HEALTHfix consulting

The Rural Practice Pathway WA

Its origins, triumphs and taking the next step

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June 2018

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PURPOSE

This paper seeks to raise the level of understanding of the Rural Practice Pathway (RPP) in WA by describing the history of rural medical training. It aims to clarify what led to the RPP being developed in the way it was and what the achievements have been over the last decade.

It has become clear that few people really understand what the RPP is and its achievements have not been well articulated.

To this end, I have provided the following short fact sheet to describe the RPP and what it has achieved. This is important as the RPP is the collective work of agencies involved in rural medical education and training. It is not profession or college specific nor does it aim to produce a particular skill set.

Rather, the collective group of agencies work collaboratively to offer all doctors wanting to practice in rural areas the support and programs to do so, consistent with the agencies' role.

THE RURAL PRACTICE PATHWAY – FACT SHEET

The Rural Practice Pathway (RPP) is the collective effort of all agencies involved in rural medical education and training. These are WA Country Health Services (WACHS), WA GP Education and Training (WAGPET), Rural Health West (RHW), Rural Clinical School of WA (RCSWA) and WA Primary Health Alliance (WAPHA). Also involved in the Committee are the Australian Medical Association (AMA) Doctors-in-Training and the Postgraduate Medical Council WA (PMCWA). It includes key actions to support a future rural practice career for rural students (RCSWA), junior doctors (WACHS), vocational trainees (WAGPET and specialist colleges) and mentoring for key disciplines (RHW).

The beginning of the Rural Practice Pathway

When it first commenced in 2007, after the completion of wide consultation with over 300 rural doctors under the "Engaging Rural Doctors" report, there was a clear goal supported by all of the agencies **to develop training programs that form a career pathway for doctors at any stage in their career to supply the rural generalist workforce required in rural Western Australia.**

To achieve this goal, the agencies recognised that not only did they need to work together, they also needed to establish some key building blocks that would allow rural WA to begin to grow its own medical workforce, reduce its reliance on metropolitan-based training and ultimately reduce its reliance on overseas recruitment.

All parties realised that this was a medium to long-term investment before real progress could be seen.

In establishing the required building blocks of the Pathway, it initially set out to:

1. Increase the number of accredited training positions of all types in rural WA.
2. Establish WACHS as a Primary Employing Health Service (PEHS) for interns and junior doctors.
3. Attract doctors and new graduates into rural practice.
4. Grow procedural training places for both specialists and GPs.
5. Ensure there was a network of educators and trainers to support rural based medical education and training.

These objectives came with some principles and requirements that the collective group believed needed to be a part of the thinking and delivery of the RPP to be attractive and credible to future rural doctors:

- Pathways are easy to understand, responsive to need, well supported and resourced and involve key stakeholders.
- Two key outcomes at the end of training - there is vocational recognition by the colleges, and the program involved hospital based (public and private), and community based (public and private) training.
- The professional standards and vocational requirement of rural generalist practice are those prescribed by the Australian College of Rural and Remote Medicine (ACRRM), whereas those of rural general practice are prescribed by the Royal Australian College of General Practice (RACGP).
- The program markets and provides for a career path at every point from medical school to rural generalist practice.
- Vocational training will be provided by General Practice Education & Training (GPET). Regional training providers will be rural centric.
- The program is underpinned by mentoring, individual learning and career planning.
- The personal and professional career needs of trainees and their families are accommodated within the workforce.
- Rural generalist trainees have priority access to appropriate accredited Health Department of Western Australia (HDWA) positions, (HDWA integrates service placement with prevocational and vocational training in partnership with training providers).

What has it achieved from 2007-2017?

The collective effort of all the agencies has seen a massive 78% increase in general practitioners working in rural WA from 556 to 992. It has also seen a 25% increase in procedural specialists over this period. This is against population growth of just over 13%.

All agencies have played a role in delivering these outcomes, consistent with their roles and responsibilities. The workforce it has sought to deliver is consistent with the make-up of the rural medical workforce. That is, almost 80% are non-procedural GPs providing traditional primary health care and keeping people well and out of hospitals.

1. It has seen a 183% increase in WA GP trainees working in the rural medical workforce (54 to 153), knowing that a GP is four times more likely to remain in the practice in which they last trained (WAGPET).
2. A threefold increase in the number of medical training positions throughout rural WA (including GP trainees, specialist and junior doctors from 97 in 2007 to 319 in 2018) (WAGPET, WACHS and STP).
3. Dedicated procedural rural GPs who stay in the country. The procedural training posts have a 75% retention rate over 10 years (RHW and WACHS).
4. An education and training infrastructure throughout rural WA, with well supported training positions and medical educators and supervisors (WACHS, RCSWA and WAGPET).
5. WACHS is now a PEHS with an intake of 10 interns each year.
6. RCSWA students has increased from around 55 to 90 a year.

These improvements to our capacity to grow the WA rural medical workforce are impressive and because the necessary building blocks are now in place, the RPP will continue to produce doctors with the right skills, matched with the medical service models that respond to the needs of our rural communities.

The Rural Practice Pathway in 2018

Through their efforts, the agencies involved with the Rural Practice Pathway (RPP) have dedicated themselves to working together to deliver the medical workforce needed for the communities in rural WA. This includes public and private, community and hospital generalist GPs and specialists.

Their approach has evolved over time as the initial Pathway objectives were achieved and medical workforce priorities changed. Initially in 2007, the medical workforce situation was so dire that any increase in the number of doctors of any kind working in rural areas was desirable.

The RPP in 2018 continues to have some key features:

1. The Pathway supports doctors with general skills as well as doctors with specialist skills. Each is needed to service our rural communities. No single skill set will satisfy the wide range of health needs in country WA.
2. It continues to be inclusive, open to anyone interested in rural practice from high school students, medical students, prevocational and vocational trainees. It is not restricted to a discipline nor is it a professional pipeline from graduation to practice. There is no selection process for entry or a guaranteed job on completion.
3. It supports the basic building blocks of career pathways for junior doctors, specialists and GP registrars by growing training positions that are rural-based wherever possible.
4. It supports procedural training, it has dedicated Anaesthetic and Obstetric training and mentoring.
5. Mentors help with career advice and support to navigate each individual's pathway.
6. It promotes and supports a shared care service model by supplying both specialists and advanced skilled GPs.
7. It promotes rural medical practice with all agencies seeking to complement each other's work.

As one person described, it is a bit difficult to navigate and the flexibility it offers looks like a lack of clarity and structure to others.

The future direction

We are now at a point in time where there are significant future opportunities and risks.

It is clear that the RPP has not fully marketed nor raised awareness of its collective achievements in recent times. Indeed, many rural doctors would not be aware of the Pathway at all, but they would be very familiar with its key actions, like the mentoring program or the extra registrar and student training positions.

We are also now beginning to see an increasing need to prioritise and emphasise particular skill sets. However, there remains a basic and extensive need for General Practitioners providing traditional primary health care services and, depending on their location, emergency medicine skills consistent with their location and local hospital capability.

Indeed, the wider medical environment in WA has changed considerably with better support through government initiatives such as the Emergency Telehealth Service (ETS) and the Southern Inland Health Initiative (SIHI). There are now many more specialists beginning to work in rural areas and this needs to be carefully planned and managed as communities grow and demand more services.

The recent establishment of the Country Medical Workforce Interagency Committee, led by the Chief Executive, WACHS, incorporates all of the CEOs of the agencies involved in the RPP. This is a timely initiative.

Importantly, this group has already commissioned work to develop a medical workforce strategy for rural WA. This work will ultimately inform the future of the RPP and the required medical education and training plan to contribute towards the future rural medical workforce that our rural communities need.

Clear accountability and a revitalisation of the RPP led by this interagency committee is a welcome development.

A history of rural medical training in Western Australia

EXECUTIVE SUMMARY

It is a worldwide phenomenon that medical workforce issues are most acutely felt in rural and remote areas.

This paper outlines a brief history of rural general practice training in WA, concentrating mainly on the last 25 years.

In the 1990s, rural communities were feeling the pressure of trying to recruit doctors. Much of this was due to changes in legislation and flawed workforce data. The Australian Medical Workforce Committee in 1996 announced that there were 4000 too many GPs in Australia but there was a shortage of 500 in country Australia.

The WA Centre for Rural and Remote Medicine (WACRRM now known as RHW) was established in 1989 to address many of the rural medical issues. Over time, many other government workforce initiatives and agencies were established to support rural practice; most of these continue today.

The shortages at this time were so profound that virtually any initiative to support and increase doctor numbers made sense. The incentives included bonded medical places, relocation grants, training grants, locum support and family support to name a few.

In the late 1990s and early 2000s, it is true to say that without the International Medical Graduates (IMGs) (these doctors could be conscripted to work in rural areas via the Medicare legislation for 10 years), rural WA would have had a critically severe medical workforce crisis. In several centres, some hospital services had to close due to the lack of medical workforce.

WACRRM introduced the Rural Training Unit (RTU) in 1993 to specifically train highly skilled procedural GPs in a vocational training program. This ran until 2001. It was a highly successful program that 20 years on has a 50% retention rate of doctors still working in country WA.

The RTU was highly innovative and well ahead of its time. Working closely with the Royal Australian College of General Practice (RACGP) and its training program, it offered excellent support, procedural training and mentorship.

However, in the early 2000s, there was a major disruption to GP training. The Commonwealth removed funding from the RACGP due to the deteriorating relationship it had with the Rural Doctors Association (RDA). The RDA had set up their own college - Australian College of Rural and Remote Medicine (ACRRM).

This decision led to the Commonwealth funding an independent organisation (GPET) to set up a network of regional training providers across Australia to deliver GP training.

After lobbying of the Commonwealth Government over the dire shortages in Western Australia, the Commonwealth government recognised WA's doctor shortage and supported a significant growth in medical student numbers.

The Commonwealth also agreed with a WA proposal that at least 25% of all these students should come from a rural background. Notre Dame Medical School took its first students in 2005. The Rural Clinical School (RCS) also commenced in 2002 to ensure that at least 25% of medical students spent a year of their training in a rural area.

In the latter 2000s, it became obvious that there was a rare opportunity with more rurally-orientated medical students than ever before wanting to work in the country.

The RCS was highly successful with their students achieving equal or better academic results than their metropolitan counterparts. This showcased that there were untapped opportunities for medical education and training in rural WA. The city hospitals were now being overcrowded with the increased number of medical students and graduates and so a door opened.

The RPP commenced against this background. There was a need to tap into the RCS students and grow well-supported and accredited junior doctor training places for them in the country. In order to do this, all agencies involved in rural medical workforce training joined together to harness their efforts and collectively build the various pathways required. This effort focussed on medical students, interns and junior doctors, in rural community and hospital settings and vocational training for specialists and GPs.

The construct of the Pathway focussed on the rural organisations developing five key areas of medical education and training.

First, it was imperative that the junior doctors did not have to spend all their time in Perth based hospitals during their prevocational years when they made career choices. This is the time when mentors influence their future training choices. Rural based junior doctor training places were expanded and have grown from 29 to 118 over 10 years from 2007-17.

Second, the procedural training of GPs through Joondalup Hospital for Anaesthetics and King Edward Memorial Hospital (KEMH) for Obstetrics has always been prioritised and supported. The RPP coordinates the selection and examination of Anaesthetics candidates and the mentoring programs for both. To have 96 graduates from these two programs, with a 75% retention rate for them working in rural Australia, is a significant achievement over the 10 year period from 2006-2015.

Third, the RPP has always been inclusive of specialists and we now have over 48 accredited specialist training posts in rural WA, when in 2007 there were only seven. This is something to applaud.

Fourth, GP registrars being trained in rural WA has grown from 56 to 153 from 2002-2017 which is another major achievement.

Fifth, an extensive education and training network was established across the regions, many of the medical educators and supervisors working for RCSWA and WAGPET also worked for WACHS.

The aim of these five key areas was to grow the workforce with the right skills in the right place for the community they serve. The success of the rural training programs can be seen through the growth in rural GP numbers and generalist specialists relative to population growth and the growth in rural based training positions for junior doctors, GPs and specialists as follows:

Comparative trends in the number of rural GPs

	Rural GPs +	WA Rural Pop	WA GPs	WA Pop
1993*	332*	409 952*		1 658 544*
2001	462	450 913	2069	1 906 274
2006	556	473 669	2187	2 050 581
2011	699	519 842	2573	2 353 409
2017	992	537 216	3712	2 580 354

Changes in GP participation over the last 25 years*

Footnote
Head count GP numbers are from the Department of Health-General Practice Workforce Statistics.
From 2001, WACRRM has kept a consistent database of rural GP numbers. Prior to that time, the number was determined by a census. In 1993, WACRRM counted the numbers and reported these in a presentation.

The GP registrar numbers are from the RHW datasets, and 2002 workforce report. Population numbers are from the ABS 2014 Historical Data and 2016 Census Quick Stats.

Growth in rural training positions

	2002	2007	2013	2018
PGY1 interns	12	12	27	30
PGY2/3	17 #	24 (7 PGPPP)	60 (13 PGPPP)	88*
Specialist registrars	7	7	28	48
GP registrars	56	54	117	153
Total	92	97	232	319

Footnote
2002 numbers from the Medical Board WA
2007-2018 numbers from WA Country Health Service
GP Registrars numbers are from Ann. Workforce update Rural Health West
In 2002 there were 3 community placements in rural WA, In 2005 the PGPPP commenced with WAGPET and RCS administering these places, by 2013 there were 13 rural community placements, in 2016 the state took over the funding and administration of the 8 community placements.

RECOMMENDATIONS

The consideration of a National Rural Generalist Pathway has focussed attention on the Rural Practice Pathway (RPP), its purpose, its achievements and whether it continues to be the right vehicle to supply the future medical workforce that rural WA needs.

While the RPP is able to demonstrate significant achievements since its inception in 2007, the wider environment has changed, and it is important that the current RPP is reviewed and reinvigorated to ensure it meets the needs of rural communities.

Recommendation 1

The RPP needs to be action orientated and come under the auspice of the Country Medical Workforce Interagency Committee. This recognises that no one single agency has the ability to address the shortages and maldistribution of the medical workforce. All need to work closely and collaborate towards a common agreed objective and not in competition with each other.

Recommendation 2

The collective approach to issues needs to be restored, for example, the establishment of new training places should be a collective effort amongst agencies at a regional level. It should cover specialist and GP training positions, as it did in the past.

Recommendation 3

The achievements of the Pathway to date need to be more broadly communicated with rural doctors and the rural community.

The future work of any rural medical education and training approaches needs to be fully informed by medical workforce analysis. A collaborative approach by the agencies involved needs to be the vehicle through which new initiatives are developed and implemented in response to changing medical workforce and service models.

INTRODUCTION

When the first Western Australian medical school opened in 1957 at the University of WA (UWA), it was hoped that this would at last address the issue of doctor shortages in WA, especially rural WA.

The rural communities raised large sums of money. In fact, 75% of all personal donations came from the country to support the local medical school hoping that finally local medical graduates would service their rural communities.

Unfortunately, this hope did not come to fruition and 60 years later, we are still facing serious doctor shortages and maldistribution. During the last 60 years, many initiatives have been introduced with varying degrees of success.

For the Australian health system to work effectively, it relies on having a fit for purpose medical workforce, which is geographically distributed and has the skills needed to serve the community they work in.

In rural WA, most of the medical workforce has consisted of generalist doctors, mainly General Practitioners. The challenge for medical educators and government is how to train and support this workforce and to encourage these graduates to see a rural career as equally rewarding and professionally satisfying.

Starfield and colleagues, in their report Contribution of Primary Care to Health Systems and Health 2005 have shown that in OECD countries, health systems with comprehensive primary care are the most efficient and effective, both in terms of overall cost and with healthier communities.

They also found that primary care is associated with a more equitable distribution of health outcomes in populations.

As a result, the work being undertaken to support and encourage doctors, especially General Practitioners, to work in rural areas is directly related to the focus on improved health for rural and remote Western Australians.

The medical workforce supply in WA is complex and uncoordinated. There has been a dramatic increase in medical students being trained (from just over 100 in the early 2000s to 300 now and with Curtin students graduating in four years' time this will increase to 400 pa).

For this reason, the agencies involved in educating and training the future rural medical workforce have sought to work collaboratively to overcome the barriers, complexities and take advantage of the large increase in new graduates.

Additional complexity arises from the multitude of training pathways that confront junior doctors and confuse rural communities on what is needed to develop a competent and confident rural doctor, including:

- University: Undergraduate and postgraduate entry, training of 4-6 years. Individual universities select individuals according to selection criteria, government subsidies and with universities taking full fee paying international students.
- Internship: Typically in a hospital for one year. This year is a fully accredited intern year that is overseen by the Postgraduate Medical Council to ensure interns are able to gain full registration with the medical board at the completion of their intern year.
- Junior doctor training: Typically, junior doctors remain in hospitals for up to two years beyond the internship. Some remain for longer periods before joining a vocational training program under one of the 24 medical professional colleges.

- Vocational training: Overseen by one of the 24 medical colleges. The colleges select their trainees, set standards of training and accreditation of training positions. They set the entry standards and award vocational registration to their college members.

Attracting doctors to rural practice

The question that has been pursued over the years is how do we attract doctors into a career in rural practice and especially rural General Practice, where the community needs them most?

The efforts to address the critical maldistribution have been largely successful through sustained effort, but there remains much to do to achieve reasonable equity of access to doctors for the rural communities.

The following table shows the constant increase in rural doctors entering rural practice through the various training pathways open to them under the RPP as well as through other recruitment programs.

This has been an impressive achievement whereby the growth in the number of rural doctors has significantly outstripped population growth in rural WA.

Comparative trends in the number of rural GPs

	Rural GPs +	WA Rural Pop	WA GPs	WA Pop
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The GP registrar numbers are from the RHW datasets, and 2002 workforce report.
Population numbers are from the ABS 2014 Historical Data and 2016 Census Quick Stats.

From 2006 until 2017, the rural GP headcount has increased 78% whilst the rural population has increased by 13%.

At the same time, the headcount of GPs working across the whole of WA has increased by 70% with a population increase of 35%.

These figures show that there has been some progress to redress the maldistribution of GPs in WA, though there is still a long way to go. Indeed, there are still some towns struggling to recruit an adequate medical workforce and still rely on overseas recruitment. Medical education and training efforts can only be part of the solution while shortages still exist. However, the positive sign is that more Australian graduates and trainees are choosing rural practice.

Interestingly, of the current 992 rural doctors, 567 obtained their primary medical degree overseas, however only 16% of these doctors are temporary residents. The rest are Australian citizens, permanent residents or New Zealand citizens.

In 2002, there were 56 GP registrars working in rural WA. In 2017, there were 153, an almost threefold increase. There have been significant increases into rural practice over this time.

THE RURAL PRACTICE PATHWAY

A major recommendation from the Engaging Rural Doctors Report of 2007 was for WA to investigate the Rural Generalist Pathway (RGP) that had been developed in Queensland.

To this end, Rural Health West received a grant from WACHS to undertake the investigation of the RGP in WA.

A meeting was held with the key stakeholders (WACHS, WAGPET, ACRRM, HDWA, RACGP, RCS, PMCWA, AMA DITs) at UWA and via video-conference with the leaders in Queensland including Dr Dennis Lennox.

At the end of this meeting, it was decided that WA needed a different model to the Queensland RGP which was a purely hospital based training model.

WA wanted a training model that supplied the needs of the WA rural community. This included community, hospital, specialists and generalist doctors. It designed a model that defined what services the rural community needs and worked out how these needs can be met by creating a training pathway for medical students and doctors working under supervision. In other words, it was not a pathway for doctors to be selected into but rather a pathway where rural educators and trainers join up to create a seamless pathway for doctors to navigate in their region.

So the initial model called the RPP in WA, was designed for maximum flexibility of entry points. It was designed to be inclusive and support all doctors wanting to work in rural WA.

This would allow undergraduate students to enter the Pathway as well as doctors further along their career who decide they want to go rural. The only way to achieve this was by all the organisations working together.

As part of this model, WACHS was to be established as a Primary Allocation Centre (now called a Primary Employing Health Service) and develop a Rural Generalist Training Unit.

The goal was to develop a training program that forms a career pathway to supply the rural generalist workforce required in rural Western Australia.

Principles

- All career pathways are easy to understand, responsive to need, well supported and resourced and involve key stakeholders.
- Two key outcomes at the end of training - there is vocational recognition by the colleges, and that the program involved hospital based (public and private), and community based (public and private) training.
- Educational standards of the training program will be set externally by the appropriate college.
- The professional standards and vocational requirement of rural Generalist Practice are those prescribed by ACRRM, whereas those of rural General Practice are prescribed by the RACGP.
- The program markets and provides a supported career path from medical school to rural Generalist Practice.
- Vocational training will be provided by GPET. Regional training providers will be rural centric.
- The program is underpinned by mentoring and individual learning and career planning.
- The personal and professional career needs of trainees and their families are accommodated within the workforce.

- Rural generalist trainees have priority access to appropriate accredited HDWA positions (HDWA integrates service placement with prevocational and vocational training in partnership with training providers).

So the basic building blocks of the RPP needed to:

1. Increase the number of accredited training positions in rural WA.
2. Establish WACHS as a PEHS.
3. Attract doctors and new graduates into rural practice.
4. Grow procedural training places.
5. Ensure there was a network of educators and trainers throughout rural WA.

So what has been achieved over the last decade?

Training positions

First, let's look at the number of training positions for junior doctors in rural WA as outlined in the rural training positions table below.

The growth in these positions was enabled by two major funding submissions.

First, the Royalty for Regions submission in 2009 which enabled funding for accommodation and travel for doctors training in rural areas.

Second, the Junior Doctor Business Case in 2010 which funded junior doctors' salaries and the establishment of medical education and training capacity in WACHS.

The growth in accredited training positions in rural areas since 2007 has been extraordinary. In the five years to 2007, the only growth that occurred in rural training places was the prevocational places funded by the Commonwealth. Initially there were three of these. One each in Busselton, Albany and the Kimberley. This grew to 13 in 2013. In the five years after the RPP was established, there was an increase of 135 places or 150%.

In the 10 years since the commencement of RPP, training positions have grown from 97 to 319 or 228%.

At the same time that the state government was investing in medical education, the Commonwealth increased the GP training positions in WA. This was the result of advocacy from the Health Department and WAGPET.

It also established the Specialist Training Positions (STP). These positions allowed WACHS to employ and train specialists under college accredited positions.

Rural training positions

	2002	2007	2013	2018
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Primary Employing Health Services (PEHS)

Despite many efforts and attempts, it took 10 years for WACHS to become a PEHS.

This ranged from a directive from the Director General to the Post Graduate Medical Council to establish WACHS as a PEHS in 2009 after an incident when RPH withdrew its interns from Kalgoorlie when RPH was short of interns itself.

This event occurred prior to the withdrawal of interns in Kalgoorlie due to lack of available supervision.

A full submission was made to the PMCWA in 2010 for WACHS to be accredited as a Primary Allocation Centre. This was not accepted by the PMCWA until a number of conditions had been met including setting up additional educational support systems throughout WACHS.

The importance of being a PEHS is that it allows WACHS to select its own junior doctors, according to its own selection criteria.

Prior to this time, all interns were employed by a Perth based teaching hospital and given rotations to the country. Each teaching hospital had certain country hospitals that they rotated their interns to. Therefore, if an intern wanted to work in a particular regional area, they had to be employed by a particular teaching hospital.

This basically meant that despite multiple efforts of trying to influence teaching hospitals about who they selected to work for WACHS and to give rurally interested doctors priority, none could be given.
WACHS now has an integrated Postgraduate Medical Education Unit throughout rural WA. It has excellent supervisors, accredited positions and medical educators. This has enabled it to be accredited by the Postgraduate Medical Council as a PEHS. Since 2017, it has directly employed ten interns per annum.

Attracting junior doctors to rural practice

There has been much work done on investigating what attracts doctors into rural and General Practice.

The RPP group work together on the careers night organised each year by the Postgraduate Medical Council so that they speak with one voice to promote rural practice.

RHW have devised a program known as Choose Country, which aims to attract medical practitioners into the country. As part of this program, they sponsor medical students to be rural ambassadors. The AMA sponsored the GP Stakeholders Group to seek to encourage doctors to consider a future career in General Practice.

The RCS is over prescribed as are a number of the WACHS junior doctor positions. This demonstrates the success of the programs to date.

Maintaining procedural practice

The report on Maintaining an Effective Procedural Medical Workforce in Country WA highlighted the changes in the rural procedural workforce from 2006-2015.

It showed that whilst the number of GP proceduralists in WA has remained the same, there has been a significant increase in the resident procedural specialists (25% increase). These specialists are concentrated in the regional centres and mostly work in a shared care model with the GPs.

The report also assessed that the growth in hospital activity closely matched the growth in procedural doctors in the right locations. Essentially, the rural procedural workforce kept pace with additional hospital activity.

It highlighted that the turnover rate of GP proceduralists is much lower than that of non-procedural GPs. It also found that the primary source of rural procedural GPs is no longer from overseas (in 2007, 70% of new procedural doctors were from overseas, in 2015, 45% were).

The report also showed that the most successful initiatives since 2007 have been the changed education and training landscape in WA and the procedural training places at KEMH (six places for O&G) and Joondalup (four training places and one available in Bunbury for Anaesthetics).

The procedural training programs have produced 96 GPs with either Obstetrics or Anaesthetics since 2007. 65% of the Obstetric graduates were working in rural WA in 2015, with 76% working in rural Australia.

Of the Anaesthetic graduates, 75% were still working in rural WA in 2015.

Part of the success of both these programs has been the mentoring component that commenced in 2006.

In 2006, RHW highlighted the issue that a number of doctors undertaking procedural training were not confident to utilise their skills independently in rural areas. They sought funding to undertake a pilot Obstetric mentoring program.

The program basically ensured that once a doctor was trained in Obstetrics, they were placed in a supportive General Practice where the supervisor was funded to attend the delivery with the junior doctor if needed. Five positions were supported for six months. A few years later, the Anaesthetics Mentoring Program commenced to ensure trainees who did not feel confident to practice independently were placed in a supportive practice and mentored to gain their confidence. This was made possible through a funded Education Research Grant from GPET and implemented through WAGPET.

In summary, both the extra procedural training places and the introduction of mentoring programs have meant that in the past 10 years, 96 procedural GPs have been trained with a 75% retention rate in rural Australia, a pretty outstanding result.

OTHER MEASURES SUPPORTING THE RURAL PRACTICE PATHWAY

Other measures that were in place and supporting the RPP included:

Establishing year-long employment options in the country

WACHS, RCS and WAGPET came together to visit rural areas, looking at ways of combining Prevocational General Practice Placement Program (PGPPP) places with junior doctor hospital positions so that PGY2+s could stay in one location.

Prior to these positions, it was often difficult to have a full-time option for junior doctors in places like Broome and Derby. PGPPP positions were established in Broome, Derby, Albany, Geraldton and Bunbury.

WACHS employed the doctors and recouped the costs of the community work through the PGPPP.

Career mentoring

There have been various attempts at career mentoring of junior doctors into rural practice.

In 2011, WACRRM, RHW, WAGPET and the RCS attempted to establish an integrated database where any inquiries about rural training could be recorded and trainees would be referred to the most appropriate agency or individual for career advice.

Unfortunately, the database was not fully implemented and the mentoring has been more ad hoc and on a basis of who you know.

This is an area where additional work is needed to have clear contacts to determine and be available to advise on the right path for individual doctors.

Formal partnerships

WACHS and WAGPET entered into a memorandum of understanding (MOU) in 2012 to work together so that data could be shared between the organisations in order to streamline a number of activities in the teaching and training of junior doctor supervisors.

In 2013, WACHS and WAGPET implemented a cross functional service level agreement to streamline the assessment processes for junior doctors. This reduced processing times for interviews and acceptance of candidates for both PGPPP and hospital positions.

WAGPET

WAGPET has always ensured that at least 40% of their GP registrars train in rural WA. They have a regionalised training model, using regional medical educators to support their trainees locally.

The number of rural registrars has grown significantly over the last 10 years as described earlier from 54 GP trainees working in rural WA in 2007 to 153 in 2017.

The most recent research by WAGPET has shown that the last GP placement of a registrar has a significant bearing on where they ultimately practice, meaning these doctors are four times more likely to remain in the practice where they complete their training.

WAGPET chairs the RPP meetings.

WAGPET recently developed an IT program to help trainees plan their training pathway. This program allows rural trainees to define what special skills they need and where they want to work. It then outlines a training program for them to progress through.

Integrated Regional Training Hubs (RCSWA)

In 2017, the RCSWA was funded by the Commonwealth Government to operate the Regional Training Hubs in WA.

No other organisations were approached or able to operate the training hubs.

This built on the successful performance of the RCSWA since 2002 in supporting rural student placements in 14 rural sites and up to 90 students each year.

The RCSWA (supported by the WA medical schools) was able to demonstrate that these rural placements were highly successful with the students achieving equal or better academic results than their metropolitan counterparts.

The rural exposure at this stage was seen as an important support for those considering a future rural career. The aim of the hubs is to expand opportunities and support rural medical training. The primary role of the hubs is to coordinate and develop rural training pathways. They must work with all the rural medical training organisations to support this role in each of their regions. There are three hub sites in WA.

NATIONAL RURAL GENERALIST PATHWAY - DEVELOPMENTS

In 2013, Health Workforce Australia held a number of meetings between jurisdictions to investigate how a national pathway might work and released a Draft National Framework for the Rural Generalist Pathway (RGP).

This led to the development of a project in WA to investigate how a RGP might work in WA. This proposal was not supported by WACHS or WAGPET on the grounds that it was too narrow and concentrated too much on the education and training resources on too few.

National Rural Health Commissioner

The Commonwealth Government recruited a National Rural Health Commissioner in 2017. His first priority is to investigate and report to the government on the development of a National RGP.

The future for rural medical training

We are now at a point in time where there are significant future opportunities and risks.

The Commonwealth wants to support a National RGP that will allow rural generalist doctors to be a protected title. This will ultimately require the approval of the COAG Health Council.

This approach has been argued and lobbied by ACRRM and the rural doctors as the solution to Australia's rural medical workforce issues. However, in WA and probably other jurisdictions, it clearly will not, on its own, address the medical workforce issues.

In normal circumstances, an initiative of this type needs to have clear supporting evidence that it will successfully address the prevailing medical workforce issues and must have the support of the jurisdictions to proceed.

Neither has yet occurred with the National RGP.

A particular reservation about the establishment of a protected title under the National Law is that it will establish an industrial demarcation between Rural General Practitioners and Rural Generalists. This is what the argument between ACRRM and the RACGP was all about in the 1990s.

While it is reassuring that the Commonwealth is committed to making sure Australian Trained Doctors want to work in rural areas, this must be done in a manner that meets the needs of both the doctors and communities. Both GP colleges are committed to having a quality, accessible GP workforce. The issue will be how this is achieved so that it does not have any unintended consequences. It must relate to the service models delivering services in rural WA. There is a great opportunity if we do this right.

As Dr Brian Williams described in his speech to the RACGP in 1997, "It is true that different vehicles (GPs) will cross the bridge (go rural) - some will be Rolls-Royce (fully procedurally trained) - these are few and far between in our workforce, in the country, and in WA, represent less than 10% of the total medical workforce.

Most (rural GPs) are general run of the mill vehicles - very sound economic and viable vehicles. It is useful to note that many of these doctors travel to rural practice and return to city practice - in fact in my experience, this is the norm - very few choose a lifelong commitment to rural practice.

Other matters of the psychosocial nature may cause a return to city practice. This does not preclude the further move to rural practice at a later date."

It is our job to make sure there are roads for all of these vehicles to best serve the rural communities, Rolls-Royce and the standard sedan. We need to show each and every one of them how to go rural and how to have a smooth transition if the need arises to return to the city.

HEALTHfix consulting

A walk through the decades of Rural Medical Education

A WALK THROUGH THE DECADES

THE 1980s

The Family Medicine Program (FMP) that commenced in the 1970s continued to educate doctors into General Practice under the auspices of the RACGP until 1993 when it morphed into the RACGP training program. They supported rurally interested doctors in obtaining rural General Practice positions.

In 1985, there was general unrest in country WA and nationally with media reports and parliamentary questions around the difficulty in obtaining rural medical practitioners.

In 1986, there was the Country General Practice Training, a program run by Royal Perth Hospital (RPH). It admitted two doctors per annum to undertake procedural training posts. It was a four year program with two years spent at RPH and two years in a North West hospital.

Kamien Report 1987

A Ministerial Inquiry into the shortage of country medical doctors was undertaken in 1986/87 with Prof Max Kamien as the chairman. The major recommendation from the report was the establishment of the WA Centre for Rural and Remote Medicine (now known as Rural Health West) to undertake the implementation of a number of recommendations aimed at increasing the recruitment and retention of rural doctors.

The centre was established in the Department of GP at UWA in 1989 with a grant from the state government. At this time, there were 258 rural GPs (36 females and 222 males). In addition to this number, there were 93 specialists and salaried doctors. The Kamien Report emphasised the need for training and education support for rural doctors. Amongst many of its recommendations, it highlighted the research showing that doctors from a rural background were more likely to work in the country and suggested a rural quota for medical schools..

THE 1990s

The Rural Training Unit 1993-2001

In 1992, WACRRM sourced funding from the Commonwealth Government via RHSET (Rural Health Support Education and Training Grant) funding. This grant enabled WACRRM to establish the Rural Training Unit (RTU). It was funded under a three year contract, after which time the state government funded the RTU through its grant to WACRRM.

The RTU established a program based at Fremantle Hospital that was designed to provide a comprehensive four year postgraduate training program. The program equipped potential rural doctors with all the skills they needed to practise in rural areas.

The program worked closely with the RACGP training program. It is important to remember that at this time the Rural Faculty of the RACGP had just started (1992) and had no formal curriculum.

The program enrolled five registrars per annum. The first year was highly formalised, with some flexibility in the later years. Registrars were mentored and supported to undertake their specific

training in the second, third and fourth year. Some did surgery, some did both Anaesthetics and Obstetrics, whilst others did extended medical terms, or more Anaesthetic terms.

In every case, the training was sourced by WACRRM and some were funded as supernumerary positions. This was the case for Anaesthetics, for the GP rotations during their residency at Fremantle Hospital and for Surgery.

First Year Fremantle Hospital Resident

- 10 weeks - A&E at Kalgoorlie
- 10 weeks - Rural GP - Kalbarri/Kalgoorlie/Donnybrook
- 10 weeks - Coronary Care FH
- 10 weeks - A&E Fremantle Hospital
- 10 weeks - Elective

Second and Third Year

- 6 months - Paediatrics - PMH
- 6 months - Obstetrics - Osborne Park, Wanneroo
- 6 months - Anaesthetics - RPH, FH, SCGH
- 6 months - Rural General Practice

Fourth Year

- 6 months - Rural General Practice
- 6 months - Elective

The program had an attrition rate of around 20% in the first few cohorts. It had annual intakes of five registrars (there were seven in a couple of years) from 1993 until 2000.

Of the 40 registrars in the program that I have been able to follow up with, 19 of them are still working in rural WA with one working rurally interstate. This means that 50% of the doctors are still working in rural Australia 20 years on. Many others have worked for significant periods in rural Australia, only ending up back in the city after years of dedicated service to their rural community.

A large number are also involved in teaching with either the Rural Clinical School or the Remote Vocational Training Scheme. A quote from one of them highlights this, "We had a fantastic education, which has made many of us want to provide excellent educational opportunities to the new rural students so that they will feel supported to stay in the country".

All the trainees I spoke to thought very highly of the program. They cited the ease of obtaining their training needs and the mentoring and career support as outstanding. They also highly valued the camaraderie of the group; each year a conference was held which brought together all trainees and their spouses for a weekend. Here they could discuss issues and help support one another. In addition to their rotations, there were a series of lectures and tutorials delivered to the registrars.

So why did the program cease?

I think there are two main reasons. First, it was a very expensive program that had been given some one-off funding which was no longer available and WACRRM at that time was in a poor financial position.

The second and biggest reason is that during the 1990s, the RACGP had developed a rural training curriculum and there was now a stream of rural trainees as well as the trainees in the RTU. Although this group may not have been as dedicated as the RTU trainees, they were numerically much larger.

The RACGP rural stream trainees were having difficulties obtaining procedural training posts and this was leading to some disharmony. So the issue was one where a decision had to be made between training a small but highly dedicated group of trainees or support a larger more diverse group.

The latter prevailed.

THE NEW CENTURY

With the breakdown of relationships between ACRRM and the RACGP, rural training became a political hot potato. It resulted in a major overhaul to General Practice training.

In 2000, Dr Wooldridge as the Federal Health Minister announced he would remove responsibility for GP training from the RACGP into the hands of an independent body - General Practice Education and Training (GPET). GPET was to establish a network of regional training providers. WAGPET was formed in 2002 by an alliance between rural and urban GP organisations and individuals in WA. From 2002 - 2004, UWA, under the school of Primary Aboriginal and Rural Health Care, was contracted to undertake major components of GP training.

During this time, junior doctor numbers were low in WA (just over 100 per annum as they had been for the last 30 years) and the argument between the two General Practice colleges had resulted in less and less doctors interested in General Practice.

In 2005, WAGPET decided it needed to become more engaged with its delivery of GP education and training and set up its own infrastructure to support this role, through a number of Regional Advisory Committees. Regional training had become a fundamental cornerstone of GP training for WAGPET. At the same time, WAGPET and WACRRM continued to support procedural training through Anaesthetics at Joondalup and Obstetrics at KEMH.

Simultaneously, RCSWA started taking its first students. In 2002, it commenced with seven students across four sites for a six month period. This grew to 22 students in 2003. Notre Dame students joined the RCS in 2007 and today there are 90 students across 14 sites.

The RCS has proved to an initially sceptical group of academics that excellent training can and does occur in the country. It has given students interested in rural practice opportunities to train and live there. Research from the RCS shows that students from a rural background who are RCS students are five times more likely to end up working rurally than other students. RCS has also been able to grow a dedicated network of rural medical educators and researchers throughout rural and remote WA.

WA now had rural opportunities for medical students and GP registrars but there was an obvious gap, that of the junior doctor training opportunities.

Addressing the junior doctor training gap

This is the time that many trainees make their vocational decisions. Perth based hospitals did not offer many opportunities for doctors to experience rural practice, General Practice or community based practice.

This gap was letting doctors interested in rural practice be persuaded by mentors in the city to undertake other vocational training options.

In 2005, the Prevocational General Practice Placement Program (PGPPP) commenced across Australia (a forerunner program known as the Remote and Rural Area Placement Program had been in place since 1998). The PGPPP was also morphed into the Community Residency Program, which allowed junior doctors to undertake part-time GP and hospital work at the same time.

The Commonwealth Government ceased funding this program in 2014 after which time the state continued funding it fully for a 12 month period; however over time this has slipped so that today there are eight rural community residency placements.

In 2005, Notre Dame Medical School commenced as a postgraduate medical school in WA. One of its main objectives was to help address the rural shortage of doctors. At this time, it was felt that any increase in medical student numbers would help alleviate the shortages. The theory at the time was more doctors would eventually mean they would have to go out to the places where they are most needed.
In 2006, WACHS contracted WACRRM to undertake the Engaging Rural Doctors Project. A committee of organisations involved in the rural medical workforce oversaw this project. Each organisation was committed to the project and to make sure any recommendations relevant to their organisation were enacted to the best of their ability. Over 361 (64%) rural doctors were consulted during this project.

One of the major recommendations was for WACHS and WACRRM to consider the application and implementation of the Queensland Rural Generalist Program (RGP). Another was for WACRRM, WAGPET and RDAWA to develop succession plans to support rural procedural GPs. This latter recommendation resulted in the report commissioned by WAGPET on Maintaining an Effective Procedural Workforce in Rural WA. The former recommendation resulted in the establishment of the RPP.

CHRONOLOGY OF EVENTS IN MEDICAL PRACTICE TRAINING IN WA

- **1958**: The Australian College of GPs is established. WA had established its own faculty in 1956. Its aim was to improve the health and wellbeing of all Australians by supporting GPs, as well as medical education of the undergraduate, recent graduate and those already in practice.
- **1965**: Apprenticeship based optional GP training.
- **1969**: The Royal Australian College of GPs was established.
- **1973**: Health Insurance Act and Medibank established. Family Medicine Program established and funded.
- **1976:** UWA establishes the department of GP.
- **1988:** The College adopts a policy on vocational registration and decides that from January 1992 that the fellowship will only be awarded after appropriate training and assessment. The vocational register commences in 1989.
- **1987:** Ministerial inquiry into the rural medical workforce is headed by Prof Max Kamien. Its recommendations establish WACRRM.
- **1988:** Doherty Report questions quality of GP education.
- **1989:** Senate Select Committee recommends Vocational Registration Register and restriction of provider numbers. VR established with differential Medicare rebates for VR and non VR doctors.
- **1989:** WACRRM established.
- **1991:** The Rural Doctors Association of Australia was formed.
- **1992:** RDAA procured a grant from the Commonwealth Government to develop an advanced curriculum for training in Anaesthetics, Surgery and Obstetrics as part of a dedicated rural training pathway. This grant was given to the RACGP to develop a specific rural pathway.
- **1992:** The establishment of the Faculty of Rural Medicine of the RACGP.
- **1992:** WACRRM is successful in getting a RHSET grant to trial a four year rural training program.
- **1993:** First intake of the WACRRM Rural Training Unit.
- **1993:** FMP becomes the RACGP Training Program with no quota (830 trainees).
- **1995:** Quota of 400 places for GP training with selection process.
- **1996:** Medicare Provider Number legislation is enacted, restricting access to Medicare numbers to those doctors who have completed their training or are in a training program.
- **1996:** The criteria for rural fellowship of the RACGP is finalised as a graduate diploma.
- **1997:** The Australian College of Rural and Remote Medicine is established with the aim to establish rural and remote medicine as a broad but discrete form of General Practice.
- **1998:** Remote Vocational Training Scheme trialled.
- **2000:** Agreement with Joondalup Hospital to continue training GP Anaesthetists as part of Rural Training Unit.
- **2000:** GP training is to be transitioned from the RACGP to the AGPT, with the Commonwealth Government able to specify funding to support workforce planning and management, to commence in 2002.
- **2001:** The final intake of Rural Training Unit registrars.
- **2002:** WAGPET was established. Its foundations were to focus on quality GP training, quarantined regional GP training funding, a rurally dominated board and have a small

Perth based office. From 2002-2004, the University of WA undertook the training of GP registrars.

- **2002:** Rural Clinical School takes its first students.
- **2005:** WAGPET established its regionalised training model. This ensured that rural WA was supported to train GP registrars.
- **2005**: University of Notre Dame commences its four year postgraduate medical course.
- **2005:** Queensland establishes its Rural Generalist Training Program.
- **2005:** PGPPP is established in all states and territories.
- **2006:** Engaging Rural Doctor recommendation was made to establish a Rural Generalist Training Program in WA.
- **2007:** ACRRM accredited as an alternative General Practice endpoint and RTPs start training to FACRRM.
- **2007:** Maintaining an Effective Procedural Rural Workforce review.
- **2007:** WA establishes its Rural Generalist Training Committee.
- **2008:** Royalties for Regions supports funding of accommodation and travel for rurally based junior doctors in WACHS hospitals.
- **2009:** Junior Doctor Business Case funds additional rural junior doctor positions and education and training units across rural WA.
- **2010:** Specialist Training Program starts with 360 places nationally, now 900.
- **2013:** Health Workforce Australia establishes a National Rural Generalist Committee.
- **2016:** Maintaining an Effective Procedural Workforce in Rural WA second review.
- **2017:** Commencement of the Curtin undergraduate Medical School.
- **2017:** Appointment of a National Rural Health Commissioner whose role is to establish a National Rural Generalist Pathway.
- **2017:** Rural Clinical School is funded by the Commonwealth to establish Integrated Regional Training Hubs.

ACKNOWLEDGEMENTS

This project was initiated by Western Australian General Practice and Training (WAGPET) to ensure that all those involved in rural medical training in WA could understand the successes and lessons learnt from previous training programs.

Special thanks to those who gave up their time to talk to me and remember the past. As Dr Peter Maguire quoted, "History is not truly objective but written through the eyes of the winners either political or military." In this history, I have tried to keep it as much as possible to the facts and attached a chronology of events as they happened.

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Dr Colleen Bradford	WAGPET
Dr Peter Maguire	RCSWA
Prof David Atkinson	RCSWA
Dr Andrew Kirke	RCSWA
Dr Sarah Moore	RCSWA
Dr Peter Smith	Rural GP
Dr Lorri Hopkins	Rural GP
Dr Karl Staer	Rural GP

Also thanks to WAGPET, WA Country Health Service (WACHS), Rural Clinical School (RCS) and Rural Health West (RHW) for sharing their data and stories with me.

Most of the data pertaining to rural GP numbers has been sourced through the Rural Health West Minimum Data Set reports over the years 2009-17. These include historical information to show data trends. Also sourced from them was the workforce analysis undertaken by Rural Health West in 2002, the RHSET grant report to the Department of Health in 1996/7, the Kamien Report and RHW annual reports 1997-2017. So thanks to Leslie, Rosalie and Julie for helping me find all the information.

WAGPET has let me access their records for all the information pertaining to the RPP, prevocational and vocational training.

WACHS Postgraduate Medical Unit helped me with the numbers of training positions now available throughout WACHS.

RCS gave me the information on RCS numbers and growth over the years.

I sourced the information on the RTU through presentations done by the late Dr Brian Williams, information in annual reports and discussions with previous training unit registrars and medical educators.