

[9] Geographic variation in primary healthcare service utilisation and potentially preventable hospitalisations in Western Australia, Curtin University March 2019

Lower PHC service utilisation and lower PPHs/ hospitalisations:	Higher PHC service utilisation and lower PPHs/ hospitalisations:
• Scattered across WA • Postcodes in Perth likely to be least socio-economically disadvantaged with low proportions of Aboriginal residents • Country areas, socio-economic status varied widely. Tended to have low proportions of Aboriginal residents and low GP ratios	• Mostly located in Perth metropolitan area and Southwest region • Least socioeconomically disadvantaged in the state • Low proportion of Aboriginal residents

Rural populations face several issues in terms of their health and hospitalisation:

- They are at higher risk of chronic diseases but have less access to PHC services
- They are more likely to be admitted for inpatient observation and management if they live a longer distance from home
- They often struggle to maintain a regular GP who knows them and the services available in the area.
- There may be a lack of alternatives to hospital admission, for example inability to arrange IV antibiotics and/or chemotherapy and other hospital in the home type services
- There may be fewer culturally appropriate services for Aboriginal and Torres Strait Islander patients which may then result in lower PHC utilisation, despite high levels of needs

What is a Rural Generalist?

A Rural Generalist is a GP who provides continuity of care across the spectrum of health care, working in the community or local hospital as necessary. The Collingrove Agreement[10] more specifically declared –

> A Rural Generalist is a medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a sustainable and cost-effective way by providing both comprehensive general practice and emergency care and required components of other medical specialist care in hospital and/or community settings as part of a rural healthcare team.

The Report to the National Rural Health Commissioner in November 2019 argued a number of core principles that could be delivered contextually, and therefore potentially differentially across not only Australia but across rural regions as well as towns. Rather than adopting the QRGP unreflectively, many sought to learn from its success and setbacks. The National RG pathways idea was born[11].

For the Rural Generalist, vocation and location are intrinsically and dynamically bound, unlike other specialties where vocation is the primary (training) consideration and location a secondary (employment) decision. We must combine training and employment, vocation and location as well as maintain the balance between both.

[10] The National Rural Health Commissioner Communique 1 (2018). Accessed at: https://www1.health.gov.au/internet/main/publishing.nsf/Content/2922D6D8BBCE122FCA2581D30076D09A/$File/National%20Rural%20Health%20Commissioner%20-%20Communique%201-July%202018.pdf

[11] Appendix 1 provides a comparison of the NRGP and WARG.

Rural Generalists do not replace rural general practitioners. They span the interface between primary and secondary care and need to be able to work seamlessly between primary care, community-based settings and hospital settings, ensuring their work is integrated with and alongside their GP and non-GP specialist colleagues. When the lens is shifted away from clinical service delivery to the patient journey, the role of the RG becomes clearer, as a scaffolding to enable community based primary care and secondary and tertiary care to be delivered in a well-integrated manner, that is patient centred and cognisant of community health needs and patient outcomes.

Ensuring a community-centric approach to Rural Generalist training

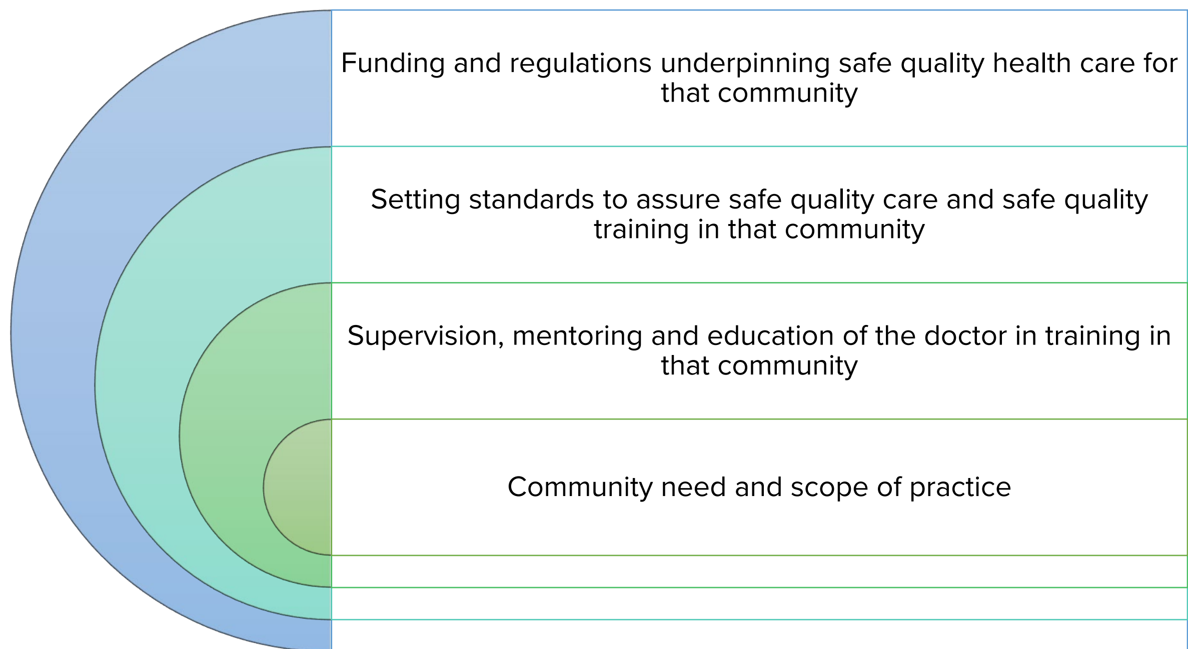
RGs span the interface between primary and secondary care. In doing so, this means that it may be possible to avoid patients using the high-cost intensive service of inpatient care as a substitute for lack of appropriate care in the community. But we need to ensure that RGs remain GP focused in nature, providing the continuity of care across the spectrum of health care, matched to each community's needs. This requires a community-centric approach to RG.

Starting with the community-centric approach, we can then better:

1. Define what are and are not Rural Generalist health services
2. Define a Rural Generalist for more inclusively than a jurisdictional or college purpose
3. Identify, respect and reward the inherent characteristics of a medical practitioner so embedded in the services and the changing services the community requires
4. Recruit, select, train, remediate, accelerate, assess those who have this community-centric approach to their vocation above and beyond a set of competencies
5. Remunerate-and with political will on our side-those who so clearly pivoted to where their services are needed compared with those who have not done so

The governance for RG training has become even more complicated with the minister announcement in 2017 that the GP colleges would lead GP training, including RG training. The department then contracted the jurisdictions in 2020 to coordinated RG training, but not to deliver it. The governance model for RG training, designed around the community needs and the required scope of practice is yet to be agreed on, particularly in terms of community-centric governance.

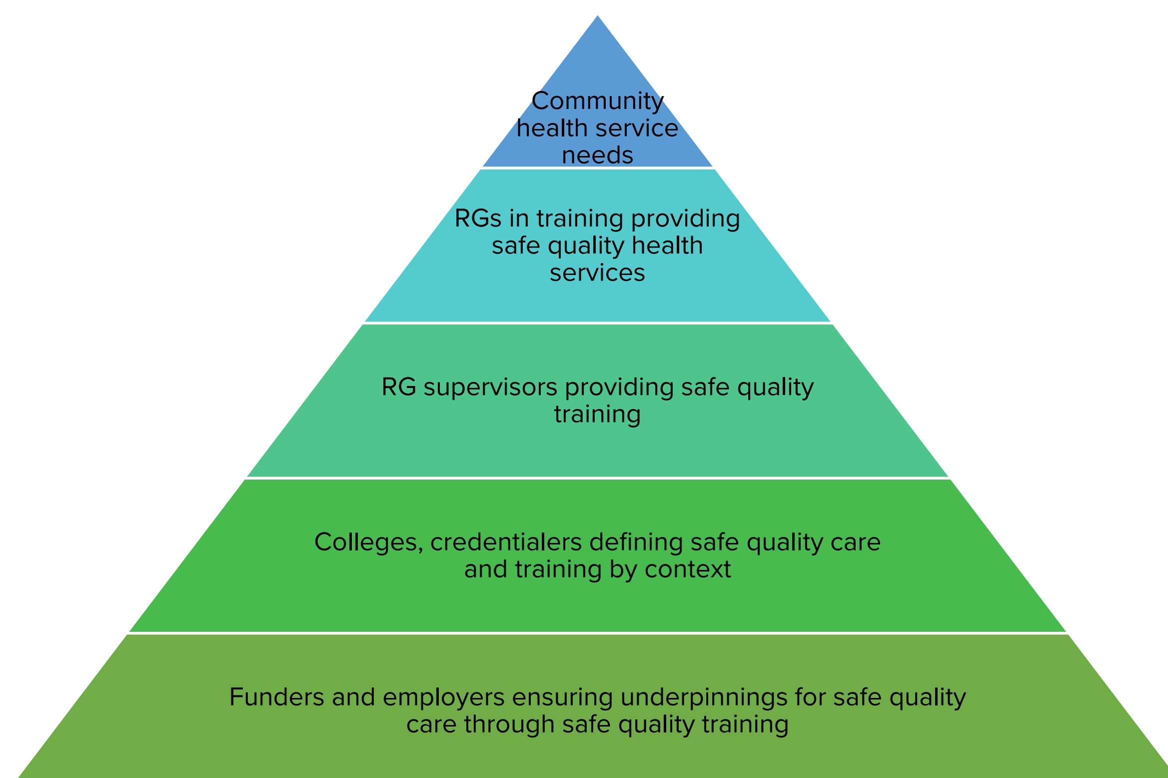
With respect to RG training, community-centric governance means that everything decision, risk, responsibility, accountability, funding, standards, policy – and even sanctions – can be understood by and from any other viewpoint on the governance map.



Community-centric governance would mean 'nothing about us without us' but also that the community would know about – and directly or indirectly set the value proposition for – GP training in their community and would start with the health service needs they need met – either in their area by local health services or by some other means. The community would likely prefer the former but as long as the latter provides safe, quality, accessible, affordable care they are likely to accept a compromise. What is provided locally and what is not needs to be negotiated within each community. a community can be a small as a local practice, and as large as a town or region. Catchment decisions can be made using quantitative and qualitative data, and sources include health usage data, clinical services plans and local opinion.

To understand the governance role and place of all contributors to RG training, we need to think in 3D. Every party will have a primary governance role but will impact the authority, responsibility and accountability of every other party – in fact without both the direct and indirect contributions the governance will fail. If a party exceeds its direct governance role, it risks distorting the purpose, the priorities and thus the outcome of the joint enterprise.

Imagine for each contributor the slice of the cake as it presents to them v another contributor.



The place of the RG-in-training or registrar-in-GP-training governance

At the next most intimate governance level for RG training the community is represented by the patient who is seeing a RG-in-training. The RG-in-training has the authority, responsibility and accountability to see patients in the community while being supervised. This will influence how objectives are set, risk is monitored and performance optimised. The RG-in-training thus needs –

a. To have been judged a safe pair of hands to deliver patient services in that context under agreed supervision provided in that context;
b. To be supervised to provide safe quality care to their patients with that supervision dependent upon the capability of RG-in-training and the complexity of the patient being seen;
c. To be upskilled as much as possible prior to seeing the patient, so not every patient encounter requires intensive supervision for being a de novo event;
d. A supervision team or supervision cascade adapted to context so the patient service remains central, not limited by the availability of rigidly deterministic support;
e. A support network for when the supervision or any other aspect of the placement threatens their safe quality training or their ability to deliver safe quality care;
f. A credentialing college or organisation that defines safe quality care and who can deliver that under what adaptable contextual and supervisory conditions;
g. A college that defines and accredits what is and is not safe quality care and safe quality training in a way that is contextually appropriate and sensitive;
h. A funder or employer that rewards services provided to the patient by the RG-in-training, by the supervisor, the educators, the placement support service and the college.

So looking it another way, and by example only –

Jurisdictions might have the primary authority, responsibility and accountability to fund / to be reimbursed for the services being provided and to ensure they are safe quality affordable and accessible services for that community. They would have the primary the primary authority, responsibility and accountability for choosing their employees and credentialing all *positions* offered by their service. Jurisdictions might have a secondary role in helping to identify community health needs, scope of practice required and sustainable models of healthcare for each community.

Private general practices might have the primary authority, responsibility and accountability to decide who and how many RGs-in-training to take on, under what conditions, and with what financial and non-financial support. They will make these decisions in part on community need – the practice business case – and the scope of practice and expectations of the RG-in-training. The training deliverer has the secondary role of managing this placement choice by both parties.

The universities and training providers might have the primary authority, responsibility and accountability to prepare and assess the RG-in-training, assisting with their pre-placement experience and competence, career navigation and placement choice so they can provide from day one safe quality affordable and accessible services for that community under supervision. Training providers may have a secondary role of providing training support during the placement to support both the RG-in-training and the facility where they are working.

The supervisors and educators might have the primary authority, responsibility and accountability to prepare, mentor, advise, educate, train, and assess the RG-in-training. The facilities might have the secondary role of providing the supervisor or supervisory team with the resources they need to undertake this role with quality, safety, accessibility and affordability in mind.

The colleges might have the primary authority, responsibility and accountability to define what safe quality care any RG and RG-in-training could be expected to deliver and is – and is not – RG quality training. The colleges would credential the RG when their training was completed successfully. They may have a secondary role in contextual credentialing, recognising that the competence or fellowship of a doctor does not singularly ensure a particular health service can be delivered in every context by that doctor.

Advocacy groups will typically choose a 'ring' in which they will hold the primary authority, responsibility and accountability to account. It may be the community in various ways, the RGs-in-training, the facilities, the colleges, the training support services, the employers, or funders. Sometimes advocates will choose multiple rings in which to focus their calls for a redress or change in priorities.

The Western Australia Rural Generalist Program (WARG)

The WA Rural Generalist Program (WARG) trains Rural Generalists in WA, providing integrated, comprehensive, accessible and responsive training to address the gap in health care to the people in WA, rural, regional and remote communities. The intention of WARG is to provide community responsive, patient centred clinicians, providing optimal patient health care where it is needed the most.

The design of WARG takes into consideration the underpinning principles of established RG program such as the Queensland Rural Generalist Program including the consideration of context and community need.

WARG leverages a workforce predominantly training and practising in community primary care settings and providing support to secondary settings. The program is based on recognition of the distinct skillset generalists bring to the rural environment including development of complex clinical reasoning skills and maturity of decisions surrounding evaluation of care in rural environments.

WARG helps to deliver skilled rural GPs and RGs capable of managing the breadth of illnesses that present in the community and competently deploying the specialist skills and resources needing to manage the acutely ill patients requiring secondary care.

The key elements of QRGP [12]that have been transferable to other jurisdictions are reflected in WARG:

1. Engagement and agreement from key stakeholders through implementing integrative processes and structures
2. Quarantined training places for rural trainees and implementation of strategies that aim at retaining doctors in rural and remote communities, including rural GPs who wish to maintain a commitment to their rural and remote hospital services
3. An integrated, coordinated and supportive system for the selection, training and placements of trainees, coupled with
    a. Appropriate orientation to primary health care practice
    b. Provision of range of training environments to enable the development of a responsive and flexible primary care workforce with the range of skills to meet the needs of the community
4. Employment arrangement by defining the role of the RG within professional and employment structures
5. Adequate resourcing to cover all aspects of training and support for it
6. Arrangements for training and credentialing of trainees that are agreed by all relevant bodies
7. A high level of vocational support to rural trainees throughout their training
    a. Career counselling
    b. Career planning
    c. Sympathetic placements
    d. Active problem solving

Doctors enrolled in WARG have access to:

- Advisory and support service of experienced medical and administrative staff to assist junior doctors
- Quarantined training opportunities providing access to priority term-paediatrics, obstetrics and anaesthetics
- Attendance at procedural skills workshops for PGY1 and PGY2
- Support and advice regarding Advanced Skills Training posts

---

[12] The Queensland Rural Generalist Program 2005-2015. Accessed at: http://ruralgeneralist.qld.gov.au/wp-content/uploads/2017/07/2015-lennox-his-rep.pdf

- Possible access to SMO pay rates as provisional Fellow based on merit selection, completion of prevocational skills and advanced specialised training in nominated discipline matched to the PD of the prospective position.

The Western Australia Rural Generalist Program (WARG) was implemented in 2018, with consideration of:

- Differences in population dispersion
- Number and capacity of rural hospitals
- Case throughput
- Access to specialist workforces
- Number and remuneration for training positions
- Local mechanisms for employing doctors to provide procedural services in rural hospitals.

There have been 269 RG trainees in WA throughout the last two decades (1998-2020).

'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09	'10	'12	'13	'14	'15	'16	'17	'18	'19	'20
1	4	11	4	4	14	7	11	8	9	10	15	12	20	12	17	13	8	14	13	15	47

Data source: WAGPET

RG trainees in WARG include trainees enrolled in the general as well as rural pathway:

Pathway	Curriculum	Total
General	FACRRM	3
	FRACGP	12
	FRACGP & FARGP	7
Total General pathway RG		**22**
Rural	FACRRM	33
	FRACGP	21
	FRACGP & FACRRM	1
	FRACGP & FACRRM & FARGP	1
	FRACGP & FARGP	9
Total Rural pathway RG		**65**
Grand Total		**87**

Data source: WAGPET

A total of 109 RG trainees have obtained their Fellowship (up to August 2020):

Pathway	Curriculum	Total
General	FACRRM	4
	FRACGP & FACRRM	2
	FRACGP & FACRRM & FARGP	1
	FRACGP & FARGP	23
Total of General Pathway fellowed RG		**30**
Rural	FACRRM	15
	FRACGP & FACRRM	12
	FRACGP & FACRRM & FARGP	6
	FRACGP & FARGP	46
Total Rural Pathway fellowed RG		**79**
Grand Total		**109**

Numbers of fellowship processed for RG by fellowship year:

Fellowship year	Number of RGs fellowed
2010	7
2011	4
2012	6
2013	9
2014	15
2015	11
2016	20

Fellowship year	Number of RGs fellowed
2017	10
2018	11
2019	2
2020 (up to August 2020)	1
Grand Total	**109**

There are currently 43 advanced skills posts accredited for RG training and WARG:

- Emergency medicine
- Obstetrics & gynaecology
- Palliative care
- Emergency
- Anaesthetics
- Paediatrics
- Aboriginal Health
- Psychiatry
- Royal Flying Doctors (retrieval medicine)
- Mental health
- Surgery

WAGPET works actively to promote Rural Generalist training in WA:

- A dedicated rural hospital Program Training Advisor is employed at WAGPET to work closely with GP liaison officers based in the health services. This PTA works closely with the GP liaison officer at each hospital and assists with recruitment of junior doctors into WARG and career navigation for medical students and junior doctors;
- Case management approach;
- Recruitment of a RG Regional Medical Educator and Registrar Liaison Officer;
- MOU in place with WACHS, the Rural Clinical School Rural Health West, St John of God hospital, Curtin Medical School and Armadale Health;
- Dedicated website for WARG and collateral (updates to made to website);
- As part of WAGPET's on-boarding process rural intent is identified early and each registrar that has indicated rural completes a career navigation meeting;
- As part of the priority placement process each registrar that has indicated a priority start regardless of pathway is encouraged to take a rural opportunity;
- MEDFEST;
- Regular REPS workshops;
- WAGPET attends stakeholder meetings rurally such as the Pilbara Health Network to collaborate on attraction and retention strategies and support packages to ensure sustainability;
- WAGPET has engaged in career navigation discussions with both registrars and pre-vocational (expression of interest) level. New cohorts are being asked to complete a Training Commencement Plan which gives better insight on what their training intent are. A career navigation discussion will then be had with the registrar to direct them to where their intended skills are more appropriately practiced according to community needs and the registrar's training needs;
- WAGPET introduced an updated Rural Support Payment Policy effective from Semester 1, 2021. The new policy leads a more equitable model which recognises greater community needs by incentivising harder-to-fill-areas to attract registrar's placements;
- WAGPET has streamlined the AST/ARST application process and work together with the hospitals to forward the interested GPRs' application.

The right doctor in the right place with the right scope of practice

RGs do not work in isolation of their colleagues in both community-based general practice, and their non GP specialist colleagues and GP specialist VMO colleagues in hospital settings. Ensuring that there is collaboration and synergistic teamwork requires understanding of what infrastructure needs to be in place to support RGs but also what each community needs in terms of clinical service delivery. An RG is not a hospitalist doctor working in general practice or a GP with specific interests or additional procedural skills. Unless this is recognised we run the risk of duplicating what we currently have in terms of a locum workforce, doctors working in general practice without specialist GP recognition, and a career medical officer workforce with no defined career pathway. RG trainees need to know there will be a clearly defined job at the end of their training which recognises the specialist qualification of RG.

The emergence of RG training nationally is being proposed as a possible solution to address the imbalance between generalism and subspecialist practice and to address the medical workforce maldistribution. It does afford an important way of ensuring consideration of community need and context, particularly if it retains a strong community-centric approach at its core. Successful implementation of RGs into the workforce is dependent on valuing the importance of practitioners demonstrating appropriate scope of practice in their specialist discipline, especially general practice. The emergence of RGs affords us the opportunity to re-centre general practice and recognise general practitioners working to their full scope of practice, alongside their specialist colleagues and RG colleagues, in an integrated and holistic manner. What will be of concern is if the RGs are practising in competition with their rural GP and non-GP specialist colleagues.

We have increasing number of interns and prevocational doctors yet to enter specialty training[13]. More demand for specialist training places and increasing complexity in the nature and type of jobs required of the medical workforce in hospital and community care has led to expansion in career medical officers in the hospital setting and locum workforce in both hospital setting and community-based specialist practice, including general practice. This has occurred at the expense of generalist practice and at the expense of being responsive to the changing health status and health needs of our communities. The health system has become dis-integrated, separatist in design and less comprehensive and less able to address the gaps in health care, particularly for rural and remote communities.

There are a range of jobs medical practitioners may undertake for a rural or remote community, including management of acutely ill patients, retrieval medicine and continuity of medical care that is responsive to community needs. The type of medical practitioner may vary but the jobs remain the same. However how the job is undertaken varies depending on the practitioner (GP-specialist vs non-GP specialist vs RG), with variation in terms of quality of care provided, cost and resource utilisation.

The appropriate configuration of medical skills and workforce numbers needs to be responsive to the changing health status of the community it serves. The right mix of primary versus secondary based medical workforce as well as RG is dependent upon the infrastructure in place supporting the workforce. An RG trainee who is developing additional skills in surgery for example, needs to know that the smaller rural town he intends to work in will have the infrastructure, including patient load, to support maintenance of his surgery skills. RG trainees, like all doctors in training, need to know the job they will be expected to do for the community they serve. No single workforce solution operating on its own, is sufficient to address the complex medical workforce needs of rural and remote Australians and their communities.

---

[13] Scott A. The evolution of the medical workforce. ANZ-Melbourne Institute Health Sector Report, 2021. Accessed at: https://melbourneinstitute.unimelb.edu.au/__data/assets/pdf_file/0011/3809963/ANZ-Health-Sector-Report-2021.pdf

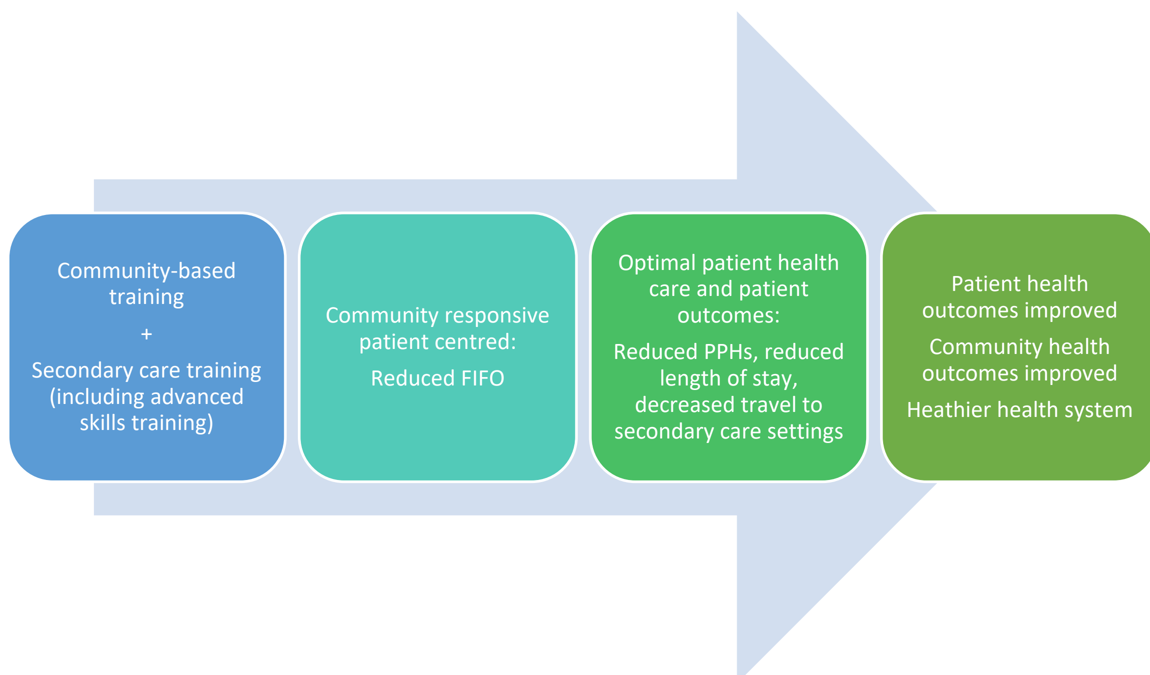
Not every town in rural Australia will need an RG, but every town needs to know that the clinical services being delivered are appropriate to the needs of the local community. In order to determine the appropriate balance in terms of medical workforce requirements, GP, RG and non GP specialist workforce in alignment, there needs to be coordinated planning and workforce mapping across the whole of the health system and medical workforce sector. This is a shared care model responsibility across Commonwealth and State.

An RG trainee has to navigate through their career pathway, fulfilling their training requirements, including the RG state-based training requirements and those of AGPT. WARG has made that journey more streamlined and personalised in approach, ensuring the passage is as smooth as possible, depending on local collaboration, cooperation and goodwill between health services and training practices, WAGPET and WACHS. The strength of these relationships act as a buffer when competing priorities and conflicting policies and processes collide at an institutional level.

There is still work to be done to ensure RG training is fully community-centric. When one organisation/institution starts to assume more responsibility, or authority in terms of the program in terms of supervision, education, financing, regulatory or policy responsibility, this will have direct impact on the governance framework and threaten the community-centric approach.

Ensuring effective implementation of RG training in WA, requires consideration of the healthcare system as a whole and the interrelationships between Federal and State, in terms of funding sources and health care mapping and mapping of the clinical services required and required scope of practice. Mapping the scope of practice, particularly in relation to continuity of care, is needed to determine the number and type of GPs and RGs required, in terms of community-based care, GP and non GP proceduralists and hospital based doctors, and non-GP specialists.

The metrics for measuring success of RG training in WA need to be measureable in terms of improvement of patient and community health outcomes.



The patient health experience in terms of navigating the health care system can then be matched with the doctor-in-training experience and the degree to which these experiences are healthier and happier, in terms of ease of navigation and more seamless integration between different settings and better community-based and hospital based healthcare.

There are proposed plans to introduce a single employer model for RG training, replacing the current employment arrangements that define the role of the RG within professional and employment structures. This needs to be done with consideration of community at the centre of governance, otherwise we run the risk of shifting from a central focus of community to focus on industrial relations and the employee-employer relationship.

The emergence of Rural Generalists has put in clear relief the gaps within the system, highlighting the inadequacy of a framework that is institution-centric. Whilst each State and Territory has its own Clinical Services Capabilities Framework for health services, there is no framework that integrates health services AND general practice. This means that the service requirements, workforce requirements, risk considerations and support services in terms of health care cannot be determined in a holistic and integrated manner to inform health service planning and delivery.

Moving to an over-arching community-focused capabilities framework would enable better strategic planning of:

- The types of services needing to be provided
- The nature, including scope of practice and number of providers
- The inter-service/inter-level relationships (e.g. service networking, referral pathways, transfer arrangements and interaction with other services, GPs, RGs, multidisciplinary teams and specialists.

This would then enable design of a Training Capabilities Framework, considering the capabilities we need to build in our future medical workforce, integrating RG into the greater workforce system as a whole.

The emergence of RG started with a governance structure that was more institution-led in design. The QRGP was designed with the initial goal of addressing rural hospital medical workforce [14]. The jurisdiction stepped into the centre of the governance circle, undertaking authority for employment, supervision, education and support as well as determining scope of practice through credentialing. It took some time and lengthy and often tense negotiations between colleges and jurisdiction to resolve the governance issues and define the end-point of RG training in terms of GP specialist qualification.

As RG has progressively rolled out, the importance of ensuring better integration between primary and secondary care was known and relationships between doctor in training and employer, doctor in training and colleges and colleges and regulator has continued to build as a result. The RTOs have maintained a strong focus on ensuring that RG training has strong community-based foundations, keeping the focus as well on community and community needs, in relation to workforce planning and building training capacity. It starts and ends with the patient and their community at the centre.

The design of RG training needs to be based on how it feeds into design of an integrated health system. Placing communities at the core, means using functions rather than roles of structures in the training framework, asking ourselves 'what job does the patient and what job does the community need doing?

The order in terms of design should always be:

- Health outcomes and health service delivery
- Health workforce design, scope and placement

[14] Evaluation and Investigative study of the Queensland Rural Generalist Program. Queensland Health. Office of Rural and Remote Health. February 2013. Ernst & Young. Accessed at: http://ruralgeneralist.qld.gov.au/wp-content/uploads/2017/07/qrgpeval_rpt_feb13..pdf

- Health workforce training
- Health workforce remuneration.

To change the order in any way leads to greater disconnectedness in the health care system and disintegration and competing priorities. This disintegration will play out in terms of disruption on the ground, for doctors in training and for communities.

Appendix 1: RURAL GENERALIST PATHWAYS AND PROGRAMS: A COMPARISON JUNE 2019

The Report to the National Rural Health Commissioner in November 2019 argued a number of core principles that could be delivered contextually, and therefore potentially differentially across not only Australia but across rural regions as well as towns.

The “vocation or location” argument is pre-eminent in this work, because with the Rural Generalist both are intrinsically and dynamically bound, unlike other medical specialties where vocation is the primary (training) consideration and location a secondary (employment) decision. But we know from national AGPT retention studies that registrars stay where they trained post-fellowship, usually for long durations. We must combine training and employment, vocation and location.

For the purpose of this RG training pathway comparison, a Rural Generalist is defined as a primary health care provider with additional skills for working in secondary and tertiary arenas in collaborative networks of other health care professionals, including other specialists. At minimum they can provide emergency and inpatient care in addition to traditional GP services in rural areas.

Note that nationally, currently less than 15% of non-GP specialists live and work rurally. Both the NRGP and WARG can be expanded to include this group but neither has done so at present.

Factor	NRGP	WARG	QRGP
Existing Funding	Co-ordination funding AMC recognition funding 50 prevocational placements p.a. (likely 5 for WA)	AGPT WACHS PMEU Training facilities employment contracts e.g. WACHS JHC SJOG	Queensland Health AGPT
Sought Funding	RG procedural grants programs GPRIPS amendments Rural MBS loadings and adaptations e.g. telehealth Industrial award with AMC and jurisdictional recognition Hospital funding agreements	Out of scope or advocacy	Out of scope or advocacy
Commenced	-	2 years (2017)	12 years (2007)
Candidates	Interns to GP registrars	GP registrars currently but opportunity to include WACHS interns and residents and service registrars (DMOs SMOs)	Interns to GP registrars
Reach	MMM 2 – 7 focus 4 – 7	MMM2 – 7 focus 4 – 7	MMM 4 – 7
End Point / Credentials	FACRRM RACGP-RG but can be expanded to other fellowship endpoints	FACRRM RACGP-RG but can be expanded to other fellowship endpoints	FACRRM (83%) RACGP-RG (41%) Industrial RG award recognition

Factor	NRGP	WARG	QRGP
	Various specialist college recognition e.g. DRANZCOG JCCA	Various specialist college recognition e.g. DRANZCOG JCCA	Various specialist college recognition e.g. DRANZCOG JCCA
Employer	Single employer model recommended from whatever entry point (intern resident registrar)	Multiple employers depending on access to quality training and employment opportunities public private and community	Queensland Health and private and community secondments
Key Elements	AMC RG sub-specialty of GP Equal pay for equal work Continuous professional development Duration of training employment contract or similar Rural vocational training Prevocational rural placements Community based selection RCS and rural medical school experience	Career planning and mentorship Own dedicated program advisor Own regional medical educator On line education program Rural essential skills workshop Training planning meetings Tailored placements Clear and approved clinical governance and supervision models Centralised application process Community orientation Peer network facilities Rural readiness assessment Cultural competence Streamlined handover across different stages of training between agencies Capacity and positions offered based on community demand Post fellowship alumni	Career planning and mentorship Own dedicated program advisor Own regional medical educator On line education program Rural essential skills workshop Training planning meetings Tailored placements Clear and approved clinical governance and supervision models Centralised application process Community orientation Peer network facilities Rural readiness assessment Cultural competence Streamlined handover across different stages of training between agencies Capacity and positions offered based on community demand Post fellowship alumni
Infrastructure	Regional training organisations Existing RG programs Regional training hubs Regional medical programs Rural clinical schools	WAGPET RPP WA WA hubs and STP WACHS interns and CRP RCSWA	GMT and GPTQ QRGP Queensland Health
Participants	350 RGs to be trained p.a. of 750 new AGPT rural GP registrars p.a. Students to FACRRM RACGP-RG	30 RGs to be trained p.a. of 60 new WAGPET rural GP registrars p.a. GP registrars to FACRRM RACGP-RG with natural extension to students to fellows of all relevant medical specialties	Interns to FACRRM RACGP-RG

Factor	NRGP	WARG	QRGP
Principles	High quality training Remuneration Country first for training jobs Community needs based Flexible and adaptive Supportive longitudinal training and career path	Safe quality patient care and medical training Community needs based training and employment positions Technology enhanced training program delivery Incentivising equitable access to registrars across all of rural Enhancing the patient journey across primary secondary tertiary services Valuing the comprehensive (Rural Generalist) skill set and relationship to the expert (specialist) skill set (shared care)	Workforce initiative Community needs based Flexible and adaptive Supported longitudinal training and career path Inter-organisational collaboration
Challenges	Improved access to more services for rural communities Attractive to AMGs RGs trained rurally supported by rural networks	Collaboration Endorsement of the program Recognition of the RG role (business case, AMC recognition) Funding training positions Distribution reflects the need for a vocation in a given location Sustainability (return on investment) Shared care design and implementation	Training jobs match RG intake Training beyond hospitalist role Advanced skills disciplines aligned with community need IMIT infrastructure Refine recruitment selection Retain trained RGs Increase RG supervisors Meet the workforce needs of under-served communities
Facilitators	3x increase in medical students Political will AMC recognition of the sub-specialty (pending)	Curtin medical school and business case AGPT RG policy and contract WARG business case (pending) WARG outcomes (pending)	
Additional Skills Offered		Anaesthetics Obstetrics Emergency medicine Indigenous health Paediatrics Internal medicine Mental health Surgery	Anaesthetics (86) Obstetrics (70) Emergency medicine (38) Indigenous health Paediatrics Internal medicine Surgery

We know that changes in policy can have widespread and longstanding consequences, both intended and unintended. Once a GP registrar trains in a rural region, they tend to stay there for longer than 12 months. As noted in the 2019 RHW Annual Workforce Update[15], "the increased intake of rural GP registrars since 2012 has had a positive impact on the number of trainees continuing to work in rural WA when Fellowed (20 registrars or 10.4% of arrivals in 2017, 22 or 20.0% in 2018 and 26 or 22.6% in 2019)".

[15] Rural Health West Annual Workforce Update November 2019. Accessed at: https://ruralhealthwest01.blob.core.windows.net/www-production/docs/default-source/marketing/publications/annual-workforce-update-november-30-2019-final_21072020_complete_lr.pdf?sfvrsn=2